

Obamacare Has Given Us the Dehumanization of Medicine

Dr. Shelley was interviewed by Marcia Merry Baker on July 12 on The LaRouche Show (<http://www.larouchepub.com/radio/>), a weekly Internet radio program. He is a family physician from Port Allegany, Pa., who has been in practice for over 20 years. At a conference in New York last year, Dr. Shelley spoke about the crisis conditions in the U.S. medical system, in which “physicians can’t do their doctoring and patients aren’t getting care.”

Last Fall, Dr. Shelley issued a call from Physicians Against Murderous Obamacare, and lobbied on Capitol Hill against the Affordable Care Act. But, even before Obama entered the White House, Dr. Shelley was campaigning against what he called the “commoditization of health care.”

Dr. Mark Shelley: ... In the United States, we’re told that we have health care, and we’re told that we have insurance, we’re told that everything is very good, when it’s exactly the opposite. So the average person is comfortable, because he’s sure that everything is okay.

But it’s almost cruel, the paradoxical way this is presented, the Affordable Care Act. I had a patient in the office yesterday, who said, “Well, it looks like I may reach my deductible.” He’s having eye surgery—he has a corneal dystrophy and he’s legally blind; he has a big farm, but he really, really wants to work. I asked, what is your deductible? He said, \$10,000.

So, from milking his cows, he has to get \$10,000—plus I think he said, it’s another \$8,000 for the premium that he pays each year. The point being, this is not the “Affordable” Care Act, nor is it the “Patient Protection Act.” It’s the exact opposite of protecting these patients. That’s why “a thousand cuts”—it’s



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from many directions, it’s from the regulations in the hospitals, it’s the regulations in the pharmaceutical industries, the insurance companies.

I had on my desk yesterday a “special bulletin” for professional providers, “attention physicians”: An insurance company will add 12 drugs to the pharmacy “prior authorization” program for Medicare Advantage members.

Prior Authorization: Care Denied

Marcia Merry Baker: Let me just interpose—“prior authorization” means you or your office has to call the insurance authorities before you dare do what you want to do?

Dr. Shelley: Well, it’s interesting. “Prior authorization”—I have to first be authorized to get—until recently it was testing—but now it’s testing and it’s medications; and this is one of the most insidious forms of rationing. Because, for example, a patient comes to my office and has a history, exam, and all findings consistent with a torn meniscus in her knee. So this should have an MRI, a magnetic resonance imaging, which the insurance companies generally say has to have a prior authorization. I’ll spend a few minutes with the patient, and I’ll understand the problem, explain to them the problem and order the test. The form for the test will go to my staff, who, when they have a chance, take it upstairs and go online, or they’ll phone and maybe be on hold, but now mostly it’s done online; and they type in the request for this study. And 48 hours later, we get a response, that either we can have the study—which usually doesn’t happen; then they ask for “more information.”

I then send to the insurance company other testing,

notes, lab work, a good bit of the [patient's] chart, which goes back to the insurance company, and in another 48 hours, we hear whether they agree to pay for the test or not.

Now, a friend of mine was in this position, and the test was refused, and he said, "I'll pay cash," to the radiologist. And they said, "You can't pay cash." He said, "I have it, right now." And they said, "It's illegal for us to do a test, for cash, if the patient has insurance." But now, the insurance has denied that he can have the test, because "it's not medically indicated." That's their "out."

So the patient couldn't have the test!

If nothing else, the resources that are being used up by this process, these are thought, energy, and time, from a nurse or a physician that should be being spent on solving medical problems and helping people. But instead, it's spent interacting with a computer, and then the study is denied.

Baker: You said you have 12 additional drugs that require prior authorizations—so this is drugs now, not just those tests?

Dr. Shelley: This unnamed insurance company will add 12 drugs to their pharmacy prior authorization program, effective Sept. 12. And there are 12 different drugs and/or medications, one of which is rabies vaccine!

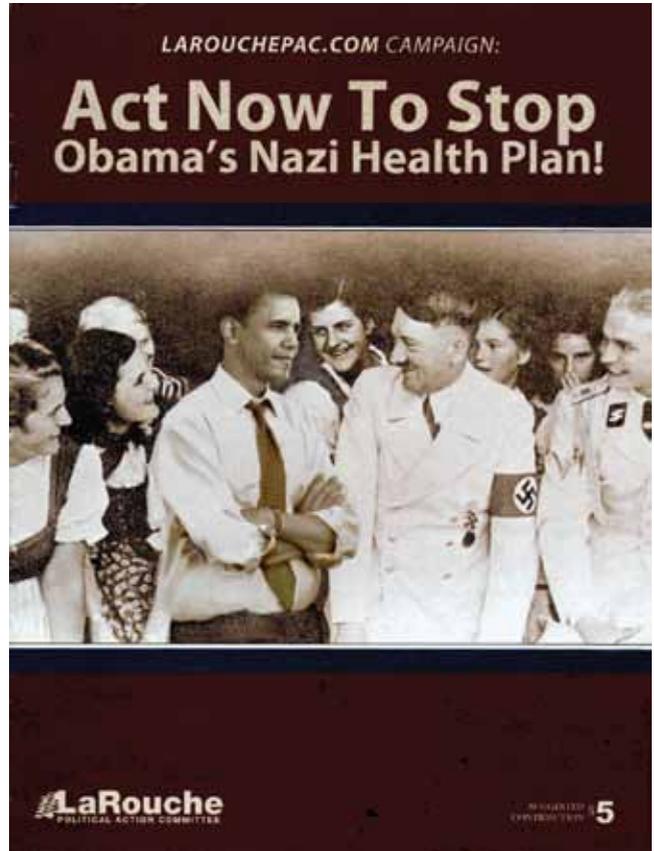
So now, if my patient is bitten by a rabid animal and comes to the office with a certainly fatal disease, I have to say, "Well! Let's think about this..."

Baker: And of course, you're in the country, with raccoons, bats, and everything else.

Dr. Shelley: Absolutely—raccoons, bats; we've had rabies from cattle that were bitten by bats. There's a lot of rabies here. Mostly raccoons, skunks, bats; a lot of rabies in bats. But anyway, the patient knows they will die without this. And they're told "Let's think about it—we'll decide whether or not you can have this."

It's the uncertainty that unravels your brain; it's the uncertainty of—maybe it's illegal for them to pay cash for this vaccine; maybe they'll have to get it on the black market, because it was illegal for [my friend] Henry to get the MRI, to pay cash for it, and he was refused that by his insurance company. So this is the "Patient Protection Act" in action...

I think for my colleagues here in the States, there's just a generalized angst and unease, discomfort with the



The LaRouche Political Action Committee (LPAC) issued this pamphlet in May 2009, and circulated tens of thousands of copies throughout the United States.

practice of medicine, we feel because we must *struggle* to do what was once so easy. And it's from many reasons: There's the prior authorizations, and the electronic medical records, which is held up and is pushed as a helpful, wonderful thing, but has cut productivity by anywhere from 25% to as much as 50%.

You Are Now a Number

Baker: It has a lot to do with this coding, right?

Dr. Shelley: Well, the electronic medical record is a parallel of the coding. Your diagnosis is now a number, just as you are a number. It's the dehumanization, the monetization: It's profaning the sacred. It's taking human life and giving it numbers. The coding is necessary—every diagnosis must have a code in order to be filed with the insurance company, and we've had the ICD-9 [International Statistical Classification of Diseases and Related Health Problems], which was to have ended last year, and we've started with the ICD-10. Re-

member, every diagnosis, everything I do has to have a code, and with the ICD-9 we had 40,000 codes. But the ICD-10 has 110,000.

Baker: Is this standard insurance coding?

Dr. Shelley: It's insurance coding if the patient is to have a test done, if the patient is to have a prescription, it's unavoidable that they have to have this code. The physician must assign a code to what he did. If I amputate a toe, there's a code for the great toe, there's a code for the second, third, fourth, and fifth; there's a code for where the toe is amputated; there's a code for if the patient is diabetic. I write the diagnosis and my staff looks it up. Again, the patient is paying for this to be done.

I've remained independent, but in the hospitals, the physicians are now required to do all their own coding. So there's 40,000 different numbers that you have to choose from to decide what it is you did! If you put down the wrong number, or you put the decimal point incorrectly, then it's fraud.

But the ICD-10, with over 100,000 codes that I have to choose from. The ICD-10 includes a code for "inju-

ries from a burning airport." It's like somebody decided to make a joke of this. There are codes for "parrot bites," it's almost making a mockery of what we do. As well as making it impossible to do what we do.

Why Physicians Are Retiring

Baker: Decades ago, you would think of the family physician, or even a specialist and others having independent practices, either partnerships or alone. But now there's a higher and higher percentage, where you are working for a hospital chain or some equivalent, and you are told what to do, not just how to code, but *everything*.

Dr. Shelley: Right. They're making it less and less possible to practice medicine without electronic medical records, and those systems can cost upwards of \$100,000; so if it's just one doc, it takes an entire year's salary to put a system in place that will *reduce* his productivity by 25 or 30%. And, now remember, the electronic medical records [companies]—there are 1,600 of them in this country, and none of them communicate with each other. So when a patient goes from one hospital to another across town, there's no way to send the records. The records come in an envelope with a kilogram of paper in it; somewhere buried in there is the patient's diagnosis, and their medications list, and what happened to them.

So that's one of the ways that the use of electronic medical records has damaged health care, is that there is much, much, much less communication. There's virtually no physician-to-physician communication, because they're relying on the electronic medical record to "have everything." There are many, many needles in many, many haystacks.

And so, I receive patients in the nursing home, maybe with a tracheostomy, maybe with a feeding tube, and they've had a six-month hospitalization; they will arrive at the nursing home for me to take care of, and I have no idea where they've been, what they're doing, what happened; the physician doesn't talk to me, because that's more or less been lost now, and I have two inches thick of papers to read through, that contain things like documentation of each day for three months when the patient received each drug. And it's extremely difficult to find even the diagnosis.

So these are frustrations for why physicians my age are retiring, even though they have 10-20 years of productive practice ahead of them. . . .

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