MEGA JOURNAL OF CASE REPORTS

OPEN ACCESS

Editorial

Compiled Date: Novembre 05, 2026

"Clinical Economics" Integrates Risk Awareness into Evidence Based Medicine, Thereby Confirming Albert Einstein's Theory of Relativity

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Keywords: Evidence-based medicine; Significance of risk awareness; Albert Einstein's theory of relativity; Financing of healthcare; Efficiency of healthcare; Restructuring healthcare

Editorial

A former editorial in this journal presented the theory that proves effective not only in experimental settings but also in the everyday clinical care of our patients [1]. Today, the next step can be confirmed, reinforcing our confidence that we may be on the right path. The aim of this contribution is to persuade those colleagues who are thus far viewing the integration of "risk awareness" into evidence-based medicine with skepticism. There is no doubt that considering the individual risk profiles of each patient will make the care we provide more complex. Without incorporating these risk profiles, it is impossible to prevent unnecessary care and costs. No one wants to withdraw funding from healthcare, but everyone wants to ensure that every cent spent on health generates added value in terms of health outcomes. Our team has been developing a concept based on justifying every cent invested in the healthcare system by the added health value it generates. My mentor at the Ontario Cancer Institute in Toronto/ONT, Dr. David Osoba; coined the term "Clinical Economics (Clinecs)" for this approach [2]. The first textbook on this subject was published 20 years ago [3].

Meanwhile, "Clinecs" refers to an interdisciplinary field of medicine that weighs health-related added value against costs in six themes: (1) The two recommendations of Hippocrates; (2) The three questions of Sir Archibald Cochrane; (3) The Ulm Legacy; (4) Operationalization of the answers to the three Cochrane questions; (5) The "Cube of Care Conditions"; and (6) Supplementing evidence-based medicine with Clinical Economics.

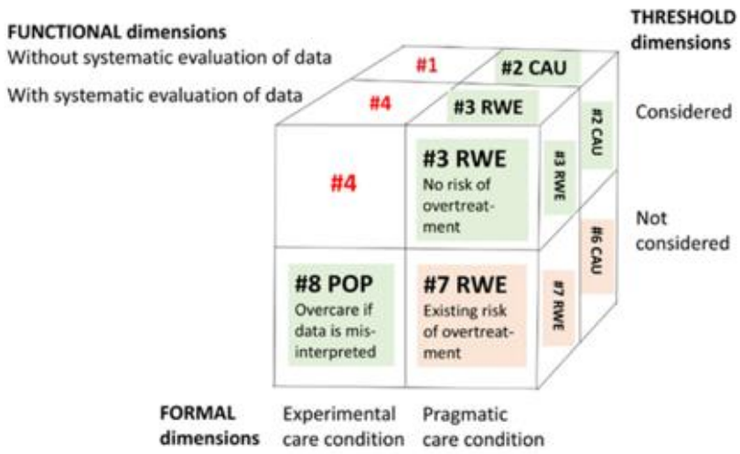
1. Hippocrates offered two significant recommendations. The first is widely known: "Do not look only at the aching knee, but at the patient as a whole." The second recommendation, however, is rarely heeded: "Do not focus solely on the type of illness from which a patient suffers; rather, direct your attention to the nature of the individual who has been affected by that illness."Unfortunately, Hippocrates was unable to describe precisely how this second recommendation should be put into practice (operationalized). Today, we assume that the "type of patient" can only be understood in conjunction with Hippocrates' requirement: assessing each patient's health risk profile makes it possible to predict the chances of recovery and the risks of failure. AI can assist us in keeping the necessary data organized and accessible. Only experts with sufficiently sound clinical experience can determine which data needs to be collected. The validity of these recommendations can only be confirmed by verifying that the assessed risks align with the actual clinical outcomes.

2. Our former editorial describes the three questions posed by Sir Archibald Cochrane, along with their answers [4].

3. The Ulm Legacy includes recommendations from Albert Einstein [born 1879 in Ulm] and the Ulm academy of design (hochschule für gestaltung, hfg ulm 1953-1968). Einstein suggested: "If I had an hour to solve a problem, I would spend 55 minutes understanding it!" and "A problem cannot be solved with the same mindset that created it." Although both suggestions can only be implemented through a strictly disciplined way of thinking, the effort is well worth it. The Ulm Academy of Design (hfg) was founded with the goal of designing not only products but also concepts, to prevent the recurrence of the errors of the Nazi regime. Within Prof. Hans (Nick) Roericht's team, we medical professionals were able to gain insight into the way designers think **[5].** Understanding and applying the principle coined by American architects and designers that "Form Follows Function (FFF rule)" revealed a contradiction: experimental studies are ill-suited for describing the effects of everyday clinical care **[6–8]**.
4. The operationalization of the three Cochrane questions has recently been described **[9].**
5. The "Cube of Care Conditions" could only be developed after the third, essential dimension of healthcare provision, "real-world effectiveness," which is non-experimental yet quantifiable, was identified. To date, we differentiate only two forms of healthcare: experimental and non-experimental. The former can be measured through experiments, while the latter cannot. This led to the erroneous assumption that the suitability of healthcare services provided in everyday clinical practice could be measured in experiments. The need arose for a third, quantifiable category of everyday care a rose only when it became clear that everyday healthcare is far more complex than can be captured within the scope of an experiment.

According to the "FFF" rule, the first two dimensions of any form of care should describe its functions and its forms (structures). The third dimension should reflect whether threshold values need to be considered when determining the need for care and the success of that care. In the era of experimental studies, it was only possible to quantify the theoretical superiority of an intervention under experimental conditions referred to as "efficacy or Proof of Principle (POP)"along with the subjective perception of "value (VAL)." Incorporating objective "real-world effectiveness" (RWE) additionally requires the definition of thresholds. Without thresholds, there is a risk that trivial health impairments will be classified as indications for treatment, and that minimal health improvements will be labeled as successful outcomes. Both forms of overestimation jeopardize the financial sustainability of any healthcare system. Following the FFF rule, the first two dimensions were intended to represent the functions and forms of care. The third dimension was to reflect whether thresholds are considered or disregarded when defining the need for care and the success of care. By replacing the "levels of evidence," this "CCC" could make EBM more objective.

Figure 1. The three dimensions of the cube of care conditions (CCC) each describe two different manifestations of each of the three dimensions. Eight small cubes are marked with numbers 1 - 8. Five of the eight small cubes (2, 3, 6, 7, 8) each describe the three forms of care (2, 3 and 8). Dice 2 describes an experimental form of care, while the two cubes (2 and 3) each describe a pragmatic, i.e. non-experimental form of care taking thresholds into account. The two small cubes 6 and 7 describe the care results under CAU and RWE not considering thresholds. The small cubes 1, 4, and 5, not visible below cube 1 represent illogical or unethical study conditions **[9].**



6. Supplementing EBM with "Clinecs" could be one of the most valuable contributions we can offer to the colleagues who pioneered EBM 30 years ago. Without their achievement, there would be no foundation upon which our own contribution could be built.

Conclusion

The function of EBM will be unchanged; only its form could be optimized to enhance that intended function. "Clinecs" supplemented by the aspect of risk awareness could contribute to this. A wood designer has created an appealing original version of the CCC, which could be produced for all interested parties once the scientific community has accepted the concept.

Declarations: This project did not receive externals funding. The author does not have to report any conflicts of interest

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Citation of this Article

Porzsolt F. "Clinical economics" Integrates Risk Awareness into Evidence Based Medicine, Thereby Confirming Albert Einstein's Theory of Relativity. Mega J Case Rep. 2026;9(11):2001-2003.

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