From the Editor's Desk

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From Bench to Benchmarking

Would it surprise you to know that the first patients with Hodgkin's disease treated with MOPP (mustargen, vincristine, prednisone, procarbazine) were continually hospitalized in the National Cancer Institute Clinical Center for 6 months? MOPP is widely regarded as the first curative chemotherapy for a previously incurable adult malignancy. The regimen also served as the prototype for development of the cyclic cytotoxic chemotherapy regimens in use today, and for decades was a benchmark for the treatment of Hodgkin's disease. Thirty-three years later, MOPP's successor chemotherapies are infused in oncologist offices, and patients then recover in their own homes.

Part of the progress made in treating Hodgkin's disease and other malignancies is derived from studying optimum chemotherapy dose delivery. While there are emerging benchmarks around chemotherapy dose and timing, there are few publicly available benchmarks to guide other aspects of oncology practice.

In this issue of *JOP*, we publish results of two early studies that benchmark medical oncology practice. One article, from the National Comprehensive Cancer Network (NCCN), focuses on oncologists in academic practice.¹ The second article, from the Onmark network of oncologists, focuses on support staff productivity and resource (ie, chemotherapy chair) allocation.² A related piece chronicles how physician work is measured and reported by the Current Procedural Terminology process and its embedded concept of relative value units (RVUs).³

To provide context, it is worth an explanatory note about the two organizations that sponsored the studies. The NCCN is an organization of 20 academic cancer centers. Membership is limited but geographically representative. Physicians represented in the survey data practice almost exclusively in an academic setting, are paid by salary, and patient care is a portion of their weekly activities. Onmark is a commercial entity and functions as a "group purchasing organization" or GPO, the main function of which is to assist office-based oncology practices with their purchase and supply of chemotherapy drugs. (Disclosure: I am on NCCN's Board of Directors, and was one of Onmark's parent, OTN, first customers.) Both entities have an interest in providing productivity benchmarks to their members.

Both surveys start with the premise that economic pressures are forcing oncology practices and faculties to efficiently use expensive staff and physician resources. Both focused on the physician and on physician work as a central unit of measure, and both used data from roughly 2005. Though there are other places to start the analysis (the oncology patient is one choice), choosing the oncology physician as a starting point makes sense. Oncologists are expensive and increasingly scarce resources; oncologists often function as leaders of teams of other expensive professionals, and rightly sizing the team is important; and finally, most oncology practices are owned and organized by oncologists.

Authors of both surveys struggled with the definition of an oncologist full-time equivalent (FTE). Both got it right, and came up with similar answers. The Onmark group defined an oncologist FTE as one who practices some or all parts of 4 days per week in the office setting. The NCCN group defined a 50% FTE as one who practices 2 days in the office or clinic setting.

The Onmark study and the NCCN productivity survey are a great start. I encourage both groups to continue their efforts. Longitudinal data will help us all understand how practice is changing, help us adjust staffing ratios and physician effort to achieve best practices, and help us calibrate our efforts and hiring. The methodology should be refined and expanded. Further surveys might explore the impact of salary incentive or bonus programs for physicians who are salaried. Also, serial surveys should explore the adoption and the impact of computerized physician order entry and electronic medical record technologies on physician and support staff productivity. Use of other standard technologies and their impact on efficacy could also be explored.

In these benchmarking efforts, we should not lose sight of our goal—to cure more patients and to spend more time with those vulnerable, sick patients who need our help.

A handwritten signature in black ink that reads "Douglas W. Blayney".

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