BUILDING WEALTH IN CHANGING TIMES

The Solari Report

November 30, 2017

The Future of Health Care
Prepping for the Perfect Storm
with
Jo Kline

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C. Austin Fitts: Ladies and gentlemen, it's a pleasure to welcome back to The Solari Report Jo Kline who is an attorney, author, and at one point, shared the largest hospice in Iowa. She has joined us several times on The Solari Report to talk about healthcare directives and healthcare proxies as well as how to manage end of life. I don't think that there is anyone more knowledgeable about negotiating and navigating the entire healthcare system than Jo.

When she sent me her new book, *The 60-Minute Guide to Health Literacy*, I was very excited. We recently did a Solari Report on why it's so important to be literate and how to navigate the healthcare system. So this is a topic very near and dear to my heart. Having somebody of Jo's extraordinary experience and expertise ready to take it on, I thought, "Perfect."

I called her and said, "Jo, one reason I love your books is because you start many of them with the description of why there is a real coming 'rush hour' in the entire US healthcare system. Nobody describes it better than you. Would you join us on The Solari Report to talk about what you have described as the coming 'perfect storm' in healthcare?"

Thank you so much for coming back to The Solari Report and thank you so much for your books and good work. You're doing tremendous things that add so much value to people's lives.

Jo Kline: Thank you, Catherine. Of course, the same back to you. This is what public education is all about. One patient at a time is what we're doing here, and I think that is the only way to approach it.

What I call the 'perfect storm' some people call 'the wall' that we are going to hit. Sometimes you hear it called the 'demographic tsunami'. I call it a perfect storm because it is three things coming together: our aging demographics in America, the dwindling financial and human resources in the healthcare sector, and then, unfortunately, our lack of health literacy as patients.

I look back and say, "If this isn't the law of unintended consequences!" Just after World War II, we were celebrating the end of the war. The way we celebrated it was by growing the American family. I know that there was no one sitting around at the time thinking, "Okay, but 70 years from now we are going to have 100 million people entering the healthcare system in their golden years with chronic conditions and end of life, and what are we going to do then?" That is exactly what lead to this.

This is all about the baby boomers that were born between 1946 and 1964, which are now ages 53 to 71. Between now and 2030 when the last boomers will enter the Medicare system is a crucial time in this country for us to prepare for those numbers and all these things coming together at the same time.

Fitts: When you mentioned Medicare, I also want to add that if you were reading our Annual Wrap Up on the pension funds system, and if you look at the state and local and other pension fund systems, what you discover – in fact – is that they have regularly been funding their pension requirements. You can debate whether it's efficient or not, but they have not been funding their medical obligations.

This is all going to hit the Medicare system one way or another. Everything is going to collapse into it.

Kline: It's fascinating that the trustees who come out with their reports have now pushed forward that date that Medicare is projected to be insolvent. I know that is a nebulous term because it's not solvent now, but it's going to be officially insolvent in 2028, which is two years earlier than they had just predicted in their 2015 report. So they have already shortened it by two years.

When you look at the Medicaid situation – and I know every state is approaching this differently – we're learning some very tough lessons here in Iowa, having privatized it. What concerns me the most is that I don't even hear people talking about the age-related Medicaid issues, which – of course – is where the funding for folks who end up without assets and end up needing nursing care. I'm not even hearing them talk about that element of the storm.

Fitts: How do we describe this perfect storm? Where do you want to start?

Kline: I think I'll start with the demographics. Throughout our lives – and you and I are boomers – we've run into this, and we've learned to live with it. When we went to school, the schools were very crowded. Back then they could build schools. Then when we wanted homes, there weren't enough homes, so the prices soared, but we could wait for a house to be built.

The difference is that end of life and chronic illnesses are things that can't be put on hold. So when you talk about a 60% increase in the number of Americans aged 65 and older by 2030 – in the next 13 years – those are the people who are sick. As we get 65 and older, that is when we are going to have those chronic conditions. Three-quarters of Medicare patients have two or more chronic conditions. They are constantly in a mode of being involved with the healthcare system and decision-making, and at the same time, we are the sickest because the oldest people are the most ill.

Guess what? The boomers who are the patients are also the providers. So that brings us to where we're now looking at the dwindling human resources. About one-third of the healthcare industry's workers are ready to retire. So we're looking at potentially a shortage of unfilled positions for 900,000 nurses and about 90,000 doctors in the next ten to fifteen years, and those are the US Bureau of Labor statistics figures; those are not trade organization statistics or the bogeyman. That is the government that is admitting that there will be unfilled positions.

If you've been in a care facility recently, imagine it with twice as many patients and half as many workers. That is the reality of what is coming.

Fitts: It's interesting. I was spending a fair amount of time in Silicon Valley when Obamacare passed. I had one software developer tell one of my colleagues at the time that they were planning on re-engineering $1.6 trillion of labor out of healthcare.

Kline: They have been very successful at that.

Fitts: If you talk to the venture capitalists, they believe that they can replace 100% of all current employees on any function, including healthcare, with robotics and AI within some reasonable period of time.

Kline: When you hear those things, you think, "I hope not in my backyard." That's not a realistic position to take, and it's not going to be a viable healthcare professional that is going to say that; it's going to be a social engineer who says that because no doctor would ever tell you or believe that.

I was poking around today on the web and found an organization. I thought, "Who are they? What are they doing?"

I discovered very quickly – on a ten-second search – that they have recently received over $5 million in Federal funding to study ways to increase longevity in America. I thought, "This isn't a bad thing. It's certainly a good thing if we could increase a quality of life for people and have them live longer and healthier," but if we're focusing on keeping people alive longer, then we should also be focusing on how we are going to take care of them while they are here.

My fear is that we are approaching a humanitarian crisis. If there really are no workers there to check that patient in that bed, what happens to that patient? What happens when you have to wait so long for a medical procedure that you don't live long enough to have it? I think that those are realistic concerns.

I have friends who live in parts of the country that are very dominated with older population, and they are already experiencing this. They have some type of a neurological incident that takes them to the ER, and it takes them six weeks to get into a neurologist to have an MRI – six weeks!

Fitts: Here is what I'm seeing: A split in the population between people who have made an effort to really learn how to navigate both natural health – preventative health – and the healthcare system. They know how to get the best of both. They will do everything they possibly can themselves or with natural health practitioners, and as a result they don't need much from the current system. However, when they need it, they are very savvy about figuring out what they need and getting the best or providing for an emergency to make sure that somebody is there in an emergency situation.

They are very savvy about doing it, and, what is amazing is that they get great results because they are a very sophisticated shopper, and they plan ahead. They network.

Kline: You've just defined health literacy, which is taking that responsibility for your own knowledge. When I use that term before they understand what I mean, they say, "I don't want to learn everything about my healthcare problems."

No. I don't want you to be a healthcare expert; that is the job of the healthcare provider. What I want you to be an expert in is gathering information and knowing where to look and knowing how to access and use the information to make informed decisions.

They are finally starting to do some studies on how they can help people be more health literate and use, what we're calling, 'navigators'. Sometimes they are called 'care coordinators' or 'case managers'. They are assigned to you when you're in the healthcare system, but they are there to make sure that you understand what the doctor just said and to make sure that you understand your options. Are we going for treatment, or are we going for cure? Are we going for symptom-control?

In a very short order they are cutting ER visits by 25%. They are cutting rehospitalizations by 50%. This has an immediate and drastic effect on the quality of the healthcare life of the patient which saves money, too.

The rationale that we don't have the money to do that doesn't make sense because, in the end game, it's a considerable cost saving to have an educated patient.

I know it's discouraging, and it's downright frightening in many parts of this country to access healthcare, but I'm with you. My friends, who I call the 2% club, are pretty savvy about their healthcare and the people they are caring for. And guess what? They get very good healthcare.

It's kind of analogous to when people said, "I don't know. I heard that teacher isn't very good." I've always observed that my friends, whose children ended up in a classroom where the teacher was 'not very good', the child did just fine because the parents were very good and they stayed on top of it.

Fitts: One of the reasons we did The Solari Report about two or three months ago on health care literacy was because I ran into a situation with a couple. I was talking with a husband whose wife was absolutely being killed by the medical system. She was being churned, and the things that you can see are frightening.

He was going bankrupt financing her complete brainwashing. She contacted whomever she got and started doing whatever they told her. She was clearly with somebody who wasn't competent, and wasn't doing the things that she could do to support building up her own immune system or detox or all the different things. So she wasn't doing her part, and was blind faith following somebody who was killing her, and it was bankrupting her husband. He was in a complete state of panic.

One of the problems is that you cannot learn this. It's like turning an aircraft carrier: You have to learn it years before you need it.

Kline: Yes, you have to have a plan.

Fitts: You have to have a plan, but it takes plenty of research to get that plan; it's not so easy.

Kline: It does, and the other thing that I've discovered – and since you've read the book, you heard my true confessions –is the legal profession and the healthcare profession for 40 years, since the case of Karen Ann Quinlan in 1976, have been telling people you really need to concentrate on decision-making that you might have to make at the very end of life. Advance care planning is what we call it, and that is the advance directive – living wills, durable powers of attorney.

I've been the leader of the parade, but now I see the reality for our population and for us as individuals, and it's these chronic conditions, which require ongoing medical decision-making. Maybe 25% of us are going to be faced with that – the ventilator or the feeding tube 'yes' or 'no' decisions for ourselves or on behalf of someone else – but we are all going to be facing the decisions where the practitioner comes in and says, "I have some bad news."

People always tell me that the problem wasn't at the end of life; the problem started the day that the doctor walked in and said what the diagnosis was. They say, "We took a wrong turn that day, and we kept going down the wrong path," for months or years or whatever. They didn't understand their rights as patients; they didn't understand the options; they didn't understand the goal of the treatment plan; and so they were never making informed decisions anywhere along the path.

Fitts: It's difficult because everybody is different.

The other thing is that if you look at your options, the only people who can make those decisions as to which options you take, is you. There are risks either way you go. You have to be prepared to take responsibility to which risks you want to take.

Kline: Yes, and you need to understand when those risks are presented to you how probabilities really work. When they quote those numbers to you, you need to know what those really mean. You need to not leave a practitioner or healthcare provider's office until your questions have been answered and until you really do understand.

I am hearing anecdotally an epidemic of people telling me about medical decisions being made for them without any consent being given at all. They are getting a phone call that says, "Mrs. Smith, we have your biopsy in, and you are scheduled to start chemo on Thursday."

Mrs. Smith says, "You know what? I think I'd like to sit down and talk to an oncologist before I make that decision," and they have literally scheduled the patient for the treatment without even knowing what the patient's treatment goals are and without the patient understanding, "Are you talking about curing my cancer, or are you just treating symptoms, or is this palliative care? Why are we doing chemo?" They have actually already scheduled them.

I have a friend whose mother has fairly advanced dementia and was hospitalized for an acute condition. I ran into the doctor who was her hospitalist during hospitalization, which is an entire different topic. He said to her casually, "Oh, by the way, I noticed that your mom is on a really high dose of such-and-such for dementia. I lowered that; that is far too high."

My friend said, "You did what? I have been working to get her regulated on that for several years. This is the dose that she needs to have some quality of life. You need to not be messing with that, and you need to go back and reverse that order."

Fitts: I had a step-grandmother who was killed by medical malpractice. She was a morphine addict. She had very serious arthritis pain, and it was managed. It was her doctors, and she was stable.

She went in for elective surgery that she really needed to have, but the doctors – without discussing it with her doctors or her family – switched her to methadone because taking morphine was 'immoral', and she needed to be 'weaned off of it'. So they gave her methadone and it killed her.

Kline: Then we have the flip side of people whose pain is not being treated at the end of their life because our providers are so paranoid about people becoming opioid-addicted. At the end of life, without opioids we have a problem in this country.

I heard Dr. BJ Miller speak not long ago, and he said, "You go to a country where they don't have opioids and watch the end of life and understand their place in our practice. There is a place for them."

It's two things: It's the provider not knowing the patient and not taking the time to get to know that patient's story and what their personal goals and treatment goals are, and it's patient and/or their proxy decision-makers who are not stepping in and being responsible decision-makers and insisting on being involved in the process and being fully informed before they make a choice.

Fitts: I would say it this way: Modern medicine is very powerful, and you had better have equal or superior power in understanding it and knowing how to access it and knowing what is good for you. Everybody is unique and everybody is different.

That requires an education that has to start before you need it.

Kline: Long before you need it because advance care planning isn't just about end of life. Advance care planning is making sure that all my medications are written down.

We have an issue in this country known as polypharmacy which is that our 65-84 year-olds in America are taking an average of 14-18 prescriptions in a year's time.

Fitts: No wonder they're sick!

Kline: No kidding! They're getting them from different prescribers; they're getting them from different pharmacies; they're not being coordinated; we have interactions; we have non-use; we have misuse;

and that is resulting in what we believe is an unreported leading cause of death in the elderly from falls and loss of independence and frailty and dementia-like symptoms, which are actually side effects from drugs.

I encourage people to take one step. Anybody they know who uses multiple medications, make sure that they have, what we call, a 'brown bag check-up', which is at least once a year. You gather up all of the drugs, including the over-the-counters and the supplements. You put them in a brown bag, and take them, either to your primary care provider. or to your pharmacist. Lay them out and say, "Tell me what is going on here. Why am I taking these? Do they go together? Do I have a problem? Am I taking them right?"

Get that all laid out, and you might be surprised what gets taken off the table or replaced. People are having side effects from drugs they are taking for side effects for other drugs, and they don't even have the condition anymore.

Four billion prescriptions are being filled every year in this country. We are drug crazy. Thank God we have many of them, but they are misused and they are non-used. Now we have a whole new specialty called de-prescribing, which is trying to figure out how to get people off prescriptions that are no longer good for them, but now we need to wean them.

We have created many of these problems by our overmedicating and overproviding medical practices. You said it so well. This has to start long before the crisis comes. You have to have a decision-making process in place, a substitute decision-maker, and a commitment to being an informed patient.

Fitts: You know something? It's easier to do now. In the last ten years alone, there has been a numerous amount of documentaries, a substantial number of books, and a real outpouring. The internet has made this much easier to get all the information.

I had a cousin that got sick with cancer and ran into doing the wrong things. He called me, and I said, "Here are your choices. Here are the documentaries you need to watch. Here are the books you need to read. Here are the doctors that understand that thing. In the meantime, I am going to call my favorite surgeon that is in your exact area and find out who the best person in your area is because you need to get to the right surgeon."

I was able to do that, but if he had to do that on his own, he didn't have the time to know what the best books and the best documentaries and all that were for his education. He was lucky that he knew somebody who could help him jump the curve on that.

I don't understand why they don't teach this in high school, to be perfectly honest.

Kline: I don't understand why they don't teach this in medical school!

Fitts: Touché.

Kline: Our doctors take very, very little time in medical school learning the subject of shared decision-making, which is sitting down, getting to know that patient, giving options that work towards that patient's goals, making decisions, discussing it, and then making informed decisions.

I like your example really well because it is that combination of, "The internet is great," and it is, but do you know what is great, too? Calling a friend and saying, "Hey, didn't you have somebody in your family who had this disease or this condition? Who did you use, and were you happy with them? Would you recommend them?"

Getting recommendations from your primary care physician, "I want to know who you would send your family member to, doctor, who may or may not be someone in your practice."

You need to ask a doctor that is honest with you. I asked one of my specialists last year a certain question. I wanted to change primary care physicians. I asked my specialist – as I happened to see them –"Who would you recommend?" and I discovered that I had specialists who were seeing as their own private doctor, doctors other than those who were in the network that they were in. I appreciated their honesty and the fact that they were willing to admit that they preferred this other doctor as opposed to one of their partners. They narrowed down my choices between that and friends.

So you are doing a great combination of the technology, which is unbeatable these days in what we can research online, and the old-fashioned, "Who do you like? Who did you see? Who does a good job?"

Fitts: When I was a child, my father was a very famous surgeon, and he was passionate about saving people. He lived to save the impossible – the case that was hopeless. They had a list of doctors who the doctors sent their children to. Who are the doctors that doctors go to? He was always proud because he continually made the list.

One thing that he would do is sit at the dinner table, and you constantly wondered what happened that day. He would basically scream into us that: 1) We always had to find the doctor that doctors go to, and 2) Whenever we were in a hospital, we had to watch what was going on. He would continuously pound into us, "Never get general anesthesia. If you can get local, I want you to have local."

"Why, daddy?"

"Because I want you to watch what is happening."

Kline: Yes, and I tell people nowadays that if you are in the hospital, you must be sick. That means that you need to have an advocate with you, preferably 24 hours a day, but certainly all of your waking hours so that when a nurse comes in, and you say, "Why are you here?" and they say, "To give them their meds," you can say, "Really? Somebody was in here ten minutes ago and gave them their meds."

Fitts: Right, and I'm passionate about that. That is why I have you on The Solari Report as many times as I do. One of my friends died in 2010, and her niece and I, between the two of us, had control of both the money and the healthcare proxy. We backed each other up and were like two-timers.

She was incredible concerning navigating the bureaucracy, and I was great regarding the law and money. The two of us together were killers. We were like Foo dogs, and I can't tell you how many times they tried to do something highly unethical or illegal or immoral. It was just appalling. I felt as though I was navigating hostile territory.

In the system, there were fabulous, excellent doctors and nurses and wonderful people. There were plenty of wonderful things occurring, too, but somebody had to be in charge, and she couldn't be; she was just out.

Kline: We are our own worst enemy in many ways. We have relied on the paternalistic model for many decades where we just did what the doctors told us to do, and we trusted them. You and I both know that the vast majority of them – I'll say 95%– are wonderful, caring, competent, patient providers. But now we've put them in a machine where they can only see us for 15-20 minutes.

My doctor breaks that rule, and that is why he is my doctor. However, by the business model, they don't have much time like doctors used to have for us, and we have put them into the business model where their patients are now, "The day I turn 65, my providers start crying because they know that they're probably going to get 40-60% reimbursement as opposed to when I was on private insurance".

When I had a rotator cuff surgery last year, I was on private pay. Now I'm having the PT under Medicare. My doctor said, "God bless you, Jo." He knows he made twice as much on that surgery than he would have made if I'd waited another 30 days to have it.

We hand string them, and then we wonder why they don't have time for us. That's when the advocate comes in – the second set of ears – whether it's an appointment buddy who goes with you to any appointment or certainly when you think there is something important that is going to be discussed. You get that relative on the smartphone sitting on the table. You ask the doctor, "Do you have any objection if my daughter is on the speakerphone?"

They're not going to say that they object. Why would they object? Then you have another set of ears and questions, and a person saying, "Mom, we need to talk about this. Can we get back to the doctor tomorrow?"

It's okay to say that. You don't have to decide on the spot. But it's having that system in place ahead of time that makes you an informed patient.

There is a growing group of Americans called Elder Orphans. We estimate that about one in five Americans aged 65 and older have no one. They have no family member, and have no friends who are willing and able to act as their advocate. Those are the people who I really worry about. They get into the healthcare system, and there is no one there to be a decision-maker for them in a crisis. Our laws are not structured to provide for them.

Fitts: That is a very serious problem, and it's going to get more serious.

Kline: Yes it is. The older we get, the fewer friends and family we have. The last one left is going to be a sole decision-maker. Our laws are entirely geared towards blood family. If you see what states call 'proxy by statute laws', where if you don't have directives, someone gets to step in. Very, very few states – only about four states – recognize unrelated parties to be those decision-makers.

That paperwork has a place for sure, but it is more likely to be used long before your end of life.

Fitts: So we've looked at demographics, and we've looked at the challenge of healthcare providers as the boomers retire. What other scary things do you have in your pouch?

Kline: The finances. You don't even hear them talking about it, and that is what has worried me. When we went to kindergarten, they said, "Where did all these five-year-olds come from?"

We said, "Remember us? We were born five years ago?" So they hurried up and built grade schools. But ten years later, "Hey, where did all these high school kids come from?"

This is what you don't hear, "Hey, where did all you old baby boomers come from?" They're not talking about this, but Obamacare cut hospice reimbursements by 10%.

C. Austin Fitts: Really? I didn't know that.

Kline: Yes. That's like taking one year out of the decade for hospice care. We only spend 3% of the Medicare budget on hospice care, but we spend one-fourth of the Medicare budget on people's last year of life. So what are we doing?

We are spending 80% of the budget on people who have four or more chronic conditions. So instead of addressing preventive care or healthy lifestyles, we just keep throwing more money at it. We're running out of money, and I don't have to tell you that. They're not accounting for the fact that we are going to have twice as many people over 85 in not very many years. Twice as many people over 85 as we have now!

Fitts: Let's talk economics. I think that economic problem number one is not the healthcare system; it's the food and environmental pollution.

If you want to lower the cost of chronic disease, you have to take away the environmental pollution and the poor food choices that are contributing to that disease.

Kline: You start with education, of course.

Fitts: I think it's more than education because, if you look at both the environmental pollution and, what I would call, the corporatization of the food system in a way that really lowered the quality, you can solve the problem if you're wealthy and have plenty of time to deal with it. However, I think that for most people, that is a real problem emanating from the corruption of government and government's failure to do the right thing.

Kline: How do we fix that? And how do we fix that in time for these 75 million people who are already into the system? That is my fear. Is there enough time to even do it? Or is the system to broken to be fixed? I don't know.

Fitts: There are many things that can be done, but they all start with doing what you have the power to do. The reality is that if most people take responsibility to push back as consumers, that is where you are making real changes. It is going to have to come down to the individual citizen saying, "I'm not eating that crap! We need to do something here."

I recently put up a video from Melissa Dykes called *Why I Talk about the Truth*, and she was 28 years old and constantly sick. She dug in and figured out that the food that she thought was food was not really food. She decided that she needed to radically change her diet, which she did.

She went to much more fresh food, and was selective about no GMOs, etc. and got really healthy. That's when she said, "What other things are going on?"

There is a great deal that everybody can do, and I don't think that you are ever too old to do it. We're just going to have to focus there, but I do think that if you wanted to radically improve the healthcare economics, you're going to have to deal with the front end.

A second thing is that, I believe, the pharmaceutical industry is out of control. For example, if you go to Canada or New Zealand or Mexico, I know a group of people in LA who get in the car once a month and drive down to Mexico for lunch and get all their meds for 10% of what they would be paying if they got them in LA.

You have to bust the pharmaceutical cartel. Whether it's the number of drugs that we are taking or the prices that are being charged relative to other countries around the world, it's just a joke.

Kline: But again, you come in and see the effect on all that system of the aging. More and more of the users of those drugs, of course, are being paid through Medicare. They are being paid by their Medicare policy and supplemental –Part D. That's where that control is all starting because they're the ones who set the formulary. They're the ones who decide how much is going to get paid for each of those drugs that I'm on.

Fitts: The third thing about the economics – and I'll be blunt – is we only need healthcare; we don't need healthcare insurance. By turning this into a financial product, you've added a considerable layer of regulation, complexity, and expense, which I think gets really detracted.

A doctor in any situation is overlaid with so much risk related to the laws and the regulation and the insurance company and this and that. It's just mind-boggling.

Kline: The Medicare budget is about $600 billion a year, and the healthcare industry estimates that it costs them $250 billion a year for what they need to do a year to comply with the Medicare system. So well over a third of the same amount of the Medicare budget is being spent only to make it possible to keep the clock ticking.

Then you throw in, probably, $200 billion a year in medication-related healthcare issues. So we've caused the healthcare issue by medication being given – not including being misused – and then we throw in $200 billion a year that is likely due to lack of health literacy.

As Everett Dirksen would say, 'We have some pretty serious numbers here – a billion here and a billion there."

We can't sustain this. As I wrote this last book, I had to stop and do some soul searching and say, "Who is my audience?" I've tried to convert people for 11 years with my writing on end of life decision-making and healthcare advance directives. Now I'm not doing that anymore. To be honest with you I want to preach to the choir. I want to preach to the people who say, "I want to know how to do this. Tell me how to do this," and I will tell you how.

I cannot spend any more time trying to convince people to be responsible for themselves. If they don't see what is coming – that big, dark thing there – that is a tsunami coming. It is going to come, and it is going to be – I'm afraid – one of the darkest hours in our country's history.

How we are judged is how we take care of our most vulnerable, and our most vulnerable are the ones who will suffer horribly if we don't get some answers right away. And we're not even asking the questions on a national level.

Fitts: Let me ask you a couple of questions about what I see as possible with different kinds of solutions that can help ease the wall.

I had to laugh. I think it was two years ago, in the middle of the intense discussion implementing Obamacare. I don't know if you heard my line, but in the first month after Obamacare, more people signed up for a one-way ticket to Mars than signed up for Obamacare. I thought that was pretty funny.

Kline: And the chances of it succeeding were exactly the same, too.

Fitts: A surgical center of Oklahoma announced that, for a list of fairly common surgeries, they were only taking cash, and they would do those surgeries for 20% of the Medicare schedule. I don't know if you saw that.

They were saying, "If we can just do cash and leave that entire thing behind, that's how economic it is."

That is my theory. If we were ready for cold turkey, if we just woke up and said, "Everybody pay cash," within five years we would be much better off. Obviously, the first year would be very painful.

Kline: There certainly are some segments , which have figured that out – the concierge providers – who have said, "Give us x number of dollars to belong to this clinic, and you will get an annual, and you will get priority service. You will actually get an appointment. For those of you who don't pay the membership fee, get in line."

Fitts: I think that is a great idea.

Kline: It works well for the people who have the money to pay the concierge membership. That's how those clinics have addressed that issue. They just said, "We're going to eliminate much of this; we're not turning that physical into Medicare anymore and going through the paperwork. We're giving them a deal. You're going to get this, and you're going to get a certain number of visits and a certain number of hours with our practitioners, and that's what you're getting for your membership," and they're not even going through Medicare.

Fitts: There is an explosion we're seeing of software development and apps and other things to make, for example, testing much cheaper and lower cost and much more accessible. In fact, somebody who is willing to take responsibility and do it themselves has more potential tools available to them.

Kline: I think no matter what the technology, and I speak about technology a bit in my book regarding being your own record-keeper and how to do that. Of course, all of our doctors are going on to the patient portal system and all that. That's fine, and when you get down to genome testing and sophisticated brain scans and the things that we can now do that we couldn't do a few years ago, it always comes down to that patient who says, "What is the end game here?"

Whether we have the technology to find this out, or we're using the old-fashioned method or we don't know the condition I have, what are my options, and what are my personal goals before I decide if I want that fancy test?

The other problem that we are going to have – and we're already seeing it – is, quite frankly, the rationing of those resources. There are limited dollars, and we are going to say, "I'm sorry. Your mom doesn't get that sophisticated test because she is x years old, and it is just not a good investment of Medicare dollars to give her a new hip so that she can have another five years of quality life. We just don't see it."

That's already happening and, of course, it's happening. It happens any time a doctor sits a family down and says, "You loved one is not a prospect for this procedure. It's medically futile; it doesn't make sense to do it."

Fitts: One of the things that I'm watching is a significant number of people moving to live abroad because the healthcare system is much more economical or much more human. There is a growing body of expertise and knowledge of where it is attractive to live in the world to avoid this wall by going to a place where the wall is not so high or so big, or the resources are there, or it's a much lower-cost area so you can afford to deal with that wall.

I'm seeing healthcare as, arguably, one of the primary drivers in sending people offshore.

Kline: If there are any hard statistics on that, I'm not aware of them. I haven't been looking for them, so they may well be out there. I can't speak to that, but that is a sad commentary, isn't it? If people have to make a move like that and that is the only reason that they are doing it, then clearly we are already in deep trouble.

We are in deep trouble, but if we're driving people out of our country with the resources here, it's not that we don't have the resources, it's not that we don't have the talent or the people or the money or the advancements. It's not that we don't have those things, but it's that we just don't seem to be able to get our act together on how to use them properly and make them available to everybody.

Fitts: When I see that happen, it's part of a decision to move to a low-cost area. I live in Hickory Valley, Tennessee because it's a low-cost area. I have three properties here, and my combined local and county property taxes on those three properties are $500 a year.

I was really worried that property taxes would skyrocket. If you doubled mine, it would be $1,000 a year.

Kline: I'm laughing because I'm sitting here in a house where my property taxes are $500 a month.

Fitts: That is one of the reasons I moved here. The other thing is that the pension funds here are fully funded.

I was looking for someplace where if you examined the state and local government finances, you were unlikely to get a big surprise financially.

There are low-cost areas where people can move to in the United States, but many of the decisions are twofold. One is that they are looking for a low-cost area, and that includes health. Health is a big part of the budget that concerns them. The other thing is that they are looking for a more human culture. I think that part of the problem is that the healthcare system is very powerful. If you walk in and it's not human, that is what I dealt with when Georgie died. I was dealing with a system which was designed to be inhuman.

Many of the people in it were wonderful and very human, but the system itself – between the government and insurance and the finances – had really become inhuman.

Kline: Let me ask you this. With your advocacy and the advocacy of the person who you partnered with to be there for Georgie, did you feel at the end of the day that you were able to maximize that system's benefits for Georgie because of your advocacy and because you took charge? Were you able to make it work for her?

Fitts: Yes, and that took a tremendous amount of time, expertise, and effort on our parts, which we were happy to do.

Kline: And that came over many years; you didn't learn that the way you walked into the job. You had done your homework all your lives.

Fitts: The number one thing that we did right was that we got her into hospice at the right time. If we hadn't done that, it would have been inhuman.

Kline: Almost half of the people in America now die in hospice – 43% - but the median number of days is about 17. More often than not, people go into it far too late, so they don't receive the full benefit of having hospice addressed and that comfort issue and addressed the loved one's issues with end of life for the patient.

We could spend a whole report talking about palliative care because palliative care is so misunderstood in America. It's a large element of hospice, but palliative care is comfort care for any serious disease. There are amazing studies being done where they start cancer patients out, and one group has palliative care from the get-go, and the other group just has oncology. Guess what? At the end of their life – and they know that these are non-curable, terminal cancers – the ones with palliative care live 25% longer.

Fitts: Wow! I never heard that statistic. That is amazing.

Kline: It's actually in the book. I will shoot you over an email and show you the page to find it. I believe it's a Massachusetts General study.

It's fascinating because when the palliative care doctor was focusing on the comfort issues, the side effects of the disease, and the side effects of the treatments, the oncologist could focus on treating the disease. They weren't spending any of the energy or time working on shortness of breath or anxiety or depression or fatigue or any of the things that came along with the oncology. They lived 25% longer.

So they lived longer lives and higher quality lives just because we reintroduced what used to be part of the practitioner's job but is now a specialty; comfort care.

Fitts: One thing that I find very intriguing is that I've been watching some of the different websites of people who are crowdfunding their diagnosis.

You get these situations where people have a hard time figuring out what in the world is wrong. That's where I feel the software and the online services can help many people. They get in there and start networking, especially on something that is not common. It's unusual, or it's a disease that is a rare situation. They get incredible results when it works, although it doesn't always work.

Kline: The software that is being introduced in the healthcare industry itself for doctors to use, which is fundamentally plugging in all the symptoms, and now we can plug in so many other things.

I'm always going to want a human being to interpret all of this.

Fitts: I would much rather have the doctor that I trust have access to it.

Kline: I always say, "I'm looking for one thing in my doctor: Are they a good diagnostician?" That is the key to success there. Can they look at the overall picture and say, "I think this is what we're looking at"?

We do have these incredible tools at our fingertips. You and I could do so much more research before we even go to the doctor – probably more than we should – and finally break down and see the professional.

The resources are all there. This is just a matter of access and prioritizing. That is what we have upside down generally in this system right now.

Fitts: It's ridiculous. I get this because I was involved in political litigation. To this day, whenever I fill out a form it says, "Who is your doctor? Who is your primary caregiver?" I write, "None." The reason is that if I put a name there, that will legally give that person decision-making authority in times and moments when I don't want them to have it. Even if I trust them, I don't want them to be pressured by anything political. I'm cautious that way.

Kline: You bring up an excellent point that I alluded to earlier. If we have a minute, I want to mention this. We do talk about having these conversations with our primary care physicians and that relationship, which is so very, very important of having a primary care physician that you trust and who will tell you the truth and who will be your number one advocate.

I don't know how many people realize that when you actually have to go to the hospital for something – whether it's unexpected or planned –

– the chances are that your primary care physician is not going to be attending you in that hospital because the great majority of hospitals in this country are now using hospitalists. They can be of two types: they can be employees of the hospital, or they can be outside practitioners that specialize in simply going to the hospital and treating the patients of other doctors – or those who do not have a doctor. There is that stranger who walks in the room, and they don't know if you came from your home that you're living in independently or if you came from a nursing facility. That is the importance of that advocate at your side who can tell your story if you no longer – whether temporarily or permanently – have the capacity to advocate for yourself.

You may well be dealing with a stranger. Or if it's not the hospitalist, it's going to be the emergency doctor or the intensivist or the specialist who has never met you. Making sure that they know your story and know your medical history and know what your personal goals are and your beliefs and values and your preferences and your priorities, those are key to them giving you options for care that matches you. That gives your decision-maker or you options that fit your situation – not the person in the bed next-door to you, but you.

Fitts: We have a great Solari Report on healthcare directives and healthcare proxies with you, but you always recommend forms that people can use to do their planning. I would ask that you do that. Is there something that you can recommend today?

Kline: I drafted my own form last year. So if they go to my website, which is www.JoKline.net, you will see there advance directives, or they can go to www.Advance-Directives.net. Those are the forms that I drafted last year. I have looked at so many forms over the years, and many states are using forms that are 40 years old. They are done post-Quinlan and post-Cruzan where we were worried about vegetative states. That's not really what is happening now. We need to be worried about the process of decision-making. So I really focus on that in my form, which is, "Catherine, here is how I want you to make a decision for me in any healthcare situation that I'm not able to participate," whether we are talking about a feeding tube or about whether or not to give me stitches after a car accident.

The other thing is that we have not dealt with the number six killer of all Americans and the number three killer of Americans over 75, which is dementia. Those are not addressed in typical advance directives where people are saying, "I know one thing. When I don't know anything about what is going on around me, I don't want you to keep me around anymore."

That is not a terminal condition, and that is not irreversible unconsciousness until the very late stages. It makes it so difficult for many people because they don't really qualify to not give them a feeding tube or not give them a ventilator or not treat their pneumonia.

I thought that it was important to make that a third category in my advance directive. So I have my own forms now. I have a multi-state form and an Iowa version, but they can go to that site and find out which states they don't work in. There are four or five states where you cannot use them, but generally, they work anywhere.

Fitts: I have to say that my friend who died in 2010, Georgie, had been in the Navy and ran Navy contracts, so she was tough. She made me sit down and go through her healthcare proxy and plan this all out.

I kept saying, "Georgie, I don't want to talk about this. This is gruesome. This is bad. This is horrible."

But I lived with Georgie through several surgeries, and I helped her manage the entire process from the time that she got cancer. She lived for a very long time, and she lived much, much longer because she had many trained Foo dogs watching out for her.

The thing that made us powerful beyond anything was that we had very clear directions from her. We were totally confident that we knew exactly what she wanted. So that made us powerful. She knew it would, but I didn't understand it. She had to beat me up and make me do it against my will, and now I understand.

Kline: The other important thing is that is what your job is as a proxy – to do what that person would do if they were able, not to do what you would do for yourself or what you think they should do. Your job is to do what they would do if they could speak and had the capacity, and there is only one way to do that. Georgie knew that, and that was to have that conversation with you over and over and over again until you got it so that there wasn't any doubt in your mind what she wanted you to do on her behalf.

Fitts: One of your books is on ethical wills. I recently had a remarkable experience. I came from a memorial service two weeks ago for my 94-year-old uncle who was an exceptional human being. He made an extraordinary effort after he turned 90 to educate us as to his life, what he had learned, and what was in his legacy, his character, and his culture that he could teach us before he went out.

Kline: Wow! What a gift!

Fitts: He was an engineer. He had a Ph.D. from MIT and managed everything to a T, but he really managed to embody, organize, and communicate, not just intellectually, but emotionally to us his legacy. It's a legacy that, for us, both in terms of our character and of our sense of the world, and of being loved in the world and of culture, is so powerful. I can't talk about it without crying. You can hear my voice crack.

Kline: That is a priceless, priceless treasure. What a wonderful gift! What a generous person he was to take the time and the energy that it took to do that and share that so you would have that piece of him always. There were things that you could only learn from him; there was no other way to learn this.

Fitts: He sat down with me a couple of months before he died. I went to see him because I knew he was unhappy. His memory was slipping, and he was a very brilliant person.

He sat down and said, "Look, I'm planning on dying. I've had a great life, but my memory is going. I don't want to stay alive if my memory is going, so I'm going to die now. I don't want you to feel bad about it. It's my decision, and it is what it is."

We had our final check-in, if you will. Then he proceeded to die.

He swore me to secrecy, and I wasn't allowed to tell anybody. He probably did this to 20 other people.

Kline: I love that! And did he say, "And you were my favorite. Don't tell anybody else that you were my favorite"?

Fitts: No, he would never do that. He wasn't a game person. There was not a gaming bone in his body.

Kline: But that's great that he did do that. Maybe he did that with 20 people, and what a gift for all 20 of you.

Fitts: You walked into the Quaker meeting service, and there was absolutely no unhappiness. You had the feeling about Robin (his name was Robin Willits) that he was on to his next thing. Every gear was always in forward with Robin. Everybody was shimmering and glowing with the legacy that he had given them before he died.

Kline: And I'm guessing that he is a man who lived with few regrets. That is always a joyous occasion.

An ethical will, just very quickly for your audience, is an ancient Jewish tradition. The first one is in the book of Genesis, and it is not a legal document; it is a statement of your beliefs and values and your life lessons and your hopes for the future. Your uncle did that.

Did he leave writings, or was this all oral history that he shared with you?

Fitts: He left a series, both of audios and written things that he shared with us. Some were audio, some were written, and then some were shared intimately like the conversation I had with him. He worked on it during his last ten years, but particularly the last four to five years of his life.

What was even better was that when we all met at the Quaker service, everybody stood up and spoke as; they are lead to speak in a Quaker service. You had people who had known Robin for a century and our family and who stood up and told story after story after story. They read different things or told different stories about Robin. Being there together and capturing all of that together just solidified the power of his legacy.

I see your work on ethical wills, and I try to explain to people, "Look, there is a major legacy that gets handed down."

I read a book review once about a great scholar in Mali. They said that when he died, it was like a library burning down.

We have to make sure as the boomer's transition that each family knows about this. The thing that makes a family powerful, among other things, is to know your history. You know your history by this legacy getting passed down and down and down. That legacy and knowing our history can make us powerful. It's very powerful in terms of protecting us from financial fraud.

As we go through this process, if we hit this wall and don't transfer that legacy, hitting the wall is going to be bad enough. Hitting the wall without the legacy transfer, everybody in the next generation is going to end up powerless on the other side, and we can't let that happen.

Kline: That is an excellent point. I think that the potential for that tragedy is there because when all your energy has to go into trying to figure out how you're going to take the next step in your healthcare story, you don't have the time or energy to devote to talking about your legacy story.

I fear that people will spend the last chapters of their lives doing nothing but being completely ensconced in the healthcare system and trying to get the care that they deserve but can't grasp onto it.

The whole ethical will, whether it's a letter or a collection of quotations or highlighting your favorite verses in your favorite bible or book, or whatever it is, it is transferring the lessons we've learned. It just doesn't get more priceless than that. That is the only place you can learn those things that are in the school of hard knocks.

Fitts: It was amusing. One of my favorite moments was from one of Robin's friends. Robin stopped skiing when he was 85 because his wife was screaming at him. He had a couple of spills, and she didn't want him skiing anymore. One of the persons who used to go skiing with him stood up and explained that Robin said he stopped skiing, not because he thought he was going to get hurt, but because he couldn't trust himself not to ski fast.

I want to go out skiing fast, if you will.

Do you have any other points that you want to make about the wall and what is coming up? Is there anything else that can help us see that perfect storm that we've talked about?

Kline: What I'm starting to see clearly is that this indeed is a patient-by-patient solution, but it's also a provider-by-provider solution. So as I'm talking to doctors and I'm talking to administrators, I'm saying, "You have the control right now. You have the power to change the system in the four walls of your institution or in the four walls of your examination room. You have that power. You don't need Congress to give you that power. You don't need the government to change a program or do one thing differently. You can start by communicating with your patients and making sure that they understand when they walk out your door what their next step is and who is going to take it when they are discharged from the hospital. What should they do next to take care of themselves? What should they look out for?"

I tell patients the same thing. We don't have to wait for Washington to change things to get the healthcare that we need and deserve. We can be responsible for our health literacy and make sure that we are informed patients and insist on exercising our right to informed consent and patient autonomy, which means respecting our personal belief systems in the midst of the healthcare system.

I have high hopes as I meet individuals, whether those are patients or providers or administrators, that there are many out there who want to make a change and they only need to know how to do it.

When I started to write this book – and it was a personal healthcare situation that lead me to write this most recent book – I looked, and what I do as an author because my books are nonfiction books is look and see what the competition is. Well, guess what? There is nothing. I was shocked.

Fitts: That's remarkable.

Kline: The only health literacy books were written for practitioners, and quite frankly, they were 300-400 page tomes on how to dumb down their communication for us. The only way they can deal with 'us stupid patients' is to minimalize the language to us so that we get what is happening. I couldn't disagree more. I don't think that has anything to do with our ability to understand; it has to do with our ability to feel empowered and to understand that as patients we have a right to understand what is happening with our healthcare, but we also have a responsibility to be an informed patient and not to let the system make decisions for us. That is our right and our obligation to do that ourselves.

Fitts: I will tell you a funny story. I decided I had to get radically simple about everything I was doing regarding preventive healthcare. I did a very serious detox after the litigation. It got me involved in trying many things, so I made a list of every therapy in the last ten years that anybody had advised – whether it was nutrition or whatever. It was all the old-time remedies and everything a doctor had advised – everything.

I was trying to figure out what was the most effective. I went through a whole sorting process and analysis, and do you know what I realized was the most effective? You are going to laugh. It was prayer.

When I didn't know what to do, if I would sit and calm down and become much more coherent and just pray about the sequence of what I should do, I would make a much wiser decision.

Kline: I hear you, and I agree with you. That is the mind-body-spirituality connection. There is where, with your technology, you become your own worst enemy. We become so dependent on our ability to do things that we have to stop and look and listen and say, "Yes, but what is the right thing for us to do?"

We often don't have the answer to that question. We have to go to a higher power.

Fitts: I tend to jump to action, and that is where I make my mistakes. I act on a symptom instead of sitting down and saying, "What is the real problem here?"

Kline: In defense of our healthcare providers, for decades and decades our mantra has been, "Fix it, doc. Just fix it. Give me a pill, give me a procedure, and make me well."

When they hit their own wall, and know they can't do anything more, we leave them hanging there. Doctors will tell you – and there have been many studies done – they feel very disloyal to a patient when they have to say, "I can't do anything for you," so they just keep doing things, even though knowing that they are no longer curing.

Many of us think they are trying to cure, and that is where that miscommunication comes in. So everybody needs to take a deep breath and say, "What's our end goal here?" Guess what, folks? None of us are getting out of here alive – the doctors, the patients, nobody. It's coming to an end, and now we are talking about what happens between now and then.

Fitts: One of my favorite lines is from *The Gladiator*. He says, "Give me a good death, a clean death."

Kline: That's right.

Fitts: I've been around many people who have died very, very well, and it has been a remarkable experience leaving a great legacy for their entire family. It can be done.

I go back and forth between many different cultures, and some cultures are totally open in talking about it, and death is just part of life, and it's all open, and everybody deals with it. It's not a horrible thing. In America, it's, "Don't talk about that; that's horrid."

Kline: Now one in every five Americans lives in a state where physician-assisted suicide is legal. It concerns me a great deal that people are thinking that. They think that is a better alternative than what the healthcare system is going to offer them. Shame on us if that is what patients think because we have a better way.

Fitts: This has been unbelievably useful, Jo, as all of your books and all of your conversations are.

There is one last thing that I want to bring up before we close. I'm concerned that if you look at what is happening in the healthcare area, we see an explosion of advancements and life extension and all of these amazing things that are only available to the very, very wealthy.

One of the things that I'm afraid of is that this wall that you are describing, combined with those technological advances, means that we are headed into a period where the inequality could become mind-boggling.

Kline: I think it's a potential humanitarian crisis. I don't think there is any question that when you have people in facilities where we do not have the worker, and we cannot say 'yes' to procedures for certain populations, it's an easy way to being cut off by age. That is just a really simple one. You reach a certain age, and it's, "I'm sorry, but you don't get any more procedures because you're past your 'use by date' according to the Medicare chart."

When we start doing that, or we start doing it by, "Oh, I'm sorry. You're an hour away from the nearest clinic. Then you can't have this procedure because you're going to need to come every day for this treatment. So if you don't have transportation and you are an hour away, that is not going to work for you, is it?"

That day is coming, definitely coming. I think it's only through patient education, self-education, and people trying to be health literate that people are going to realize, not only to take care of themselves, but now they start thinking about their neighbor and their loved ones and their family members and their friends. You begin to think; "I need to talk to them about this, too, because I don't think that they've made plans for this. They're healthy right now, but what if that day comes?"

When that day comes, it comes very quickly. It's always unexpected. That is the definition of 'emergency'; it's unexpected.

If you don't have that plan in place of who is going to step in and who is going to be responsible for being your advocate in the healthcare system, which will be a healthcare crisis for you. I guarantee that. If you multiply that by 75 million, it is a humanitarian crisis.

Fitts: Quick questions from a great subscriber: He starts off, "I had an uncle decline cancer treatment. He just skipped it and went into hospice care instead. He was at peace spiritually to make that decision. I think the comment 'no torture' was used."

The first question is: Do most healthcare directives suffice for skipping treatments?

Kline: First of all, let's remember that a healthcare directive, which is really your advance instructions, only needs to kick in – at all – if you can't make decisions. So as long as you have the capacity, and it sounds like this gentleman did – you can make your own decisions. The only time a healthcare directive should even be referred to is if you are incapacitated and can't make a decision – whether that is a temporary thing because you are under an anesthetic or it is a permanent incapacity like dementia.

Most directives could definitely suffice, but the key to the directive is always: Has a triggering event occurred? That is when those 'no procedures, no antibiotics, no feeding tube' and all kick in once a triggering event occurs. Traditionally, the triggering events have always been, "I have a terminal condition, which means I'm very close to the end of life." It's not just that you are going to die, but you are close to the end of life. Or, it could be that you are irreversibly unconscious.

If it's one of those two things, then, "This is my instruction. I don't want treatment. I don't want to be hospitalized."

The first thing is always: Is the patient capable of make their own decisions? You know what? You don't have to have 100% capacity in your life. You don't have to be able to take care of yourself anymore or live alone, and you can still make medical decisions. People know towards the end of life if they want a feeding tube in them if they're conscious or whether they want a ventilator.

You will hear competent and compassionate doctors talking about all kinds of communication methods, which is putting a hand up or shaking a head or just looking like you're in pain when someone is trying to do something to you medically.

However, no treatment would be in an advance directive if, indeed, a triggering event had occurred. It's that long time before then that worries most of us. It might be the months or years where I don't know where I'm at and I don't know anybody, but I'm not terminal, and I'm not irreversibly unconscious, so you're all going to feel obligated to keep me around.

That is why it is important to understand what your directive says. Read it yourself. If you could follow it if it belonged to somebody else, then you are probably okay.

Fitts: The next question is: States change their health directives over time. Are most states respectful of the person's wishes?

Kline: No. There is an old saying under the law, "The law abhors a vacuum."

Whenever we have a sad case like Karen Ann Quinlan or Nancy Beth Cruzan or Theresa Marie Schiavo, the lawmakers – and that's really us – come rushing in to fill the vacuum and to try to make laws so that these bad things don't happen to good people.

The thing of it is that when you try to make laws that fit everyone, they often fit no one. Most laws in the United States were made 30-40 years ago. Do you think maybe we've had some advances in medical care since then?

So many of the life-extending options we have – not life-prolonging like ventilation tubes, but dialysis and these high-tech antibiotics – didn't even exist when these laws were made. They weren't even an issue because they didn't exist.

Laws don't keep up with advancements. That is number one. Doctors aren't lawyers, for the most part. They are asked to look at a legal document and say, "Gee, I wonder what this person wanted." So that doesn't work. Usually, the advance directive isn't really what the person wanted anyway, and they didn't even understand it when they signed it. So what are we left with? A proxy. Our proxy is the most important.

I encourage people to get that written appointment because then there isn't a concern of, "Well, I know you think of her like a sister, but she is a sister-in-law, and that is not recognized under our law."

If somebody is a trusted person who knows what you want and they will stand up for you as you did for Georgie and like my 2% club will for me, but bar the door if my team of advocates has to help me. Get it in writing, and appoint that proxy, and have the conversation. Then you are protected. Then you don't have to worry about whether or not the law protects you or the doctors respect you because you have a strong advocate.

Fitts: My only concern is what happens if you do all of that and we are in a Katrina type of situation, and your 2% club is overwhelmed and swamped just like you.

Kline: Absolutely. You can't prepare for every contingency. I always tell people to have a proxy and an alternate proxy because often, while undoubtedly true for married couples, they will name their spouse. If it were to be an accident or something, your number one decision-maker might be in as bad of shape as you are. So always have an alternate.

It's impossible to address every situation, but the thing that people need to remember is that whatever is done medically can be reversed. I don't mean that the procedure can be reversed, but your permission can be reversed.

A doctor told me not long ago that people will come rushing into the emergency room the next morning and will say, "My mom never wanted a ventilator. I can't believe you have my mom on a ventilator." The doctor said that he would look at them and say, "First of all, you weren't here last night, and your mom was in a crisis, and we did what we needed to do to save her.

Now let's sit down and talk about our options. We can try this for a time-limited trial, and then you most definitely can decide to remove that ventilator."

So you always have the option to stop a procedure that has already been started.

Fitts: Last question from my subscribers: I've seen a certificate of cremation being used. What does it take with a cremation to get a death certificate?

Kline: I wouldn't call that my area of expertise. That is going to be different in every state. We have these peculiar rules across the United States of who even has authority to decide if you are going to be cremated, even if that is what everybody knows you wanted. Different states have different rules about who can actually make that decision.

A death certificate would be done before a cremation.

Fitts: That is what I assumed.

Kline: I don't want to make light of this, but after the cremation would be too late. A death certificate is always going to be produced. For people dying in hospice, hospice has the authority to issue those death certificates. Typically, an unattended death requires an autopsy, but, of course, hospice is the significant exception to that. There would always be a death certificate before a body would be allowed to be disposed of.

Fitts: If someone dies at home, is it required to do an autopsy in some states?

Kline: No. If you died at home and you were not under hospice care, and they could not very easily determine what the cause of death was, then yes, most laws would require an autopsy because they would want to make sure that there wasn't any foul play.

If someone was found dead in their home, chances are there is going to be an autopsy. There is undoubtedly going to be a preliminary investigation by an ME to make sure that it was natural causes.

If you are enrolled in a hospice program, you call the hospice doctor and say, "Mom passed away," and the hospice doctor does not need to come and examine the body. They just write the certificate because everybody knows that that person was dying.

Fitts: I'll tell you that if you are listening to you and me, you will not be shy about talking about death anymore.

Kline: That's right. That's the way that it should be. I have to tell you that a couple of months ago I decided I had a responsibility to do this, and I thoroughly planned my funeral. Actually, it was fun, and I'm sorry I'm going to miss it.

I thought ahead of those things, "What do I want to leave those people with? How do I want those people to feel when they leave this event?"

Fitts: I disagree with you because everybody who I loved that I went to their funeral, they stuck around for the funeral. Georgie was there at the funeral. She left in the middle, and I'll never forget that. I think that people hang around in the spirit for a couple of days, and most of them come to the funeral as a spirit.

Kline: Trust me, I'm going to be there; yes I'll be there.

It was a fascinating process for me to pick the music and the readings and the message. I wanted people to feel good when they left. I had to think very hard, "What is the last song that I want them to hear? What kind of music do I want to have?"

I would love to do a workshop on that sometime because it was cathartic. It was very interesting.

The other thing is that I want people to stop and think, "What a burden to put on your loved ones." They're in the midst of trying to work through the fact that you've died, and now they have to plan this huge party and wonder what you wanted. They have to think, "Would she want this, or would she want that?"

I've done all that now, and I know my friends are going to appreciate that when the time comes. All they have to do is plug in the CD and fill in the date after the dash.

Fitts: I confess that I haven't even thought about that.

Kline: I encourage you to do that, and it was fun to do. I know it sounds strange, but it's like an ethical will.

Fitts: You're way ahead of me. Given the work that you do, particularly on the ethical will, it makes total sense.

Before we go, could you remind every one of your books, including your new one on healthcare literacy, and your website? How do we find you? How do we get a hold of you? How do we get your books?

Kline: You can access everything through my website. You can go to Amazon or to the website, which is www.JoKline.net.

You know about my books because you've always been so supportive of my writing. I first wrote about advance directives in 2006, and I updated it in 2015. So that is *The Practical Guide to Health Care Advance Directives*, which came out in 2015. My most recent one, just this year, is *The 60-Minute Guide to Health Literacy: A Common Sense Approach to Informed Medical Decision Making*.

What I do is hit the top areas that you need to know ahead of time and think about and be ready and do a little paperwork, and you will be a much more informed patient, and prepared to be a decision-maker for yourself or a loved one.

Fitts: If you don't have a health care directive, you need to go to her website and get the forms and the documents, and start planning. It's a remarkable thing to do, and you might as well just dive in and start learning how to do it. We are all going to have to.

Kline: Healthcare is a challenging journey – managing healthcare for yourself or a loved one. I think that being health literate is like having a roadmap.

Fitts: It's unbelievable. When I first moved to Tennessee, I went to see the original homestead. My ancestors came to Tennessee from the East Coast, trying to get away from the civil war. Some went to Texas, and some came to Tennessee. It was a log cabin with no windows, obviously no running water, and a dirt floor. It was just a one-room cabin, and ten people lived in it through the winter.

I took one look at that, and I was in the middle of the litigation, so it was sort of an extreme survival experience. I said, "What am I complaining about?"

It was when I first gave up my healthcare insurance. I thought, "My ancestors have made it for centuries and centuries without healthcare insurance."

However, what it made me realize is that the reason it's complicated and the reason we all have to do the kinds of things we're talking about is because we have incredible blessings. If you look at what the healthcare system offers, it's just amazing and fabulous.

My grandfather started a clinic that became the first hospital in Jackson, Tennessee. Working with another relative who was in the state legislature, he was able to get authorization to first introduce penicillin to Tennessee. Now we take antibiotics for granted, but remember the world without them.

Kline: When you look at the medical devices and procedures that we've only had about the last 20 years, it's mind-boggling. The MRI and the CAT scan and the dialysis and the things that feel as if they've always been there, have not been. The medical advances are leaps and bounds, and it's tough to keep up with it.

Fitts: We've become a bit of a sarcastic culture. I want to recognize – whether it's the traditional healthcare system or what is now happening with natural healthcare or the hospice system – that we have incredible blessings, which most people around the world would give anything for.

Kline: And with those blessings come great responsibilities. I think that is the crossroads where we are.

Fitts: We are not going to 'jump the curve' or, in your case, I'll call it 'jump the wall'. We're not going to jump the wall and take advantage of all these blessings without taking that responsibility. I agree with you: You have to help the people who will take responsibility; you can't help the ones who won't. It's just that way.

Kline: People should not hesitate to talk to their providers about this, too. Talk about concerns because I think often we don't give our health care providers credit for the fact that we understand that there is only so much they can do. We want to give them permission to give us bad news and tell us when it's time to start thinking about care rather than cure.

Fitts: Exactly. Well, Jo Kline, you're the best. Thank you so much for joining us on The Solari Report.

Kline: It's always a pleasure. It's such a privilege for me to be able to talk to you and to address your audience who are so engaged and so sophisticated. It was a joy to be with you again.

Fitts: They take responsibility. They are unbelievable.

You have a great day.

Kline: You, too. Thank you so much.

MODIFICATION

Transcripts are not always verbatim. Modifications are sometimes made to improve clarity, usefulness and readability, while staying true to the original intent.

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