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The health care reform legislation that President Obama signed on March 23 runs well over 2,000 pages. In addition to expanding insurance coverage, the law includes many far-reaching provisions. One that could prove particularly powerful and controversial will establish comparative-effectiveness research (CER) as a means not just to improve the quality of care but also to control its cost. CER compares the various approaches that physicians use to manage a disorder. Unlike traditional clinical trials, which test how drugs, devices or new methods stack up against a placebo or an alternative treatment, CER weighs all of the options' pros and cons, including their cost.

In this issue of *Proto*, we describe the sort of information that can be gleaned from CER studies and show how a comparison of treatment methods can inject pragmatism into clinical choices. Sometimes, tried-and-true methods turn out to be as good as, or even better than, the newest technology or drug. But it is not all upside; CER risks adding costs to the process of bringing new drugs or devices to market and stifling innovation if applied too early in the development cycle.

Critics worry that CER could be used to ration care. As a result, the health care reform law states that comparative-effectiveness findings "may not be construed as mandates, guidelines or recommendations for payment, coverage or treatment; or used to deny coverage." It is clear that the idea of limiting services based on cost is disturbing to many and a political third rail. Right now this explicit attempt to reassure the public that costs won't dictate care is at odds with the intent of the undertaking. If there really isn't enough money to cover everything for everybody, CER is needed to bring objectivity into decisions that have a profound impact on the national economy.

As medical innovation moves ahead, comparative-effectiveness research must help us define high-quality, cost-effective care. Applying CER to clinical practice will be a delicate task, both politically and pragmatically. Every patient is unique, and deciding who gets what, based on rapidly evolving knowledge, will be very tough.

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