

AAMD ANNUAL MEETING · 2026

From Hub to Leader: How Dosimetrists Can Improve Workflow

Teams · Power · Psychology · Performance — A Dosimetrist's Field Guide

1



1

The Human Element

What actually drives job performance — emotional intelligence, self-awareness & the Big Five personality model

2



"The human condition has three basic activities: labor, work, and action."
- Hannah Arendt

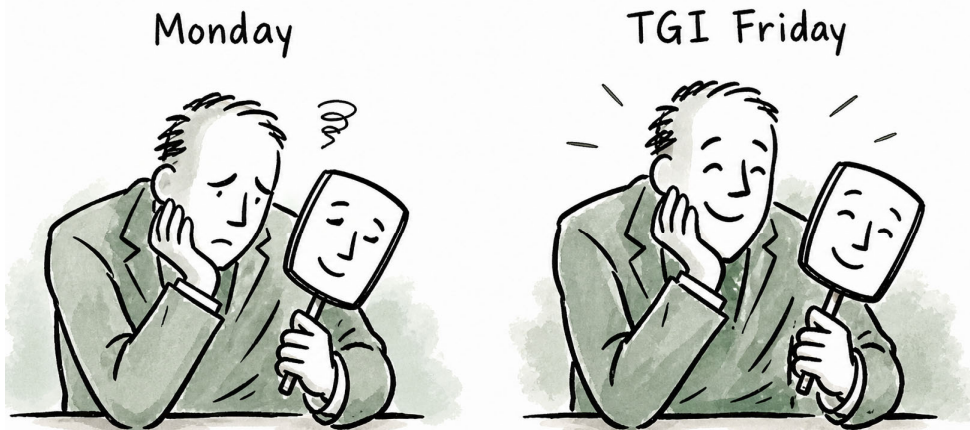
HANNAH ARENDT: 3 LEVELS

≡ A FRAMEWORK FOR MEANINGFUL WORK ≡

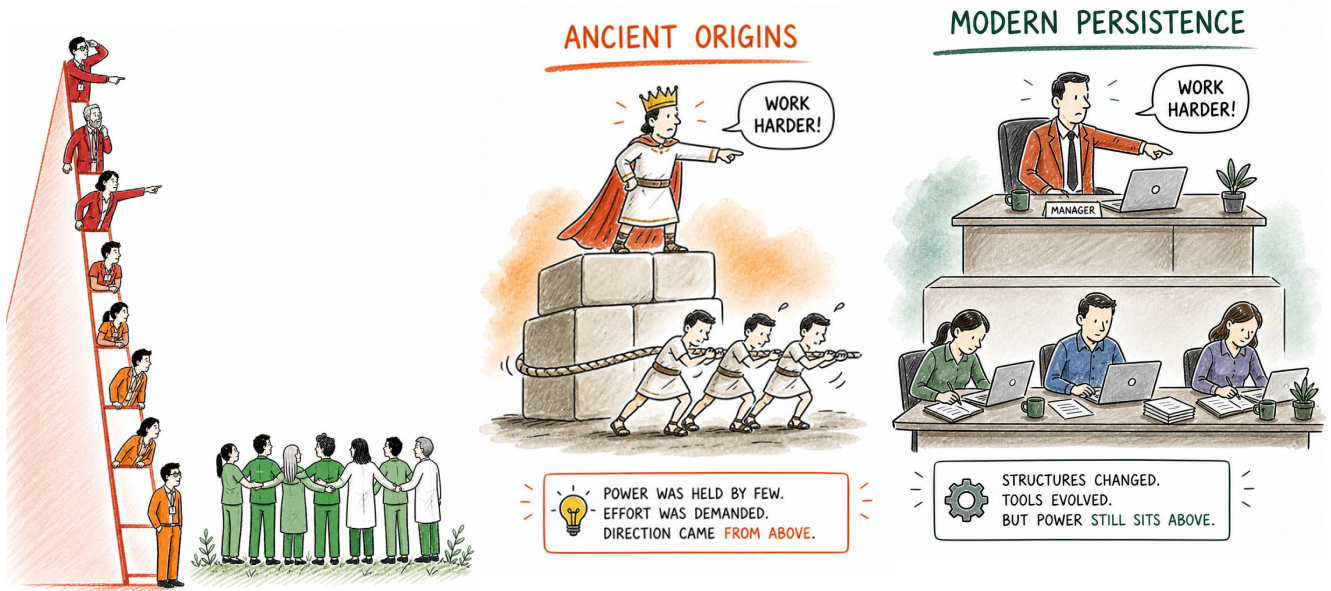


| | | | | |
|---|--|--|--|--|
| <p>1 LABOR Sphere of necessity and sustenance.</p> | <p>The activities we perform to sustain life. It is cyclical, necessary, and never-ending.</p> <p>Basic needs Survival Care for self & others Repeats daily</p> | | <p>KEY POINTS</p> <ul style="list-style-type: none"> ✓ Provides income and stability ✓ Supports health and family ✓ Offers professional status ✓ Foundation for a good life | |
| <p>2 WORK Sphere of making and building.</p> | <p>The activities that build and create the world of things we use and rely on. It produces something durable and valuable.</p> <p>Creates value Builds & designs Quality & mastery Leaves a durable impact</p> | | <p>KEY POINTS</p> <ul style="list-style-type: none"> ✓ Applies knowledge and skill ✓ Creates something of value ✓ Contributes to patient outcomes ✓ Takes pride in craftsmanship | |
| <p>3 ACTION Sphere of plurality and political freedom.</p> | <p>The activities through which we appear before others, speak, initiate, and create together. It is unpredictable, irreversible, and creates history.</p> <p>Speaks & is heard Builds relationships Shapes direction Changes the common world</p> | | <p>KEY POINTS</p> <ul style="list-style-type: none"> ✓ Influence without authority ✓ Voices ideas and concerns ✓ Builds alignment ✓ Shapes decisions informally ✓ Creates culture and trust ✓ Enables collective progress | |
| <p> LABOR gives security. WORK gives meaning. ACTION gives freedom. ALL THREE ARE NEEDED FOR A FULFILLING PROFESSIONAL LIFE.</p> | | | | |

Action is important in life and politics



Time has changed, but management is same



5

A 100-year-old management method is still in place!

COMMAND-AND-CONTROL

F. W. Taylor (early 1900s)

Managers think. Workers execute.



BELIEFS:

- ✓ Break work into tasks
- ✓ Measure and control
- ✓ Standardize behavior
- ✓ Trust is low

RESULT:



EMPOWERED KNOWLEDGE WORK

Modern mindset

People closest to the work help improve the work.



BELIEFS:

- ✓ People have judgment
- ✓ Teams solve problems
- ✓ Leaders remove barriers
- ✓ Trust enables change

RESULT:



6

3

Patient Safety status

2024 SENTINEL EVENT REPORT: KEY TAKEAWAYS

The Joint Commission Annual Review



1 1,575 REPORTS

1,575

↑ 12% above 2023

Reported sentinel events received in 2024

2 MOST COMMON EVENTS

| | |
|---------------------------------------|-----------|
| Falls | 776 (49%) |
| Wrong surgery | 127 (8%) |
| Delay in treatment | 126 (8%) |
| Suicide / self-inflicted injury death | 122 (8%) |
| Retained foreign object | 119 (8%) |
| Violence-related | 65 (4%) |

3 OUTCOMES

| | |
|--------------------|-----|
| Severe harm | 49% |
| Death | 21% |
| Moderate harm | 21% |
| Mild harm | 5% |
| Psychological harm | 2% |
| No harm | 2% |

4 IMPORTANT CAUTION

Reporting to The Joint Commission is voluntary.

These data should not be used to infer actual national event frequency or trends over time.

WHAT THIS MEANS

- Serious safety events continue to reveal system vulnerabilities
- Falls remain the dominant reported category
- Learning should focus on systems, communication, and shared understanding
- Use the data to learn — not to blame.

Source: The Joint Commission. Sentinel Event Data 2024 Annual Review (2025).

Why should we care?

1. ACTION GIVES WORK MEANING

WHAT SHOULD WE DO NEXT?

- OPTION A: Adjust Process
- OPTION B: Try New Approach
- OPTION C: Escalate Issue

DECISION ✓

Let's choose Option B and reassess.

The level where people make decisions about their own work is where meaning lives.

Arendt

2. OUR STRUCTURES CAME FROM ANOTHER ERA

They were designed to coordinate effort from above — not judgment

Laloux

3. POLICY-LED SAFETY HAS NOT CLOSED THE GAP

POLICY
CHECKLISTS
COMPLIANCE

SEVERE HARM (REPORTING)

2004 2024

After twenty years of policy-led safety work, severe harm is still rising.

The Joint Commission

When Apple was a fruit

When Amazon was a river

Before 'Google' was even a word



Power & Influence

The six bases of power, how authority affects empathy, and how dosimetrists lead without a title

LUKES, 1974 — POWER: A RADICAL VIEW

Power is not just who makes the call.

1 FIRST DIMENSION (VISIBLE POWER)

Power that is exercised openly in decision-making.



- Open decisions
- Visible authority
- Easy to see and challenge

EXAMPLE: A policy is decided by leadership and announced.

2 SECOND DIMENSION (HIDDEN POWER)

Power that shapes the agenda by controlling what gets discussed.



- Controls the agenda
- Limits options
- Questions don't get asked

EXAMPLE: Staffing levels are never discussed, so workload issues persist.

3 THIRD DIMENSION (INVISIBLE POWER)

Power that shapes beliefs, values, and what people think is possible.



- Shapes beliefs and norms
- Limits imagination
- Keeps the status quo in place

EXAMPLE: "We've always done it this way" stops ideas before they start.

Only 3 of 6 require a title.

1 LEGITIMATE POWER

Power that comes from a position or role.



- Comes from a position or role
- Official authority
- People comply because they have to

2 REWARD POWER

Power that comes from the ability to provide rewards.



- Comes from the ability to reward
- Can motivate and encourage
- People comply because they want to

3 COERCIVE POWER

Power that comes from the ability to punish.



- Comes from the ability to punish
- Can force compliance
- People comply because they fear

4 EXPERT POWER

Power that comes from knowledge, skills, or expertise.



5 REFERENT POWER

Power that comes from being liked, admired, or respected.

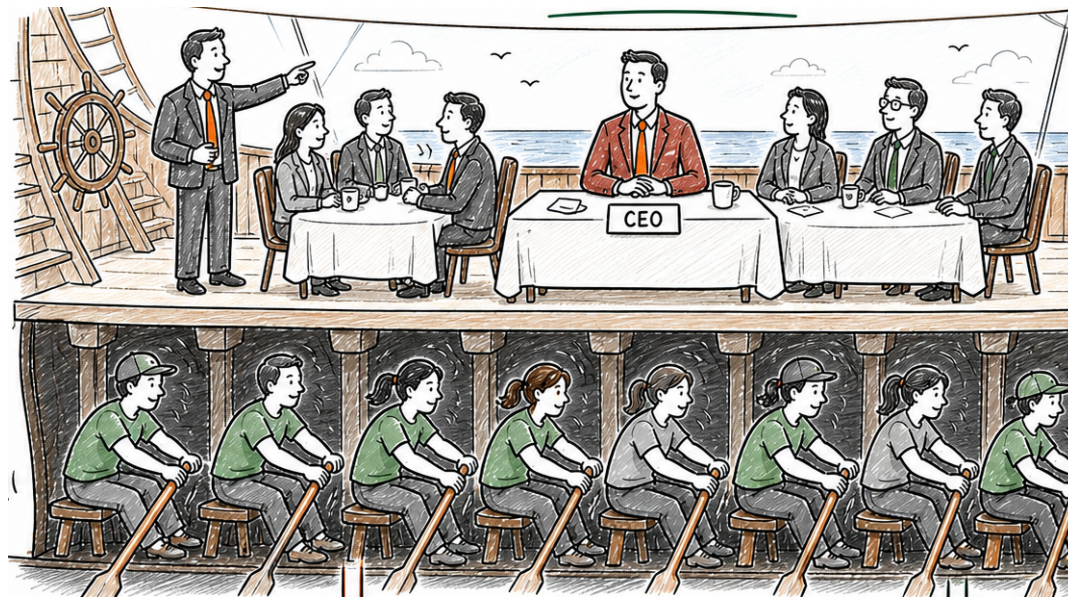


6 INFORMATION POWER

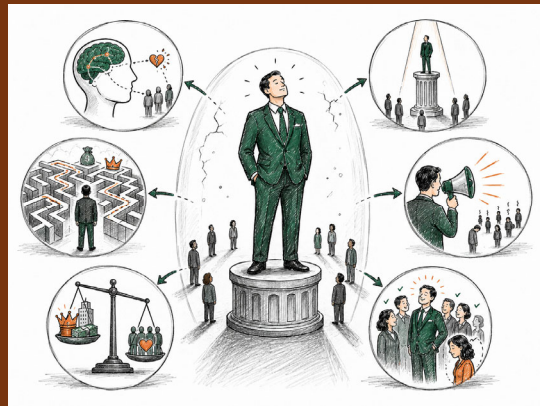
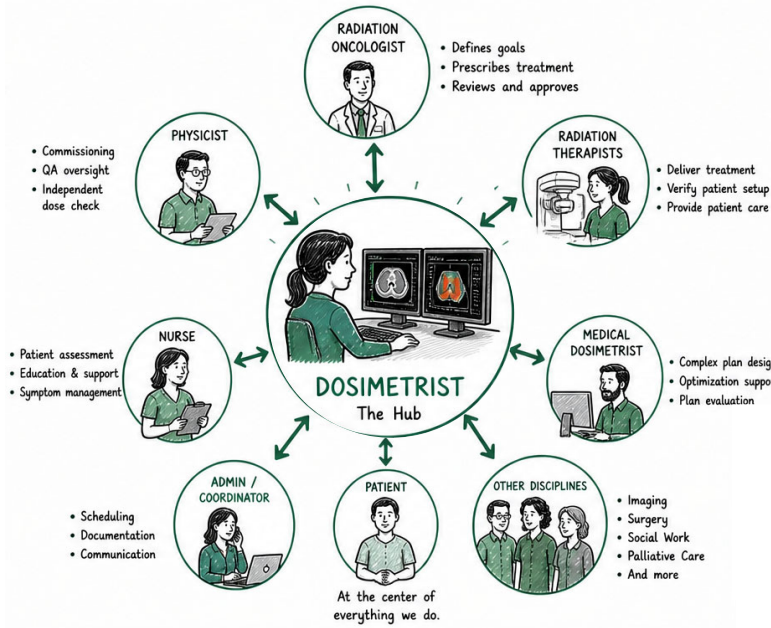
Power that comes from controlling or possessing valuable information.



Who is doing the work?



The most valuable node isn't always the most senior.



The Ethics of Power

Neuroscience and psychology of power

Power Changes what we are!

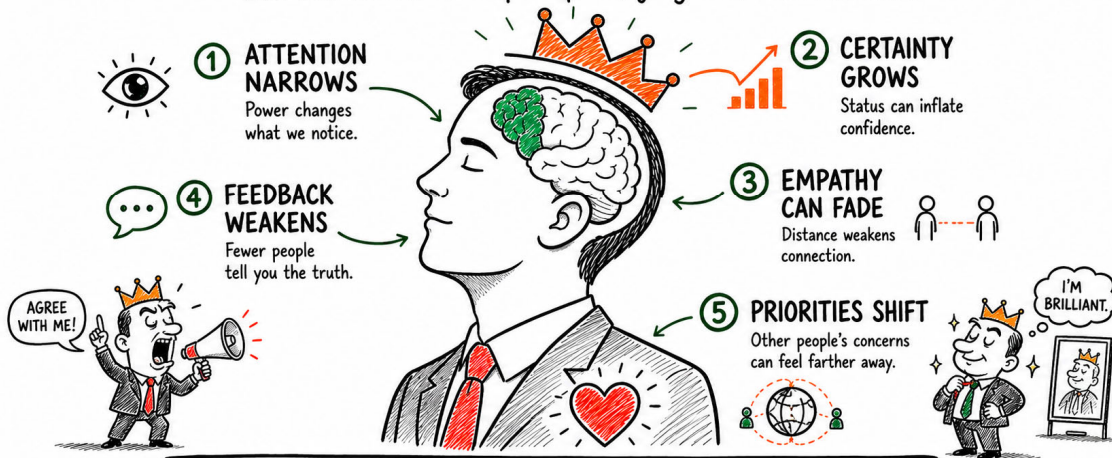


I've got the power

When Power Goes To Your Head, It May Shut Out Your Heart

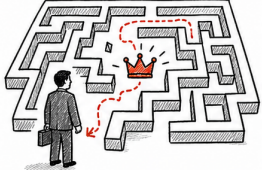
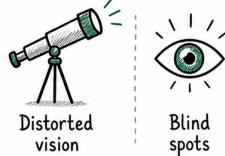



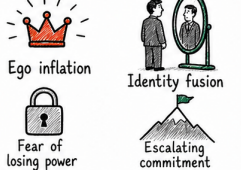
POWER CHANGES THE OBSERVER

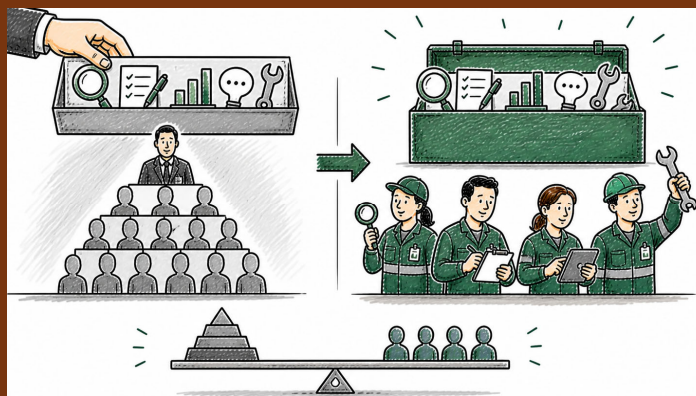
How status can alter perception, judgment, and connection.



★ Power can change perception, judgment, feedback, priorities, and connection. ★

Corporate morality

| | | |
|---|---|--|
| <p>1. THE MAZE OF POWER</p>  <p>You gain power. You can get lost in the maze.</p> | <p>2. POWER CHANGES WHAT YOU SEE</p>  <p>Distorted vision Blind spots</p> <p>Perspective narrows; risk becomes harder to see.</p> | <p>3. POWER CHANGES WHAT YOU HEAR</p>  <p>Silenced voices Isolation Reduced accountability</p> <p>Feedback weakens; truth travels poorly.</p> |
| <p>4. POWER CHANGES WHAT FEELS URGENT</p>  <p>Shifting priorities Disconnected from impact</p> <p>Urgency shifts; consequences feel farther away.</p> | <p>5. POWER CHANGES WHAT YOU JUSTIFY</p>  <p>Rationalization Justifying the means</p> <p>You explain away what once felt wrong.</p> | <p>6. POWER CHANGES WHO YOU ARE</p>  <p>Ego inflation Identity fusion Fear of losing power Escalating commitment</p> <p>Power becomes personal; changing course feels like loss.</p> |



The Hierarchy Asks for These Tools. Now Use Them to Level the Field.

Huddles · Peer Review · QI Meetings · ILS · Multidisciplinary Teams · Policy & Procedure —
six structures already in your department that can redistribute power if used with
intention

Compliance vs Alignment

ILS USED FOR COMPLIANCE ONLY

BOSS UP THERE
Are we 100% compliant?
✔ Policies exist
✔ Training done
✔ Audits done
✔ Check the box
DONE.

FRONTLINE DOWN THERE
It's locked up. Not for us.
ILS
⊗ Just compliance
⊗ Checkboxes ticked
⊗ Archived, no feedback
⊗ No learning
⊗ Same risks remain
⚠ LOOKS GOOD ON PAPER. RISKS STAY IN PLACE.

COMPLIANCE IS THE GOAL. PROTECTION IS THE PRIORITY.

ILS USED FOR IMPROVEMENT

BOSS UP THERE
Are we 100% compliant?
✔ Policies exist
✔ Training done
✔ Audits done
✔ Check the box
DONE.

FRONTLINE DOWN THERE
PROCESS MAP
RCA
💡
✔ Learning every day
✔ Issues surfaced early
✔ RCA finds root causes
✔ Fixes make a difference
✔ Risks go down
🛡️ GETS BETTER EVERY DAY. PATIENTS ARE SAFER.

IMPROVEMENT IS THE GOAL. PATIENT SAFETY IS THE PRIORITY.

Safety and Quality Tools in Healthcare

1. DAILY HUDDLE

Share risks. Plan together.

2. PEER REVIEW

Learn from each other.

3. QI MEETING

Improve systems. Track impact.

4. INCIDENT LEARNING SYSTEM

Report safely. Learn together.

5. MULTIDISCIPLINARY TEAM

Different skills. One purpose.

6. POLICY & PROCEDURE

Clear, consistent, fair.

Safety and Quality Tools in Healthcare

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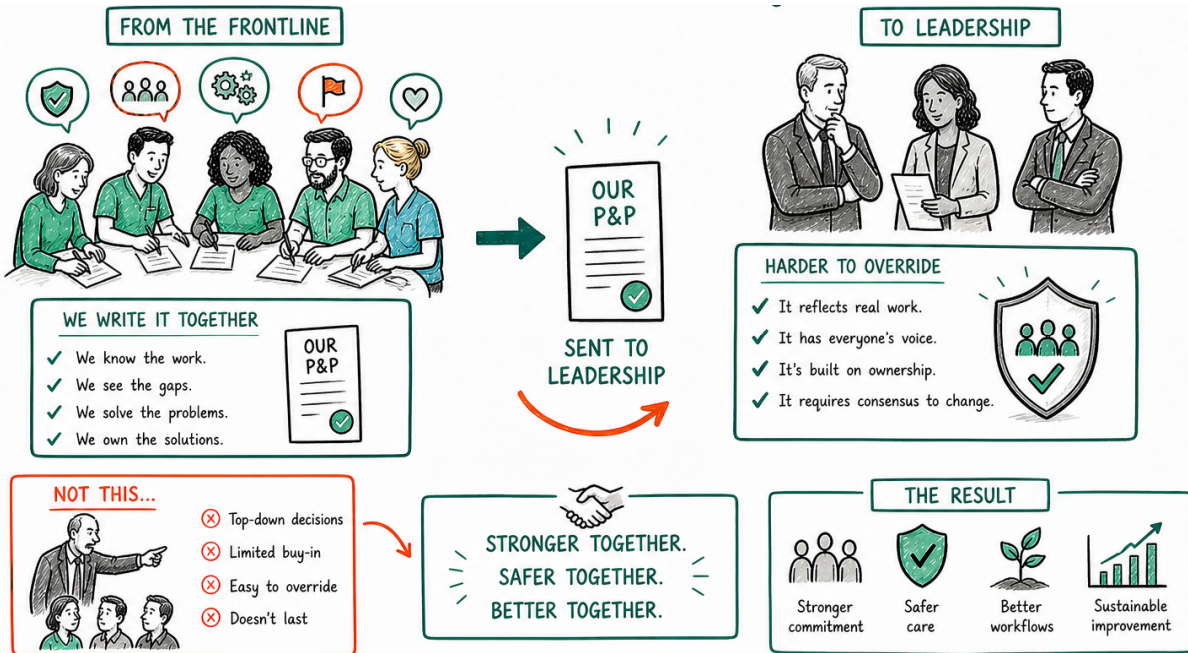


Clear, consistent, fair.

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POLICY & PROCEDURE — CO-AUTHORSHIP AS A POWER-BALANCE TOOL

A P&P written by everyone is harder to override by one.



1 1

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Meeting charters

1. Rank Parity



Every role. Equal voice.

2. Leader Speaks Last



Hear the team first.

3. All Ideas Welcome



No idea is too small.

4. Structured Voice



One at a time. Listen fully.

5. Co-Authored



We build it together.

6. Post the Charter



Visible. Revisit. Hold us accountable.

Meeting charters

WITHOUT A CHARTER



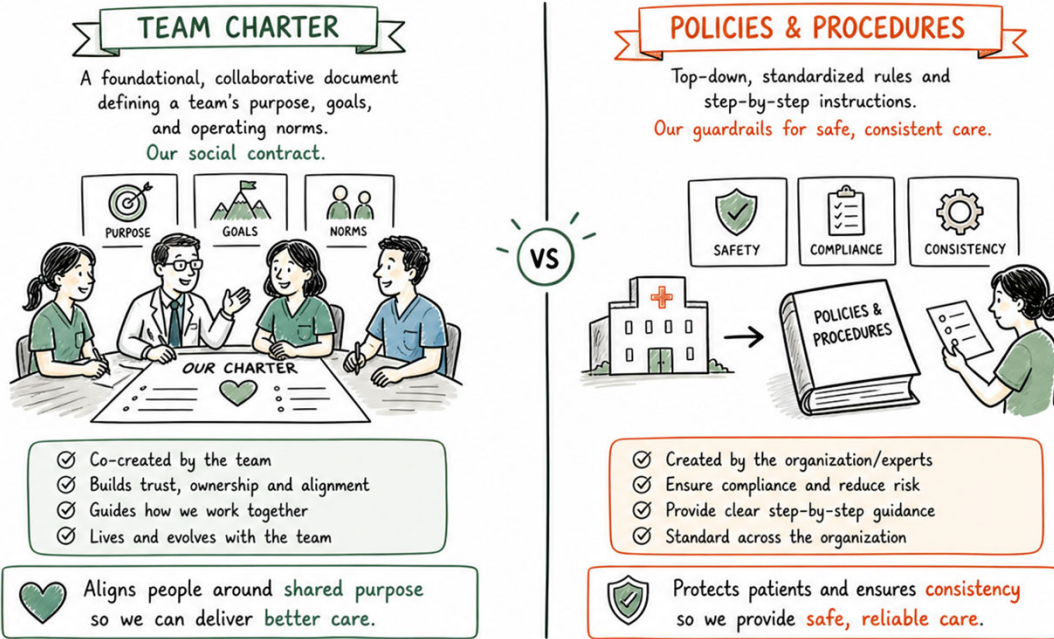
-  **⊗ UNCLEAR PURPOSE**
-  **⊗ SIDE CONVERSATIONS**
-  **⊗ HIERARCHY DRIVEN**
-  **⊗ DISENGAGED**
-  **⊗ WASTED TIME**

WITH A CHARTER

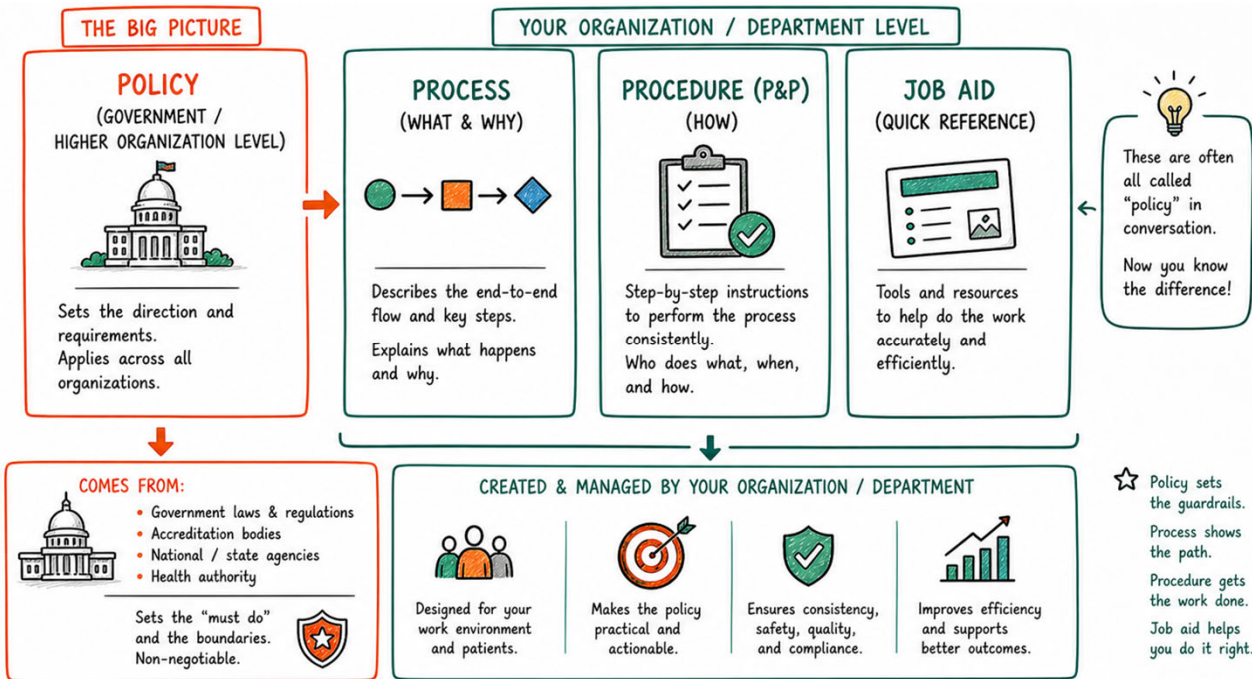


-  **✓ CLEAR PURPOSE**
-  **✓ INCLUSIVE PARTICIPATION**
-  **✓ SHARED OWNERSHIP**
-  **✓ EFFECTIVE DECISIONS**
-  **✓ BETTER OUTCOMES**

Meeting charters



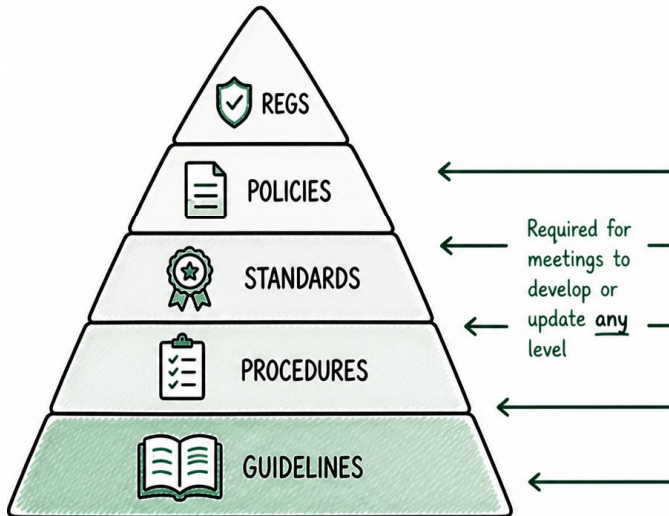
Policy and Procedure



Policy & Procedure

THE STRUCTURE (WHAT)

What we develop and maintain



THE CHARTER (HOW)

How we work together in any meeting

MEETING CHARTERS are required to develop or update any of these.

- Equal voice (rank parity)
Everyone has a voice.
- Leader speaks last
Encourages openness.
- Structured dialogue
Disagree well. Stay curious.
- Psychological safety
Safe to speak up. Safe to challenge.
- Clear purpose & follow-up
Align, decide, own, and review.

STRUCTURED VOICE TOOLS — REPLACING OPEN DISCUSSION

Open discussion is not neutral. Highly Paid Person Opinion (HiPPO) effect.

OPEN DISCUSSION

- Director speaks — 3 min
- Senior physician agrees
- RTT stays silent
- New dosimetrist stays silent

HiPPO wins. Best idea never surfaces.

ANONYMOUS POLL

- Director: 1 vote
- Physician: 1 vote
- RTT: 1 vote
- New dosimetrist: 1 vote

Best idea wins. Regardless of who had it.

THE PROBLEM

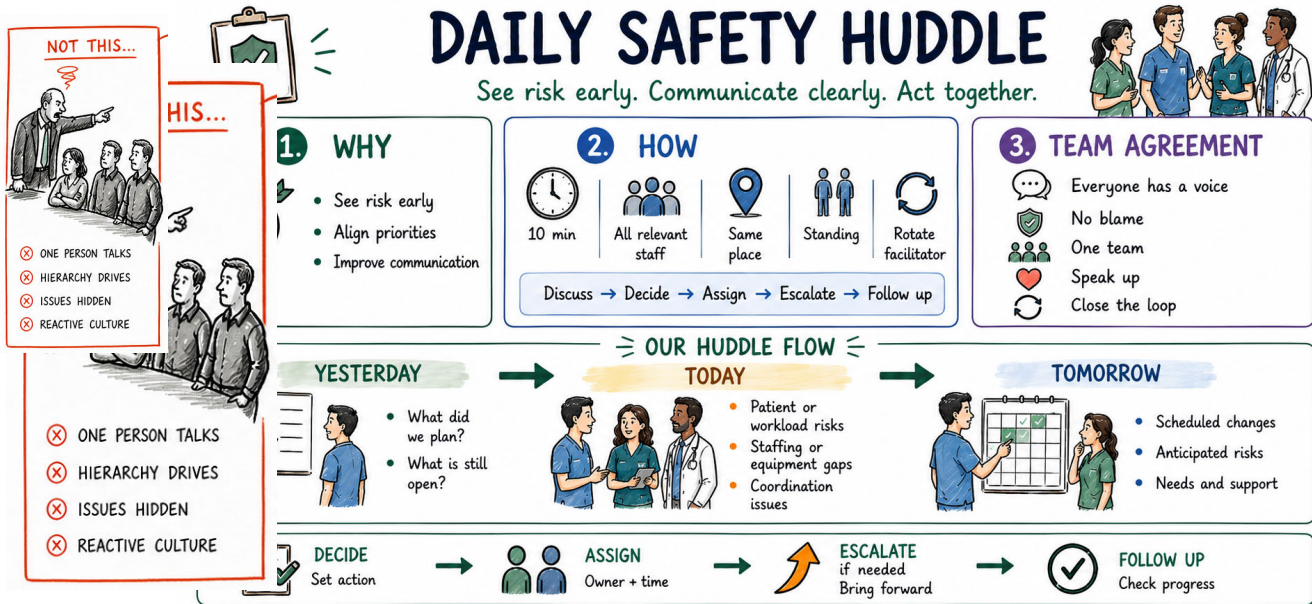
- Ideas get shut down early.
- Groupthink goes up.
- Better solutions get missed.

THE BETTER WAY

- More voices. Better insights.
- Stronger decisions.
- Everyone contributes. Everyone wins.

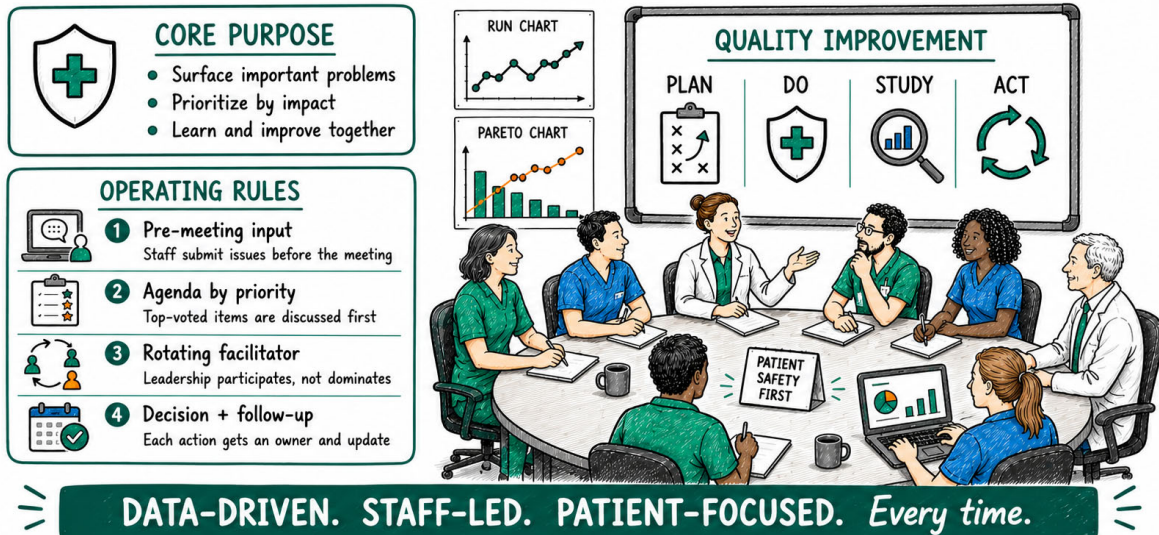
LEADERSHIP ISN'T ABOUT BEING HEARD FIRST. IT'S ABOUT CREATING SPACE FOR THE BEST IDEAS TO EMERGE.

Huddle charter/P&P



QUALITY IMPROVEMENT MEETING CHARTER

A staff-led, data-driven forum for solving patient-safety and workflow problems.



Risk Assessment

1. POLICY

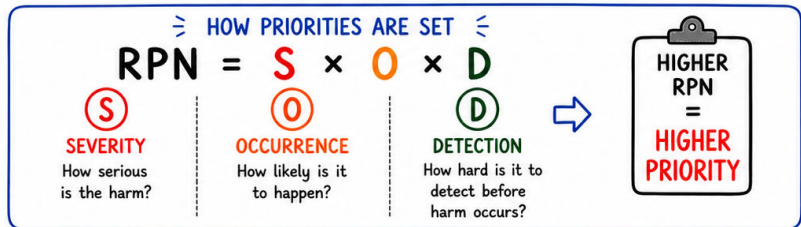
- Assess risk proactively
- Prevent harm
- Prioritize action
- Learn before failure reaches the patient

2. PROCEDURE

- Select the process
- Form a multidisciplinary team
- Complete the 6 FMEA steps
- Prioritize top risks
- Assign owners and timelines

3. WHEN TO USE

- New process or equipment
- Process change
- Incident or near miss
- Repeated safety concern
- Annual review



Risk assessment

1. THE INCIDENT (LONG TIME AGO)

Electron therapy patient.
No dosimetrist available for consult.
Delays happened.

No dosimetrist available... We have to wait.

2. REACTIVE RESPONSE

A reactive manager ordered:
Dosimetrists on-site. Every day!

| EVERY DAY | | | | |
|-----------|-----|-----|-----|-----|
| MON | TUE | WED | THU | FRI |
| ✓ | ✓ | ✓ | ✓ | ✓ |
| | | | | |
| | | | | |
| | | | | |

- ▲ Blanket rule
- ▲ High cost
- ▲ Low precision
- ▲ Not sustainable

3. QI TEAM TAKES IT FORWARD

1 Bring to attention of QI team

"We had delays in electron cases when dosimetry input was needed."

2 Risk assessment (Using TG-100 mindset)

| | | |
|---------------|----------------|------------------------------------|
| Severity (S) | Occurrence (O) | Detectability (D) |
| Moderate-High | Rare | High (visible at scheduling stage) |

RPN (OxSxD) → VERY LOW
Risk is conditional, not constant.

3 Root Cause (Better RCA)

Not: No dosimetrist present.
But: No anticipatory process for identifying electron cases that need dosimetry support.

4 Better, Smarter Solution

Process-based control instead of blanket rule.

- Daily huddle includes next-day cases
- Electron case flagged in advance
- IF electron + complexity → dosimetrist present at simulation

5 P&P REVISED BY QI TEAM

Co-authored. Reviewed. Approved.

6 POWER SHIFTED TO WHERE THE WORK IS

FROM: Top-down one-size-fits-all
TO: Shared ownership by those who do the job

- ✓ Right support
- ✓ Right time
- ✓ Right cases
- ✓ Better care
- ✓ Sustainable system

RCA2: Utilizing tools to address issues

1 EVENT HAPPENS AGAIN & MANAGER REACTION
Same electron delay next day.

Didn't I say so?
We need stricter control!!

2 TEAM LOGS IN ILS
Capture the event as a signal.

Event Type: Workflow / Coordination

✓ No blame. Just data.

3 5 WHYS IN QI MEETING
Find the root cause.

WHY? Why did the delay happen again? Tomorrow's schedule was not reviewed.
WHY? Why was it not reviewed? It was not consistently discussed in huddle.
WHY? Why not consistently? Depends on facilitator memory.
WHY? Why memory-dependent? No structured checklist.
WHY? Why no checklist? Huddle process not standardized at that level.

ROOT CAUSE: No checklist to ensure review of tomorrow's schedule.

4 INTERVENTION
Fix the system gap.

HUDDLE CHECKLIST

- Review patient list
- Review new starts
- Review tomorrow's schedule (Flag special cases: electrons, SBRT, etc.)

TRIGGER / RULE
If special modality → Dosimetrist consult at simulation.

5 UPDATE P&P & OWNERSHIP
Make it standard.

Huddle checklist and P&P updated.

Reviewed by multidisciplinary QI team. Shared ownership. Not top-down.

6 PDSA CYCLE
Test, learn, and improve.

PLAN Add checklist to huddle.

DO Implement in huddles.

STUDY Track missed cases and outcomes.

ACT Adjust as needed. Standardize what works.

Fewer misses. Better consistency. Safer care.

Vulnerability is power not weakness

A LEADER SHOULD BE VULNERABLE.

— BRENE BROWN

NOT THIS

I HAVE THE ANSWERS.

FOLLOW MY PLAN.

TRUST ME.

- ✗ Pretends to be certain
- ✗ Hides doubt
- ✗ Creates distance

THIS

I DON'T HAVE ALL THE ANSWERS.

I NEED YOUR PERSPECTIVE.

LET'S FIGURE THIS OUT TOGETHER.

- ✓ Acknowledges uncertainty
- ✓ Shares openly
- ✓ Builds connection and trust

Safety and Quality Tools in Healthcare

THE OLD WAY: ANNUAL REVIEW



Review once a year.
Often rushed.
Often disconnected from reality.



THE PROBLEMS



⊗ Outdated before it's even used.
Reality changes daily.



⊗ Staff work around it.
Compliance drops.



⊗ Missed opportunities to improve safety and quality.



⊗ Treats documents like paperwork, not tools for care.



Result: Documents don't work.
People stop trusting them.

THE RIGHT WAY: CONTINUOUS IMPROVEMENT

PUT IT IN PRACTICE



SOMETHING HAPPENS



ENTER IN ILS



DISCUSS IN HUDDLE / QI

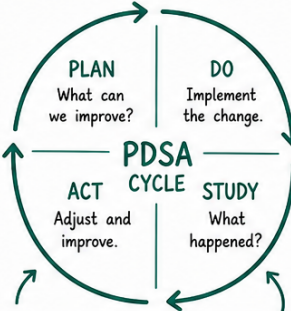


UPDATE P&P



DRIVEN BY REALITY

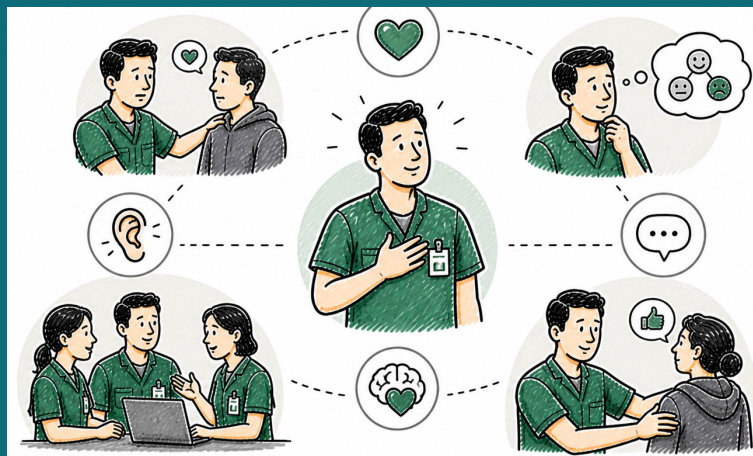
- Staff experience
- Patient impact
- Safety events
- Data & trends



RESULTS

- Safer care
- Better outcomes
- Stronger teamwork
- Trusted & used by all

Small changes. Often.
Big impact. Always.



Emotional Intelligence

Leading across difference — how CQ shapes safer, more effective healthcare teams

Most of us think we're self-aware. **Most of us are wrong.**

EMOTIONAL INTELLIGENCE

The Hidden Driver of Performance

75% of performance differences are explained by **EI**.

1. SELF-AWARENESS GAP

Most people think they are self-aware.



Believe they are self-aware



Actually are (externally validated)

Source: Tasha Eurich, Harvard Business Review (2018)

2. WHAT THIS MEANS



In teams:
The least self-aware person creates the **biggest risk**.



In healthcare:
Blind spots → decision errors → **patient risk**.

3. SUPPORTING STATS

According to Daniel Goleman:



50%

Emotional intelligence (EI)



25%

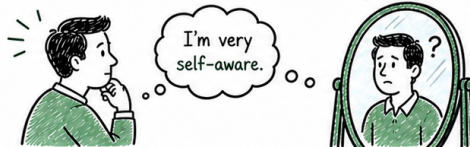
Technical skills (expertise)



25%

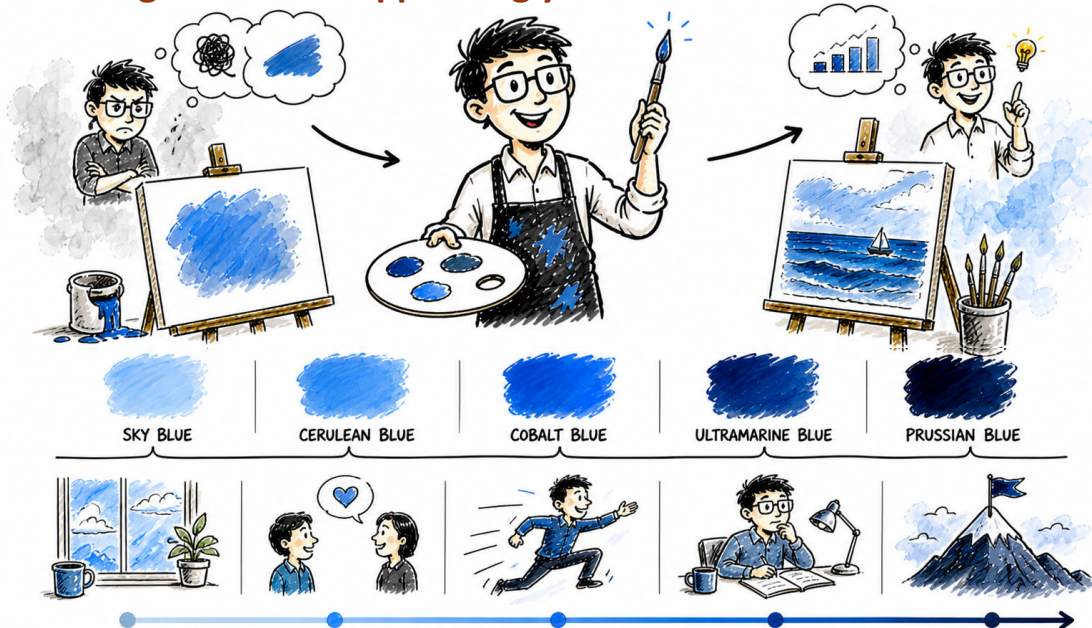
IQ (cognitive ability)

Source: Goleman, D. (1998). What Makes a Leader? Harvard Business Review.



Leaders with low self-awareness create **high-risk systems**.

Emotion Intelligence is not suppressing your emotion



EMOTIONAL INTELLIGENCE

≡ Goleman's 5 Components ≡

? WHAT IS IT?

Understanding ourselves and others to make better choices.

★ WHY IT MATTERS

- ✓ Better decisions
- 👥 Stronger relationships
- 🛡️ Greater resilience

📁 AT WORK

EI helps us lead, collaborate, and thrive.



1 SELF-AWARENESS



Know your emotions.

- Awareness

2 SELF-REGULATION



Manage your emotions.

- Self-control
- Adaptability

3 MOTIVATION



Stay driven and focused.

- Purpose
- Achievement

4 EMPATHY



Understand others.

- Perspective
- Compassion

5 SOCIAL SKILL



Connect and work well with others.

- Communication
- Teamwork

HOW EI SHOWS UP EVERY DAY

Notice how I'm feeling.



Pause before I react.



Focus on what matters.



Try to understand others.



Speak and listen with respect.



THE IMPACT

- 👥 Stronger teams
- 💜 Healthier culture
- 📈 Better outcomes
- 🌱 Sustainable success



EI is not about being nice. It's about being **aware**, **in control**, **motivated**, **empathetic**, and **socially effective** — especially when it matters most.



Empathy

1 PITY



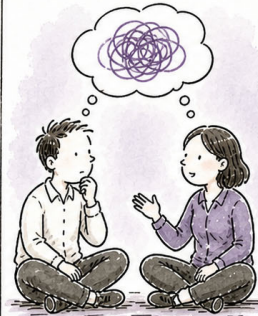
I feel bad for you.

2 SYMPATHY



I feel for you.

3 EMPATHY

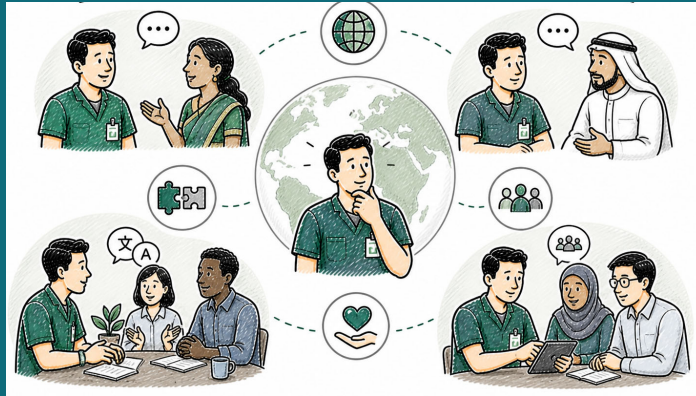


I understand how you feel.

4 COMPASSIONATE



I'm with you. Let's get through this together.



Cultural Intelligence

Leading across difference — how CQ shapes safer, more effective healthcare teams

Culture Map, Erin Meyer

Cultural Intelligence is the ability to work effectively across cultural differences.

1 COMMUNICATING
 Low-context ↔ High-context
 USA (Low-context): THE REPORT IS LATE. PLEASE SEND IT BY 3 PM.
 JAPAN (High-context): IT WOULD BE GOOD IF WE COULD ALIGN TIMELINES A BIT MORE CLOSELY...
 SAME MESSAGE. ONE SAYS IT. THE OTHER HOPES YOU NOTICE IT.

2 EVALUATING (FEEDBACK)
 Direct ↔ Indirect negative feedback
 NETHERLANDS (Direct): THIS SLIDE IS CONFUSING.
 USA (Indirect): THIS IS GREAT... MAYBE JUST A TINY TWEAK HERE...
 AMERICANS SANDWICH CRITICISM. DUTCH PEOPLE SKIP THE BREAD.

3 PERSUADING
 Principles-first ↔ Applications-first
 FRANCE (Principles-first): LET'S START WITH THE PRINCIPLES... HERE IS THE THEORY...
 USA (Applications-first): HERE'S THE SOLUTION. HERE'S THE ROI. DONE.
 ONE CULTURE WANTS THE EQUATION. THE OTHER WANTS THE ANSWER.

4 LEADING
 Egalitarian ↔ Hierarchical
 SWEDEN (Egalitarian): LET'S HEAR EVERYONE'S IDEAS!
 CHINA (Hierarchical): THE BOSS DECIDES.
 IN SOME CULTURES, THE BOSS IS FIRST AMONG EQUALS. IN OTHERS, HE'S... JUST FIRST.

5 DECIDING
 Consensual ↔ Top-down
 JAPAN (Consensual): 10 MEETINGS... EVERYONE ALIGNED...
 USA (Top-down): I'VE DECIDED. WE'RE DOING IT.
 DECISION!
 SOME CULTURES TAKE FOREVER TO DECIDE... AND THEN EXECUTE PERFECTLY. OTHERS DECIDE INSTANTLY... AND SPEND MONTHS FIXING IT.

6 TRUSTING
 Task-based ↔ Relationship-based
 GERMANY (Task-based): LET'S REVIEW THE CONTRACT AND GET STARTED.
 BRAZIL (Relationship-based): LET'S HAVE DINNER FIRST... THEN WE CAN TALK BUSINESS.
 IN SOME CULTURES, YOU EARN TRUST BY DELIVERING RESULTS. IN OTHERS, BY SHARING A MEAL.

7 DISAGREEING
 Confrontational ↔ Avoids confrontation
 FRANCE (Confrontational): I TOTALLY DISAGREE! HERE'S WHY!
 JAPAN (Avoids confrontation): I SEE YOUR POINT... (BUT I THINK DIFFERENTLY)
 IN SOME CULTURES, ARGUING MEANS YOU CARE. IN OTHERS, IT MEANS SOMETHING HAS GONE VERY WRONG.

8 SCHEDULING
 Linear-time ↔ Flexible-time
 GERMANY (Linear-time): MONDAY 9:00 AM 9:00.
 BRAZIL (Flexible-time): 9:00 MEANS WE'LL GET THERE AROUND THEN.
 IN LINEAR CULTURES, TIME IS MONEY. IN FLEXIBLE CULTURES... TIME IS NEGOTIABLE.

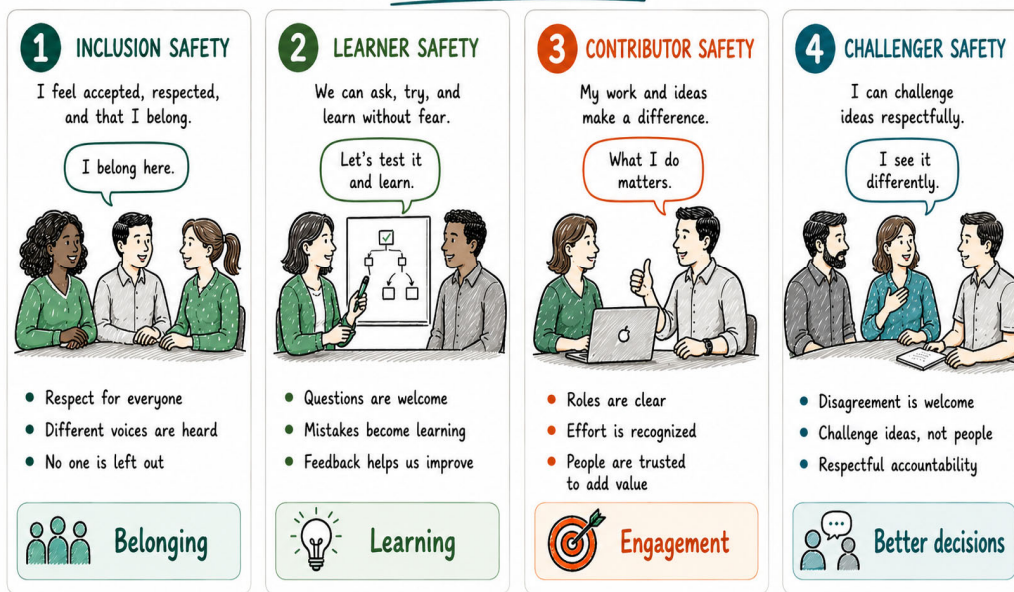
Psychological Safety

The four stages that determine whether your team can include, learn, contribute, and challenge — without fear

Fearless Organization, Amy Edmondson

Psychological Safety

Four Stages of Psychological Safety



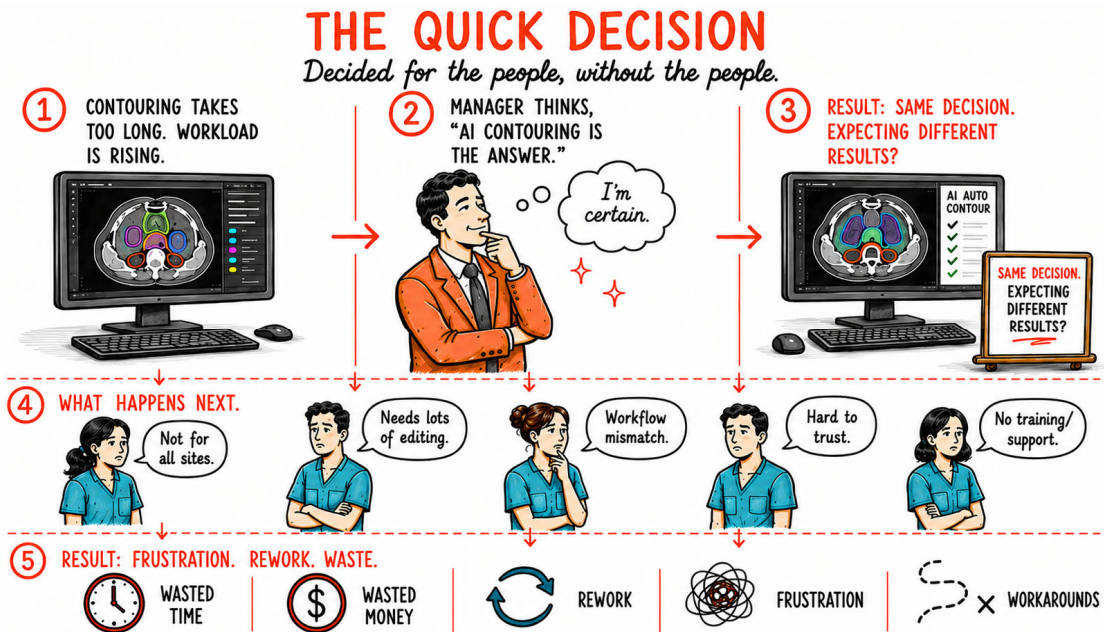
8

Our Iceberg Is Melting

Kotter's 8-Step Model for leading change — through the lens of a penguin colony

Our Iceberg is Melting—John Kotter

Change Management



Change Management

The Systems Approach to AI Contouring

with Kotter's 8-Step Overlay

The people closest to the contouring work understand the workflow.

1 Log the issue in ILS / QI
Kotter 1 – Create urgency

Enter the concern into the ILS or QI agenda.

Contouring burden, variation, delays, and rework are increasing.

2 Gather input from the right people
Kotter 2 – Build a coalition

Form a small working group: physicians, dosimetrists, physicists, therapists/smg, and IT as needed.

Accuracy, Editing burden, Site coverage, Integration

3 Compare vendor options
Kotter 3 – Form a vision

Compare different AI contouring vendors to find the best fit for our context (patient mix, disease sites/case types, workflow, and resources).

Option A, Option B, Option C

4 Compare against what matters
Kotter 4 – Enlist support

Volunteer frontline users can help evaluate the options using practical criteria: accuracy, editing burden, site coverage, integration, QA transparency, and cost.

| CRITERIA | OPTION A | OPTION B | OPTION C |
|-----------------|----------|----------|----------|
| ACCURACY | ✓✓ | ✓✓ | ✗ |
| EDITING BURDEN | ✓ | ✓✓ | ✗ |
| SITE COVERAGE | ✓ | ✓✓ | ✗ |
| INTEGRATION | ✓ | ✓✓ | ✗ |
| QA TRANSPARENCY | ✗ | ✓✓ | ✗ |
| COST | \$ | \$\$ | \$\$\$ |

★ BEST FIT

5 Decide together and remove barriers

Choose the best-fit option with the people who will use it. Address training, trust, coverage, workflow integration, and exception handling.

6 Pilot the best-fit option
Kotter 6 – Create short-term wins

Pilot selected sites. Measure contour quality, edits needed, time saved, and user experience.

7 Refine and expand
Kotter 7 – Sustain acceleration

Use feedback from the pilot to improve the workflow, expand carefully, and update training and QA.

8 Anchor the new workflow
Kotter 8 – Anchor the change

Make the new workflow part of policy, onboarding, QA, QI review, and culture.



What Makes Teams Work

The four evidence-based components that separate a group of professionals from a genuinely effective team

Tuckman's Stages of Group Development

1 FORMING

Getting to know each other.



FOCUS

- Orientation
- Clarifying goals
- Building initial connections



Uncertainty is normal.

2 STORMING

Differences surface. Tension rises.



FOCUS

- Address conflict
- Encourage healthy debate
- Establish respect



Discomfort creates clarity.

3 NORMING

Understanding grows. Ways of working emerge.



FOCUS

- Build trust
- Define roles
- Create team norms



Alignment builds momentum.

4 PERFORMING

The team works well together and gets results.



FOCUS

- Leverage strengths
- Stay adaptable
- Keep communication open



Focus drives high performance.

5 ADJOURNING

Task complete. Transition ahead.



FOCUS

- Celebrate wins
- Capture lessons
- Plan the transition



Close well. Carry forward.

1 COHESION

"We belong together."

The bond that helps people feel like one team.



Belonging



Connection



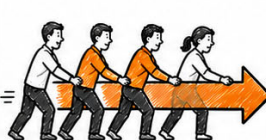
Interdependence

Do we feel like a team?

2 COOPERATION

"We pull in the same direction."

Shared goals, clear roles, and support under pressure.



Shared goals



Role clarity



Support

Are we aligned?

3 COMMUNICATION

"How we talk shapes performance."

Clear, respectful communication helps teams succeed.



Listening



Clarity



Speaking up

How well do we communicate?

4 TRUST

"I can rely on you."

Confidence in each other's intentions and reliability.



Reliability



Good intent



Consistency

Can I count on you?

WHAT MATTERS MOST

COMMUNICATION — NOT IQ, SKILL, OR INDIVIDUAL TALENT



Interaction patterns beat individual traits.

THREE KEY FACTORS

1 ENERGY

Frequent, rich exchange.



2 ENGAGEMENT

Everyone participates.



3 EXPLORATION

Reach beyond the core team.



★ How a team communicates matters more than what any one member knows.

1 COMPETENCE TRUST

“I trust your ability.”

You can do what you say you can do.



Can you deliver?

2 INTEGRITY TRUST

“I trust your character.”

You do what is right, even when it costs you.



Can I rely on your principles?

3 BENEVOLENCE TRUST

“I trust your intentions.”

You want good outcomes for me too.



Do you care about my good?



Trust grows in three layers: ability, character, and care.



Every team is vulnerable to these — including yours.

① GROUPTHINK

The team suppresses dissent to preserve harmony.



Trigger: Leader signals the answer early

Fix: Cognitive diversity

② SOCIAL LOAFING

People exert less effort when responsibility is shared loosely.



Trigger: No clear owner

Fix: Assign named owners

③ THE ASCH EFFECT

People conform to group judgment even when they doubt it.



Trigger: Confident majority opinion

Fix: Independent input before discussion

10

The Evidence Arsenal

When authority pushes back — the guidelines, mandates, and research already on your side

You are not proposing something radical. You are proposing what the evidence already requires.

THE HIERARCHY (NO EVIDENCE)

Decisions are based on opinion, power, and "that's how we've always done it." Challenge is punished. Change is resisted.

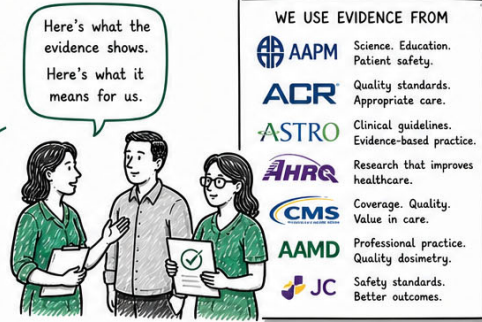


- ⊗ No data.
- ⊗ No context.
- ⊗ No accountability.
- ⊗ High risk.
- ⊗ Poor outcomes.
- ⊗ Burnout and turnover.

THE RESULT

THE EVIDENCE-BASED TEAM

Decisions are based on best available evidence, expertise, and shared responsibility. We speak up. We check the facts. We improve care.



WE USE EVIDENCE FROM

- AAPM** Science. Education. Patient safety.
- ACR** Quality standards. Appropriate care.
- ASTRO** Clinical guidelines. Evidence-based practice.
- AHRQ** Research that improves healthcare.
- CMS** Coverage. Quality. Value in care.
- AAMD** Professional practice. Quality dosimetry.
- JC** Safety standards. Better outcomes.

- ✓ Best available evidence
- ✓ Shared accountability
- ✓ Better decisions
- ✓ Lower risk
- ✓ Better outcomes
- ✓ Stronger team
- ✓ Higher trust
- ✓ Better care for patients

THE RESULT











When They Say It — What You Can Say Back

Evidence-grounded responses to the 34 organizational phrases that push safety out of the narrow corridor

What they say, what you can say









AUTHORITY & SILENCING · PART 1 OF 2

When hierarchy decides whose concerns count.

| | |
|---|--|
| <p>WE HEAR THIS...</p>  <p>"That's above your pay grade."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>AHRQ TeamSTEPPS Two-Challenge Rule overrides authority gradient for patient safety.</p> |
| <p>WE HEAR THIS...</p>  <p>"You are a newbie" / "You are outdated."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>Using tenure as a silencing mechanism is a safety culture failure pattern.</p> |
| <p>WE HEAR THIS...</p>  <p>"Bring me solutions, not problems."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>AHRQ's PSNet requires near-miss reports regardless of attached solutions.</p> |
| <p>WE HEAR THIS...</p>  <p>"Prove to me there is no safety issue."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>Just Culture specifies the burden of proof runs toward safety, not away from it.</p> |

AUTHORITY & SILENCING · PART 2 OF 2









When the concern gets redirected instead of addressed.

| | |
|--|--|
| <p>WE HEAR THIS...</p>  <p>"You can be right, but they decide."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>IOM calls for evidence-based, decentralized decision-making.</p> |
| <p>WE HEAR THIS...</p>  <p>"Don't make this bigger than it needs to be."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>TJC requires escalation of safety concerns through a defined process.</p> |
| <p>WE HEAR THIS...</p>  <p>"Your email / comment was inappropriate."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>CMS CoP includes the right of staff to raise concerns without retaliation.</p> |
| <p>WE HEAR THIS...</p>  <p>"Let's take this offline."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>TJC PI standards require safety discussions to be documented and traceable.</p> |

What they say, what you can say









PRODUCTION & SPEED · PART 1 OF 2

When throughput becomes the reason safety can wait.

| | |
|--|--|
| <p>WE HEAR THIS...</p>  <p>"We don't have time for that."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>IHI data shows a 10-minute daily huddle reduces downstream communication failures by up to 40%.</p> |
| <p>WE HEAR THIS...</p>  <p>"Safety is as high as affordable."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>CMS Conditions of Participation and TJC accreditation standards contain no budget qualifier.</p> |
| <p>WE HEAR THIS...</p>  <p>"We need to focus on production first."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>IOM's Crossing the Quality Chasm names production-first cultures as a primary driver of preventable harm.</p> |
| <p>WE HEAR THIS...</p>  <p>"We need to keep the ship on schedule."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>IOM identifies schedule pressure as a failure mode, not a safety feature.</p> |

PRODUCTION & SPEED · PART 2 OF 2

When the system failure gets transferred to the individual.

| | |
|--|--|
| <p>WE HEAR THIS...</p>  <p>"We can't afford to slow down."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>CMS QAPI §482.21 requires tracking the cost of quality failures.</p> |
| <p>WE HEAR THIS...</p>  <p>"It's just a few hours / not that much work."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>AHRQ identifies normalization of workload concerns as a precursor to burnout and error.</p> |
| <p>WE HEAR THIS...</p>  <p>"Just make it work."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>IOM established that 94% of failures are system failures, not individual ones.</p> |
| <p>WE HEAR THIS...</p>  <p>"We'll fix it later."</p> | <p>EVIDENCE-BASED RESPONSE</p>  <p>Deferred correction is a latent condition accumulator per Reason's Swiss cheese model.</p> |

What they say, what you can say

NORMALIZING RISK · PART 1 OF 2

When familiarity gets confused with reliability.

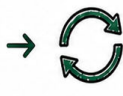
WE HEAR THIS...

EVIDENCE-BASED RESPONSE

1



"We've always done it this way."



TJC requires continuous review of safety culture, not preservation of it.

2



"Everyone does it."



Diane Vaughan's normalization of deviance research shows widespread practice predicts unchallenged risk.

3



"It's never been a problem before."



IOM identifies absence of reported harm as a lagging evidence, not evidence of safety.

4



"We are already safe."



HRO theory defines safety as a dynamic non-event requiring active maintenance.

NORMALIZING RISK · PART 2 OF 2

When the organization stops looking for what it hasn't found yet.

WE HEAR THIS...

EVIDENCE-BASED RESPONSE

1



"The numbers look fine."



AHRQ distinguishes leading indicators from lagging indicators; fine numbers may mask under-reporting.

2



"We don't see any other solutions."



IHI requires frontline workers on improvement teams because leadership's view is structurally narrower.

3



"We know you don't like it, but this is the only way."



CMS QAPI requires identification of improvement opportunities from all levels.

4



"The inspectors will look for this."



Compliance is the floor, not the ceiling; the real question is whether the practice makes patients safer.

What they say, what you can say

LEARNING & ACCOUNTABILITY AVOIDANCE · PART 1 OF 2

When fixing blame replaces fixing the system.

WE HEAR THIS...

EVIDENCE-BASED RESPONSE

1



"People don't always do what they're supposed to do."



IOM: 94% of errors are system failures. Just Culture distinguishes human error from recklessness.

2



"If you don't document it, you haven't done it."

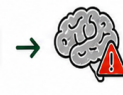


Documentation-centric cultures suppress verbal near-miss reporting.

3



"Let's not overthink this."



"Overthinking" in safety contexts is called vigilance; penalizing it is inconsistent with HRO standards.

4



"I trust our people."



HRO research distinguishes trust in people from trust in systems; trust without system design isn't a safety strategy.

LEARNING & ACCOUNTABILITY AVOIDANCE · PART 2 OF 2

When the feedback loop gets closed before it can teach anything.

WE HEAR THIS...

EVIDENCE-BASED RESPONSE

1



"Let's not point fingers."



Just Culture: the goal is identifying the system failure, not assigning blame — but applied to system analysis, not people.

2



"We already reviewed that."



TJC requires ongoing data analysis, not one-time review. PDSA requires repeated cycles.

3



"If you can't measure it, you can't improve it."



AHRQ identifies qualitative signals as leading indicators that precede measurable events by months.

4



"We need to be consistent across all sites."



IOM calls for local adaptation where evidence supports it; mandated consistency may serve administrative convenience over safety.

Conclusion

FROM HUB TO LEADER

Beyond Taylorism — from task-doer to trusted leader.

