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President's Page: Who Is Responsible for the Cardiovascular Patient?

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Health care system reform in the private sector has been based on two (at least) major unproven assumptions: 1) that primary care physicians can provide "nearly equivalent" care to specialists if they are aided by guidelines, critical pathways and access to technology (e.g., exercise tests, echocardiography); and 2) that the care thus provided is less expensive. Specialists are axiomatically perceived to be too expensive. The widely used Milliman & Robertson Healthcare Management Guidelines (1) state that the primary care physician should manage all common cardiovascular disorders and only seek consultation from a cardiovascular specialist when an interventional procedure is needed or when the patient develops a life-threatening complication.

Recent peer review studies do not support this approach (2–7). When treatment for the same disease is compared, cardiologists consistently have the best outcome (for both mortality and morbidity) compared with general internists, who in turn demonstrate better outcomes than family practitioners. Indeed, this is what one would expect. Generalists need a significantly broader and, consequently, less in-depth knowledge base to care for a wider variety of patients. When one looks at the long-term course of a disease (and most cardiovascular disease is chronic), initial use of complex and sophisticated diagnostic studies and therapies is cost-effective by reducing the number of subsequent hospital admissions, lost work time due to illness or lost income generation due to premature death. The old idea that getting the correct diagnosis as early as possible is the most cost-effective approach has been validated. The well trained cardiovascular specialist is most likely to do this and therefore must be readily accessible in the system.

Managed care's reduction of medical costs has thus far been demonstrated most easily in areas of the country with excess hospital (and physician) capacity and in non-Medicare patient populations. In managed care systems where costs have already been reduced, the cost of care for the Medicare population is five times that for the non-Medicare population, regardless of payment mode (8). This is most likely due to the complexity and severity of the illness in the Medicare population, much of which is cardiovascular disease. In complex disorders the experienced specialist is far more efficient and effective in diagnostic workup and therapy.

It is widely believed that excessive use of technology is the major cause of increased costs of health care around the world. However, the dramatic reduction in mortality from cardiovascular disease in the past 30 years is due, in large part, to technology developed and managed by cardiovascular specialists. Does this country wish to limit the availability of this technology, which patients have come to demand? It is of interest that in Britain the government has finally realized that there are too few cardiovascular specialists, and the number of cardiovascular training positions has recently been increased.

Many gatekeeper paradigms encourage use of noninvasive cardiovascular tests, particularly echocardiography, in lieu of referral to a cardiologist. Unfortunately, a test alone seldom provides the information required to manage the patient properly. The result must be integrated into clinical decision making by a physician who understands the strengths and limitations of the test. Perhaps more to the point is that the decision to do the test should be made by the experienced cardiovascular specialist, who may decide that it is not necessary.

Randomized, placebo-controlled clinical trials have become extremely popular for determining optimal treatment for patients with cardiovascular disease. Few other areas of medicine have been subjected to such extensive analysis by trials, and the information gained has greatly improved care. However, trials do not always clearly indicate optimal treatment for an individual patient who may not resemble those in the study population (often the majority of patients). Once again, only an experienced physician can properly integrate results from

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trials into practice. Similarly, even the widely accepted practice guidelines developed by the American College of Cardiology (ACC) and the American Heart Association need to be individualized by an experienced clinician for direct application to patient care. Decision making in cardiovascular medicine is not as simple as it may seem to noncardiologists.

Cardiologists must take longitudinal care of patients to gain the clinical experience described here. Currently, the majority of patients with chronic cardiovascular disease are not regularly seen by a cardiologist. Evaluation and management services must extend beyond the acute illness (e.g., myocardial infarction). Regular care by a cardiologist allows new concepts, such as secondary prevention and management of congestive heart failure, to be implemented as soon as possible. Regular care also encourages patient compliance with the medical regimen. Much benefit in long-term care derives from the patient's understanding that his or her care is being provided by an "expert" who is able to answer questions and make individualized midcourse corrections. Not coincidentally, the loyal patient population thus gained is a major way for cardiovascular specialists to maintain a "seat at the table" in negotiations with either government or managed care.

"Principal care" is a term favored by many cardiologists and was recently deliberated by the House of Delegates of the American Medical Association. In such a model, the regular care for patients with chronic diseases is provided by subspecialists. The cardiovascular specialist is the major decision maker, working in conjunction with primary care doctors or other specialists. American College of Cardiology member surveys show that this model exists for at least 30% of our patients (9). I personally prefer the term "conjoint care," but the point is that patients need *both* a primary care physician and a cardiovascular specialist (10). This model has existed for many years and can work well, provided that there is good communication and acceptance of responsibility for the patient by both parties.

Managed care will continually seek what it perceives to be the least costly model for patient care. Therefore, we must strive to get our message across to employers, insurers, the medical industry and government. This is clearly a role that the ACC is playing and will continue to do so. Furthermore, our cardiology training programs must change to create more "general cardiologists" who are comfortable with caring for all types of cardiovascular disease and desire to provide long-term care. This may not include many interventional cardiologists, but should include most noninvasive cardiologists. General cardiologists are necessary to provide the link between the remarkable technology of cardiovascular medicine and clinical practice.

Finally, the College should work with the leadership of the American Academy of Family Physicians and the American College of Physicians to develop continuing medical education programs specifically designed for generalists. We should also work with these organizations to develop guidelines for referral to cardiovascular specialists, such as those developed by the California Chapter of the ACC (11). This will not be an easy task, but it is my opinion that the increased knowledge of cardiovascular disease by generalists is likely to lead to more appropriate use of the cardiovascular specialist, even in the managed care setting. Nonetheless, the ultimate responsibility for care of patients with cardiovascular disease must reside with the cardiovascular specialist if the remarkable gains in therapy of cardiovascular disease in the last 30 years are to be preserved and improved.

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