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# Correspondence

## Authority and Responsibility

In a recent editorial,<sup>1</sup> you identified bureaucratic incompetence, consistent with landmark caveats from the U.S. Supreme Court before the advent of Medicare, in which that Court warned the citizenry against relying on any federal agent:

Anyone entering into an arrangement with the government takes a risk of having accurately ascertained that he who purports to act for the government stays within the bounds of his authority, even though the agent himself may be unaware of the limitations upon his authority (emphasis added).<sup>2</sup>

It is not the function of our Government to keep the citizen from falling into error; it is the function of the citizen to keep the Government from falling into error.<sup>3</sup>

While the "Justices" of the U.S. Supreme Court thus relieved federal agents of responsibility, they disregarded a cardinal principle of organizational administration in failing to reappportion administrative authority by transferring federal agents' authority to citizens:

To hold a group or individual accountable for activities of any kind without assigning to them or him the necessary authority to discharge that responsibility is manifestly both unsatisfactory and inequitable. It is of great importance to smooth working that at all levels authority and responsibility should be coterminous and coequal.<sup>4</sup>

Though the Constitution assigns ultimate authority to The People, federal agents retain more administrative authority, e.g., the authority to deny citizens' Medicare claims. Official approval of that combination of overwhelming federal authority and irresponsibility is unworkable, intolerable, and unacceptable.

The parallel disjunction between responsibility and authority, among hospital administrators and trustees, who have great administrative authority but no practical qualification for accomplishing the organization's patient-care mission, and physicians, who have minimal to no

authority but who bear the entire *de facto* burden of responsibility for accomplishing the organization's patient-care mission, is likewise unworkable, intolerable, and unacceptable.

**Eric N. Grosch, M.D.**  
Largo, FL

<sup>1</sup> Huntoon LR. Medicare: incompetence-based bureaucracy. *J Am Phys Surg* 2004;9:102-103.

<sup>2</sup> *Federal Crop Insurance Corp v. A A Merrill*, 332 US 380 (1947).

<sup>3</sup> *American Communications Association v. Douds*, 339 US 382, 442 (1950) (separate opinion, concurring in part, dissenting in part, by Robert Houghwout Jackson, Associate Justice of the US Supreme Court and Chief Judge at the War-Crimes Tribunal in Nuremberg).

<sup>4</sup> Urwick L. *The Elements of Administration*. New York, N.Y.: Harper and Brothers; 1943.

## Maintenance of Certification

Kudos to Dr. Schlafly<sup>1</sup> for his poignant commentary on the "maintenance of certification" mandate. The American Board of Anesthesiology instituted this mandate in 2004, but chose to impose it only on diplomates who had received their original certification in 2000 or thereafter. Over the past year, I have sent several communications to the board asking for: (1) a substantiated rationale that the "maintenance of certification" might improve the quality of patient care; and (2) an explanation as to why only its newest diplomates are burdened with these onerous requirements. I have yet to receive direct answers to these inquiries. As Dr. Schlafly points out, there are dire consequences of refusing to jump through these new hoops to maintain board certification. When will we, as a profession, require our specialty boards to justify their impositions with some evidence-based data? When will we expose the political agendas disguised as concern for patient care?

**Jason B. Tingey, M.D., D.A.B.A.**  
Great Falls, Montana

<sup>1</sup> Schlafly B. Certification and recertification: where will it end? *J Amer Phys Surg* 2005;10:20-21

## PVS and Living Wills

Although the Schiavo case prompted considerable discussion about living wills, I have not heard anyone address the possibility that one might change her mind under some circumstances. Consider the case of an individual who was in an impaired state of consciousness for 20 years, who later regained significant function, including the ability to talk, as reported on CBC News, Feb 11, 2005. Had that individual prepared a living will, she might now be dead. She would be dead, not because of her physical condition, but solely because of the legal document that she created prior to the change in her condition.

I do not believe that medical science has reached a point of fully understanding brain capabilities under all circumstances of impaired consciousness. A recent article discussed brain function examination, by functional MRI scanning, of severely brain-damaged individuals. When personal events in their lives were discussed in their presence, their brain reactions closely resembled the responses of normal controls. The authors admitted that the results gave them cause to ponder.

What has been termed a “vegetative state” might well be recoverable to large extent in some patients. The patient referenced above said she could tell that others around her were present and she was far more aware of her surroundings than most thought. Imagine a circumstance in which you find yourself in a severely compromised state, but still have the will to live. Imagine that you cannot communicate that will to anyone who can influence the decision whether you live or die. What if the only remaining evidence of your wishes is the previously expressed desire to die, an outcome that is in total conflict with your present intent? Such is the material of Hollywood horror stories.

Ultimately, collectivist society appears to be driving us away from a “sanctity of life” philosophy towards a “culture of death.” In the culture of death, the “good of the state” and judicial edicts that err on the side of death trump the rights of the individual to life. Physicians must oppose this culture of death as strenuously as possible, since, ultimately, we may be used as “agents of the state” to carry out medical death sentences imposed by the courts.

**Ward S. DeWitt, M.D.**  
Missoula, Montana

I would like to thank AAPS for the amicus brief you filed with the U.S. Supreme Court in the Terri Schiavo case. The Schiavo case was another trial balloon launched by pro-euthanasia groups, and was a gross miscarriage of justice.

Unfortunately, many bioethicists have accepted the call to become agents of change, as they work diligently to extinguish any remaining remnants of what they consider that “superannuated credo,” the Oath of Hippocrates. Government-subsidized physician-assisted suicide and euthanasia loom on the horizon as we inch toward the slippery slopes of Holland and Belgium.

Given the pervasive culture of death, those who value their lives and the lives of their loved ones may need to protect themselves from court-imposed starvation and dehydration should they become mentally incapacitated. In this regard, I found AAPS general counsel Andrew Schlafly’s comments and the “Will to Live,” posted on the AAPS website ([www.aapsonline.org](http://www.aapsonline.org)), to be very timely and helpful.

**Gary Gillespie, M.D.**  
Williamston, MI

## Illegal Aliens

“Illegal Aliens and American Medicine,” by Dr. Madeleine Cosman, highlights a problem that many would prefer to ignore: illegal immigration either creates or significantly exacerbates many of the cost and quality problems in American medicine.<sup>1</sup>

In 2004, for example, Colorado ended presumptive Medicaid eligibility for prenatal care. Headlines portrayed this as cutting prenatal care for poor women. In fact, the state simply said that poor women must apply for benefits before receiving them. It had found that 47 percent of the women various clinics were certifying as presumptively eligible were not, primarily because they were illegal aliens. This cost Colorado taxpayers \$1,000 per case, or a reported \$9,000,000 a year.

As Karen Reinertson, Director of the Colorado Department of Health Care Policy and Financing, pointed out, “If they’re Spanish speaking and just arrived from Mexico three weeks ago, maybe someone should have a clue that person isn’t eligible.”<sup>2</sup>

Medicaid is a big business for the Section 330 federally qualified health clinics. Their trade association enthusiastically supports virtually any Medicaid

expansion. Chartered by the federal government, the clinics enjoy federally subsidized budgets and preferential malpractice coverage. Federal law also requires that state Medicaid programs pay the Section 330 clinics “reasonable costs” for treating Medicaid patients. In Colorado, the *Rocky Mountain News* reported that this is about \$130 per visit. Medicaid pays private physicians less than \$30.<sup>3</sup>

Faced with an end to the cash flowing from the presumptive eligibility scam, Peter Leibig, president of Clinica Campesina, repeated the usual cant. Reserving Medicaid funds for the care of eligible U.S. citizens is “stupid state policy,” he reportedly said, because “all of these women’s babies are going to be U.S. citizens covered by Medicaid,” and “our best investment is to provide prenatal care and infant care to break the cycle of poverty.”<sup>4</sup>

The elephant in this particular room is the obvious fact that a return plane ticket is cheaper than prenatal care. It is also less expensive than adding yet another anchor baby, and 18 years of associated health care expenses, to the Medicaid rolls. Mr. Leibig and his colleagues in the charity health business are free to use as much of their own money as they can afford to pay for prenatal care for Mexican nationals, but scheming to require Colorado taxpayers to do so is both illegal and wrong.

So far, this point is lost on many Colorado legislators. A bill in this year’s General Assembly would restore presumptive eligibility. Ironically, many of the elected representatives who support it also support a November referendum to increase Colorado taxes. Among other things, they say they need the money to pay for Medicaid expenses.

**Linda Gorman**  
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<sup>1</sup> Cosman, MP. Illegal aliens and American medicine. *J Am Phys Surg* 2005;10:6-10.

<sup>2</sup> Bill Scanlon, Prenatal care for thousands on the line, *Rocky Mountain News*, online edition, Aug 12, 2004. Available at: [http://rockymountainnews.com/drmn/local/article/0,1299,DRMN\\_15\\_3105307,00.html](http://rockymountainnews.com/drmn/local/article/0,1299,DRMN_15_3105307,00.html). Accessed May 9, 2005.

<sup>3</sup> Rachael Brand. Colorado pediatricians avoiding Medicaid kids. *Rocky Mountain News*, online edition, Aug 11, 2004.

<sup>4</sup> Bill Scanlon. Clinics lose money to give prenatal care. *Rocky Mountain News*, online edition, Nov 8, 2004. Available at: [http://www.rockymountainnews.com/drmn/state/article/0,1299,DRMN\\_21\\_3312893,00.html](http://www.rockymountainnews.com/drmn/state/article/0,1299,DRMN_21_3312893,00.html). Accessed May 9, 2005.