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MIDC METRO INFECTIOUS DISEASE CONSULTANTS

Town or Gown? ID Needs Both

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Submitted: 28 September 2023, accepted: 24 October 2023, published: 31 December 2023

How to cite: Segreti, J. Town or Gown? ID Needs Both. *Priv. Pract. Infect. Dis.*, 2023, 3(4): 11; doi:10.55636/ppid3040011.

In 1978, Robert G. Petersdorf, MD, made the statement that the war against infectious diseases had been won and that additional ID specialists were no longer necessary. He went on to say that if additional specialists were trained, they would end up culturing one another [1]. He continued that: Infectious disease is destined to function best as an academic specialty whose trainees should pursue careers primarily as investigators. The number of clinicians leaving training should be reduced and not further glut the marketplace; they should be based in academic divisions and devote their clinical time and effort to the care of complex referral and to indigent patients [1].

Fortunately, these predictions did not transpire. ID specialists in private practice and in academia have proven to be essential in the management of complex patients with HIV, SARS-CoV-2 infection, multi-drug resistant bacteria, and emerging high-consequence infectious diseases such as Ebola.

Antibiotics stewardship and Infection Prevention programs would be much less effective and robust if not for the active involvement of ID specialists. In addition, the involvement of an ID specialist has been shown to improve quality of life and even survival in patients with *Staphylococcus aureus* bacteremia, candidemia, and HIV, and the list of such examples continues to grow.

However, today, we are faced with dire predictions for the future of infectious diseases [2]. Over the past decade, ID fellowship programs have failed to fill their open positions. ID has also been perceived as a specialty with low professional satisfaction and has consistently ranked poorly in terms of professional pay and burnout. The underlying reasons are certainly very complex and include changes in immigration policies, hospitals and insurance companies undervaluing our specialty, and the massive debt load experienced by graduating medical students and residents.

In this issue of *Private Practice Infectious Disease*, Petrak et al. describe a private practice model in which partners and employees not only considered themselves well-compensated but also had very high job satisfaction [3]. This is likely the result of aggressive practice management to optimize reimbursement that, in turn, allows the practice to attract high-quality clinicians. This has

allowed the practice to offer flexible schedules and the assistance of physician extenders that likely lead to better job satisfaction.

Obviously, not all private ID groups can match these results. However, this report suggests that if we want more medical students and residents to express an interest in pursuing a career in ID, such a practice opportunity should be presented as an option. In fact, medical schools, residency programs, and fellowship programs should encourage trainees to experience private practice ID so that they may judge for themselves whether it is worth pursuing.

Unlike Dr. Petersdorf, we must not favor gown over town careers. If ID is to survive and flourish, it will need both.

Funding: This research received no external funding.

Conflicts of Interest: The author declares no conflict of interest.

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