Future perspectives
In recent years, the assessment of outcome in the medical field has shifted from traditional parameters such as bypass patency and patient survival, towards a more abstract concept of outcome: the patient related outcome measure (PROM). The research presented in this thesis indicates that the use of PROMs provides us with an abundancy of new, important health information, directly from the patient’s perspective. However, the use of PROMs (e.g., quality of life measurements) also introduces a number of dilemma’s that are difficult to overcome: PROMs are labor intensive, time consuming, difficult to interpret, to weigh and to compare. The complexity of the QoL concept makes it hard to determine its value. But most of all, a specific scientific observation of a difference in QoL, whether in a population or in an individual patient, does not always translate to an effect that is actually noticed or experienced by the patient.

Quality of life is usually not determined or limited by a single factor or illness. It is questionable whether quality of life can really be influenced by a vascular surgeon by means of a simple (but always risky and costly) mono-organ intervention in this population of very sick patients with many other QoL-limiting comorbidities. A small and temporary improvement in quality of life after successful revascularisation that is soon to be overshadowed again by the burden of other concomittant diseases is perhaps not worthwhile. Maybe, PROMs as we know them are just not appropriate to be used in every patient category and should we, at least for now, focus at less complex and easier to measure outcome parameters that can actually be influenced, for example, pain and mobility. For quality control and comparison, 'effect' should be measured in clear, non-abstract, reproducible parameters rather than in multi-interpretable and very hard to measure, merely academic concepts such as QoL; not only to allow unequivocal assessment of our treatments, but also to protect our patients against the risks of treatments that will result in marginal, temporary improvements at best, this at tremendous cost at the expense of society. The key principle is that treatments should be measurable, cost-effective and proportionate in every aspect, especially in this very fragile and costly
population with an a priori very limited quality of life and life expectancy. For this purpose, the available PROMs may not be sufficiently refined. The usefulness of PROMs to serve as a main outcome parameter - in comparative clinical research, for the comparison of healthcare providers and institutions by governments or health care insurance companies, or as a basis for health care policy making - seems limited. In their current form, the use of PROMs should probably be implemented with some restraint - perhaps even for academic purposes only. The development of simpler tools that can be used for comparison of populations that are not quite similar (e.g., randomized populations with a specific affliction and treatment, but from different regions in the world, or patient populations from different hospitals with a different case mix) is imperative for a broad and successful implementation of PROMs in the health care industry. Maybe the only question should be: “Are you satisfied with your treatment?”.