



Infection preventionists and the

# art of storytelling:

## APIC 2015 closing plenary sneak peek

BY VICKY UHLAND

**O**n the surface, healthcare and storytelling may not seem to have much in common. After all, healthcare is scientific while storytelling is an art. And healthcare is fast-paced while storytelling is leisurely. So why is the closing plenary address for this year's Annual Conference titled "Storytelling as Best Practice?"

"As we learn more about how our brains work, we're also discovering that stories are intrinsic to decision-making and shape our view of the world," said Andy Goodman, who will deliver the closing plenary address during the APIC 2015 Annual Conference, June 27–29, in Nashville, Tennessee. Goodman is director of The Goodman Center, which specializes in strategic communications, including storytelling. Through his work with the Centers for Disease Control and Prevention and the National Association of County and City Health Officials, Goodman has shown hundreds of public healthcare specialists how important storytelling is for engaging disparate audiences, delivering information, and motivating them to act.

We asked Goodman to give us a sneak peek of what he'll be discussing during the closing plenary.

**APIC**  
**2015**  
June 27-29  
Nashville, TN

Early bird deadline: April 20  
Don't miss the APIC  
2015 Annual Conference,  
June 27–29, in Nashville,  
Tennessee  
[www.apic.org/ac2015](http://www.apic.org/ac2015)

**Q: Why is it important that infection preventionists (IPs) learn about storytelling?**

My central belief is if you're in the business of communicating with people and changing what they believe in and act on, you're also in the business of changing what they hear in their heads. Human beings walk around with a set of stories in their heads about the way the world works. And everything that happens to them and all the information coming their way is filtered through those stories. So as communicators, we need to be telling stories so people look up, pay attention, nod their heads and go, "Yes, that makes sense to me; that's the way the world works."

I believe that stories are the single most powerful communication tool we have available to us, bar none. Always was, still is, always will be. If we're talking about spreading knowledge and preventing infections, that knowledge will spread more through stories than through spraying data.

**Q: Can you give an example of how storytelling applies specifically to healthcare settings?**

There was a study recently conducted at the University of Southern California about Mexican-American women and Pap tests. Mexican-American women, because of cultural norms, issues of privacy, or issues of cost, are not getting Pap tests as much as they should. So how do you convince them to do what's in their own interest, to protect their health?

For the study, the researchers rounded up several hundred women in three cohorts: Mexican-American women, Caucasian women, and African-American women. They then divided each group in half. One half watched a short film that was a straight, talking-head presentation with feedback from doctors, nurses, typical women, etc., about why you should get a Pap test. You've seen it a million times. The second half of each group saw a little 10-minute story about women in a kitchen preparing tamales, getting ready for a quinceañera. They were just talking among themselves, and the subject of cervical cancer and Pap tests came up. They covered the same key facts that were in the straight presentation, but it was a little narrative, a little story.

After the women had seen the films, the researchers asked them whether they'd scheduled a Pap test. In the case of the Mexican-American group, 14 percent more went on to schedule a Pap test after seeing the story film rather than the straight presentation. That's a sizeable difference. If you extended that nationally, think of the

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**Andy Goodman**  
Director and Co-Founder  
The Goodman Center  
Los Angeles, California

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thousands of lives that could be saved because of the information contained in a story, with real people in a real situation, as opposed to talking heads, diagrams, and numbers.

**Q ■ Infection prevention programs are very data-driven. How does storytelling mesh with data presentation?**

One of the things I like to say is that people will not face facts if they're looking the wrong way. What I mean by that is that you will not pay attention to data if you have a story in your head that prevents that data from getting in. And so the reason we tell stories is because people can relate to them, they can be moved by them, and they can feel something. And then, only then, will they stop, look, and listen and then consider the data.

**Q ■ Can you apply that to a real-life infection prevention situation? For instance, how could storytelling help an IP convince a doctor to wash his or her hands more frequently?**

Say, for example, that you have a doctor who feels like he's washing his hands enough and he's not interested in any advice about how he can do it more or better. Even if you show him the data saying he needs to wash his hands more, he already has a story in his head saying "I'm doing it enough." So he'll ignore the data, even if he will tell you "I'm a rational person; I'm convinced by data." But if you were to tell him a story of another doctor, just like him, who also thought he was washing his hands enough and then something happened to prove to him that he wasn't, that story might get him to finally look up and say, "Oh, that does sound like me; now let me take a look at your data."

That's how we all are as human beings. If you've ever been confronted with facts—often provided by your spouse—that prove that you're dead wrong, and you have responded, "Well, that's not my experience," then you know what I mean. We all walk around as a focus group of one. Whatever happens to us, that's just the way the world works, right? I like to say that in the ongoing research study that is our life,  $N = 1$ .

So minds are not changed by data. But if you tell someone a story they can relate to, then they'll

stop and look and listen, and then the data can get in. That's just the way our minds work. So when you're talking about preventing infection, you have to give them a story that they can relate to and feel something and open up, and then they're interested in hearing the data. That's just human nature.

**Q ■ How can IPs tell those kinds of effective stories?**

That's a long discussion, but one of the things that makes storytelling work is that we get into a story because we identify with people in the story. If you tell a story where there are no people—it's about an institution or an entity or a concept—that's not a story. A story, as I define it, is about somebody who wants something and must go through a process to get there, running into problems and solving problems until they end up on the other side. A story is sort of a classic hero's journey.

So when we tell stories, it's incumbent on us to decide who it's about, what they want, and what problems they run into on the way there. The very first thing you have to figure out is who's your protagonist, and how do you create an appealing person so that someone listening to the story will go, "I like her, I want to see what happens to her." Or "I identify with her; she's just like me, so I'm going to take this journey with her." Some sort of identification has to take place so that people decide to enter the world of the story and feel the things that the protagonist feels. Then you're on your way. If that doesn't happen, everything that follows doesn't matter, because the audience doesn't care about the protagonist.

Let's go back to that doctor who's not washing his hands enough. Who is he most likely to identify with in a story? Probably another doctor just like him. So that tells you who the hero of your story needs to be.

**Q ■ Any other storytelling advice you can give?**

I don't want to reveal all my secrets. Come to my presentation, and I promise there's more interesting stuff to come. 

*Vicky Uhland is a medical writer for Prevention Strategist.*

# Learn more at the APIC 2015 ANNUAL CONFERENCE



Learn more by attending Andy Goodman's closing plenary on Monday, June 29, 4–5:30 p.m. And be sure to catch the other great plenary presentations:

## Opening plenary presentation

Saturday, June 27, 8–10:30 a.m.

### Preparing globally, acting locally: Applying infection prevention lessons learned from the Ebola crisis

- **Michael Bell, MD**, Deputy Director, Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention
- **Jeffrey P. Gold, MD**, Chancellor, University of Nebraska Medical Center
- **Russell N. Olmsted, MPH, CIC**, Director, Infection Prevention and Control, Patient Care Services, Unified Clinical Organization, Trinity Health
- **Seema Yasmin, MD**, Professor of Public Health, University of Texas at Dallas, Staff Writer, *Dallas Morning News*, former CDC Epidemic Intelligence Service Officer
- **Moderator: Mary Lou Manning, PhD, CRNP, CIC, FAAN**, Associate Professor at the Thomas Jefferson University School of Nursing and 2015 President of APIC

This session will examine Ebola preparedness from several different perspectives with a focus on the ways in which Ebola can help convince healthcare leaders, policy makers, and the public of the value of infection prevention preparedness. Attendees will gain a better understanding of the lessons that can be learned from Ebola preparation and what they can teach us about other more day-to-day issues such as HAI reduction, antibiotic resistance, and what's needed to strengthen infection prevention preparedness overall.

## Day two plenary sessions

*(choice of two)*

Sunday, June 28, 8–9 a.m.

### Respiratory infections—What really works in infection control

- **Wing Hong Seto, MD**, Director, WHO Collaboration Centre on Infectious Disease Epidemiology and Control

After SARS, the World Health Organization (WHO) developed an infection control guideline for acute respiratory infections. Based on this guideline and other research findings, a summary of what actually is effective will be presented.

### Professional accountability in pursuit of a culture of safety

- **Gerald B. Hickson, MD**, Assistant Vice Chancellor for Health Affairs; Senior Vice President for Quality, Safety and Risk Prevention; Joseph C. Ross Chair for Medical Education and Administration; Professor of Pediatrics; Vanderbilt University

Despite having great systems in place to reduce preventable infections, what do you do when individual or group behaviors undermine our best plans? This presentation will explore how the Vanderbilt Model has been used to balance systems and human accountability to promote safety and quality.



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