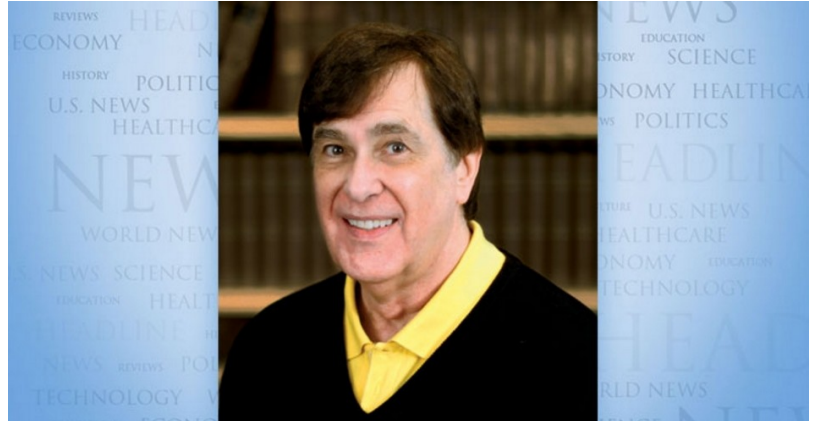




Written by [Tom DeWeese](#) on February 18, 2014

## ObamaCare: The Terrifying Consequences To Healthcare

As the ObamaCare debate rages, we hear much about insurance companies, costs, and people's ability to pay. We hear the policy defended as proponents tell us it will provide healthcare to those who never had it. Of course, these proponents never seem to explain how those who couldn't afford healthcare when it was a choice can now afford an even more expensive cost now that government mandates it.



However, these debates about the pros and cons of ObamaCare basically focus on money. What about the real issue — healthcare? What will ObamaCare do to our medical system? How will it affect the quality of our care? How will it affect doctor's decisions as they attempt to take care of our health needs? And, ultimately, in a system controlled by government bureaucrats and government-written manuals — who will really be making the decisions that determine our quality of life? These are the real questions that need to be the center of the debate. And the answers are terrifying.

I recently received a report from an oncologist, Dr. John Conroy, who is fighting the desperate battle to treat cancer. All of those concerned Americans who wear their pink ribbons and dash for miles in their stop-cancer marathons should take a long hard look at what Dr. Conroy reports to be the future of all American medicine. They may want to start running straight at Congress to save their own lives.

Obviously, Oncology is a very detailed science, difficult for the layman to understand. That's why American healthcare has always promoted specialists. Let's begin with a patient who has discovered a lump on her breast. She takes a mammogram, undergoes a biopsy, and is found to have adenocarcinoma. She is seen by an oncologist and certain questions need to be addressed.

As Dr. Conroy explains the process, first, doctors must determine the "Stage" or extent of the disease. The most common system for determining classification of malignant tumors and the extent of a person's cancer is called the TNM system. "T" measures the size of the tumor and if it's invaded nearby tissue. "N" determines regional lymph nodes that are involved. "M" measures the distance the cancer has spread from one part of the body to another. These measurements are critical in determining how sick the patient may be.

In fact, there are four stages, classified under the TNM system, with multiple possible results determined by a large variable of TNM data. With an adenocarcinoma cell type under the microscope, there are about 40 pathological (histology) types which could lead to as many as 36,000 possible variable combinations of the cancer. The grade or aggressiveness of the cancer is measured in 10 grades. So,  $10 \times 36,000 = 360,000$  possibilities. Next, hormone sensitive status = eight possibilities. So,  $360,000 \times 8 = 2,880,000$  and with menopausal status = 5,760,000 possible computer input combinations. These are the possible combinations on just one page of data in staging. So the computer system has to evaluate these combinations.

Whew! That's a lot of data to determine how sick a patient may be, with what kind of cancer, at what stage. It's all necessary data to determine the most effective course for treatment. Again, that's why we



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have specialists who focus entirely on certain diseases and other maladies that affect our bodies. No one individual could possibly be knowledgeable in all aspects of the human body.

But now, with the growing control by government over healthcare decisions, things are changing. Over the past several years, a growing number of bureaucrats from insurance companies have been armed with manuals, guidebooks, and calculators to step in to the decision making process to decide what treatment procedures are allowed. And it's going to get far worse under ObamaCare, as a new layer of government bureaucrats is added to affect what doctors can do to save your life.

As Dr. Conroy explains, to look into the body and make a determination on where to start planning treatment, he uses X-rays and CAT-scans (CTs). "I generally cat-scan head to toe and look for metastasis and get a baseline." However, such decisions for care by the doctors are now being decided by others. Says Dr. Conroy, "In the past, it was ok (to X-Ray and CT), not now. Over the last few years all the X-rays have to be approved, so there are companies now that have algorithms to evaluate your request (for a CAT-scan or X-ray)." He explains that these companies, which work in partnership with hospitals and insurance companies, "process thousands of requests a day." They decide who gets to use the machines for what purposes. "So," he explains, "if there's no headache, then there is no cat-scan of the brain. If a normal chest x-ray is taken, then no cat-scan of the chest."

Here's where these rules and regulations start to really get scary. If he, as the doctor, wants to challenge the decision by the company as to whether he can get both a CAT-scan and X-ray, he will call them to do so. "I have to discuss this with the 'medical director' who will say yes — if I use certain 'key words" Or the medical director will say "no," the procedure does not fit the guidelines. Without having the medical background of the doctor or all of the data he has been trained to read, the company medical director can make the call — all based on a manual written to one size fits all!

Meanwhile, the doctor is responsible for the health of his patient, tasked with the job of making the right decision as he is forced to move forward blindly. He's unable to get the complete information he needs to make an educated evaluation, because a bureaucrat rejected his request for the proper testing. Yet, if the doctor makes the wrong decision and the patient suffers or dies, he is liable for legal action by the patient's family. He has no legal protection if he missed a lesion in the brain. Says Dr. Conroy, "I am liable, let alone the damage to patient."

### **How "Red Tape" Strangles Treatment**

The most important detail to expose here is that, while the doctor has had years of training and experience in the field, the medical director does not have to be qualified.

He's an employee! Dr. Conroy provided a resulting horror story that is certain to be repeated over and over again once ObamaCare gets control of the medical system. He reported, "I had a young patient with Hodgkin's disease and I needed a follow-up cat-scan of the chest. It was refused (by the company medical director). I challenged the decision (I challenge all of them) and called the company. The medical director was a retired General Practitioner, playing golf in Florida." Says Dr. Conroy, "the review companies intentionally have out of state physicians as medical directors so they do not have a state license that can be challenged."

Then there is the massive mountain of paperwork required for each patient and each procedure. The official guideline for treatment paths for patients with malignancy is called "Pathways," found at [www.nccn.com](http://www.nccn.com). There are over 30 medical issue paths to choose. A doctor needs to match a pathway with his data, as described above. As mentioned, that can be a huge number of possible combinations.



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The insurance companies are already restricting treatment options by forcing doctors to accept their approval for therapy, or they won't pay for it.

Now, follow the bureaucratic ball created by this mass of rules. Explains Dr. Conroy, "We are still on the first visit by the patient, (or second visit if something was challenged). It now takes 45-60 minutes to register a new patient. I get an hour for the history, exam discussion of treatment plan and then we have to load everything into the computer and fill out the required forms. With each patient visit we review all the data for accuracy, and again report it."

All this for one patient on the first visit. And with each visit it all has to be continually rechecked and reported. If the doctor makes an error on a Medicare bill submission, the fine is \$5,000 PER LINE. A typical chemotherapy visit may have 20 or more lines of code per visit. Says Dr. Conroy, "one year we used 250 cc bags of IV fluids for chemotherapy. It was more than enough fluid for treatment, but Medicare retroactively decided not to pay for 250 cc bags so, we had to repay Medicare Reimbursement for all the 250cc bags for an entire YEAR! We then changed to 1000 cc bag, charged more, threw out most of it but got paid."

So, now the patient has had surgery, some radiation treatment, and chemotherapy and the cancer is in remission. All of those procedures would have had to go through the bureaucratic review process.

### **Are There "Death Panels" in ObamaCare?**

Let's say, after treatment, unfortunately, the patient goes into relapse — the cancer returns. In the past, the doctor would start again, repeat treatment, and keep the patient alive over multiple cycles of chemotherapy. But things are changing.

Reports Dr. Conroy, "enter the 'death panels.' I actually read the ACA law. They are not death panels *per se*, but panels appointed by the President, NOT reporting to Congress, that establish the funding and treatment for patients." Those on the appointed panels are not physicians.

And what are the potential results of the decisions of such panels? Dr. Conroy explains what happens through the example of a pediatric lung transplant case, involving a young boy who needed the treatment. According to Dr. Conroy, the case required official approval from Kathleen Sebelius, now the nation's top healthcare official and in charge of ObamaCare. Sebelius refused to approve the transplant and the family had to go to a federal court. She followed the official guidelines as outlined in Pathways. According to its rules, the transplant was not approved for a child of that age, so "the kid was out of luck."

These panels can decide whether care can be provided or refused based on age, finances, and the treatment required. That brings us back to the whole debate based on money. This time it becomes the "government's money." And, suddenly, when the government decides it doesn't want to spend "its" money, it can become very stingy. It saves money by not providing care for the elderly, which it says are a burden to society. Or, in the case of the lung transplant victim, too young. The result is the same if care cannot be provided — death of the patient. Death panels? Perhaps not in name — but in practice. The panels do not report to Congress, but to higher bureaucratic panels. As Dr. Conroy describes it, "more like a central committee in the Soviet System."

Another example provided by Dr. Conroy is the NCCN Guidelines (National Comprehensive Cancer Network). There are a comprehensive set of guidelines detailing the sequential management decisions and interventions for the malignant cancers that affect 97 percent of all patients living with cancer in the United States. In addition, separate guidelines provide recommendations for some of the key cancer



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prevention and screening topics as well as supportive care considerations.

Explains Dr. Conroy, “they are fantastic for guidance in treatment plans, but imagine writing a program for any of the guidelines and then constantly changing them to meet new changes in care.” He goes on with another example, “Check out the Palliative Care guidelines, there is a section explaining how to order an IV infusion to sedate a terminal patient, the plan is for them to not wake up. The guidelines recommend that nurses who feel uncomfortable ethically with this order should be assigned elsewhere. This is a concern because Hospice is recommended over and over in the guidelines more than ever before.”

This is the real cost savings in ObamaCare — as money runs out, you change the parameters for treatment. Age, stage, and diagnosis care exclude aggressive therapy. In the past, this was a decision of a patient, minister, and family; now you have an insurance company/government agent making an “impartial” decision of no further treatment.

In a progressive secular society, ethics are not based on God or morality or individual wants and needs, but on the “common good” of the state. Concludes Dr. Conroy, “Obamacare is not about medical care but rather social and government control of the population.”

Over the past decade or more, government rules have been slowly creeping into healthcare decisions, making it more and more difficult for doctors to care for their patients. ObamaCare with its avalanche of rules and regulations and the reporting required of every doctor, every step of the way in treatment can only result in short-cuts and less care in the medical procedures. The result will be a bureaucratic takeover of the system, as unqualified political hacks will make life-and-death decisions for patients. It will lead to the end of innovation and advancement of medical treatments. Free thinkers seeking new ways will be swallowed whole by the bureaucratic system. The victim will be the American healthcare system. Quality doctors will quit, and mediocrity will rule the system, just like in every other socialist healthcare system from England to Canada. Welcome to the coming Utopia of ObamaCare.

The Supreme Court called ObamaCare a tax. And that is exactly what it is. It is not a healthcare system. It is simply another way to redistribute individual American’s wealth into the bottomless pit of government control. The health of the patient is not even in the equation.

*Tom DeWeese is one of the nation’s leading advocates of individual liberty, free enterprise, private property rights, personal privacy, back-to-basics education and American sovereignty and independence. Go to [americanpolicy.org](http://americanpolicy.org) for more information*



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