



## Summary Feedback

### DKT Seminar -The RCR's concept of REALM (Learning from your own mistakes) - Part 1

(22<sup>nd</sup> August 2024)

**DKT Seminar Leads:**  
Sami Khan & Andrew Hails

**DKT Seminar Team:**  
Khalid Shakeel Babar, Maha Elaassar,  
Mehvish Zahra Alavi, Azhar Ali, Sandeep Singh Awal,  
Hollie Campbell, Amin Arshad, Bhoomika Biradar, Manoj Mathew,  
Aakriti Dhiman, Naman Arora, Keyur Ranpariya,  
Olarotimi Omidiora, Fatima Sikandar, Muhammad Ali Qureshi,  
Anushka Shanmugarajah, Danial Ghafoor, Sadiyah Raquib,  
Lien Salcedo, Eimad Basit, Nitin Menon & Mudassir Pirwani

**DKT SEMINAR**  
The RCR's concept of REALM  
**LEARNING FROM YOUR OWN MISTAKES**  
(Part 1)  
Thursday, 22<sup>nd</sup> August 2024  
1830-2100 BST

**Seminar Leads**  
**Dr. Sami Khan**  
Consultant Radiologist  
Basildon University Hospital  
MSE NHS Foundation Trust  
**Dr. Andrew Hails**  
Consultant Radiologist  
Basildon University Hospital  
MSE NHS Foundation Trust

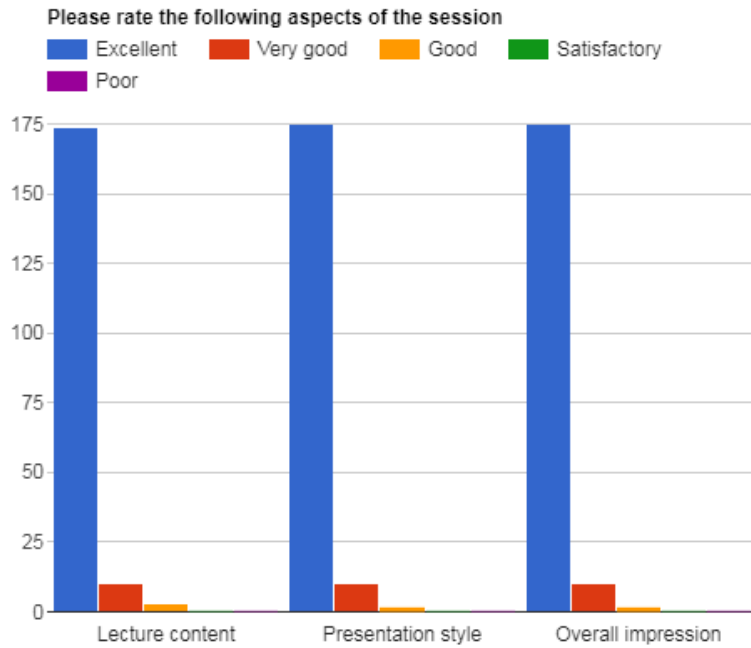
**DKT Seminar Team**

<b>Dr. Khalid Shakeel Babar</b> Locum Consultant Radiologist Liverpool Heart and Chest Hospital	<b>Dr. Maha Elaassar</b> Locum Consultant Radiologist SBU-HB	<b>Dr. Mehvish Zahra Alavi</b> Consultant Paediatric Radiologist James Cook University Hospital	<b>Dr. Azhar Ali</b> ST4 Radiology Registrar Mid and South Essex NHS Trust, UK	<b>Dr. Sandeep Singh Awal</b> Consultant Radiologist Bedfordshire Hospitals NHS Foundation Trust	<b>Dr. Nitin Menon</b> STS Radiology registrar Nottingham University Hospitals	<b>Dr. Hollie Campbell</b> ST3 Radiology Basildon University Hospital, UK	
<b>Dr. Naman Arora</b> Clinical Fellow South Wales	<b>Dr. Bhoomika Biradar</b> Clinical Fellow Basildon University Hospital, UK	<b>Dr. Manoj Mathew</b> SHO Southend University Hospital	<b>Dr. Aakriti Dhiman</b> Clinical Observer Basildon University Hospital, UK	<b>Dr. Eimad Basit</b> FY1 Basildon University Hospital, UK	<b>Dr. Keyur Ranpariya</b> Clinical Observer Basildon University Hospital, UK	<b>Dr. Olarotimi Omidiora</b> FY2 Southend University Hospital	
<b>Dr. Amin Arshad</b> Junior Clinical Fellow Basildon University Hospital, UK	<b>Dr. Muhammad Ali Qureshi</b> Clinical Observer Basildon University Hospital, UK	<b>Dr. Anushka Shanmugarajah</b> Clinical Teaching Fellow (FY3) Broomfield Hospital	<b>Dr. Danial Ghafoor</b> FY2 Salford Royal Hospital (Manchester)	<b>Dr. Fatima Sikandar</b> FY2 Basildon University Hospital, UK	<b>Dr. Sadiyah Raquib</b> FY2 Doctor Basildon Hospital	<b>Dr. Lien Salcedo</b> FY1 Basildon Hospital	<b>Dr. Mudassir Pirwani</b> FY1 Southend University Hospital

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<https://www.instagram.com/drkhansteaching>

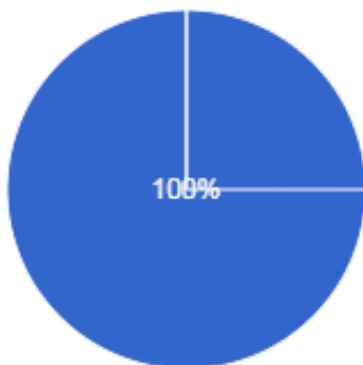
## Summary Points:

- Duration: 2.5 hours
- Total Attendees: 416 from 35 Countries (Algeria, Australia, Bahrain, Canada, Dominica, Egypt, Ghana, Hong Kong, India, Indonesia, Iran, Iraq, Ireland, Jordan, Kenya, Kuwait, Lebanon, Libya, Malaysia, Mauritius, Nepal, Nigeria, Oman, Pakistan, Qatar, Saudi Arabia, South Africa, Sri Lanka, Sudan, Swaziland, Türkiye, UAE, UK, Yemen, Zimbabwe).
- Total feedback received from 187 participants



Did you find it useful  
187 responses

Yes  
No



## Testimonials

- Dr Khan's humility in sharing his biggest career mistake was the most exceptionally inspiring thing I have ever seen from a senior colleague. I am motivated to do better in sharing with others and learning from my own mistake, so as to encourage safe radiology reporting culture. Thank you Dr Khan! Also the historical perspective from the extensive research in medical errors, as well as drawing similarities from the aviation industry, helped to drive the message home (Saudi Arabia).
- What an incredibly insightful session on the concept and history of REALM! It has made me appreciate much more the importance of learning from mistakes in an organised way yet without the "blame" culture. I think this session is incredibly important to help change the cultural norms for so many countries. DKT is truly paving the way forward! (UK).
- I really appreciate your great effort to make us a safe radiologist, indeed you are our bravest teacher, so lucky today to be in your golden session (Yemen).
- Wonderful idea learning and reflecting on our mistakes. We develop strong awareness of not missing it again in the future (Algeria).
- Showing your own mistakes to us so that we become a safe radiologist requires courage. You are great sir. Thank you sir (India).
- Big boss do make mistakes too. The case shared by Dr Khan has made me view things differently as a registrar from now on (South Africa).
- It needs a brave heart to accept your mistake and accepting and then making others to learn from it needs a big heart, Pakistan needs many more seniors like you (Pakistan).
- Dr. Khan's lecture was the most useful. No blame culture is a thing that should be applied in all countries (Egypt).
- Dr Khan, you inspire us every time to be a good and safe radiologist (Oman).
- This is a new/different concept from how we practice in Zimbabwe (Zimbabwe).
- Great presentation. We need more of such presentations. Thank you DKT team (Ghana).
- Using the lecturer's personal mistakes and experience to learn was something new and very useful (Nigeria).
- I'm glad Dr. Khan took out the time to explain the concept of REALM and kicked off this series of sessions by discussing his own mistakes, because that encourages us junior radiologists to own up to our mistakes and to learn from them. Looking forward to seeing and learning from many real life cases in upcoming similar sessions (Saudi Arabia).
- Great initiative from DKT- really appreciate this new concept of REALM sessions hosted by DKT and think its impact will go very far (UK).
- An excellent introduction to the concept of REALM. I hope such meetings can be a mandatory part of all radiology departments worldwide (Saudi Arabia).
- The humbleness and courage of accepting mistakes in front of so many students needs guts. Hats off (Pakistan).
- How to be a safe radiologist and how to accept and improve our errors during our career journey was the most useful aspect taught (Saudi Arabia).
- What an interesting session and looking forward to the new plans with DKT REAL. It's really inspiring how you are constantly innovating and improving DKT to even greater heights with new endeavours such as this! It is a privilege to learn from this! Thank you so much (UK).

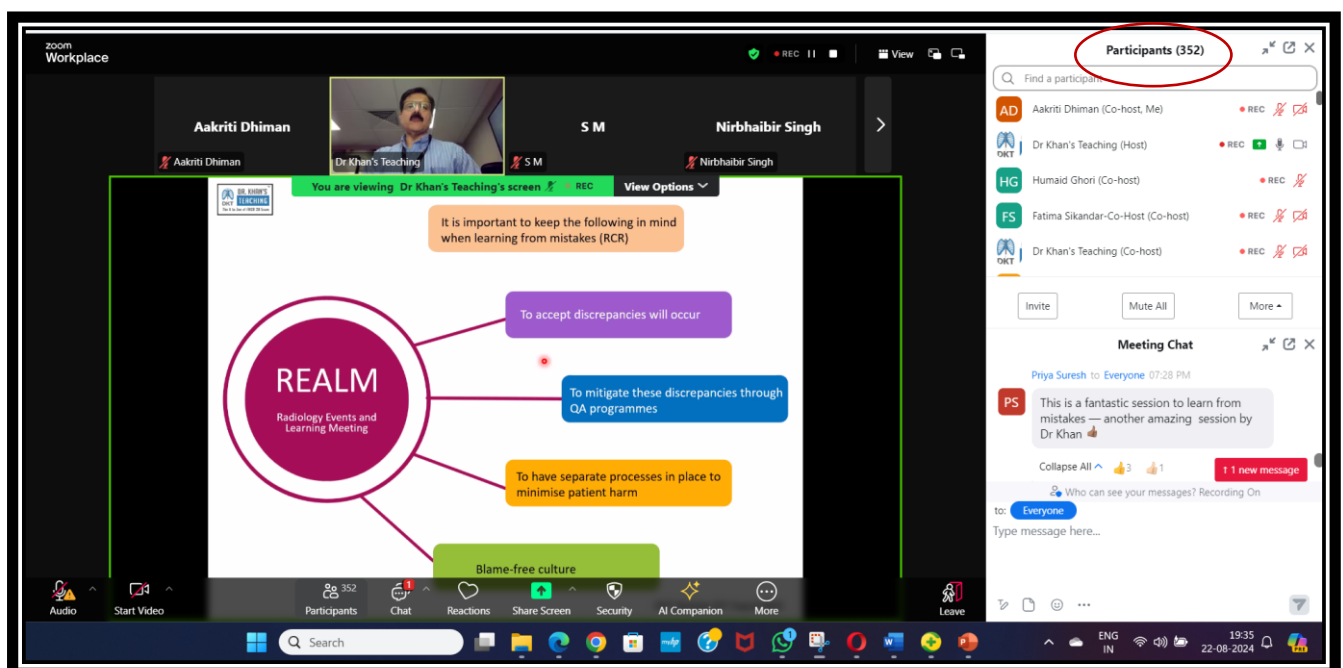
- This is the first time I came to know about REALM. It's a very encouraging and useful session for radiologists (Pakistan).
- Learning about no blame culture as a doctor who comes from a totally opposite culture was the most useful! (UK).
- All the aspects were useful. REALM concept and mistakes of Dr Khan to be more specific. It's appreciated that he told us about it all on this big platform. Hats off sir, you are a role model. It gave us assurance that anyone can make mistakes; big or small. Human error can happen (Pakistan).
- Excellent lecture with good contents (India).
- A very good concept of learning from one's mistakes and no blaming others. Needs to be applied everywhere and on all the fields (India).
- Not hiding behind our mistakes and no blame culture were the most useful (UK).
- The most valuable aspect was the message of accepting one's own mistake and to learn from it, and promote a blame free culture (Pakistan).
- It makes us realise that we are not the only ones making mistakes. Mistakes happen and if you own up to it, the probability of not repeating it again is very high (India).
- What an amazing session! Huge respect for the king of radiology, Dr Khan (Pakistan).
- Overall presentation and teaching style is very good (UK).
- The idea of no blame culture and how we all can learn by feedback were the most useful (Pakistan).
- Just keep up the good work. Looking forward to seeing how the initiative progresses and I hope to attend the future DKT REALM meetings (UK).
- Learning from mistakes. Reflection on mistakes. Presenting our own mistakes. Well done DKT team (Pakistan).
- Amazing! A special and great thanks to Dr Khan for sharing his experience with us (Kuwait).
- I am very satisfied and grateful that I didn't miss the lecture. Thank you DKT TEAM! (Saudi Arabia).
- Very useful lecture. Another fantastic work from Dr Khan. Thank you, sir (UK).
- Thanks a lot sir, great professor & educator. The best indeed (Egypt).
- Learning from our mistakes was useful (Yemen).
- Satisfaction of search. Always looking outside area of interest was the most useful (Ghana).
- Great effort to learn from our mistakes (Saudi Arabia).
- Good advice for future practice (UK).
- All of it was useful with highly valuable information (Egypt).
- REALM concept was the most useful (India).
- Sharing experience was the most useful (Pakistan).
- Amazing learning experience (UK).
- The whole concept was presented brilliantly :) (UK).
- Eye opener and very informative seminar (Egypt).
- Nice new concepts. Dr Khan always amazes us by his updated ideas (UK).
- Good explanations (India).
- Everything was useful. It was so informative and facts based plus Dr Khan was excellent with it (Pakistan).
- Good information (UK).
- Useful lecture (UK).

- Very informative lecture (Pakistan).
- Knowing about REALM first time. Thank you for this session (Pakistan).
- Enlightenment on the no blame culture was most useful (UK).
- Learning from the mistakes was useful (UK).
- It is illuminating (Nigeria).
- Brilliant lecture (Libya).
- How to improve with our mistakes was the most useful (Pakistan).
- Everyone makes mistakes and learning from them was most useful (UK).
- REALM is very important to learning processes (UK).
- Learning a new concept (Zimbabwe).
- The topic itself and associated data was useful (Pakistan).
- Got to know another aspect of radiology (Pakistan).
- Excellent session on learning from mistakes (Saudi Arabia).
- Explanation of whole process of conducting REALMS was useful (Pakistan).
- Information provided was useful (UAE).
- Great idea about REALM (Oman).
- The cases at the end and looking at the edge of films was useful (Pakistan).
- Excellent presentation sir (UK).
- Excellent session (Pakistan).
- The real life cases were most useful (Pakistan).
- Explanations of the images were useful (UK).
- This whole REALM concept was useful (Pakistan).
- It was perfect (UAE).
- The images and Dr Khan's reflection on his missed case were useful (UK).
- Different experiences shared which happen in our part of the world due to over working (Pakistan).
- Really good to have personal experiences (UK).
- To learn from your mistakes and own it was most useful (Pakistan).
- The courage of telling their mistakes was valuable (Pakistan).
- To be honest with myself was most useful (Oman).
- The learning points were useful (UK).
- How to learn from your mistakes was the most useful (Sudan).
- Personal experience case was the most useful (UK).
- Good introduction (UAE).
- Learning and analysing own mistakes and improving ourselves each day was the most useful (Pakistan).
- Amazing concept of REALM. Wasn't aware before (Oman).
- REALM is an absolutely new concept for me. Very very impressive and awesome (Pakistan).
- Looking out of the region of interest in all sequences was useful (Zimbabwe).
- Excellent service (Pakistan).
- The concept of learning from real life mistakes was useful (Pakistan).
- Discussions about cases and big misses was very educative (UK).
- Enlightening session (UK).
- How to overcome viewing bias was useful (UK).

- Explanation and cases were useful (UK).
- Improving skills (UK).
- Showing how to deal with mistakes, communication were useful (Egypt).
- Relatable to real life (UK).
- Great as always (Iraq).
- Sharing own lifetime mistakes and idea of learning from them were amazing (Pakistan).
- Common subtle pathologies which are a MUST to include in the checklist were useful (Pakistan).
- Interesting session (Sri Lanka).
- Good basic introduction to learning from discrepancies (UK).
- I liked the case discussion the most and found it the most valuable part of the session (UK).
- Identifying the deficiencies and the way to tackle in the real time practice was useful (Sri Lanka).
- Good to understand new ways to improve and new concepts in work place (Pakistan).
- I look forward to 2nd part of this. Real-time cases would be more interesting (Pakistan).
- Every aspect was outstanding (Saudi Arabia).
- I would love to join and learn from these sessions (Pakistan).
- This lecture was just excellent (Saudi Arabia).
- Please keep doing the good work (Pakistan).
- Best session (Pakistan).
- Superb lectures (UK).
- Fascinating topic (UK).
- Good principles coming up at a good time (Nigeria).
- Outstanding (Saudi Arabia).
- Very useful and important topic (UK).
- The smartness with the humbleness of Dr. Khan is outstanding! (Pakistan).
- Very educative (UK).
- Marvelous (UAE).
- Very informative (UAE).
- Very informative session (UAE).
- Wonderful session with a totally new concept for me. Dr Khan is a great person, Ma-sha-ALLAH. May Allah bless him even more (Pakistan).
- Very good presentation (Yemen).
- High standard (South Africa).
- Very useful session, and one best concept shared. No blame idea is perfect (Pakistan).
- Really very instructive (UK).
- Excellent learning as always (UK).
- Excellent teaching by Dr. Khan (UK).
- Very good and useful session (Egypt).
- Brilliant session (Pakistan).
- Very informative (Saudi Arabia).
- Excellent concept of REALM (Pakistan).
- Super excellent (Nigeria).
- Superb session indeed (India).

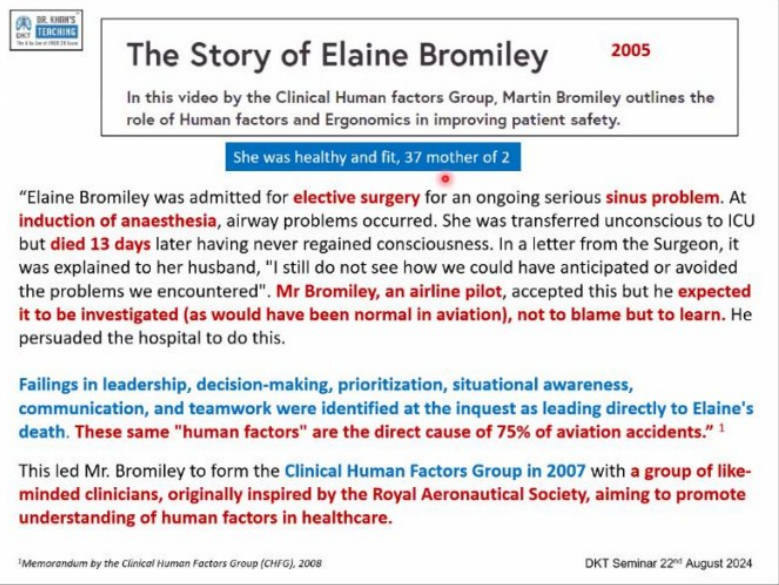
## Some Selected Feedback Quotes from Chat

- Your expressions and body language show how hard it must be for you to talk about it. Hats off to you. My supervisor always says that we are humans, and all humans make mistakes and whenever you do so, the best thing you can do is to own them.
- Hats off to you Sir, It need tremendous courage to discuss your own mistake on the platform you have build. I am overwhelmed. I salute you.
- We all are very thankful to you for sharing your good and bad experiences who most of people hide their bad ones but just for humanity's purpose you did this. You are great sir, salute you and your purpose.
- From now onwards I will call subtle Convexal SAH - KHAN SIGN (UK).
- Sir you've given us courage to accept our mistakes and gave us a new professional aspect. My mentor Dr Khan.
- Telling own mistakes to others is a big courage no one likes to do but sir is doing this for us and for humanity.
- You are a role model for us no doubt, a living legend. May Allah put barakah in your life, Ameen.
- Wonderful learning session. Learning from mistakes and reflection on mistakes.
- Youre a great teacher and honest sir.
- Really inspiring Dr. Khan. It's eye opening to all of us. Any of us could be in the same position.
- Thanks, really eye opener for all of us.
- Thank you very much for sharing this case and your learning. It is a great reminder that we don't look at scans, we are looking at patients.
- Sir with your story I will never forget these findings.
- Point for me is not giving verbal report when on duty!
- Sir if you are teaching all this, you are saving many many lives sir.





Recording...
You are viewing Dr Khan's Teaching's screen
View Options
Sign in View



**The Story of Elaine Bromiley** 2005

In this video by the Clinical Human factors Group, Martin Bromiley outlines the role of Human factors and Ergonomics in improving patient safety.

She was healthy and fit, 37 mother of 2

“Elaine Bromiley was admitted for **elective surgery** for an ongoing serious **sinus problem**. At **induction of anaesthesia**, airway problems occurred. She was transferred unconscious to ICU but **died 13 days** later having never regained consciousness. In a letter from the Surgeon, it was explained to her husband, "I still do not see how we could have anticipated or avoided the problems we encountered". **Mr Bromiley, an airline pilot**, accepted this but he **expected it to be investigated (as would have been normal in aviation), not to blame but to learn**. He persuaded the hospital to do this.

**Failings in leadership, decision-making, prioritization, situational awareness, communication, and teamwork were identified at the inquest as leading directly to Elaine's death. These same "human factors" are the direct cause of 75% of aviation accidents.**<sup>1</sup>

This led Mr. Bromiley to form the **Clinical Human Factors Group in 2007** with a **group of like-minded clinicians, originally inspired by the Royal Aeronautical Society**, aiming to promote understanding of human factors in healthcare.

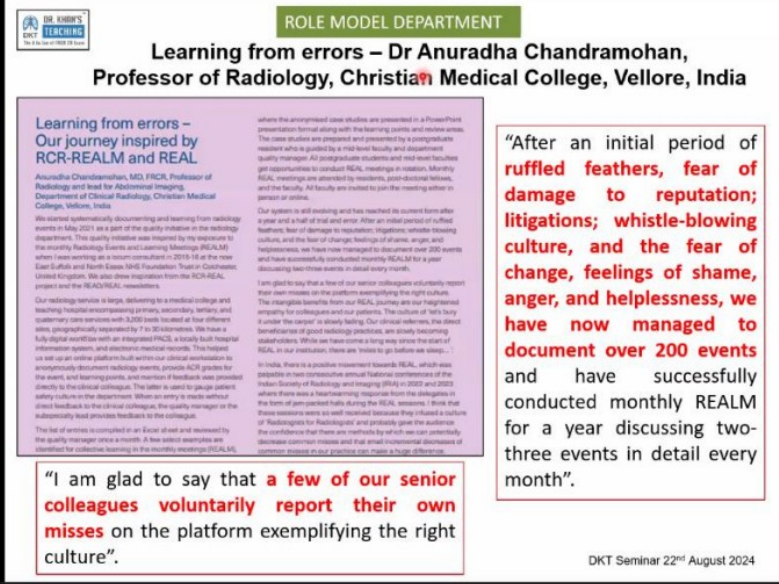
<sup>1</sup>Memorandum by the Clinical Human Factors Group (CHFG), 2008

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S M	Humaid Ghorri
S M	Humaid Ghorri
Dr Khan's Teaching	Dr Farhana Naz Amir
Mohamed Dam	Mohamed Dam
Hatem Abdulla...	Zahra Nasrullah...
Hatem Abdumajeed	Zahra Nasrullah Muh...
OSAMA AL ASH...	Hesham Abdelk...
OSAMA AL ASHRY	Hesham Abdelkader
Arun Prasad	JERRY george
Arun Prasad	JERRY george
Dr F	P
Dr F	Priya Singh
KASTURI RAKS...	rd
KASTURI RAKSHIT K.R.	rd
M	Asma Hassan
Maria Ashraf	Asma Hassan

Mute
Start Video
Security
Participants 4/10
Chat
Share Screen
Summary
AI Companion
Pause/stop recording
Show Captions
Breakout Rooms
Reactions
Apps
Whiteboards
Notes
Leave

Recording...
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**ROLE MODEL DEPARTMENT**

**Learning from errors – Dr Anuradha Chandramohan, Professor of Radiology, Christian Medical College, Vellore, India**

**Learning from errors – Our journey inspired by RCR-REALM and REAL**

Anuradha Chandramohan, MD, FRCA, Professor of Radiology and lead for Abdominal Imaging, Department of Clinical Radiology, Christian Medical College, Vellore, India

We started systematically documenting and learning from radiology events in July 2021 as a part of the quality culture in the radiology department. This quality culture was inspired by the experience of the monthly Radiology Events and Learning Meetings (REALM) when I was working as a senior consultant in 2013-14 at the Royal East Sussex and North Essex NHS Foundation Trust in Chichester, United Kingdom. We also drew inspiration from the RCR-REAL project and the REALM newsletters.

Our radiology services is large, delivering to a medical college and teaching hospital encompassing primary, secondary, tertiary and quaternary care services with 3,200 beds located at four different sites, geographically separated by 7 to 30 kilometers. We have a fully digital workflow with an integrated PACS, a locally built hospital information system, and electronic medical records. The hospital set up an online platform built within our clinical ecosystem to anonymously document radiology events, promote RCR grades for the event, and learning points, and mention if feedback was provided directly to the clinical colleague. This later is used to gauge patient safety culture in the department. When an entry is made without direct feedback to the clinical colleague, the quality manager or the subsequently build provides feedback to the colleague.

The list of entries accumulated in an Excel sheet and reviewed by the quality manager once a month. A few select examples are discussed for collective learning in the monthly meetings (REALM),

where the anonymized cases reviews are presented in a PowerPoint presentation format along with the learning points and recommendations. The case reviews are prepared and presented by a postgraduate resident who is guided by a mid-level faculty and department quality manager. All postgraduate students and mid-level faculty get opportunities to conduct REAL meetings in rotation. Monthly REAL meetings are attended by residents, post-graduate fellows, and the faculty. All faculty are invited to join the meeting either in person or online.

Our journey in real learning and has reached its current form after a year and a half of trial and error. After an initial period of ruffled feathers, fear of damage to reputation, litigation, whistle-blowing culture, and the fear of change, feelings of shame, anger, and helplessness, we have now managed to document over 200 events and have successfully conducted monthly REALM for a year discussing two-three events in detail every month.

I am glad to say that a few of our senior colleagues voluntarily report their own misses on the platform exemplifying the right culture. The encouragement from our REAL, faculty and our heightened empathy for colleagues and our patients. The culture of 'let's help a hand under the carpet' is slowly being. Our clinical culture, the direct beneficiaries of good radiology practices, are slowly becoming safer places. What we have come a long way since the start of REAL, in our radiology, there are 'things to go before we sleep'...

In India, there is a positive movement towards REAL, which was possible in view consecutive annual National conferences of the Indian Society of Radiology and Imaging (ISRI) in 2021 and 2022 where there was a learn/teaching, responsible for the delegates in the form of group presentations during the REAL sessions. I think that these sessions were so well received because they created a culture of 'Radiology for Radiologists' and probably gave the audience, the confidence that there are methods by which we can understand, decrease common misses and that small incremental decreases of common misses in our practice can make a huge difference.

**“After an initial period of ruffled feathers, fear of damage to reputation; litigations; whistle-blowing culture, and the fear of change, feelings of shame, anger, and helplessness, we have now managed to document over 200 events and have successfully conducted monthly REALM for a year discussing two-three events in detail every month”.**

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Dr F	M
Dr F	Maria Ashraf
Asma Hassan	Ema G.
Asma Hassan	Ema G.
Kaustav Jain	Ghada Mohamed
Kaustav Jain	Ghada Mohamed
Ary Ahmed	Reema Bakrain
Ary Ahmed	Reema Bakrain
Phani Deepika K...	Noro Mon
Phani Deepika Kamin...	Noro Mon

Mute
Start Video
Security
Participants 3/14
Chat
Share Screen
Summary
AI Companion
Pause/stop recording
Show Captions
Breakout Rooms
Reactions
Apps
Whiteboards
Notes
Leave



# DKT Seminar - The RCR's concept of REALM (Learning from your own mistakes) - Part 1

The screenshot shows a Zoom meeting interface. The main content is a presentation slide titled "Inattentional Blindness in Radiologists". The slide includes a definition, a study overview, objective, method, key results, and conclusion. A CT scan image is shown with a red box highlighting a gorilla. A red banner at the bottom of the slide reads: "Remember: all of us CAN and all of us DO make mistakes ....we are human!". The Zoom interface shows participants: Aakriti Dhiman, Dr Khan's Teaching, S M, and Nirbhaibir Singh. The meeting chat on the right contains a message with a link to a "DKT Learning from mistakes platform" and a feedback link. The system tray at the bottom shows the date as 22-08-2024 and time as 19:10.

**Inattentional Blindness in Radiologists**

**Definition :** inattentional blindness, a phenomenon where people miss unexpected objects due to focused attention.

- Study Overview:** Conducted in 2013 by Trafton Drew, Melissa Vo, and Jeremy Wolfe in Boston, MA, at Brigham & Women's Hospital Boston USA and the ABR meeting.
- Objective:** Investigate if expert radiologists are immune to inattentional blindness.
- Method:** 24 radiologists performed a lung nodule detection task in CT scans. A gorilla image was embedded in the final scan.
- Key Results:**
  - > 83% of radiologists did not notice the gorilla.
  - > Even when looking directly at it, many failed to see it.
- Conclusion:** Expertise does not eliminate inattentional blindness.

**Remember: all of us CAN and all of us DO make mistakes ....we are human !**

=====**XX**=====