More on value(s)

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This issue of the *Journal of Medicine and the Person* is again dedicated to “value(s)”. Values mirror the person to a point that one may construct the person as his/her values. The scope of the *Journal of Medicine and the Person* is medicine as an expression of one’s living values. The goal of the journal is to highlight the influence of values in medical decisions.

The first “value” issue was focused on “values”, that is, on that set of beliefs and aspirations that give meaning to the life of both the practitioner and the patient. It has been emphasized that medical care is a worthwhile endeavor only to the extent to which it enables the patient to pursue her/his personal values [1]. A value-neutral medicine is as realistic as a value-neutral person, that is, a person devoid of the person, an oxymoron. In that issue, the importance of diversity and narrative was emphasized in the assessment of the patient and the practitioner’s values. That excursus will be completed in the present issue by the article of Puchalski et al. [2], that describes a simple and validated method of assessing religiosity and spirituality and the impact that these values may have on the reception and delivery of health care.

The focus of this second issue is the assessment of the value of a medical intervention. Value is seen as an economic, albeit not necessarily a monetary issue [3]. Ultimately the value of a medical intervention is a balance of benefits and risks. Both benefits and risks involve objective and subjective components. For example, a 6-month prolongation of survival may be worthwhile for a patient who desires to reach a pre-specified milestone (a birth, a wedding, a graduation) and to reach that milestone he/she is

willing to undergo all forms of discomfort and all sizes of expenses. The same prolongation of survival may not be worthwhile to another patient whose major goal is to die without pain and to devote the cost of medical care to other investments, such as a good-bye travel to his/her country of origin or an inheritance to bequeath on his/her survivors.

This analysis of value requires first of all the documentation that the intervention is effective. As illustrated by Pathak et al. [4], the benchmark of effectiveness is represented by randomized clinical trials where a new treatment is compared to standard treatment. That being said, it is necessary to recognize that the majority of ongoing medical interventions have not been assessed according to that benchmark. Also, randomized clinical trials may show that a treatment is superior to another by a statistical standpoint when the difference may be negligible from a clinical standpoint, and this difference may be achieved at a cost in terms of toxicity and of money that is unacceptable by the majority of patients. Last but not least, the results of randomized clinical trials are obtained from a highly selected population that is particularly fit, and may not be applicable to the majority of the population affected by limitations that may reduce the benefits and increase the risk of complications of the intervention. Outcome studies are still in their infancy and the scarcity of these studies is the main hindrance to decide whether an intervention that is efficacious (that is, it works in a selected population) is also effective (that is, it works in the population at large).

When faced with multiple treatment options, the choice of the most valuable treatment is clearly based on cost that involves both human and monetary cost. The most cost-effective treatment is clearly the one that achieves the best results at the lowest cost. To this end the development of clinical pathways is paramount, as illustrated by Schippits et al. [5]. Unlike guidelines that offer different treatment

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options irrespective of the cost, clinical pathways direct a practitioner and a patient toward the most cost-effective form of treatment in individual circumstances. Though not perfect, clinical pathways are the best validated guidance toward the delivery of “value-based” care, that is, of personalized care.

The article of DeSouza and Wong et al. [6] highlight the issue of monetary cost, something that practitioners so far have been reluctant to address. Yet financial distress is a major cause of compromised quality of life, at least in countries where patients are responsible to underwrite part of the cost of their medical treatment, including the United States. Monetary cost is indeed an expression of value. When the resources are limited what would an individual prefer to do with her/his money? How are those limited resources best invested toward a person’s accomplishments of her/his personal goals? Like any other resource, money is above all a means of self-realization.

This perspective of medical value is kind of novel and somehow disturbing for professionals used to think that health is an absolute value. Yet the equation medical value–economic value is made necessary by the changing panorama of medical care that includes:

- *Evidence-based medicine* A clear documentation of what works and does not work as well as a realistic appreciation of the size of benefit of an effective treatment allows the patient to decide whether this benefit is worthy of the human and monetary cost involved.
- *The emergence of chronic diseases as the most common form of illness* In chronic diseases, the treatment involves a number of complications that may be inconsistent with a person’s values. For most older adults, the loss of personal independence is a major

tragedy and many of them may prefer to trade a small prolongation of their survival for the maintenance of their independence until the time of death.

- The development of specialized medicine that may represent a forest where patients may lose the direction of their health care. To get out safely of this forest, the patient needs the guidance of a practitioner familiar with his/her desires and values.
- The rising cost of medical care that compels the individuals as well as the society at large to choose how to allocate limited monetary resources

In the last two issues of the journal we have tried to lay a blueprint for the practitioner willing to deliver personalized medicine, that is, medicine consistent with a person’s value. The steps include: assessment of personal values; assessment of the effectiveness of an intervention in individual circumstances; a negotiated medical decision that reflects the patient’s own values.

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