James L. Holly, M.D.

December 22, 2013

Dear Dr. Chandra:

Thank you for your holiday greetings and to your note of December 21, 2013. I want to respond to your statement, "…what I do say is that I don't talk to people whose mind is made up and whose views cannot be challenged." (see full note at the end of this letter) I feel certain that you misspoke and that you don't mean to say that you don't talk to people "whose mind is made up," but that you only don't talk to people do not allow their "views…(to) be challenged." To exclude from your conversation mature thinkers whose study and life experiences have led them to firm positions would mean that you refuse to talk to people who know what they currently believe. Hopefully, those whose minds have been made up by years of study and experience, but who remain students and remain "learners," thus, who delight in interacting with those who will challenge their positions in dialogue, are welcome in your courses. My life experience has taught me that I most often learn more from those with whom I disagree than with simply interacting with people who already agree with me. The only way I know for us to learn is for people who have firm beliefs and positions to dialogue and for them not to have simultaneous monologues where they talk "at" one another and not "with" and "to" one another.

It is very easy to judge people who are highly self-confident as being arrogant and/or as unwilling to allow their views to be examined or challenged. On the other hand, it is very easy for university professors, particularly at prestigious schools of learning, unwittingly to fall into the trap of demanding that others allow their views to be challenged while the professor becomes increasingly unable or unwilling to allow his/her views to be challenged. We all must be lifetime learners, even when we have terminal degrees which affirm great depth and breath of learning.

Several years ago, I invited a Harvard Professor to visit SETMA and to accompany me on a day-long trip through coastal Louisiana. During that visit, we had a great dialogue. At one point he made a declarative statement that he could not imagine an educated person holding certain beliefs. I responded gently, "I believe those things." At the end of our trip, I said, "Your challenge is that I can be your friend even though we have significant differences about the matters we discussed. The problem is that I suspect that you cannot be my friend if I hold to my beliefs." Time has proved the validity of my observation. He has not passed the challenge.

I describe myself as a "social liberal, a fiscal conservation and a theological fundamentalist." Strange bed-fellow, some would say, but totally logical and consisted in my view. In the following letter to CMS (An Appeal to CMS and ONC for a Temporary Exemption to Meaningful Use 2), I described SETMA's positions on Health Policy and Philosophy with the following observations:

1. As defined by Don Berwick, we believe that healthcare is a human right.

2. We embrace the "moral test for government" as defined by Hubert Humphrey in 1977.
3. The SETMA Foundation was formed in 2009. Annually, SETMA's partners give $500,000 to the Foundation. These funds are used to pay for the care of patients who cannot afford care and also for support for health education for students who need assistance. These funds cannot profit or benefit SETMA.
4. In 2003, we initiated a zero-co-pay for our Medicare Advantage (MA) patients to remove all financial barriers to care. We have actually demonstrated a significant difference in outcomes of care between a zero-co-pay-MA population and fee-for-service Medicare beneficiaries. We attribute this to a barrier created by the cost of care for the FFS Medicare beneficiaries.
5. We have eliminated ethnic disparities in diabetes and hypertension care. (See AHRQ - Diabetes Ethnic Disparities AHRQ letter about ethnic disparities by James L Holly, MD)
6. To validate our commitment to excellence and transformation in healthcare, we have published our opinions on public health policy at Your Life Your Health - Healthcare-Reform-Public-Policy.
7. In 2009, we began publishing SETMA provider performance by provider name on over 300 quality metrics at Public Reporting - Reporting by Type.
8. We provide care for many uninsured and indigent patients and in March, 2014, will assume responsibility for caring for ALL indigent and uninsured patients who come to our largest hospital. This is a practical expression of items 1 and 2 above.
9. Most of our providers hold adjunct or clinical academic appointments at Texas Schools of Medicine and are committed to life-time learning.

With this foundation, let me illustrate my "learning".

Setting out to correct and conclude with being corrected

In my February 6, 2003, newspaper column, I wrote the following:

"(Editor's Note: On February 5, 2003, Dr. Holly addressed the Massachusetts Medical Society's Medical Informatics meeting in Boston Massachusetts. Today's article and the next two weeks installments of *Your Life Your Health* are excerpts from this address which was entitled: '*Beyond Electronic Medical Records: The Hope and Promise of Electronic Patient Management*.' These excerpts will give *The Examiner*'s readers an opportunity to see the efforts which are being made on a national stage to improve the quality of healthcare in America.)

"Several years ago, I was browsing in a book store, and saw a book with a black fly leaf. I picked it up and it fell open to page thirteen. An interlinear jumped out at me, which stated: '*Metanoia*: -- A Shift of Mind'; The paragraph went on to say, (*Metanoia* is) the most accurate word in Western Culture to describe what happens in a learning organization.'

"I knew the word *metanoia* and I knew that it had nothing to do with business. As a Christian and a Bible teacher, I have studied, written and taught that word for years. It is the Greek word for 'repentance', and means to 'have a change of mind or to change one's direction.' I was absolutely confident that it had nothing to do with American business. In order to "debunk" what the author said, I read Peter Senge's *The Fifth Discipline*. Needless to say, 'I had a change of mind.'

"I found in Dr. Senge's book a structural and philosophical foundation for what we were already doing at Southeast Texas Medical Associates (SETMA, www.jameslhollymd.com) in Beaumont, Texas. I also found another illustration of a principle a friend had taught me years before; he said, 'the person who helps you

the most is not one who teaches you something new; it is the person who teaches you how to say that which you already know or suspect.'"

A Learner will grow through mistakes

In a March, 2013 article entitled, "Continuous Professional Development: Learning from a Convergence of Events," which can be found at Continuous Professional Development: Learning from a Convergence of Events
I said the following:

"Conclusion: Unintentional Neglect of a Patient

"All weekend, I thought and even dreamed about the patient I saw several years ago. Over and over and over, the words rang in my head, 'I want to lose weight.' I remembered well that once I had completed the patient's history and settled on treating her/his diabetes, I unintentionally ignored the patient's desires. I was certain that the patient had diabetes; which she/he did. And, I was determined to give the patient excellent care; which I didn't. Rather than explaining to the patient why I don't treat weight loss with Ionamin, thyroid and diuretics, I just ignored her/his goal.

"Because I ignored the patient's goal; the patient ignored my plan. As I think of that patient and yesterday, as I and my staff tried to locate the patient without success, I realized that while I would have labeled the patient 'non-compliant' using ICD-9, ICD-10, or SNOMED codes for that diagnosis, the real diagnosis should have been 'failure to communicate,' 'non-patient-centric care,' 'failure to activate the patient,' and/or 'failure to engage the patient.'

"The fault was not the patient's; the fault was mine. What if I had engaged the patient in a conversation about weight reduction? What if I had discussed with the patient, the reasons why I don't prescribe Ionamin, thyroid medicine, and diuretics for weight reduction? What if I had walked the patient through SETMA's Adult Weight Management program? What if I had said, 'While we are helping you lose weight, we can also help you control your diabetes?'

"Until last week, my memory of this patient's care was that of excellence and of the sad rejection of that care by the patient. Today, I remember this patient's care as my failure due to the hubris of 'my thinking that I knew better.' If my goal had been to help this patient and it was and is, then I should have met the patient's needs and expectations in order to gain the opportunity to meet the patient's real health needs. As it turns out, I have the opportunity to do neither.

"The recognition of having made a mistake

"Plutarch said, 'To make no mistakes is not in the power of man; but from their errors and mistakes the wise and good learn wisdom for the future.' My mistake can be forgiven if I learn from it. And, how will I evince that learning?

"I think I shall never see a patient without asking the question, 'What is your goal?' 'What do you want to achieve in this visit and in the care you will receive from this clinic?' That question is partially answered when the patient-encounter record documents the patient's 'chief complaint.' But to make it more explicit, we are today adding a comment box to each disease management suite of templates and to each suite of templates. It will be labeled: 'Patient Goal.' It will be expressed in the patient's words. While we want to use structured data fields, this may be one case where structured data fields obscure

the issue. As we have more experience with shared-decision making, we will clarify this data field more precisely. But, we will never ignore a patient's personal goal again. And, if the patient's goal is something which is inappropriate, or which can't or shouldn't be done, we will address that directly and frankly, rather than just by ignoring it.

"Learning and Personal Mastery

"We all do still have a great deal to learn, but if we are alert and attentive, if we are willing to be honest with ourselves, we can and we will learn. We will do this as we continue to pursue what Peter Senge's calls 'personal mastery,' which is 'the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively which is the learning organization's spiritual foundation.' (Senge, *The Fifth Discipline*, pp. 7-8)

"People with a high level of personal mastery share several basic characteristics:

- 'The have a special sense of purpose that lies behind their vision and goals. For such a person, a vision is a calling rather than simply a good idea.
- 'They see current reality as an ally, not an enemy. They have learned how to perceive and work with forces of change rather than resist those forces.
- 'They are deeply inquisitive, committed to continually seeing reality more and more accurately.
- 'They feel connected to others and to life itself.
- 'Yet, they sacrifice none of their uniqueness.
- 'They feel as if they are part of a larger creative process, which they can influence but cannot unilaterally control.
- 'Live in a continual learning mode.
- 'They never ARRIVE!
- "(They) are acutely aware of their ignorance, their incompetence, their growth areas.
- 'And they are deeply self-confident!' (IBID., (p. 142)

"I hope I get to meet this patient again. And, if I don't, I shall see her/him in the face and eyes of every patient I see, as I focus upon their goals and desires in order to have the privilege and opportunity to meet their real health needs."

Paternalism or Partnership

Perhaps nothing illustrates continuous learning and the willingness to have one's opinions, positions and even convictions challenged than is the underlying structure and dynamic of healthcare delivery which when I did my formal training was a "paternalistic" didactic model between teacher and student and then between physician and patient. The change from paternalism to partnership which we found in the patient-centered medical home was dramatic and stressful, but it was necessary and critical.

Healthcare and Paternalism

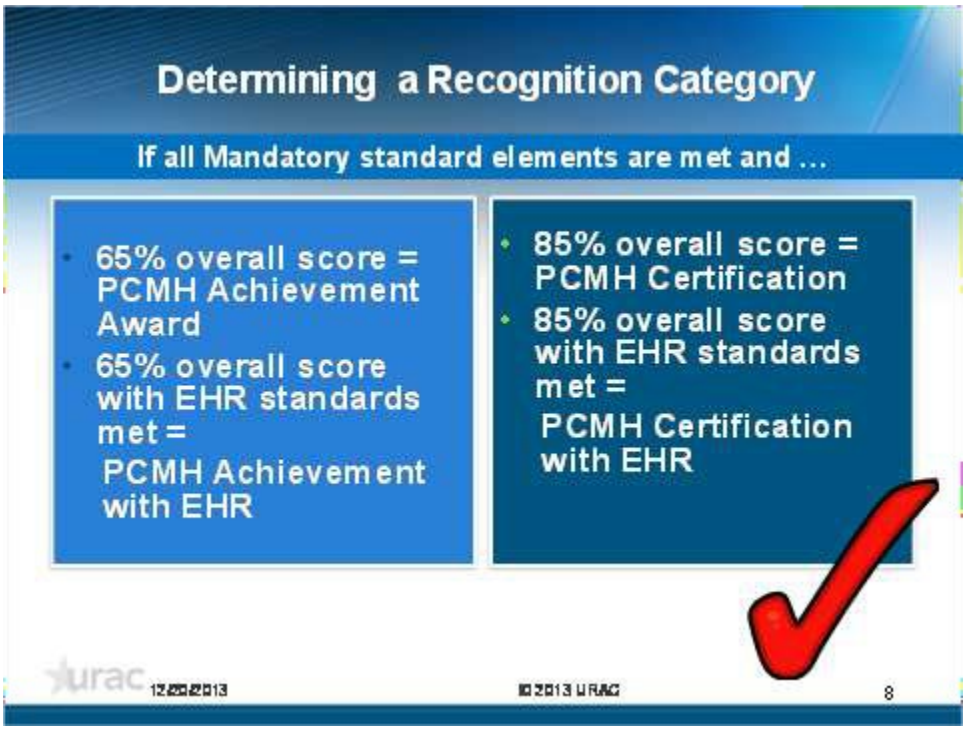
In a September, 2013, article which can be reviewed at: Paternalism or Partnership: The Dynamic of the Patient-Centered Transformation, I said:

"These structural principles will only take SETMA so far in becoming a true 'medical home'. The next step is a radical change in the dynamic of care, a dynamic which will address how medical colleagues relate to one another and how they relate to those they serve. As will be seen below, five months after

SETMA defined the structural changes needed for being a medical home, we discovered that on October 1, 1999, we had defined the new dynamic. Under the old model of care, which we might refer to as a paternalistic healthcare system, patients were very often told what to do and it was expected that they would follow the healthcare providers' instructions without modification. The definition of 'paternalism' helps understand the old model of care; it is: 'A policy or practice of treating or governing people in a fatherly manner, especially by providing for their needs without giving them rights or responsibilities.'

"The dynamic of the medical home redefines the relationship of healthcare provider and patient, and changes how they relate! Rather than the patient encounter being **didactic** (to lecture or teach, as one with knowledge, instructions or informs those who do not) - where the healthcare provider tells the patient what to do, how to do it and when to do it - the patient/provider encounter becomes a **dialogue** (An exchange of ideas or opinions) - where the healthcare provider and the patient discuss a mutual concern and then together come to a mutual conclusion with a mutually agreed upon plan. This new relationship is somewhat like a partnership. In that context, the following is a note I wrote to my colleagues Friday, December 20, 2013. The note said:

"SETMA's URAC Medical Home Survey is over.



"URAC gives two levels of results to an application for a survey. If all mandatory standard elements are met and an overall score of 85% is met for PCMH and 85% score for EHR is reached then the practice will receive PCMH Certification with EHR.

"That is SETMA's result. We now have:

- **"NCQA Tier III PCMH (2010-2016)**
- **"AAAHC PCMH and Ambulatory care (2010-2014)**
- **"URAC PCMH with EMR (2014-2017)**

"In February we will have a survey by Joint Commission. Congratulations to all. SETMA has done and is doing a great job. If we continue to learn and continue to improve, we will lead the way into the future of healthcare transformation.

"Of the 15% of practices in America who have one Medical Home accreditation, only one has more than one, and that is the only one which has three and which will soon have all four, i.e., SETMA,LLP. We work hard at being a Learning Organization which is made up of learners. We ARE extremely self confident, while at the same time feeling that we never ARRIVE, and while we are acutely aware of our ignorance, our incompetence, and the areas in which we need to grow."

Dr. Chandra, I enjoyed my time with you last year at the Harvard Kennedy School. It is unnecessary for you to know me better, but hopefully this note will let you know that while I hold my beliefs deeply, I am as deeply committed to dialoguing with others from the position of openness, transparency and willingness to learn. We should welcome into our conversations those who are deeply committed to their world view and to the lessons learned from their life-experiences and study, as we invite and even challenge them to look at their views and as we allow them to challenge our views and opinions.

Larry

James (Larry) Holly, M.D.
C.E.O. SETMA
www.jameslhollymd.com

(409) 504-4517

Adjunct Professor
Family & Community Medicine
University of Texas Health Science Center
San Antonio School of Medicine

Clinical Associate Professor
Department of Internal Medicine
School of Medicine
Texas A&M Health Science Center

The above is in response to

From: Amitabh Chandra
Sent: Saturday, December 21, 2013 3:32 PM
To: Ling, Horace; James L. Holly
Subject: RE: Harvard Shaping Healthcare Delivery Policy Program Updates

Hi Dr. Holly,

So good to hear from you! One point of clarification to your email where you say that I am "...not interested in talking to those who were knowledgeable or at least opinionated about the issues being discussed." I don't remember saying this, and I certainly don't believe it. But what I do say is that I don't talk to people whose mind is made up and whose views cannot be challenged. We have to be open to learning— as your writing reiterate again and again!

Hope this helps.
Merry Christmas and Happy Holidays to you and your family
-Amitabh.

Which was sent in response to the following note:

From: James L. Holly [mailto:Jholly@jameslhollymd.com]
Sent: Thursday, November 07, 2013 9:28 AM
To: Ling, Horace
Subject: RE: Harvard Shaping Healthcare Delivery Policy Program Updates

Thank you for the contact. I had not thought about coming back to the conference because Dr. Amitabh Chadra made it clear to me that he was not interested in talking to those who were knowledgeable or at least opinionated about the issues being discussed. I assumed then that the conferences were for beginners. If that has changed I may arrange my schedule to return for another conference. I will be interested in your response. Thank you James (Larry) Holly, M.D.