Are You Kidding Me? Clinical Comparative Effectiveness or Evidence-Based Medicine

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The panel for the new Federal Coordinating Council for Comparative Effectiveness Research has been appointed by the new administration, and the Recovery and Reinvestment Act has allocated $1.1 billion for comparative effectiveness research.

So the ministers of change agents have been released, to empower and direct “comparative efficacy” processes intended to fix the medical needs of our country. But this hand-selected federal council includes no pharmacists or drug experts, even though the major portion of the work likely will involve pharmaceuticals. Furthermore, this administration has a great amount of explaining to do to ensure healthcare stakeholders a useful outcome could result from this. The rapid-fire implementation of rope-a-dope stimulus packages continues to lack significant and sufficient details to embrace the hope for useful outcomes.

Let us not forget the noble attempts to bring useful and fruitful clinical drug evidence to light for decision-making by the “Blues,” the National Institutes of Health, or by others engaged in developing clinical comparative evidence data to seek value and improved outcomes. All such previous attempts have been lacking appropriate funding—but now there is money, yet not for programs with a solid track record for solutions, or for those who already have a footing and the ability to provide non-biased results. Indeed, what America needs now is comparative effectiveness. This cannot wait; crisis looms large, and a rush to this cause is in full stride.

Most of the members of this enlightened council have been servants placed in public jobs for most of their lives, sheltered from the carnage of real-life medical practice, life experiences, and the day-to-day drama of actually helping our citizens plow through the never-ending bureaucratic paper maze, attempting to get a semblance of healthcare.

Why use an old term like evidence-based medicine? It’s not snappy enough, and it is truly too descriptive. This may lead the public to expect to see a superior outcome resulting from such a clear approach. The simple renaming of a process has worked for other projects in the economic stimulus coming from this administration. The

metamorphosis to comparative effectiveness is clever and can be effectively substituted; slightly obscure, mysterious, with just a hint of respectability toward medicine. Adoption of rewording has been met with enthusiasm for many projects we see coming from this administration.

Is there a difference between evidence-based medicine and clinical comparative effectiveness? The creators of the latter would certainly suggest there is. Comparative effectiveness, being voiced from Washington as the next solution to our healthcare problems, is buzzing around at light speed. New programs that may be adopted in these times of change may include Medical Complementary Research Associate Program (CRAP) or Perfunctory Operational Referendum Collaboration (PORC). Regardless of the slogans, the new and hyped terminology indicates that this is a charade, attempting to show advancement where none exists. Perhaps the new word for drug profits should be “clinical derivatives” when referencing comparative evidence outcomes.

Don’t you miss the days when we spoke in terms that had simple and shared meaning—when TARP (Troubled Asset Recovery Program) would have been understood as “stupid investing”? With the basis of solid comparative evidence for medications currently available from many unbiased databases, it is wasteful and inefficient to reinvent this process.

Evidence-based medicine has enhanced the care delivery and reduced mortality and morbidity, while providing a logical pathway for value to follow. The Pharma lobby has exerted pressure to carefully carve out the inclination of relative clinical effectiveness associated with value. As with other administrative initiatives, value is not a good word any more. Pharma’s strong lobby against value is associated with the inability to have value removed from evidence-based medicine. So let’s rename value, using a specifically nonspecific prestidigitation gyration to eulav.

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