Where Expert Opinion Meets Public Resistance

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There is concern and growing evidence that the supply of medical oncologists in the United States will be insufficient to meet the needs of future patients. With an aging population and increasing complexity of cancer therapies, it is clear there will be more patients and that they will live longer and require expert care. It is equally clear that the number of specialists trained in cancer medicine is not growing fast enough to meet projected needs, so new models of care will need to be designed and implemented. Innovation in practice models will require the integration of non-physician practitioners (nurse practitioners and physician assistants) into multidisciplinary teams, broader use of technology to allow virtual consultations and the secure exchange of vital health information, increased utilization of community services, and public acceptance.

In this issue of ONCOLOGY, Bunnell and Shulman reflect on the challenges facing oncologists and governmental agencies in the United States, both of whom are struggling to define value in health service and to allocate dollars to best meet the needs of a public that appears to be both divided and opinionated. Solutions will require negotiation and compromise and will inevitably leave some feeling angry or frustrated. The authors endorse rational and data-driven means of establishing a solid foundation for personalized decision making, clinical trial design, practice strategies and re-imbursement. In their view, “coverage with evidence development” policies could provide the necessary incentives for use of new and costly treatments while collecting the information needed to generate safety and efficacy data. Re-aligning incentives for discovery and practice while considering the best interest of patients may turn out to be the best way to reduce costs and energize the workforce.

Emerging standards and metrics of “quality care” are being adopted by oncology practices and used to promote compliance with regulations, to offer incentives for efficiency, to improve safety, and to negotiate reimbursement. The use of computer programs to minimize errors in chemotherapy ordering systems has wide appeal and we foresee little resistance to implementation other than cost. On the other hand, when there is room to maneuver, doctors sometimes follow their own beliefs rather than available evidence. For instance, there is considerable variation in the utilization of hospice care, which is in part driven by doctors’ recommendations and practices. Some physicians prescribe multiple lines of chemotherapy for patients with metastatic cancer, others encourage patients to participate in clinical trials, and still others endorse models of early palliation. This serves to illustrate the concept that in certain situations, physicians prefer to follow their own instincts and beliefs instead of evidence-derived standards or guidelines.

Bunnell and Shulman provide a clear analysis from the special vantage point of a thriving academic institution. We share their enthusiasm for using comparative effectiveness research to generate rational diagnostic and treatment guidelines, to change the ground rules of clinical trials, and to work towards a more equitable method of reimbursement for highly specialized cognitive services. Nevertheless, we worry that without public acceptance and the endorsement of politicians, such data-driven approaches will meet significant resistance and may not succeed.

There is ample evidence of public distrust of both science and experts, coupled with a preference for new and costly interventions.[1,2] In a recent publication, Carman and colleagues used mixed methods to determine how the concept of making health care decisions based on evidence of
effectiveness could be translated into language that consumers would understand and accept.[2] Through focus groups, interviews, and online surveys, these researchers identified a disconnect between the central tenets of evidence-based health care and the knowledge, beliefs, and attitudes of consumers.[2] Not only were respondents often unfamiliar with terms such as evidence and guidelines, but they also had significant misconceptions and biases. In general, respondents believed that more care is better and equates to higher quality, and that costly and newer care is also better.[2] The authors concluded that to the extent that the public perceives that the application of comparative effectiveness research will limit their choice and interfere with their physicians’ recommendations for treatment, attempts to incorporate its findings into the health care system will encounter resistance and could lead to a broad consumer backlash.[2] It is likely that the interaction of science, politics, and public perception will mold the future of health care. Without both political and public support, the accumulation of scientific data, no matter how valid, will not lead to a comprehensive, high quality, and cost-effective medical system. As oncologists, we are comfortable evaluating data and using it to inform and care for patients. Thus, we should use our experience and knowledge to assist the public and elected officials to understand and best utilize the information generated by health research.

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