James L. Holly, M.D.

My Initial Response to the Primary Care Week and the Center for Medical humanities and Ethics

For the past twenty years, I have written a weekly newspaper column. Today, I left San Antonio at 3 AM and during my four-hour drive, I though about the excellent experience I had at the Primary Care Week at UT Health San Antonio Long School of Medicine, and the "Conversations About Ethics – A Series of Ethics Lectures," presented by Methodist Healthcare Ministries, The Ecumenical Center for Education, Counseling, Health and UT Health San Antonio Center for Medical Humanities and Ethics.

In separate venues, the presenters were equally excellent: Anna Lembke, MD and Ronald Epstein, MD. Both addressed topics about which each has written a book, Dr. Lembke *Drug Dealer, MD*, (Johns Hopkins Press, 2016) and Dr. Epstein *Attending – Medicine, Mindfulness, and Humanity* (Scribner, 2017).

My life has been greatly enhanced by this week. Drs. Lembke and Epstein affirmed many things I already believed and they have challenged me to "practice what I preach." I shall always admire both of these teachers, educators, healers and practitioners.

In reviewing both presentations and both physicians' person, manner and message, I realized that in my experience the foundation for healthcare improvement is hope. Also, both exampled and encouraged my belief that personal transparency particularly with patients is often the missing element in success and failure in treatment strategies. The following link is to the same article I have copied below: Value, Virtue, Trust and Hope - The Foundation of Health Improvement. Following that are references to four other related topics.

Your Life Your Health - Value, Virtue, Trust and Hope - The Foundation of Health Improvement

July 02, 2015

June 18 & 25, July 2, 2015

In the past seventeen years, this column has often addressed the important of hope in the healthcare process. Without hope, personal healthcare improvement will not happen. Increasingly, in the context of a patient-centered medical home model care, we have realized that while technology and science can treat diseases, neither can produce health.

Hope is the basis for all human effort. In the face of futility -- the vacuum of hope -- men and women become acquiescent." But, what is hope? Obviously, there are elements of hope which are a matter of faith. Many of us have strong beliefs which undergird, inform and give substance to our sense of and definition of hope. Yet, there are common elements of hope which are universal. It is these which concern us as health care providers and which we would like to "tap into" in order to help our patients achieve the health they desire.

1. The first element of hope is the affirmation that the future is positive and good.
2. The second element of hope is the confidence that if I make a change it will make a difference.
3. The third element of hope is that it is my actions which can make a difference, i.e., the result of hope is not an accident.
4. The fourth element of hope is the confidence that I can personally make a change which will make a difference.
5. The fifth element of hope is the determination that I am willing to persist in the change until it makes a difference. Relentlessness is a character trait birthed of hope.
6. The sixth element of hope is the knowledge that while changing does not make me a better or more valuable person, it can make a difference in my personal health.
7. The seventh element of hope is that our exercise of hope always impacts others whom we love and care about. Here is the ultimate payoff in community terms of hope and its result. We get to influence for good those we love because hope is contagious.
8. The eighth element of hope is that we do not hope alone; people who have significant and efficacious hope do so as a part of a community, while despair is often experienced alone.
9. The ninth element of hope is that it is personal.
10. The tenth element of hope is that our future is not competitive, i.e., for me to win, you don't have to lose.

Value

The beginning of hope is the belief that I have personal worth; I have value. This is the foundation of hope. Where does hope come from? How is hope created? First, hope is founded upon the intrinsic value of the individual. "Intrinsic" means "belonging to the essential nature or constitution of a thing." In other words, a person's value is not a result of what they have, what they do, or who they are; the value of a person is as a result of their being a "person."

This is a foundational principle of western civilization and particularly of the value system of the United States of America. It is not the state which is of ultimate value; it is the individual and it is not the individual as a "concept," but as a person, as an individual. There is no doubt that some are honored more than others because of what they have and/or of what they have accomplished, but objectively in our culture, we do not value the life of one above another.

If hope is necessary for a person to take steps to improve their health, and if the foundation of hope is a sense of personal value, and if a healthcare provider's responsibility in a patient-centered medical home is to motivate and empower a person to improve their health, how then, can healthcare providers instill in others the sense of their having personal value? How does this practically operate every day?

It may be that the essence of a profession, which classically included the ministry, the law and medicine, is that they directly communicate to an individual their sense of personal value. In medicine, individual and person value is built by the respect, dignity and compassion with which each person is treated in the clinical setting, whether hospital, clinic, emergency room, nursing home, or other location. Simple things like shaking the hand of a person while looking them in the eye and greeting them by name are the beginning of this exercise. In the healthcare setting, each individual, whether a bank president, or not, can be addressed by their title -- Mr. or Mrs. or Miss -- until and unless the relationship is such that addressing a person by their first name is appropriate.

It may be that the respect and dignity with which an individual is approached in the clinical setting instills a greater sense of the personal worth of an individual than even the excellence of the care they receive. This is not to suggest that inferior care is balanced by compassion, but it is a fact that excellent care given in a negative environment will not benefit the patient as much as that given in a caring, affirming relationship.

The value of life and the personal value of an individual are the root of our healthcare decisions. The choice to live rather than to die is the first choice based on that value. The choice to make healthy decisions about behavior, access of care, follow-up and follow through on treatment recommendations are all founded upon the value a person places on life and on their own life. Because these judgments of value are often not cognitive -- they are often not things we consciously think about -- a person may be unaware that they are making a decision about their personal, intrinsic value, but they are nonetheless.

Beyond their personal interaction with patients in the clinical setting, how can healthcare providers contribute to the development of hope in a patient through the affirmation of personal value? An optimistic view is helpful. Optimism is not created by the ignoring of reality, but it is assuming the best while facing other possibilities. If an individual has no personal value, it is possible to be fatalistic and to assume the worse; if they are highly valued, optimism - the expectation of the best -- will be the intuitive, default position.

The healthcare provider also builds a sense of the value of the individual when he/she addresses the future of the patient from a perspective of change. "Here is where you are today, but with the following actions, you can change that future," is not only an expression of optimism but it is a

result of clinical competence to know what can and what should be done to make things better. Rather than quickly dismissing the patient -- and this is not a function of time spent with the patient but of total focus on the patient's future -- providing the patient with a plan of action and treatment plan for improvement of their health invests in them value.

Follow-up is one of the most important evidences of the value of the individual. When a person is given appropriate interval follow-up, it instills in them a sense that someone else cares, and even if life's experience have diminished their own caring about themselves, that caring can be regenerated through others caring about them. A part of follow-up is access. When the only access a person has to a healthcare provider is when they are in the office, generating a bill and making a payment, the relationship becomes commercial. When the patient has access to the counsel and attention of a healthcare provider at an appropriate frequency, at other times, the patient begins to see that he/she has value to someone else and is more likely to begin having a sense of personal value. When a healthcare provider answers telephone calls in a timely fashion, he/she is instilling value, which is the foundation of hope, in the life of the patient.

And, while this may not be a conscious transaction in the mind of the patient or provider, it is nevertheless the case. A dramatic change in the patient’s sense of value takes place when they have personal and private access to the healthcare provider as is given by the provider gives the patient his/her personal cell phone number. When this is done as a commercial exchange as in concierge medicine, it has less benefit to the patient but when it is done as a expression and declaration of personal value, i.e., without a payment “buying” the number, it has immeasurable value in the life of the patient.

Virtue

The second foundation of hope, which is actually the "engine," or the power source of hope, is virtue. Like hope, virtue has many definitions. Webster's gives one of them as "a capacity to act, potency." This is the sense in which virtue is an aspect of hope. We often, and appropriately, associate "virtue" with morality, but it means more than that. Without the capacity - the power -- to act, hope has no means of impacting a person's life. However, a person who recognizes the value of their person -- regardless of their education, position, pocketbook or other external measure -- and who has virtue -- the ability to make decisions and act on them -- can change their future. Virtue provides the patient with the courage to make decisions which are uncomfortable but beneficial.

Virtue allows a person to persist in a decision until the promised benefit is realized. The presence or absence of virtue is often the difference between success and failure. And, the absence of virtue does not mean that a person is evil or immoral in the sense in which we are using the term. The absence of virtue simply means that the person lacks the courage, the conviction, the consistency, the perseverance, or the capacity to change their behavior over a long period of time for the good of their person.

Here is a more difficult question, "Can a healthcare provider help a patient develop virtue?" Without doubt, it is hard, but it is possible. Virtue is more than the development of habits, but virtue's presence, or absence will result in habits being formed. The healthcare provider can help

a patient develop positive habits with accountability and reinforcement of positive conduct. The healthcare provider can promote virtue in the life of the patient by celebrating success however small and by cheering the patient on to success.

In fact, the more successful the healthcare provider is in accomplishing the first element of hope -- instilling value in the life of a patient -- the more success he/she will have in promoting virtue. For the more a patient feels that the healthcare provider "cares" about them -- values their person, intrinsically -- the more "power" the provider will have to promote positive habits in the patient from which will spring virtue -- the capacity to act.

As we continue to work to help patients get control of their lives and health, it is clear that all of the answers will not be found in a test tube. Life's experiences can "beat the life" out of us. How to "re-inflate" our lives is a question which we all must address, but it is a question which is critical to the mission of healthcare providers. While we are striving for clinical competence and excellence, we must never forget that we are not dealing with simple machines, but with complex and complicated individuals, each of which is incredibly important.

Without hope, which is a function of value and virtue, all of the healthcare financing and access in the world will not change a person's health. Public policy must address this central element to the efficacy of our efforts at improving the administration, financing and distribution of healthcare in the United States.

Trust

The third element of hope is trust. In order to complete the journey to hope in regard to personal healthcare and after experiencing a sense of personal value and virtue, a person must have trust in the healthcare system and in their personal healthcare provider and/or clinic. Trust in a provider is built upon the patient recognizing that the provider values them as a person and that the provider believes the patient has the virtue to change their lives for the better.

One of two books which has influenced SETMA is Tom Morris' *If Aristotle Ran General Motors*. Before becoming a business consultant, Morris was a professor of philosophy at the University of Notre Dame and applies the four cardinal virtues identified by Aristotle to 21st Century American business. One of those virtues is "truth." He states: Truth is the foundation for trust, and nothing is more important for any business endeavor than trust."

In medicine trust is built upon the patient's judgment of the provider's competence which at its root is a matter of knowledge, but which is facilitated by transparency. When the patient believes that the provider is going to tell him/her the truth, no matter what, they begin to "believe" - trust - what the provider says. 'When healthcare providers transparently tell their patients, practice and community how they are performing as a provider, the "trust quotient" of hope goes up dramatically.

When it comes to practicing quality medicine, SETMA believes that trust must be the foundation of patient care. Not only is transformation at the root of excellent healthcare, it is also at the root of a patient's trust of the provider. Here is an example where trust grew out of a attitude of

contention and anger. An angry and hostile individual could not be persuaded to think or behave otherwise during hospital rounds After leaving the hospital, The patient arrived at SETMA with the same frustrating and agitating persona as seen in the hospital. But during his visit, SETMA learned:

1. He was disabled and could not pursue his job.
2. He could not afford his medicine and took only four of the nine prescribed medications.
3. He was losing his vision due a chronic condition.
4. He could not pay for the gas to drive to education classes that might help him better his health, and he could not pay for the education class co-pays.
5. He could not afford to see an eye specialist.
6. He had no idea how to apply for disability.
7. He had no insurance and no money.

SETMA knew that if we prescribed the best care, but if he couldn't afford to access that care, it would do no good. Therefore, according to the dynamic of Patient-Centered Medical home, this patient left with:

1. All medications paid for by the SETMA Foundation, established by the fourteen SETMA partners as a 501-C3 foundation to assist their patients with care they could not afford. A gas card to cover his fuel expenses for the education classes, again provided by the Foundation.
2. Co-pays waived for the education classes.
3. Help in applying for disability income
4. A referral from SETMA's ophthalmologist to a regional research program that could help save his vision.
5. Assistance from Care Coordination to apply for disability

Six weeks later, the patient returned with hope. He believed the rest of his life could be good. For the first time in his life, his diabetes was at goal. Now, he is the poster child for the medical home. He knows that he has personal value, virtue, trust, all of which morph intohope.

The entire focus and energy of "health home" is to rediscover that trusting bond between patient and provider. In the "health home," technology becomes a tool to be used and not an end to be pursued. The outcomes of pure technology alone are not as satisfying as those where trust and technology are properly balanced in healthcare delivery.

The challenge for our new generation of healthcare providers and for those of us who are finishing our careers is that we must be technologically competent while at the same time being personally compassionate and engaged with our patients. This is not easy because of the efficiency (excellence x time) of applied technology. A referral or a procedure is often faster and more quantifiable than is a conversation or counseling.

In 2002, Onora O'Neill gave the Reith Lectures. She addressed trust in modern life:

"Trust, as I saw it, was mainly of interest to sociologists, journalists and pollsters: they ask regularly whom we trust. Some of our answers show that many of us now claim not to trust various professions. Yet I noticed that people often choose to rely on the very people whom they claimed not to trust.

They said they didn't trust the food industry or the police, but they bought supermarket food and called the police when trouble threatened. I began to see that there is a big gulf between saying we don't trust others and refusing to place trust, between (claimed) attitudes and action.

Bit by bit I concluded that the "crisis of trust' that supposedly grips us is better described as an attitude, indeed a culture, of suspicion. I then began to question the common assumption that the crisis of trust arises because others are untrustworthy. I began to notice that there were lots of news stories about breach of trust, especially about supposedly scandalous cases, but that there was surprisingly little systematic evidence of growing untrustworthiness.

"Our revolution in accountability has not reduced attitudes of mistrust, but rather reinforced a culture of suspicion. Instead of working towards intelligent accountability based on good governance, independent inspection and careful reporting, we are galloping towards central planning by performance indicators, reinforced by obsessions with blame and compensation. This is pretty miserable both for those who feel suspicious and for those who are suspected of untrustworthy action - sometimes with little evidence.

"In the Reith Lectures I outline a much more practical view of trust. The lectures are not about attitudes of trust, but about actively placing and refusing trust and the sorts of evidence we need if we are to place trust well. Far from suggesting that we should trust blindly, I argue that we should place trust with care and discrimination, and that this means that we need to pay more attention to the accuracy of information provided to the public."

Placing trust well can never guarantee immunity from breaches of trust: life does not provide guarantees. There is no total answer to the old question "Who shall guard the guardians?', and there is no way of eliminating all risk of disappointment. Nevertheless, many of us would agree with Samuel Johnson "it is better to be sometimes cheated than never to have trusted'.

"If we are to reduce the culture of suspicion, many changes will be needed. We will need to give up childish fantasies that we can have total guarantees of others' performance. We will need to free professionals and the public service to serve the public. We will need to work towards more intelligent forms of accountability. We will need to rethink a media culture in which spreading suspicion has become a routine activity, and to move towards a robust configuration of press freedom that is appropriate to twenty first century communications technology. This won't be easy. We have placed formidable obstacles in our own path: it is time to start removing them."

The origin and the fruit of hope - value, virtue, trust

> As we move deeper into the 21st Century, we do so knowing that the technological advances we face are astounding. Our grandchildren's generation will experience healthcare methods and possibilities which seem like science fiction to us today. Yet, that technology risks decreasing the value of our lives, if we do not in the midst of technology retain our humanity. As we celebrate science, we must not fail to embrace the minister, the ethicist, the humanist, the theologian, indeed the ones who remind us that being the bionic man or women will not make us more human but it seriously risks causing us to being dehumanized. And in doing so, we may just find the right balance between technology and trust and thereby find the solution to the cost of care.

Additional aspects of these concepts are found in the following articles:

- **Teaching from my mistakes:** Continuous Professional Development: Learning from a Convergence of Events -- **Another title could be, "How Others can Learn from My Mistakes Through my Transparency."**

- **What happens when we become a partner with our patients rather than a parent.** Paternalism or Partnership: The Dynamic of the Patient-Centered Transformation.

- **If a patent threatens to kill a doctor is that the end of that patient's care**? From Homicidal Threat to Reciprocal Caring: A Patient-Centered Journey. -- **An Example of Creating a Sense of Value in a Patient**.

- **Technology can deal with disease but cannot produce health.** Technology and Humanity: The Critical Balance in 21st Century Healthcare.

The Tension between Technology and Humanity

In our recent two part series "Entrepreneurism and Professionalism" we have explored causes of the escalating cost of healthcare. It is this writer's contention that the principle driving force of healthcare cost increases is technology and its cost coupled with decreasing trust between healthcare provider and healthcare recipient. Technology, beginning with the invention of the wheel, has increasingly improved our lives, while at the same time unwittingly being the catalyst which often makes us islands until ourselves. Technology, which has made it possible for us to have instant access to one another via cell phones, video phones and now iphones, has also increasingly caused us to be isolated from another. Technology has built barriers to intimacy replacing personal interaction and social intercourse with information and exposure. A kind of "social voyeurism" born of technological advances has made us spectators of life through television, cinema and computers rather than our being participants in life. This voyeurism has caused us to substitute watching others live for our own living.

The Front Porch - a Great Technological Advance

One of the greatest inventions in western civilization was the front porch. The porch so defined the American culture that in the first decades of the "technological 20th Century," the most popular magazine, The Ladies Home Journal, which was published monthly, had an annual "Porch Edition," in which illustrations, diagrams and building plans for various kinds of "front porches" were described. The front porch was the community center, family gathering place, neighborhood visiting center and the communication hub for much of what was great about America. My mother's parents, who were very poor and who lived in an old house were, in my judgment, the richest because they had a porch that went all the way around the house. My brother and I dreamed all our lives of having a house with such a porch. He succeeded. His home, secluded by a wooded area in the midst of development all around, has 4,800 square feet under roof. 2,400 square feet is a porch all the way around the house. But, alas, the function of his porch suffers technological advancement.

The porch was the coolest place in the house. It provided the opportunity for families to connect with their friends. It was the place where people who did not have the time to visit, greeted one another with a wave, or a loud "howdy." I remember as a child sitting on the porch, or returning home to find my parents sitting on the porch. Whether singing "Swanee River" or reviewing the family album which is in my mind, the porch and my parents will always be cherished parts of my memory.

Sometimes the porch was the seat of justice. I remember returning home one day, having had the privilege of taking the family car to town for an errand. I dented my father's new car, which though being used was new to us. Returning home, I crafted a tall tale about how this had happened. My parents were rocking on the porch when I returned. It looked like something out of Whistler's Mother. As I began telling my story, I realized that it was full of holes and finally with a chuckle, I said, "I have just realized that there are three fatal flaws with this story, let me tell you what really happened." My father said, "No, let me tell you what happened; three people have already called and said, "Billy, you will not believe what that boy did to your car.'"

The Encroachment of Technology

The porch tied families and communities together. I remember sitting on the porch and wishing that there was not so much dust when someone passed on the dirt road in front of our house. Then one day, the road was paved. However, this technological advance of a "black top" road actually increased our isolation, as less and less time was spent on the porch and more and more time was spend on the smooth road. Then the ultimate advance came. I was a teenager when our family physician replaced the air conditioners in his home in town. He gave the old air conditioners to his dear friend, my father. I can feel the coolness today. It was a great day to have "conditioned air." You could be warm in the winter - we had heat - and cool in the summer, but what you could not have was the community connection of the front porch because it was not air conditioned. We didn't sit on the porch very often after that.

Healthcare Technology

Like the loss of the community created by the loss of the front porch, technology has improved what we can expect of healthcare but it has not necessarily ultimately improved the quality of our lives. There was a time, because there wasn't much that we could do about it, that we did not spend all of our time thinking about extending the length of our life; we spent all of our time living.

The New York Times Magazine of May 2, 2010, carried an article entitled, "The Data-Driven Life,." which asks the question, "Technology has made it feasible not only to measure our most basic habits but also to evaluate them. Does measuring what we eat or how much we sleep or how often we do the dishes change how we think about ourselves?" The article asks, "What happens when technology can calculate and analyze every quotidian thing that happened to you today?" I admit, I had to look up the word "quotidian." It means "daily; occurring or recurring every day; common, ordinary, trivial**."** Does this remind you of Einstein's admonition, "Not everything that can be counted counts, and not everything that counts can be counted?"

Technology must never blind us to the human. Bioethicist, Onora O'Neill, commented about our technological obsession with measuring things. In doing so she echoes the reality that that not everything that is counted counts. She said, "In theory again the new culture of accountability and audit makes professionals and institutions more accountable for good performance. This is manifest in the rhetoric of improvement and rising standards, of efficiency gains and best practice, of respect for patients and pupils and employees. But beneath this admirable rhetoric the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is."

Technology Can Deal with Disease but Cannot Produce Health

In our quest for excellence, we must not be seduced by technology with its numbers and tables. This is particularly the case in healthcare. In the future of medicine, the tension - not a conflict but a dynamic balance - must be properly maintained between humanity and technology. Technology can contribute to the solving of many of our disease problems but ultimately cannot solve the "health problems" we face. It is my judgment that the major issue facing healthcare delivery today is that men and women, boys and girls have replaced the trust they once had in their physician with a trust in technology. It is as if the "front porches" of healthcare have disappeared and the air-conditioning has forced us inside the building so that we can't say "howdy" to one another any longer.

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efficiency (excellence x time) of applied technology. A referral or a procedure is often faster and more quantifiable than is a conversation or counseling.

Preoccupied with not dying; often having forgotten to live

In our quest to extend our lives, again quantified by the number of years lived rather than the content of the life itself, we want to have our trust restored in healthcare professionals. To do so, we turn to technological evidence of trustworthiness. We turn to quality metrics and the reporting of performance. This "trust" of numbers often blinds us to the inadequacy of technology to replace or even to display character, convictions and principles. We must never forget that often "the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is."

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"In the Reith Lectures I outline a much more practical view of trust. The lectures are not about attitudes of trust, but about actively placing and refusing trust and the sorts of evidence we need if we are to place trust well. Far from suggesting that we should trust blindly, I argue that we should place trust with care and discrimination, and that this means that we need to pay more attention to the accuracy of information provided to the public. Placing trust well can never guarantee immunity from breaches of trust: life does not provide guarantees. There is no total answer to the old question "Who shall guard the guardians?', and there is no way of eliminating all risk of disappointment. Nevertheless, many of us would agree with Samuel Johnson "it is better to be sometimes cheated than never to have trusted'.

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suspicion has become a routine activity, and to move towards a robust configuration of press freedom that is appropriate to twenty first century communications technology. This won't be easy. We have placed formidable obstacles in our own path: it is time to start removing them."

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This process is continuous. As Dr. Senge addressed “creative tension” as being the difference between your “reality” and your “vision,” the human spirit will drive for the resolution of tension. But, as our reality approaches our vision, our vision will grow, producing another “creative tension.” If we are fortunate, this process will last all of our lives. Seen in its greatest promise, in death our reality and our vision finally become one and the same.

Thank you all for a great gift.

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

Adjunct Professor
Family & Community Medicine
University of Texas Health San Antonio
The Joe R. and Teresa Lozano Long School of Medicine

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