LETTER FROM THE EDITOR

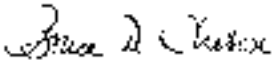
Last year, our Hematology/Oncology Division embarked on an experiment: We hired hospitalists to manage our inpatient service. This rapidly growing subspecialty came about in response to the decreased hours and patient caps imposed by the ACGME on residents. Hospitalists are generally right out of their residency training, and they are taking a bit of a break in their career by assuming a 7 to 7 (or 8 to 5), no weekend or night, hospital-based position. For the most part, they do not have subspecialty training. Since July, the oncologists within our division have utilized the services of our 2 hospitalists, both of whom are planning to stay with us for only a single year before they move on to a Heme/Onc fellowship program. Nevertheless, we hematologists have decided to assess the success of the program from a distance before we relinquish our current situation.

I recently participated in a departmental retreat during which we presented a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of our division. One of my colleagues presented the abundant S's, while it was clear that I was the more appropriate authority on the W's and T's (I kept the O's for continuity). Towards the end, the topic of the hospitalists came up. I have no idea whether our issues are generalizable to other institutions or are unique to us. Whichever, here are my impressions pursuant to that discussion: The strengths are that attendings spend less time with inpatients, although they still often make at least social visits to their own patients, while still covering the dreaded weekends. The fellows are in favor of the system because it allows them to manage fewer patients, and patients will potentially experience a shorter hospital stay. The weaknesses include, most importantly, that the revenue to the attendings has greatly diminished. The inpatient revenue loss was supposed to be offset by ramping up the outpatient clinic; although, given the already 8 or more hours in the clinic day, it is hard to envision increasing volume, and to add another day would merely take time away from all those other things you now were supposed to have time to do. The variable number of inpatients may not always keep 2 hospitalists sufficiently busy, especially with the hematologists holding out. As far as patient management goes, the level of care offered by the hospitalists is that of someone right out of residency, without sufficient experience to manage the more complicated hematologic malignancies and coagulation disorders. The predestined turnover limits the possibility of acquired proficiency over time. The hospitalists also lack the investment of a patient's actual attending. Teaching of fellows suffers, as the hospitalists are often less knowledgeable about the patients and diseases even than the fellows. This arrangement does afford potential opportunities, including more time for attendings to devote to house staff and fellow teaching, although up to this point, the attendings have managed to fill their time with other responsibilities. And then there are the threats: as one colleague at the retreat stated, he is losing his comfort in conducting inpatient medicine. As more patient care is shifted from the inpatient to the outpatient setting, the number of hospitalists may actually decrease just as we begin to depend on them.

So with all of that spare time in the day created for us by hospitalists, we will have ample opportunity to educate ourselves by reading *Clinical Advances in Hematology & Oncology*. For example, in this month's issue, Drs. Sumanta Kumar Pal and Robert A. Figlin review the latest data on therapies for renal cell carcinoma. In our columns, Dr. Michael Deininger explores therapy for chronic myelogenous leukemia beyond imatinib, and Dr. Craig M. Jackson describes the development process of biosimilar low molecular weight heparins. In addition, Dr. Deborah A. Thomas discusses the use of rituximab in acute lymphoblastic leukemia, Dr. James F. Pingpank describes melphalan therapy for colorectal metastases to the liver, and Dr. Alison Stopeck examines new data on denosumab in metastatic breast cancer.

I am writing this letter towards the end of February, the month during which, for over a decade, I have conducted my inpatient service (short month, fewer travel opportunities). Nevertheless, I still feel the need to be the attending, not only of record, but of the day-to-day management of my patients, whose care has been the focus of my training as well as my clinical career. The hospitalist program is still in its infancy and, perhaps at some point, I will have a level of comfort sufficient to relinquish my inpatient responsibilities, but that time has not yet arrived.

Until next month . . .



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