Podcast 113: A New Perspective in Health Care with Twila Brase

John Marchica:

Welcome to season four of Health Care Rounds. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care and obtaining joy in work. I'm John Marchica, host of Health Care Rounds. I'm also the CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Please don't forget to rate and review us wherever you get your podcast, and send your questions, comments or ideas for Health Care Rounds to podcast@darwinresearch.com. Let's get started.

Today, I'm speaking with Twila Brase, who's president and co-founder of The Citizens Council for Health Freedom. She was voted number 75 on Modern Health Care's 2009 list of the 100 most powerful people in healthcare. Her commentaries have appeared in CNSnews.org, The Daily Caller, LifeZette, The Pioneer Press, The Star Tribune, The Hill, Townhall, The Wall Street Journal and The Washington Times. Her article, Blame Congress for HMOs, is in the Congressional record of the US House of Representatives.

So Twila, to get started, I've got a lot of questions for you. I've gotten about three quarters of the way through your book, Big Brother in the Exam Room, it's very well written, Very well sourced I should tell you. And you certainly have a lot of testimonials in here. Writing is a labor of love for me as well. I did a book a number of years ago and thought about dusting it off and doing a new edition, but I do so much writing for work that it's just when am I going to have time to do it?

Twila Brase:

What was your book called?

John Marchica:

It's called The Accountable Organization: Reclaiming Integrity and Restoring Trust. I wrote it in the wake of the whole Enron debacle when all those companies were getting nailed for ethical violations.

Twila Brase:

Oh, interesting. Well, I wrote one last thing for the book that you might find amusing, but I haven't seen your book but you've seen mine. There's more than 1500 end notes, and Beaver's Pond Press told me that they have end notes before Big Brother in the Exam Room and end notes after Big Brother in the Exam Room. Now, they charge everybody 75 cents per end note.

John Marchica:

Oh, no kidding?

Twila Brase:

So, I've kind of changed that for them and unfortunately for every writer to come afterwards.

John Marchica:

Yeah, like I said, it's very well sourced. I will say, while mine was written from an entrepreneurial perspective and some of it was kind of just inwardly looking at what are things I that I thought were important with companies, I wanted to make sure that I had it well sourced with a lot of other thinkers on the subject. And it doesn't come anywhere near to your end notes.

Twila Brase:

I had to, because there's a lot of industry that wouldn't be in my camp and I needed to tell the story with credibility.

John Marchica:

Certainly. So, before we get into the main topic, which is talking about EHRs, tell me a little bit about the Citizens Council for Health Freedom, how you got involved in that and what the organization is all about?

Twila Brase:

Citizens Council for Health Freedom is a nonprofit group that was started in the mid 1990s as a result of the push at the federal level toward a national healthcare system run by managed care organizations. It really started with the Health Security Act in the Clinton administration and then it just proceeded onward from there. It has become an organization that is particularly patient-centered, always looking with the patient's perspective on every policy issue. It's an organization about freedom, freedom for patients and doctors, which will bring the best and most affordable actions for patients. And it's also known for what it does for patient privacy. I would say that we're one of the few, or only, patient center organizations that puts such an emphasis on privacy, because we say he who holds the data makes the rules and we want the patients and the doctors to be making the rule over what happens to their medical care.

John Marchica:

So, are you an advocacy group? Do you engage in lobbying? I get the point of view, but tell me a little bit about your efforts in some of the things that you've done.

Twila Brase:

So, a lot of our efforts are about education, and of course, lobbying is education for legislators. But that is a small part of what we do. We do engage in lobbying at the state level and some at the federal level, but most of our efforts are a variety of educational avenues. So, we have the Health Freedom Minute, which goes out nationwide to more than 850 radio stations. It's heard every Monday through Friday. That's a big educational piece for us. We also do our own research and put out reports. Every week we have an e-news which shares information, including our most recent press releases or our interviews or things in the news that we feel people should know that aren't typically in the mainstream news. But also, maybe sharing our perspective about something that they've heard about but not our angle. We also have several ongoing projects, like The Wedge of Health Freedom, which is an online directory essentially, of direct pay practices around the country.

Right now, I think we're at about 470 or so practices. There're several states that we're not located in, and I know North Dakota and South Dakota and Iowa we don't have any direct pay practices, but that doesn't mean they aren't there. They just may not have discovered The Wedge yet and joined. It costs

nothing for patients or doctors to be on The Wedge. Our whole initiative here is to get medical care back the way we believe it should be, which is the patients and the doctor have a very private, personal contract and interaction without third party payer influence, and it's also an affordable way to get medical care. And then, another project is to refuse to sign the HIPPA privacy form or the notice of privacy practices, and this is all meant to get the public to understand that HIPPA does not protect privacy. And it helps them to not be part of the continued propagation of this myth that HIPPA has anything to do with privacy.

And then we have a project that goes by Baby DNA, where we are trying to stop the storage at the state level of a child's DNA, every newborn, and to stop the use of it without parent consent. So, we've got several projects, lots of informational avenues and some lobbying.

John Marchica:

So, how are you funded?

Twila Brase:

We are funded privately. We receive no government grant. We have individuals, we have foundations, we have corporations, it's all private funding.

John Marchica:

You mentioned HIPPA, and you do write about this in your book. Tell me about what's your beef with HIPPA?

Twila Brase:

Well, HIPPA is called a privacy rule, but in point of fact, it is a permissive data sharing rule, and that is acknowledged within the industry. It's even acknowledged at the government level. But it has never been portrayed that way to the American public. The American public believes that HIPPA protects their privacy, that their information can go nowhere outside the exam room without their consent. They sign the HIPPA form thinking that that is what protects them and that HIPPA is just a form that they sign to make sure that HIPPA is protecting them. It's this great deception. And so, HIPPA, for example, unless you're in a state that has a real privacy law like Minnesota does, you do not have any right of consent for most sharing of your data. HIPPA says that your data can be shared by those who hold it, by what are called covered entities, and it can be shared without your consent for payment, treatment, healthcare operations. These words have far broader definitions than any patient, any American, except those in the industry really, understand.

Healthcare operations, for example, is essentially a list of more than, or at least, I should say, 65 different activities that are non-clinical activities, and a definition that is nearly 400 words long. So, when patients see on something healthcare operations, it looks so innocuous but it's really not. For instance, Google has recently received, from the Ascension Healthcare System, the medical records fully identified all the data on 50 million patients as a part of a business associate agreement, which is approved under HIPPA. So, this is the kind of sharing that can happen through HIPPA but the patients have no idea. So, we really want to let the patients know that HIPPA is not what anybody thinks that it is. And then, from our perspective as an organization, we want to get back to pre-HIPPA time where patients actually had control over where their data went.

John Marchica:

It's interesting that your perspective on that is, maybe because a researcher in the industry, what I felt like when I signed those forms is that I was giving my consent to share data.

Twila Brase:

That is absolutely not. All you have to do is look at that form and what it says is I have received or read or understood, depends on what word they use, the notice of privacy practices. Then, if anybody looks at the notice of privacy practices, they will see all the ways that their data can be shared without their consent. So, the HIPPA rule says the clinics and the hospitals have to make a good faith effort to get you to sign that form, and so the deception is long, deep and wide. That's what that form is all about by the American public. But all it is, is really a deception. It says that you understand, you've read the document that say that you don't have any privacy. And most people just look at the name of the document and notice the privacy practices, which most clinics and hospitals don't actually hand to them. They will hand it if they ask for it. It might be on the wall, but often isn't, and so people look at that and notice the privacy practices and they'll go, "Great. My privacy is protected. Why would I read it?"

In fact, I had an assistant to a member of Congress who I was talking to her about this, and she was an attorney. She was actually somewhat appalled at the fact that as an attorney she hadn't actually taken time to read the notice of privacy practices because she had just believed it for what the title said. But of course, if you look into it you'll see it's really a notice of disclosure practices and that's what it should be called.

John Marchica:

Right, right. So, tell me, and I think this is a nice segue, tell me about your fundamental argument against electronic health records.

Twila Brase:

We don't oppose electronic health records per se. There were electronic health records before the 2009 mandate which went into effect in 2014. So, we don't oppose the ones that doctors had that worked for them, that they created to do what they wanted them to do. But when Congress mandated that all of these doctors and hospitals and practitioners put an electronic record in place or lose money on every Medicare patient that they see, this was an electronic health record that is government certified to do what the government wants it to do. It has to be meaningfully used, according to the government's definition of that. There's meaningful use stage one, stage two, stage three, all of this has to do with reporting requirements to outsiders. And so, unless they have the government certified version of electronic health records that does what the government wants it to do, which has to do with data collection and reporting, not actual patient care, unless they have that version of electronic health record and unless they do what the government says is meaningful use of that record, then they're financially penalized.

And so, this is not freedom in the exam room, this really becomes the tool of control, as one physician said a command and control mechanism within the exam room. All you have to do is even talk to the physicians about this, and see how if there's something they want to do, they know it's good for the

patient to do, but it's not there. It's not there in the electronic health record and it's difficult for them to actually order it because they don't create what's there in the record. Often times, it is outsiders who create what's there, particularly in the hospital. The EHR is calculated to do, use whatever materials and whatever protocols that others above the doctors have decided what needs to happen. I think one of the great ways to see this right now in the midst of COVID-19, is what happened with Dr. Cameron Kyle-Sidell. So, Dr. Kyle-Sidell came to a New York City hospital, I don't remember which one, but he came very early in the COVID-19. He was up in the ICU and it didn't take him very long to figure out that the ventilators were actually doing more harm to the lungs than help.

And so, he goes onto Vimeo, which eventually ends up on YouTube, and he does this video, actually putting a call out there for those who create the treatment protocols to change the protocols because it was hurting people, it was killing people. And he is later interviewed by Medscape, where he says that essentially despite the fact that he changed everything, his call changed everything. Doctors around the country, maybe even around the world, started to let people be happy hypoxemic, or happy hypoxia patients, letting their oxygen state go lower and lower and lower and lower before they ever put them on a ventilator, is really Dr. Kyle-Sidell's call that did this. And yet, at his own hospital he could not get the administrators to change the protocols. And so, as he says in Medscape, he moved to the ER. He had to leave the ICU because he could not ethically and morally do this to patients when he knew it would harm them.

And so, I think that shows the power of the electronic health record. As he said, the protocols are put in there, the nurses follow them, the doctors follow them, everyone follows them. So, unless they change them on the electronic health record nothing changes. And so, it does become a tool of command and control over what happens to patients.

John Marchica:

I see that, but also in your example, certainly with the COVID issue, there's a lot of things that people were doing back in February and March that they're not doing now. And there are a lot of things that they weren't doing that they are doing now, such as giving patients anti-clotting medications and steroids and other things. So, that's just a function of how science works and being able to have some give and take and learning through either peer-reviewed mechanisms or from things like the doctor that you mentioned, seeing that something wasn't working and then being able to fix that.

Twila Brase:

But not in his own hospital, because he couldn't get them to change the protocol.

John Marchica:

Well, that's the fault of the hospital. That's not necessarily the fault of the nature of having clinical pathways.

Twila Brase:

The New York Times did a video of different doctors and it was interesting because most of the doctors were saying this is so mysterious and we don't actually know how it's working, and every day is new in just trying to figure it out. But there was one doctor in there who said we have to stick with the protocols. We have to stick with the protocols until we have gotten clinical trials that tell us that we

should do something different. Every patient wants to be treated as an individual. Now, if you look on Twitter, you can see, I think it's Dr. Kyle-Sidell, who's wondering if COVID-19 will lead to a new age of personalized medicine where every patient is treated according to what the patient needs. The electronic health record, with doctors now who are more employees than they are individual practitioners, now the electronic health record often limits what they can do. I've had doctors say to me, "Protocols, protocols, protocols. We're limited by the protocols in what we can do." So, I think that that is a concern and you can see some of those written in my book as to the comments of doctors about the protocols.

John Marchica:

I don't disagree with you. I think, however, it also is a function of whatever system that you're practicing in. So for example, I had a really interesting conversation with a researcher from UT MD Anderson, and we were talking about the difference between... I think the question that I asked is, something along these lines... are you in the clinical pathways camp or are you in the personalized genomic medicine camp as it relates to cancer treatment? And his comment was something... I'm paraphrasing here... but they're not mutually exclusive. While cancer care is how we're learning about genetic markers and certain drugs that work with certain tumor types in certain patients, that the clinical pathways that have been developed at MD Anderson over the years are evidence based. While they have the ability to, and this is when I come back to the system, they have the ability to divert away from a clinical pathway if they feel that it's not right for the patient. But the clinical pathways that are in place have been supported by lots and lots of evidence in trials and in patients over the years. And then, of course if something changes, and they meet regularly regarding their pathways and they have experts on each of those, if something changes then they will amend the pathway.

Twila Brase:

Yes. So, I think that there's a lot of good ideas about treating patients out there. It's really all about the freedom. It's about the freedom. You can have a pathway and maybe that works for 85% of the patients, but you have to have the freedom without great hassles to go outside of those recommended, or that guidance. When it's more than guidance or recommended, when it becomes something that the doctor is, for instance, judged on as to whether or not they followed the pathway, when the pathway didn't even work. I am reminded of this one television producer that I was being interviewed once for something, and I was just talking to him about protocols and stuff. He said that he was at, I think it was a Mayo, I'm pretty sure it was at a Mayo conference. So, there's all these doctors. The question came up about how to treat ear infections with children. And he said you would never believe in the different ideas of all those doctors. They could not agree on the same way to treat children's ear infection. So, I think that the pathway has tried to bring it down to one standard, but critically thinking minds have different experiences and different thoughts and different relationships with the patients and different things work for different people.

It's all about the freedom. You can have the pathways, but they can't be handcuffs. They can be sitting there but you can't be judged on whether you're a good doctor or not because you do or do not follow the protocol. And as a matter of fact, in 2005, I did a report on evidence based medicine including a lot of quotes from a guy who did an even bigger report on this kind of what he called technocratic approach to medicine, and really, just looked at even all the peer reviewed studies and what researchers themselves say are the problems with some of the peer reviewed studies. And so, I don't necessarily buy into the whole evidence based medicine thing as though it were concrete, real, factual. I think there's a

lot of things that come into what you choose to study, the evidence that you bring. I had a speaker from Michigan from the Henry Ford Center, and he called himself a clinical trialist, and he had been doing cardiac trials for 41 years.

He came and gave a speech and he just talked about going from 36,000 candidates for his research project and then he got down to like 3000, and a lot of them were eliminated for this reason or that reason or another reason he said, but they all could end up with this cardiac condition. But, my research doesn't say how it would happen with them because I've narrowed it down. And so, he too was looking askance at this whole idea of evidence based medicine because as a clinical trialist, he understood all the sorts of things that are never in the trial that would make a difference for what really happens to real people in the clinical setting.

John Marchica:

Yeah, I had a physician on last year, Dr. Lazarus, that's his name. I always think of him as the running doc unhinged. You should check him out on YouTube. It's hysterical. It's very serious the way that he talks, but his method is, he's literally running and he's talking, and then he'll stop and set down his phone like in a tree branch or something, and then he'll go on a rant for like five minutes on a specific topic. But his point was, is that... he has a geriatric population... and that a lot of the quality metrics for, let's say ACOs, really don't apply when you're talking about an 85, 90 year old person. Do you really need to be lowering their... there might be a reason why their blood pressure needs to be higher for example. Do you want to be adding on a statin at that point in that person's life? So, I think that speaks to more of what you're talking about is understanding the patient.

I do disagree with you however, on the principle of evidence-based medicine because to me that's just science. And that science progresses in very small increments, and then every once in a while you get this boom, where there's a new way of looking at things. I don't know if way back in your college years you were ever forced to read Thomas Kuhn and The Structure of Scientific Revolutions, but that's where he talks about a paradigm shift. I think that's where that term originally came from. But things like the Cochran Collaboration, I think that it's invaluable for advancing medicine, for our understanding of what works and what doesn't. While you always have to keep the patient in mind, front and center, that there are best practices just like there are best practices in business.

Just like Atul Gawande and his surgical check list. There are things that can be done in the practice of medicine that are, well I'm using the term again, that are best practices, that come from experience over time. So, throwing the baby out with the bath water, if you just say that there's no use in best practices or clinical pathways or things like that.

Twila Brase:

Not exactly doing that, but looking at them with, I think, the critical eye that one needs to look at them. I think that's one thing that I found in doing this report of evidence based medicine, is that I just looked at everything that researchers themselves said were all the limitations in their own studies or the problems with studies. I've got bulleted lists in the paper about what they have said themselves in peer reviewed journals about the problems with the evidence, or problems with the way it was looked at, or the problems of what was left out. I didn't look at that report before I came to chat with you, but I think the paper actually speaks for itself because it points out that researchers themselves know that what they

have chosen and what comes out, has a lot of basis for what they chose to study, what they chose to pick, what they never did.

The other thing that I found out was how much of a delay there is between the so-called best practice and when it ever gets out recommended somewhere and by that time it's already behind. And yet, they're basing what you do or do not do best practices on something that already become old because it's taken so long for it to even get out. And then, there's just the fact that different organizations chose different best practices about the very same thing. So, we've got this entire best practice industry that doesn't even agree with itself. So, there's lot of money to be made in the creation of best practices that then somebody will embed on the computer or somebody will choose. I remember looking at United Health Group's huge thing on evidence based practices.

I think that science and study is good, but I think you have to look at it with the reality that it too is limited. It's not like science is this absolute top-dog in the discussion, because science is made of a whole lot of subjectivity that nobody often thinks about.

John Marchica:

Sure, to which I would say, you would not get a paper published in any decent peer reviewed journal if you didn't have a robust discussion of limitations and anybody following that particular study needs to recognize those limitations, whether it's the patient population that they chose, whether it's certain things that they weren't able to address due to their study design. But I will say that the randomized clinical control trial is not perfect, but it certainly is the gold standard that we have today. Just by design, it's intended to remove as much bias as possible, where the researcher or the patient doesn't know what drug they're getting. So, a couple of other topics that I got to that I thought you had an interesting take on, what are your thoughts on population health?

Twila Brase:

So, population health, I think, drives away from patient health. It's this idea of looking at patients as groups. It is a much more socialized way of looking at it. Doctors being judged for what they do for their populations. Some of the comments that are made about you need to do things for your... you need to think about the entire population when you're looking at your patient. Or even the whole combining of the public sector and the private sector, kind of fit in there too. And so, that's a concern. We haven't done a whole lot with it. I kind of opened up the subject in the book, but as an organization we haven't done a whole lot with it. But I do think of it as much more of a way to move away from the focus being on the patient, which should be the focus of medicine, and moving towards looking at populations. Populations don't need anything.

The only thing that needs something is an individual in the population. So, it's a little bit like when Margaret Thatcher said there's no such thing as society, there's just individuals. And this is the same thing. There's really no such thing as population health. There's just individual patients. And if the move is away from the individual patient and what the individual patient needs, to look instead at the so-called population to decide what you can and cannot do, or will or will not do, for the patients, or if you start to look at your population being people who aren't even in your practice, then you've changed the entire focus of medicine away from the patient and to this amorphous, faceless, entity that really only exists in somebody's definition of it.

John Marchica:

What I'm thinking of, in terms of population health, like for example Montefiore, I read about this a couple of years back, in the Bronx, went out and was installing air conditioning units into low income housing because they had a very high asthmatic population and they were getting a lot of hits in the ER. And felt that it was best to kind of donate and give these a/c units to be able to improve the health of that particular disadvantaged population. And then you've got Kaiser Permanente in California that has a huge fund set up for building housing for the homeless, if I remember right. When I think of population health, that's usually the way that I think of it, which is more around social determinants of health and understanding the needs of disadvantaged populations, let's say, that might be living in a food desert. I'm aware of another health system that partnered with a private entity to essentially build a supermarket where there wasn't one so that they could get affordable healthy food.

Twila Brase:

From our prospective, and I do know what you're talking about, and so then I guess that is the other way of thinking about it, although I feel like that's more social determinants of health than population health. That's how I view it. Nonetheless, to discuss what you're talking about, that is a concern for us because... well, several things. One is how premiums keep going up. Right? And I don't think that the average person understands that a part of their premium is now going to build housing or to put in a/c units or there're all sorts of other things. And so, that's one. It's just the rising premiums, because the idea of medical care has now expanded to the overall person's life and everything in their life from food to housing to whether they have a car or a phone or a computer, whatever it is, everything possible in their life. And that their premiums are paying for that. So, that's one level, is the premiums.

The other has to do with the fact that lot of people, when they get really sick, find it difficult to get the care that they need. Medical necessity definitions, appeals processes, all of this sort of thing. Right? And so, here's all this money going for things that are not actually medical care, that do not fit into the "I'm insuring you against the cost of your medical care," but now all this money is going into other things. And then when people who are paying these premiums actually get sick, and when they find themselves facing restrictions, on access to care, I think those are at least two of the problems with this whole thing about moving insurance to indemnify you against the high cost of medical care to suddenly this really... what would I call it... sort of a subsidized, an entire subsidy system being set up in the insurance industry for all sorts of things that are not actual medical care that all the rest of the premium payers have to pay out of their own pockets. And they think that's all they're paying for but they're not.

John Marchica:

Well, I think in the case of Montefiore it's more taxpayer dollars rather than premium, because from the health systems perspective, they're trying to reduce overall costs because the people who are hitting their emergency room may be uninsured or Medicaid. If they're uninsured, certainly then they're not getting paid anything at all. And if they're Medicaid, they're getting paid at a sub rate. So, I think it was in their self-interest. I think a lot of these health systems undergo, even when they don't have an insurance product, like I don't think Montefiore has one, they may have a Medicare Advantage plan. But it's in their financial interest to be able to head certain things off at the pass before they hit the emergency room and before they seek care.

The last question I had for you, Twila, is... I kind of chucked a little bit when I was reading the section on scribes. You seem to have an aversion to scribes, even digital scribes. Tell me about that.

Twila Brase:

Yes, so scribes, virtual or physical, are often coming into the exam room unbidden, by those who want to have a private conversation with their physician. So, I think there are two things. One is just how this person comes in and you want to have a private conversation with your doctor without a third person listening in. And you don't even know who this third person is, what their qualifications are, they're just coming in and they're writing. And they're often writing, it appears to be, every word that you're saying, and it's going into the electronic health record, which is also often part of a health information exchange which increasingly is part of the e-health exchange, the nationwide one. Under HIPPA, of course, there's no consent for who gets to see all of this information. Whereas a doctor, and being a nurse myself, I know what kind of notes that I wrote and I know when they were on paper.

You do a lot of listening and you write down these certain things. But the scribes are regularly just typing away. People often feel like they don't have a choice to tell this person to stop. Stop writing, don't take every word that I have to say, or to tell the doctor I don't want the scribe. And then of course, when I get to the virtual one, every word is being uplifted probably into some... sometimes in a cloud, somewhere, right? And sometimes the way that it looks like it's going, the patient may or may not know about the virtual scribe. I found interesting instances about the scribes being outside and listening in so they weren't in the room or the idea of a person knowing about the virtual scribe. And so, I encourage people to tell them to turn it off if they don't want this scribe.

Of course, some of these scribe companies, these virtual scribe companies, they're somebody in India or parts unknown that are taking all this information and then sending it back to the doctor. So, all of this data from all of these once private discussions in exam rooms are being opened up through the scribing process.

John Marchica:

Well, I think the Genie is out of the bottle on that one, because certainly with AI, I think that a lot of people think that regardless of what... so, let me back up a second. I think you'd find a doctor hard pressed to say that they like their EHR, I mean the statistics on that are always miserable. The documentation is listed as a major source of stress when Medscape does their annual survey. So, I think that's a given, that it's an annoyance and that in many cases it causes... in fact in all cases it increased costs for a practice. From what I understand, or what I've heard is that one difficulty with the EHR and the typing away gets in the way of the patient interaction or having a scribe there gets in the way of the patient interaction. AI will be able to take that information, put it in the cloud, put it in the medical record, and will kind of solve much of the documentation challenges with the EHR.

Twila Brase:

Yes, and so the mandate for an electronic record has led to a third person or an electronic device, and all the information being sent to the cloud, all by virtue of the mandate. Of course, the doctors like it better because they want to have the interaction with their patient, but all of this is coming out of the government mandating that everybody has to have an electronic health record, so that all of this data is available to all of these people who want all of the access to all of our data, which is private property. It's really private property of the patient. HIPPA took that away. The electronic health record took that away. The exchange has taken that away. So, everybody has said that the patient-doctor interaction is no longer, and should no longer, be confidential and that's not true. Nothing has changed about the patient-doctor relationship being confidential. But the government's intrusion with the influence and

pressure from the outside organizations like hims and who all wanted to get access to all of this data. That's what's led to this no longer being a confidential relationship.

Okay, so the doctors are relieved that they don't have to, but the whole interaction is wrongly open to outsiders as a result of the government mandate. So, we're just fixing things. Right? So, you impose something that's terrible and then you do fixes that make it worse and worse and worse, until all this data is in the cloud and as I say in my book, the government is looking forward to all the data being in the cloud so they can dig deep to get information buried. I use that word, buried, in the electronic health record. So, all of this starts with HIPPA. Moves to the electronic health record, moves to the cloud, all dismantling confidentiality of the patient-doctor relationship and autonomy of the patient and doctor in this encounter. And genies that are out of the bottle can be stuffed back in. Just saying.

John Marchica:

Well, you've got a big mountain ahead of you, Twila. So, Twila Brase, thank you so much for spending time with me today. I really, really appreciate it. It's interesting to hear your perspective.

Twila Brase:

Thanks so much, John.

Kim Asciutto:

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