



**Patient Advocate  
Foundation**

# **Clinical Trial Conversations in Primary Care**

2026

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# Background & Objectives

Building on the insights generated from the prior patient-focused clinical trials research, this next phase of work is designed to understand the primary care provider (PCP) perspective—specifically how they perceive clinical trials, how (and whether) they discuss them with patients, and what barriers or biases may influence those conversations.

The earlier patient research demonstrated that lack of awareness and engagement with clinical trials is driven less by disinterest and more by limited information and limited invitation. This study is intended to explore the “other side” of that dynamic by examining PCP knowledge, attitudes, and behaviors related to clinical trials, including the role of structural factors and social determinants of health (SDOH) in shaping access and communication.

1

Understand how PCPs learn about and perceive clinical trials, and how that knowledge influences whether trials are discussed with patients.

2

Examine when and with whom PCPs raise clinical trials, and the circumstances that prompt or prevent those conversations.

3

Identify key barriers—including time pressure, assumptions about patient interest, and bias—that limit PCP engagement in clinical trial discussions.

4

Explore how PCPs consider structural factors and social determinants of health (SDOH) when discussing or enabling clinical trial access.

# Methodology



## Audience

n=503

American PCPs, defined as:

- U.S.-based, age 18+
- Primary care providers
- Board certified
- Duly licensed
- Actively practicing in the United States



## Field Timing

March 5–18, 2026



## Mode

10-minute online survey



## Weighting

Data are weighted where necessary by gender, age, and specialty to bring them in line with their actual proportions in the population

### **Full Method Statement: *(To be included in all press materials)***

The research was conducted online in the United States by The Harris Poll on behalf of the PAN Foundation among 503 PCPs, aged 18+ who practiced actively in the continental US, were board certified, duly licensed, and had a specialty in family practice/general practice or internal medicine. The survey was conducted March 5–18, 2026.

Data are weighted where necessary by gender, age, and specialty to bring them in line with their actual proportions in the population.

Respondents for this survey were selected from among those who have agreed to participate in our surveys. The sampling precision of Harris online polls is measured by using a Bayesian credible interval. For this study, the sample data is accurate to within  $\pm 5.0$  percentage points using a 95% confidence level. This credible interval will be wider among subsets of the surveyed population of interest.

All sample surveys and polls, whether or not they use probability sampling, are subject to other multiple sources of error which are most often not possible to quantify or estimate, including, but not limited to coverage error, error associated with nonresponse, error associated with question wording and response options, and post-survey weighting and adjustments.

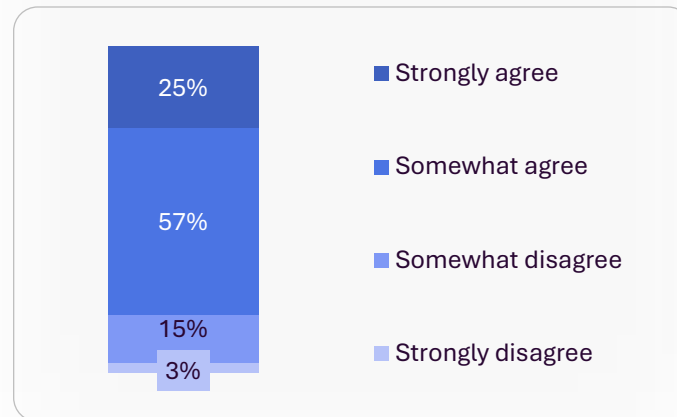
# Notation Guide



## Scale NET Notation

### 82% Agree

The percentage above indicates that 82% of respondents strongly or somewhat agree with the statement.



## In Tables and Charts

- Percentages may not add up to 100% due to computer rounding, and/or the acceptance of multiple responses.
- \*Indicates a percentage greater than zero but less than one-half and “-” indicates a value of zero.
- Results based on small bases (n=50–99) should be interpreted as directional only.
- Results based on extremely small bases (n=31–49) should be interpreted as qualitative only.
- Results based on base sizes <30 are not included and should not be reported on publicly.



## Subgroup Analysis

- Within the report we dive into analysis of the following spotlight populations starting on slide 52:
  - Urbanicity of Practice
    - Urban (n=159); Suburban (n=264); Rural (n=80)
  - Years in Practice
    - <10 years (n=42); 11–30 years (n=304); 31+ years (n=157)
  - PCP Race/Ethnicity
    - White (n=303); POC (n=183)
- Statistical significance tests were conducted using the Student’s t-test at the 95% level of confidence. All comparative claims in this report are statistically significant.
- Due to space limitations, not every significant difference among groups is displayed.



## Base Notes

Each slide includes a base note that displays the full question text as shown to respondents that can be found on the Notes section of the slide.

# Executive Summary

# Context: Bridging the Gap in Clinical Trial Participation – From Patient Barriers to PCP Dynamics



## The broader challenge

Clinical trial participation remains persistently low, particularly among underrepresented populations, despite broad recognition of their importance in advancing patient care and medical innovation.



## What we learned from patients

Prior research from the PAN Foundation found that low participation is driven less by lack of interest and more by limited awareness, information, and invitation, with many patients reporting they were never presented with clinical trial options in the first place.



## What this study adds

This research examines the PCP side of that equation, revealing how knowledge gaps, structural constraints, and decision-making patterns shape when – and with whom – clinical trials are discussed, ultimately influencing patient access and participation.

Together, these findings point to a system where opportunity exists, but is not consistently activated

# What We Found: Positive Sentiment is Not Translating into Consistent Engagement



Clinical trials are widely viewed as valuable, and PCPs express openness, but this does not consistently translate into action.

**98%** view clinical trials positively; **96%** see them as having value for the broader medical community

**86%** say they are likely to refer patients

**45%** report direct experience, while **42%** remain uninvolved

Among the uninvolved, **3 in 10** are open to learning more

Openness exists, but activation is inconsistent

# What We Found: PCPs Lack Visibility and Control Over Clinical Trial Participation



PCPs operate with limited visibility into participation and limited influence over trial access and offerings within their own practices.

PCPs estimate **~8%** of patients, on avg., participate in trials

Prior PAN research suggests participation closer to **15%**

Only **29%** report strong influence over trial education

Just **5%** report a wide range of trial opportunities

Limited visibility and control may be key barriers to engagement

# What We Found: Knowledge Gaps and Informal Information Channels Limit Confident Engagement



Limited familiarity and reliance on informal learning environments contribute to inconsistent understanding and lower confidence in clinical trials.

Only **16%** are highly familiar with available trials for their patients

Only ~ a quarter report familiarity with referral processes

**51%** rely on colleagues as their primary source of information

**14%** report not receiving clinical trial information at all

Inconsistent information ecosystems may be reinforcing uneven engagement

# What We Found: Clinical Trial Conversations are Inconsistent, Reactive, and Selectively Applied



Conversations around trials lack clear ownership and are often initiated only under specific conditions, leading to uneven patient engagement.

**46%** say patients or caregivers initiate clinical trial conversations

Top triggers include patient request (**67%**), lack of response to treatment (**65%**) and disease progression (**55%**)

**94%** of PCPs differentiate which patients they engage

Patients with logistical or social determinant of health barriers like health literacy, transportation access, and English proficiency are less likely to be engaged in a conversation by their PCP

Engagement is driven by triggers – not built into routine care

# What We Found: Structural Barriers and Limited Support Constrain Engagement and Risk Reinforcing Disparities



Operational challenges, patient burden, and lack of institutional support limit participation and may unintentionally widen gaps in access.

**88%** cite practice-related barriers (e.g., time, admin burden)

**62%** cite logistical challenges for patients

**76%** do not feel well-equipped to support referrals

**68%** say clinical trials are not a priority in their practice

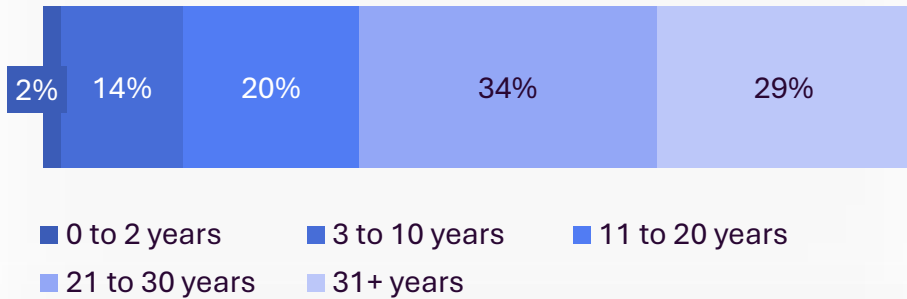
System and patient barriers must be addressed to enable equitable participation

# Detailed Findings

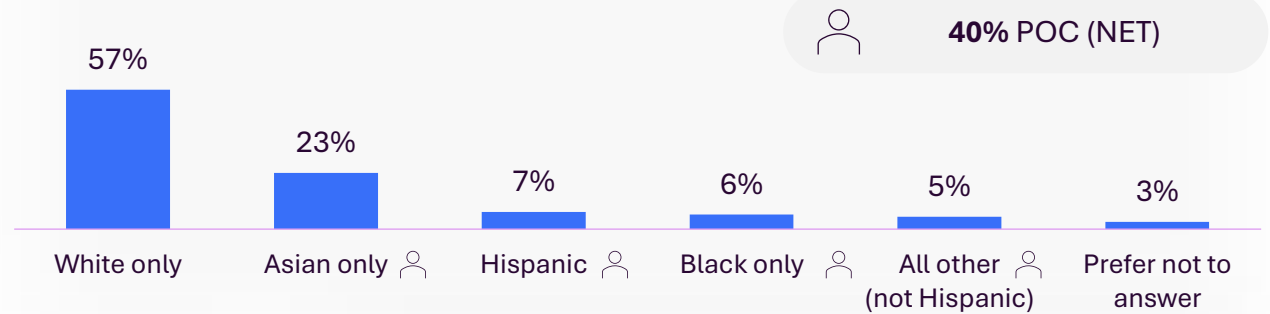
# Respondent Profiles

# PCP Profile

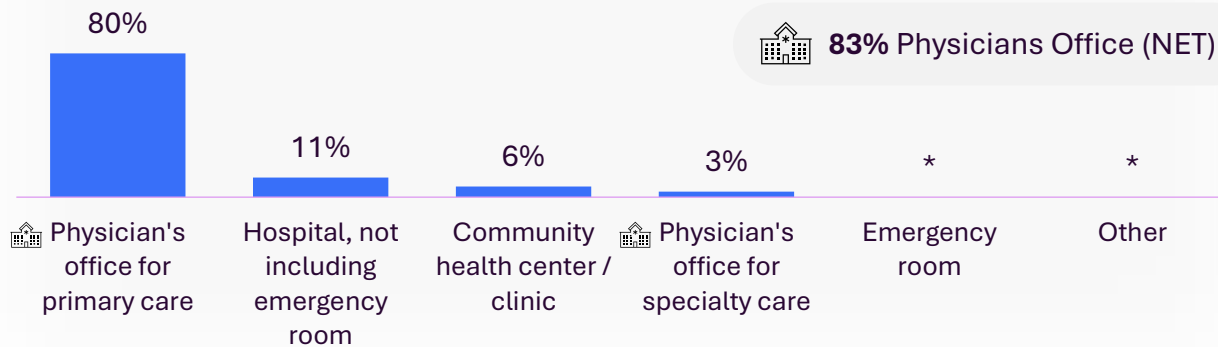
## Years in Practice



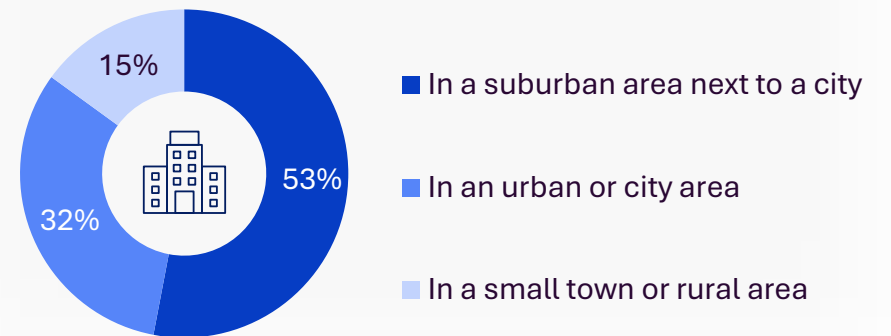
## Race/Ethnicity



## Practice Setting



## Urbanicity of Practice



# Patient Population Overview

## Insurance



### Privately insured

Mean: **46%**  
25%+ (NET): **85%**



### Using Medicare

Mean: **34%**  
25%+ (NET): **75%**



### Using Medicaid

Mean: **15%**  
25%+ (NET): **25%**



### Uninsured

Mean: **6%**  
25%+ (NET): **5%**

## Patient Population



### Patients with chronic conditions

Mean: **59%**  
25%+ (NET): **93%**



### Women patients

Mean: **50%**  
25%+ (NET): **96%**



### Elderly patients

Mean: **41%**  
25%+ (NET): **79%**



### Patients of color (Black, Hispanic, Asian, Native American / Pacific Islander)

Mean: **28%**  
25%+ (NET): **52%**



### Patients from low income households

Mean: **25%**  
25%+ (NET): **41%**



### Patients whose primary language is not English

Mean: **16%**  
25%+ (NET): **17%**



### Disabled patients

Mean: **13%**  
25%+ (NET): **15%**



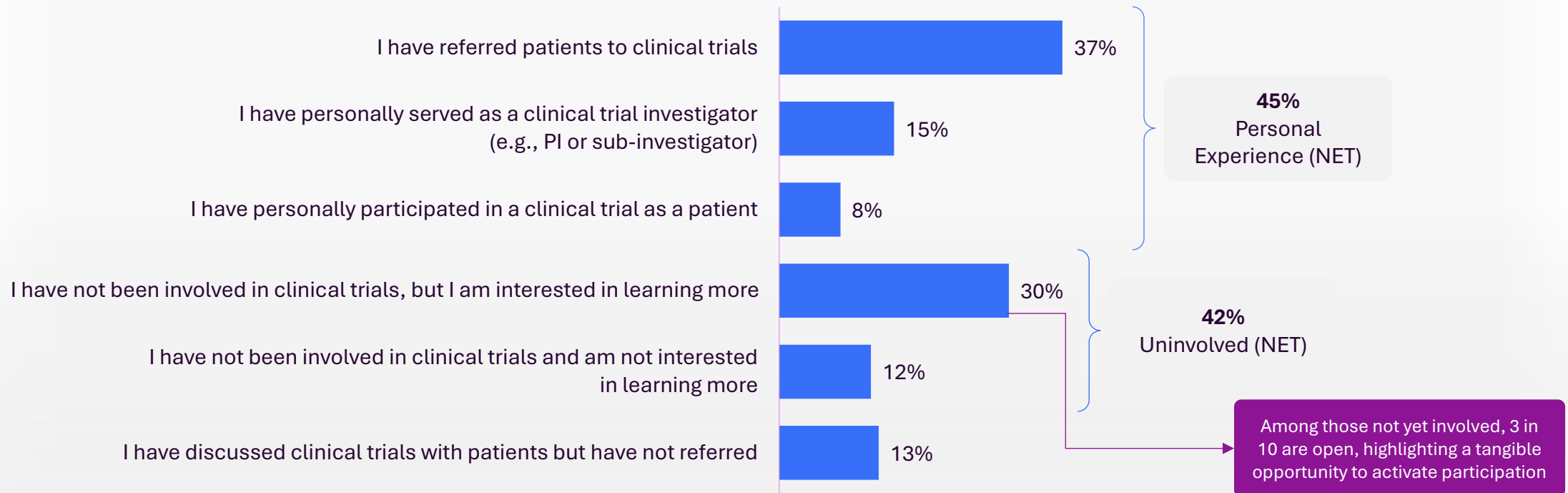
# Clinical Trial Familiarity & Perceptions

Clinical trials are viewed positively among PCPs, and many express openness to engaging, but participation remains uneven and intent to refer is often tentative. At the same time, PCPs appear to underestimate patient participation, suggesting limited visibility into how and where engagement is actually occurring.

This gap is reinforced by structural and knowledge barriers. PCPs report limited influence over trial access and only moderate availability within their practices, alongside low familiarity with key processes shaped largely by informal peer networks. Combined with operational complexity and administrative burden, these dynamics create a system where interest exists, but engagement remains constrained.

# PCPs are Split Between Clinical Trial Involvement and Non-Involvement, Revealing Uneven Engagement Across the Field

## Experience with Clinical Trials

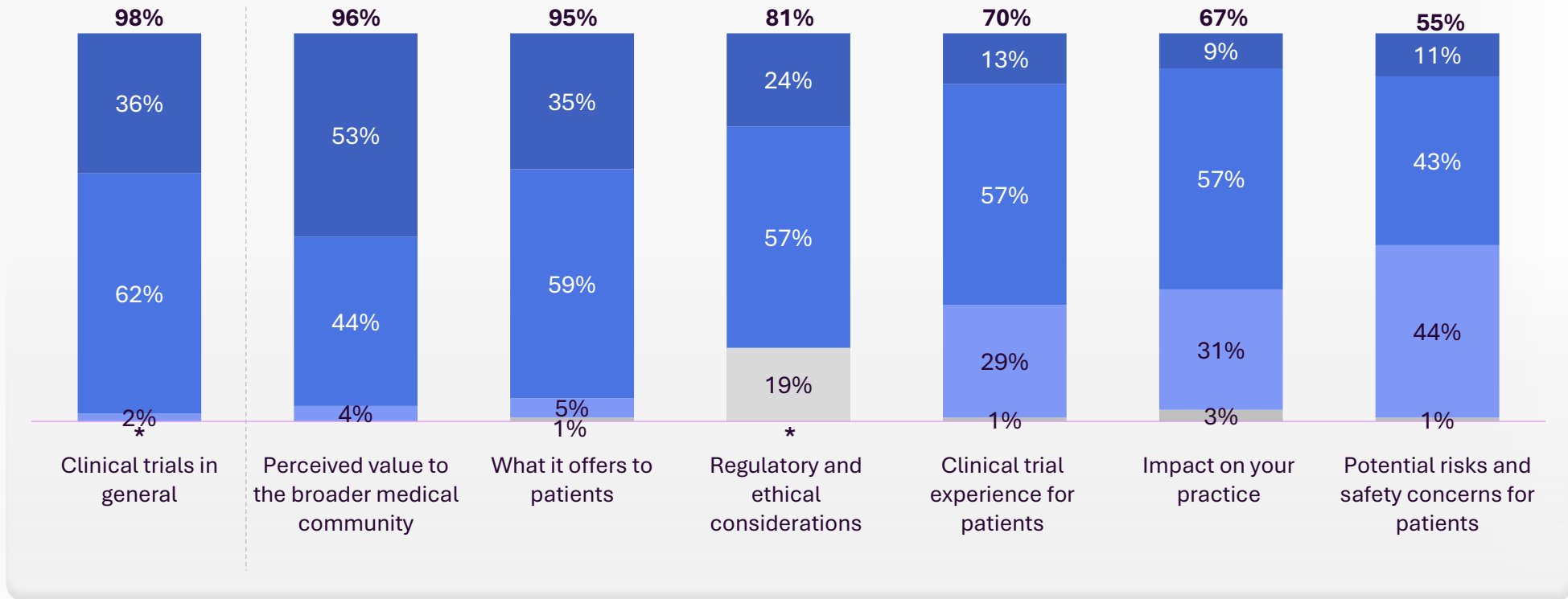


# Clinical Trials are Broadly Viewed Positively, but Conviction Softens on Operational and Patient Burden Realities

## Views on Clinical Trials<sup>^</sup>

Positive (NET)

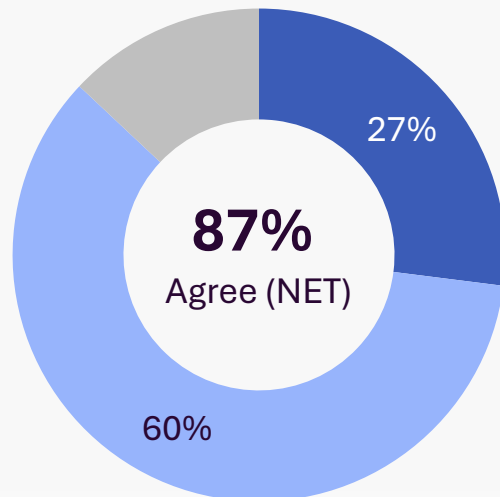
- Extremely positive
- Somewhat positive
- Somewhat negative
- Extremely negative



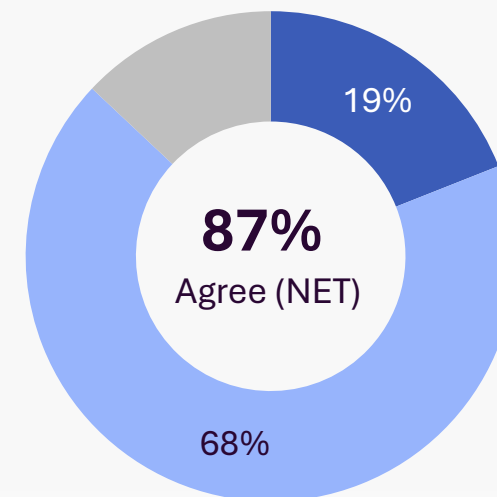
# PCPs also Express Strong Belief in the Value of Clinical Trials

## Benefits of Clinical Trials for Patients

“Clinical trials can provide meaningful benefits for many of my patients.”



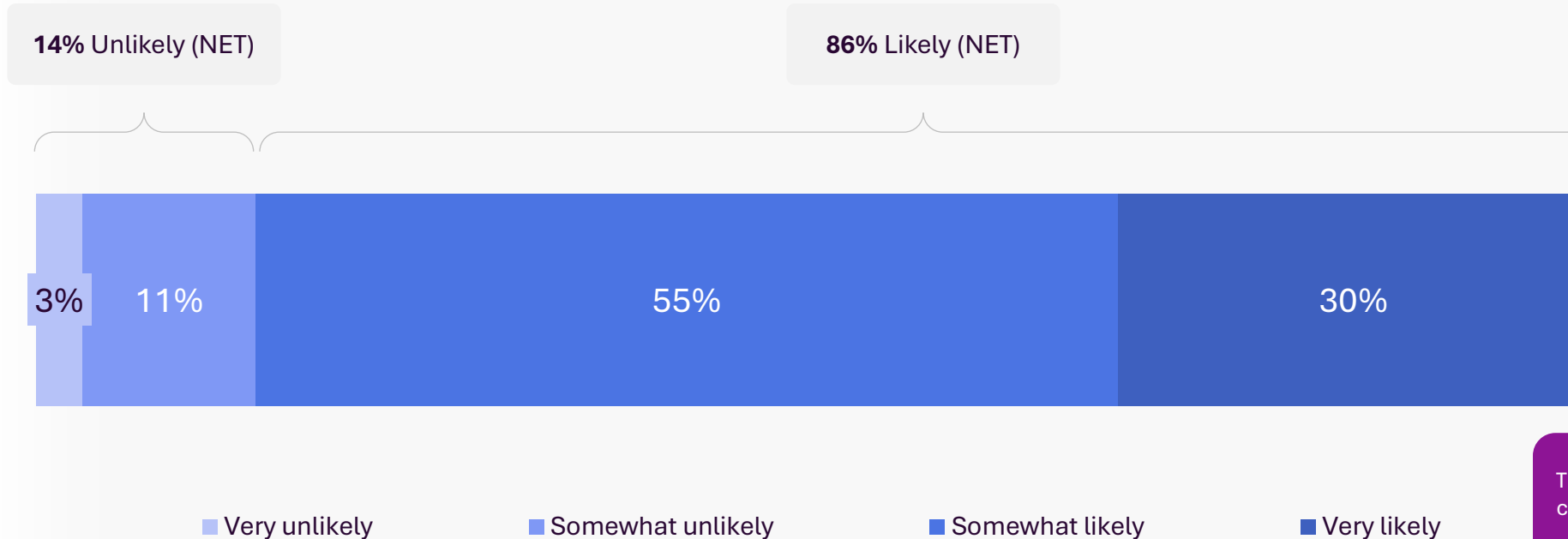
“Clinical trials meaningfully improve patient outcomes.”



■ Strongly agree    ■ Somewhat agree    ■ Disagree

# Most PCPs Say they are Likely to Refer Patients, but Intent Skews more Tentative than Strong

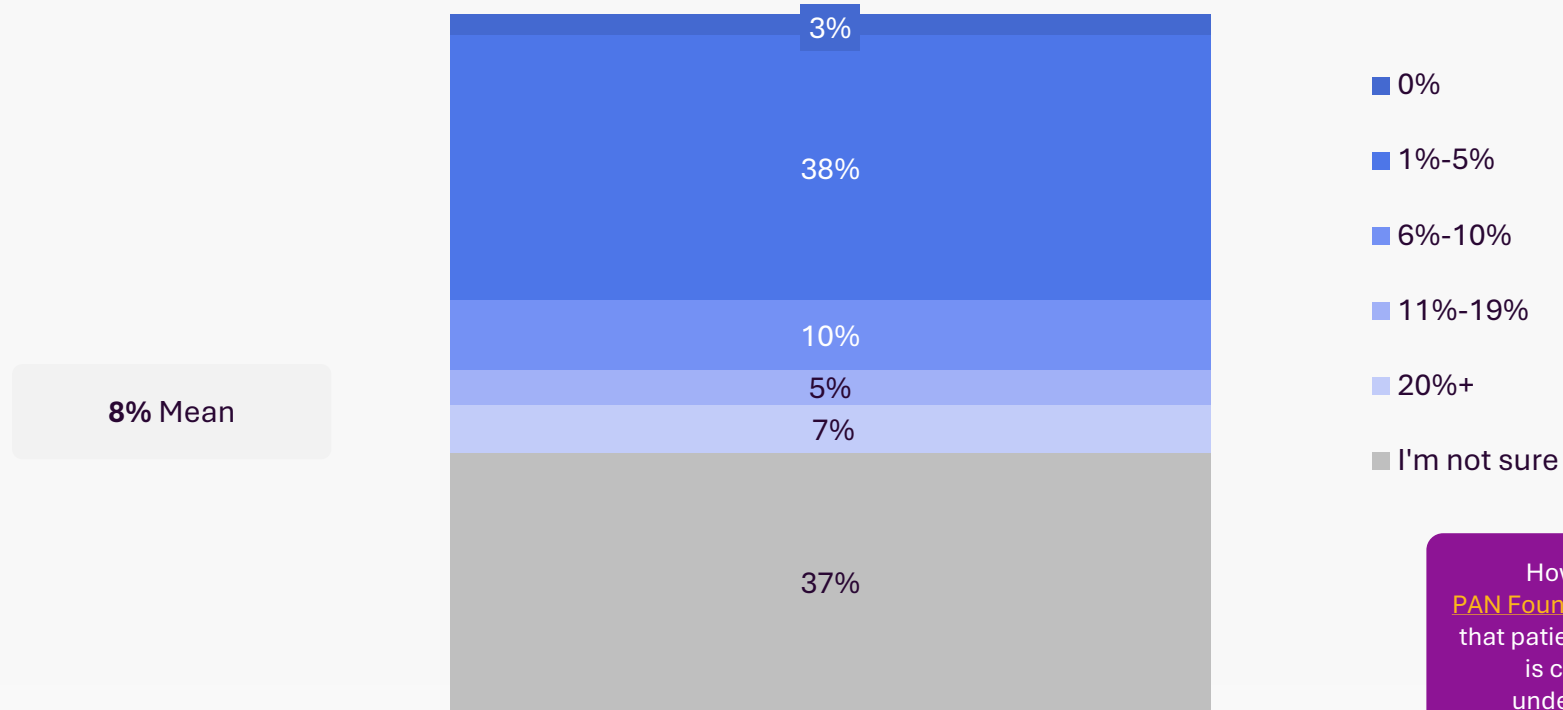
## Likelihood to Refer Patients to Clinical Trial in the Future



This tells us that interest is high, but conviction is not there yet – pointing to a gap between openness and follow through

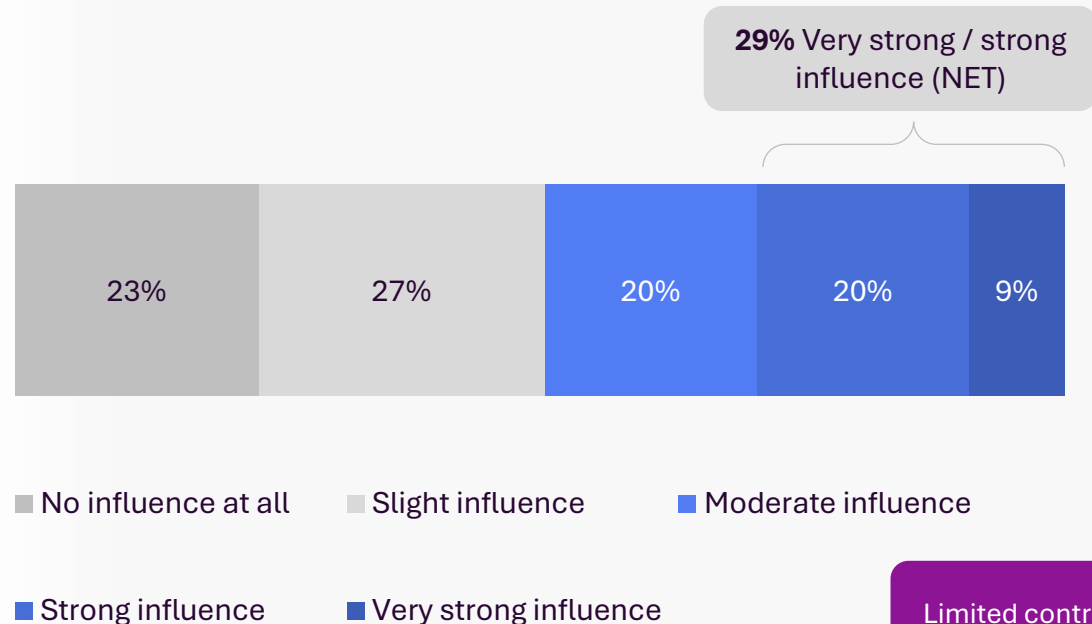
# PCPs Likely Underestimate Patient Participation, Suggesting Limited Visibility into Clinical Trial Engagement

## Proportion of Patients who Participated in Clinical Trial

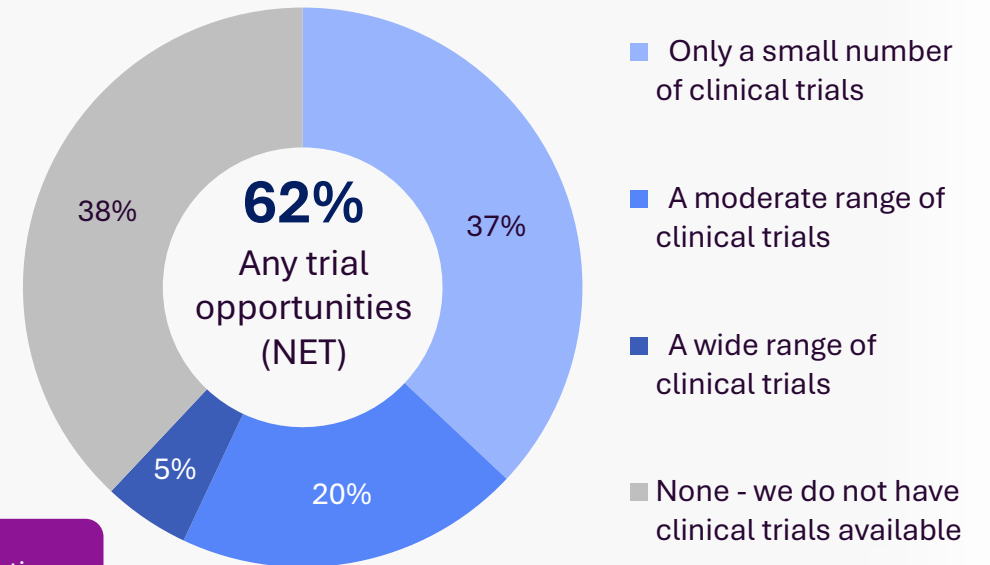


# PCPs Lack Influence over Trial Options, and Access Reflects it – with Most Reporting only Limited Trial Opportunities

## Personal Influence over Clinical Trial Education in Practice



## Range of Clinical Trial Opportunities Available within Practice / Affiliated Institution



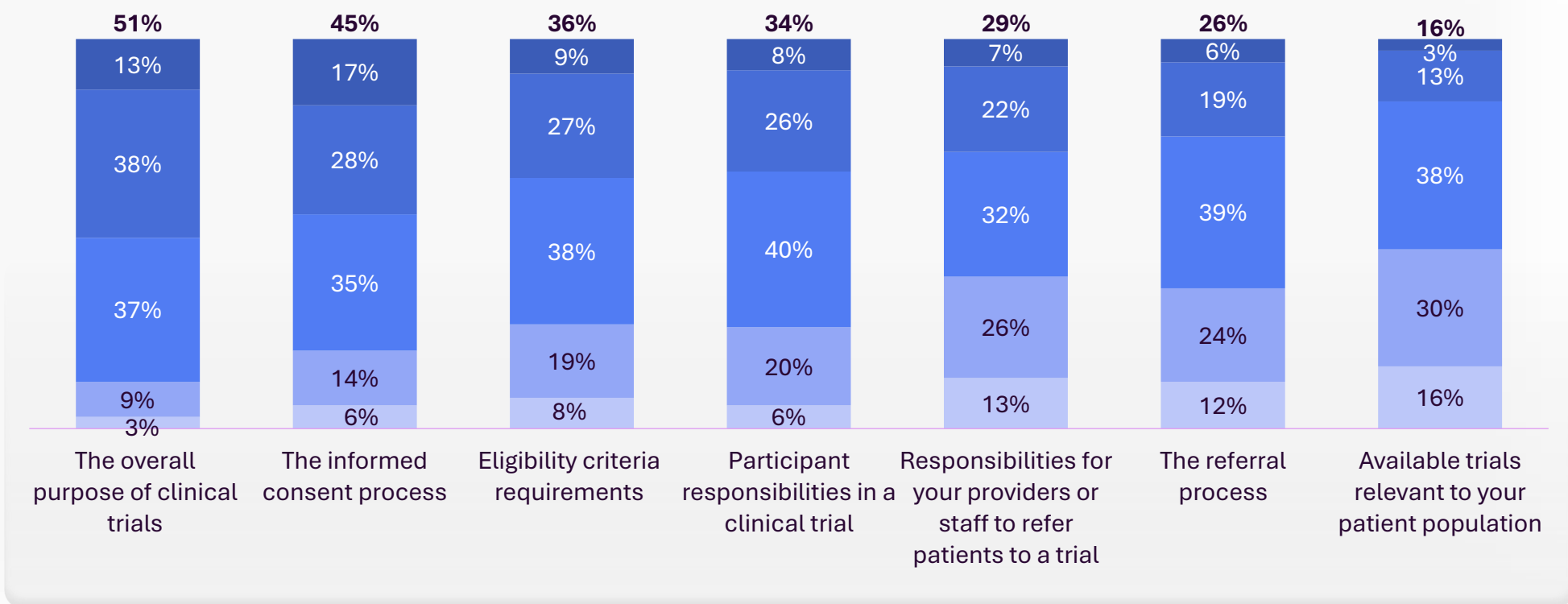
Limited control within practices may be a key barrier to activation

# Familiarity with Clinical Trial Details is Limited, with Few PCPs Reporting Strong Understanding of Key Processes and Requirements

## Familiarity with Clinical Trial Components<sup>^</sup>

Extremely / very familiar (NET)

- Extremely familiar
- Very familiar
- Somewhat familiar
- Not very familiar
- Not at all familiar



Limited understanding of trial mechanics may hinder confident participation and referral

# Clinical Trial Information is Primarily Sourced through Peer Networks, with Limited Reliance on Formal or Centralized Channels

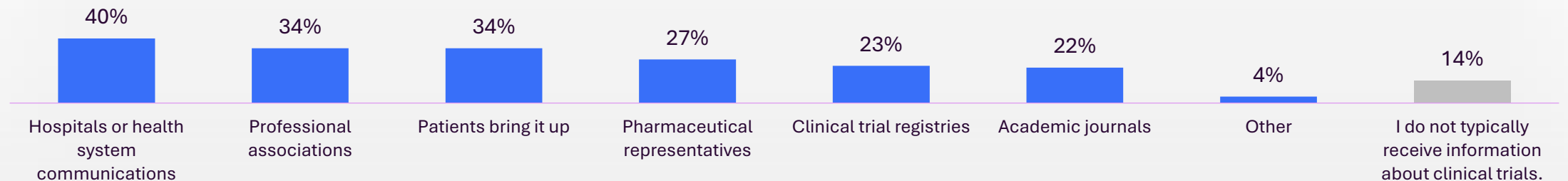
## Sources Used to Learn about Clinical Trial Opportunities for Professional Education

**Top Source**



**51%**  
Colleagues or specialists

An informal information ecosystem may contribute to inconsistent understanding and engagement



# Key Clinical Trial Activities Present Notable Challenges for PCPs, Creating Friction for PCP Participation

## Task Complexity in Clinical Trials

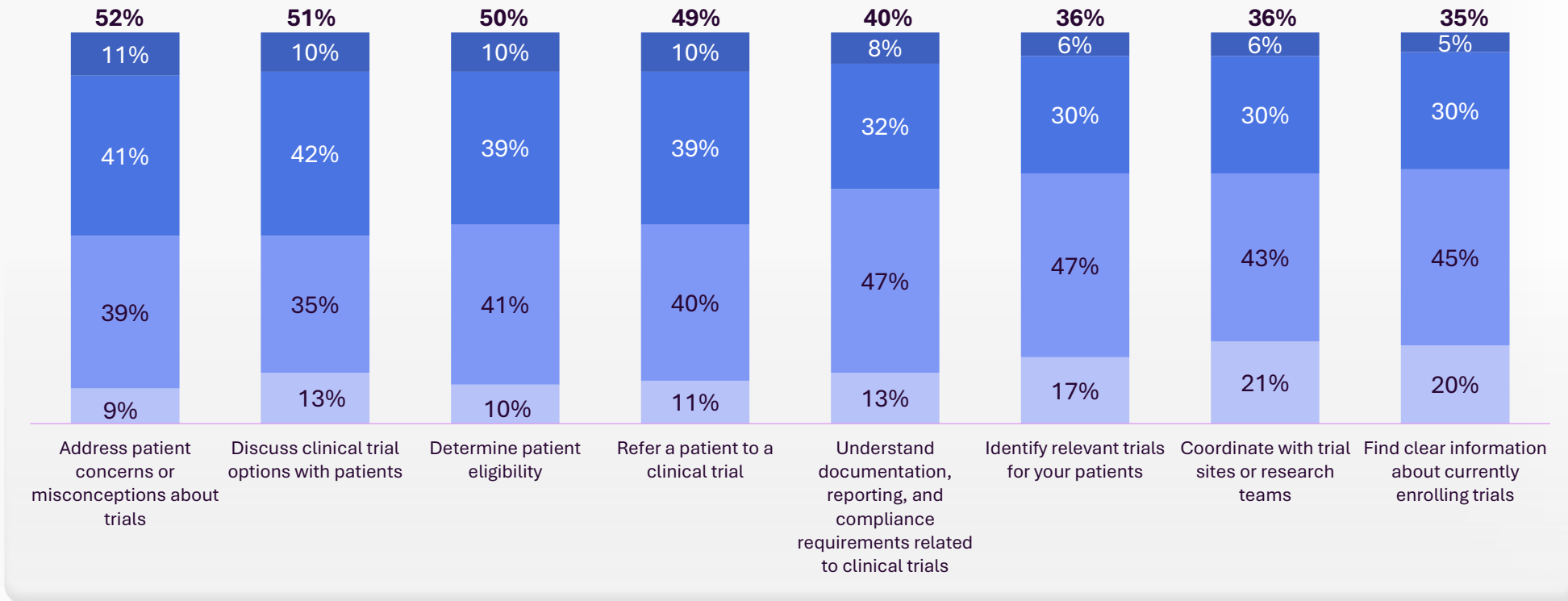
Easy (NET)

Very easy

Somewhat easy

Somewhat difficult

Very difficult



# PCPs' Concerns Span both Patient Safety and Operational Burden, Reinforcing Hesitation Toward Deeper Engagement

## Concerns about Clinical Trials




82% Safety / ethical concerns (NET)



78% Admin / business concerns (NET)

### Top 4



62%   
Time, cost, or logistical challenges that may impact patients



59%   
Unknown side effects



58%   
Patient safety risks



53%   
Administrative burden

30% 

Liability concerns

30% 

Ethical concerns

30%

Patient mistrust

19%

Lack of transparency

11% 

Potential loss of revenue or reimbursement concerns

1%

Other

3%

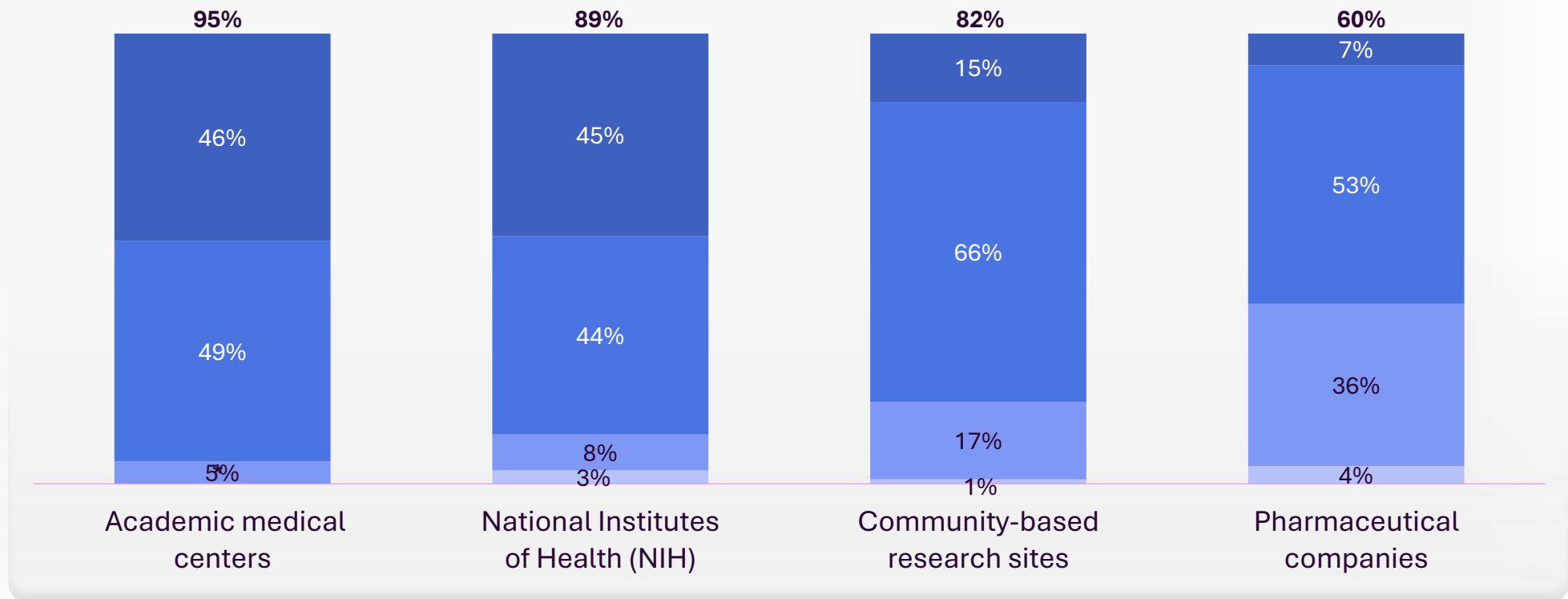
Nothing

# Trust is Highest in Academic and Government Institutions, with More Moderate Confidence in Pharmaceutical Companies

## Trust in Entities Involved in Clinical Trials

High / moderate trust (NET)

- High trust
- Moderate trust
- Low trust
- No trust at all





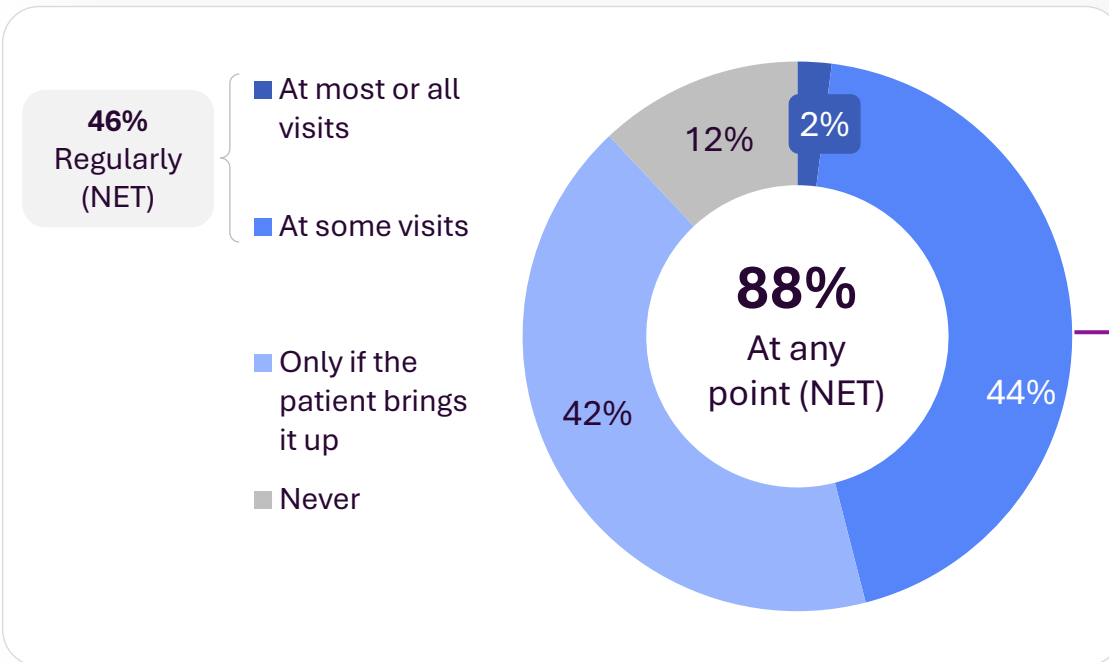
# Clinical Trial Conversations in Practice

Clinical trial conversations are inconsistent and lack clear ownership, often occurring reactively in response to patient prompts or disease progression rather than as part of routine care. When they do happen, PCPs take a selective approach—prioritizing patients with advanced disease or clear treatment need, while engaging less frequently with those facing social, logistical, or perceived readiness barriers.

These patterns are driven by both structural and perceptual constraints. PCPs cite operational challenges, patient burden, and limited referral infrastructure, and many do not feel fully equipped to support participation. While most recognize a role in facilitating engagement, concerns around patient interest, eligibility, and equity suggest current approaches may unintentionally reinforce disparities in access.

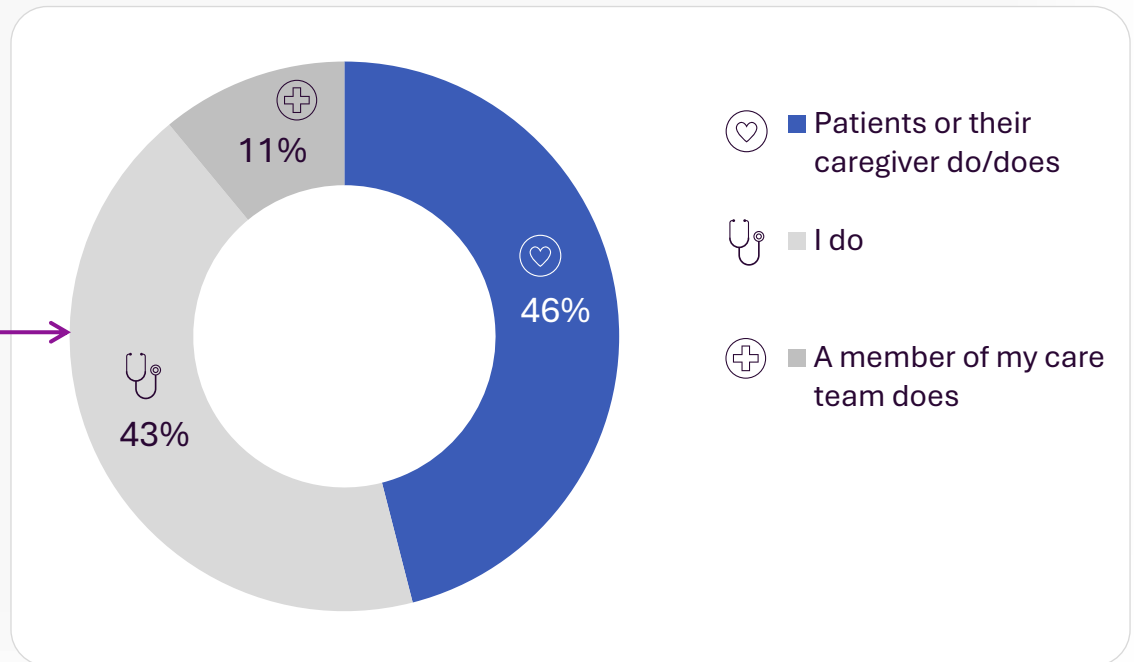
# Clinical Trial Conversations Lack Clear Ownership, Likely Contributing to Inconsistent Discussion

## Patient Clinical Trial Discussion Frequency



## Initiator of Clinical Trial Conversations

(Among those who have discussed clinical trials with patients)

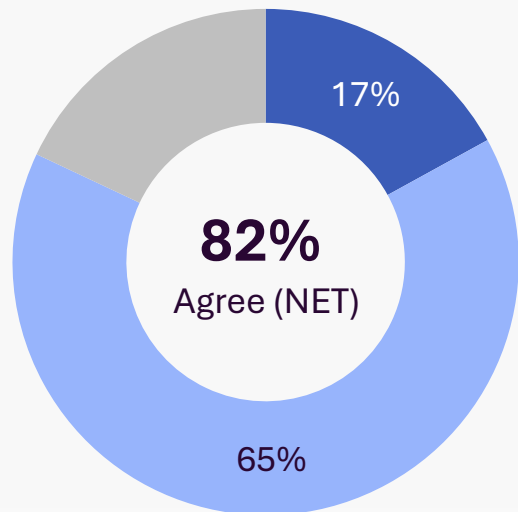


Without a clear owner, conversations may not happen consistently

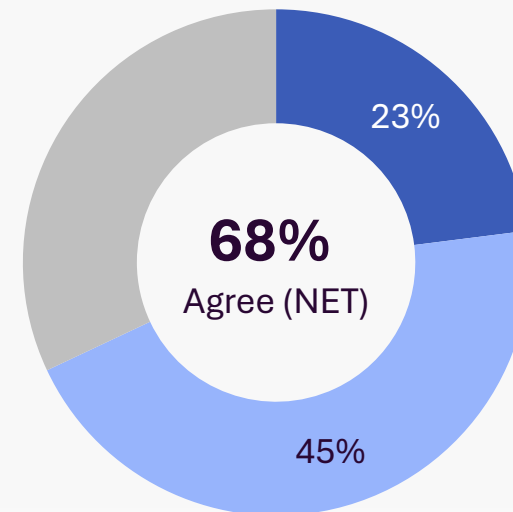
# PCPs Recognize their Role in Advancing Patient Care, yet Many Claim these Trials are Not a High Priority Currently

## Practice Support and Prioritization for Clinical Trial Engagement

“I believe my practice or institution could do more to support clinical trial engagement.”



“Clinical trials are just not a high priority for my practice right now.”



■ Strongly agree    ■ Somewhat agree    ■ Disagree

# Clinical Trial Conversations are Largely Reactive, Driven by Patient Prompts or Disease Progression Rather than Proactive Outreach

## Factors Prompting Clinical Trial Conversations With Patient

*(Among those who have discussed clinical trial with patients)*

**Top 3**



**67%**  
Patient request



**65%**  
Lack of response to  
standard treatment



**55%**  
Disease progression

36%

New data/publication

35%

Trial site outreach

24%

Institutional recommendation

2%

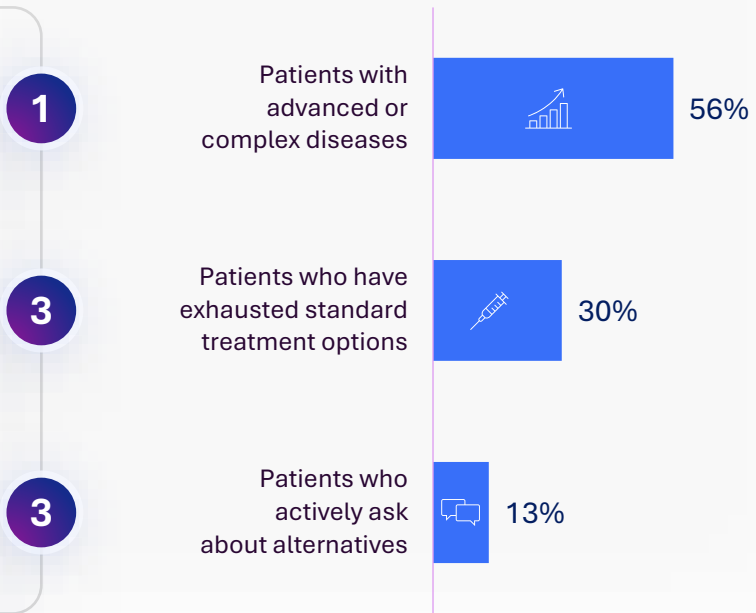
Something else

# PCPs Selectively Initiate Trial Discussions, Prioritizing Patients Based on Condition Severity and Treatment Stage

## Patients Most Likely to have Clinical Trial Discussions Initiated by HCPs

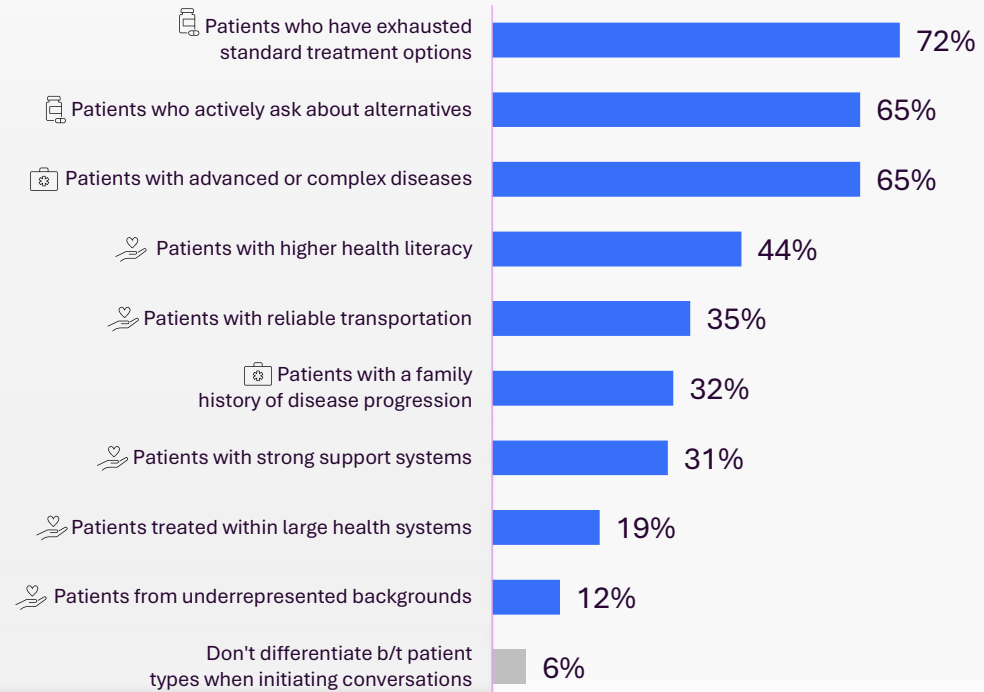
(Among those who have discussed clinical trials with patients)

### Top 3 Open End Coded Response Categories



## Patients More Likely to have Clinical Trial Discussions Initiated by HCPs<sup>^</sup>

(Among those who have discussed clinical trials with patients)



**94%**  
Differentiates among patients (NET)

**83%**  
Based on treatment options (NET)

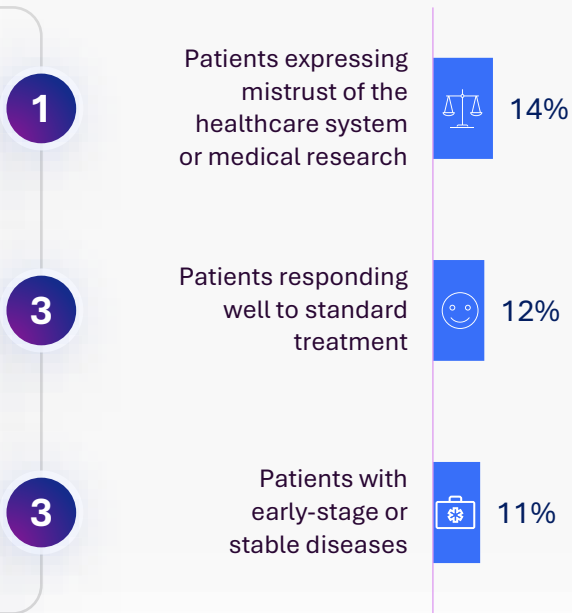
**73%**  
Based on disease / condition (NET)

**69%**  
Based on SDOH Factors (NET)

# PCPs are Less Likely to Initiate Discussions with Patients Facing Access Barriers or Perceived Readiness Challenges

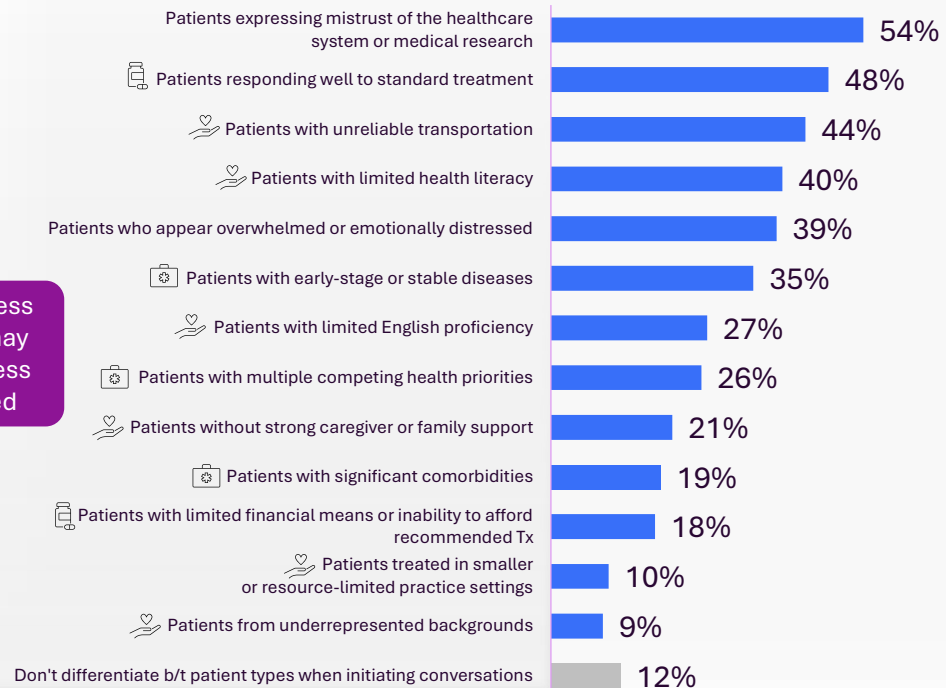
## Patients Least Likely to have Clinical Trial Discussions Initiated by HCPs

### Top 3 Open End Coded Response Categories



Patients facing access or social barriers may be systematically less likely to be engaged

## Patients Less Likely to have Clinical Trial Discussions Initiated by HCPs<sup>^</sup>



**88%**  
Differentiates among patients (NET)

**65%**  
Based on SDOH Factors (NET)

**57%**  
Based on treatment options (NET)

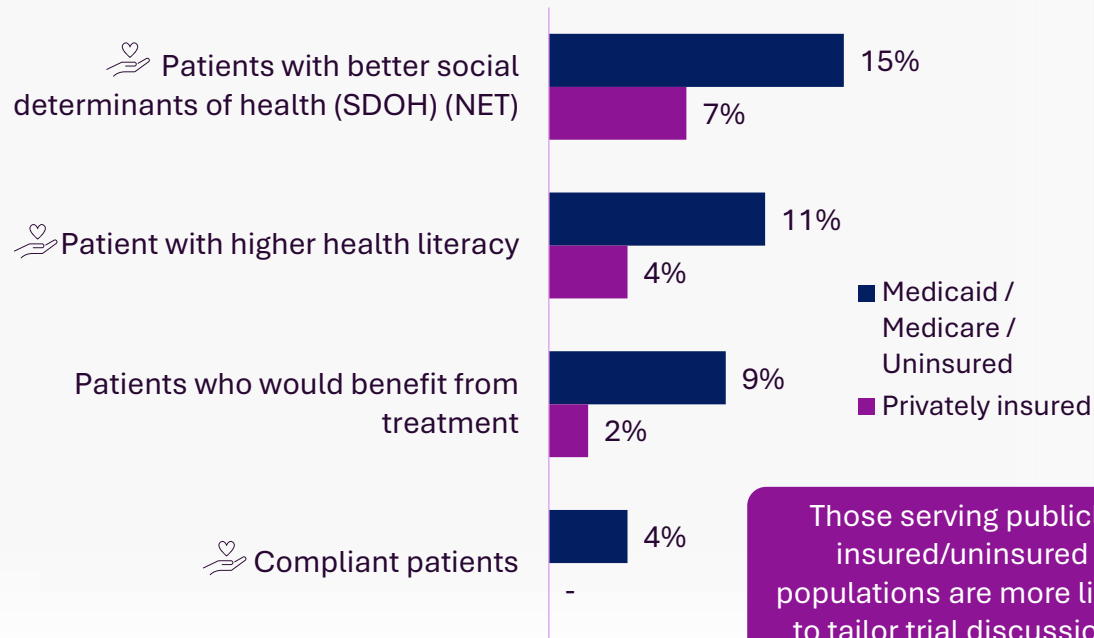
**54%**  
Based on disease / condition (NET)

# Trial Engagement Gaps Emerge at the PCP Level Based on The Patient Populations that They Serve

## Patients that HCPs are Most Likely to Initiate Trial Discussions with - by Insurance Mix

(Among those who have discussed clinical trials with patients)

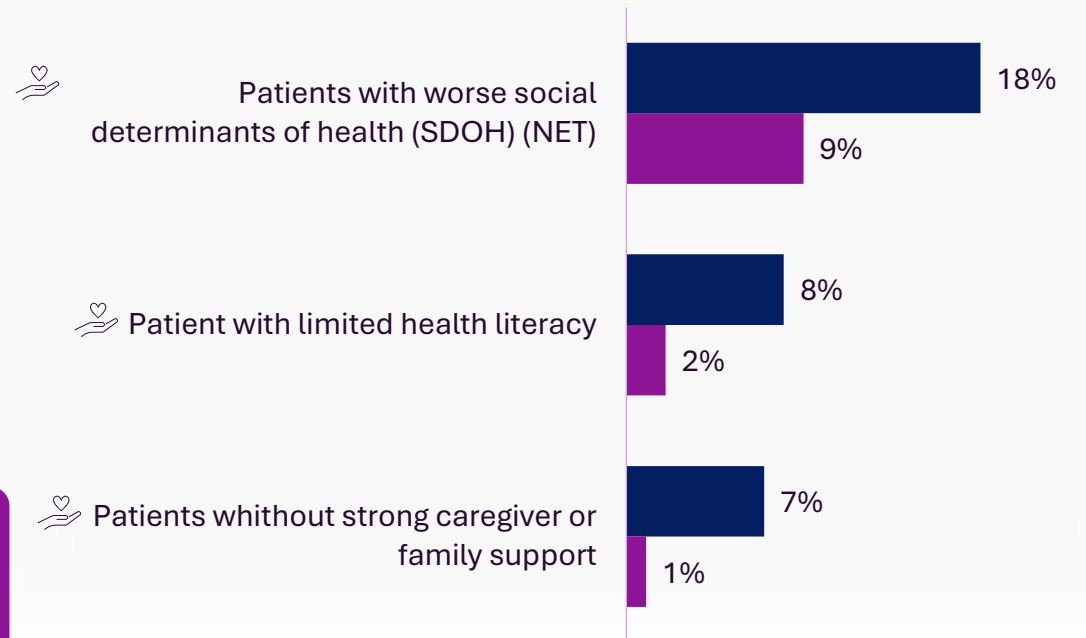
Statistically Significant Open End Coded Response Categories



Those serving publicly insured/uninsured populations are more likely to tailor trial discussions based on patients' social determinants and health literacy factors

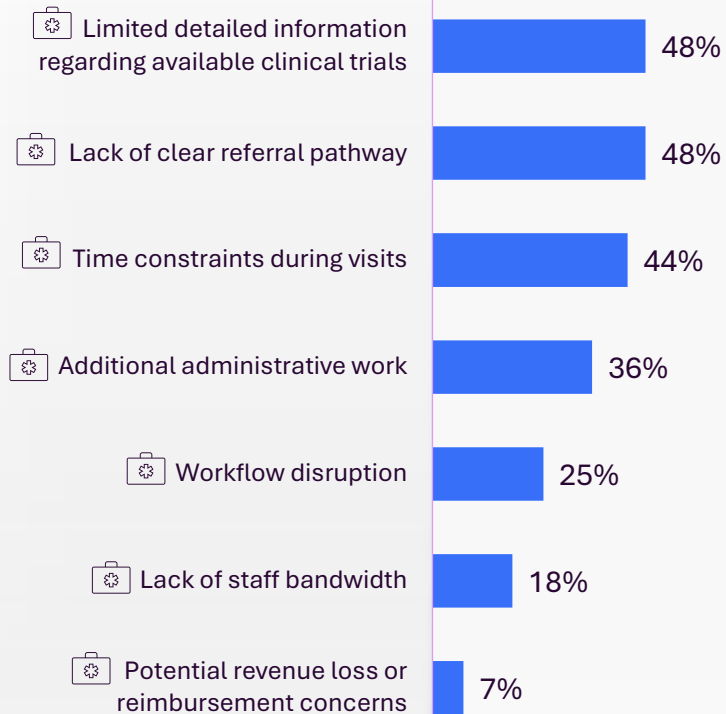
## Patients that HCPs are Least Likely to have Clinical Trial Discussions with - by Insurance Mix

Statistically Significant Open End Coded Response Categories

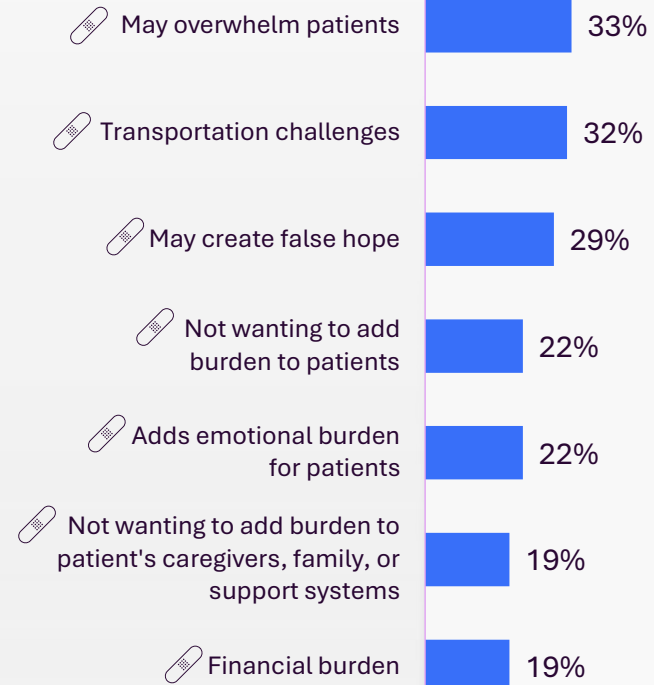


# Operational and Patient-Related Concerns Limit Clinical Trial Conversations, with Logistical and Emotional Burden Weighing Most Heavily

## Concerns Limiting Willingness to Initiate Clinical Trials Conversations with Patients



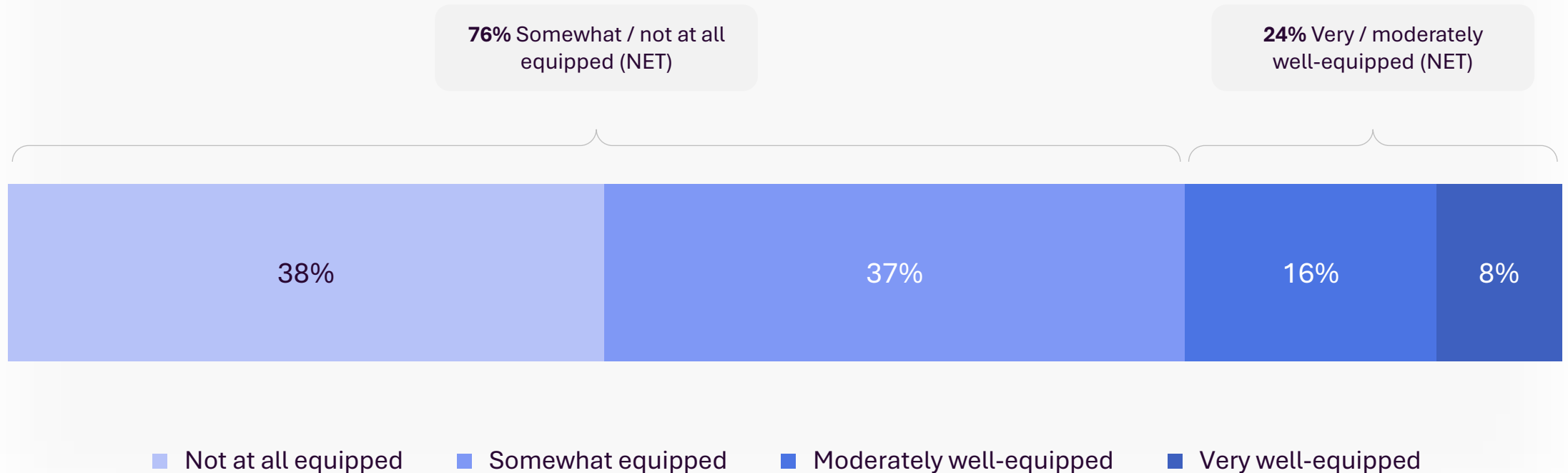
**88%**  
Practice  
Concerns (NET)



**73%**  
Patient  
Concerns (NET)

# Few PCPs Feel Well-Equipped to Support Clinical Trial Referrals, Highlighting Gaps in Capability

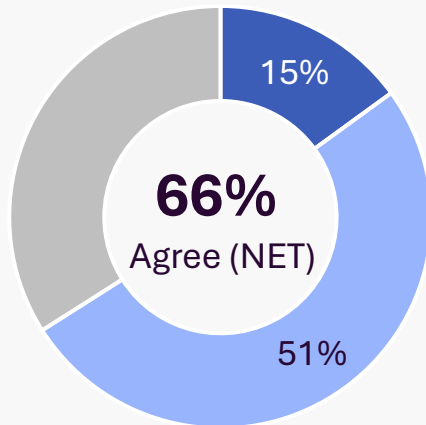
## Level of Being Equipped to Fully Support Clinical Trial Referrals



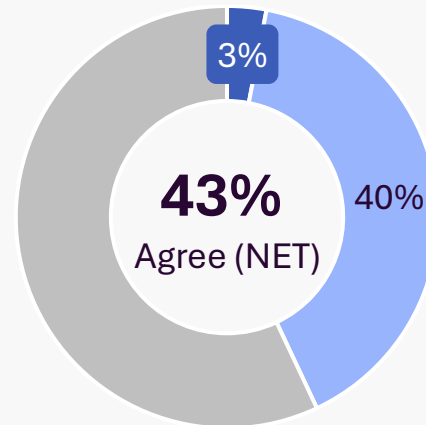
# PCPs Recognize a Role in Supporting Patient Participation, but Question Patient Interest and Eligibility

## Perspectives on Discussing Clinical Trials with Patients

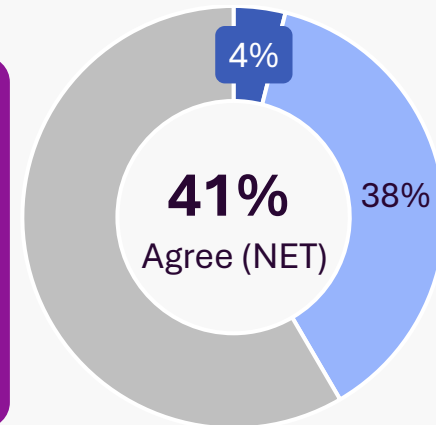
“It is part of my responsibility to discuss clinical trial options with eligible patients.”



“I don’t think that my patients would be interested in participating in clinical trials.”



“I don’t think that my patients would be eligible for many clinical trials.”



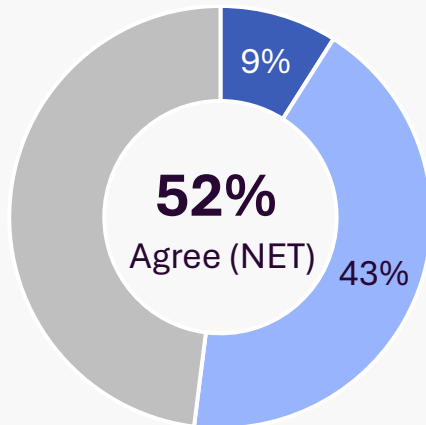
However, we know from past **PAN Foundation research** among patients that ~half of patients express interest in participation - highlighting a key misalignment.

■ Strongly agree   ■ Somewhat agree   ■ Disagree

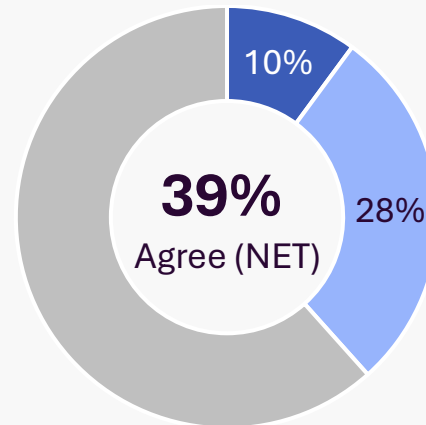
# PCPs Feel Equipped to Help Patient Navigate Structural Barriers, Yet Some Worry about Unintentionally Increasing Disparities

## Attitudes Toward Addressing Disparities and Barriers in Clinical Trial Participation

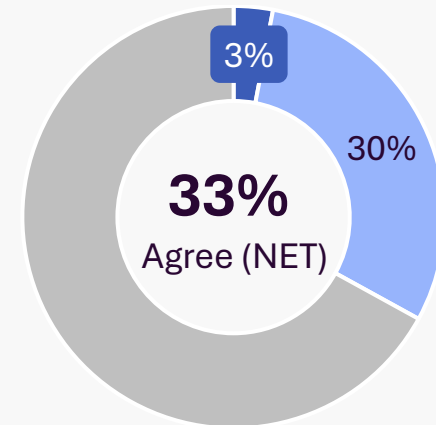
“I feel equipped to help patients navigate structural barriers to clinical trial participation.”



“I hesitate to raise clinical trial participation with patients from groups that have historically been mistreated in medical research.”



“I worry about unintentionally increasing disparities when raising trials.”



■ Strongly agree   ■ Somewhat agree   ■ Disagree



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# Structural Barriers & SDOH Considerations

Structural and operational constraints play a central role in limiting clinical trial discussions, with time pressures, staffing limitations, and lack of institutional support emerging as key barriers. These system-level challenges are compounded by patient-level factors, as PCPs widely perceive social and economic barriers to participation and often view trials as a last-resort option best suited for patients with greater flexibility.

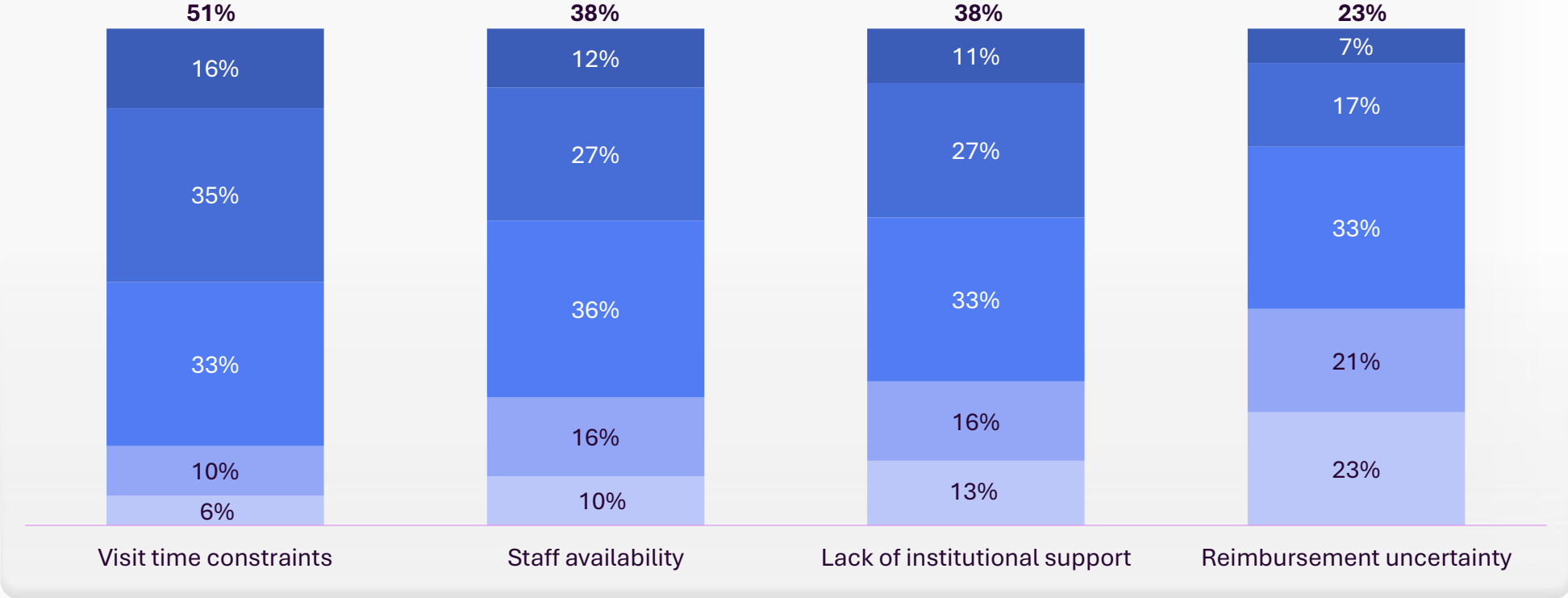
Rather than a single dominant driver, decisions around clinical trial discussions are shaped by a combination of access, trust, and resource-related barriers. This layered dynamic reinforces a pattern where structural and social factors collectively limit both the frequency and breadth of patient engagement.

# Time Constraints are the Primary Barrier to Clinical Trial Discussions, with Staffing and Institutional Limitations also Contributing

## Frequency of Factors Limiting Clinical Trial Discussions

Always / Often (NET)

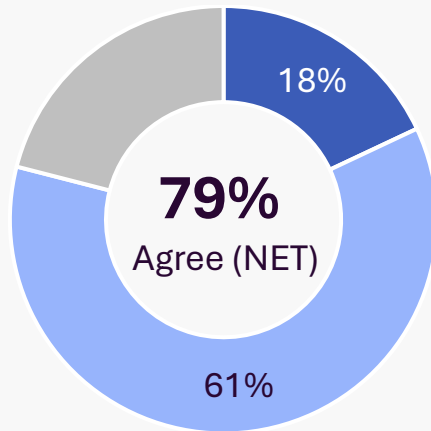
- Always
- Often
- Sometimes
- Rarely
- Never



# Social and Economic Barriers also Limit Participation, with Many PCPs Viewing Trials as a Last-Resort Option

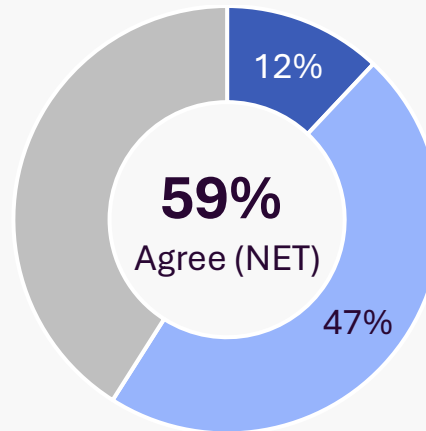
## Limitations to Clinical Trial Participation

“Social or economic factors limit many of my patients' ability to participate in trials.”

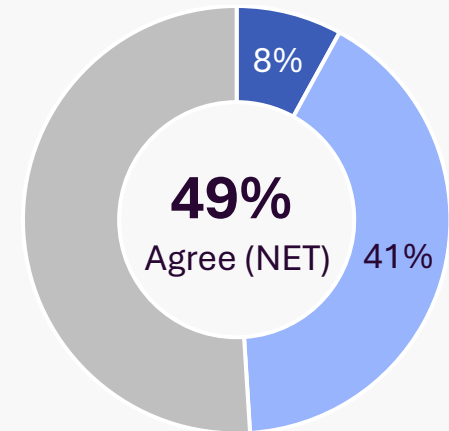


Perceived fit may limit access for patients with fewer resources or flexibility

“Clinical trials are typically a last-resort option for my patients.”



“Clinical trials only make sense for patients with flexible lifestyles or extra time.”



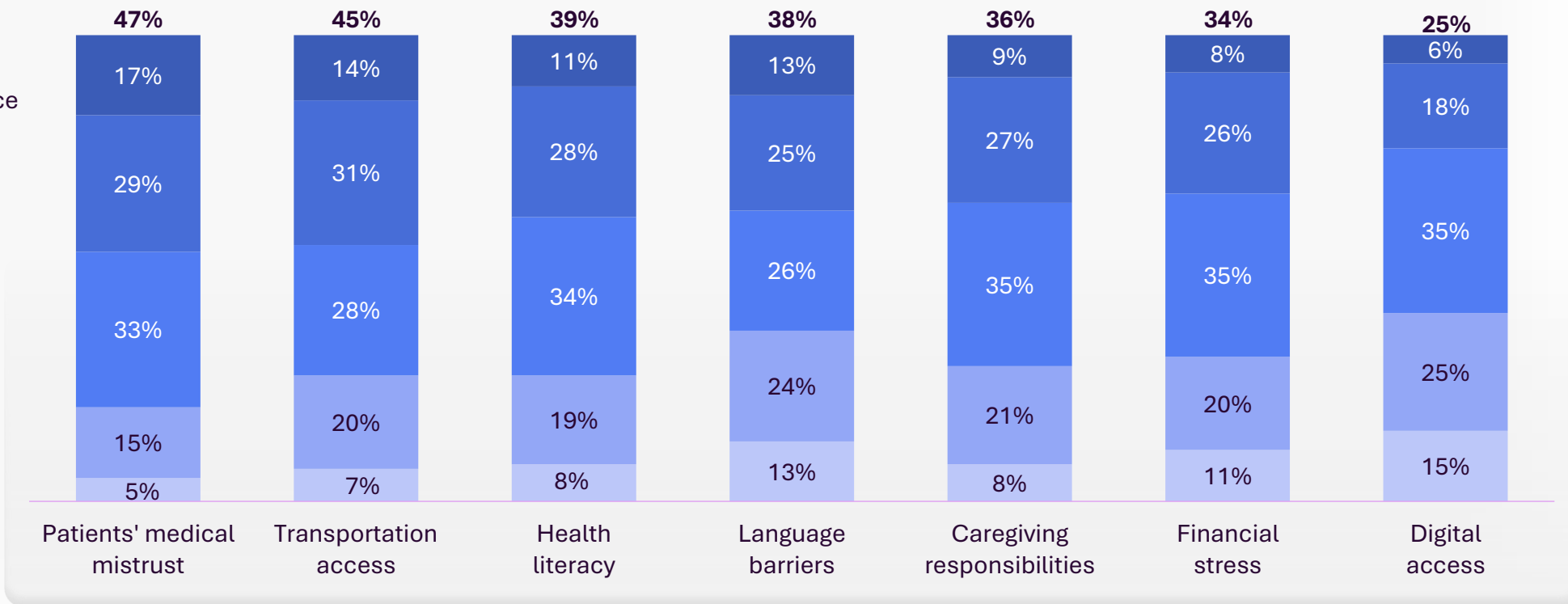
■ Strongly agree   ■ Somewhat agree   ■ Disagree

# No Single Barrier Dominates Trial Discussions – Decisions are Shaped by a Combination of Access, Trust, and Resource Constraints

**Influence of Factors on Whether to Discuss Clinical Trials With Patients**

Very strong / Strong influence (NET)

- Very strong influence
- Strong influence
- Moderate influence
- Slight influence
- No influence at all





# Resources & Support Needs

Interest in deeper clinical trial involvement remains modest, but PCPs point to clear levers to increase engagement – particularly improving knowledge, access to practical tools, and reducing financial and logistical barriers for patients. At the same time, gaps between available and needed resources highlight unmet demand for more accessible, coordinated support.

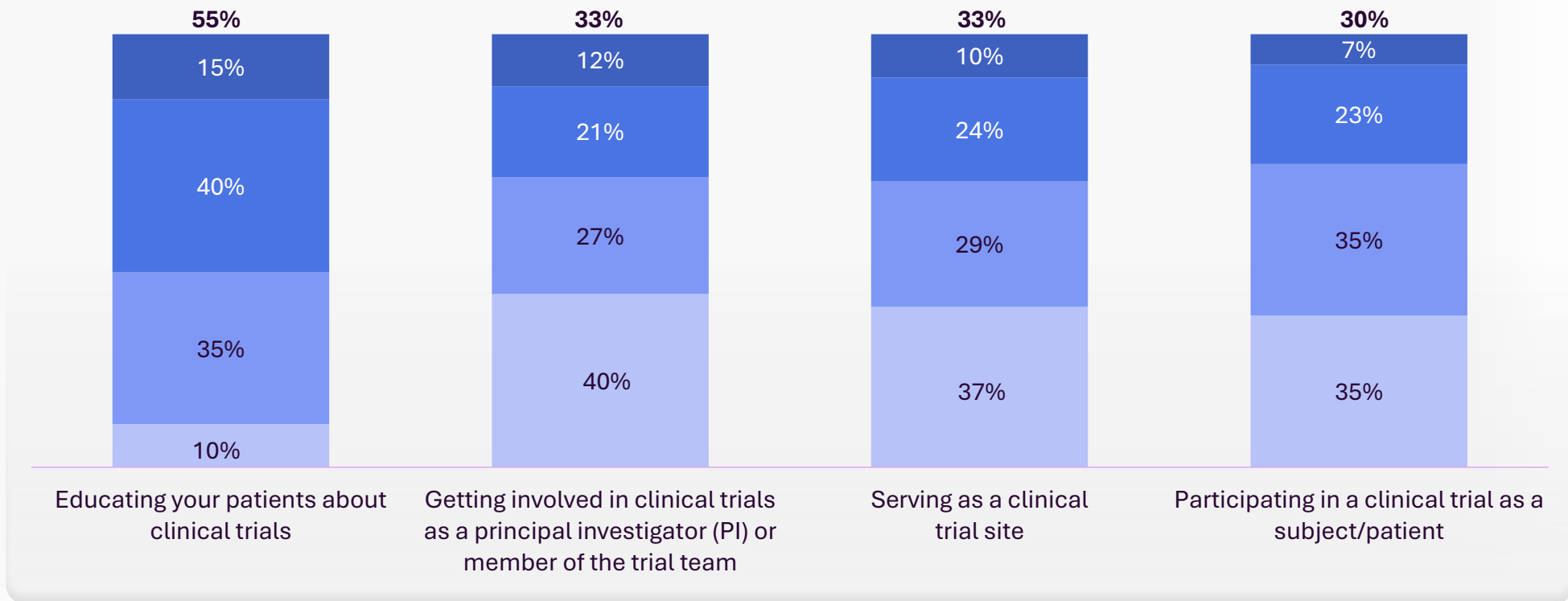
Even with these opportunities, structural constraints persist. Clinical trials are often not prioritized within practice settings, and PCPs emphasize the need for greater institutional support. These challenges, combined with ongoing patient-level barriers, risk reinforcing existing inequities in participation.

# Interest in Deeper Clinical Trial Involvement is Modest, Signaling an Uphill Path to Greater Engagement Among PCPs

## Interest in Becoming More Involved in Different Clinical Trial Aspects

Very /  
Moderately (NET)

- Very
- Moderately
- Slightly
- Not at all



# However, Improving PCP Knowledge is the Clearest Lever to Enable more Clinical Trial Discussions

## Elements Facilitating Clinical Trial Discussions with Patients

**Top 3**



**75%**  
Knowledge on clinical trials

Closing knowledge gaps may be the fastest path to increasing engagement



**66%**  
Ready-to-share educational materials for patients



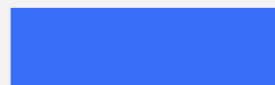
**58%**  
Dedicated trial coordinators

50%



Patient navigators

35%



CME/education tools

1%



Other

5%



None

# Reducing Financial and Logistical Barriers is also Key to Increasing Patient Participation in Clinical Trials

## Factors Facilitating Patient Participation in Clinical Trials

**Top 3**



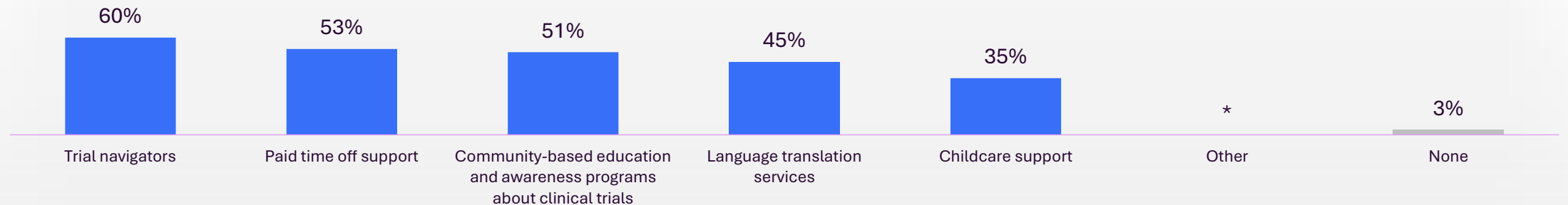
**68%**  
Financial assistance



**66%**  
Transportation support



**63%**  
Patient-friendly educational materials



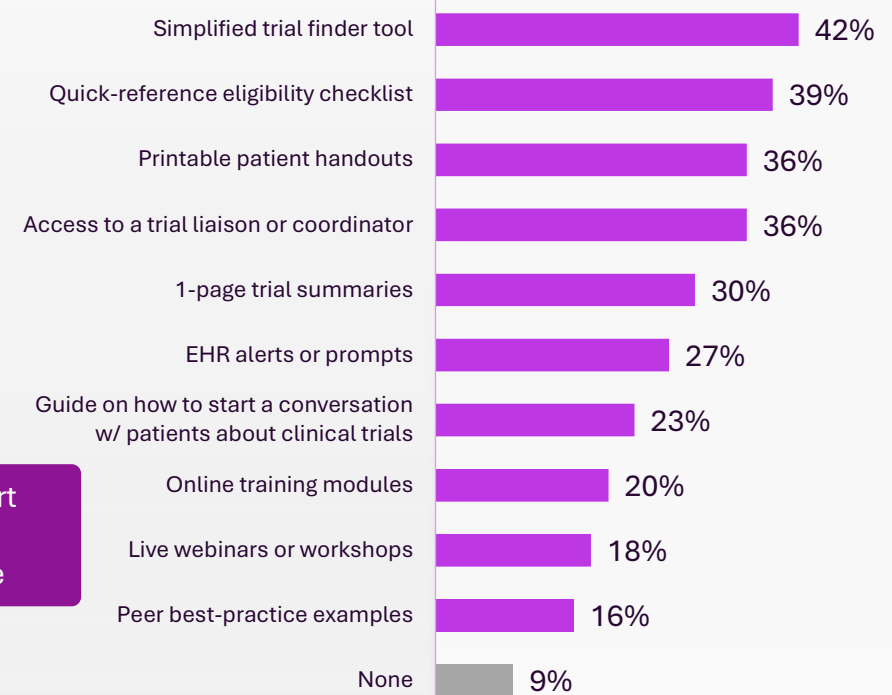
# Clear Gaps Exist Between Available and Needed Resources, with Strong Demand for Practical Tools and Coordination Support

## Resources Available When Discussing Clinical Trials



## Most Helpful Unavailable Resources for Clinical Trial Discussions

(Among those who do not have some resources – variable bases)



Demand for support outpaces what is currently available

# “Old School” Approaches Still Appear to Win, as Patients Respond Most to Direct, In-person Conversations over Digital or Passive Outreach

## Most Responsive Communication Approaches Among Patients

**Top 3**



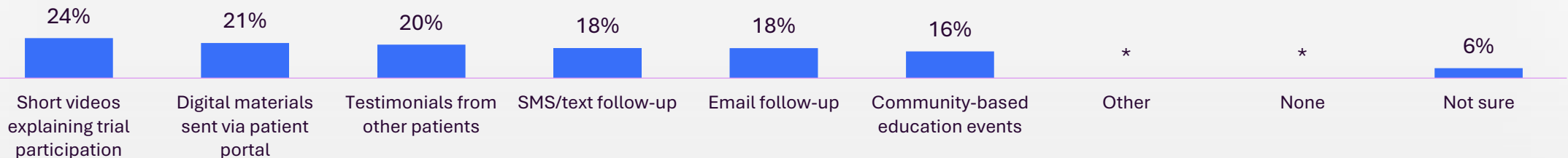
**69%**  
One-on-one discussion during visit



**44%**  
Printed materials provided during the visit

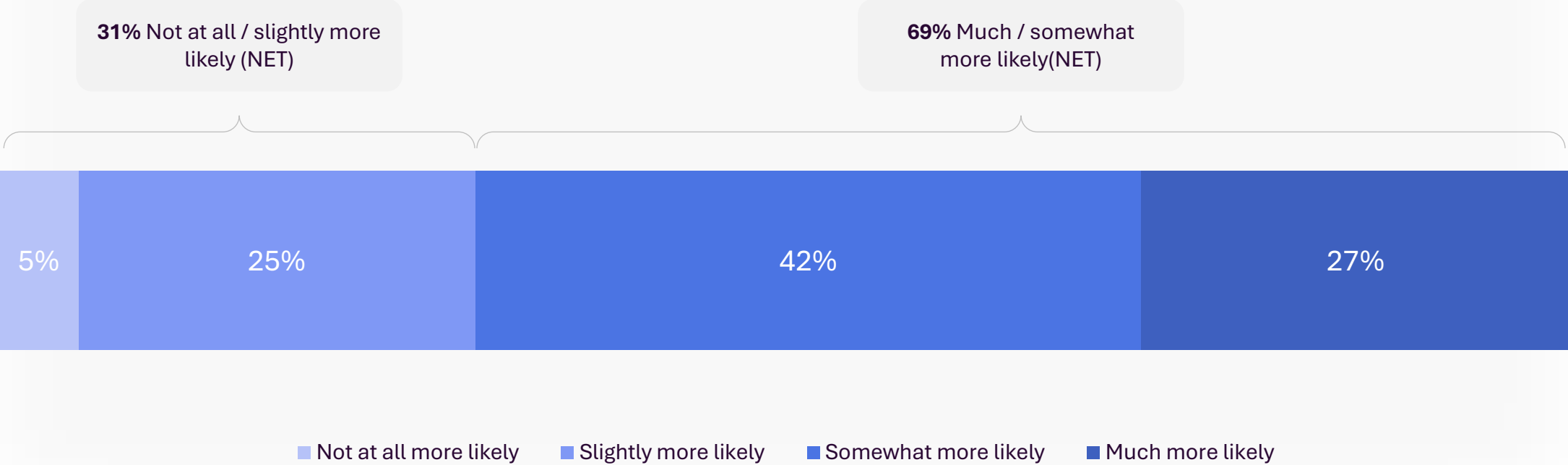


**42%**  
Follow-up call from care team member



# Addressing Logistical Barriers would Meaningfully Increase PCPs' Likelihood to Discuss Clinical Trials

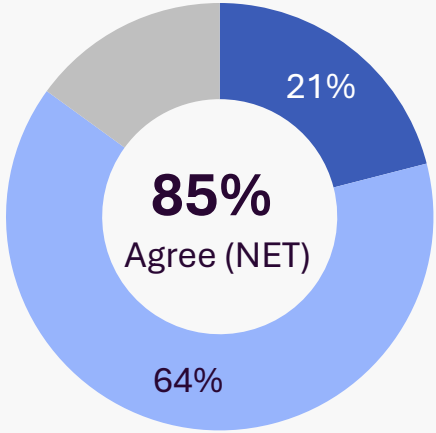
## Likelihood to Discuss Clinical Trials if Barriers Are Removed *(Excluding N/A)*



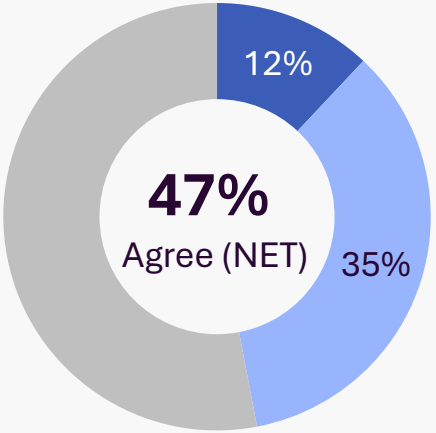
# Structural Gaps Persist, with PCPs Calling for Greater Institutional Support to Enable Clinical Trial Engagement

## Barriers and Facilitators to Discussing Clinical Trials

“With the right tools and support in place, I would increase how often I discuss clinical trials.”



“Revenue loss or reimbursement concerns limit my practice’s engagement with clinical trials.”

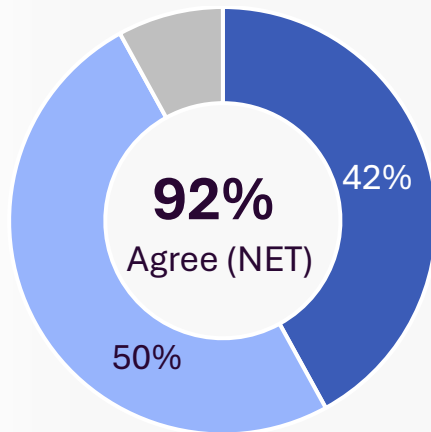


■ Strongly agree    ■ Somewhat agree    ■ Disagree

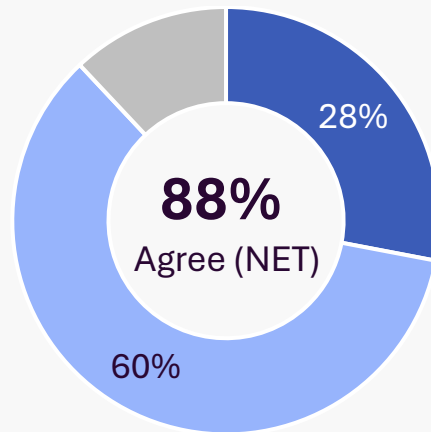
# Patient-Level Barriers and Inequities Continue to Limit Participation, Particularly for Vulnerable Populations

## Underrepresented Communities and Clinical Trial Experiences

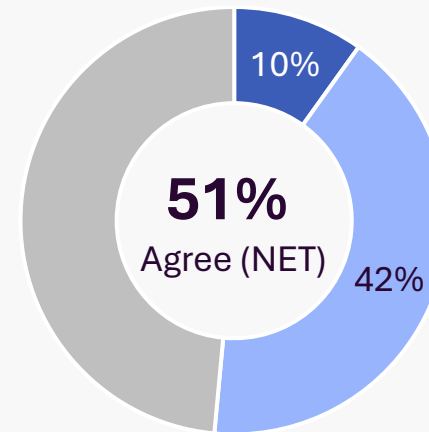
“Representation in clinical trials is essential to medical advancement.”



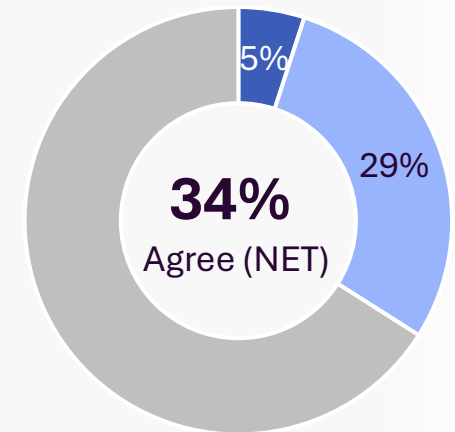
“My patients would be more open to clinical trials if they received clear, culturally appropriate information.”



“My patients of color tend to be less likely to participate in clinical trials.”



“My LGBTQIA+ patients tend to be less likely to participate in clinical trials.”



■ Strongly agree    ■ Somewhat agree    ■ Disagree

Without targeted support, existing gaps in participation may persist or widen

# Spotlight Populations

# Spotlight On: Rural PCPs\*

Rural PCPs operate in a more constrained environment, with lower perceived participation, limited infrastructure, and greater reliance on patients to initiate trial conversations.



**Participation gaps start at the top:** Rural PCPs estimate <5%\* patient participation vs. 9%+ among urban practitioners – and are more likely to say their practice offers no trials (54%\* vs. 29% urban, 38% suburban)



**Negative perceptions reflect real constraints:** Nearly half worry about negative impacts on their practice (48%\* vs. 25% urban, 34% suburban) and patient experience (45%\* vs. 27%, 28%), driven by time, cost, and logistical concerns (76%\* vs. 60%, 60%)



**Limited infrastructure creates access barriers:** 61%\* disagree they are equipped to help patients navigate structural barriers (vs. 39% urban), and 50%\* report having no support or resources (vs. 30% urban)



**Patients fill the gap, but eligibility confusion remains:** 55%\* say patients/caregivers initiate trial conversations (vs. 39% urban), yet 56%\* believe their patients are not eligible (vs. 36% urban, 40% suburban)



**What they need:** Quick-reference eligibility checklists and access to trial liaisons/coordinators to bridge structural and knowledge gaps

\*Results for rural PCPs based on small bases (n=50–99) should be interpreted as directional in nature.

# Spotlight On: Years in Practice

PCPs newer to practice are eager but cautious, while more experienced PCPs are confident—but more selective in who they engage.



**Untapped interest among newer PCPs:** 56%\*\* of those with <10 years in practice have not been involved in trials—yet 44%\*\* are interested in learning more, and 46%\*\* would consider serving as a trial site (vs. 27% with 31+ years)



**Ethical concerns shape early-career hesitation:** 47%\*\* of PCPs with <10 years cite ethical concerns around clinical trials (vs. 29% with 11–30 years, 22% with 31+), including concern about unintentionally increasing disparities (43% vs. 22% with 31+ years)



**Experienced PCPs lead conversations, but not equitably:** 57% of those with 31+ years typically initiate trial discussions, yet 72% are least likely to bring them up with patients facing social determinant barriers (vs. 50%\*\* among those with <10 years)



**What this means:** The next generation is open but needs guidance on ethical engagement, while experienced PCPs may require support to ensure more equitable patient access

\*\*Results for PCPs with <10 years in practice based on extremely small bases (n=31–49) should be interpreted as qualitative only.

# Spotlight On: PCPs of Color

PCPs of color demonstrate strong belief in and commitment to clinical trials yet recognize ongoing participation challenges among the patients they serve.



**High intent and advocacy:** 40% have not yet been involved but are interested in learning more (vs. 23% among white PCPs); 91% say they will refer patients to trials (vs. 81%), and 72% believe it is their responsibility to discuss trials (vs. 60%)



**More positive perceptions of the system:** 86% view regulatory and ethical considerations positively (vs. 77%), and they estimate higher patient participation on average (10% vs. 7%)



**Eager for tools to support conversations:** 81% want basic clinical trial knowledge (vs. 70%), and 71% say patient-friendly education materials would ease participation (vs. 58%); 22% also see value in community-based education (vs. 11%)



**Clear-eyed on equity challenges:** 60% say patients of color are less likely to participate in trials (vs. 45% among white PCPs)



**What this means:** PCPs of color are highly motivated partners in expanding trial access, but need foundational tools and community-centered resources to help close persistent participation gaps

# Implications

# Implications: Unlocking Clinical Trial Engagement Requires Activation, Enablement, and Equity Focus



## Activation

Clinical trial discussions must become more proactive and embedded in routine care – not reliant on patient prompts or late-stage triggers.



## Enablement

PCPs need simple tools, clearer pathways, and stronger institutional support to translate intent into consistent action.



## Equity

Addressing logistical, financial, and trust barriers is critical to ensuring more equitable access to clinical trials.

Real progress will come from making clinical trials a routine part of patient care, not an exception

# Demographics

# Demographics



## Primary Medical Specialty

<b>50%</b>	Family Practice / General Practice
<b>50%</b>	Internal Medicine



## Age

<b>3%</b>	25–34
<b>20%</b>	35–44
<b>22%</b>	45–54
<b>30%</b>	55–64
<b>25%</b>	65+
<b>55</b>	Mean



## Gender

<b>58%</b>	Man
<b>40%</b>	Woman
<b>*</b>	All others
<b>2%</b>	Prefer not to answer



## Primary Medical Specialty

<b>22%</b>	Northeast
<b>26%</b>	Midwest
<b>32%</b>	South
<b>20%</b>	West



## Office / Clinic Type

(Among those who work in an office or clinic)

<b>40%</b>	Single-specialty partnership or group (2 or more physicians)
<b>39%</b>	Multi-specialty partnership or group (2 or more physicians)
<b>21%</b>	Solo practice



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# Thank you

Contact information goes here.

[uniting.patientadvocate.org](http://uniting.patientadvocate.org)