

*Editorial***UNSUSTAINED VENTRICULAR TACHYCARDIA — TO TREAT OR NOT TO TREAT**

PHYSICIANS have long struggled with the vexing problem of how best to treat patients with myocardial infarction, reduced left ventricular function, and asymptomatic unsustained ventricular tachycardia who may be at risk for sudden death due to ventricular fibrillation. The Multicenter Automatic Defibrillator Implantation Trial (MADIT) was a randomized clinical trial that addressed whether such patients might benefit from an implantable cardioverter-defibrillator. In this trial patients with asymptomatic unsustained ventricular tachycardia who had inducible sustained ventricular tachycardia or ventricular fibrillation that remained inducible after the intravenous administration of procainamide were randomly assigned to receive implantable cardioverter-defibrillators or antiarrhythmic-drug therapy. The results of the trial, published in this issue of the *Journal*, suggest that survival among the patients who received implantable cardioverter-defibrillators was better than that in the drug-treatment group.¹

If the results of this trial were incorporated now into our clinical practice, the consequences would be staggering. Approximately 1.3 million patients annually survive a myocardial infarction in this country, of whom 16,000 would probably fit the clinical profile of the patients who underwent randomization in MADIT.²⁻⁴ Using hospital charges and physicians' fees at Brigham and Women's Hospital as a model, we estimate that the cost of identifying, evaluating, and implanting cardioverter-defibrillators in these 16,000 patients would be over \$1 billion annually, not including the cost of follow-up evaluations every three months after implantation, or the cost of treating device-related complications. Should this economic burden be added to an already overlaid health care delivery system on the basis of a single clinical trial involving fewer than 200 patients?

The inability of procainamide to suppress inducible ventricular arrhythmia also predicts the failure of other antiarrhythmic drugs.⁴ MADIT was therefore a comparison between implantable cardioverter-defibrillators and antiarrhythmic-drug therapy in a group of patients who were resistant to antiarrhythmic-drug therapy. The superiority of therapy with implantable cardioverter-defibrillators in such patients should therefore come as no surprise. Although 74 percent of the patients assigned to receive an antiarrhythmic drug were taking amioda-

rone one month after entry into the trial, it is incorrect to view the trial as a comparison of implantable cardioverter-defibrillators with amiodarone. Information about the maintenance dose of amiodarone and whether loading doses were administered is lacking. Only 45 percent of the patients in the antiarrhythmic-drug group were still taking amiodarone at the time of the last follow-up visit. Indeed, at the time of the last follow-up visit, 23 percent of the patients in the drug-treatment group were receiving no antiarrhythmic therapy at all, not even a beta-blocker.

Ten percent of the patients in the trial who were assigned to antiarrhythmic-drug therapy were being treated with class I antiarrhythmic drugs one month after entry into the trial; 11 percent were still taking such drugs at the time of the last follow-up visit. An even greater proportion of patients in this group may have been treated with a class I drug within the first month, since it was common practice when the trial began in 1991 to reserve amiodarone therapy for patients with no response to or tolerance of a class I drug. This is a crucial point, because we now know that these drugs in general increase the risk of death in patients who have previously had a myocardial infarction.^{5,6} With some drugs, such as moricizine, the risk of death is greatest early during therapy.⁷ The survival curves of the two groups in MADIT diverged sharply within the first year, particularly within the first six months, but were virtually parallel thereafter. This difference in early survival could plausibly be attributed to the harmful, proarrhythmic effect of class I antiarrhythmic drugs rather than to a survival benefit of therapy with implantable cardioverter-defibrillators.

One of the chief difficulties in the interpretation of the trial is that treatment with implantable cardioverter-defibrillators was compared with another active therapy — namely, an amalgam of antiarrhythmic drugs, many of which we now know to be harmful. It is unfortunate that antiarrhythmic drug therapy was referred to in the trial as “conventional therapy.” Conventional therapy is therapy that is known to be beneficial and that, in the absence of a contraindication, should be given to everyone. In patients with a previous myocardial infarction such therapies would include beta-blockers, angiotensin-converting-enzyme inhibitors, aspirin, and lipid-lowering drugs but not antiarrhythmic drugs.

The real question, one that cannot be answered by MADIT, is whether treatment with implantable cardioverter-defibrillators offers any survival benefit over truly conventional therapy. In the present “thrombolytic” era, an annual mortality rate of 8 to 10 percent would be expected among patients with recent myocardial infarctions, left ventricular ejection fractions below 40 percent, and asymptomatic unsustained ventricular tachycardia.⁸⁻¹⁰ Such a sur-

vival rate is similar to that in the group that received implantable cardioverter–defibrillators. The selection of patients for the trial who had inducible sustained ventricular arrhythmias may have led to the inclusion of a higher-risk group. However, in order to put this management strategy into perspective, it is necessary to know what proportion of the patients had noninducible arrhythmias during base-line electrophysiologic studies, in what proportion the arrhythmias became noninducible after procainamide therapy, and what the outcomes were in these groups, including procedure-related complications. All this information is lacking.

That 60 percent of the patients who received implantable cardioverter–defibrillators in the trial received shocks from their devices within the first two years of follow-up should not be viewed as evidence that the devices saved lives. Many of the discharges could have been triggered by sinus tachycardia, atrial fibrillation, or unsustained ventricular tachycardia that would have stopped spontaneously even in the absence of a shock.

One point must be stressed: The results of the trial should not be extrapolated to other populations of patients, such as those who have survived an episode of symptomatic, sustained ventricular tachycardia or ventricular fibrillation. Optimal therapy for such patients will be clarified in the Antiarrhythmics versus Implantable Defibrillators trial,¹¹ the Canadian Implantable Defibrillator Study,¹² and the Cardiac Arrest Study of Hamburg.¹³ MADIT neither diminishes the need for nor reduces the importance of these trials.

How, then, should the results of MADIT be incorporated into our daily practice? As any wise clinician knows, each patient must be approached as an individual, with consideration of all relevant clinical factors, including the degree of ventricular dysfunction, the presence or absence of heart failure, the patient's ability or inability to tolerate medicines such as beta-blockers and angiotensin-converting-enzyme inhibitors, the time elapsed since myocardial infarction, and the frequency of episodes of unsustained ventricular tachycardia. It is also worth remembering that the quality of life of patients with asymptomatic unsustained ventricular tachycardia cannot be improved by an implantable cardioverter–defibrillator. Although the Food and Drug Administration has broadened the indication for implantable cardioverter–defibrillators to include patients who fit exactly the profile of those in MADIT, we would hope that this treatment would be reserved for a carefully selected subgroup of survivors of myocardial infarction who are at highest risk for sudden death.

More than 700 patients with coronary artery dis-

ease and asymptomatic unsustained ventricular tachycardia have been enrolled in the Multicenter Unsustained Tachycardia Trial, a study that includes a group treated with implantable cardioverter–defibrillators in its design.¹⁴ Now in its follow-up phase, the trial has not yet demonstrated a statistically significant survival benefit in any of its treatment groups, including the one treated with implantable cardioverter–defibrillators. It would be prudent to await the results of the other important clinical trials already in progress before deciding, finally, what MADIT has taught us about the value of treatment with implantable cardioverter–defibrillators in patients with unsustained ventricular tachycardia.

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*Sounding Board***STATE REGULATION OF MANAGED CARE AND THE EMPLOYEE RETIREMENT INCOME SECURITY ACT**

THE federal Employee Retirement Income Security Act (ERISA)¹ is the federal law that governs employee-benefit plans offered by private employers and unions. ERISA has long hindered state efforts to expand access to health care, because it prohibits states from requiring all employers to offer benefits to their employees.² States have shifted their attention from seeking universal insurance coverage for health care to regulating the benefits of people who already have health insurance. Reports describing how some managed-care organizations limit the care provided to their enrollees have prompted a rash of legislative efforts intended to protect patients from receiving substandard care.³ Yet here too, ERISA has prevented state laws regulating managed care from being uniformly enforced.⁴

For example, women and their physicians sought protection against so-called drive-through delivery — the practice of severely limiting coverage for postnatal hospitalization — by proposing state laws that would require managed-care organizations to pay for specified minimum hospital stays for mothers and their newborns after birth.⁵ More than two dozen states have adopted such laws or regulations.⁶ Yet many women enrolled in employee group health plans were surprised to learn that they were not protected, because ERISA prohibited the state from requiring their plans to pay for specific medical benefits. Thus, of two women giving birth in the same hospital (with normal vaginal deliveries), one might have health insurance that would pay for the 48-hour stay required by state law, but the other might have to pay for the second hospital day out of pocket or leave the hospital after 24 hours, because her health plan was governed by ERISA and not obligated to comply with the state law. Or the hospital and the attending physician might have to absorb the expense. A 1995 Massachusetts law, for example, prohibits hospitals from discharging new mothers within 48 hours without their consent.⁷ Accordingly, if neither the woman nor her health plan paid for the full 48 hours, the hospital and the physician would be left uncompensated.

Such unevenly applied state laws persuaded Congress to amend ERISA to require that all ERISA health plans offering childbirth benefits pay for hospital stays of at least 48 hours after a normal vaginal delivery and 96 hours after a cesarean section (as recommended by the American College of Obstetri-

cians and Gynecologists and the American Academy of Pediatrics).^{8,9} Although the Newborns' and Mothers' Health Protection Act of 1996, which was signed into law on September 26, may have resolved the specific problem of premature postnatal hospital discharges, it does not affect other state laws regulating managed care. Unless Congress is prepared to legislate health benefits on a case-by-case basis for every medical condition and managed-care practice that creates controversy, patients and physicians will remain subject to rules that vary with the type of health insurance involved.

Almost 150 million Americans are enrolled in health plans governed by ERISA.^{10,11} Some state laws, such as those pertaining to reporting, do not apply to any of these plans. ERISA has also prevented patients from suing managed-care organizations for corporate negligence under state malpractice laws.¹² State laws that mandate benefits, such as those regulating postnatal hospital stays, can indirectly affect ERISA plans that purchase insurance policies for employees. However, self-funded ERISA plans, which have more than 44 million enrollees,¹⁰ do not have to comply with these laws. Employers with self-funded plans (sometimes called self-insured plans) do not purchase health insurance policies for their employees or contracts enrolling them in managed care. Instead, these self-funded employers use their own assets to pay for health services, effectively acting as their own insurers. In this article I pursue my earlier consideration of ERISA^{2,12} and describe how it inadvertently handcuffs the regulation of managed care at the state level and why the act should be amended to allow states to set uniform standards for managed care.

ERISA'S ORIGINS AND THE REGULATORY VACUUM AFFECTING HEALTH PLANS

ERISA was adopted in 1974 to reform the management of voluntary pension plans by private employers.^{13,14} Traditionally, the states, not the federal government, have regulated the insurance industry.^{15,16} State laws, however, proved ineffective in preventing employees from losing their pensions. ERISA established federal standards, superseding state law, for the funding and payment of employee pensions.

Late in the process of debating ERISA, and with little discussion, Congress decided to prohibit not only state laws that affect pensions, but also those governing all types of employee-benefit plans, including health care.¹⁷ One reason was to free employers from inconsistent state regulation of benefit plans in general.¹⁸⁻²² Some supporters of the new legislation also wanted to maintain the pressure for federal reform of health care by forestalling reforms at the state level.

When the federal government takes over the reg-

ulation of an industry from the states, it ordinarily creates a federal regulatory system with uniform standards and mechanisms of enforcement, such as the Food and Drug Administration. ERISA established uniform standards for pension plans (which work reasonably well) but did not do so for health plans. Although health plans governed by ERISA are often described as federally regulated, the law does not prescribe any substantive standards for them. It requires only that a health plan provide employees with a brief summary of the main terms and conditions of the plan, invest its funds prudently, and report to the Department of Labor.²³ ERISA does not require health plans to offer any specific benefits or meet any standards for contracting with physicians, setting payment rates, or deciding about patient care. The result is an anomalous law that precludes state regulation of ERISA health plans without substituting federal standards, leaving the plans in a regulatory vacuum.

LIMITATION OF STATE LAWS BY ERISA

Less federal regulation does not necessarily mean fewer rules. Instead, it means that managed-care organizations set the rules in the contracts they draw up. Private contracts between managed-care organizations and physicians prescribe the rights and duties of physicians in caring for enrollees, just as private contracts between managed-care organizations and employers define employees' rights to medical care.²⁴

Most states have passed or are considering passing consumer-protection laws intended to protect patients from unfair managed-care contracts and practices.^{3,6} Examples of such measures are laws requiring coverage for specific benefits (such as emergency care provided without advance approval), detailed disclosure of the benefits and procedures of the plan, the reporting of data on outcomes and the results of patient surveys, the creation of impartial mechanisms to resolve disputes, and the establishment of minimal levels of expenditure for patient care as a proportion of health-plan revenues (the "medical loss ratio").²⁵

Because protecting patients often means protecting physicians and other health care providers as well, another category of laws regulates providers' relationships with managed-care organizations. These include so-called any-willing-provider laws, which prohibit managed-care organizations from having closed panels of participating physicians; laws prohibiting "gag rules," which bar physicians from telling patients about the terms and conditions of the plan,²⁶ and laws regulating the degree of financial risk that can be transferred to providers, as in capitation arrangements. Three examples — mandated-benefit laws, any-willing-provider laws, and laws prohibiting gag rules and requiring the disclosure of

information — illustrate how ERISA limits state regulation of managed care.

MANDATED-BENEFITS LAWS AND DIFFERENTIAL TREATMENT OF HEALTH PLANS

States can affect some employee health-benefit plans indirectly, by regulating the insurance policies sold to ERISA plans instead of regulating the plans themselves. Because ERISA contains an exception allowing states to regulate insurance,²⁷ state laws can force insurance companies and managed-care organizations to include specific "mandated" benefits and certain other provisions in the insurance contracts they sell. However, ERISA expressly states that employee-benefit plans themselves are not to be considered to be in the business of insurance; therefore, they are not subject to state laws regulating insurance.²⁸ The effect of these exceptions, according to a 1985 decision of the U.S. Supreme Court, is to permit states to regulate the benefits covered by policies sold by insurance companies, but not the benefits provided by self-funded ERISA plans.²⁹

State laws requiring health insurance and managed-care organizations to pay for minimum postnatal hospital stays are a recent example of mandated-benefit laws. Other examples include state laws that require insurance to cover specific kinds of treatment (such as treatment for mental health problems, substance abuse, or infertility; prenatal care; the screening of children for lead poisoning; and mammography for women at least 40 years old) and types of providers (such as psychologists, chiropractors, and podiatrists). Employers who purchase policies from insurance companies find that mandated benefits are of necessity included in the group coverage.²⁷ Self-funded employers, who design and fund their own employee health plans, do not have to offer any mandated benefits.

Most states have passed legislation mandating specific benefits on the theory that the benefits are essential to basic care and ought to be provided to all enrollees. The states also have an interest in spreading the cost of these services over a large population, because state programs are often the payers of last resort for patients whose insurance does not cover these costs. Providers seek mandated benefits so that they will be compensated for their services. Although not all services should be mandated, ERISA makes it impossible for those that should be mandated to benefit everyone.

ANY-WILLING-PROVIDER LAWS

Several states, such as Virginia and Louisiana, have passed laws requiring managed-care companies to contract with any physician who agrees to the terms and conditions of a health plan or pay nonparticipating physicians for treating a patient enrolled in

the plan. Any-willing-provider laws take many different forms, but they typically prohibit managed-care organizations from having a closed panel of physicians, hospitals, or other providers.³⁰ The laws are supported by physicians who fear that managed-care organizations will not employ otherwise qualified physicians whose practice styles are considered too expensive. Although costs need not rise if providers are obligated to accept the plan's payment terms, managed-care organizations are concerned that they may not be able to negotiate sufficiently low fees to providers if a physician cannot expect a large volume of patients. Moreover, it may cost the organization more to monitor quality and use of services among a large number of widely dispersed physicians than in a small group.

Any-willing-provider laws have been challenged in federal court by ERISA plans and managed-care organizations. In 1993 the Fourth Circuit Court of Appeals treated Virginia's any-willing-provider law as if it were a mandated-benefit law: insurance companies had to comply with it, but self-funded ERISA plans did not (they could limit the physicians with whom they contracted).³¹ This past year, however, the Fifth Circuit Court of Appeals found that a similar law in Louisiana did not regulate insurance³²; the court held that the law could not apply to any ERISA plan at all, either insured or self-funded.

Part of the difference in approach between the two courts lies in complicated legal arguments over what is meant by "regulating" insurance.^{29,33,34} Many managed-care practices, such as the credentialing of providers and the setting of payment rates, may not qualify under the legal definition of insurance. State laws intended to regulate managed-care practices that do not qualify as insurance cannot be enforced with respect to any ERISA plan. Louisiana asked the Supreme Court to review the decision of the Fifth Circuit, but in November the Supreme Court refused the case. Nonetheless, the court may ultimately decide how, if at all, states can regulate managed-care contracts with physicians whose patients are enrolled in ERISA plans.

DISCLOSURE LAWS

The benefits of competition — better quality and lower prices — depend on consumers' having enough information to make knowledgeable choices. Thus, state laws often require insurers and managed-care organizations to provide enrollees with descriptions of their benefit contracts. Traditional summaries, however, do not capture the complexity of many managed-care plans, which may restrict access to physicians, require preauthorization for treatment, and include other mechanisms intended to improve care or reduce costs. In response, several states have adopted laws requiring insurers and managed-care organizations to describe more adequately what a

health plan covers and how it actually operates.³⁵ New laws in Arizona and Wyoming require plans to disclose whether providers are subject to incentives or penalties intended to induce them to withhold services or avoid referrals to specialists.³⁶

Most courts have found that ERISA prohibits states from requiring ERISA plans to disclose specific information about how they are administered and how they decide claims. Whether an insurer's rules for selecting and paying physicians must be disclosed depends on whether those rules are considered to be included within the scope of insurance that the state can regulate. In a 1996 case in the Connecticut Supreme Court, an insurer conceded that despite ERISA, it had to comply with a state law requiring insurers to list the physicians participating in their preferred-provider networks, along with the insurers' criteria used in selecting physicians and terminating their employment.³⁷ In the case in question, patients and physicians were permitted to sue the insurer for false advertising, because it did not adhere to its own criteria when it terminated the employment of individual physicians in the network. The court's reasoning, if followed by other courts, may force insurers to follow their own rules for selecting physicians, but it does not allow the state to prescribe what those rules should be.

The limits placed by ERISA on the requirements for disclosure also affect gag rules — provisions in physicians' contracts with managed-care organizations that prohibit the physicians from communicating information to patients that the plan administrators wish to keep private.²⁶ This information may include services the plan does not pay for, utilization review and procedures for deciding what to pay for, and compensation arrangements and financial incentives that affect the kind of care that is offered. The Supreme Court has held that states cannot require employers to comply with state laws that prescribe the way their health plans should be designed or administered.³⁸ Contracts with providers could be considered part of a plan's design or administration. For this reason, some states are considering the alternative of requiring physicians to disclose this information to their patients. Laws that regulate physicians and other providers directly do not run afoul of ERISA. Managed-care organizations should not be able to require physicians to keep quiet about matters that state law obligates physicians to disclose. Nonetheless, state legislatures generally have neither the expertise nor the desire to regulate medical practice.

OPTIONS FOR REGULATING MANAGED CARE

The failure of national health care reform has left the states with the primary responsibility for achieving fairness in health insurance coverage, but ERISA

prevents them from setting uniform standards for managed care. The patchwork nature of this regulation results not from thoughtful distinctions about policy, but rather from interpretations of a federal law that was never designed to regulate health benefits.

The 1995 Supreme Court decision in *New York Blue Cross Plans v. Travelers Insurance*,³⁹ in which ERISA was interpreted in a way that increased the states' options for financing health care for the uninsured, has encouraged a long-overdue reexamination of ERISA's prohibitions against state laws. That case unanimously upheld New York's hospital-rate-setting laws, which imposed higher charges on commercial insurers and ERISA plans in order to help fund state health programs for the indigent and make Blue Cross plans more competitive. The Supreme Court found that these rate-setting laws did not regulate ERISA plans and only incidentally and indirectly increased their costs of doing business. The *Travelers* decision, however, did not address ERISA's prohibitions of state regulation of managed-care practices. It indicated that ERISA still prohibits state laws that "preclude uniform benefit administration or the provision of a uniform interstate benefit package" in ERISA plans.³⁹ Most state laws regulating managed care do affect ERISA plans and interfere with uniform benefits and administration. As a result, the states have more legal freedom to expand health benefits for the uninsured than they do to regulate managed care.

Responding to the problems with managed care on a case-by-case basis is inefficient and ineffective. As more employers stop offering health plans or shift to self-funded plans, state laws benefit fewer and fewer people. Most important, piecemeal legislation treats the symptoms arising from the ERISA prohibitions, not the prohibitions themselves.

Some incentive for more uniformity may come from Medicare and Medicaid regulations, as managed-care companies increasingly enroll the beneficiaries of these federal programs. ERISA cannot restrict federal law,⁴⁰ and the federal government has the authority to require managed-care organizations to adhere to federal rules affecting beneficiaries of Medicare and Medicaid. In addition, Congress is considering additional legislation to require the same kinds of consumer protection that states cannot now enforce evenly, such as mandated benefits for emergency care and prohibitions on gag rules. Federal laws could apply to all health plans, but case-by-case legislation still falls short of resolving the underlying problem coherently. In the face of political opposition, Congress has not adopted comprehensive federal rules governing health benefits.

As long as states are charged with regulating private insurance, Congress should amend ERISA to permit them to regulate managed care, whether or

not it is provided through an ERISA plan. There is no reason to deprive patients of basic consumer protections merely because their health benefits are provided by an ERISA plan or because their employers fund the plan in a given way. This is not to suggest that all proposed state laws regulating managed care should be enacted. Different managed-care practices and arrangements could be treated differently under state law — that is, on their merits, whether or not they serve ERISA plans. Such differences should be based on sound public policy, however, and should not be the inadvertent result of ERISA prohibitions.

CONCLUSIONS

ERISA was enacted to keep employees from losing their pensions. Now it interferes with their obtaining health benefits.^{2,41} One reason for prohibiting states from regulating employee-benefit plans was to discourage employers from reducing the benefits they provide in order to afford compliance with state laws.⁴² Employers are now encouraged to reduce benefits precisely because they do not have to comply with state laws. Many large employers, insurers, and managed-care organizations oppose amending ERISA to permit state regulation of ERISA plans, even though almost all other state laws apply to them. Some who are opposed to amending ERISA have also objected to federal legislation to reform health care on the grounds that reform of health care should be left to the states.⁴³ With comprehensive federal legislation unlikely and state legislation limited by ERISA, some plans are subject to almost no regulation at all. State regulation of managed care is no substitute for comprehensive health care reform, which will probably require federal legislation. If Congress is unwilling to act on comprehensive reform, it should at least amend ERISA and free the states to address the problems it has failed to resolve.

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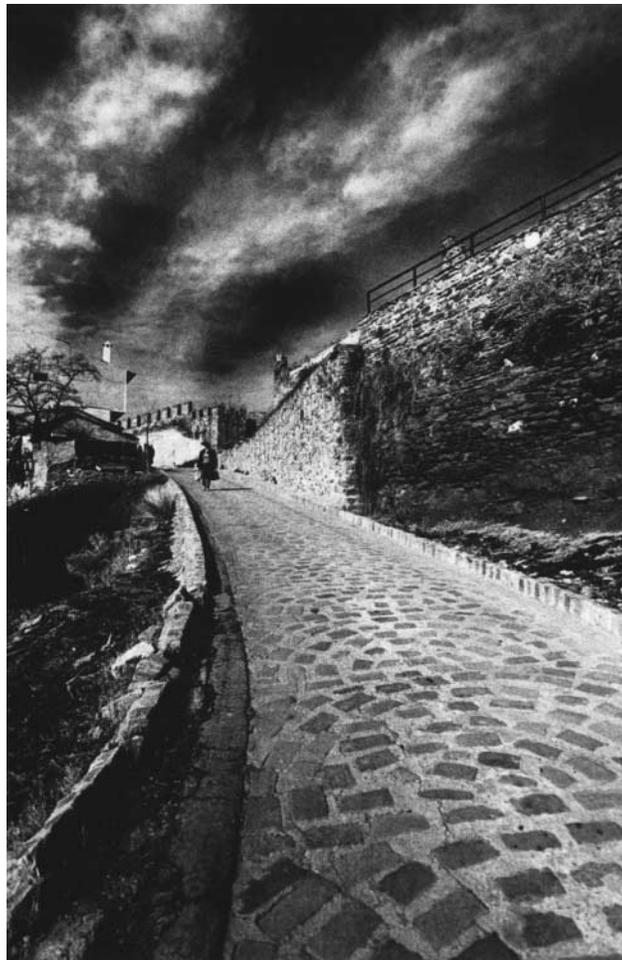
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Castle of Salonica

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Occasional Notes

HEARING VOICES

How Should Doctors Respond to Their Calling?

TYPICAL damn day. I am running behind, swilling lukewarm coffee, and whittling away at the tower of charts and messages the nurse has stacked on my desk. I peep around the corner to survey the crowded waiting room, and I recognize every dependable name and complaint on the morning roster.

A family meeting has been scheduled over the lunch hour so that I can meet a patient's two sons who are visiting from out of town. They have left a list of items for me "to consider" before we gather. Scrawled on the back of a coffee-stained envelope are the words: "Crisis! Dad drunk most of the time. Mother in constant pain. Too weak to eat Meals on Wheels or climb the stairs, using ropes Dad has rigged for her. Doctor, you've got to do something."

What they hope I will do is rescue Nancy, now in the last stages of her liver cancer, from a relationship she has borne willingly and not without joy for 45 years. At our meeting they learn that she loves her home, her morning cup of Smooth Move and the view of the harbor, her adoring nurses, and the minister who comes a-calling. The battle over Dad's drinking — the sons' battle to seize the upper hand — takes a back seat to their mother, who despite her struggles has found peace in the cradle of our collective acts of affection.

Back in the office, stomach crawling, I receive a telephone call from the nursing home. My new patient has just arrived by ambulance, the one I accepted in transfer from the oncologist. "He is dying," I hear for the first time, "and the ride has racked him with pain." The nurse reports a dismal set of signs: blood pressure 80 over 50, respirations 8. "Just give a little morphine SQ," I suggest. "Careful not to suppress his breathing altogether. If you do, bag and push an amp of Narcan until I can come by to assess him."

But not five minutes later, another urgent call from the nursing home. "The family says no to Narcan, no to bagging. If he dies, he dies. He's in pain, and they won't stand for it."

What do they want from me — the oncologist who unloaded this patient on me, the family who cannot bear the moans of their dying father? Give them Jack Kevoorkian's number, I mutter. No, I will not order the lethal injection. I don't know this patient, or the family, or the disease. And if you ignore my orders, bear the responsibility!

Playing the sequence in my mind — the one

from the movie *Frankenstein* where the monster is swarmed by a pitchfork-flailing mob — I step into the next examination room to seek a calm in the storm. Instead, the patient is here to relive with me her unhappy childhood, to acquaint me with the sisters who belittled her and the mother she could never please. I fidget in my chair and eye the clock as she avoids every subtle cue that our time is up. "Is there something you want from me, Mirabelle? Why did you tell me this today?"

"Because," she answers with imploring eyes, "the priest is out of town and somebody needed to know."

There it is, finally — what I had suspected all along. The priest is away! So the family doctor, poor substitute that I am, is left to pick up the pieces. Mirabelle and I teeter on the edge of the abyss, imploring the same good God to save us for another day.

What do they expect of me? Who do they think I am? Have they no regard for my skills, or the certificates that hang on the waiting-room wall? I write prescriptions, that is what I do. I deliver babies and wield a knife. I remain calm in a crisis. I manage risk and broker the odds of survival. This, I mutter meekly to myself, is who I am.

On the tranquil drive home that evening, in the sanctuary of my car, I remember Kafka's surrealistic tale about the country doctor who took a chance on a night call. The doctor was summoned in a blizzard to an ailing boy's side. But when he arrived, he found an axe wound in the boy's abdomen, now several days old and wriggling with worms. Alas, no hope. But what of the family's expectations, their superstitious beliefs? The best he might manage would be their disappointment; the worst, a loss of reputation.

That is what people are like in my district. Always expecting the impossible of the doctor. They have lost their ancient beliefs; the parson sits at home and unravels his vestments, one after another; but the doctor is supposed to be omnipotent with his merciful surgeon's hands. Well, as it pleases them; I have not thrust my services on them; if they misuse me for sacred ends, I let that happen to me too.¹

We are called upon, it often seems, for unreasonable requests at unsuitable times — times that we often later judge to be the finest hours of our days. We are chosen as witness or agent in some hidden drama: a flash of understanding, a cathartic explosion of tears, the tiniest turn toward reconciliation, a simple act of kindness that spills out at the close of a dead-run day. These are the times when doctors earn their credibility, which "grows out of compassion and trying to help, depending less on expertise than good intentions."² Gayle Stephens suggests that the public will accord moral credibility to whoever shoulders the suffering and uncertainty of illness, the grief of painful life events, the loneliness of death. This was the hallmark of the general practitioners, and their lasting legacy.

In the shadow and glare of car lights on wet asphalt, another notion rises from the road ahead. It is the question we, as members of the medical profession, ask ourselves more often, the one that stalks us on our daily rounds and steers our political agenda: In these changing times, who should the doctor be? During the formative years of family practice, we sought answers from rank-and-file general practitioners. They were a hard-working breed, independent operators, jacks-of-all-trades. They were often willing to sacrifice everything — marriage, family, and personal life — for the well-being of their patients and their practices. They might die heroes or martyrs, or consummate “good providers,” as did my father at the age of 49.

Many involved in the rebirth of general practice were concerned about families, including their own. They considered the patient’s spiritual and emotional well-being, along with the physical; they practiced preventive medicine as vigorously as they pursued the outright cure. In the process, ironically, they distanced themselves from the objects of their “personal care.” The patient and the patient’s relationships became something to be diagrammed. For the good of the patient, new family doctors warded off the trappings and intrusions of authoritarianism, addiction to work, so-called enabling behavior, and countertransference.

Now reigns the age of managed care. More and more of us have moved under the shelter of the corporation. We have learned to pass patients between specialty pools of preferred providers, to control “risk” through the use of practice guidelines, and to pursue only those clinical questions that can be answered expeditiously. We are specialists. We have a job to do, one that is limited by the clock, the protocol, and our role at the bedside, which we have increasingly consigned to mid-level technicians.

But there is a fourth tradition, an older and more venerable one, that still engages the primary care clinician. It is kept alive by the parish priest, the rabbi, and the country minister who quietly go about their pastoral duties. We wear their robes, too, at every deathbed, and when grief or fear plays prominently in the patient’s disease. We recognize this tradition in arms that hold, hands that stroke, shoulders that bear the brunt of responsibility when no one else steps forward. We know it as part of a life in service, something subsumed by that oddly antiquated word “vocation.” We feel drawn to the downtrodden, the ignorant, the disadvantaged. But not out of a sense of altruism or noblesse oblige, duty or guilt. Perhaps we still act, like the Good Samaritan, out of compassion and recognition of ourselves in those who suffer, and with a deep conviction that salvation is to be gained by sharing the load.

Many of us still look upon medicine as a calling. We feel its privilege even when it draws us outside

our comfortable roles and the advantage of our expertise, which quells the patient’s doubts or words of dissension. If patients choose us for sacred purposes, we let that happen, too. I am reminded of the movie *Dead Man Walking*, in which Sister Helen Pr jean is asked to provide spiritual counsel to a convicted murderer. She responds to his need out of mercy. She sees the difference she might make in his limited life. She knows she is too entangled to walk away.

I am that entangled nun, who feels overwhelmed, undertrained, or besieged at a family meeting and who squirms at the sight of my patients’ tears. I feel the bear hold of the family’s expectations: Can’t you do something? When will Mother die? Will it be painful? Is there any hope? But patients often demand just our presence. They need us not only for what we can do, but for the suggestion of what they might become: changed, well, whole, happy. Or barring that, at peace before they die.

What has become of our calling? The answer depends on whom we listen to. We are obliged to listen to licensing boards, credentialing committees, peer-review organizations, and insurance carriers. But they do not define us. We have listened to the general practitioners who laid the moral foundation for family medicine, the humanists who reformed it, the market analysts who will repackage it for the 21st century. But these voices tell only part of the story. The one person who will challenge us the most, who will deliver us to our finest hours, who will talk us through every moral conundrum, is the patient, who we thought needed *us*.

I am still a doctor, destined for more uncertain times, unmanageable days, undeserved rewards, and the inexhaustible opportunity to touch the lives of those I treat. And to change their lives as they have changed mine. Our work bears the stamp of a centuries-old tradition and is carried forward by each new class of physicians. Some 30 years ago, as general practice stood on the brink of extinction, a colleague of mine addressed the readership of the *Journal*. His words are dated, but his sentiments beat yet in the heart of every generalist I know:

When I, personally, considered the study of medicine, the concept of family practice was one of a great calling. One admitted that the surgeon under the bright lights had more glamor or that the obstetrician and gynecologist made more money, but the idea of being a skilled personal servant to the family seemed to promise the most satisfaction from being a doctor in the ancient tradition. . . . [Physicians] must concern themselves with perspective, insight, art, mercy and humility as much as with monoamine oxidase inhibitors or the diagnosis of phenylketonuria.³

Yea, though we walk through the valley of managed care and our business (if not our soul) is traded

on the floor of the New York Stock Exchange, we are lucky to be here, doing what we do, still students of medicine, tending to the afflictions and infirmities of those who call us doctor.

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