

Embracing the Sub-Sub Specialists

I have a friend and colleague named Raisa Lev, M.D. She's a bright, young, warm and friendly physician full of energy and enthusiasm. Dr. Lev also happens to be a "neurorad interventionalist". This means that she is a radiologist who is specially trained in neuro-radiology (the study of brain imagery and diagnostics) AND she is also trained as an interventionalist (a physician who does procedures on patients through the use of catheters, stents, etc). The type of patients that Dr. Lev diagnoses and treats include brain cancer patients, patients who have cerebral aneurysms, patients with arterio-venous malformations of the brain, patients with blocked carotid arteries, etc.

Dr. Lev, a BayCare Clinic physician, is the only physician of her kind in the Greater Green Bay area and probably 1 of only 6 in the state. She is also one of a growing number of physician specialists who are considered "sub-sub specialists". This means that they are specifically trained in a very complex niche of diseases that we treat in healthcare today. As medical research advances, the fingers of medical knowledge grow and extend into greater depth in a multitude of areas, and as this knowledge-base grows, so does the need for physicians who treat patients with complex disorders in these specific medical niches.

Another example of a sub-sub specialty is Dr. Alan E. Beer, an OB/Gynecologist who specializes in obstetrics, sub-specializes in fertility disorders, and then sub-sub specializes in fertility disorders caused by the immune system. He runs a Reproductive Immunology and Genetics clinic based in Los Gatos, CA.

We're finding that many young students entering medical schools today may be practicing in the near future in specialties, sub-specialties, or sub-sub specialties that don't even exist yet. This is an exciting thing, and yet a challenging thing. As we navigate through the upcoming health reform, we need to be very cautious that we continue to provide positive incentives for research and development, constantly reassess our physician supply and demand, and pave the way for new training programs to provide the physician talent that we need that can take advantage of these new and exciting disciplines.

How do we do this and yet maintain a fiscally viable health system within the U.S.? The answer is through pragmatic health reform. We are missing the boat in my assessment of the health system overhaul so far. We should be concentrating on seeking value for our precious healthcare dollar. Important value-based questions need to be asked in this order: How can we best prevent disease? How can we prevent injury and accidents? How can we improve our treatment for acute and chronic disease? How can we avoid unnecessary treatment? What is the most reliable but lowest cost treatment which will yield good results? How can we reform the health system to aggressively pursue these value-based solutions? How can we incent the behavior we want within the system?

Why waste time fighting about a public option or expanding on Medicare, Medicaid, and SCHIP? The real savings in healthcare is in answering these value questions and applying the answers to all Americans. We need to lay the groundwork for a future which continues to support research and development, that carefully manages the physician supply and demand curve, that allows for the creation and training of sub-sub specialists, that cuts waste out of the system, and that embraces the diversity of the population with its varying reactions to standard treatments. If we do this well, there will be plenty of dollars to cover the uninsured, but the uninsured must be incented to do their part also. This includes maintaining their own health, and paying their fair share of the costs of a system in the midst of transformation.