As cardiologists, we are justifiably proud of the care we deliver. We think that we are more capable than other physicians to render treatment to patients who have heart disease and that those patients will have better outcomes if we are their doctors. But what proof is there to support such a conclusion?

The crucial role of the cardiologist in patient care was dramatically underscored in a recent study by Norcini and colleagues (1). They investigated the outcomes of some 30,000 patients suffering an acute myocardial infarction (AMI) in Pennsylvania in 1993. These investigators set out to determine whether in-hospital mortality rates among AMI patients were affected by whether the attending physician was certified by the American Board of Internal Medicine (ABIM) as a specialist in internal medicine or in cardiology or was noncertified. The findings were striking. First, ABIM certification made a difference. Patients treated by certified physicians were 15% less likely to die than those treated by physicians lacking certification. Second, being treated by a board-certified cardiologist greatly decreased the likelihood of mortality compared with noncertified physicians or board-certified internists. Treatment by either a noncertified family practitioner or a certified internist, instead of a cardiologist, was associated with about a 25% increase in AMI patients’ mortality. Related to this finding is a correlation between patient volume and outcome. Norcini et al. (1) found that for every additional 16 patients with AMI a physician treated, there was a 10% decrease in mortality. Had ABIM-certified internists treated all of the patients in this study, the authors projected a savings of about 480 lives compared with treatment of all patients by noncertified practitioners. But had board-certified cardiologists treated all of the approximately 30,000 patients in this study, there could have been as many as 802 fewer in-hospital deaths, compared to treatment of all patients by primary care doctors.

Other groups have also investigated the impact of physician education and training on cardiovascular outcomes, and AMI is not the only condition examined. A literature search quickly yielded at least a dozen articles related to physician specialty and outcomes. Joining Norcini in a look at AMI outcomes were Jollis et al. (2), who merged information from Medicare and medical specialty listings in four states to assess the relation of admitting physicians’ specialty to the outcomes of their patients with AMI. They found that cardiologists were more likely than generalist physicians to use thrombolytic drugs and beta blockers, which may be why their patients did better. Patients who were admitted by a cardiologist were 12% less likely to die within one year than patients admitted by a primary care physician. These results confirm the idea that “expertise adds value” (3). Ayanian et al. (4) also conducted a study focused on AMI. They surveyed 1,211 cardiologists, internists, and family practitioners about four treatments shown by clinical trials to improve AMI survival and two treatments lacking evidence of effectiveness in AMI patients. Analysis of the survey results showed that cardiologists were more aware or more certain about advances in cardiovascular care than were internists and family practitioners. For example, 94.1% of the cardiologists—compared to 82.0% and 77.3% of internists and family practitioners, respectively—reported that they were likely to prescribe thrombolytics to treat AMI. Likewise, the cardiologists were less likely to prescribe the drugs lacking evidence of effectiveness.

There are findings in support of care by cardiologists for unstable angina and heart failure, too. In a southeast Michigan study of 890 unstable angina patients treated by cardiologists and internists, Schreiber et al. (5) found that the cardiologist-treated patients were more likely to receive effective medical therapy, including aspirin, heparin, and beta blockers, or revascularization procedures. The cardiologists’ patients also tended to have lower mortality rates.

Three recent studies have investigated treatment of patients with heart failure. Both Edep et al. (6) and Go et al. (7) found that cardiologists delivered care to heart failure patients that was more in line with published guidelines and evidence of effectiveness. For example, Edep’s group found that routine evaluation of left ventricular function was performed by 87% of the cardiologists in the 2,250 sample, whereas only 77% of the internists and 63% of the family practitioners/general practitioners routinely checked this symptom. Similarly, angiotensin-converting enzyme (ACE) inhibitors were more likely to be prescribed by cardiologists (80%) than the other physicians (71% and 60%, respectively). Go et al. (7) also noted increased use of ACE inhibitors among cardiologists as well as greater prescription of lipid-lowering drugs and lower short-term readmission rates. Baker et al. (8) also conducted a study on management of patients with heart failure. They found that family physicians were less likely than cardiologists to rate measurement of left ventricular ejection fraction as “very important,” to order an echocardiogram or test for ischemia, to identify...
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reduce medical errors, such as assessing the care we deliver the quality of the care we deliver. That means implementing this year.
must work to ensure that a patient's bill of rights is enacted (ACC) and the Patient Access Coalition to pass patient protections that permit—and even encourage—care by specialists. As I noted in my July president's page (9), we (10) makes a strong case for the conclusion that physicians who are ABIM-certified as internists and cardiologists experience better survival outcomes in the care of patients with AMI than do physicians who are not so certified. Furthermore, all of the above-cited studies strengthen the case for patients having access to specialists. We cardiolo-
gists are engrossed, day in and day out, in the intricacies of cardiovascular care. By our own choice and after years of specialized study, we become experts on the cardiovascular system—from the complex functioning of the normal heart to the devastating effects of a variety of toxins, such as high cholesterol and tobacco, and a panoply of diseases. Unlike internists and family practitioners, who must maintain more than a working knowledge of multiple human systems, we focus on cardiology. Each month, hundreds of medical journals disperse thousands of articles, many of them reveal-
findings that are directly relevant to patient care. As overwhelming as this volume can be, we cardiologists have the obligation (and some would say luxury) of selecting from the stacks those articles that focus on cardiology. Most of us also read selections from the more general medical journals, such as the Journal of the American Medical Association and the New England Journal of Medicine, so that we remain aware of the noncardiological issues facing our patients. But we do not have to maintain intimate knowledge of all of these areas. The needs of our patients—generally restricted to people with cardiovascular disease or risk for it—receive our undivided attention.

We do, indeed, have a great deal to be proud of. However, while these studies reinforce what we suspected all along—that patients with heart disease are best served when they are cared for by cardiologists—they also place on us a great responsibility. By demonstrating that care by specialists results in lower mortality rates, these studies beseech us to fight for patients' access to us. We must support the efforts of the American College of Cardiology (ACC) and the Patient Access Coalition to pass patient protections that permit—and even encourage—care by specialists. As I noted in my July president's page (9), we must work to ensure that a patient's bill of rights is enacted this year.

Similarly, we bear a responsibility to uphold and improve the quality of the care we deliver. That means implementing practice guidelines within our own practices and enabling the use of these guidelines within the health care environment as a whole. It also means participating in efforts to reduce medical errors, such as assessing the care we deliver as individual physicians against national benchmarks. Mea-
suring our own performance is indeed a good step toward maintaining and improving care. Physicians and, therefore, cardiovascular specialists, have the enviable status of embodying a profession that enjoys the "relative" freedom to regulate itself; this also means we have to guard our freedom by doing just that. Research has demonstrated that we deliver quality; we must make every effort to ensure that we continue to do so.

How can we do that? First, as a profession, we must demonstrate accountability. As Kassirer (10) has made clear, pseudoaccountability—self-serving and lax standards produced under the guise of accountability—will not do. We must promote actual accountability based on standards set "unimpeachably high" (10). That is how we will show the public that we take their trust in us seriously. Like the ACC, the ABIM is dedicated to the provision of the highest-quality care. Since the Board was founded in 1939, it has adhered to a set of core values with quality care at their root. First among these values is professionalism and excellence in the practice of medicine. Second is commitment to science-based medicine and intellectual rigor. This grounding in science supports the third value, promoting leadership in evaluation and standard setting. Finally, the ABIM is committed to maintaining its autonomy so that it can preserve these values for internal medicine and its subspe-
cialties. The ABIM provides one means for us as physicians to demonstrate our accountability as well as the excellence for which our profession is known. The Board's Continuous Professional Development (CPD) recertification process not only goes a long way toward meeting the expectations of the public, but it also demonstrates our individual commitment to professionalism, excellence, and rigor. By partici-
pating in this ongoing—in fact, lifelong—process of testing ourselves and improving ourselves, we will both improve care and show the public that we are vested in continuing scholarship. As an ABIM director and Chair-Elect, I am personally recertifying (even though I have a time-unlimited certificate; as a matter of fact, the entire Board of Directors of the ABIM is voluntarily recertifying). I recently com-
pleted the CPD module on peer/patient assessment. It was an excellent experience—one that put me in touch with my colleagues and my patients in an entirely new way and helped me to examine my own skills. I urge all of you to embrace the CPD recertification process.

We also have a duty to educate our patients and the public about their cardiovascular health. If consumers are to turn to us for the very best care when they are sick, then we must help them to maintain their health when they are well. The ACC took on this challenge as an organization last year when it joined with the National Football League and Merck & Co., Inc., to teach the public about the hazards of high cholesterol and how very important it is for everyone, even people who feel healthy, to have their cholesterol levels measured. Now, the College is working with the World Heart Federation to promote "a heart for life." September is World Heart Month, and September 30 is World Heart Day. Throughout this month, and especially on World Heart Day, organizations around the world will be spread-
ing the word about the risk factors for heart disease—still the number-one killer of men and women throughout the world. The College is helping by making available to its chapters and members an easy-to-read patient booklet that explains the risk factors and how cardiologists treat heart disease. As individuals, we cardiologists can participate in this effort by working with our chapters to teach the public how to prevent and manage cardiovascular disease. And as the world’s experts in cardiovascular disease, that is precisely our responsibility.

NOTE

For more information about the College’s patient booklet, *Caring for Your Heart: Do You Have the Facts?*, contact the ACC Resource Center at 800-253-4636, ext. 694.

REFERENCES