The Changing Role of the Infectious Disease Specialist: A Conversation with Timothy Babinchak, MD

By Sonja Sherritze, Editor, P&T

My original plan had been to write a one-page “Spotlight” about Dr. Timothy Babinchak, author of the smallpox cover story in the July 2003 issue of P&T and one of our most active editorial board members. Dr. Babinchak was the driving force behind last year’s four-part series on drug shortages, and he acted as a consultant for this year’s five-part series on the principles of antibiotics. It became apparent, while I was talking to him, that he had plenty of interesting things to say and, certainly, more than would fit on one page. I asked him about the changing role of infectious disease (ID) specialists, and what follows is an abbreviated version of our conversation.

SS: Has your job changed a lot since 9/11?
TB: Oh, absolutely; for those of us in infectious diseases, the job has changed significantly. We have a much higher profile now. In infectious diseases, you know you are doing your job correctly when no one knows you are there. When I was going into medical school, there was an editorial, I think it was by Petersdorf, who wrote that ID as a specialty was dead, because now we had antibiotics that could take care of most of the infections. Then within two years, AIDS was identified. So the ID clinician took on a whole new role in the medical world.

SS: It must have been a very exciting time for you—and maybe somewhat depressing?
TB: It was very humbling. Human arrogance is what got us into this situation—the idea that ID physicians are not necessary anymore because science has somehow conquered all of the modern diseases. Remember, this was the time when smallpox was being eliminated from natural transmission. Nature is a very powerful force, and we learn all too frequently how vulnerable we are. So, to me, it was very humbling—it says “don’t take credit for things that you think you have done, especially when it comes to Mother Nature.” We can no more control nature now than we could hundreds of years ago.

SS: And Mother Nature extends beyond what most people think of it as being . . . it’s not just storms and so on . . .
TB: Absolutely. Nature includes the introduction of the new SARS [severe acute respiratory syndrome] virus, as you pointed out in your Editor’s Memo [P&T, July 2003]. We now have to turn our attention to West Nile virus, to SARS, to all of these new threats—these are all things we have to respond to, and I think we are much better able to do so now. However, I would caution that we need to remember that we have to focus our resources not only on the new things but also on the old things that are still threats to us as well. Pneumococcus and influenza are old pathogens that still kill 30,000 people in the U.S. every year.

SS: It’s amazing.
TB: And they’re not glamorous. They don’t always come to the forefront of the news, but they are far more major killers [than SARS or West Nile]. You saw how the nation and the world were gripped by the SARS spread. SARS is a terrible disease, but it has to be put into context and perspective.

SS: Well, you see people on TV walking around with these masks over their faces, and that is a powerful image. You don’t see images of people with the flu.
TB: Right! The elderly are disproportionately affected by the more common killers (influenza and pneumococcal pneumonia), and they are also more easily diagnosed, treated, and—in many cases (with vaccines)—preventable, so they are the dog-bites-man story that no one is interested in.

SS: The people you saw with SARS were young, and so a lot of people thought, oh my gosh, if they’re affected, then . . .
TB: It could happen to me.
SS: Exactly.
TB: But you know, everybody wants to live longer lives, so there are eventually going to be more elderly people.
SS: Right. So anyway, you obviously couldn’t have foreseen any of this when you first decided to become a doctor.
TB: No, not at all.
SS: What made you decide to become a doctor?
TB: Well, it’s interesting. I come from a very blue-collar, hard-working, steel-mill background. Neither of my parents had gone to college or anything like that. So there was no guidance, no one who had gone before me for any of that stuff. I just realized that I get bored very easily, so I needed to be doing something that was continually challenging. That’s why medicine opened up the most possibilities to me; that’s more or less what drew me to medicine. Here were all of these possibilities, and there was still so much that we didn’t know. Illness was something that affected everyone, and it was all around us. I guess this is a little of my philosophical bent: the things that people create are temporary, industries can open and close, laws are created and changed, but people will always need physicians. That’s something that never changes—no matter what happens to the rest of the things we create, people will still get sick. I looked at it as kind of job security for me.
SS: Why specialize in infectious diseases?
TB: Mostly because of the range of possibilities. I really enjoy the fact that, every day, I have no idea what I’m going to encounter that day. I mean, a cardiologist knows that he’s going to deal with heart disease, heart attacks, and congestive heart failure, with various signs and in various ways. Granted, I know that I’m going to deal with infection, but I don’t know if I’m going to deal with heart infection, lung infection, surgical wound infection, bone infection, obstetrical infection, etc. And so my calendar, my schedule, is never the same, because I never know what infection is going to show up that day. Just as we don’t know what infection is going to show up in the world at anytime . . . now it’s SARS, now its monkeypox, now its smallpox—it’s that variety that keeps me interested.

SS: So how do you keep from getting sick? Do you take vitamins?

TB: No. It’s knowledge. I always told people that I’d much rather be the one who knows what’s going on than the one who doesn’t know. Knowing who the sick people are means you can take the proper precautions. I think the SARS outbreak showed that very well. Once we were able to institute the appropriate infection-control measures, then we were able to control this outbreak and it didn’t spread worldwide. But it was a matter of identifying those people, and identifying the virus, and being able to isolate it. That’s basically how you keep from being sick—and you have this cautious optimism.

SS: I guess by the time you encounter people, they’ve already got whatever they’ve got—you’re not seeing them when they’re on the verge of coming down with something.

TB: Well, lots of times we do. Unfortunately, there were some very brave physicians and other health care workers who lost their lives during the SARS outbreak. They gave the ultimate sacrifice, to use the military phrase, to try to combat this. That’s something that you have to be aware of, but again, if I put that risk in perspective, I’ve got a much better chance of being killed by someone on the drive home today than I do of being infected by someone with smallpox or SARS. And yet, I don’t think twice about getting in the car and driving. So it’s a little irrational for me to walk around with a continued fear. I mean, we took an oath, and I believe in that oath.

SS: So what’s the most challenging and/or frustrating thing about what you do?

TB: Oh, you don’t want to talk about that. That’s all the things David Nash talks about—all the regulation and all of the issues surrounding those kinds of things.

SS: Is this the most time-consuming thing about your job?

TB: Yeah, from reimbursement to malpractice litigation—the business of medicine, the fact that medicine has become a business. Having people you know you are able to help, but you aren’t necessarily able to help, because of their insurance plans or the lack of certain capabilities with public health. But we’re very lucky in this country, because we have more resources than a lot of other parts of the world do—especially in infectious diseases.

SS: I saw an article from a few years ago about a country in Africa that had an incredible AIDS epidemic, and they weren’t accepting our offer of low-cost drugs; I had kind of forgotten about that. I thought the problem was on our end—that we weren’t helping out enough.

TB: No, not always. South Africa has just come around. The South African government for a long time refused to recognize that HIV was actually what was decimating their population. And it was taking a terrible economic and social toll on them.

SS: Right. Now, changing gears—how did you decide to join a P&T committee? You were on one before you came to Thomas Jefferson, right?

TB: Yes, well, I think that’s part of the role of infectious diseases. Pharmaceuticals are the things that we use—those are the tools of our trade. And because of our training, we have an inherent role to play in P&T committee work. From pharmaceutical development to assessment of safety to cost-effectiveness analysis to all of the things that go into that kind of work—of all the specialties, we probably have more of a role to play in those kinds of decisions than others do.

SS: That’s probably pretty accurate. So what do you think of the role of P&T committees, generally speaking?

TB: I think they’re absolutely essential in any health care institution that is directly involved with patient care. If nothing else, then from the safety standpoint, they’re an added layer of protection. There really needs to be someone reviewing all of these decisions to make sure that the right drugs are being used, and that the way in which they’re being used is appropriate. It’s really gratifying to come together with my colleagues in all of the different specialties, in an area where we all feel very strongly that it’s important to monitor and to continue to deliver the best care that we can under the circumstances that we have to deal with. That role in itself is absolutely critical to any health care organization.

SS: Well put. So how much time do you actually spend with patients?

TB: I’m still primarily a clinical infectious disease person. I would say that a good 60% to 80% of my time is spent in patient care. That’s usually in a teaching setting—teaching other physicians, fellows, residents, and medical students. Then the other 20% to 40% of my time is divided between clinical research, which is still patient care, in a lot of ways—and then administration. I try to limit my administrative activities as much as possible, but it gets harder and harder to do so.

SS: What brought you to Philadelphia?

TB: Well, as I said, I am always looking for different opportunities. Jefferson gave me the chance to expand on things that I was doing in Pittsburgh.

SS: You’ve been at Jefferson since 1998?

TB: Right, for almost six years.

SS: Do you have any suggestions for the journal?

TB: I really think that longevity is your best marker of success, and you’ve been around . . . it’s not an easy world out there. But I think that the print media have a unique position to play now and have standards that I don’t think the Internet will ever be able to achieve, because of its speed. But with that responsibility comes a higher calling. I know you’ve got to chase the advertising dollars, because that’s what pays the bills, but I would pitch it to the advertisers as: “You are a reputable company looking to do your advertising, and what we’re putting out is a more reputable product” [than what appears on the Internet]. The peer-review process and the things that we do to ensure that what’s in here is valid are all important, and they will stand the test of time. I think quality will always rise to the top. That’s what I see happening here, and that’s what I try to contribute to the journal.