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Solution Series: Navigating a Failed Healthcare System with Jennifer Walters and Matt Hales

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James White: Hi, this is James White once again for the *Solution Series*, brought to you by CoreysDigs.com and *Solari.com*. We are delighted to be joined by two great guests. Before we continue, we would like to welcome Corey Lynn, who is the cohost of the *Solution Series*. Corey, it's always great to be with you.

Corey Lynn: It's great to be here. I can't wait for this one! I'm 'super-stoked' about this one!

White: Before we get into the introductions for Jen and Matt, we want to thank you for all the great feedback that we've had from people who watch these or read the *Solution Series*. It means a great deal to Corey and I. We do this because we do want to put solutions out for people and power people to be able to find solutions for themselves.

With that being said, I will introduce our guests: Our first guest is Jennifer Walters. She is a wife, a mom of two boys, and a registered nurse who left the mainstream medical industry after her oldest son was vaccine-injured by his baby vaccines in 2008. She has dedicated her life to healing her son and helping others do the same, and she hosts the *Health Series* on *Solari.com*. Jennifer, welcome here today.

Jennifer Walters: Thank you.

White: Also, with us is Matt Hale. He has been practicing law since 2004. He is a successful litigator who has focused his career in representing people who were harmed by others' negligent acts. For almost 20 years, Matt has successfully litigated complex injury claims including medical malpractice claims against large medical systems and medical providers.

He is often brought into cases by other attorneys who need additional expertise in medical injury claims. He also writes articles for *The Solari Report*. Matt, welcome.

We appreciate both of you being here with us today on the *Solution Series*.

Matt Hale: Thank you.

White: Corey, I am going to turn it over to you. I know you have many

We want to thank our guests for being here. Corey, go ahead. I'll send it over to you.

Lynn: I'm excited about this because I think that this is going to be power-packed full of information. I spent a long time talking with both Matt and Jen about navigating the healthcare system, and they have so many key points to make. I'm hoping that we can get to all of the points.

The reason we decided to do this is that Matt mentioned a study that recently came out on misdiagnosis.

Matt, I'm going to address you first. Just so we understand and to get us going on this, can you let us know what this study is about and why it's important that we need to learn how to navigate the healthcare system?

Hale: This was a study that was done by the government. It said that every year in the United States, there are seven million misdiagnoses in the emergency rooms throughout the country. It leads to about 300,000 deaths and serious disabilities.

We've known since 2001 when Barbara Starfield and Johns Hopkins questioned whether American healthcare was the best in the world, that medical malpractice and iatrogenic injury (which is injury from healthcare) has been the third leading cause of death in the United States. This 'triggered' me, especially in the context of our current climate, to make the conversation for people to know what to do when you are interfacing with a healthcare provider who may be 'screwing up' your life and you don't know it.

Too many people, in my experience over 20 years, blindly trusted and had blind faith with these people in white coats who were so far off the mark that by the time they got to me and my practice and had a lawsuit, they were devastated, or they were dying, or they were dead and I was speaking with the survivors. It's heartbreaking.

If we can come up with some solutions and some ways in which people can find

their diagnoses or find ways to lower their risks of being misdiagnosed, I think we can make a real impact for people to survive healthcare.

Lynn: I agree. I think it was one out of 18 people who go to the ER are misdiagnosed.

Hale: Right, they are misdiagnosed in some way. The study goes through and lists 15 conditions that lead to horrific outcomes that are misdiagnosed a lot. They list five that cause the most serious harm, and I will list these:

Misdiagnosis of stroke
Myocardial infarction (heart attack)
Aortic aneurism and dissection (when your aorta, which is the largest vessel in your body, is basically blowing up)
Spinal cord compression and injury
Venous thromboembolism (blood clot in the leg or somewhere in your body)

These things are missed shockingly frequently. One of the things that the study points out, in terms of heart attacks, some hospitals miss them zero percent of the time, and other hospitals are missing as much as 29% of them – almost one-third of the heart attacks coming through the door.

With stroke, for example-having litigated stroke cases-you have about three hours from the onset of symptoms to treatment before that injury becomes permanent, depending on the type of stroke. The ability to diagnose that comes down to certain CT scans, MRI scans, and other scans, and they don't happen.

White: Matt, can I interject here and ask you a question? Is this something that has gotten worse? Managed healthcare took over about 20 years ago, and doctors were in and out. You didn't get the same quality of healthcare that you did previously. Was it always like this, or is this a trend that you see now? Do you have any numbers on that?

Hale: I think it's always been like this, but I think it has gotten worse as these hospital systems have gotten bigger and run by more administrators than actual physicians. There is plenty of pressure now. I hear insider talk in these big organizations about patient metrics and patient satisfaction surveys and how

many patients the doctors turn, like tables at a restaurant. There is plenty of pressure on doctors because they tie it to their compensation.

I know doctors who are in systems where they are asked if they are on a committee, if they are participating on that committee, and if the patient satisfaction surveys are coming back – all this that really doesn't have much to do with the practice of medicine, but more to do with the business of medicine. I think it leads to these problems, and then no one really addresses these in a serious way that I've seen.

There are doctors who are going to listen or read this, and they are going to be 'throwing a fit'. I think that's fine if you don't agree with what I'm saying, but let's talk about it because this isn't getting discussed.

You can walk into an ER that is bad – and I've seen this in multiple ER's. I practice mainly in Washington state, but I've seen it over and over again. The same ER has the same doctor making the same mistakes over and over and over again, and nothing seems to 'boot' that doctor out of practice or to wake up and realize that what they are doing is insane.

Lynn: Then the people will continue to go back to that same ER. It's the same case with doctors. They will have problems with the doctors, but they will continue to go to them.

You and I had discussed certain things that you said are important, and I'm sure that Jen will be able to add to this as well. We talked about the critical tests and diagnoses – blood tests or certain scans or certain things – that you want to make sure that you have if you are concerned about something, especially if they are not suggesting to do it whether it's in urgent care or ER. Tell me a little about that, Matt. Then I want you, Jen, to answer that as well.

Hale: Let's take the example of a heart attack. I hope this has changed, but I was shocked to learn in 2008-2010 when you went into an ER, first you went through the financial part because they want to make sure that they get your insurance information and all of that, and then you go to triage. Triage is where they are going to figure out where you are in line. Most ER's didn't even have an EKG in their triage. So, you would walk in with chest pains and a heart

attack, and they can't plug you in triage to see what your heart rate looked like.

Heart attacks can be diagnosed from an EKG, and they can be diagnosed with blood tests – something called a troponin level. Troponins show up in your blood when you have cardiac damage happening.

We've had cases – old cases – where someone walks into the ER with chest pains, and they are found dead three hours later in the waiting room because nobody did anything. It can be to the point, especially with heart attacks, where this is a serious thing, and they are not running blood tests. I don't know why this happens in some cases. The blood tests will get ordered, and that order never translates into action. Or sometimes the blood test gets ordered, and then it is at the lab for an hour or two before they run it because it wasn't ordered 'stat' or whatever language the hospital tends to use for emergencies.

Lynn: This makes me think about something that I talked about with Jen. Let's say that I went in (ER) and said, "You know what? I feel like I need an EKG," or, "I need a CT scan," and they say, "We can't do that. We're going to do this instead."

We were talking about the HR systems and CMS and where they come in and it basically tells them or assigns them to how it is they can treat you. Can you explain that a bit, Jen?

Walters: I experienced working as a nurse before there was the 2009 mandate that every single system had to go with electronic health records, but it had to be the ones that the government told them to run. CMS Medicare has a preferred system, so that is what they started using.

When that happened, many things changed. Before that, obviously, there were issues, but you were still able to take notes and write down things and keep everything on what we called the 'bedsheet'. You could fold out your chart, and it would be as big as a bedsheet because you would have every single 12-hour shift with tiny pieces all over it. Then you would fold it back up, and you could use that to look back and see what happened the day before. You had those three 12-hour shifts for your patient right in front of you, and you would know what was happening.

I think that a huge problem happened when CMS came in. The Medicare system (the government) had all the data mining. They have electronic health records, and they not only tell the people what to do, but the quality metrics or the quality measures are not about, "Did you die from a heart attack? Did you die when you came in with chest pain?"

I was reading about some of the metrics, and I talked to some of my nursing friends. One of them was depression; they want to search for depression. If they find depression, you can get paid for that.

Here is another metric: 90% of all people should have the flu shot. That is another reason when they go into the ER and you are say, "My chest is killing me. It's been killing me for five years, and I don't know what is happening. Now it's really bad." They will say, "Sit down. Let's take your blood pressure and do everything." They type it into the computer, and then they will turn to you and say, "Have you had your flu shot?"

You think, "What?"

Some of them say that 90% should have high blood pressure, and that is the number. So, let's say that somebody comes into the ER and says, "I broke my finger." It's not a life-threatening injury, but you broke your finger. Sure, your blood pressure is going to be a little high. You've broken your finger, you've just had to put your children with somebody who you don't know, you've driven yourself to the ER with one hand, and your blood pressure is taken, and it's high.

Now the computer or the electronic health records or the quality measures tell us that we not only have to do something about your finger, but now we must get your blood pressure lower. We must show that we've done that, otherwise we're not getting paid. I don't mean that I did this. This is the reason I left the system.

I went back in 2011 after I'd been off for a while, and I started working again, and the hit of not being able to touch my patients was strong. I was doing 60-70% of my time sitting and collecting things on a computer. I wasn't holding

their hand; I wasn't checking anything; I wasn't looking at their 'poop'; I wasn't doing anything that I am supposed to do because most of what I was doing was filling out the computer forms and figuring out what shots and other metrics, and having them fill out all their HIPAA forms and all that. It's overwhelming.

Basically, it's all about quality measures. The people who work there care, but the system doesn't care.

Lynn: Are these same systems being implemented if you go to an urgent care or a doctor's office?

Walters: They are everywhere except doctors who have opted out of the Medicare system, and there are numerous of them out there. There are also surgery centers and urgent care clinics and all kinds of different doctors who have opted out of this. They have their own electronic health record system, and they don't need to be on the ones that do the quality measures and all the 'crazy stuff'. They are entirely off Medicare, so they are direct-pay cash only, but I have also found them to be very, very affordable. If you have no money, they figure out how to help you. It's called charity, and we've been doing it for years.

White: To finish this off, and to 'lay the groundwork,' how do the drug companies and big pharma work into all of this? I know they have to have a component in this somehow.

Walters: I was reading this article from 2019. I kept it because it had such a great title, *Data Mining, Artificial Intelligence, and Angels of Death*. I thought, "My kind of article!"

Everybody is using their Fitbits and all the technology to track their health. Well, Google acquired that. Then they also started looking at their electronic health records' intelligence program of Transcribe Medical. Then they also worked that into a horrific Palliative Care and Hospice Education Training Act. This wasn't Google that did this, but the government and Google. Everybody works together on it.

So, everyone has gotten together, and they have Transcribe Medical. The AWS (Web Services in including cloud services) of Amazon also has their PillPack,

which is where big Pharma comes in.

I'm only using this as an example. For Amazon, all their employees have their pharmacy supply with PillPacks. My sister is mentally challenged, and has seizures from a birth injury. She's in her 60's, so she has six or seven different meds, and they all keep her alive. These are the meds that work for her. So, she could send in all of her prescriptions to PillPack on Amazon, and they would divide up all the prescriptions and put them into little square plastic sheets that say, "Monday, 3:00," and that type of thing. It organizes it for you.

As humans, we have been doing this for years. We can organize our pills into a container, but at PillPack they do it for you. Then they have Transcribe Medical where you walk into your doctor's office or the clinics that Amazon owns, which are spreading everywhere, and you talk to your doctor and say, "Oh my God! I'm going to kill my kid! He spilled pizza everywhere!"

That is getting transcribed into your record; everything you say goes into your electronic health records. On top of that, you have Berkshire Hathaway at JP Morgan Chase backing that up.

I think that is where big pharma comes in. They are all working together with the government and the Medicare system. It seems that they are all part of the quality measures. The quality measures for 90% of the human race is a flu shot. How is that not big pharma?

Hale: I was going to add to that: The old saying that a law professor of mine was, "When all you have is a hammer, everything looks like a nail."

It pertains to the doctors, "When all you have is a prescription pad, everything looks like a pill." It depends on the training and experience that person, who is talking to you about whatever in the ER has, and whatever else is on their mind. Maybe they are thinking about their golf game.

Walters: Or maybe it's the fact that they are having to spend 60% of their time filling out forms because they got in trouble the last time when saying, "No, I don't want you to be on that." I'm not backing up the doctor and saying that they aren't making mistakes; it's awful, and everybody is making mistakes.

I think that much of it has to do with the electronic health records and the way they are taught in schools now. You're not taught to think; you are taught from the very beginning that medicine fixes this, and you must follow these measures in order to get paid. If you don't suddenly break off and start your own practice and do something good, then you are just in that 'wheel'. The whole system is poison from the ground up.

Hale: A mentor of mine once said, "Beware the 'odds' medicine." It's when you can sit down and repeat to your doctor, "Odds are you have…" There is no science behind that; it's a guess as to what you have. "Odds are that you have the flu," or, "Odds are that you just have heartburn," and they send you home with some antacids, and then two days later, you drop dead of a heart attack.

Beware the odds medicine. If you can repeat what the doctor said and say, "Odds are I have…" and they haven't proven it, then the brain should start to engage in either, "I need to find a new place," or, "I need to think this through." The odds are that they are wrong.

One other thing that I hear of now in the Seattle area is the staffing levels have gotten so bad in emergency departments that people are waiting for two and three hours in the ambulances because they can't transfer care to the ED because there aren't enough beds.

Walters: I don't think it's the beds as much as there aren't enough people to run those beds. They run like hotels. When I was training in cardiac at the VA, I remember they would shut two wings. They would say, "We can only accept nine patients today."

I was looking at this huge hospital thinking, "I could take a nap in 24 beds. What are you talking about?" That was 'back when', but that is how they run, just like hotels. That is what I discovered when I worked in hospitals, which is frightening.

White: So you have MD's, osteopaths, nurse practitioners, physician assistants, allopathic medicine, and holistic medicine. How do you choose the right doctor or the right one to go to? I know that holistic medicine has been

around for a long time, but I think it's becoming more mainstream than it ever has been. I think that is largely due to the fact that people have lost confidence in the establishment medical system.

What do you think about all these different choices that people have? There are many choices, and we know that the osteopathic medicine is more of people helping themselves or more like manipulating the spine with osteopathics as opposed to MDs. Do you have any comments on that? Both of you could comment on that if you would like.

Walters: I absolutely love that we have all those choices. We just have to be careful. I remember Dr. Tenpenny, who is an osteopath, was disinvited to some lecture because of her vaccine stance. She said, "You are osteopaths. What is going on?" They were osteopath who had invited and then disinvited her. I forget the whole story.

The other thing is that it's not so much the type of doctor, because you can choose whomever you like. If you are going to a homeopath, you probably are not going to be in the middle of a hospital system. But we all must know that someday – and hopefully this won't happen – someone is going to have a heart attack or get hit by a bus or break their finger, and they will need some urgent care. That is where I think we will come in and focus on who doesn't have Big Brother looking over them with these electronic health records.

I'm not saying that when you walk into the office they are scribing things on stone, but they can opt out of the Medicare system. There is a place called JoinTheWedge.com, and a nurse runs CCHFreedom.org. I think I sent you the link. It stands for the Citizens' Council for Health Freedom, and they have a thing where it is actual medical doctors that you can find that don't use the Medicare system. So, they are not going to be under that CMS that says, "We want to help you, and we think that something is wrong with you, but…"

Let's say that you want to go to a medical doctor or a DO or a homeopath or naturopath. Just ask them, "Do you take Medicare? Are you under government control?" Then you find out from there. I think that is where we need to start looking. It's not so much the type of doctor, because that is a personal choice, but I think that we need to see where their electronics and data sharing are.

What are all those things that are happening? Do they have a digital scribe sitting in the room, and do they put it in the system using their scribe app so that it transcribes everything you say? So, when you are making a joke to the doctor about, "I could take care of that by just sitting in my bathtub with a bottle of wine," and you're kidding, they transcribe that even though you're just joking. (Everybody knows that I drink outside the tub with my bottle of wine. Just kidding!)

White: Of course, me too! I was going to say the same thing.

Walters: It's frightening. I think it's more about finding the right medical practice and seeing if we can stay out of the system. Then it's knowing the ways that we can work the system that is controlled when we have an emergency. I know that The Wedge group at the Citizens' Council for Health Freedom and the American Physicians and Surgeons, who have been around since the 1940's fighting the AMA, have written great books, and they want to create hospitals where we don't have this mess.

We need to find small surgery centers. If we start pouring our finances into that and concentrating our focus into that instead of our HMO plan, I think that is where we will be able to make a change.

Lynn: What I've been trying to 'spit out' is an outline for people so that they understand where we are going. First, we will have a huge list of resources underneath the commentary for this. We also have resources that Jennifer has put together in PDF format for subscribers to be able to download.

Between the two of you, you have both shared wonderful information with me, even before we started this. We want to cover several things. One thing is what is happening when you go into these places – whether it's an urgent care, an ER, or a doctor. It's about how you talk with them. It's making sure that you say certain things or that you don't say certain things, and how that information is being recorded. I want to cover what forms you want to fill out and what you don't want to fill out.

I also want to talk about getting into a system and a structure that works for your family where everyone says, "These are our individual health needs. These

are the types of physicians we are going to need. These are the medicines that we need, or these are the natural medicines we need." Then people can have a plan from there. Then they can build into, "Now let's look at what is affordable. Do we need insurance? If we do, maybe it's the shareable group-type plans." We have resources for that here as well.

It's putting together a whole new system of how to navigate this atrocity that has been going on for a long time. I want to go back to Matt for a moment because we talked plenty about how people are caught up in this, "Doctors are gods, and they are the authorities, and we just listen, and we don't ask enough questions, and we just trust."

That is one big thing that people need to develop is a healthy sense of skepticism, but I also want to talk about what to be careful to say or not to say, especially when they get into, "Have you or your child gotten the COVID jab yet," and that type of thing. Could you talk on that a bit, Matt?

Hale: I've had my moments because I'm a 'hothead' lawyer sometimes. I'll tell a brief story about my grandpa who had a fall in his house. He had 72 stitches right across his head. So, he went to the ER. By the time we got there, they had him dressed. He was still bleeding into his eye from his stitches. This was early on in my career when I wasn't as refined. I asked the nurse, who was the tall person, about 6'4, "Did they do a CT scan?"

By that point, I had at least two or three cases where someone fell, hit their head on a hard object, didn't get a CT scan at the ER, went home, and died of a brain bleed. So, the nurse turned to me, got in my face, and I could feel his hot breath. He was screaming at me about how the doctor didn't think that it was necessary, and that it was none of my business. So I escalated, and he escalated.

Finally, a social worker came in, and I was able to eventually talk to the ER doctor. When I talked to her, I said, "Have you done a CT scan?"

She said to me, "No, I didn't think it was necessary. He's oriented to date and time, and he said that falling is normal for him."

I looked at her, and said, "Then can you guarantee in writing that he doesn't

have a subdural hematoma?"

Her eyes got big, and she said, "We'll get a CT scan right away."

What I learned from that experience was: 1) Sometimes you don't just shut up and take it. 2) Be nice; you must be nice to these people, and you have to be kind. They deal with combative all the time. If you can turn it to a positive, kind, nice encounter, you are likely to get them on your side. That's important.

What Jennifer said in understanding the pressures that they have will help you to not get instantly annoyed when they are asking you about your vaccine status, and your 'palm is touching your elbow'. It's a way to relax as much as you can and turn this into a positive interaction.

I had another ER experience, and I made my wife drive me downtown to the hospital. The doctor said that I smelled nice and that I was his best-smelling patient because all he dealt with were homeless people who had experienced these traumatic events.

It makes a difference how you present yourself. Remember, when they chart, they're not charting for you; they are charting for them and to 'cover their butts'. So, if they ask you if you've been drinking, they are not going to write, "Patient wasn't drinking." They are going to write, "Patient denies drinking." The response to that is, "I don't know if you really weren't drinking or not."

The charting, especially now with electronic health records, and I think this is why it's critical in your community to understand the various medical systems. You need to know, for example, that south of Seattle is controlled by Franciscan Health, which is CHD Franciscan from Colorado. The urgent cares are mostly owned by these big medical facilities, and they all share records. So, once you have a misdiagnosis in your record, it gets repeated and repeated and repeated.

The only thing that you can do if you have the time and the ability is to get out of that system until you can get a new medical record that shows you don't have that, and maybe some diagnostic proof. That means, maybe you would have to get copies of all the diagnostic information that happens.

They will send it to you in your MyChart record, which is like the *Reader's Digest* version of your record, which is 'pasted' all over – all the diagnostic codes and everything else. Now you are handing that to a new doctor who is going to look at it and read it for the diagnostic codes, and you are not getting a fresh look; you are getting somebody looking at you through the same lens as what the prior provider did. So, you want to find out where the labs are and get copies of the labs, even if you have to scratch that out so that you get a fresh look.

One doctor will say, "Your blood levels aren't that bad." But then another doctor might say, "Oh my God! We need to do something here."

White: Is there any advantage to keeping your own personal health record and marking down certain things, like you wake up in the morning with a fever, and you mark that down? How valid would that be to have your own personal observations? Or are they always going to rule with what the doctor says?

Hale: That is an interesting question because the lawyer in me hates diaries when they show up in lawsuits. It's like, "Why did you write that?"

I think that it can be helpful to keep track if you have a provider who is willing to take the five or ten minutes to listen to you.

Lynn: What about when you are asked if you or your child has received the COVID jab? Either of you can answer this.

We know that they are documenting all of this.

Hale: They already know; you know that; everybody already knows. The person asking you may not know, but they are supposed to ask you. Everybody already knows because they have a system. Every single person who got the shot got on an app. So, all that information is there. They can match that up with your driver's license or whatever they can find. They can cross-match it with your social security number. They can go into many different things. I'm almost sure they already know that we didn't get it.
To stay out of any trouble, I give as little information as possible because I'm in

California, and it's really bad here. I will go in and they will ask, "Is your son up to date with his shots?"

He fell the other day and hurt his elbow, and I thought, "I'd better get an x-ray." I didn't want to go to that stupid urgent care, but I had to because the x-ray place that I usually pay cash for wasn't open. So, we went there, and I said, "Can you just check him?"

They asked, "Has he had all of his shots?"

I said, "Yes. We are completely compliant with everything he needs." That was all I said.

When they specifically asked, "Oh, does he have the COVID shot?" I told them no, he didn't have the COVID shot. I don't want to be marked down somewhere that he had a COVID shot. I'll take that hit. But here, you get in trouble for not having a hep B shot, and you get in trouble for not having a flu shot. If you don't have the childhood schedule, you get kicked out of school. My children were kicked out of school in 2015 with SB277 (California law that removed personal belief as a reason for an exemption from the vaccine).

I always give as little information as possible.

Lynn: My laptop fell on my foot last year and broke it, and so I had to go into the podiatrist. I looked at the forms, and I thought, "No. I don't enter my social security number. I don't do my medical. It's not necessary for what I'm going in for." I only give pertinent information.

This brings me to HIPAA. Jen, you say that people should not sign that form and it's not a privacy form. Tell us about that.

Walters: I have so much information on HIPAA, but I will try not to talk too much about it.

Basically, HIPAA is not about privacy. The 'P' in HIPAA does not stand for privacy; it stands for portability.

Lynn: What do you mean by it being a 'portability' form?

Walters: This 'kicked in' right around the start of Obamacare. People think this means that you are private.

You know when you have to go to the drugstore and are standing ten feet behind the next person in line so you don't hear what they are talking about, and you think, "It's HIPAA. It's private." Or you call and say, "I want to send my grandma flowers at the hospital. I don't know what room she is in," and they say, "Oh, I'm sorry. We can't give you that information to deliver the flowers," and you say, "Oh, it's privacy. That's HIPAA. That's good."

Those are fake, phony things they put in there to make it look good. Basically, it's a portability act. That means that you don't have to sign it, but it's going to happen anyway. When you go in, the HIPAA form is their way of telling you, "All of your information is going to get shared with all of these people." It goes all the way to the CDC. It's thousands of things that can be shared with other people or entities, and I think somebody figured out that it's going to be 7,000 or 70,000 more people and businesses and companies that shouldn't even see any of your data.

HIPAA means that your data – all of your health records and all of your information – is now portable to be seen by anybody who is involved in your care or, sometimes, isn't involved in your care.

Lynn: Matt, if I went in and refused to sign the HIPAA form at places, and then later found out that my information was shared, what does that look like?

Hale: There is no private right of action under HIPAA. None. Each state has its own privacy laws and disclosure laws. But then again, if the disclosure is required by law, there is nothing that you can do about it.

Lynn: So not signing it doesn't really do anything because it's still going to be shared.

Hale: Correct.

Walters: That is right.

Hale: If you have health insurance, you already have released your information to them. So, if you have medical payments insurance, they have a right to get your records. They have their own sharing databases, too.

Lynn: So, if these are state laws and federal laws where they can share this information, then why bother having this form anyways? Why even have people sign it?

Hale: It's an administrative requirement to make you feel good.

"I signed this form. Great!" Jennifer is right. It doesn't protect your information; it goes to whatever people they need to share it with.

The health insurance companies and the insurance companies at large get it all, and it's there. They share it in their databases, and they know full well where you've been and what you've done.

Walters: In fact, since 2010, 2.2 million entities (not people, but entities) now have access to your data because of HIPAA, and only 700,000 of those are the ones that you expect to have your data. It's doctors, labs, x-rays, and health plans, but the rest are business associates.

Lynn: Jen, you have a great system going. Of course, you have the benefit of being a nurse for your family. That said, it's still a great system that could work for everyone; they are just not necessarily going to have the in-home skill added benefit that you have.

If someone were to go to some of the physicians through the networks that you've talked about with me, which we are including in the resources, is it the same there? Is your information going to be shared out to multiple databases if they can stay in with those types of doctors and medical professionals?

Walters: They have signed a form to opt out of Medicare, and they are not accepting any health insurance plans. So, they are only working as a doctor with their Hippocratic Oath. You go into their office, and your data stays with them

unless they are 'weird' and they tell you, "Get on an app and put all your info on an app."

That is why I'm a little worried about the telehealth companies that are coming out. Even though I'm happy and thrilled that people have telehealth, because it's easy to get to, I'm concerned that now they are putting them on apps, and you are doing your blood pressure on an app. It's 'appity app'.

I think we need to have more home visits or hands on the patients, but that is just me.

Lynn: What is the main group that we were talking about where people could go in and could look for physicians in their states and their local areas?

Walters: There is the American Association for Physicians and Surgeons, which is at http://AAPSonline.org. You can go under 'Resources' and 'Patients', and you can check to see if there are any doctors that belong to that place because the physicians who sign up for that are usually independent. Some of them still accept Medicare.

Even if they've opted out of Medicare, if there is an emergency situation, the doctor can still bill Medicare. So, if you are going to a surgery suite that only accepts cash but then an emergency happens, I think they can still bill it. It's some sort of 'weird thing'.

With the AAPS, you can find a doctor in your state, or they sometimes still have Medicare, and they accept the healthsharing insurance. The Wedge is a little stricter at http://JoinTheWedge.com. They have it that there is no government recording, they are cash-based, and there is no outside interference. You can basically find your doctor in your state. They have many of them.

Remember that there aren't that many doctors in the world. When you look at the number of pediatricians, you think, "Really? There are only a few thousand?" And I'm talking about the United States, not the world or the planet.
I found that there is a large number. There probably should be more but I think the more we get out of our system and support them, and we find the Citizens'

Council for Health Freedom or AAPS, we can ask, "How can we help you?"

Instead of paying Starbucks or putting more money into something, let's all get into a healthshare plan, which is half as much as an ACA. Then you don't have to pay any penalties on your taxes or anything because it's accepted. You are paying less, and you can choose whatever doctor you want that is in that particular system, or you can see if you can get shared from that. Or find a practice under The Wedge or AAPS and pay them cash for their services. If you think about it, if you keep yourself healthy, you are only going to go in when you need it, or they can help you maintain your health.

Lynn: You can also negotiate.

Walters: Yes, you can negotiate all the time.

Lynn: Always negotiate with everything in life.

Walters: I've been out of health insurance for years. When my son was vaccine-injured, I found that everything that helped him get better with his brain injuries, his therapies and everything, I had to barter and do cash for everything because nothing was covered by health insurance – nothing that helped.

Lynn: That's not surprising.

Walters: So, I pulled out of my health insurance for my husband and I. I did healthshare for a while. I have an AAA policy, so in case I'm driving in a car or I'm on a bus or any transportation situation where I get injured, all my medical will be covered under that.

Lynn: Is it a catastrophic plan for vehicle-related injuries?

Walters: Yes, but when I worked in ER, people were always on some sort of transportation when they would come in for the big things. So, we have the big health issues covered. The rest of it, we just figure it out.
My son needed an MRI. I called around to 17 different MRI places, and I negotiated like I was buying a Toyota. I found the best price. When they found out that I was paying cash, they were like, "Oh yeah!"

Even with labs, I go to http://MyMedLab.com, and I determine what labs I want. You can call and talk to them. You can ask a doctor to give you a prescription for all the labs that you want. Then you go through them, or you can order your own labs, and the doctor for that company will order them.

I found that they were much cheaper that way. The insurance that I dropped out of long ago said that his viral panel was going to be $3,000 if I didn't use their insurance. I thought, "Well, I've got to figure something out." It ended up being $300.

I don't know why the discrepancy. It's not like I went to 'Vinnie' and he took the blood in some back alley. I just went into a regular blood place and handed them the prescription.

Lynn: Let's say someone goes off Medicare. I tell the older people, "Just ditch your Medicare plan." What options are there? How does that work?

I know that my parents are on Medicare, but they also have a back-up plan that picks up the difference. So, if you were to get off Medicare, how would you work something like that out?

Walters: I don't have my sister off her Medicare, and I don't have my uncle off his Medicare either. We have it in case of hospitalizations or big things, but we found a doctor who does a concierge-type service. So, he will bill Medicare for certain things, but he doesn't for others. He's in his 80's, and she is in her 60's with many things wrong, so I kind of monitor it.

We pay this doctor cash for a concierge service. So, he's not reporting to Medicare and he's not part of Medicare, but if she needs Medicare because she goes into the hospital, that is when that part kicks in and he will monitor her status because she has been put in the hospital. Does that make sense?

You can have a healthshare plan and be on Medicare, but you can still see any doctor you want that doesn't take Medicare. Just tell them, "Don't bill Medicare."

You can stay on Medicare. I'm not talking about the HMO plans; I'm talking about the ones that your social security covers.

I would love it if people could choose to not have their social security pay Medicare and they could choose to be out of it completely because they could decide on their own health. Instead of money going to that, now your money will go to what you really want.

I'm not telling people to dump their insurance; I'm saying that I did because it wasn't helping me with what I needed. Then I found this great place where I bargain and figure things out. It saves me money, and I do pay the penalty – except for the one year that Donald Trump took the penalty away.

Lynn: Is that penalty back?

Walters: It's not back this year, but I think it's back next year and the penalty is coming back. At least that's what I heard.

Lynn: I'm happy to pay the 'damn' penalty to those idiots. I'm not actually going to pay it, though.

Walters: It's approximately $800. So, let's say that if I were to get a plan right now from the ACA (Obamacare), it would probably be about $3,000 a month for my family. That's not even the gold plan. I wouldn't be able to choose my doctor, and it would be a high deductible. So, when we went into the ER for a few things for my son, I said, "No, I'm cash."

They said, "Okay, then you need to choose everything that you're getting."

I said, "Exactly! I don't want your x-ray machine because that's pricey. I'm going to take it across the street to another x-ray machine," because in the hospital center, you can do much better.

Then the nurse came and said, "We're not going to give him any of this or give him any of that because of this, this, and this." My bill wasn't that bad. I went and made a payment plan just like you're buying a pair of shoes.

Lynn: Matt, I have a few questions for you pertaining to things like a power of attorney for parents in a hospital scenario, and you and I talked about private autopsies. Autopsies are becoming a thing where the doctor has to order them, and in some cases, he won't. People can now get private autopsies.

The other thing is the way of getting out of hospital hospice. We talked about that as well.

I think those would be three good points to cover.

Hale: I want to circle back to this conversation about privacy first. I want people to assume that their records, no matter where they go, are not private. Here is why: If you get rear-ended, your entire medical history becomes relevant. If you are going to have to sue an insurance company, they are going to get everything. And guess what? If you don't tell them, they will find out. I don't care.

If I had a magic wand, I would wave it and say, "No more social media." People don't just go to the ER anymore; they take selfies, and they are talking about their interaction on Facebook or whatever. All that information is waiting for some insurance defense lawyer or some government lawyer or some social worker or someone from CPS to get from you.

Even if you are going to some doctor who handwrites his notes, they must keep those notes. There are laws; both state and federal laws require those notes.

Those notes will show up in some lawsuit somewhere if you end up getting rear-ended or if you end up having something like that happen. So be very careful.

Assuming that you are going to walk into a doctor's office and 'spill' everything in your life, and that it's not going to show up later, that's not going to happen. You don't have the right to remain silent in a medical office, but beware.

Lynn: I want to add that when people are asked about mental health or anxiety or depression – because this is becoming a big push right now – unless they are at their medical appointment for an anxiety disorder or something, don't divulge that information or agree to fill out the forms that are structured

to be circulated. That is a trap.

Walters: Right. Don't fill out any of those forms. In fact, that is a quality measure.

Exactly like Matt said, do not tell them anything that you don't have to. When he said, "You have the right to remain silent," yes you do.

I remember when I was first dating my husband. He was driving a car, and we had to go through a DUI checkpoint. He never rolled down his window. I sat there thinking, "I am so going to marry this guy because he is right on it."

The cop was knocking on the window, and my husband thought, "Thanks, officer. Don't need to roll down my window. Have a nice day," and the officer let him go.

So be very specific. Write everything down that you want to know from your doctor. I make a list: My throat hurts, my 'butt' itches, and my head hurts. That's it.

You can make small talk in the front office or whatever with the secretary, and you can be very nice and helpful, but do not divulge anything. Even if you fill out one of those questionnaires, the one about the drinking – the one where they ask, "How many drinks do you have a week?" You're thinking, "If you only knew!" I'm just kidding! Now that's going to go on my medical record. I'm through, I must hire Matt!

White: I took my daughter to the doctor several years ago. The doctor came in and said, "Do you have guns in your home?"

I said, "That's not important information for you to know. What does that have anything to do with my daughter's health?"

Walters: It's because it's a quality measure; it is going on their form. Then they will use it at some point. The insurance companies will use it to say, "You need a kidney transplant now? It seems to me that you've been drinking one drink a month for 20 years, so we're not giving you a kidney."

If they can do that with the COVID shot, they will that with you saying that you have a couple of drinks.

The answer is 'no' to everything. You don't even have to refuse it; you can just say, "No, don't drink." Even if it says 'denies drinking', it's better than saying that you have one that they can add.

It's bad; all our data is out there completely. It's why I'm staying healthy.

White: Matt, did you want to comment on that?

Hale: I did want to comment to what you said is a classic, Doctor; that's none of his business."

That is going to start a combative relationship with this doctor. Sitting in the hospital with your child, and you now have gotten into a verbal fight or started an escalation with this doctor, they have a lot of power suddenly.

White: He didn't like it.

Hale: You kindly say, "Thank you for asking. I would rather not answer that. Thank you."

Lynn: Let's go back to the power of attorney, the hospice, and the autopsies. Can you go over those quickly?

Hale. There is plenty of work on *Solari* about healthcare proxies and powers of attorney. You need somebody with medical decision-making authority, but you need somebody on the 'same page' with some cojones. The last thing you want is to have somebody come in and say, "Yes, doctor. Whatever you say, doctor. Sure, doctor." That is going to lead you down a 'path to hell' – literally.

My other grandfather went to the same ER and saw the same ER doctor – time and time again. He was having TIA's, and they put him on a medication. The medication caused Parkinson-like symptoms. The next I knew, grandpa was getting loopy, and they were putting him in a mental facility all because of the

medication.

Finally, my uncle did the research and said, "This medication is causing this." He had to 'fight like hell' to get him off of it. Guess what? They went back to the same ER and got the same doctor who wanted to start him down the exact same path again.

My uncle was able to stand up and say, "No." You need somebody who can say, "No," and you need somebody who is educated.

If you are in an emergency situation where you are in the hospital and they are treating you, and you have somebody who can give consent, you need somebody who is smart enough to say, "No COVID shots," and work with these doctors and make the situation better for you. So often they are going to be pressured into making rash decisions. So that is very important.

You wanted me to talk about private autopsies. There are cases that use experts – retired coroners and pathologists – who can do autopsies. In fact, if somebody dies in the hospital, you can ask for that to be done. Sometimes the counties don't have time or they are understaffed and underbudgeted.

The last I checked, the gambit in pricing ranged between about $2,500 and $10,000. If you have somebody who dies because of something and you want to know why, you may want to push to have an autopsy done. Don't let them race the person to the embalmer or to the crematorium. You can find somebody in your community. If you call your local medical malpractice lawyer, they will probably know where to go.

Lynn: As you were saying, you want to make sure that you get certain documentation and slides or images or something from the actual autopsy.

Hale: Here is what we are seeing: In the autopsies that are being done in relation to the vaccine deaths, they are taking slides, tissue samples, stains, and all that, which is way beyond a normal autopsy. That is happening because those pathologists are doing it.

I wouldn't count on your county coroner to do that thorough of an analysis, if

that makes sense. What happens all the time, in my experience with wrongful death cases, is if you don't establish a documented, scientific cause of death, you have a problem because they will come up with 'lightning strikes from Jehovah' and anything that sticks to beat your case.

People say, "I don' want to sue. I'm not that type of person." Trust me, when you lose the main breadwinner of the family with children left behind, sometimes that is the only way that families get enough money to move on. So don't just throw that possibility 'out the door' like you're never going to go down that road.

Lynn: As far as hospice, which I think is an interesting one, if someone is in a hospital and they are dying and they get to the point of hospice, the hospital has certain levels of power and control over that. You were talking about how you get out of that and get someone home. Can you speak to that?

Hale: This is where you need to know the various people who work in hospitals. The social worker in the hospital is a powerful individual. They have social workers for different aspects of the hospital. For us, my mom was dying of cancer, and it was advanced. She wanted to get out of there. It became a fight to get her onto hospice because she had good insurance.

I had to go to three different social workers to finally get one to get on the phone to find a program.

Hospice is a legally-defined term: You are dying. There is no cure for you. All curative care is going to stop, and we are going to move you where you want to go to have a good death. That is essentially the idea behind it. So, you can go home at that point.

I talk to people anecdotally who have had people in the hospital with COVID and they were dying, so they pushed for hospice. They were able to get them home and get them treatment and turn them around.
The hospitals will say, "It's time to pull the plug."

Lynn: So basically, it's kind of the reverse of what I was saying: If they are in the hospital and the hospital determines that they are dying from COVID,

allegedly, they are not going to want to release them unless you say, "We are going to do hospice care, so we are going to get them out of the hospital." Is that accurate?

Hale: Somewhat. It comes to a point where the hospital is telling you, "There's not going to be much more that we can do. There is nothing more that we can do."

Lynn: The hospital needs to know that there is care if you pull them from the hospital, right?

Hale: It's the hospital determining that there is no opportunity to cure anymore; there is no more curative care. So then, you go into an entirely different system; you go into a system designed for comfort, for maybe not being in the hospital setting, going home, and suddenly, different tools become available. Nurses visit your house. You're not in that building with all its administrative regulations and computers and telling people what and how to do their job.

Lynn: And you can get your loved one the treatment that they might need.

Walters: But for curative, they are not going to pay for anything that will help them at all. If they want to get out of hospice, that is what is hard. Yes, you can get other people and you can work around it, but there was the Palliative Care and Hospice Education Training Act that they adopted.

Palliative care is a cash cow right now. I have friends who are hospice nurses forever, and they are like, "Wow! Everybody is on hospice now!"

Palliative care has become the new term, and there is a large amount of funding for it. They've made educations for this. They can't wait to get us all dead.

Medicare will not pay for any curative treatments or medications, and they won't pay for emergency room visits unless the hospice team arranged it or someone decided it wasn't related to the hospice diagnosis.

My mom died in 2019. I fought like 'hell' for her; that's all I did. I basically put

my 'battle axe' on every morning, and I would go down and try to take care of her and make sure that she was getting everything that she needed. Everything that they were doing to her was making her sicker, and everything was worse. It was just a downward spiral when she was 87. There was nothing that I could do.

I tried my very, very best, but she loved her doctor, and she loved her HMO, and she loved her flu shots. I didn't know what else to do. I couldn't boss my mom around because she was the 'queen bee'.

I did my very best, but I know that once she got placed in a palliative care program, which was five years before she died, getting any sort of treatment for wound care or anything, I had to beg the hospice people to write that it had nothing to do with her hospice diagnosis. Then I could get that treatment paid for.

Lynn: That is interesting.

Walters: It's quite awful; it's hard to jump those hurdles.

Hale: Everything that we are talking about is so fact specific and so nuanced that you have to take a step back and look at your situation and say, "What is going on here?"

For us, when my mom was dying, she had small cell lung cancer, and she didn't even get breathing treatments until she was in hospice. I was going 'nuts' because I hated the hospital that she went to anyway. I drive a very nice truck because of the hospital.

It was so frustrating to watch somebody suffering in a hospital because of incompetence. You're right: They will not pay for curative anything. That would be cash out of your pocket, at that point.

There is a point when you will have to part with some dollars. I'm amazed at how many people decide that they would rather die than spend their money. There are so many people who are like that; the statistics are shocking.

Walters: I think that COVID is going to change that because there are so

many vaccine-injured, and they are going to notice that nothing is covered.

All my friends who were nurses now injured from the vaccine are now saying, "Any treatment that helps me isn't covered?"

I say, "Yes. You've kind of been watching me do that since 2008 with my son. I'm sorry."

I think that if we invest in it now and try to create this new process, there is still going to be data. There is data everywhere, and you know that they are gathering the data. Corey, you wrote the book, and you know what they are doing with this. You have your national patient ID now and everything that we must fight. We can't keep Rand Paul in forever. He is the one who is keeping it out, and Ron Paul was the one keeping the national patient ID from going forward and for funding it. Now we have Rand fighting it. We have to get that taken off. We have so many things we must work on to get our data out of people, but all we do is keep loading 'crap' into our phone and wearing our Fitbits.

Listening to Matt, there is a complete other thing that we have to think about.

Lynn: You had a great idea, Jen, as far as nurses. Do you want to talk about that? I think that would be fantastic for people and nurses.

Walters: I interviewed Nicole from American Frontline Nurses on the *Solari Health S*eries. Nurse Nicole Sirotek started the advice nurse line. It's on their website. You can get a nurse advocate and talk to them. You can do a Zoom with them, or you can call them on the phone and have a real person who you are talking to.

Through COVID, they have been getting in touch with people, showing them how to escalate through the hospital to get the right people to talk to. They have been rescuing people from the hospital; they have been going house to house, helping people. So that is something that she has started.

I've been working as a community nurse forever, and I volunteer this part of my life. I can't work fulltime anywhere anymore, so I'm doing design work and I'm

doing 'this and that'. I would dig ditches. That's what you have to do; I'm not going to work in the hospital system.

I go around to people's homes, and I help doctors. I'm the person that smells, sees, and touches; I'm with the patient. I might be on the phone with the doctor – not using an app because you don't want to do the privacy thing unless it's a specific HIPAA portability act privacy thing. I'll be on the phone with the doctor, and I can say, "He doesn't look right. His eyes are kind of yellow. I think his sugars are off because he's not answering the questions. He's oriented, but just barely oriented."

Then the doctor will say, "Okay, bring him in," or, "Oh, let's do this." Or I'll get an IV bag and bring it to his house. It's that home healthcare that is not part of hospice and not part of palliative; it's a community nurse that can come around. It's not 'community' like the globalists call community nurses because now I think they are coming up with robot nurses or something like that.

It doesn't have to be nurses; it could be doctors or anybody. But if everybody would volunteer their time and find out who needs something, and then find out what medicines they are on and go through that to see if that is causing their problems.

Cory, it's as you said: My dad had the same thing. He was put on a medicine to help with one thing, and it gave him a Parkinsonian effect. They killed him with all the things they put him through with Parkinson's when he didn't have Parkinson's. There was nothing I could do.

You can do everything, but if they believe the doctors, I'm only the daughter.

Lynn: You talk about volunteering, but couldn't this be something where it builds on a local level to where they are working for doctors and getting paid?

Walters: Yes. I was thinking of the Wedge doctors and the private doctors. I work for all these doctors, and every once in a while, they will 'throw' something at me, but I can't take money for it because I don't have the time to be on a schedule. I could definitely make a career out of it; I could work for a doctor.

My nursing license does nutritional counseling, and I could work under a doctor to help them. I do my own nursing process, so I have my own nurse's diagnosis, and then there is the medical diagnoses. Basically, I help them read a lab and understand what the lab was. Then I call the doctor, and we talk about it. We all discuss it, and I'm there to help the patient figure out what questions to ask the doctor.

We definitely could start a process.

Lynn: Both of you have given me a list of books that you think everyone needs to have in their homes. Matt, what were the books that you had shared with me?

Hale: There is a great book called, *The Unvaccinated Child*. There are many remedies and plenty of advice on what to do with various ailments.

If you find a used *Physician's Desk Reference*, which are huge books called *PDR*'s. They are the list of every medication that a doctor is going to prescribe. What is great is that you can flip through them, and you can find the medication, and can see for yourself what the side effects are, what was found, and about the studies. The vaccines are included in there. It's a wonderful resource.

Brand new, they are quite expensive, but a couple of years old, they will still have good information, and they will only be about $30. It's worth it to have one because the doctors aren't looking at them; they're not. They just write the prescriptions out, "Odds are that you have this, and odds are that this will help."

Then you will have to come back with symptoms, and they are going to say, "Odds are this will help," and the next thing you know, you are on a 'train' of medications, each one causing more symptoms.
Those two books are great. There is a whole litany of books that you can get.

Lynn: I have one that is rather thick on medical emergencies at home if you can't get to a hospital. They have diagrams and visuals showing you how to do wraps and different things. I think that is very important to have on hand.

Jen, I know that you probably have several books that you can tell people they should have in their home.

Walters: I have an abundance. I acquired a new one that I started reading, and I really like it. It's written by Dr. Sam Bailey. She found a doctor who had written this in the 1920's. It has diet, living habits, and divine thinking. It's called, *Terrain Therapy*. It's her newest book, and it's great! I love it. I'm going to try to get her on the *Health Series* to talk about it.

One of my favorites is, *Big Brother in the Exam Room*. It's written by nurse Twila Brase. It will give you the overview of what is happening and when it happened.

Another one is a baby book called, *Common Sense Medicine* by the AAPS. It's written by one of the doctors, Jeff Danby, but it's the Association of American Physicians and Surgeons. I sent you the link so that you can get it.

It's a quick read, but it somewhat goes over restoring the patient-physician relationship. Those books are good, and then I had a homeopathic book that I don't have on me right now. It's probably somewhere in my house with pages falling out. It was for acute care homeopathy. So, if you have bleeding or a headache, it will help you with the quick answers. You can look it up like first aid, but it's homeopathy. It helps with bee stings and different things like that.

The last one is my *Nurse's Drug Guide*. The *PDR* is the same type of thing. I find the *Nurse's Drug Guide* to be great. They come in all different kinds – new, old, whatever. They are 'really cool'.

They go through the dosing, which is very important. Many people only read, "Oh, I'm going to give this much." It's not that I give Tylenol to my children, but let's say that on a 'blue moon' I would have to give an Advil or similar to them. You read the back of it, and you think, "I have to give how much to a skinny 11-year-old?"

It says if the child is 11 years old, give them this much, but the *Nurse's Drug Guide* shows you how to dose to weight; it's milligram per kilogram. It's a

simple math process. If I can do it, anyone can.

Those are my favorite books.

Lynn: I have one final question for you. James, if you have something else that you want to add, feel free.

I wanted to ask you this: In order for people to keep their house in order, in addition to sitting down with their family and individually writing up what their health needs are and developing a plan and finding the right doctors and insurance versus no insurance, how should one keep their house in order? From a medical standpoint and a legal standpoint what are some good things that people should do?

You start, Jen.

Walters: Basically, you get your necessary medications, and keep extra ones. You can always ask your doctor for an extra prescription. You will have to pay cash for it because your insurance company probably won't cover it. You can find coupon programs and different things like that, and you can build up a stockpile.

My sister has seizure medications that are very important. I always keep at least three to six months' supply on hand.

Don't worry so much about expiration dates; I try to change them out. I keep an emergency 'stash' of that. Then I try to get off as many medications as possible. If you can find an herb that will take care of it instead, that is better.

I know many people were using ivermectin and different things like that. I saw them do many great things. I also work with doctors who used silver, hydrogen peroxide, vitamin c, vitamin d, and zinc, and they worked as well. You can have ivermectin on hand, but then also have a big bottle of silver. Do that kind of remedy.

Put together a first aid kit. That book you have sounds wonderful. I love the idea of that. Knowing how to splint things and do those things at home so

you're not running into the emergency room and you're so 'freaked out' that you're screaming at the person. Knowing that you've handled it to a certain point is great. To that point, when my child cut himself, I'm a nurse, but I was able to butterfly the wound. When we went to the emergency room, I was able to stay calm. Even if you're a nurse, when it's your own child, sometimes your training can go 'out the window'. So just have things prepared so you have it all ready.

I also have an ER plan just in case of emergency. Know where you are going to go. I think that is important. Go visit the hospital and see what kind of doctors work there. Find the doctor you like who is on staff. Know their schedule. That is what I do. I have an idea about where I would take my husband if he fell off his ladder.

Every time he gets on a ladder, I say to myself, "If he were to fall off that ladder, this is my plan."

Lynn: I found the book that I was talking about earlier, and the title is, *The Survival Medicine Handbook: The Essential Guide for When Help is NOT on the Way*. I have the fourth edition, which is by Joseph Alton, MD, and Amy Alton, who is an APRN. It's 'pretty cool'. It's rather thick; it's a big book!

Matt, what do you suggest?

Hale: I was taking some notes. Primarily, with your healthcare, know what is going on; no blind faith. If you are going to have a surgical procedure, you better know the risks. In fact, write them down so that you have a list. I can't tell you how many tragic cases result from, "Mom got her tubes tied, and she died."

Any time a doctor operates on you, they can hurt another organ, and that can lead to your death. So, know what the risks of your procedure are, and communicate that with the person who is helping you through it. Any sort of surgery has risks; know them. Ask your doctor: Ask, ask, ask. When you end up in the ER with symptoms, you can have that, and you can tell them, "I just had abdominal surgery, and this is how I feel." Then you can at least have a chance of them finding it and ruling it out.

We talked earlier about MD's and DO's and naturopaths and chiropractors. They all have different skills and different tools. They are not all 'one size fits all'. Like Jennifer said, if somebody falls off a ladder, you're not going to take them for herbs; you want to take them to where they can put 'Humpty Dumpty back together again'.

At the same time, you don't want to go to an orthopedic surgeon right away just because your knee hurts because they only have one tool. So read and learn. Get yourself educated on everything. I think you can avoid a lot of interaction if you read and learn.

One note that I wrote is, "Shut up! Mind your privacy!"

Walters: Yes! Keep that window rolled up!

Hale: Yes, we have an adversarial system, legally speaking. That means that people can push, and you need to know when it's time to draw the line.

All these forms that they want you to fill out, 'less is more' most of the time. Just be nice. If you get pushed on it, be nice; stay friendly.

With your healthcare proxies and your powers of attorney, make sure that they are on the same page as you. The last thing that you want is someone who is going to agree to all of this because the doctor said so. We all know what happens there.

That would be my advice.

Lynn: That made me think of one thing that I forgot to mention, which we are all on the same page, and that is the networks. Everywhere you go there are insurance group networks. So, you have your primary doctor, and they are sending you to this doctor. Then you have to go back to the primary, and they send you to the next one.

It's frustrating. I've talked with many people, and it seems like they will send you to someone else. Jen, you brought up how someone doesn't know how to read

their labs or their tests, and they can't get their doctor on the phone, and four days have gone by. They are looking in MyChart, and they are seeing this and wondering, "What does this mean?"

The system has gotten more and more broken. So, I think we all agree that these networks that are under one insurance group with the primary is not necessarily a great way to go.

Walters: It might be a $5 copay, but it's not necessarily great. My uncle is 89, and I just got him out of his Medicare HMO. Now he is in Medicare with a Part G or something in case something horrible happens, like getting hit by a bus where he has to go to the hospital or he has a heart attack or something like that. He belongs to a concierge doctor where he pays a small amount per month, and then the doctor is his full-time. This is nice because then he can call and talk to them. The doctor's visits are an hour and a half; that is a typical doctor's visit for them.

There are doctors available, but they are quite pricey? It's not cheap, but this one is not expensive. I'm telling you that doctors are willing to work with you. I'm broke, and I was able to get with very good doctors throughout this thing for my son because I would offer them things. I would say, "Hey, I can work for you; I can do medical writing; I can do research; I can answer the phones; I can sweep the floor; I can get coffee," and all those kinds of things. So, we would barter different things.

Lynn: Matt, any thoughts?

Hale: I want to add to that: There are the insurance referral networks, and then there are the doctor referral networks.

I've noticed patterns in my own meandering experience that certain large hospital systems that own multiple hospitals refer from hospital to hospital, but you don't get outside the system. So, what that means is sometimes they don't offer the best trauma care or they don't offer the best whatever, but you are going to stay in that hospital system to keep the business in that system.

Like we said earlier, the urgent care clinics might be owned by some of these big

systems. You are getting referred into that system. You are not getting referred to the best; you are getting referred as part of a business plan.

Be aware of that. Be aware that the doctor may be referring you to somebody who is in that doctor's network, not yours. So do some research. That's why it's great to know a local nurse who has friends who can call and find out about Dr. So-and-so. Sometimes their information is much different from the smiling picture on the website.

Lynn: I think that the moral to the story is that everyone needs to focus on taking health into their own hands. Focus on fitness, diet, herbs, and natural medicines. Do as much as you can to keep healthy, but then come up with a good 'game plan' for yourself and your family that works the best for your health situation. Figure out the most affordable scenario that works for you as well.

James, do you have anything to add?

White: No, that nearly covers everything. We covered a great deal. This is one of the longer interviews that we've done, and it's great. We appreciate you both being here.

Is there anything that you think is vital that we didn't cover here before we 'wind things' down? I think that on these last couple of questions, you answered the important things to do.

I do have one quick question: When I was in Michigan, they had a small clinic there. The doctor charged $100 a month whether you had services or not. It was a local clinic, and they had a group in their network of 100 or 200 patients. All of them paid in every month, whether they went or not. That was sort-of like an in-home health plan. Is that popular? Are they doing that still?

Walters: That sounds like concierge service to me. That is what I do to have a geriatric doctor for the elders in my family.

We did that a little with one of our pediatricians. It was $60 a month, and that was only because I needed that to be able to sign forms and different things like that, but we have chiropractors instead of pediatricians for actual health.

Concierge service plans are great. Then join The Wedge. They are doctors who got out of the Medicare system, so they are not in it at all. That is another positive. Then you have the individual doctors who have their own practices, and they are not in the big hospital systems. That is the AAPS.

White: In closing, it comes down to what you mentioned earlier: Basically, they want you in their system. If you take your health into your own hands, you can certainly save money and probably get better healthcare, quite honestly. As you were mentioning, Matt, sadly you may have to use an ATM these days. They want to continue to cash you out. If you can break that cycle, you may actually have better health and save yourself some money.

I appreciate you both being here. Corey, is there anything else that we didn't cover that you wanted to cover here before we close out?

Lynn: I think we got it all. Anything that we didn't, we have an extensive resource list that will be going underneath the commentary.

For subscribers, we have a few PDFs that Jen put together with additional tips. So, there is plenty of good information from both of you, Jen and Matt. I appreciate it, and I appreciate the work you are both doing in your own lives and in helping people who are with *Solari*.

White: Indeed! Once again, we are at the end of one of the *Solution Series* podcasts. We do appreciate you joining us today. We want to thank Jennifer Walters and Matt Hale for being here with us.

If you like what you heard or read here, you can find out more at www.CoreysDigs.com or www.Solari.com. We appreciate you being here. Until next time, this is James White for the *Solution Series* saying goodbye for now.

MODIFICATION

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