Subspecialization in Community Pathology Practice

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I have spent more than 30 years practicing community anatomic and clinical pathology. During my career, I focused my personal practice on different subspecialty areas at various times, depending on the needs of my pathology group. These areas included breast pathology, gastrointestinal pathology, clinical chemistry, hematology, gynecologic cytopathology, information technology, and fine-needle aspiration. This varied career has been deeply rewarding for me, both personally and intellectually, and I believe that I have served our community's clinicians and patients well. I always rejected arguments that subspecialists could do a better job.

But during the past several years, I have changed my mind. I now believe that in the future, most community pathologists will need to practice as subspecialists, and my kind of career path will become obsolete. Community pathology will come to resemble the way subspecialty pathology is practiced in many academic centers.

Why? The unabated information explosion in pathology and laboratory medicine—including genomics—is making it impossible for generalist pathologists to effectively play our role as the "doctors' doctor" across the spectrum of anatomic and clinical pathology.

More and more of the clinicians we serve are subspecialists, and if they are going to continue to turn to us for diagnostic and consultative services, we must possess corresponding subspecialty expertise in pathology and laboratory medicine. The breast surgeon needs a breast pathologist; the endocrinologist needs a pathologist with deep knowledge of clinical chemistry; the infectious disease specialist needs a microbiologist; and so forth. A generalist pathologist simply cannot command a sufficient depth of subspecialty knowledge to adequately serve these clinicians. Primary care physicians and physician extenders will also expect subspecialty expertise from their pathology group, just as they expect it from their clinical subspecialty consultants.

How will pathology groups achieve full subspecialty coverage? Only the largest groups will be able to do it internally. But other groups can provide full coverage by contracting with outside subspecialists, who, through electronic connectivity including telepathology, will provide real-time diagnostic, consultative, and interpretive services in anatomic and clinical pathology. Such electronic networks (which could be termed "virtual practices") will enable even small pathology groups to provide coverage across the full spectrum of pathology subspecialties. Conversely, the network will allow a small pathology group to have its own subspecialty practice by selling its services to other groups in the network. For instance, a 3-person pathology group might include members with subspecialty expertise in cytopathology, gastrointestinal pathology, dermatopathology, and gynecologic pathology. Through the network, the group could access sufficient cases for a full-time practice in these areas. In turn, the group would use remote subspecialists in the network to sign out its cases in other areas of anatomic pathology, as well as provide clinical pathology consultations and interpretation. At least one intergroup pathology network already exists.[1]

When fully developed, networks will include multiple pathologists for each subspecialty. For example, there will be no reason for anyone to look at a brain frozen section except for a network's neuropathologists.

Generalist pathology skills will remain sufficient to deal with some types of cases, but my guess is that this generalist core will get smaller and smaller over the years.

Community pathology groups lacking subspecialists will need to invest in subspecialty education of their members—for example, through providing sabbatical leave to pursue fellowships or other forms of training.

Many, if not most, younger pathologists possess subspecialty expertise through fellowship training. However, I question whether fellowship training grafted onto 4 years of residency is the most cost-effective route to subspecialty expertise. I would welcome input on this point from my colleagues responsible for resident and fellowship training programs.

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It is not just our clinical colleagues who will demand subspecialty expertise in pathology. We all know that our health care system is undergoing a massive shift in its reimbursement paradigm, from payment for quantity to payment for quality. In this new paradigm, insurance companies, hospital systems, and other payers will ask, why pay for a generalist interpretation or diagnosis when real-time subspecialty services are available at the same cost?

Reference

1. Herriman LEJ. *Promising Practice Pathways*. Northfield, IL: College of American Pathologists; 2012:366. http://www.yourpathyourchoice.org/. Accessed January 31, 2014.

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Dr Sarewitz practiced anatomic and clinical pathology in community hospital and independent laboratory settings for more than 30 years in the Seattle area, starting in 1980. He received his MD from Columbia University, New York, New York, in 1975. After residency training in anatomic and clinical pathology at Hartford Hospital, Hartford, Connecticut, he completed a fellowship in tumor pathology at Memorial Sloan Kettering Cancer Center, New York, New York.