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Presidential address: Dead wrong—thinking about...thinking about... health care

Josef E. Fischer, MD, FACS, **Cincinnati, Ohio*

From the Department of Surgery, University of Cincinnati College of Medicine, Cincinnati, Ohio

I AM DELIGHTED TO HAVE SERVED as your President this year. This is a wonderful organization and embodies characteristics I hold dear. This organization is composed of bright, warm, caring surgeons with excellent camaraderie who are interested in patient care. Many of the spouses of the members are also good friends, which adds greatly to the organization and brings a special pleasure in serving as your President. And speaking of spouses, let me thank my friend and helpmate, Karen, for her companionship, love, and support over these past almost 40 years. As many of you have astutely noted to me on several occasions, without my better 7/8ths, as many of you call her, I'd be nowhere. To my family, thank you for love and support during the difficult times.

I am also delighted to see the turnaround in the organization, the presence of new young members, the competitiveness of the program, as well as a newfound spirit about which many of us were concerned several years ago. Many of you sitting here today have participated in initiatives that made the turnaround possible.

Today I would like to focus on some of my concerns as surgery goes forward in the next millennium.

It is ironic that at a time when this country and a good part of the developed world are experiencing unparalleled prosperity with increased income and disposable funds for development and investment, that in medicine this is sorely lacking. Physicians have sustained tremendous cuts in their income, and especially surgical care is being reimbursed at a lower level each year. Various third-party payors attempt to deny payment post hoc for care already rendered by stipulating noncontributory components of evaluation and management exams and technical walls such as waiver letters and referral letters, the absence of which, even if

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*Christian R. Holmes Professor and Chairman.

Reprint requests: Josef E. Fischer, MD, Department of Surgery, University of Cincinnati, PO Box 670558, 231 Bethesda Ave, Cincinnati, OH 45267-0558.

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one has rendered care, one will not be paid. For those of us in academic surgery, this has largely deprived us of the ability to take bright, young, aspiring people and start them off in the research so important to our future, while at the same time providing for their development for the first 3 or 4 years until outside peer-reviewed funding can be sustained.

However, what is most troubling to me is the degradation of the profession. The economic paradox, while damaging, is at least acceptable, as it represents the return of the medical profession to its historical middle-class status. In Boston, for example, at the turn of last century, physicians entered stately homes through the tradesmen's entrance. This change in economic status will ultimately result in diminution in the quality of medical care as well as the inability to keep up technically. What bothers me most, however, is that the degradation of the profession is a response by society to its perception of medical care. In retrospect, the country experienced medical care in a way that was not salutary, that was not satisfying, and that did not meet its needs. In short, the country responded to corporate medical care or to our overall approach to medical care in a way that suggested that not only was it dreadfully unhappy with what was transpiring, but that the quality of what it was receiving was wanting. While one cannot discount the globalization of business and that business was unwilling to pay health care costs that were much greater than its global competition, whose health care costs were distributed on a much broader governmental base, it seems that society decided it was no longer suitable to continue to reward physicians at the economic level at which they had been rewarded in the past. To be sure, not everyone regarded their own physician as rendering poor-quality service, but it is clear that in looking at the entire system, the country as a whole—and patients in particular—regarded the system as arrogant, out of touch, too expensive, and not of the expected quality.

How did this happen? In order to understand how this happened, one must go back to the way in which we educate and train physicians. I could argue, for example, that the emphasis on admitting science majors rather than liberal arts majors to medical schools, a change that began in the middle 1950s, resulted in trying to educate physicians who did not know their place in the world and could not really come to grips with humanity's place in the world, as opposed to a liberal arts major in whom this is inculcated during college. This resulted in production of a technocrat, a physician who viewed individuals in terms of diseases rather than the entire patient. However, it is not that simple. The medical educational system has, in my view, been held captive over the past 30 to 35 years by a group and by a philosophy that did not reward patient care or excellence in patient care. If one were to look at the academic medical centers of the 1960s, 1970s, and 1980s, it is clear that the clinical departments that were assigned the principal role of turning medical students into physicians, our future workforce in medicine, were driven by a philosophy in which patient care, and especially excellence in patient care, was downgraded. Medical care was relegated to those who could not "cut it" in what was thought to be important—research. The excellent clinician, the "Mr Chips," the clinical hero that residents and medical students looked up to, was relegated to the sidelines. I remember my wife Karen, the daughter of a highly respected surgeon, being appalled while sitting next to an excellent internist at dinner who said that the reason that she was relegated to patient care was because she wasn't "smart enough to be on the A-team." Patient care was something to which she was relegated because she did not belong to the scholarly, pure-bred group. I also recall that a number of years ago, the long-time dean of an excellent medical school visiting our own medical school told me in our discussion of standards that while surgery set the standard of patient care at an institution, it was internal medicine that set the intellectual level of the college of medicine. It was interesting to me how he separated the two, that patient care (yes, there was patient care) was not really the province of those who were the true "high priests" of medicine and medical schools—they had their eyes fixed on a loftier goal, leaving medical care to those who could not participate as "class A citizens." Oh, yes, there was some participation: the one month on service in which someone who had very little experience with a given disease state acted as a traffic director, getting one consult after another, and sitting at morning report interminably reviewing problem-oriented histories, but never actually making rounds and seeing the patient. In most departments of medicine, the true anointed do not hold mortality and morbidity conference, a conference at which patients who did not do well had the reason for their failure examined in a critical way. No one—no one except perhaps the fourth-year student on service and the intern—looks at the patient, examines them, and asks a single question: Is this patient doing well? Is this patient as a whole feeling better? No. The unfortunate patient is dissected into 12 problem-

oriented areas, but no one—no one—looks at the patient as a whole.

I thought at the time that this was very curious conversation. Here was one of the leaders of medical education giving up the high moral ground intentionally without a struggle. Going to a military analogy, it was almost as if Gen John Buford, attached to Reynold's 1st Corps, would have given up Seminary Ridge without a struggle at the Battle of Gettysburg, and later Logan, Hancock and Meade, the Union commander at Gettysburg, intentionally abandoning the high ground at Cemetery Ridge, which enabled their victory.

Have you noticed that the educational elite of medicine, those leaders at our colleges of medicine who are responsible for the education of our medical students, have almost never come forward with an initiative that deals with patient care? How many times have any of you seen an initiative, a major speech, or a proposal that emphasizes patient care from that group? Research—yes. Other scholarly activities—yes. Desires for money—always. Patient care— almost never. Indeed, we in colleges of medicine and university hospitals have been told that we can't compete, that we are too expensive, that we can't do as well with our patient care as do community hospitals, that the education of medical students must perforce be delegated to those who are less expensive (in the community hospitals) and to whom, therefore, we entrust the teaching of our medical students. All that brainpower, all those elites, all those superior human beings, all those class-A faculty, and we can't compete. We can't put that superior intellect to work to compete. We just abandon the field.

So it's pretty clear, in retrospect, that the public's perception was correct. What they perceived was a group of individuals entrusted with setting the tone of medical care, and especially with the education of the future physicians of this country, who simply did not set a priority on achieving first-class medical care. Why? Because there was no interest. It wasn't and isn't on the radar screen. The public perceived this and simply stated that what they were getting wasn't worth the money that they were paying. Was the public correct in its perception? Absolutely.

Almost in response to this perceived lack of interest in medical care, we viewed the emergence of a new era of scholarly activity in medicine, so-called "outcomes research." Colleges of medicine and departments of medicine have discovered it and have established institutes. The NIH has discovered it. I must say that I am confused by outcomes research. I am always confused about "outcomes," which the internal medicine establishment has seized upon as the bright new day of their interest in patient care. Surgeons have also jumped on the bandwagon. This is even more difficult to comprehend. Isn't this what surgeons have been doing for decades? Hasn't surgical clinical research always emphasized risk-benefit ratios, ways in which surgery could be improved, comparison of different forms of treatment, and outcomes, mortality, and complications? Samuel Gross reported results in Philadelphia in the mid-19th Century and insisted that others do the same. Emery Codman got thrown out of the Massachusetts General Hospital for insisting on "end results" and founded the end-results hospital. However, instead of saying that surgeons had been doing outcomes research all along, we bowed to the new idols, were intellectually cowed, jumped on the bandwagon, and said that now we too have learned how to do outcomes research. Certainly, there are some aspects of the new fetish that are different than what we have traditionally done, but the same basic principles have applied: We seek the most cost-effective, most direct, and most beneficial outcome to a given disease state, given the choice of a number of alternatives. What is remarkable is that we have bowed down to the idol erected by people who have spent their lives avoiding patient care, who have spent their lives not practicing but observing the results of practice, and never really indulging in combat, all with the courage of a noncombatant and all the reserve of the intellectual seer who observes the battlefield from a distance.

Such attention to outcomes and the new fetish convinced the various well-meaning foundations that this is the proper way to instruct students in patient care, that this is the proper way to do research concerning patient care. Much treasure has been expended by the well-meaning foundations in an (in my view, misguided) attempt to improve patient care.

When I finished my residency, I had expected that, with an intellectual bent and a desire to do research, I would apply and hopefully attain a grant from the Markell Foundation to be a Markell Scholar. For those of you who do not remember the Markell scholars, the Markell Foundation was extraordinarily important in providing those destined to be the leaders of American academic surgery with research support during their initial 5 years out of residency. The Markell Foundation provided funds for technicians, supplies, and some for salary, so that they could devote their time to scholarly activities and research. Unfortunately, just about the time that I finished my residency

and was to apply, the Markell Foundation decided that its funds would be better spent by supporting Sesame Street. Not that Sesame Street wasn't important, but what the Markell Foundation had previously done was very important. So I never became a Markell Scholar. Fortunately, there was someone at the Massachusetts General by the name of Davey Crockett whose job it was to get people like myself, who were interested in research, some funding from elsewhere. I felt very much protected, and we tried mightily over a period of a year without success, but by that time I had secured an NIH grant and was able to carry out my research as I had hoped.

But let us look at what the foundations have done since 1969, at the amount of money that has been spent, and what it has accomplished. I have reviewed the enormous expenditure of funds of the Robert Wood Johnson Foundation and of various other foundations, reviewed a number of the proposals, and wondered what the outcomes were. It is of course possible that some good has resulted. However, if one looks at the enormous expenditure of funds on such projects as (1) Prospect Associates, Rockville, MD, $51,588 for "Feasibility of involving major league soccer in preventing tobacco use by youth" (for 7 months, ID #30913); or (2) Points of Light Foundation, Washington, DC, $475,000 for "The Citizens Service Summit: Connecting Americans to get things done for the next generation" (for 5 months, ID #30843),[1] one wonders whether any good resulted. Is there any reason for such research activities other than to provide employment for some of the friends of those people who direct such foundations? Will anything good result from an investigation of the following? (1) Religion in American Life Inc, Princeton, NJ, $49,506 for "Invite a friend project" (for 1 year, ID #30935); or (2) Investor Responsibility Research Center, Washington, DC, $424,479 for "Tracking the tobacco stock divestment issue" (for 2 years, ID #29765).[1]

Yes, we've done a lot of thinking about how to think about medical care, but I don't think we've improved medical care one whit despite the expenditure in the past 15 years of literally billions of dollars.

How did this happen? How was this enormous expenditure of funds sanctioned without improving the lot of patients, without improving the way in which our students are educated, or the way in which our patients are cared for? I think the reason is very clear. We have left the fox in charge of the henhouse. The very same people who gave up the intellectual and moral high ground in the care of patients, the care and feeding of medical students, and the education and orientation of medical students toward patient care are the same people who determined the directions of the foundations. Is it any wonder, therefore, that very little is directed in any way, shape, or form at improvement in patient care? Yes, we talk a lot about delivery, and we talk about access, and we talk about outcomes, and we have spent a king's ransom in pursuing thinking about thinking about medical care. We have spent a fortune in talking about health delivery to underprivileged populations, which is important, to the poor and near-poor, which is also important, and concepts by which medical care can be delivered. What medical care are we delivering? Aren't we delivering the same substandard class-B, disinterested, type of medical care that academic medical centers and academic leadership of academic centers have dispensed to the indigent for the past 40 years, with the month-on-service participation of individuals who have little interest and less experience in excellent patient care? Yes! Will any benefit derive to patients given the intellectual snobbery of the so-called intelligentsia of American academic medicine and their view of high-quality patient care? High-quality patient care in most academic medical centers remains the province of those who "can't hack it as 'Class-A' citizens" and are not rewarded in the mainstream, and it is highly unlikely that those individuals will provide a renaissance and an improvement in the public's perception of either the education of physicians or the type of quality the public expects to receive. As long as that is the case, our economic lot and the priority that the public places on organized medical care in this country will be dismal. And, regardless of NIH funding increases, those young people who apply for grants will simply not exist.

Is there anything that can be done about this sorry state of affairs? I believe there is. I believe that we have real opportunities. Not pie-in-the-sky opportunities and pronouncements about things that we can do that are really not achievable, but achievable opportunities that are well within our grasp.

First, we have an opportunity with respect to patient care as far as managed care is concerned. I believe, and some of my faculty think I am delusional, that managed care is dead. Not moribund, but dead. To understand why it's dead, we must first examine the working hypothesis. The working hypothesis was that there was enough fraud, waste, and inefficiency in the system so that care could be managed, and in doing so, there were 5 axioms—that if one cut out all the fraud, waste, and inefficiency, costs would decrease and in fact:

(1) There would be no decrease in quality. In fact, quality would be improved.

(2) There would be no decrease in access. In fact, access would be improved.

(3) There would be no change in the demographics or quality of those going into medicine. Therefore, the quality of medicine would not diminish because of an improved pool of individuals going into medicine.

(4) In cutting costs, generalists could substitute for specialists, and physician extenders could substitute for generalists without decreasing the quality of care.

(5) Professionals could be treated as employees and still act as professionals.

Our medical schools, again in the grip of those who had little experience with practice, bought into these hypotheses and responded by changing the mix of the medical school product to generalists, including general internal medicine, family medicine, pediatrics, and in some cases obstetrics and gynecology. Medical schools were rewarded for doing so by state legislatures and by foundations. Redistribution of income from specialists to generalists became national policy:

> The trend in practice expense relative value units redistributions under a resource-based system is clear, and section 1848(c)(2)(G) of the Act is another step in that progression, consistent with the preceding redistributions that the Congress mandated in 1993. The direction of payment changes for major categories of service—increases for medical visits and reductions for surgical procedures— has been mandated by the Congress, implemented by health care financing administration, and known to the public for some time. The exception of office-based services from the 1993 practice expense RVU reductions clearly indicated that the Congress intended a relative redistribution toward those services. While the Congress could not know, on a procedure-by-procedure basis, the impact of the new resource-based system, it was cognizant of the general direction of a resource-based system before it enacted section 121 of the Social Security Act Amendments of 1994, mandating resource-based practice expense RVUs.[2]

The public, on the other hand, has discovered in relatively short order that things are terribly amiss. First, the public has discovered that managed care is essentially discounted fee for service, and secondly, denial of services, or rationing (the "R" word). In addition, the public thinks that the new care paradigm is lousy. In response to the public's clamor in attacking managed care, the legislators, including the US Congress, seem finally to have discovered that something is terribly amiss, and patients' "bill of rights" abound at both the federal and state levels. These have as their components appeal mechanisms and stipulations as to procedures and services available as well as the length of stay. In the professional liability (malpractice) area, awards for failure to diagnose, failure to refer, failure to take timely action, and preventing patients from seeing specialists by now far exceed the suits for untoward events following surgical procedures.

Let us now examine what the public thinks of the 5 axioms:

(1) The public does not think that quality has been improved. The public thinks that quality has suffered.

(2) The public does not think that access has been improved. The public is livid about their limitation of access.

(3) Are more people going into medicine? Entire segments of the student population have now abandoned medicine. Those who have gone into medicine will probably never be able to pay their debts incurred in obtaining a college and medical school education.

(4) Do professionals treated as employees continue to act as professionals? No. They act as employees and will continue to act as employees. Physicians who can afford it are retiring early. Second, and more important, is the effect on indigent care. Professionals get up in the middle of the night and take care of indigent patients when they don't get paid; employees do not. I would predict that there will be an enormous crisis in indigent care within the next 5 or 10 years.

(5) What about the concept that generalists can substitute for specialists, and physician extenders for generalists? The public has been very loud and clear on this. They will trust generalists or even physician extenders to measure their blood lipid, counsel them as far as weight reduction, prevent and care for their hypertension, and screen for diabetes. They also expect their generalist to be able to recognize when they are truly ill or have a life-threatening disease such as cancer. Once they understand that they are ill or have life-threatening disease, they want no part of generalists. They want specialists, and they want highly trained specialists.

The public is increasingly better informed with the Internet. Some of the material they obtain is reasonable and some is unreasonable, but in time they will learn how to sort out what is correct and what is incorrect.

With respect to primary care, my own belief is that over the next 5 or 10 years, primary care will no longer be done by physicians. Advanced nurse practitioners will do most of the primary care. Indeed, 3300 advanced primary nurse practitioners graduated last year, and by 2006 there will be

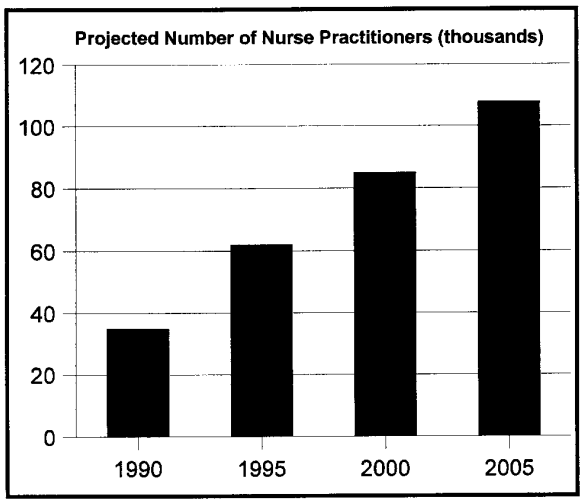

Fig 1. An estimate of the number of advanced practice nurses that will be graduated in the United States during the next 5 to 7 years. Note that by the year 2005, there will be approximately 120,000 advanced practice nurses in this country, many of whom will be doing primary care. (Source: Cooper RA, Land P, Diefrich CL: Current and projected workforce of nonphysician clinicians. JAMA 1998; 280:78.)

120,000 advanced nurse practitioners, most doing primary care (Fig 1). The State of New York, working with the Columbia University School of Advanced Practice Nursing in what I believe is a landmark step, licensed an advanced primary care practice nursing site without physicians, giving them the right to do everything that generalist physicians will do. In a recent study in New York, patients cared for by advanced nurse practitioners did as well as those treated by primary care physicians. I do not know what will happen to all of the generalists that the medical schools are educating.

With the public's demand for well-trained specialists, we have an opportunity, and the opportunity is not a pie-in-the-sky opportunity; it is an opportunity that is well within our grasp to seize. That is, as well-trained, highly motivated specialists, we have the opportunity to do what we are perfectly capable of doing: giving first-class, committed patient care with excellent communication. We also have the ability within our colleges of medicine to point out to the medical students and to the residents what a real doctor is about and how a real doctor takes care of patients. To the medical students, we can provide excellent role models. And we should include our colleagues in the community to allay the medical students concerns with respect to the academic surgeon's lifestyle.

There is a new movement called "professionalism." It involves knowing one's place in the world, communicating with patients, the ability to write and communicate, and the ability to view patients as human beings. I must say that I am confused about this. Isn't that what colleges do with liberal arts majors, and isn't that the group we turned away from years ago?

With respect to our training of residents, we need to pay attention to and enforce standards. The Board and the Residency Review Committee simply do not have to do anything other than enforce the standards that currently exist. If we do, we will produce a superior surgical product, and we will stop sustaining training programs that produce a substandard product, which the public increasingly recognizes as such. The public will once again begin to trust its physicians and its surgeons, and the degradation of the profession will cease.

To the public, to the Congress, and to the world at large, medical and surgical specialists must give a single, monotonous, boring, but repetitive message: Specialist care is better. Specialist care is more cost-effective. Specialist care provides not only shortterm cost-efficient care, but in the long term provides most cost-efficient care. Fifty percent of the health expenditures of this country are spent within the last 6 months of life. Early discovery of carcinoma of the colon or carcinoma of the breast, and earlier proper treatment of these diseases, as well as all other diseases, as has now been very well documented, result in lower costs both short-term and long-term. Perhaps the foundations would care to fund, although I doubt it, a study of whether generalist care and specialist care is more effective in the long term. A number of studies, including asthma, coronary heart disease, etc,[3-9] have now shown that specialist care is more cost-efficient than generalist care.

We need to provide leadership in our colleges of medicine. For many years, surgeons, with a few exceptions, have eschewed leadership of academic medical centers. As surgeons sat around the table and talked about deans, they never saw themselves as deans and they never saw themselves as individuals who might aspire or actually lead academic medical centers, providing first-class patient care and making excellent patient care a priority. Not to the detriment of scholarly activity, but to raise patient care to the same level of priority. In many medical centers, vice presidents and deans have pronounced at the inauguration of their new office and tenure that the medical center would be directed to be in the top 20 as far as research and

Fig 2. The famous Winslow Homer painting *The Gulf Stream* (1899). Note that the mast has snapped, the ship is rudderless, and sharks are circling. The analogy is meant to signify Medicine's current status. (With permission from the Metropolitan Museum of Art, Catharine Lorillard Wolfe Collection, Wolfe Fund, 1906. Photograph © 1995 The Metropolitan Museum of Art.)

NIH funding was concerned, never ever saying or even suggesting that excellent patient care was a priority of that medical center. Frank Spencer once noted that the difference between a class A and a class B medical center is the generosity of the community in which it exists (personal communication). In fact, such generosity is most likely to result from individuals of wealth who may know that research is important, but who understand they have been the beneficiaries of first-class medical care at that medical center.

My thesis, in conclusion, is that surgeons are risk-takers who clearly see patient care as the center of medical education, who see excellent patient care as the center of medicine, who see patient care as not something one does as a sideline one out of every 12 months, acting mostly as a traffic director, but something one does constantly, striving for excellence. My thesis is that such surgeons should aspire to the leadership of academic medical centers to help determine the way in which medical students are educated. Such individuals would be able to redirect the way in which academic medical centers think about patient care and to raise them from ones in which patient care is just an afterthought to ones in which it is of highest priority, that the class-A citizens do first-class patient care, not the class-B citizens, that individuals who aspire to be class-A citizens are treated with respect and dignity—yes, and even promoted, and that promotion and tenure committees pay attention to excellence in patient care as well as weigh the papers of those who come before them; that even quality institutions may grant tenure to excellent clinicians.

This has begun to happen, and the purpose of this address, and much of the leadership of American surgery here, is to encourage and call for continued development of surgeons as leaders of academic medical centers. Surgeons need to think consciously of other surgeons when searches for deans and vice presidents are initiated, not think of internists, pediatricians, or radiologists who have spent most of their lives trying to avoid patient care once their training is complete, but to think about someone who is actively interested in patient care. I know this runs counter to the grain of individuals who believe that patient care is the only true calling, but the damage that has been done from our not getting involved as deans and as vice presidents, and therefore not getting involved as the directors and members of the boards of various foundations, has been devastating. It needs to change.

The ship is rudderless. As the Homer painting indicates, this is organized medicine (Fig 2). The mast has snapped; there is no sail, no way to steer the ship. The rudder has not been seized, and the outcome is clear. The sharks are circling. If the

rudder is seized, if the mast is rebuilt, if there is some purpose with respect to the primary role and goal of academic medical centers toward providing the best patient care, competing in the most cost-efficient way and not relinquishing the high ground to other individuals, then we have a chance of bringing the ship to port. If the rudder is not seized, if the mast is not restepped, if no one steers the ship, then the outcome is as clear for medicine as it is for the poor individual on the deck of the rudderless, dismasted ship in Homer's painting.

Surgeons can provide that leadership, putting patient care where it belongs, at the center of our colleges of medicine and university hospitals. If we do that, we have an opportunity to regain the trust and the help of the patient population in the United States. We can renew the intellectual capital of our once great, but now pitifully degraded, profession. And rather than being the one institution that is poverty-stricken at a time of great prosperity in this country, we will, perhaps, share in that prosperity, both intellectually as well as otherwise.

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