

Values Genetics: Who are the Real Smartest Guys in the Room?

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The greatest organizations in America teach us that our values are our destiny and our treasure lies in our talent.^{1,2}

The value set below is from a corporation that ranked seventh in the United States and has been recognized as one of the most admired companies in the world:

- Respect. We treat others as we would like to be treated ourselves. We do not tolerate abusive or disrespectful treatment. Ruthlessness, callousness, and arrogance do not belong here.
- Integrity. We work with customers and prospects openly, honestly, and sincerely. When we say we will do something, we will do it; when we say we cannot or will not do something, then we will not do it.
- Communication. We have an obligation to communicate. Here, we take the time to talk with one another...and to listen. We believe that information is meant to move and that information moves people.
- Excellence. We are satisfied with nothing less than the very best in everything we do. We will continue to raise the bar for everyone. The great fun here will be for all of us to discover just how good we can really be.

The company was Enron. It took 16 years to reach its zenith at \$70 billion in value. It took 24 days to completely collapse, casting 20,000 employees adrift who lost \$2 billion in their pension plans.³⁻⁵

The leaders of the company, and their best and the brightest, were often referred to as “the Smartest Guys in the Room,” which is also the name of the book and documentary that are the chronologies of its disaster.^{3,4}

There are two fundamental differences between most hospitals and Enron. First, most hospitals are governed and run by honest and well-meaning hospital trustees and senior leaders who are just starting to learn about their systems failures. Enron’s values had been grounded in profit and leveraged by deceit known by the Senior Leaders. Second, hospitals are among the most complex organizations in the world to run; and Enron, although cryptically disguised to the business community, was all about gambling on deregulated markets and bluffing analysts. It was much simpler than it seemed.

What lessons can we learn from the downfall of this organization and the others that have experienced the same systemic failures? Are we, in health care, at risk of sliding down the same slippery slope of compromise? Complexity, the fog of war against disease, and doing more with less can easily blind our focus. Who are the smartest guys (men and women) in the room running hospitals today? Who will they really be in the future, and why?

THE RHETORIC AND REALITY GAP

In the motion picture documentary of the Enron downfall, the narrator asks: “Was it a few bad people or the dark shadow cast by an evolving American Dream?”³

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"I do not believe...I did not do anything wro... [he stumbles] that was not in the interest...in all the time that I worked for the Enron Corporation that was in the interest of the shareholders of the company."

The statement above was from Jeff Skilling, CEO of Enron in 2001, through CSPAN 2 coverage of congressional testimony, answering a question by Representative Cliff Stearns.³

The culture at Enron was described as one of pride, arrogance, intolerance, and greed, according to business historians and senior leaders, as told by Amanda Martin-Brock, ex-Enron senior executive.³ Clearly, there was a tremendous dissonance between its stated values, its culture, and its behaviors. Yet, as of 2001, this organization was heralded as the "Most Innovative Company in America" by *Fortune Magazine* for 6 years in a row.⁶

Patients and hospital staff often state that the real operational values of a hospital and those espoused by its leaders are often very far apart. Many staff believe that financial priorities trump care quality and employee satisfaction on a daily basis.⁷⁻⁹

Today, almost every organization, regardless of industry, has its requisite vision, mission, and values statements emblazoned on the walls and etched in every promotional piece. However, if put to the test, precious few of its senior leaders can recite or even remember them in entirety. Other than our highest performing hospital leaders, fewer still can communicate specific stories supporting behaviors of their employees that mirror their stated values. Yet all can rattle off financial performance metrics such as revenue and patient volumes with ease. Why?

The reality is that values drive conscious and unconscious behaviors. The collective behaviors of the individuals in our organizations define our corporate cultures; and in most organizations, there is a huge gap between stated and real operational values.

Great organizations have, somehow, been able to make the lofty values on the wall so real that they are vividly mirrored by the behaviors of their people every single day. The question is—how do they do it?

VALUES GENETICS

Highly technical clinicians and highly analytic operations and financial executives alike often find the concepts of values and culture to be soft density and amorphous at best, and worthless psychobabble at worst. Yet they might change their tune if a rational model was used to describe the processes at play.

High performance organizations have been able to systematically leverage the principles of corporate and

personal values to post extraordinary performances year after year by even the toughest measures. Yet even the business guru Jim Collins described leadership, and such soft issues as "plug factors," until his research team convinced him with data. The soft stuff held up to a very disciplined analysis that led him to write "Level 5 Leadership: The Triumph of Humility and Fierce Resolve"¹⁰ and the book *Good to Great*.¹

One way of decoding the science of values, behavior, and organizational performance is to apply the model of genetics.

We propose, in this paper, to consider the application of a "values genetics model" that can be applied to explain how values are expressed by the collective behaviors of a corporate body and by individual people. By doing so, one can rationalize the impact of nature versus nurture and perhaps learn, not only from the Enron debacle but also from the successes of high performers. We can then apply such principles to improve our hospitals and health care organizations. Although not as concrete as the science of genetics, the model provides a starting point for discussion.

Using this "values genetics model" approach, we can consider the intrinsic core values of human beings as their values genetic code or genes that are expressed through behaviors. That is nature. The environment where they work and deliver care is how nurture factors can come into play. The core values of an organization can be considered its genetic code or corporate genotype expressed through the collective behavior of its people or phenotype.

The translator or mediator between values and behavior is "choice." Values are about choices we make that are expressed through our behavior. In some cases, we choose to behave one way or another; however, this is not a simple issue of conscious preference. We, as individuals and as organizations, make conscious and unconscious choices every day. We are blind to many of the unconscious choices that are embedded in the systems of which we are a part. Also, certain instincts, such as self-preservation and survival instincts, can trump conscious choices.

Careful analysis of Enron revealed that the core values were anything but those described above. Not only had their real values uniformly migrated to become greed-centered, they developed a very systematic approach to thin the herd and purge employees who did not contribute to the ever-increasing demand for revenue.

Even good people developed what could be called a "greed scotoma." A *scotoma*, we know from ophthalmology,

is a blind spot some people develop because of congenital defect or disease, which the brain learns to normalize; thus, it becomes invisible or consciously unapparent to the inflicted. The person learns to accommodate to this blind spot and becomes unconscious of its existence. Enron slid down the slippery slope of self and corporate self-interest. In effect, it normalized deviancy from the golden rule they espouse in the first line of their values statement. Their golden rule became “seize the gold and rule.”

THE ENRON GENERATION: EN-GENS

According to Bethany McLean, who authored the Enron documentary “Smartest Guys in the Room,” “Jeff had a very Darwinian view of how the world worked. He was famous for saying once in Enron’s early years that money was the only thing that motivated people.” “Skilling’s notion of how the world should work really trickled down through every way Enron did business.”⁴

One of his favorite books was *The Selfish Gene*.¹¹ He interpreted that human nature is steered by greed and competition in the service of passing on our genes. At Enron, Skilling wanted to “set free the basic instincts of survival of the fittest.”⁴

Skilling instituted the system known as the performance review committee (PRC). It required that people be graded from 1 to 5; roughly, 10 percent of people had to be a 5, and those people were supposed to be fired. Hence, this came to be known as “rank and yank.” In video footage, Skilling stated, “I’m personally convinced that the PRC process is the most important process that we conduct as a company.”³

Natural selection is the process by which favorable traits that are heritable become more common in successive generations, and unfavorable traits become less common.¹² Through the hiring process, the PRC, and reward system, Enron had created a kind of “accelerated natural selection.”

The concept of “Generation X,” first coined by Jan Deverson in a study of British teenagers in 1964, has been assigned to the demographic group of those who were born between 1961 and 1981, who would be between the age of 26 and 46 years in 2007. In general, it was found that this group did not believe in God, disliked the Queen, and did not respect their parents. In the United States, this was further characterized by a lack of optimism for the future, nihilism, cynicism, skepticism, alienation, and mistrust in traditional values. This group grew up in a rapidly deindustrializing Western World, experienced the economic recession of the 1990s and 2000s, with offshoring and outsourcing of jobs. This has been described as having left a deep sense of insecurity in the Gen Exers, whose usual attitude to work is “Take the money and run.”^{13,14}

Consider taking an individual with these potential predispositions, a high IQ, and provide a premium business education steeped in a religion of profit, you then have the prototypical Enron candidate. Thus, we propose to call a subdemographic of Generation X “En-gens.”

“The Enron story is so fascinating because people perceive it as a story that’s about numbers...that it’s somehow about all these complicated transactions. But in reality, it’s a story about people. And it’s really a human tragedy.”⁴

The quote of Jeff Skilling, CEO of Enron, cited earlier, captures it all. He stumbles when he begins to say that he did not do anything wrong and then corrects himself. He states that what he did was for the shareholders. It is almost as if he knows that he is doing wrong but clinging to the real operational values that Enron held dear, that the analysts who set their stock value reinforced, and that those who traded Enron stock pursued to build short-term wealth. The “end justifies the means” mentality worked until the music stopped for this group of En-gens.

FROM MISSIONARIES TO MERCINARIES AND BACK AGAIN

Many of our hospital staff, clinicians, and administrators are ashamed of the care we now deliver. The honorable calling that many of us followed has migrated through external forces, perhaps a shift in our national values and even a shift in our own values to a level that humiliates us all.

We are treating sicker and sicker patients faster and faster with more and more complex diseases, yet we are drawing from an ever-shrinking pool of funds. This has forced our health care organizations into a collective survival mode. According to Jennifer Daley, MD, CMO, Partners Community Healthcare, there are risks to this model (oral communication, August 15, 2007):

“When unenlightened administrative leaders run into financial problems, the first budget cuts they make are in housekeeping, infection control, education, and quality or patient safety. I respond with: ‘So you are telling me that you want a dirty, infected hospital, run with ignorant staff who are providing more dangerous care.’”

When the real impact of managed care hit, we drew on our leading consulting firms that provided their stock

financial and operational tools in revenue cycle optimization, supply chain management, and head count reduction to keep our organizations afloat. Unfortunately, to finance and operations experts who have a hammer, everything looks like a nail. Yet we saw them as the “smartest guys in the room.”

Common is the experience of quality and safety leaders who come into senior staff meetings and find finance and operations leaders rolling their eyes, referring to their personal digital assistants, and expressing a collective sigh when performance improvement programs are presented. Many clinicians who come into such sessions believing that they will be supported because their new technology or idea “saves lives” are met with a group response of a silent or even audible “so what?” They do not realize that their trump card was played by the last group that made a pitch for project support.

“Patient safety failures are just a cost of doing business. The board will likely do nothing if we do not have a burning platform. The current management team is making money.”

The quote above was made by an anonymous trustee (oral communication, October 1, 2006). Not too infrequently, we have a standoff between the clinical “saints and martyrs,” who play the role of long suffering victims of a system gone wrong, and the opposing operations and finance executives who bully them with demands of return on investment calculations without providing the desired formulae.

The former are often either too passive or too arrogant to learn simple finance and operations management tools. The latter often turn such interactions into blood sport, knowing that they hold the ultimate trump card of “the budget” and that most performance improvement programs are dead on arrival if they pull that card.

Oddly, few finance and operations people can provide a balanced return on investment method that integrates operations, finance, and clinical impact because they have so little clinical know-how. The question is, have we created an environment of “natural selection” where we allow these behaviors to be reinforced? Performance consultants have found that many nursing and medical leaders have given up, have been demotivated, or have even gravitated to a place where it is easier to complain about the barriers than to overcome them. Have we also allowed an environment where operations and finance leaders rule so unopposed that we stifle creative entrepreneurship in performance improvement? The most appalling and likely very worst example of the erosion of values

expressed through caregivers’ behaviors is the widely publicized story of a woman who died of a perforated bowel on the floor of a West Coast urban hospital while custodian staff cleaned around her, clinical staff ignored her, and onlooking patients and family members were rebuffed by 911 operators when they desperately called for outside help.

The quote below by Mr Zev Yaroslavsky, LA County supervisor, captured the essence of this experience (oral communication, June 17, 2007; Channel 4, KNBC):

“It was a complete meltdown of humanity and morality.”

If this had not been caught on video, and the 911 call recordings from the emergency department of the hospital had been made public, most of us in health care would be skeptical that this had even occurred. Yaroslavsky’s words are truly sobering: “Now that it is a national story, if any good can come of this, it is that every one of us, as Americans, can look at ourselves in the mirror—when someone is in agony and needs help, that the proper humanitarian response is to offer a hand of help and not to turn your back on them.” (oral communication, June 17, 2007; Channel 4, KNBC).

In September of 2007, this hospital was closed because of multiple issues that all stem back to culture, despite many attempts to correct the problems with high octane consultants and multiple approaches.¹⁵

So unbelievable too are the hundreds of other stories this author is collecting from patients, caregivers, and family members about appalling care delivered here in the most powerful of industrialized nations. Is it possible that we have developed an industry-wide scotoma that makes such systems failures invisible until we are hit, seemingly out of nowhere, with a celebrated case that “stops the line?”

How much different are the decisions made in hospitals where we trade lives for dollars by distancing ourselves from the accountability for preventable harm by looking at spread sheets instead of patient charts? Although there are no videos, no faces, and no one being singled out for denying patient safety, the issue is a moral one nonetheless. How long can we hide between the “no margin—no mission” line that evokes burning resentment from frontline caregivers who viscerally react to this tired old phrase?

The bright lights on the horizon are the organizations that have embraced patient safety as a moral imperative.

Lars Houmann, president of Florida Hospital, which is beginning its journey of transformation, believes that clinicians will have to move outside of their formal training of

the science of medicine and see the social side and business side of delivering care.

Houmann's comment (oral communication, July 5, 2007) is:

"We need 'care guys' back in health care. Our leaders of the future will have to see a purpose and be inspired by that purpose."

Finance and operations people will need to do more than rely on input from their clinical colleagues. For instance, Houmann uses the example of "running a code." Finance and operations leaders must learn the basics of running a code, so that they understand the process and realize the impact that financial and operational decisions can have on delivering whole care.

Truly great organizations have learned to manage what Jim Collins describes as "the tyranny of the OR."¹⁶ They can live with 2 seemingly mutually exclusive concepts such as improving short-term financial performance while driving long-term quality improvement. They are able to maintain short-term financial objectives while investing in quality and safety with the ultimate long-term result of sustainability. This is a counter-mercenary mentality and requires real discipline to get people to think out of the current budget-year box. It requires faith—the currency of the heart, the belief in things not yet seen.

When Dr. David Pryor, CMO of Ascension Health, another one of our leading faith-based organizations, was asked who the future "smartest guys (male or female) in the room" will be, he emphasized that they will be good listeners. He went on to say (oral communication, August 30, 2007):

"They will be listeners—to the voices within the organization and voices external to the organization. They will listen to business, patients, caregivers, and yes, even divine voices and callings."

Dr. Pryor paints a picture of the future: "The next decade holds tremendous change—where care is given and how it is given. Our great leaders will be those that continue to learn, remain open, and ever receptive to new ways of doing things. The whole paradigm shift of personalized medicine will require the unusual ability to integrate and balance clinical, operational, and financial perspectives across the continuum of care." (oral communication, August 30, 2007).

The organizations that seem to be developing effective sustainability strategies for the future are those that have returned their focus on their more noble core values. Many are faith based or vigorously evangelizing their mission and core ideologies that serve the common good.

The fact that missionaries of performance improvement grounded in the concept of the golden rule are succeeding is no surprise to Fred Reicheld,¹⁷ the author of *The Ultimate Question*. He has found that such focus is a statistically significant common denominator of the most successful companies in multiple industry sectors.

OUR COMMAND AND CONTROL MODEL

The model for modern business dates back to the German General Staff model that evolved from early Prussian military command. The general staff, C-suite, departments, and sections were organized to carry out certain tasks.

Clearly, the design of early business structures and management principles did not anticipate the complexity of a typical hospital nor the demands of integrated care. Jamie Orlikoff, thought-leader in governance, adds to a Peter Drucker quote (oral communication, June 27, 2007):

"Peter Drucker states: 'Even small healthcare institutions are complex, barely manageable places...large healthcare institutions may be the most complex organizations in human history'...Orlikoff adds: "...largely governed by well-meaning amateurs."

Our command and control mode of management has driven a production silo-centered model of delivering specific services that is not centered on the patient's passage through our organizations. The military has, since, moved to a much more team-based model in tactical units, leaving us way behind in organization performance models. We are only just starting to adopt such methods.

The 1970s through the 1980s, which we could call the "Love Boat Era," when resources were more plentiful, was a relationship-management period. It evolved into a high technology era simultaneously hit by reimbursement constraints.

The HMO Act of 1973 set us into a new wave of changes. Allegheny Health Education and Research Foundation filed the largest health care bankruptcy in history in 1998 with more than \$1 billion in public debt, which was a wake-up call to trustees about their own fiduciary risk, and put focus on fiscal discipline. A year later, the Balanced Budget Amendment struck. In the 1990s, the HMO movement hit, the medical arms race was in full swing, and the financial survival tail started to wag the health care dog. We were fully in the "Titanic Era."

LOVE BOAT ERA

Twenty or 30 years ago, hospital leadership teams and CEOs succeeded through their relationships with physicians. Like the television program, “The Love Boat,” which was broadcast between 1977 and 1986, much was centered on the relationships between players as the platform moved somewhat effortlessly forward in time.

Chief executive officers managed “donors, owners, and loaners.” A major component of revenue was endowed, which has dramatically shrunk over succeeding years. Their job security required that they maintain “the 3 keeps:” keep the doctors happy, keep the board happy, and keep your job.

The quality course and even the long-term course of the hospital was managed and greatly impacted by the physicians who drove the volume of patient care and ultimately the financial success of the hospital.

The physician’s pen was the most expensive device in health care as it drove 80% of expenditures in patient care.

Quality and safety matters were handled informally and formally by the medical leadership who naturally spent a great deal of time at the hospital. Continuity of care occurred with continuity of relationships among primary care physicians, specialists, and the hospitals.

The smartest guys in the room were administrators who were great relationship builders. They respected the smartest guy physicians who were typically pillars in the medical community. These physicians felt that it was their duty to serve a major role on the bridge of the hospital vessel and guide it through the seas of change.

With the advent of contracted care and diminishing resources, many new survival behaviors began to set in.

TITANIC ERA

As care became more fragmented, technology exploded, and reimbursement became constrained. Unfortunately, at the same time, the physicians, whom administrative teams relied on to manage the helm of quality and chart the course for the organization, had left the ship to deliver care outside of the main plant. This left administrators on the bridge, lacking the knowledge and skills to run that part of the ship.

As the medical arms race accelerated, we relied on the silo saviors—those clinical expert specialists who brought new payment codes, fresh revenue sources, and prestige to our organizations. A by-product of their specialization was their narrowing scope; they knew more and more about less and less of a patient’s care trajectory, until they knew nothing about the integrated care being delivered.

Unfortunately, as in the story of the Titanic, more emphasis was placed on the virtues of the individual technologies than on the basics of the social infrastructure that operated them. The unintended consequences were new systems of care that had no safety net and diminished reliability along the continuity of care delivered for a given patient.

At the same time, a new breed of smart guys came on the scene. Freshly minted finance and operations-focused executives and consultants from the outside, who were members of the Gen-X demographic, were a welcome help to develop the fiscal discipline needed for survival and decision making as

the stakes and risks rose along with the price point of new technologies. Our biggest critics argue that they may have replaced our moral compass with profit and loss spreadsheets.

A little known fact about the Titanic was that the finance team had the greatest impact of all on the loss of life.

Although the Titanic had the most advanced technology of its time, the investors opted to scrimp on life boats, skirting a regulatory requirement loophole. In their rush to beat the competition with a transatlantic record, the crew had no standard operating procedures and launched into the business of servicing customers without systems safeguards. Sound familiar?

During this era and dating to the present, many CFOs have been “silo scorekeepers” who hammer down budgets and roll up margins by silos. They became the head of the “no department,” as opposed to great CFOs of today, like John Owen, CFO of JetBlue, who shares with us that the best CFOs are “enterprise score makers,” get involved on the line, and make good financial decisions that drive enterprise-wide performance and quality (oral communication, February 1, 2007).

The need for chief information officers (CIOs) was driven by the new technologies. Their focus in information technology was heavily weighted to the basics, where 90% of their time was spent on acquiring and making the “T” reliable; and less than 10% of their time was spent on the “I” or power of information.

The 1999 Institute of Medicine Report: “To Err Is Human”¹⁸ and the report that followed “Crossing the Quality Chasm”¹⁹ catalyzed the development and expansion of new roles for chief medical officers, chief quality officers, and patient safety officers. The recently published “NQF Safe Practices for Better Healthcare—2006 Update”¹⁹ specifies specific roles for Patient Safety Officers and has been harmonized with requirements of The Joint Commission, the Centers for Medicare and Medicaid, The Leapfrog Group, the Agency for Healthcare Research and Quality, and the Institute for Healthcare Improvement’s 5 Million Lives campaign.²⁰

The expanding role for hospitalists, who have assumed much in patient care, now includes a terrific opportunity to lead patient safety initiatives because they have great basic training, they are on site in the hospitals, and they have the opportunity to provide critically needed clinical input on systems performance improvement.

THE NO OUTCOME—NO INCOME TSUNAMI

Whether a hospital today has hit 1 big catastrophic event, such as a major iceberg, or whether it is running flat out with high technologies in place, great physicians daring to push the envelope of clinical boundaries, and a social infrastructure ill-equipped to deal with the complexity, the numbers are against them.

It is simple. We have clinically out-innovated our social and information technology infrastructures and fixated our attention on financial outcomes. Through a transaction code-centered and financially driven period, many hospitals, like Enron, have collectively built a “house of cards built over a pool of gas.”³

The lack of investment in our social infrastructure to serve our core values is like deferred maintenance in the financial world. It is a debt that will come due.

Like in Las Vegas, your destiny is in the numbers. Eventually, the house always wins.

The pay-for-performance impact will be incredibly toxic to hospitals that are what Reicheld would say are “addicted to bad profits.” He states, “While bad profits don’t show up on the books, they are easy to recognize. They are profits earned at the expense of customer relationships.”¹⁷

Hospitals that guarantee unrealistic financial performance will be imprisoned by their own promises to Wall Street and the bond rating community.

Release of the Centers for Medicare and Medicaid rule regarding its policy of not paying for certain health care-associated infections and other serious reportable patient safety events are just a ripple of what is yet to come. Private payers can only profit by following suit. Hospital boards, C-suite, and service line leaders will not be able to plead ignorance in the future.²¹

“You can’t hold me responsible for something I did not know.”

The quote above is from by Ken Lay, chairman of Enron.^{3,4}

As we have stated in prior articles, there will be 3 phenotypes that will be exhibited when the full tsunami of pay-for-performance hits: “The surfers who leverage the power of the wave and make things happen, the swimmers who watch what happens and barely ride it out, and the sinkers who wonder what happened.”²²

History will not be forgiving. When we look back in the decades to come, it will not be hard to determine who the smartest guys in the room really were.

A number of national quality leaders were interviewed regarding the characteristics of the future “smartest guys in the room.”

The response from Don Berwick, MD, President and CEO of the Institute for Healthcare Improvement sets the context for the discussion perfectly. “Health care workers—doctors, nurses, pharmacists, respiratory therapists, managers—they want to do better. They live in a world that is shaped, molded by their leaders, articulating values, creating direction, helping define tasks, and providing support. Without leaders, we can’t do it right. The system’s too fragmented and health care’s too complicated. So we need the leaders to pull us together, support us, and create the values platform that is the right basis for our work together.”²³

VALUES GENETICS

By exploring the application of the concept of values genetics, we may be able to develop an understanding of the traits of organizations and individuals that may predictably be expressed as conscious and unconscious behaviors. This may allow us to be better architects of the cultures and performance of our future hospitals and health care organizations.

Jim Collins, renowned business guru, tells us that “visionary companies have core ideologies. They are basic precepts that say “this is who we are; this is what we stand for; this is what we are all about. Those aren’t just words but vital, shaping forces.”²⁴

We cannot talk about the values genetic code of the future “smartest guys” we want in our room without dealing with the values genetic code of our organizations. Ann Rhoades, people systems thought leader, culture architect, and advisor to airlines, hotel chains, and health care organizations, tells us that our extraordinary people will self-eject from a less-than-extraordinary culture that mirrors consistent and compatible values.

Therefore, it is critical that we, at least briefly, discuss dimensions of high-performance cultures when we consider the characteristics of future leaders who will meet their full potential within them.

CORPORATE DNA OF HIGH PERFORMERS

In our research of hospitals adopting the National Quality Forum Safe Practices for Better Healthcare—2006 Update, we have been studying 7 dimensions of culture using a number of survey instruments and assessments:²⁵

- **Communication.** High-performing organizations have very clear communication channels within their structures and systems and excellent linkages with outside organizations. A great deal of consistent effort is placed on clear and simple communication throughout team structures and up and down the command chain.
- **Underlying values.** The real underlying values (which may not be those on the wall) drive everything about the organization. High performers mirror their values at every level. According to Ann Rhoades, “Leaders drive the values, values drive behaviors, and behaviors drive performance” (oral communication, November 28, 2007).
- **Leadership.** The success of high-performing organizations revolves completely around leaders at every level and the structures and systems that they put into place that enable expression of the values through everything.

- **Teamwork.** If teamwork provides the gears of how we work collectively, then communication is the lubricant that allows this to be manifested. Great organizations have invested in the knowledge and skill development to build great teams. This does not happen unintentionally.
- **Unity and trust.** Unity around a constancy of purpose cannot happen without trust. Trust is faith in the future performance and behaviors of others that is not yet seen.
- **Reliability.** High-performance organizations are those that have either formally or informally adopted the characteristics of high reliability organizations, as described by Weick and Sutcliffe.²⁶
- **Energy State.** Cultures that are transforming or constantly improving have a capacity for extra effort over and above that needed to deliver basic care. Those with a fatigued and short-handed workforce are greatly handicapped in this area.

SMARTEST GUY VALUES AND TRAITS

The values, traits, and characteristics identified by leading quality and performance leaders through multiple interviews are defined below. Virtually all cited agreed with the entire list; however, specific quotes from each interviewee were selected.

- **Humility.** Ann Rhoades, People Systems Expert cited above, says: “One word comes to mind: Humility. The smartest guys in the room will be those who know they don’t have to be” (oral communication, June 30, 2007). This is echoed by Jim Collins in his article “Level 5 Leadership: The Triumph of Humility and Fierce Resolve” and book *Good to Great*, where he makes a convincing argument supporting leaders of transforming organization having humility as a key defining trait.^{1,10}
- **Courage.** Maureen Bisognano, COO of the Institute for Healthcare Improvement and mentor to many high-performing CEOs and leaders from high-performance organizations, says: “They have courage....they are not afraid to fail. They know that fast failures will drive ultimate success” (oral communication, June 25, 2007). Justine Medina, RN, MS, director of Professional Programs at the American Association of Critical Care Nurses says: “I think they will be heroes—they won’t be afraid of taking a bullet for the team if it is the right thing to do for patients” (oral communication, June 30, 2007).
- **Integrity.** Situational ethics and moral relativism have allowed us to back away from walking our talk and mirroring our values. Dr. Thomas Knight of Sutter Health concurs and states: “It is not what you stand for that counts...it is what you stand behind” (oral communication, July 3, 2007) Clearly, integrity is core to building trust.
- **Vigilance and Passion.** Dr. Chris Olivia, High Performer CEO of Cooper Healthcare underscores Collins’ belief that great leaders have fierce resolve. “Our future leaders will be vigilant. It will take real vigilance to meet future financial challenges without sliding back into convenient and immediate financial interventions. Our future leaders will appreciate the enterprise-wide ramifications of seemingly narrow focused budget cuts”(oral communication, June 29, 2007). All of our interviewees described the critically important characteristic of passion for performance, for patient-centered care, and for delivering the best care possible to the community whether they are clinically trained or not.
- **Inspiration.** All of the experts agreed that the smartest guys in the room and future leaders would have to have the gift of the ability to inspire, to breathe life into the passion of others, and to be the kind of leader whom highly gifted people would want to follow. John Nance, patient safety expert, author, and respected journalist says: “Leadership in healthcare is not good financial control or managerial stability, but the art of inspiring humans to accomplish together what they can’t do alone. Indeed, patient safety is the ultimate expression of that principle, since only teams of dedicated colleagues, well aware of their own fallibility can be a successful group” (oral communication, June 27, 2007).
- **Sense of Duty and Dedication.** When commenting on subject matter experts contributing their time to help establish new national measures, standards, and practices—specifically the NQF Safe Practices for Better Healthcare—Dr. Lucian Leape, the father of patient safety, stated: “This is in the highest and best tradition of our professionalism. As physicians, our greatest joy comes from taking care of individual patients, one on one. But we all know that we need to help each other and to elevate the standards. One of the great traditions in medicine has been the selfless willingness of doctors and nurses and pharmacists to donate their time to improve quality. This is just another recent and outstanding example that makes me proud to be a doctor” (oral communication, March 17, 2007).
- **Compassion.** Although compassion is listed as a value or mission statements of many of our hospitals, it is clearly lived by organizations such as Ascension Healthcare, which has declared that they will prevent all needless harm by 2008. Compassion for our patients, fellow caregivers and administrators, and the underserved is a common trait to be sought in future leaders by organizations that want to thrive. Dr. Peter Angood, CMO of The Joint Commission, states of our future great leaders that “they will be those leaders who have wisdom and maturity grounded in deep core values that allow them to facilitate and promote the ‘whole-person needs’ of patients and caregivers” (oral communication, July 12, 2007).
- **Discipline.** Ruthita Fike, the widely respected CEO of Loma Linda Medical Center, states that “they will be leaders that combine the rigor and discipline of delivering financial and medical outcomes with a culture that provides an opportunity for people to thrive. They will develop supervisors who are the connectors between senior leaders, values, and the action at the frontline. Without the balance of bottom line performance, focus, and investment in the human dimension, sustainability, is not possible” (oral communication, July 19, 2007).
- **Generosity.** As noted above by Ruthita Fike, all experts interviewed agreed that our great leaders of the future will be dedicated to the development of their teams and colleagues. Giving, in many ways, seems to run a common thread through the observations of the experts polled.
- **Dedicated to Continuous Learning.** Dr. Gary Kaplan, CEO and chairman of Virginia Mason, one of our most

progressive hospitals, believes that “thought leaders in healthcare will need to be focused on ‘continuous learning’ rather than ‘knowing’ as the rate of change and the requirements for continuous improvement will only increase in the years ahead. This will require a willingness to look for learning both inside and outside of the healthcare industry” (oral communication, June 29, 2007).

- **Collaborative.** Dr. Betsy Tuttle-Newhall, Associate Professor of Surgery at Duke Medical Center and one of the leaders of the highly successful national organ donor collaborative sponsored by Health Resources and Services Administration, states: “There is a Berlin wall of middle managers between the frontline and the boardroom that can insulate the C-suite and the Board from the tough decisions. The great leaders in the future will create an environment where the ‘us versus them’ culture will become replaced by an ‘all teach all learn’ team performance model” (oral communication, July 3, 2007).
- **Competitive.** This author had the opportunity of a conversation with Dr. Watson of Watson and Crick who discovered DNA in the fall of 1998. When asked what first went through his mind when they knew they had made the discovery, he said “we beat the other guys by 6 months” (oral communication, September 15, 1998). Yes, competitiveness is a great trait of the high performers.

SMARTEST GUY SMARTS—FROM INTELLIGENCE QUOTIENT, EMOTIONAL QUOTIENT, AND PERFORMANCE IMPROVEMENT QUOTIENT

“Smarts” has a unique meaning to everyone and comes in all flavors; however, there are certain consistent characteristics or attributes that our national thought leaders in quality and experts in high performance believe are vital to our future leaders of health care organizations.

Attitudes, conscious behaviors, and unconscious behaviors are defined by the values DNA of individuals and how they interact within their host culture; however, cognitive intelligence, emotional and social intelligence, knowledge, skills, academic credentials, and competencies developed over time are critical as well.

Intelligence Quotient

Clearly, the demands of increasingly information-centric work will require that our future leaders have good native cognitive ability, and those demands will likely drive self-selection of many of our future leaders. The secret that hospitals and health care organizations are some of the most difficult and challenging entities in the world to run will no longer be a secret in the years to come. The driving market forces for transparency and quality accountability will virtually assure it. The baseline-given requirement of above average intelligence is self-evident, which we will not discuss any further in this paper.

Emotional and Social IQ

Emotional and social intelligence will be the focus of much debate in the years to come. One thing is certain, however, is that developing these characteristics is critical to

the success of our future leaders, regardless of how we measure them or precisely define them. For the purposes of brief discussion, Goleman²⁷ describes emotional intelligence as having the capacity for self-awareness and self-management. Some describe it as an ability, capacity, or skill to perceive, assess, and manage the emotions of one’s self. Goleman also states that social intelligence addresses the capacities of social awareness and social facility (or relationship management). Social awareness means primal empathy, empathic accuracy, listening, and social cognition. Social facility means synchrony, self-presentation, influence, and concern. Others have simply defined social intelligence as the intelligence that lies behind group interactions and behaviors.²⁸ Because the social infrastructure and dynamics are so critically important to the “make or break” of health care organization improvement, it is important that we do not ignore these non-purely-cognitive capacities.

Thomas Hamilton, the widely respected director of Survey and Certification at the Centers for Medicare and Medicaid, underscores the importance of partnering and collaborating with even broader social networks than we have today:

“There will be less emphasis on solitary leaders and more on teams of leaders and a role for everyone to lead. There will be partnering leaders who partner with people inside and outside the organization.”

He goes on to say, “transparency will bring an emergence of consumer leaders—they are going to be more and more informed and will become more active in their care, which is good news for everybody” (oral communication, June 29, 2007).

Social entrepreneurship will be a defining characteristic of our future leaders, like Dennis Wagner, deputy director, Center for Quality, Health Resources and Services Administration. Using highly effective social performance methods, he, with multiple other leaders, facilitated development of breakthrough performance for organ donorship, saving more than 4100 lives through national collaborative campaigns.

Performance Improvement Quotient

A new area of expertise critical to our future leaders is that of performance improvement which may become more measurable as the science of improvement evolves. As mentioned by Dr. Kaplan and others earlier, our leaders will need to improve at improving and learn to learn about performance improvement. Dr. Allan Frankel, director of Patient Safety at Partners in Boston and a thought leader in performance improvement, states: “In the next decade, the smartest guys in the room will optimize care by applying their

expertise in improvement, human factors, and cognitive psychology to their innate understanding of variation and patient flow—they will make what feels hard to do today look easy tomorrow” (oral communication, June 27, 2007). Our leaders of tomorrow will need to be well versed in the various methods used today and those that evolve in the future, such as 6 Sigma, Toyota Lean, Kaizen, and the improvement model of the Institute of Healthcare improvement using Plan-Do-Study-Act (PDSA), just to name a few.

Knowledge domains of performance improvement that we should expect future leaders to understand include those we expect of patient safety officers who will be working with them. They include the following:

- **Reliability science.** Understanding the principles of reliability and characteristics of high-reliability organizations.
- **Human factors.** Understanding the limits of human performance and critical need for systems optimization that compensate for the limits of human ability.
- **Building a just culture.** Moving away from blame and shame, building a just culture that treats patients and caregivers with respect and just behaviors.
- **Interpersonal communication and teamwork.** Understanding the knowledge, skills, attitudes, and behaviors that are critical to move to a team-centered performance culture.
- **Influencing and inspiring others.** Understanding how to help shape stakeholder perspectives on safety improvement and understanding how to support tested safety improvement techniques.
- **Basic critical analysis.** Understanding the basics regarding investigative tools such as root cause analysis and proven observational techniques.
- **Frameworks for safety.** Understanding and being able to help develop structures and systems that help move organizations toward safety and reliability.
- **Spread.** Understanding and engaging key stakeholders in the process of spreading successful improvements across health care organizations.
- **Technology.** Understanding the basics and typical pitfalls of unexpected consequences and realities of technology adoption for quality improvement.
- **Leadership.** Understanding how to leverage great leadership methods up and down the organization to drive clinical, operational, and financial performance.
- **Quality and safety strategy implementation.** Developing the competencies necessary to drive quality.

Safety Measures, Standards, and Practices

The quality and safety requirements that certifying, quality, and purchasing organizations use will be more and more important to the financial performance of organizations. Future leaders will not be able to completely delegate their responsibilities because there are increasingly specific requirements of administrative and governance leaders.

The evolving NQF Safe Practices for Better Healthcare, The Joint Commission requirements, CMS requirements, and national quality collaboratives such as the Institute for Healthcare Improvement’s 5 Million Lives Campaign will become very important to the effectiveness of our next generation of leaders. The national harmonization

initiatives that are bringing them into alignment are leader centered, so again such participation will not be easy to delegate to mid-level managers without administrative leadership engagement.

Education and Experience

Although not absolutely critical, a clinical background is a great asset for our future leaders. Traditionally, many of our leaders have come up through operations and finance. Our best leaders who come from those backgrounds have a passion for learning and enjoy leveraging how the “wet side” of the hospital works to deliver enterprise-wide performance. Clearly, physicians, nurses, pharmacists, radiology technologists, and the other various clinically trained applicants will have the respect of the peers whom they have to influence to drive change. For such individuals to have effectiveness in leadership positions, they must supplement their capabilities with finance, operations, leadership, and team building know-how and skills. They have big hurdles to overcome to have balanced capabilities as do those with no clinical background.

Clinical, Operations, and Finance Knowledge and Skills

Regardless of an individual’s background, there is much to be learned regarding hospital-wide performance. All leaders must have a greater balance of clinical, operational, and financial knowledge than in the past. No longer can accountabilities or the act of inspiring the troops be delegated to subordinates who know the business. Future CEOs cannot merely be asset managers and responsible for allocation of resources. If future leaders are clinically trained, they must develop continuously updated operations and finance skills, and they must complement these disciplines with clinical and performance improvement knowledge and skills.

GROWTH AREAS FOR DEVELOPMENT OF CURRENT AND FUTURE LEADERS

Figures 1A and B are stylized charts depicting a very subjective impression of the current status of typical hospital executives. Figure 1C is, again, a stylized rendition of the kind of balance we will need in the idealized future leader. Although not grounded in data or measured objectively, these graphics serve to illustrate the growth areas for development of our future leaders. We provide them merely for discussion.

Transforming Organizations

Hospital leaders at our more progressive organizations believe that transformation is survival critical. Systems failures are occurring very rapidly because of increasing fragmentation of care per patient trajectory and increasing complexity. The typical impact generated by our incremental performance improvement programs is not keeping up. Transformation of the process of care requires leadership engagement, not management, or monitoring of business processes.

When Dr. Nancy Dickey, President and Vice Chancellor of Health Affairs at Texas A & M System Health Science Center, was asked who the smartest guys in the room will be in

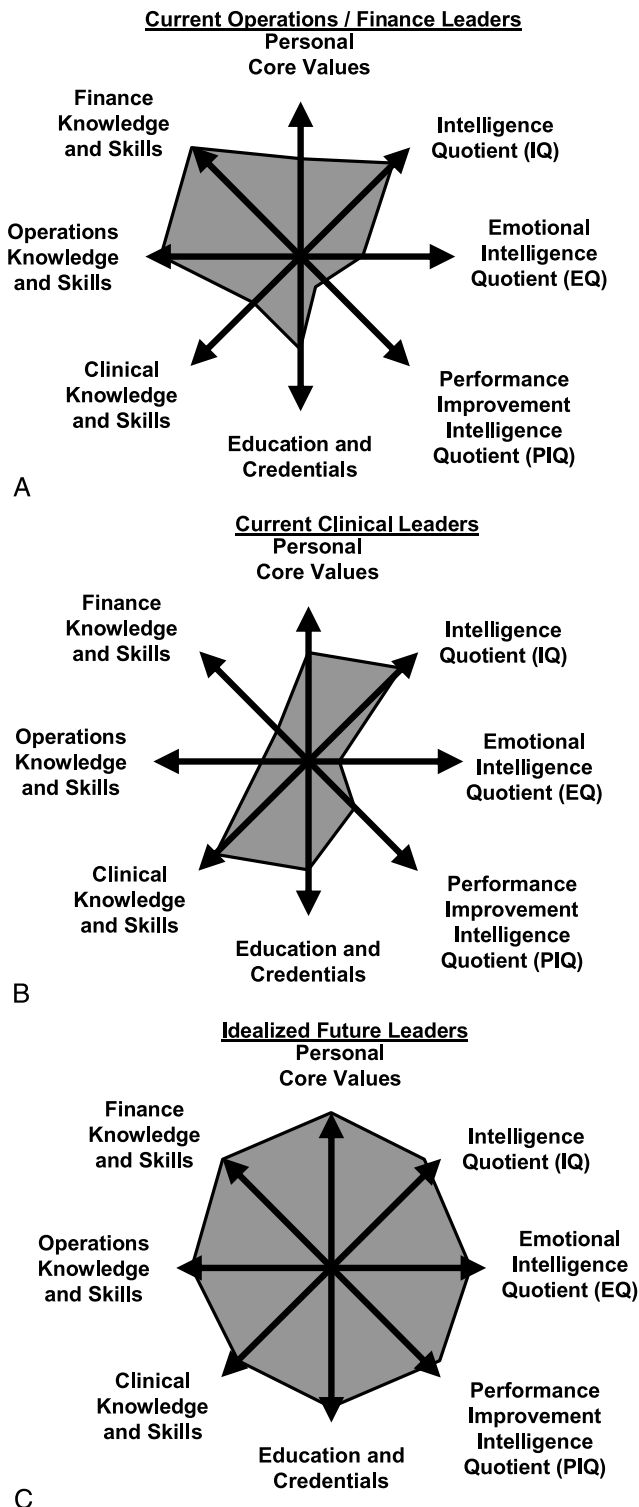


FIGURE 1. Growth areas for development of current and future leaders.

future years, she stated: “The fairy tale of Hans Christian Andersen of ‘The Emperor’s New Clothes’ comes to mind: the smartest guys in the room may be the newest in our employ—the freshly minted doctors, nurses, pharmacists, and

administrative staff. Their untainted eyes may see what we cannot see” (personal communication, July 17, 2007).

“We must listen to and cherish the view of the naive observers who may be looking through a clearer lens of our core values. We must make sure to prevent the normal course health care business from stomping out the child’s voice that may save a life.”

Our future leaders will be dedicated to transformation, dissatisfied with the status quo, and ready to drive continuous process improvement by listening to everyone. They will resist being hypnotized by complexity.

Those who envision themselves as tomorrow’s future leaders, with finance and operations backgrounds, need to intensely focus on learning clinical performance improvement methods—they are not as complicated as they may seem. Their clinically trained counterparts should not presume that their clinical training is enough. They must learn performance improvement methods, leadership principles, and basic finance and operation fundamentals as well.

They will be great team builders who, as mentioned earlier, will have the knowledge and skills to recognize and develop talent. They will appreciate the nuances of fine-tuning leadership team performance. When Jerry Jurgensen, the very successful CEO of Nationwide, one of the largest diversified insurance and financial services companies in the world, was asked about the essence of great leadership teams, he said: “It is not just the strength of the individual ingredients that counts. It is also, the power of the mixture that can have terrific impact.” He went on to say that even changing one team member can have an impact on a high-performance team (personal communication, August 1, 2007).

Transformation will not be easy, but it is critical to succeeding in the years ahead. It will require great communication, steadfast dedication to values, leadership at every level, and new and better ways of developing teamwork. It will require leaders who create unity around a common purpose and earn trust of employees up and down the line. The knowledge and skills of high reliability will be an absolute requirement of our leaders. Finally, they will create the environment, so that the energy state of their organizations is high and ready to meet the challenges ahead.

CAN WE REALLY DEFY THE BUSINESS LAWS OF GRAVITY?

As the planets of health care realign, the gravitational forces of transparency, pay for performance, and consumer-driven choice will pull back the tide of complexity and reveal how we really do our business.

“Only when the tide goes out do you discover who’s swimming naked,” a quote by Warren Buffet.²⁹

Cost, quality, value, speed, trust, and customer choice are intrinsically interdependent and tightly coupled. As those who are receiving care become those who are directly paying for that care, and corporate groups understand the price they pay for poor quality, the fundamental business physics or “magic of the market” will come into play.

The U.S. health care industry is the largest industry in the world as measured by dollar volume, yet business forces and market dynamics have been held in suspension by a third-party payer model. For decades, the government automatically paid our bills regardless of quality, and private payers’ profits were coupled to total cost—when cost went up, their profit went up.

Now that U.S. health care cost is at crisis proportions, the market is adjusting. How long it will take for major adjustments is anyone’s guess. However, we are 37th in the world in quality,³⁰ with 1 in 4 American families experiencing an adverse event, medical costs as the leading cause of bankruptcy even in those with health care insurance, and employers shedding risk to employees by the day. We are heading for some kind of tectonic shift.^{31,32}

Hospital leaders must ask themselves: “How long can we defy the business laws of gravity and continuously ramp up volume, cut cost, and year after year wring out profits with only a head nod to quality and safety?”

How long can we allow the devils of self-preservation shout down our better angels for the common good?

The forces of transparency and cost containment will be unrelenting. The lack of investment in our social infrastructure is a deferred maintenance cost that is a compounding debt. It is paid when degrading performance causes a slow motion spin out of control or, more abruptly, when your hospital hits the front page of the local newspaper with a celebrated catastrophic event. If the press peels back the onion of bureaucratic paralysis to describe you and your board asleep at the wheel, your reputation will be permanently changed.

It is critical to address the genetic code of our organizations to honor the sacred trust of our patients. We must examine how we are incubating our future leaders and make sure that our “natural selection” process delivers leaders who truly are the smartest guys in the room. Our destiny is our values, and our treasure is our talent.

Peter Uberroth,³³ famed entrepreneur and philanthropist provides the “secret sauce” of success in his 1989 Notre Dame commencement speech:

“There is no problem that cannot be solved or challenge that cannot be overcome if there are enough people who care.”

Our future leaders will have to have the knowledge and skills of many roles. They will be great communicators, diplomats, negotiators, educators, students, analysts, and social entrepreneurs. They must have personal values that match the DNA of your organization.

Seek in your future leaders the personal attributes of humility, courage, integrity, vigilance and passion, openness to continuous learning, and dedication to the common good.

Make sure that they are disciplined and collaborative and that they have the capacity to listen to all voices—even the new ones.

Most of all, seek men and women who really care from the bottom of their hearts. If they do, they will be generous and dedicated and inspire your organizations to do better. If you recruit and develop them, you will leave an organization behind that is truly “built to last.”

Will one person possess the values genetic code with all of the wonderful attributes described above? Absolutely not. However, the threads of the collective values DNA of your leadership team will define the tapestry of the culture you weave.

To return to the maritime metaphor, there are many sea changes on the voyage ahead. They will unfold hand in hand with the “C” changes in the leadership lineup of your C-suites and senior management teams. It is critical to act now, so that the right people will be at your helm.

Only history will tell your story, whether you are leading a Ship of Fools, Noah’s Ark, the Mayflower, or a fleet discovering a new world.

Stay tuned to the History Channel. The only thing we know is that the greatest future organizations will be led by the real smartest guys in the room.

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