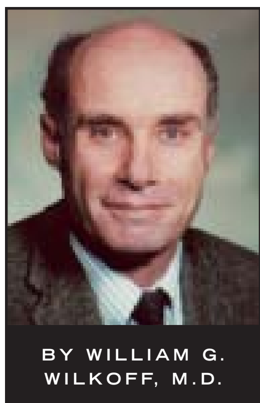

BY WILLIAM G. WILKOFF, M.D.

LETTERS FROM MAINE

In Short Supply

"Sure, we can see your patient. How about 2 o'clock tomorrow? But if you think he needs to be seen sooner, send him right over and we can squeeze him in." Those are words that can make any harassed and worried primary care pediatrician feel all warm and fuzzy inside.

Even if you are pretty sure the patient is healthy, it's a great relief when someone else agrees to share the burden of an overanxious parent. Unfortunately, none of us has the luxury of working above a completely impermeable safety net of willing and accessible subspecialists. A lot has been written and said about the "open access" practice model for primary care physicians. In theory, it makes sense, and with some simple modifications it has worked well in our office for more than a decade.

> **A few saintly subspecializing physicians are so well organized or compassionate that their receptionists can offer timely rescue service to my patients.**

But for a variety of good and bad reasons, the easy-open-door policy doesn't seem to work well for most subspecialists. I can see why the depth and complexity of the problems they see may dictate that their initial office visits be time-consuming. Nonetheless, there are a few saintly and busy subspecializing physicians who are so well organized and/or compassionate that their receptionists can offer timely rescue service to my patients.

I'm not sure how they do this, but I suspect that they do what I do when I feel swamped: I temporarily suspend my usual practice of doing a complete exam and history on every new patient. I try to ferret out the patient's primary problem and his parents' overriding concern and begin the process of getting to the bottom of it. I reassure the family that when we have time I will address all of their concerns, but I tell them that to squeeze them in today I will have to temporarily narrow my focus. Most families are so happy to be seen promptly that they are more than happy to accept my triage approach.

When I stumble across busy but easy-access subspecialists, I try to treat them as I would fine wines. I call on them only for special occasions and send them concise and focused histories. They also receive thank-you notes and some of Marilyn's baked goods at Christmas.

But despite our careful husbandry, my partners and I still must live with critical shortages in some subspecialty areas. If you share our pain and frustration, I urge you to read Dr. Daniel Goodman's commentary, "The Pediatric Subspecialty Workforce: Time to Test Our Assumptions," in the December 2006 issue of Pediatrics.

Dr. Goodman doesn't claim to offer any solutions. But he poses a collection of thought-provoking questions, the answers to which may lead us out of the woods. For example, he wonders if fellowships need to take 3 years or sometimes longer. Is a niche always so deep that a subspecialist in training must invest what could be productive time exploring every abstruse nook and cranny?

Could providers with a modest amount of training learn to care for the bulk of a subspecialty's patients? Unusual and complex patients could be bumped up the ladder to a few master subspecialists.

In selected subspecialties, why can't physicians who were originally trained to see adults broaden their practices to include children? I don't think we have to worry that this change would herald the demise of general pediatrics.

If we read Dr. Goodman's commentary with an open mind and join him in thinking outside the box, we may have some solutions to the subspecialist shortages. Until then, I'm going to continue writing effusive thank-you notes and encourage Marilyn to keep baking her scrumptious cookies. ■

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