Community Level Care: Are Clinical Trials Available in Small Cities?

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Andrew Schorr:
Mike, you know, people are—one of the ladies wrote in on Facebook I posted about this program, and she said, well, the trials are not really accessible to me, because I live in a rural area, and they are only in the big cities. You're in one, Milwaukee, but Jim's in Grand Island, Nebraska. I mean, and some people if you set requirements for the trial, well, you've got to come see me or come to the clinic for a variety of tests with some frequency, and somebody has to drive four or five hours and take off work and get babysitters and all that. It just makes it impractical.

Where are we with more trials being available or having an aspect of it like testing closer to home?

Dr. Thompson:
Yeah, so I work in a community setting. I'm at our kind of flagship hospital, but we cover most of the population centers of Wisconsin, so I think we cover about 70 or 80 percent of the population. So that's a huge issue for our site is we—when I talk to sponsors, including as recently as last week, I say, if we can't do it at all our sites I'm not really interested in doing your trial.

There are exceptions, of course. If we're doing a surgical trial or radiation trial that has to be at one site or sometimes a Phase 1 trial, which is a lot of blood monitoring, very intensive, they can only be done at a few sites. But in general I completely agree that we should try to have the drugs available to the people in the communities they live in, because that's where their social networks are, right? So that's where their family is. They can stay at home. They don't have to just go into a hotel. They don't have to pay for travel, and I think it's better for everyone.

And for companies, I've been trying to tell them that it's more generalizable to the reality of where cancer patients are. So 85 percent of cancer patients are in the community setting and are treated there, and drugs should be accessible to them there. So both using the CCOP mechanism or N triple C-P, and now we have the NCI Community Oncology Research Program or NCORP, the whole idea is to increase that access to community sites. So this has been going on for a long time.

I think there were budget cuts, and so the U.S. and the way we've established our cancer budgets has been to decrease access, at least NCI trials, and usually need some of those NCI trials to support some of the infrastructure to do other studies, so I think part of that—you know, a lot of these things you follow the money, and if there was more money for community research sites you could hire more research staff to get these things done. But I think we need to get them done in the community because we know if you do early phase studies and they look promising in high selective patients then when you expand them and put them in a community you go from efficacy to effectiveness and the effectiveness isn't there because the patients are different.

So there's all these things with real world data and comparative effectiveness research and ASCO's cancer link trying to get some of that not on study to just try to get the data. But we need to have access to people. And the way to make drugs cheaper, make them develop faster and answer more questions both scientific and patient oriented is to get more people on trial.

There's a big example for immunotherapy drugs where there are so many immunotherapy drugs in trials there are not enough patients to get it done. So we're going to be enrolling in trials which don't complete or we're not going to be able to answer these questions, so it's going to stall and limit out our process of moving faster. In myeloma we move very fast, but we need to do this in other areas too.