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Back to the '90s — The Supreme Court Immunizes Managed Care

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Should the law let patients sue health plans for damages when plans deny coverage and bad results ensue? A June ruling by the U.S. Supreme Court has returned this question to the forefront of the nation's political agenda. The decision, in *Aetna v. Davila*,¹ immunized employer-sponsored health plans against damage suits for wrongful denial of coverage. It voided statutes in 10 states that expressly allowed such suits and barred courts everywhere from permitting such claims to go forward under judge-made law. Consumer advocates, congressional Democrats, and their party's presidential nominee, John Kerry, vowed legislative action to end managed care's immunity, setting up a struggle with the Bush administration, which backed the industry in *Aetna v. Davila*. What does this mean for patients and physicians?

Americans with private health insurance typically obtain their coverage through the workplace, under the terms of a convoluted federal statute that was not designed with medical care in mind. Congress passed this law, known as the Employee Retirement Income Security Act (ERISA), in 1974 to protect workers' retirement income in the wake of a series of pension-fund scandals that were the Enron and WorldCom affairs of their day. Because ERISA supplanted wide areas of state law, it nullified most rules governing workplace-based health insurance.

The rise of managed care in the 1980s exposed this regulatory void, as aggrieved patients sought remedies and found that they had none. By the mid-1990s, the conventional wisdom, supported by sev-

eral court rulings,² held that managed-care health plans could not be sued for withholding coverage or care. The public's ire over insurers' impunity helped to fuel the late-1990s backlash against managed care. Market pressures and the prospect of a "Patients' Bill of Rights" pushed health plans away from intrusive cost-control methods, including the refusal to cover medically prescribed treatments.³

Interest-group gridlock stymied congressional efforts to enact a "Patients' Bill of Rights," but federal judges began to reinterpret ERISA in such a way as to shrink the legal void. In the late 1990s, lower courts allowed patients to sue health plans for malpractice committed by plan physicians, and in 2002, the Supreme Court upheld laws in more than 40 states mandating independent medical review when plans deny coverage.⁴ Since 2000, a number of lower courts have permitted damage suits against plans for withholding care. When the Supreme Court agreed to consider *Aetna v. Davila*, many observers expected the justices to craft an obituary for managed care's immunity from such claims.

Instead, the Court fully restored this immunity, striking down a Texas law authorizing such suits. As a candidate for president four years ago, former Texas governor George Bush pointed to this law, passed on his watch, as proof of his commitment to patients' rights. But last December, the Bush administration asked the justices to reject the law, warning that it and similar laws in other states would push health care costs skyward.

The evidence, however, suggests that empowering patients to seek damages for coverage denied

would not lead to large increases in medical spending. In 2001, the nonpartisan Congressional Budget Office estimated that Senate and House proposals to permit such claims would raise health insurance premiums by 0.3 to 0.7 percent. This is hardly chump change — it adds up to billions of dollars — but it is a 15th to a 30th of the double-digit increases in premiums that have occurred annually for the past several years, and it is a one-time-only add-on to health spending. Thus, over the long run, health plan accountability of this sort would have a very small effect on medical costs.

This effect can be reduced through congressional passage of a liability scheme that protects health plans against suits for failure to cover treatments that are ill supported by either scientific evidence or mainstream medical opinion. Understandably, plans worry about the open-endedness of their contractual commitments to cover “medically necessary” care. Uncertainty about the efficacy of tests and treatments, professional differences over how to value risks and benefits, and wide variations in clinical practice make medical need into a roulette wheel for health care payers.⁴ In suits for wrongful denial of coverage, courts have adopted the fiction that there are one or a few correct standards of care, and they have looked to plaintiffs’ and defendants’ medical experts to define these standards. When a health plan declines to cover treatment prescribed by a physician and, as a result, the treatment is not provided and the patient fares poorly, the physician can testify against the plan, giving jurors a basis for a verdict against it. By saying no to idiosyncratic, unproven, high-cost therapies, plans risk large verdicts when tragic results follow.

An answer is to bar damage awards for denial of coverage on the grounds of medical necessity unless the care at issue is either well supported by clinical-outcomes research or consistent with mainstream professional opinion. Ideally, the absence of scientific support for a therapy should be enough to defeat damage claims. But since there are not research-based “right answers” to most of the clinical questions physicians face, this ideal is unrealistic. More

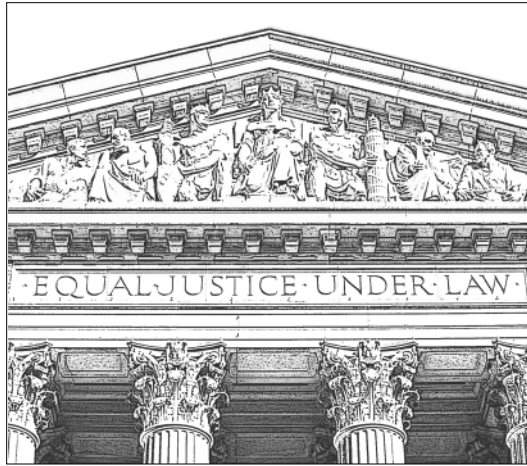
medical-outcomes research is needed, but for now we must make do with the profession’s best collective judgment. Health plans intent on more economizing than this judgment permits should replace the “medical necessity” standard with contract language that allows consideration of cost.

Is the revival of managed care’s immunity a fleeting thing, or will *Aetna v. Davila* have lasting effects? American voters will have a large say in November. If they reelect President Bush and the Republicans keep control of Congress, the decision will probably survive, since the administration supports immunity and few congressional Republicans would be inclined to oppose Bush on this issue, even if they disagree with him. If voters choose John Kerry, legislation permitting patients to seek damages for denial of coverage is likely, even if the Republicans retain the House and Senate. Kerry has promised such a bill, and there are enough Republican opponents of immunity to join with Democrats to pass it.

If managed care maintains its immunity, the consequences for patients may not be as far-reaching as they were 10 years ago. Not only have health plans edged away from denial of coverage as a cost-control tool³; independent medical review of denials is available to plan subscribers in more than 40 states. On the other hand, immunity reduces the legal risk associated with coverage denial. Under mounting pressure to contain costs, health plans may return to this approach.

Immunity will have its largest effect on less prosperous subscribers. Patients who prevail through independent review can obtain coverage for care delivered but not damages for the consequences of care withheld. Thus, Americans of means can pay for care, then fight for coverage.⁵ People who cannot afford this option are more likely to forgo care, then suffer the health consequences.

For physicians and hospitals, the main result of managed care’s renewed immunity is higher liability risk. Caregivers who prescribe treatment but do not provide it because health plans deny coverage can be forced to bear the full cost of liability. When plans say no to prescribed therapy, caregivers must



choose between offering it for free (or for a reduced fee) and refusing to treat the patient. The risk of liability for this refusal is theirs alone: they are vulnerable to being sued for both malpractice and patient abandonment.

Moreover, when plans refuse coverage, physicians who do not appeal this decision risk liability. There is, as yet, no well-defined legal duty to appeal coverage denials, but the emergence of independent review as the only way to hold health plans accountable will probably spawn such an obligation. For physicians, wrangling with health plans is distasteful and taxing. But it has become essential.

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BECOMING A PHYSICIAN

Teaching Anatomy in the Digital World

Kitt Shaffer, M.D.

Anatomy has a long and checkered past as a scientific discipline. In ancient Egypt, dissection was a religious ritual. During the Renaissance, it was considered an artistic and spiritual exploration of life, suffering, and death. Its heyday came in the 19th century, with the development of quick, effective surgical techniques on the battlefield and, later, the introduction of anesthesia, when knowledge of the structural intricacies of the body began to have practical significance for doctors. Throughout the 20th century, dissection of the human body served as an initiation rite for first-year medical students, even as the research focus in the field began shifting from gross anatomy to microscopical and ultrastructural anatomy.

Today, the teaching of anatomy is at a crossroads. As an introduction to the language of medicine and an underpinning of the study of pathophysiology, anatomy remains an essential component of medical knowledge. But anatomy as a discipline is disappearing, and few new anatomists are being trained. This decline, in combination with an increased emphasis on early clinical experience and decreased time in medical school for basic science, is forcing a reexamination of the way in which anatomy is taught. A more focused approach has become essential, and traditional methods, based primarily on light microscopy and dissection, are being challenged.

There are obvious logistic problems with dissec-

tion. Storing cadavers is expensive, and issues such as preservation, reduced suitability for dissection due to illness or obesity, public perception,^{1,2} and a natural abhorrence on the part of some students are all potential barriers. Careful dissection is time-consuming, and it is increasingly difficult to fit it into the shrinking portion of the curriculum devoted to basic science. Light microscopes are expensive to maintain, and their effective use requires training and practice. It is difficult to obtain slides of consistently high quality for all students in a large class, and the cost of newer methods of preparation, such as immunohistochemical staining, is prohibitive.

It is simplistic, however, to propose eliminating light microscopy and dissection because they are time-consuming or unpleasant. Both have educational features that are particularly valuable for the teaching of anatomy. One vital function is their graphic demonstration of the wide variation in human structure, a concept that is difficult to capture in a textbook or atlas. Most students are astonished by the extent to which their specimen differs from the images in their atlas — a common source of confusion in early sessions in the dissection or histology laboratory. Any substitute for these methods would have to address this variability in a substantial way.

In performing dissection and light microscopy, students must spend considerable time searching for objects of interest. They learn subliminally about the surrounding tissues or structures while seeking