In 1947, the World Health Organization broadened the definition of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ [1]. This new paradigm, representing the ideals of modern medicine, measuring patients’ views on their psychological fulfilment, satisfaction and well-being, became an important outcome both in clinical assessment and in policy decision-making. A number of instruments were then developed and used to measure the views of persons with chronic illness. In particular, regulatory agencies such as the Food and Drug Administration in the USA, the National Institute for Health and Clinical Excellence in England and the National Authority for Health in France recommended assessing the quality of life in patients with chronic illness.

The quality of life measurement has thus become increasingly accepted as playing a key role in helping individual patient care, in addition to the traditional assessment of clinical outcomes. Considering this evolution, oncology and surgery were precursors in the quality of life assessment and in policy decision-making. A number of instruments are in use to measure the views of persons with chronic illness. In particular, regulatory agencies such as the Food and Drug Administration in the USA, the National Institute for Health and Clinical Excellence in England and the National Authority for Health in France recommended assessing the quality of life in patients with chronic illness.

In addition to the importance of measuring patients’ views and the evident interest of these findings, a necessary autocritique tends to clearly moderate our enthusiasm. An important limitation concerns the multiplicity of measuring scales and the absence of common metrics. The literature identifies a large number of instruments that have been psychometrically validated with varying evidence and without clear conceptual models. Little guidance for selecting the most appropriate instruments may mean that the failure of these measures to have a real impact on clinical management and policy decision-making. In particular, several studies have reported that clinicians believe that quality of life measures lack clinical relevance for their patients [3]. In the present study, we find two common problems in publications on patients’ views. The first one concerns the ‘Life Meaningfulness Scale’, which constitutes the originality of this work [4]. Metrological properties integrated aspects such as content validity, construct validity and responsiveness, are not detailed in the manuscript and the reference does not allow easy access to this information. The validation process is particularly important for professionals seeking an effective instrument because it assures the questionnaire’s performance. The absence of the metrological properties may prevent professionals from using this instrument, or on the contrary professionals may use this instrument although it is not adapted to their needs.

Another problem concerns the use of the SWL scale for two reasons [5]. The SWL was published in 1985 and significant developments in psychometric theory and practice have been made in the last 25 years. Modern psychometric methods need to be applied to the instruments currently in use. Moreover, the content of the SWL, as for a majority of instruments, still relies on literature or experts to determine domains and concerns that are important for patients. The perspectives to which the questionnaires refer to are an important issue because of discrepancies between patients’ and physicians’ points of view. The risk here is to mislead clinicians and policy deciders by providing a false measurement of patients’ views.

Finally, another important concern is the interpretation of the results, which may traduce physician-centred beliefs. With respect to the transversal design of this research, two causal interpretations can be proposed. Is it the perception of disease which influences SWL and meaning with life (‘sub-optimal hospitalization-related perception of the disease due to self-realization constraints profoundly impairs psychological welfare of patients’), or the contrary (‘patients with the lower degree of satisfaction of life tend to perceive their illness as leading to some important self-realization constraints’)? By proposing a very convincing and practical conclusion, ‘surgical patients require early psychological, social and spiritual support to prevent the harmful psycho-social consequences of illness and hospital stay’, the authors tend to choose the former hypothesis, which may be seen as a bit presumptuous about the role and the effectiveness of medicine. The latter hypothesis should not be overlooked. The ability of patients to cope with their disease and to redefine life meaning are also based on a person’s individual characteristics and behaviours, social conditions and environment, probably more than on health care.
REFERENCES


