# James L. Holly, M.D.

**Why I Rejected the Conference on Dental Health Part IV**
**By James L. Holly, MD**
**Your Life Your Health**
***The Examiner***
**July 14, 2016**

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."