

Story Power: The Secret Weapon

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Objective: The objective is to introduce story power as an untapped vehicle to inform, equip, and challenge leaders to drive change that can save lives, save money, and build value in communities through adoption of the National Quality Forum Safe Practices.

Method: A review of storytelling best practices from industry complemented findings from a direct survey of hospital safety leaders who presented a video story to hospital personnel. The video captured the story of death of a child from failed communication and teamwork.

Results: Interviews of safety leaders at 675 hospitals who had presented the video to hospital staff revealed that more than 90% of the respondents strongly recommended use of the video by other organizations as a tool to reduce harm to patients. Three hundred sixty-three organizations showed it to more than 100 viewers. Two hundred seventy-six institutions reported that between 50 and 100 people viewed the video at each institution. Of the 675 organizations that presented the video, 84.9% believe that it either saved lives or positively affected patients. Respondents from 205 hospitals believed that more than 50 patients had been positively impacted by changes in care inspired by viewing the video.

Conclusions: Health care leaders have much to learn from storytelling practices from other industries, such as film and business, that they can apply to driving patient safety and improving the care they deliver. However, they must face the fear of reputational and financial risk that transparency through storytelling will create when they honestly address shortfalls that cause harm to the patients they serve. The National Quality Forum Safe Practices provide a roadmap for leaders. However, they must become personally engaged in the action. They can do so by activating their teams using stories as weapons against the fears that pose barriers to improvement of preventable harm.

Key Words: story power, patient safety, safe practices, health care leadership

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STORY POWER

The stakes in patient safety have never been greater. The battle is not about the how, where, or when we need to act. It is the battle between fear and hope. It is up close and personal. We need heroes, we need action, and we need help. Now.

Whether you are an actor, a screenwriter developing a script, or a producer trying to get a movie made, in the end you are a storyteller. In the movie business, the better a storyteller you are, the greater your chances of succeeding. As it turns out, health care leaders who strive to heal patients can be more effective by being better storytellers. There is great power in this

medium to do good, to drive improved care performance, and, yes, even to enhance the bottom line.

Stories: Core to Living, Learning, and Leading

Whether you are a physician in training, reciting a patient's history at rounds, an actor playing the part of a hero in a movie, a parent telling a bedtime story, or a chief executive officer (CEO) inspiring the troops in a hospital, the power of your words rests on telling a story. The art and even the science of storytelling are core to living, learning, and leading.

"Story power" lies in the ability to change or reinforce the behavior of others. The relatedness of rhetoric can change a person's destiny, drive the success of a team, and even define the history of a nation.

Consider Churchill, Gandhi, and even Jesus Christ as examples of storytellers whose words ring in our ears and impact our behavior. Journalists tell us that every story has a hero, a victim, a villain, a crisis, and a resolution. Joseph Campbell's classic, *The Hero With a Thousand Faces*⁴⁷ brought to light the importance of the hero, and became the blueprint for the movie and great story, *Star Wars*. A screenplay has a beginning, a middle, and an end. Stories come in many forms and can be framed in many ways, yet the power of all good stories is what touches the reader and the audience.

The purpose of this article is to inform, equip, and challenge health care leaders, to inform them about the power they can tap for their mission, to equip them with communication concepts, tools, and resources that they may engage in their leadership role, and to challenge them to become active heroes—to take risks and lead rather than being passive managers who are enslaved to a budget. The leaders we target are along the entire continuum of the health care enterprise, from governance leaders to administrators, their midlevel managers, and front-line caregivers who are some of our greatest servant leaders: yes, and even independent informal medical leaders in the community.

Our task was to make a convincing argument that both leadership and storytelling are "performance arts." Stephen Denning, author of *The Leader's Guide to Storytelling*,¹ proposes that there is a place for bringing the reason of analytics into juxtaposition with an emotional call to action. Moreover, leveraging the 2 together is a force multiplier.

Stories can be your leadership secret weapon. Conversely, stories that others tell about you can be invisible secret weapons against you. If you behave counter to the values held by dedicated caregivers, you have lost them as supporters and, worse, will have them working against you.

Awakening Your Inner David

Fear is the personal Goliath that paralyzes good people from taking action. We hope to encourage your inner David to take a stand.² So what are the important questions?

- Why are stories so powerful?
- What is the value of stories to a patient safety mission?
- Is there a return on investment (ROI) for stories?
- Can stories heal?

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- What is the evidence for story impact—are there truly clinical, operational, and financial improvements that we can tie to stories?
- How can leaders and managers use stories, and why are their uses different?
- How can a governance board use stories?
- External forces demand transformation of health care. How can stories be used for the massive “turnaround” that our nation is demanding?
- Have we turned the corner in safety, and are there still unfolding stories from which we can learn?
- Is there an opportunity for caregivers and consumers to collaborate on stories? Might the threads of our lives be more interwoven than we think?
- Can we leverage the energy of each story’s light? Might the light be leveraged into heat and focused with real impact? Can you leverage this heat to serve your mission?

STORY IMPACT

On a fall day in 2002, a visibly anxious young woman approached a microphone and podium in front of a theater full of strangers. She was to speak about the catastrophic and preventable death of her 18-month-old infant. She had only told her story one other time when she faced the physicians, staff, and leaders of the hospital that had failed her child.

The videocamera pointed at her from a seat in the theater was invisible to her. There were no lights, no makeup, no special microphones, and no producers. Alone and naked of any support, she spoke from handwritten notes. She faced a sober audience of caregivers who were used to medical presentations by polished speakers, usually armed with slide sets of charts and graphs.

Nervous and in pain, she took an uneasy breath ... and then Sorrel King spoke from the heart:

“Josie was 18 months old. She had brown eyes and light brown hair. She loved to dance and just learned to say ‘I love you.’ She was admitted to hospital after experiencing first- and second-degree burns from climbing into a hot bath. Two days before she was to return home, she died of severe dehydration and misused narcotics. What were the events that resulted in this needless tragedy? Josie spent 10 days in the pediatric intensive care unit. I was by her side every day and night. I paid attention to every minute detail of the physicians’ and nurses’ care, and I was quick to ask questions. I bonded with them and was in constant awe of the medical attention she received. Every time Josie moved or fussed, someone would be quick to push her pain medication button. Her burns were healing beautifully.

“She was sent down to the intermediate care floor with expectations of being sent home in a few days. Her central line had been taken out and I began noticing that every time she saw a drink, she would scream for it. I thought this was strange, but I was told not to let her drink. During her bath, she sucked furiously on a washcloth. As I put her to bed, I noticed that her eyes were rolling back in her head. Although I asked the nurse to call the physician, she reassured me that, oftentimes, children did this, and her vitals were fine. Nurses and physicians saw her and assured me it was OK for me to sleep at home. I called to check on her during the night and was assured she was fine. That morning I took one look at Josie that and demanded that a physician come at once. She was not fine. I asked if she could have something to drink. The request was approved, and Josie gulped down nearly a liter of juice. Verbal orders were issued for there to be no narcotics given. I became alarmed when a nurse walked over with a syringe of methadone; I told her that there

had been an order for no narcotics. She said that the orders had been changed and administered the drug. Josie’s heart stopped as I was rubbing her feet. Her eyes were fixed, and I screamed for help. I stood helpless as a crowd of physicians and nurses came running into her room. I looked into their faces and said to them, ‘You did this to her, now you must fix her.’ Two days later, her siblings Jack, Relly, and Eva were brought to the hospital to kiss their beloved Josie good-bye. Josie was taken off of life support. She died in our arms on a snowy night in what is considered to be one of the best hospitals in the world. Our lives were shattered and changed forever. Josie died of severe dehydration and misused narcotics and careless human errors.”³

A simple missed order to start oral fluids, followed by a medication error, took this child’s life. The story power was felt by the audience of caregivers. This child experienced the pain of unquenchable thirst up to the moment when she was given a narcotic that snuffed out her life. She had been dehydrated by 15% because of a simple missed verbal order that would have allowed her to drink.

This Could Happen in Our House

As she closed her story, Sorrel’s pleas for action transcended the complexities of explaining systems failures and human factors performance errors. The audience heard themselves in her voice calling out for help. They faced dread knowing that this could happen in their own house. If this happened at Johns Hopkins, one of America’s greatest hospitals with legions of physicians in training and medical leaders, it could certainly happen anywhere.

“You are the only ones that can solve this problem. Not lawyers, not insurance companies and not people like me. Much has to be done to accomplish this. We can start by first to admitting to ourselves that we are fallible. The medical community must be open to the possibility that shortcomings do exist. And you must be prepared to make the necessary changes.

“Please take the time to listen to a parent when they’re concerned. Please learn to trust a parent’s instincts. Please communicate with each other. Nurses to doctors, one team to another team. Please listen to the child. Is she crying because she is in pain or is there some other reason? Please look at the child. Not all of the answers are on your clipboards or computers.

“Thank you for listening to me today. For the past year and a half, I have known that I would one day have the strength to share this story with those who could make a difference. My precious memories and everlasting love for Josie give me the strength. And I will not rest until we make something good come from her senseless death. I will not rest until hospitals become safer places.

“I am not asking for your pity, I am asking for your help. I do not know the answers; I only know that there is a problem that must be solved. Some of the best and brightest doctors and nurses in the country are in this room. And I know that together, if we are all committed, and work hard, we can control hospital errors, and we can save the lives of other potential victims, other helpless children. Thank you.”³

Now, 7 years later, the 10-minute videotape that was created that day is being used in more than 2000 hospitals and watched in 3 languages, and has raised more than \$200,000 for the Josie King Patient Safety initiatives. It is being studied as a new weapon in the war on medical harm, attacking the real enemy of improvement—fear.

How could a grainy, poorly lit video, with production values that any Hollywood or TV producer would immediately reject, penetrate the market so deeply? And although it might

be an attention grabber, did it really have any impact on changing care behaviors, or did it just drive short-lived emotion as an awareness device?

The now-retired Dr Sandy Tolchin, a quality leader at Ascension Health, related his own story of the impact of the videotape, where it was shown at a leadership meeting with little setup or foreknowledge by the audience.

"I'll never forget the first time I heard the Josie King story. A number of us were gathered at a hotel in Chicago ... clinical leaders. And we watched this video. I remember the very morning in November when we'd watched this. And I sat riveted to my chair. I couldn't believe what I had witnessed in viewing the tape. And I had to speak immediately afterwards. I was speechless. First of all, I was choking back tears and ... absolutely speechless. It had an enormous impact, not only on me, but on every clinical leader who was present in the room that day ... and there were over 200 of us. It was unbelievable.

"The Josie King video, as it turns out, came at a time soon after we had developed the call to action: 'Healthcare that works, healthcare that's safe, and healthcare that leaves no one behind.' Witnessing and experiencing that video ... and it was an experience ... It actually galvanized everyone in the room – all the clinical leadership at Ascension Health to commit to eliminating preventable death and injury. That helped that whole strategy to evolve. And it was profound. It was a profound moment for me, as well as all the other clinical leaders at Ascension Health. I had an opportunity to talk to Sorrel King about two years later and I mentioned how much her video 'The Josie King Story' had meant to all of us. We wound up embracing. And both of us had tears in our eyes because she realized the impact that she had had on all of us. It was profound." (Dr Sandy Tolchin, oral communication, December 9, 2007)

"Ascension Health set out a bold 5-year plan: No needless death. No needless harm." They calculated clear, measurable targets—putting to action Dr Don Berwick's phrase, "Some is not a number and soon is not a time," which he used so effectively to lead the successful IHI 100,000 Lives Campaign. Ascension distributed clocks to be placed on each leader's desk, which counted down 5 years of days—a clarion call of urgency to keep them on mission. Even before the clocks ran out, they reached their goal. In fact, they beat it by 3-fold! They targeted saving 900 extra lives during 5 years in their 67 acute care general hospitals. Raw mortality improved by more than 10%, and adjusted mortality suggested that more than 4000 lives had been saved. Dr David Pryor, Chief Medical Officer of Ascension Health, says that "stories like Josie's bring the numbers to life and make the critical needs compelling" (oral communication, December 22, 2009). As one of Ascension's senior visionary leaders, he has presented these results to the Institute of Medicine (IOM) and has redefined what we can expect from leadership, putting competitive pressure on all of us.^{4,5}

Will You Stand Down Your Goliath?

Now, the recreational critics may have wanted to challenge Ascension's calculations for needless harm and needless death; however, it is those same critics who would not have the backbone, heart, or intestinal fortitude to back down their own attorneys with such a courageous "gamble." You see, these legal advisors would claim that such a statement would make them a magnet for malpractice attacks. When Ascension put forth these goals, which indicted the care before and at the time of the declaration, it was an admission that needless death and harm existed! Is that not a major hidden argument made to you for not declaring safety "job number one" at your hospital? If we make a bold claim now, are

we not risking revealing our past as substandard? Here lies the convenient myth that never materializes for the courageous.

Ascension stood down Goliath, remained steadfast, and put their core values to work. The sky did not fall in, rivers did not run dry, and the world did not stop rotating. In fact, malpractice costs went down dramatically. Goliath disappeared, another triumph of hope and courage over fear.²

THE RESULTS: CONTAGIOUS MAGIC

When Sorrel King finished her speech that fall day in Boston, it was as if she had sucked the oxygen out of that meeting room. The audience was stunned.

The film crew who captured the video had been working for Texas Medical Institute of Technology (TMIT), a medical research organization that was filming some of its scholarship winners in a program it funded at the Institute for Healthcare Improvement (IHI). After her talk, TMIT asked Sorrel if it could have permission to fund production and distribution of the video through its "Pay-It-Forward" program. This program had been conceived on the principle embodied by the movie of the same name, Pay It Forward, starring Kevin Spacey, Helen Hunt, and Haley Joel Osment. TMIT proposed to send a video to a hospital as a gift, and if the hospital would donate \$250 to the Josie King Patient Safety Center, created by Sorrel in her daughter's name, TMIT would send out videotapes to 3 more hospitals in their honor. The gift of each hospital would pay forward a gift to 3 more hospitals, and so on. If each made a donation, the geometric progression would expand exponentially. Now, almost 7 years later, with no marketing other than grassroots word-of-mouth communication, the video has been sent out to over 2000 hospitals all over the world, with no evidence of abatement for requests.

But what, beyond presenting an anecdote, were the direct results on hospitals receiving the tape? Leaders of TMIT had an inkling from informal dialog through its 3100 hospital research test bed that something was happening. In early 2009, a study was designed to answer key questions:

- Knowing that the armchair skeptics might challenge any study that was measuring something so soft and silly as the power of stories, TMIT decided to interview all 2000 hospitals.
- The preliminary findings of interviews at 675 hospitals were so encouraging that an even more comprehensive initiative will be undertaken in 2010 to reexamine the impact of the Josie King story on the first wave of interviewees and then carefully assess the impact on the rest of the hospitals that received it.
- TMIT used a very reliable industry standard "Net Promoter Score" approach to evaluate recommendations by users of the value of the video. To get a Net Promoter Score, detractor scores are subtracted from promoter scores.⁶ As of this writing, TMIT found that more than 90% of the respondents would strongly recommend the use of the video by other organizations (giving it an 8, 9, or 10, where 10 is the best score). Only 1 interviewee gave it a 2 and no other respondent rated it less than 7. Eighty-eight percent of respondents rated it a 9 or 10, and 71% gave it a 9. Respondents were typically from quality, safety, or nursing departments.
- The video was mainly used and viewed by nursing staff, administrative leaders, and committees. Three hundred sixty-three organizations have shown it to more than 100 staff and clinicians within their institutions. Between 50 and 100 people have viewed it in each of 276 institutions. Of the 675 organizations that have presented the video to staff, 84.9% believe that it either had saved lives or positively affected patients. Two hundred five organizations felt that more than 50 patients

had been positively affected by changes in care inspired by viewing the video.

TMIT plans to reinterview all hospitals to further tease out the nuances of the impact of the video to determine how the video could be used as an even better weapon in the war on harm.

Weapons of Mass Destruction Against Our Health Care Soul

The question the TMIT research team has to answer is as follows: how can we use this story and others as viral pathogens against our foe, the Goliath of fear in health care leaders? Our enemy incites self-preservation behaviors of malpractice avoidance and safety-blind cost containment to justify their actions. These are weapons of mass destruction on our national health care soul.

When reminded, many remember hearing of the Wisconsin nurse, Julie Thao, who was criminally indicted for yet another predictable human error that had been compounded by systems failures. A nurse for 15 years, proud of never making a mistake that caused harm to patients, Julie made a simple human error that cost the life of a young mother. Fatigue from taking on an extra shift to help her unit, common IV connectors for two drugs, a formalized work-around to improve efficiency, and a barcode system not functioning at optimal performance changed her life. Her statement of what happened found its way to the local attorney general. She was terminated and was turned away from pastoral services at her hospital when she sought help. Then, criminally indicted, without resources for her defense, facing jail time, a \$25,000 fine and loss of her license, she was forced to plead to a misdemeanor, only to find out later that this would bar her from working as a nurse in any federally funded health care organization for 5 years. Her story, further described in a previous article,⁹ led to the development of a National Quality Forum (NQF) safe practice for care of the caregiver.^{7,8} This administrator-centered practice makes sure that we treat our caregivers appropriately after they are involved in unintentional harm to patients.

As you read this article, you may recognize that one of its co-authors is, in fact, that same nurse. Now, thanks to the intervention of Dr Lucian Leape, the father of patient safety, and the benevolence of Dr Don Berwick, CEO of IHI, and Maureen Bisognano, COO of IHI, Julie was allowed to train as a patient safety officer. She has also been the lead interviewer for the study of the impact of the Josie King video described above, and is now helping to heal organizations through their stories and helping others understand how stories work. Some have not been so blessed, however. Eric Cropp, an Ohio pharmacist, is now in prison for making another entirely predictable human error.¹⁰ Could he have been another easy target on whom to hang systems and leadership failure? Cases like this send a chill through the entire caregiver community. We wonder how many hospital leaders have not taken the time to read the NQF safe practice for care of the caregiver.^{7,8}

Are there other stories that are having an impact? The Josie King story is 7 years old. Are patient safety and leadership failures old news? We do not think so.

The following stories of the Quaid twins, Braxton Rel, and Sue Sheridan, are just a few others who are known to this article's writers, and there are many more, even in the "best" hospitals.

The near-death experience of newborn twins Zoe Grace and Thomas Boone Quaid, the children of one of this article's authors, has been highly publicized and covered in news releases and on television.¹¹⁻¹³ They received 1000 times the intended

dosage of the blood thinner, heparin, than they should have. This led to a 41-hour fight between life and death. The fact that the same accident had occurred a mere 11 months earlier, killing other children, and that similar accidents have occurred since, speaks to the issue of leadership failures and known systems faults. The look-alike packaging of 2 concentrations of heparin had been fixed by the manufacturer but not recalled from the hospitals, hence, the question is, as follows: "Have the systems faults and leadership issues been fixed at every hospital?"

Another Hospital Hit-and-run?

What about Braxton Rel? He was a 10-year-old boy who loved sports. A hockey player and goalie for his local team, he always had a smile on his face. It was with that knowing smile beyond his years that he would encourage other players when they missed a play or when he helped special-needs kids at a local school. He went in for a simple tonsillectomy at a local hospital, and within 12 hours he was dead. What is amazing is that it took 4 months for the surgeon or the hospital to return the family's calls about what had happened: calls that started that terrible night and continued until finally a non-executive level risk manager responded.¹⁴

Braxton's parents experienced what Sue Sheridan, now the leader of the World Health Organization's Patients for Patient Safety Initiative, calls a hit-and-run. This is what happens when well-intentioned caregivers abandon you at the scene of the accident because of their fear of malpractice and shame.¹⁵ It is what happens when hospitals shut down communication with families after an adverse event, forcing the families to seek legal help just to find out what happened. No stranger to this type of behavior, Sue Sheridan experienced it twice: once with a medical error that caused serious brain damage to her son, forever changing his life, and a second time when a misplaced pathology report at another hospital led to her husband's death in another state.

As of this writing, Braxton's family is still trying to find out what happened. Yet the telling of their story, about the bleeding that drowned their son as he slept, saved another life.

A Death Saves Another Life

As Braxton's story was being written for another article, it was shared by Vivian Lauderdale, the TMIT editor, with her son-in-law, Chris, who had been scheduled for the same surgical procedure. Weeks later, Chris went in for the surgery. Home a day later, Chris felt an overwhelming wave of fatigue as he sat in his car. Every fiber of his body told him to go into his home, lie down, and rest...that it would pass. Then he thought of Braxton's story, of his quietly bleeding to death in his bed, and Chris forced himself to drive to the hospital. In the parking lot, he collapsed as bleeding drained his strength. When he managed to get into the hospital, he was immediately taken back to surgery. Braxton's story saved not just the life of a young father; it also saved the happiness of his little girl and his wife, pregnant with twins, whose lives would never have been the same. Braxton must be smiling.

Steve and Lorna Rel, Braxton's parents, have dedicated themselves, like Sorrel King, to give the loss of their beloved son some meaning—to make sure his story saves more lives than just that young father's. They, like Sorrel King, Sue Sheridan, and so many other advocates, plan to go into that dark valley of the shadow of their son's death to help you be a better governance leader, CEO, medical leader, or frontline nurse. Knowing full well that they will have to reopen their wounds for you to see, they will be praying that there is just a chance that you might change.

Can Story Threads Become a Lifeline?

Are the threads of the lives of Sorrel King, Sue Sheridan, Braxton Rel, Julie Thao, and Zoe Grace and Thomas Boone Quaid merely thin story strands of emotionally evocative narrative? Separately, perhaps, they can be drowned out by administrators chanting the “no margin – no mission” maxim when it comes to investing in safety. Or can they be woven together into a lifeline that can help pull our hospital leaders by their hearts out of a quagmire of paralysis? Can they help potential leaders step out into the arena of reality and help them awaken their inner David? Can they help them face their personal Goliath?² We think so.

TELLING THE RIGHT STORY AND TELLING THE STORY RIGHT

John Nance is arguably one of the greatest storytellers in health care. This best-selling author of 19 books, national media expert in aviation safety, a lawyer, and veteran airline captain states, “The power of story to move human beings is inestimable and eternal; we have been doing this since we were sitting in caves around campfires. My writings have been successful only because I have told stories, even in my non-fiction books. This is what people want to hear about; it is what motivates us. We cannot substitute pure facts for the stories of how humans interact.” He is the author of the best-seller *Why Hospitals Should Fly*, a novel he uses as a vehicle to communicate powerful safety concepts, which has become a must-read for many hospital leaders.¹⁶

We believe, like many of the storytelling experts, that it is a myth that only a divinely selected few can be good storytellers or even leaders. Leaders need to equip themselves with communication concepts, tools, and resources to fulfill their leadership roles so that they can tell the right story and tell every story right. Experts from other industries outside health care possess best practices that can leverage the power of communication.

Storytelling: A Leader’s Performance Art

At first glance, the worlds of reason and emotion would seem to collide; yet the research in almost every industry reveals that they coexist in great leaders. It turns out that both leadership and storytelling are what business experts like Stephen Denning describe as performance arts.^{1,17} Formerly the director of information management of the World Bank, Denning discovered that storytelling is a more powerful medium than technical presentations, even with the toughest of analytical audiences. He was so successful, in fact, that he developed a new career as a writer and expert, starting with his first book, *The Springboard*, which articulates his discovery.¹⁸ He goes into great detail in later writings, describing how various story constructs can have desired outcomes for leaders.¹

Leadership is essentially a task of persuasion—of winning people’s hearts and minds. By making that 18-inch connection between the mind and the heart, one activates the hands to act and even the lips to spread the word through a viral contagious energy. If the main aspiration of leadership is to build consensus and to ignite the passions of the troops to pursue common goals, then it is more about communicating the destination than the specific tactics and course to be taken. Execution of the tactics toward objectives is the domain of the managers, who can also use the power of stories in their own way.

First, consider the framework of stories. Denning states that there are many types, and they bear study beyond what can be covered here. For the purposes of our discussion, suffice it to say that the basics would serve our health care leaders very well, and deeper study, outside health care, is a “must do” for those aspiring for greatness. Some stories have a clear framework, and

others are looser narratives that demonstrate causal relationships. But all are powerful in ways that graphs and figures can never be. Why? Because stories are about humans and health care—despite our tendency to dehumanize it. Health care is a human enterprise first, last, and always.

The film industry is in the business of moving people through visual images and emotional relatedness so that the audience feels a part of the story. A story expresses how and why life changes. It begins with a situation in which life is relatively in balance. Then there is an event called, in screenwriting, an “inciting incident” that throws life out of balance. The hero or protagonist has to deal with a challenge, discover a truth, go into the darkness, and ultimately rise to the occasion.¹⁹

Political activists, such as Professor Marshall Ganz of the Harvard Kennedy School, have shown us the power of what he calls “public narrative” storytelling. He used a disciplined formula of the “self-us-now” story framework for his work in the Obama campaign. The “self story” focuses on the storyteller and activates personal commitment. The “us story” communicates the joint calling of a group. The “now story” element addresses the consequences that will occur if the hearers of the “self-us-now” story do not act on the message. This formula inspired and activated the grassroots force of campaigners that helped carry a future president to victory.²⁰ This technique could easily be used to galvanize the resolve of a hospital board, administrative, medical, and staff leaders of a hospital to a common mission. It could be used for turnaround scenarios requiring immediate action.

Once a right story framework is adopted, telling the story right is critical. Communication scientists, such as the Heath brothers of the best-seller, *Made to Stick*, tell us that the most powerful stories have certain characteristics. They use the acronym SUCCES to capture the essence of powerful stories: *Simple Unexpected Concrete Credentialed Emotional Stories* are what stay with us and affect our behavior.²¹

In what Peter Guber called a continuing effort to unlock the secrets of storytelling for leaders, this master storyteller in film says in his *Harvard Business Review* article, “The Four Truths of the Storyteller,” that storytelling is “a force for turning dreams into goals and then into results.”²² He describes 4 essential truths of stories, which we briefly summarize below:

- **Truth to the Teller:** Authenticity is a crucial quality of the storyteller. You must be in congruence with the story—you must reveal your deepest values with honesty and candor. You must show and share real emotion—you must be really vulnerable. How often have we been in the presence of leaders who parrot the “talking points” but do not feel them?
- **Truth to the Audience:** There is an implicit contract between the storyteller and the audience. A promise that the listeners’ expectations, once aroused, must be fulfilled. Guber says that listeners give you their time—you should spend it wisely. If not, you will pay dearly.
- **Truth to the Moment:** A story must be told to the moment—rarely are good stories ever told the same way twice. The context of the telling is always part of a good story. Great storytellers and great leaders always prepare obsessively and map their message to the moment it is told.
- **Truth to the Mission:** A great storyteller is devoted to a cause beyond self. That mission is embodied in the teller’s stories, which must capture and express values that he believes in and wants others to adopt as their own. Thus, the story itself must offer a value proposition that is worthy of its audience.

These truths, if taken to heart, can really set us free from the chains of inertia that bind us, and we can do better leading others to a more noble calling.

As we turn from storytelling experts to some of the most respected business gurus of our time, we find that they have solid and reinforcing advice for our health care leaders. John Kotter²³ attests to the power of stories in business communication. Rosabeth Moss Kanter,²⁴ international expert in entrepreneurship, drives home the importance of the core values of great vanguard organizations in her book *SuperCorp*. Bill George,^{25–27} former CEO of Medtronic, emphasizes that authentic leaders rely on their core values, especially in the time of crisis. Clay Christensen,²⁸ a professor at Harvard Business School, as are Kotter and Kanter, challenges us to seek disruptive business models that improve quality, accessibility, and affordability by improving how we work and embrace change. Frighteningly, Jim Collins²⁹ unconsciously paints the trajectory of many of our hospitals through his recent book, *How the Mighty Fall and Why Some Companies Never Give In*, in which he addresses the demise of businesses in other industries. He identifies 5 stages of decline, which are (1) hubris born of success, (2) undisciplined pursuit of more, (3) denial of risk and peril, (4) grasping for salvation, and (5) capitulation to irrelevance or death. These stages described by Collins accurately chart the story of hospitals that fail without discussing a single hospital. They have leaders who have not awakened their inner Davids.^{29–31} Many hospital leaders do not realize the magnitude of the risk and peril that patient safety issues pose today—many of our hospitals are in Collins' stage 3 (denial of risk and peril).

On a final note regarding stories, our finance colleagues may say, "Fair enough – stories may have power, but is there any evidence that there is an ROI for storytelling?" Interestingly, economics professor Deirdre McCloskey has calculated that persuasion constitutes more than a quarter of the U.S. gross national product. Business experts hypothesize that if just half of this amount is storytelling, then it would represent 14% of the gross national product, which is more than a trillion dollars.¹ For those in a highly analytical field such as medicine, this sounds like an outrageous claim. Because health care and administrative leaders believe they are so very different from any other business, we will not propose a value to those running hospitals. However, given that stories can easily be embedded in ongoing day-to-day communications, the cost of using stories is so low that even a minuscule impact could drive substantial ROI numbers.³²

FROM LIGHT TO HEAT

The stories and characters listed in this article may seem to have been presented earlier just to drive home a series of unrelated points. Are they interrelated and intertwined, and can they be leveraged together? Can the diffuse energy of their light be focused by a magnifying glass to create heat on discrete targets? Can it become like a laser with stories in phase and synchronized that target specific power centers? Could this be done to help caregivers save more lives on a national basis? The answer is "Yes."

First, let us discuss the light. A lot has changed since the IOM's report, *To Err is Human*, published 10 years ago, which shed light on the magnitude of medical-related harm, unconsciously inflicted by well-intentioned and dedicated caregivers.³³ Although there have been certain gains in patient safety, medical-related harm has risen from the eighth leading cause of death to the third, with the recognition by the Centers for Disease Control that health care-associated infections we give patients during hospital care take almost 100,000 lives a year.^{20,34} The traditional press continually adds new light energy to the system with sensational stories. However, the news industry and traditional media outlets have had to evolve into "for-profit" businesses under extraordinary survival pressure because of new media. Negative

stories that appeal to base instincts drive ratings, and ratings drive profits; thus, negative stories drive financial survival.

We Have No Health Care Hope Channel

It is almost impossible to get a positive, inspirational story into the press. The 3 maxims of "If it bleeds, it leads," "Never let the facts get between you and a good story," and "Get the 3 C's: controversy, combat, and contradiction," have never been greater drivers of their focus for ratings. If a story has been told once, even with poor reach, the media resist telling it again, even if it could save lives. When stories are told, the emotional sizzle trumps the factual steak because most in the industry believe consumers have no attention span for anything complicated. This has left a huge gaping hole in our popular culture. We rarely hear stories anymore that appeal to our better angels, our hearts, and our optimism. There is no health "hope channel."

The characters and stories put forth earlier seem separate and follow many twists and turns, but they may be more related than you think. Certain events have brought them together today, just as events have brought you to reading this article. So how do the characters relate to each other over time? Is there a common connection?

- **Dr Don Berwick and the IHI:** Originally seen as radical zealots for performance improvement in the 1990s, IHI has become the most respected and leading quality improvement organization in the world, having an impact in many countries far beyond the United States. Dr Berwick has been knighted for the work he has accomplished in the United Kingdom. At least 70% to 80% of the NQF's *Safe Practices for Better Healthcare*^{7,8} can be tracked directly back to small IHI development teams. Core elements of these were part of the IHI 100,000 Lives Campaign, which saved more than 122,000 lives in an 18-month period,^{35,36} and the 5 Million Lives Campaign^{37,38} that followed it, proving that we could beat the status quo.
- **The National Quality Forum (NQF):** The NQF, in Washington, DC, was created to establish national measures, standards, and practices on the basis of recommendations to Congress by the IOM report, *Crossing the Quality Chasm*, published in 2002.³⁹ What is not well known is that the process makes their output "shovel-ready" so that federal agencies, such as the Centers for Medicare & Medicaid, can use them to tie payment to performance. The best examples of such elements are the NQF Safe Practices, now the most evidence-based and vetted practices ever created. Originally developed in 2003, they had comprehensive updates in 2006, 2009, and 2010. Designed for implementation by health care organizations, they embody life-saving practices.^{7,8,40}
- **TMIT:** Founded in 1984, TMIT, a nonprofit medical research organization, has developed a national research test bed, including 3100 US hospitals representing 60% of care in the United States. TMIT has been a collaborator with IHI on performance improvement since the mid 1990s. Dr Charles Denham, its founder, has been cochairman of the NQF's Safe Practices committee since 2004. TMIT's network of 500 experts has supported the safe practices development and updates. In 2005, TMIT helped convince leaders of The Joint Commission, Centers for Medicare & Medicaid, AHRQ, The Leapfrog Group, IHI, and NQF to agree to harmonize their requirements of hospitals into one common platform—the NQF Safe Practices. TMIT has coordinated such harmonization through updates, up to the current 2010 standards.
- **Sorrel King:** Ms King gave her first speech to a national audience at an IHI meeting in October 2002. After founding

- the Josie King Patient Safety Center with money from her settlement and investing in work at Johns Hopkins, she has gone on to write a book,⁴¹ is a coauthor of an article on disclosure as a safe practice with Dr Denham and Sue Sheridan,³⁷ and has created a personal bond with the hospitals they all serve. You see, the IHI followers, the TMIT test bed, and the users of the Josie King Story are in the same hospital set.
- **Sue Sheridan:** Making her first speech at one of the first national meetings on patient safety in 2001, the week after the 9-11 attack, she met Dr Denham of TMIT and went on to convene mothers of children with brain damage from kernicterus to prevent this adverse event. They led development of the first consumer-inspired Joint Commission Sentinel Event. Sue has gone on to speak at national meetings, has coauthored articles with TMIT and Sorrel King, has become the global leader at the World Health Organization for patient advocates, and has been recognized as 1 of the 25 most powerful women in health care.⁴² She is a frequent speaker at IHI meetings, which are a common touchstone event for this cast of characters.
 - **Dennis Quaid:** A movie actor and his wife, thrown into the world of patient safety, are now aware that the suffering of their little twins can save the lives of others if their story and other stories can be leveraged to create change. Having originally formed a family foundation to pursue this goal, they have now teamed with TMIT and the other characters to write a new story about the hearts of health care leaders.
 - **Steve and Lorna Rel:** Having lost their son to postoperative bleeding, still with no answers due to the lack of response from their hospital and surgeon, the Rels have become part of a TMIT patient advocate team, meeting by phone Saturday mornings, readying them to help hospital leaders through telling Braxton's story. They became part of this group when a friend referred them, as there is no program and no help for such families when they are cast adrift as the Rels were.
 - **Julie Thao:** When Dr Lucian Leape weighed in to encourage the hospital to step up and report what had happened, he introduced her story to Dr Denham at an IHI meeting. TMIT provided a patient safety fellowship and salary to Julie with the mission of using her story to save other lives. Don Berwick gave Julie the opportunity to train as a patient safety officer, and now she is a coauthor of this article, a researcher, and a spreader of stories among hospitals seeking to do no harm. She is a coauthor of the chapter on Patient and Family Involvement in the *NQF Safe Practices for Better Healthcare - 2010 Update* with the Rels, Sue Sheridan, and other characters in this evolving story.^{7,8}

A CAST OF "DAVIDS"

Now, as we look back through the "what-if-retrospect-o-scope," the stories of our characters might well be different. What if?

- What if Sorrel King had not had the courage to relive her pain for others, had not taken that breath at the microphone, and, instead of speaking, had stopped and stepped away from the podium in her pain? What if Dr Peter Pronovost of Johns Hopkins Hospital had not supported Sorrel King in telling her story?
- What if Sue Sheridan had stayed by her husband's side in the intensive care unit in November 2001, when he was recovering from heroic cancer surgery, to rescue him from the impact of a medical error—a misplaced pathology report that delayed treatment? What if that fateful day, right after the 9-11 attack, she had not faced her fear of leaving him and not faced the fear of getting on a plane when we were all so afraid of flying? What if she had not made the trip to give her first

national speech and had not met others in safety like the TMIT team in Dallas?

- What if Don Berwick had caved to the risk of criticism before making the bold challenge of saving 100,000 lives in front of an audience of thousands when he launched the IHI 100,000 Lives Campaign?
- What if Lucian Leape had not weighed in on Julie Thao's case and had not told her story to Charles Denham at an IHI meeting? What if he had resigned himself to inaction instead of pressing for justice from the hospital that had abandoned her?
- What if Steve and Lorna Rel had withdrawn in their pain and had not decided to take a message to where Goliath lives in our industry?
- What if Dr Sandy Tolchin and the Ascension leadership team had thought Sorrel's tape was too controversial to show and their bold initiative too risky?
- What if certifying, quality, and purchasing organizations had not taken the bet on a "mission impossible"—the crazy idea of quasicompetitors harmonizing their requirements through the NQF Safe Practices? What if they had not come to an agreement on the detailed line-item specifications with the TMIT team leading the effort?
- What if the NQF Committee had covered before critics who said that the process of disclosure and care of the caregiver practices did not have enough evidence to be considered a national safe practice?
- What if hospital leaders had decided, in 2004, to boycott transparency and reporting of their adoption of the NQF Safe Practices through The Leapfrog Group surveys?

What about the "inner Davids" of the 3 coauthors of this article? One is a professional storyteller in film, thrust into the safety movement through an accident that ill-prepared him to advise or inspire caregivers and leaders. In the face of fear of what he does not know, and fear of drawing criticism for acting as an expert when he is not, he is still hopeful that his celebrity and children's story can somehow help health care leaders save lives. The second is a nurse involved in an awful accident—fearful that she might be perceived as using the concepts of systems failure and human performance factors to avoid the personal responsibility for a life lost in her hands. She is fearful of having to relive a painful story again and again, and hopeful about moving forward with a new mission. And the third is the leader of a national test bed, fearful that his organization cannot work fast enough or effectively enough to prevent the 15 deaths each hour^{43,44} due to medical errors that are occurring, just in his 3100-hospital test bed, which represents 60% of the total US patient population. He is hopeful that this art and science of storytelling might hold the key to breaking down adoption barriers to the practices that he knows will save lives. In all three, there is a battle between fear and hope.

Now consider the crystal ball questions of a "what-if-future-scope":

- What if there were a roadmap targeting the biggest safety problems that hospital leaders could use to drive safety programs?
- What if such a road map had been harmonized with all of the major certifying, quality, and purchasing organizations, which included some of the most recently prioritized areas, such as healthcare-associated infections, so that hospital teams could work from a single playbook?
- What if programs were being established to provide impact calculators to hospital leaders so that they could make the best resource allocation decisions?

- What if the cast of characters in this article united and wove their stories together through broadcast and news media to target those in communities who make health care decisions? What if these same people targeted the governance board leaders, administrative leaders, and medical leaders who have the greatest influence on hospital performance?

The future is here. Each of the questions has been answered, and the solutions exist or are in the making:

- The *NQF Safe Practices for Better Healthcare - 2010 Update*, released in the first quarter of 2010, provide a roadmap outlined for leaders. The first safe practice, entitled “Leadership Structures and Systems,” provides the blueprint for governance boards and administrators.⁸
- The entire set of 34 safe practices is the most harmonized and evidence-based ever created. Thanks to the efforts of servant leaders like safety expert Dr David Classen, the infection practices have been synchronized to provide a common sheet of music that has also integrated specifications from the Centers for Disease Control and Prevention, Association for Professionals in Infection Control and Epidemiology, Infectious Disease Society of America, and the Society for Healthcare Epidemiology of America.
- The TMIT “Greenlight Program” is a collaborative initiative of America’s leading hospitals, which will generate impact calculators for each of the NQF Safe Practices. These calculators have been designed to allow hospital Chief Financial Officers (CFOs) to “greenlight” investments in patient safety. Greenlight is a term stolen from the movie industry, meaning a project is funded and approved. The results of the program will provide CFO-validated givens, assumptions, and variables that will secure the CFO vote to “greenlight” safety investments *before* they are presented for discussion by administrators.⁴⁵
- The characters presented in this story have come together to create broadcast documentaries and news media to drive safety. Rather than the “doom and gloom” stories so often told by the press, they will bring forth messages of hope and of “ordinary things that drive extraordinary impact” that any hospital can adopt.

The team of patient advocates woven into the story of this article has embarked on a journey to create documentaries to help tell patient safety stories. In this process, they have been able to learn about effective storytelling from producers and media leaders of organizations, like the Discovery Channel. As an example, Wayne Barbin of Discovery Studios and Dr John Whyte of Discovery Health Channel have given them concepts like “arc to action” stories and the importance of the consumer media target, such as the CFO – Chief Family Officer, who is typically a woman making most health care decisions. Jeremy Kagan, a famous Hollywood director and film school professor, is teaching them about the power of “education entertainment” and the nuances of using media to deliver a message.

What they did not expect, however, was that just the act of collecting stories would, in fact, start to save lives. It started happening through word of mouth viral spread across story subjects being interviewed, even before the first documentary could be created! Who says caregivers are not ready to innovate and adopt best practices?

For instance, after the Quaid twins’ accident, Dr Steve Swensen, the quality leader for Mayo Clinic-Rochester, leapt to action after looking in the mirror and asking: “Could this happen at Mayo?” Stories collected in Rochester by the team went far beyond medication management and included the discovery of pathogens on high-contact surfaces, such as TV

remote controls and pulse oximeters. Led by Dr Bob Cima, the Mayo surgical quality leader, this initiative resulted in new checklists that were created by custodial staff after they heard of the findings—they created the checklists of their own volition without being told what to do. Other terrific practices were uncovered at Mayo and spread across the documentary interview subjects, such as SHARE Rounds, which is the process of nurses doing their report at shift change in front of the patient, driving up safety, patient satisfaction, nurse satisfaction, and doing so more quickly and more cheaply than most hospitals do today.

Other stories include that of Dr Bill Rupp at Mayo Clinic-Jacksonville, who is turning around performance through 72 initiatives, 71 of which came from his staff, and how he, his leadership partner Bob Brigham, and their teams brought in a NASCAR pit crew chief to advise them on practices to optimize their operating room teams (oral communication, October 21, 2009).

Other subjects of the documentaries, like Dr Mike Henderson, head of quality at the Cleveland Clinic, will help us “prioritize the basics.” Dr David Bates, of the Brigham and Women’s Hospital and the World Health Organization, will help us adopt the right information technologies.

The viral spread of the simple practices among the various collaborators on this work is an amazing process. When stories are being composed and told, it is natural to share them, refine them, and spread them. One final example is that of the IHI Open School, which has catalyzed a grassroots phenomenon. Here, more than 10,000 health care students have organized themselves into 169 chapters, convening on 181 campuses in 24 countries, creating programs to take on their Goliath.⁴⁶ You see, they do not have the baggage of the fear or denial about the care they have given; their fear is in the harm they may create in the care they have yet to give. Their fear is of being unsafe, and they are not going to wait for someone to give them their slingshot. After an IHI maxim, they are putting to work “all teach, all learn.”

The story characters of this article are no longer satisfied with being wheeled out onto a stage to make you cry at a meeting, then return home, take days to recover, and hope that someone acts. They are getting ready help you do battle with your Goliath by developing media that will help you win the minds and hearts of your teams, so that we can put their hands to work and bring to their lips the sharing of hope that all of us need to tackle the unknown and untried. Like a magnifying glass or even a laser, they will combine their stories and focus their light into heat, making it too hot for Goliath to survive.

CONCLUSIONS

The true battle being waged in patient safety is between fear and hope. Discussion of the complexities of systems failures and predictable human error, although real, is only a distraction. They are the science of why we are unsafe. But what is holding us back is the battle between the devils of our flawed human nature and the angels of urgency for action. It is being fought in the hearts and minds of leaders at every level. Fear is an enemy that never sleeps.

A Battle for Your Heart and Mind

Fear of shame: If we change now, the past of which we are so proud might have less meaning. A leader must descend into a deep valley of personal pain to have to admit that there are many we may have harmed. One has to suffer the grief that comes with examination of his role, and the role of his organization in harming patients and families. The only too convenient “do not ask – do not tell” approach that many in-house lawyers and defense attorneys encourage may offer insulation from reality. If we change now, are we not risking legal attacks for past care? Great fuel for

denial, it provides enough of a buffer for governance and administrative leaders to take their own press releases for fact and safety warnings for fiction.

Fear for financial survival: If the price of safety erodes revenue or demands more money than we have budgeted, it is a threat to the organization. Administrative bonuses are tied to margin too—so out-of-budget costs get personal. Maybe it would be easier to voice the “no margin – no mission” maxim and tuck preventable harm into the “cost of doing business” file.

Fear of the future: If we make a bold claim to transform and miss the mark, are we not risking criticism of our failure? Is it not better to hang back and wait until “they” make us act? The purchasers and accrediting forces always take so long to act. Maybe we can put them off for another year. Perhaps it is better to take a common administrative route—“create a program and check the box.” If we have a program in place and a person in charge, we can distance ourselves from the harm and make it someone else’s problem.

We forget that, before David faced Goliath, the giant had taunted the leaders of the Israelites again and again. They were paralyzed with fear. Their inaction was supported by the group-think of the herd. David was offered the traditional armor when he stepped up to take on the giant. But the traditional weapons and armor defenses encumbered him. He shed them and picked up stones and the sling he used to protect his flock—things he knew worked. Do you think he calculated the risk-benefit ratio of success or the tradeoff between personal gain and risk before he squared up with Goliath?

Heroes descend into the valley of fear with only one thing: faith, the belief in the substance of things hoped for and not yet seen. Heroes do not play defense—they face the bully with hope in their hearts, powered by the principle of giving to help others. They have hope:

Hope that their risk, sacrifice, and pain will be rewarded by less pain and suffering of others.

Hope that their actions will have direct translation to an impact on the common good. Our greatest heroes do not seek awards, do not make their plays just for the fans, and do not seek the spotlight.

Hope that there is some justice in the world—that by doing good, their teams will do well; they do not calculate the benefit of heroic action before launching their efforts. They know that commitment cannot be contingent on strategy. They tell stories about their teams, using this secret weapon against their foe instead of cowering and letting stories about them become a weapon against them. They are powered by principle founded on faith. By calling on their core values, they reconcile that doing the right thing is the right thing to do.

What Will Be Your Story?

As you finish reading this narrative and return to your life in health care, we challenge you to think about your own story. If every story has a hero, a victim, a villain, a crisis, and a resolution, we want you to see yourself as a hero. It is time to write your own story. Turn that light into heat and focus it on your villain: the villain that protects the status quo—the way we have always done things. A best friend of this villain is survival-centered, blind cost-cutting that drives enormous safety risk and harm to patients.

The crisis is happening now in your facility and your community. We are harming patients and putting our own caregivers at risk. They are all future victims.

Heroes take personal risks to help others. Your patients have put a sacred trust in you. We are asking you to embrace the new NQF safe practices and to look for ordinary things that can

have extraordinary impact. Many practices cost no money, just leadership engagement. Consider developing the performance arts of leadership and becoming a storyteller to the troops. Tie powerful stories to the great factual, precise, and quantitative knowledge that health care leaders are known for. Ground them in your values—do it now, put on a jersey, and get into the game. To lead by example means acting right now. Actors only play action heroes. You must become one.

Do Not Be the Last Action Hero

Time is wasting, people are dying, and children are suffering in your communities and your hospitals. Please do not be the last action hero to step up and be counted. In the years to come, do not be a victim of your past. Do not ignore your inner David. Do not risk knowing that an error harming a loved one or a child could have been prevented if you had acted when you put down this article and read this last word.

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Sincerely,

Charles R. Denham, M.D.
Chairman