James L. Holly, M.D.

Why I Reject the Model Presented at a Recent Conference
By James L. Holly, MD
May 20, 2016

Yesterday (May 18, 2016), I had a new experience, I flew across the country to attend a conference and after the first session and brief discussions with several leaders, flew back to Beaumont on the same day. I did not leave angry but realized that if I stayed, I would be disruptive. I was there at the invitation of someone I greatly respect and did not want to embarrass or disappoint that person, so my only option was to leave.

I will not identify the conference or the leaders as my goal is to explain my objection to what I heard and to think about how to solve the dental healthcare problems which were to be addressed. My goal is not to embarrass anyone and I am reasonably certain that the leaders of the conference are not interested in hearing a contrary opinion.

The remarkable thing is that I totally agree with the goals of this conference and I even understand the rationale of their approach. However, I do think that their philosophy and rationale are counter productive. The stated goals are:

1. Eradicate dental disease in children
2. Incorporate oral health into the primary education system
3. Include an adult dental benefit in publically funded health coverage
4. Build a comprehensive national oral health measurement system
5. Integrate oral health into person-centered healthcare
6. Improve the public perception of the value of oral health to overall health

SETMA's Commitment to Dental Care

When I was asked to attend this conference, I responded with the following explanation of my commitment to dental care and health:

1. SETMA, my practice, tracks dental care in patients with diabetes because those who get annual teeth cleaning have better diabetes control
2. Spends the largest amount from The SETMA Foundation for extensive dental care. The funding for the Foundation comes totally from contributions by the Partners of SETMA.
3. SETMA has extensive evidence of the value of dental care for overall health. Seven years ago, we asked a dentist for the cost of properly repairing a patient's teeth. He said $10,400. We asked him to make a $4,000 contribution to our Foundation and we would pay him $10,400 for her care. In the

years prior, she had been hospitalized 10 times, was on 9 medications, had poorly controlled diabetes and was getting sicker. After the dental restoration, she has not been hospitalized once and is on one medication.

4. Screens pediatric patients for dental health.

It is SETMA's contention that if Medicare and all insurance companies pay for screening, preventive maintenance and restorative dental care that the return on investment would be significant.

My Life-Long Support of Dental Care for All

When I was a college sophomore in 1962, a boy in my dorm had totally rotten teeth. I went to a dentist and arranged a total extraction and dentures which I would pay for by working the following summer. I was 18 years old. There was another student who agreed to pay for half of the dental work. When we returned from the summer vacation and I had paid my half, he said that he was not going to keep his commitment. I had to be at school two weeks before the cafeteria opened so I had money for two weeks of food. It was exactly half the cost of the dental work. I gave it to the dentist and fasted for two weeks. The debt was paid, the boy's life was changed forever and I received a great blessing. And I had my first experience with the joy and the discipline of giving to others.

What Offended Me at this Conference's Initial Presentation?

Through my 43-year medical career, I have known that there are identifiable differences in care received by various groups or populations of patients. Sometimes those groups are identified by ethnicity and the differences, which almost always represent lower quality of care, are referred to as "Ethnic Disparities". When these disparities are recognized, it is possible to design treatment programs which can mitigate or hopefully eliminate them. Due to the use of business intelligence, statistic analysis, and health data informatics, SETMA has been able to demonstrate the elimination of ethnic disparities in diabetes and hypertension treatment. SETMA's approach to healthcare is defined in our Model of Care. (See: The SETMA Way - SETMA's Model of Care Patient-Centered Medical Home: The Future of Healthcare Innovation and Change) This model includes personal and personalized care for individuals and population-health-methods for groups or panels of patients.

SETMA is accredited as a Patient-Centered Medical Home (PC-MH) by all four national organizations that provide such (see: Accreditations - SETMA's Accreditation, NCQA, AAAHC, TMF Health Quality Institute, URAC and Joint Commission). SETMA has also been involved with Medicare Advantage and its predecessor organizations for 20 years. We know and practice the Triple Aim defined by the Institute for Healthcare Improvement and we support and participate in Alternative Models of Care (AMC) to that end.

In the introductory session at this conference, the discussion was not about defining the problem of dental care and designing a solution. It was about who is to blame. Terms like "health equity" and "social justice" were used to explain our current dental health. It was even said, "White people get dental care," implying that the absence of dental care among other groups could have a race basis.

"Social Justice" and "Health Equity," while popular and familiar terms are not healthcare terms; they are political terms. The vocabulary of the presentation sounded like a training program for a Community Organizer group and the spirit was like a cheer leader among people who shared a common belief. The presentation was given by a liberal, qua progressive, qua socialist who, rather than promoting a solution,

placed responsibility for the solution, not upon the individual, but upon society. The presentation was well rehearsed and well presented and had obviously been practiced before.

Also, I had heard it before. If "social justice" is the solution, then it must be to undo the result of "social injustice," and it was implied that the solution to the problem was to find who is to blame, and that it might actually be "white people." After all, if they are absorbing all the resources, there is no balance or equity in the distribution of those resources.

I will soon be 73 years old. My personal experience with dental health came through my father and mother. I grew up in a lower, middle class home. 70 years ago, in my family, there was not a great deal of money, Nevertheless, my father, who lost all of his teeth at age 30 due to poor dental care, made sure that his children and wife had excellent dental care. It was a choice he made. He did not use alcohol. He did not have a fancy car. He lived in company housing and he grew most of our food. But, he provided for our dental care. He did not expect society to provide it.

Repeatedly, it was said that "we," implying government, society and "white people" are responsible for providing dental care to everyone. Here is where it got curious. PC-MH was touted as the model of care for the future. Terms familiar to those of us involved in PC-MH, like "patient activation" and "patient engagement" were used. Unfortunately, it was never stated that these terms refer to personal participation and personal responsibility for one's own health and dental care.

Everyone understands that some people need help, but it should be help, not societal assumption of full responsibility for all healthcare. Seven years ago, SETMA formed a Foundation and the partners of SETMA have given $500,000 a year to that foundation in order to have funds to help our patients who cannot afford their care. In the following section of SETMA's website (www.jameslhollymd.com), you can read some of our stories which illustrate the above. (See: Medical Home - The Story and the Ideals) (For more detail see: Your Life Your Health - Medical Home Series Two: Part XVIII - Introduction to SETMA's 2009, 2010 and 2011 Series of Articles on Medical Home and for the update of this story see: Your Life Your Health - Patient Centered Medical Home Poster Child: An Update after Five Years of Treatment in a Medical Home))

We have continued this even though due to the 20% CMS reduction in Medicare Advantage reimbursement and the Affordable Care Act's "tax" to our IPA of $1,500,000 annually to be increased this year to $1,700,000 resulted in a revenue decrease such that some of the partners of SETMA have not been paid since December 3, 2015. Yet, we still support our employees and patients without any decrease in their benefits. We are taking steps to respond to this pressure, but none of those steps are taken at the expense of the quality of care our patients receive.

Twelve years ago, SETMA went to the HMO with which we work and requested that our patients have a zero co-pay to see a primary care provider in order to eliminate all economic barriers to care. We can now demonstrate statistically that our patients with a zero co-pay have a better outcome than our fee-for-service Medicare patients who are still responsible for their 20% payment.

Our practice, patients and partners are made up of African American, Oriental, Asian, Middle Eastern, Indian and other racial, ethnic and national groups. Collectively, we are the solution to the problems which together we all face.

White People

It was very disappointing to hear the reference at the conference to “white people.” And, the term was used derisively. Why can’t we eliminate the phrase “white people?” I have never seen a "white man." My shirts are white; my skin is not!! I and all men and women are "colored." Some, like me, are Caucasian with skin tone which vary from light brown, to slightly pink, to dark black. Others are Mongoloid which has more to do with physiognomy than skin color. Others are Negroid, which varies from dark brown to black.

In reality, we are all "colored." If more proof is needed, I offer the following observation. Pakistanis are Caucasian, yet some have skin tones darker than any African-American. There is no uniformity between skin color and ethnicity. Denzel Washington played the role of Steve Biko (one of my heroes) in the movie, *Cry Freedom.* In Steve’s trial in a South African court, the judge asked, "Why do you people call yourself black, you are browner than you are black?" Steve responded, "Why do you call yourself white, you are pinker than you are white?" To which the judge responded, "Precisely!" If we are going to refer to Caucasians by a color, let’s agree to call them “pink,” or “brown,” or “black.” All apply.

The foundation of racism

In 1970, I was in a medical meeting in Los Angeles In a plenary session of 1,000+ people, an African American professor assumed the microphone and began to address her theory of the foundation of racism. She argued that prejudice is produced in people who resent others having something which they don't. She opined that white people were missing melanin and resented it.

When she finished, I was recognized. I said that the absence of melanin is not the issue of racism as Caucasians only have a relative, not an absolute, melanin deficiency. I said that the absence of melanin which resulted from a metabolic abnormality did not result in Caucasian-ism but albinism. At that time, I quoted verbatim and correctly the biochemical pathway for the production of melanin, pointing out the point of the blocking of its production resulting in albinism. (I could do that 46 years ago; today I can't.) Needless to say, my observations won the day.
Now, here we are 46 years later, still fighting the same fight of skin tone but blaming “white people” for all of societal ills, and as we now know, “white people,” really don’t exist. It is implied that it is because of white people that others don’t have dental care. And, it is the responsibility now of “white people” to provide dental care for everyone. Both propositions are false.

Social Justice and Healthcare Equity

Studies of “justice” and of “social justice” are long and tortuous. It is a canon of progressivism, 20th Century Liberalism, Socialism, and Communism – which are not used as synonyms but which may be a linear “procession” -- that “social injustice” exists in any setting, where there is a difference in wealth and/or of the fruits attached thereto. The clear implication is that any disparity in distribution of any goods, whether a process or a product, is *ipso facto* the result of injustice.

The political model of “social justice” does not allow for differences in personal choice and assumes injustice at the root of all differences in resources. This creates simplicity and a uniformity which demands the stifling of initiative, creativity, ingenuity and/or industry in a society. All differences among people are reflective of an evil influence even though one worked hard, created utility (in the John Locke scheme) and received a reward, while another opted for lassitude or at least lesser

expenditure of effort, discipline, or energy, and consequently received a lesser return. It is one of the pernicious theories of the "big four" above – progressivism, liberalism, socialism and communism – that the resulting differences are evidence of and proof of the presence of injustice which must be eliminated by the artificial and societal elimination of those differences.

On the other hand, one asks, "Are there inequities and/or injustices in society?" Absolutely! Is the fact that more African-American men are executed for murdering a Caucasian than Caucasian men are for murdering an African-American evidence of injustice? If you support the death penalty, which I do not, it certainly is highly suggestive. Is it injustice that when I was a college student, an African America student could not attend the same school? Absolutely! On May 6, 2016, when I gave the Commencement Address at my undergraduate University, I was introduced by an African American graduating senior. After his introduction, I embraced him and commented that 51 years before, he could not have attended that school and that the proudest moment of my life in a commencement ceremony was being introduced by him. We have a long way to go, but having experienced the consequences of supporting civil rights in the South in the 1960s, I know we have come a long way.

The concept of justice requires a moral judgment of a behavior and/or of an outcome to call it injustice, and in the context of "social justice," it is required that the negation and/or correction of that behavior must produce justice in order to prove that the outcome was the result of injustice. It is unclear whether all differences in human experience and/or differences in resource distribution are the result of a morally deficient process which would be judged as injustice. Injustice requires an intentional, willful and/or premeditate act which injures another in which injury was the goal.

Sociology versus Injustice

I would argue that sociology identifies many more reasons for societal differences than injustice. And, that while some of those sociological determinants qualified as injustice, all do not. Progressives and their fellow travelers, while rejecting absolute values held by others, believe absolutely that injustice is at the root of everything they want changed. While all of us would like to eliminate poverty, and while at times poverty has been the result of criminality and injustice, all of us do not believe that all poverty is the result of the evil intent of others. It is equally unclear to me that "blame," the determination and the declaration that a certain deficiency is the result of an intended negative attitude or action, is a part of the solution unless the "injustice" remains as a legal, structured barrier to equality, justice and equity.

A Subtle but Real Dilemma

There is another problem with the philosophical foundation of this conference. That is that the emphasis upon "social justice" and/or "health equity" takes on the appearance that the solution to societal problems is not the elimination of discrimination and injustice but it is to reverse the roles so that those previously oppressed become the oppressors. This collectivist mentality tends to place ultimate value upon the class rather than upon the individual. In my value system, it is the elimination of disparities, prejudice and injustice for all that is of value, not simply changing the roles of different groups in the society.

As described in SETMA's Model of Care (see above), the primary emphasis is upon the health of an individual and the health of the group is of concern but is subordinate to the person. The group is used as a model for how to promote individual health but the quality of care is measured by the well being of the individual. In the collectivist model the individual is almost a pawn in the intended remodeling – in

the manipulation – of the group to produce an outcome which is not based on the well being of the individual but upon the change in appearance of the group. This is unspoken and perhaps even unseen but it is nevertheless true. A System and a solution which will be successful and satisfying are focused on the individual primarily and only incidentally upon the group.

The following is the foundation of how to develop hope in a society, as hope is the only power which can change individuals and society. And, hope must be had by each person, one at a time, and hope is only recognized in the society as it becomes the majority experience of the members of that group. The following is a discussion how to develop hope.

Value

The beginning of hope is the belief that I, as an individual, 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." It is the song I sang at church when I was a child and it changed my life: “Red and Yellow, Black and White (there is that word again), they are precious in His sight.” I learned that everyone was a “person,” a “real and valued” 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 the professional 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, dentist office, 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 upon 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 for 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 giving 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 an 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 transparency 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 an 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 to 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 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.
2. A gas card to cover his fuel expenses for the education classes, again provided by the Foundation.
3. Co-pays waived for the education classes.
4. Help in applying for disability income
5. A referral from SETMA's ophthalmologist to a regional research program that could help save his vision.
6. 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 into hope resulting in improved care.

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 woman 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.

Conclusion

There is no doubt that there are different opinions which are often founded upon different world views. While I am not unaware of injustice in this world, I do not see the world through a prism of injustice. Others can see it no other way. The solution to healthcare problems to me is not to assign blame but to design solutions. I begin with the value and virtue of the individual and design a system which will ultimately benefit society. Others believe the way to solve problems is to change society and indirectly to impact the lives of individuals.

If the conference I attended had begun with goals which are well defined (which it did), looked at active solutions which are in place by attendees, and also looked at public policy issues which will benefit dental health, I would still be there at the conference since it is not over until later today.

It was not necessary to couch the entire conference in what to me and to many healthcare providers are radical, liberal, Community-Organizer vocabulary, which blames society for all of the ills of individuals and relieves all individuals of any responsibility for their own well being.

If the goal is to enlist healthcare providers into the battle, the focus must be on health and not politics. If the goal is to promote a world view which requires the embracing of a collectivist, progressive, liberal, socialist ideal, then we will never agree.

It is possible for people with different world views to collaborate on a common goal. I support the value and imperative of dental health but there is no area of health where individual responsibility and policy decisions are so clearly wedded. The individual, beginning at an early age, needs to practice good oral hygiene. Society cannot brush everyone’s teeth and society cannot floss everyone’s teeth every day. The society needs to value dental health and make sure that it is part of health policy and insurance policies because it makes good health and economic sense.

I will never buy what was being sold in that first session and I feel certain that those selling it will never relinquish their affection for their model, but if we are going to collaborate it will have to be around goals and methods, not political or philosophical ideals, which are irrelevant to both goals and methods.