ALBERT W. MUSSCHENGA

THE RELATION BETWEEN CONCEPTS OF QUALITY-OF-LIFE, HEALTH AND HAPPINESS

ABSTRACT. In the last two decades, the term "quality-of-life" has become popular in medicine and health care. There are, however, important differences in the meaning and the use of the term. The message of all quality-of-life talk is that medicine and health care are not valuable in themselves. They are valuable to the extent that they contribute to the quality of life of patients. The ultimate aims of medicine and health care are not health or prolongation of life as such, but preservation or improvement of the quality of life. The primary aims of medicine and health care, such as the prolongation of life, can – but need not always – come into conflict with the ultimate ones: medical treatments do not always benefit a patient. In this article I will, first, summarize the results of my explorations of the use and the meaning of the term "quality-of-life." The use and the meaning of the term turn out to depend on the contexts of medical decisionmaking in which it is used. I will show that there are at least three different concepts of quality-of-life. Second, I will argue that the different concepts of quality-of-life are not unrelated. They point to different components of and/or conditions for happiness. Third, I will analyze the relation between the three concepts of quality-of-life, health and happiness.

Key Words: enjoyment, excellence, happiness, health, medical evaluation research, quality-of-life

I. CULTURAL BACKGROUNDS OF THE RISING POPULARITY OF THE TERM "QUALITY-OF-LIFE"

Originally the term "quality-of-life" was used for criticizing policies aiming at unlimited economic growth. The critics pointed at the devastating long-terms effects (exhaustion of resources) and side-effects (pollution of the environment) of economic growth on the future conditions for a good life. In using the term "quality-of-life," these critics expressed a concern for the *quality of the external conditions for living*.[1] The belief in the blessings of economic growth was part of a conception of good life in which material

Albert W. Musschenga, Ph.D., Institute for Ethics, Vrije Universiteit, Amsterdam.

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values were central. In the eyes of the critics that was an impoverished conception of the good life. For them not only the external quality of the conditions of living was at stake, but also the *internal quality of human life or human excellence*.

After World War II, the influence of welfarist and utilitarian ideologies on politics increased. The aims of social policy were formulated in different terms as "happiness," "well-being" and "quality-of-life." A new discipline – "quality-of-life research" – had to provide policy makers with the data for designing effective social policies. Not surprisingly, social policy makers were also interested in the role medicine and health care could play in improving the quality of life. However, that is not the reason the term "quality-of-life" became popular in medicine. The term turned out to be useful in discussions about the value of medical treatments, and of medicine in general. Already in 1966 in an editorial in the *Annals of Internal Medicine* under the title 'Medicine and the quality of life,' Elkinton discussed the need to allocate the health care budget such that it delivers a maximum contribution to the health and quality of life of all members of society. In connection to that, he points at the ambivalent effects of strongly invasive treatments as kidney dialysis and kidney transplantation. Compared to social sciences, the term "quality-of-life" became in medicine, much more popular than the rival "well-being." The most simple explanation is that the opposite of "well-being" in the socio-political domain, "(material) welfare" is not applicable within the domain of medicine. The pair of concepts "quality-of-life" and "quantity-of-life" was found to be appropriate both for characterizing and for criticizing the dominant aims and goals of medicine. The core of the critique on the dominant kind of medicine was that it measured its success and progress solely in purely quantitative terms.

II. QUALITY OF LIFE IN MEDICINE

As I will show, the term "quality-of-life" has different meanings in medicine and health care. The common purpose in using the term is to question the role of biological parameters, such as survival or reduction of the size of tumors, as the sole criteria for the effectiveness of medical treatments. The term "quality-of-life" then refers to other factors that have to be considered in making medical deci-

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sions. The nature of factors deemed relevant will depend on the nature of the decision that has to be made. That is why it is understandable that there also are different kinds of quality-of-life considerations, related to different concepts of quality-of-life. The preference for one particular concept depends on its usefulness for the kind of decision one has to make. Why were quality-of-life considerations needed? I mention two reasons. First, until a couple of decades ago, infectious diseases were the main cause of death. The discovery of new drugs such as antibiotics provided effective treatment for diseases such as pneumonia and tuberculosis. Patients mostly regained complete health after treatment with these drugs. As the incidence of infectious diseases decreases, the relative and the absolute incidence of other diseases such as cancer and cardiovascular disease increased.

In the course of time some successful treatments were developed for these diseases. However, the effects of most treatments are partial, uncertain, and temporary. Partial, because the disease may be stopped so that the patient survives, while it is impossible to restore health completely. Uncertain, because it is not possible to predict the degree of success of a treatment. Temporary, because the diseases can recur, perhaps in other parts of the body, as is the case with cancer. In addition, treatments such as chemotherapy for cancer cause burdensome side-effects, e.g., nausea, vomiting, loss of hair, etc. In view of all this, survival times are no longer a sufficient measure of success. The term "quality-of-life" is the common denominator for diverse sets of other criteria of success.

The second reason is related to the first one. It is common to measure the success of medical interventions either in terms of complete restoration of health or in years of prolonged life. Chronic diseases are incurable and can lead to irreparable impairments. Usually, as with rheumatoid arthritis, they do not have to lead to a substantial decrease in life-expectancy. Therefore, it is difficult to quantify the successes of medicine and health care for patients with chronic diseases. Again, the language of quality-of-life turned out to be useful for referring to the effects of medical and non-medical treatments of patients with highly disabling diseases.

In previous works I have examined the role of quality-of-life considerations in various contexts of medical decision-making (Musschenga, 1987; 1994). The two most important contexts are:

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1. comparative evaluation of the effectiveness of alternative treatments (e.g., kidney dialysis and kidney transplantation), in general, and in individual cases (e.g., choice between different treatments for individual patients); and
2. decisions about the initiating or foregoing life-sustaining treatments.

I have identified three different meanings in the use of the term "quality-of-life" in these contexts. Because of the diversity of these meanings, I prefer to speak of three different, but related *concepts* of quality-of-life:

1. quality-of-life as (the degree of) normal functioning (as a member of the biological species homo sapiens);
2. quality-of-life as (the degree of) satisfaction with life; and
3. quality-of-life as (level of) human development.

These first two concepts are the most common. They appear in both of the above two contexts. The third is, as I will show, more specific. In the following I will only give a short summary of my analysis of the use of the term "quality-of-life" in these two contexts.[2]

III. THE CHOICE OF A (STANDARD-)TREATMENT

In this section, I will deal with the meaning and the use of the term "quality-of-life" in what is called "medical evaluation research." The aim of this research is to collect data that are relevant for the improvement of the effectiveness of treatments, the comparison of the effectiveness of alternative treatments, and decisions about the treatment of individual patients. The concern for the ambivalent character of, for example, chemotherapy, dates from before the time the term "quality-of-life" became popular. Soon after World War II, Karnofsky and Burchenal called attention to problematic features of treating cancer patients with nitrogen mustard (Karnofsky and Burchenal, 1949). They were the forerunners of a tradition of medical evaluation-research. In the beginning of the seventies the term "quality-of-life" became popular. The term then covered a rather loose set of indicators, relevant for measuring *normal functioning and independence*. Normal functioning consists of a number of activities of daily living such as

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walking, dressing, washing, etc. This concept of quality-of-life is an *objective* one. A patient's ability to perform activities of daily living can adequately be evaluated from an external point of view. The first generation of quality-of-life researchers did not worry much about conceptual and methodological problems pertaining to the definition and measurement of quality-of-life.

Since the beginning of the nineteen-eighties there was an increase in the participation of social scientists in medical evaluation research. These social scientists had a keen interest in conceptual and methodological questions. They brought with them their own concepts and methodology which stemmed from the tradition of sociopolitical quality-of-life research. The dominant concept of quality-of-life in that tradition was the one developed by Campbell *et al.* in their book *The Quality of American Life* (1976). Quality-of-life, according to these authors, refers to the *subjective* evaluation and experience of life. The final measure is "*satisfaction with life as a whole*" or "*overall-satisfaction.*" "*Overall*-satisfaction" means that one does not need to be satisfied with all aspects of one's life – e.g., one's housing conditions, wealth or health – to be satisfied with life as a whole. The capacity to adjust one's aspirations and ambitions to one's talents and opportunities is as important for quality-of-life as the level of achievements. A very ambitious person will not easily be satisfied with his life.

So there are two concepts of quality-of-life in medical evaluation research: the objective one of normal functioning and the subjective one of overall satisfaction. I will return below to the distinction between subjective and objective concepts of quality-of-life. In my view there is no need to choose between a subjective or an objective concept of quality-of-life: which concept is relevant and appropriate depends on the kind of questions that have to be answered.

IV. NON-TREATMENT DECISIONS

The second context is that of decisions about initiating or foregoing life-sustaining treatments. In this context the term "quality-of-life" is used in very different senses.

Although there is a close analogy between the choice of a treatment out of a range of alternatives and the choice between treatment and non-treatment, an important change in perspective takes

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place. Normally in all medical decisions there is a tacit presumption in favor of prolonging life. The question to be answered is which possible treatment is the best in an individual case. However, sometimes the condition of the patient will already be so bad that even the best available treatment is perhaps not good enough. In that situation a choice has to be made, not between alternative treatments, but between a treatment with an uncertain, temporary and ambivalent outcome and non-treatment with the certain outcome of death. The question – which is characterized by Brock as a "threshold question" – is whether the quality-of-life of a patient will be so poor that for that person continued life is worse than no further life at all. "The only discrimination in quality of life required here is whether the quality of life is on balance sufficiently poor to make it worse than non-existence to the person whose life it is" (Brock, 1993, p. 280).

In discussions about criteria for non-treatment-decisions, still another quality-of-life concept is found, namely, a concept of quality-of-life in which "quality" refers to level of development as a human being. That concept is, as I will show, present in discussions about the (non-) treatment of severely disabled newborns. It reminds us of Joseph F. Fletcher's "indicators of humanhood" (Fletcher, 1975). In the Netherlands neonatologists broadly agree on the criteria that should be used in deciding about treatment or non-treatment of severely disabled newborns. These criteria are: expected length of life, intensity of pain and suffering, degree of independence (normal functioning), and expected maximally attainable level of development. The last three criteria together are used in formulating the prognosis concerning what they call "the child's quality-of-life." However, such a judgment about a child's quality-of-life consists of two different kinds of quality-of-life considerations: considerations about normal functioning and pain (the objective concept of quality-of-life that we already met in medical evaluation research,) and considerations about attainable level of development.

V. A THEORY OF HAPPINESS

What are the relations between these three concepts of quality-of-life? In order to analyze the relations between these concepts, I will outline a comprehensive theory of happiness.

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In everyday common language as well as in philosophical literature, there are several terms available for evaluating the quality or goodness of a person's life, including happiness, well-being, welfare, contentment, satisfaction, pleasure, flourishing, and excellence. None of these terms has a fixed meaning. Their meaning (their connotation – defining characteristics – and also their denotation – range of application) and the relation between them is highly culture and theory dependent. Brock distinguishes three broad kinds of theories of the good life. He calls them hedonist, preference satisfaction, and ideal theories of a good life (Brock, 1993, p. 270). Common to hedonist theories is that they take the ultimate good for persons to be the undergoing of certain kinds of conscious experience, which are variously characterized as pleasure, happiness, or the satisfaction or enjoyment that accompanies the successful pursuit of our desires. Preference satisfaction theories take a good life to consist in the satisfaction of people's desires or preferences. Desires and preferences are here to be understood as taking states of affairs, and not states of minds (feelings of satisfaction) as their objects. If I desire to be a president, my desire is satisfied if I win the election, even if I have no pleasant feeling of enjoyment. In ideal theories the good life consists of the realization of specific, normative ideals.

Theories of the good life tend to be one-sided and reductionist. An author in the Aristotelian tradition will usually not make a distinction between happiness and excellence, while a true utilitarian will define happiness solely in quantitative terms (number and intensity of pleasures) and will have no room for a qualitative notion as excellence (in Mill's terminology: "higher pleasures"). Brock argues that it is not necessary to make a choice between these kinds of theories. Each of these theories points to different components that one should give an independent place in a theory of happiness (Brock, 1993, p. 271). Following Sen, Brock regards these components as independent vectors, each of which contribute to an overall assessment of the degree of a person's happiness (p. 274).

I agree with Brock in saying that the different theories of the good life refer to diverse values which should have a place in a theory of happiness. Such a statement, however, presupposes the framework of an ideal theory. My view is that the good for human beings is not one and harmonious, but consists of plural and potentially conflicting values. The values of pleasure and enjoy-

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ment, of satisfaction and contentment, and of excellence are the relatively independent, irreducible and incommensurable components of happiness. Many of the contemporary theories of happiness are utilitarian, either in the sense of the classical hedonist utilitarianism or in that of preference utilitarianism. My theory is different, not only because it tries to combine elements of preference utilitarianism and hedonist utilitarianism, but also because it recognizes the value of excellence as an independent component of happiness.

I regard the values of enjoyment, satisfaction and excellence as objective in the sense of being trans-individual. They apply to everybody, regardless of the content of their desires and preferences. In my view a person may only then call himself happy, if he enjoys his life, is satisfied with it and regards it as valuable and worthwhile. (Further on I will make a distinction between self-assessed and ascribed happiness.)

What is then the difference between my theory and Aristotle's ideal theory of eudaemonia? The main difference is that my theory presupposes a pluralist value theory, while the Aristotelian value theory is monistic. The independence and incommensurability of the values of enjoyment, satisfaction, and excellence leaves a broad zone of freedom of choice for persons to determine their own life-plans that take account of their own talents and capacities and the external conditions for living. My theory of happiness does not prescribe a certain life-plan as the only road to happiness. It only implies that life-plans in which it is the case that not all three (clusters of) values – those of enjoyment, those of satisfaction and those of excellence – are present, should be regarded as impoverished. In that sense, my theory of happiness is a meta-theory.

So I distinguish between three components of happiness:

enjoyment: positive mental states (the hedonic component);
satisfaction: evaluation of success in realizing a life-plan or personal conception of the good life (the cognitive-evaluative component);
excellence: the virtuousness or value of a person's activities (arètic component).

An analysis of common sense experience shows that enjoyment, satisfaction, and excellence are indeed independent components

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of happiness. It is possible that one is satisfied with one's successes without experiencing feelings of enjoyment. This observation is confirmed by researches of social scientists. Campbell *et al.* mention that there is only a 0.50 correlation between "happiness as emotional state" and "happiness as satisfaction." They conclude that "...the two items appear to be tapping somewhat the same state of mind, but at least moderately different facets of the state" (1987, p. 35). In the same context, Veenhoven points to the fact that younger people are generally less satisfied with life than older people, while older people enjoy their life less than younger ones (1984, pp. 185, 186). There is apparently only a weak correlation between hedonic level and level of satisfaction or contentment.

Usually people justify their preferences for states of affairs by referring to their value. When they discover that a state of affairs is not as valuable as they thought, they will lose their interest in it. However, if I prefer to be non-autonomous and to do what I am told, I may be quite satisfied if I succeed in executing my orders, without being interested in the value of what I accomplished. It also can happen that a person is satisfied with his life, because he has done what he could, given the limitations in talents and opportunities. His being satisfied, however, does not imply that he is also convinced of the value of what he has accomplished. In his eyes his accomplishments may appear trivial and unimportant.

Besides the distinction between the three components of happiness, I also distinguish between *components of,* and *conditions for* happiness. Conditions for happiness contribute to the realization of happiness. There are different categories of conditions for happiness:

material conditions:	wealth and other impersonal resources; and
person-dependent conditions:	physical, intellectual, social, and emotional capacities.
good fortune	

I agree with Barrow that there are no logical connections between material and person-dependent conditions and happiness (Barrow, 1980, pp. 67–72). The same applies to the relation between good fortune and happiness. Neither of these conditions are necessary conditions for happiness. Someone can be rich, but unhappy;

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extremely intelligent, but unhappy; fortunate, but unhappy, and so on.

Life-plans can be evaluated along different dimensions. One of these is, as I said before, the dimension of richness. Another one is the dimension of rationality. Rich life-plans are not *ipso facto* rational. Life-plans are irrational if they are not adapted to a person's talents and capacities and do not take into account the presence or absence of important social and material conditions for realizing central life-goals. Life-plans can also be irrational if they are not based on sufficient information about the nature of the main objects of desire. The importance of the possible conditions for happiness also depends on the content of someone's life-plan. For an athlete who aspires to win a gold medal at the Olympics, strength and good health are necessary, but not sufficient, conditions for his happiness. If he wins because his main competitor broke his arm and could not participate in the game, his success is also due to good fortune.

My theory of happiness can contribute to the clarification of the debate – within medicine and the social sciences – about the nature of quality-of-life judgments: are they subjective or objective? In my view, the answer depends on which components of, or conditions for, happiness the evaluator wants to encompass in his judgment. Someone's judgments about the level of his enjoyment as well as about that of his satisfaction with life are necessarily first-person judgments. I would not deny that it is possible for outsiders to judge about an other person's level of enjoyment and level of satisfaction with life. However, their judgments have to be based on information that only that person himself can provide. In the case of enjoyment that is easily understood: enjoyment is an internal mental state. Satisfaction is the evaluation by a person himself of his successes in realizing his life-plan. Of course anyone who is sufficiently acquainted with that person and his life-plan, can form an opinion on the degree of his success. However, satisfaction is more than success. It is the personal evaluation of (one's own) successes *in relation to one's aspirations*. Two equally successful people need not be equally satisfied with their achievements.

Are judgments about the value or excellence of a life also subjective? I want to make a distinction between self-assessed excellence and ascribed excellence. A person who judges the value of his own life takes his starting point in his personal ideals of excellence. These ideals of excellence are person-dependent; they are

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not subjective, in the sense that a person does not claim universal validity for them. I do not only prescribe my ideal of excellence to myself, I also recommend it as a valuable way of life to others with the same talents and capacities, for whom the same conditions, necessary for realizing that ideal, are available. I used deliberately the term "recommend," instead of "prescribe," because as a pluralist I recognize that there are many valuable ideals of human excellence, among which a person may choose.

In a pluralist society with its diversity of ideals of excellence it is inevitable that a person's ideals will be disputed by others. When someone enjoys life, is satisfied with his accomplishments and is convinced that he meets the standards of his ideals, he may rightly call himself happy. I will call that "self-assessed happiness." Let us suppose he is a monk who has dedicated his life to the contemplation of God. His ideals of excellence are rejected by a nonreligious social reformer. In his eyes the monk confirms the unjust status quo. Judged by the standards of the social reformer, the life of the monk is useless and meaningless. The reformer will not call the monk happy. The monk's self-assessment as well as the judgment of the reformer about the monk's life are equally valid. Both are derivable from the point of view of their respective ideals of excellence. That is why one has to distinguish between self-assessed and ascribed happiness. If an honest person (who does not deceive himself) calls himself happy, the only ground for disagreeing with him is that one does not share that person's ideals of excellence.

VI. THE DIFFERENT CONCEPTS OF QUALITY-OF-LIFE IN MEDICINE AND HEALTH CARE AND THEIR RELATION TO HAPPINESS

My theory of happiness makes it possible to understand the nature and the meaning of the different quality-of-life considerations as used in medicine and health care. "Objective" quality-of-life considerations that refer to aspects of normal functioning belong to the *person-dependent conditions* for happiness. One can assign "subjective" quality-of-life considerations to the *components of enjoyment and satisfaction*. Both "subjective" and "objective" quality-of-life considerations are relevant for medical decision making. In some situations, it may be sufficient, in regarding the effects of treatments on quality-of-life, to confine oneself to their effects on normal functioning. In other situations, however, for

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example those involving a trade-off between length of survival and normal functioning, it is imperative to know what the effects of a treatment will be on someone's satisfaction with life. The reason is there can be great differences in the way trade-offs are made by patients. A well-known example from the literature is the choice that patients with cancer of the larynx sometimes have to make between laryngectomy and radiotherapy. Laryngectomy offers the best chances for survival, but destroys the capacity for normal speech. With radiotherapy that capacity is not affected, but the chances for survival are lower. Research by McNeill *et al.* has shown that some people for that reason prefer radiotherapy, while others have less problems with adjusting to alternative forms of speech, e.g., oesophageal speech, and prefer laryngectomy (McNeill *et al.*, 1981, pp. 982–987).

The third group of quality-of-life considerations, which refer to attainable level of development, can be headed as well under the component of excellence as under that of person-dependent conditions for happiness. The main reason that physicians are interested in the way a disabled child will develop is because they want to know to what extent it will function normally and will gain independence. Normal functioning generally contributes to life-satisfaction. In that sense, level of development is a condition for happiness. The question is whether the same holds for reaching a normal level of *intellectual* development. The emphasis on intellectual development might reveal an ideal of "humanness" in which intellectual values and capacities are regarded as the most important components of human excellence or flourishing. The relevance of such quality-of-life considerations for deciding about treatment or non-treatment of severely disabled newborns is highly disputable.[3]

VII. HEALTH AND ITS RELATION TO HAPPINESS

Until now I have not considered the contribution of *health* to happiness. In the philosophy of medicine there is an ongoing debate on the meaning of the concept of health and related concepts such as illness, disease, disability, etc. There are two "families" of theories of health. The first family is that of biomedical – more precisely biostatistical – theories; the second that of more holistic theories. An influential biostatistical theory is that of Boorse

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(Boorse, 1977, pp. 542–573). Health for him is the normal ability of organs to perform their functions that contribute to individual survival and reproduction. Normal functional ability is calculated statistically with respect to an age group of a sex of a species. A disease is an internal state that reduces the normal functional ability below typical levels of efficiency. Health and disease are basically statistical concepts. Not every disease is also an illness. A disease is an illness if it is serious enough to be incapacitating, and therefore is (1) undesirable to its bearer, (2) a title to special treatment, and (3) a valid excuse for normally criticizable behavior. On the other hand, a person can be ill only if he has a disease. Disease is for Boorse a descriptive concept, while illness is a normative one.

Boorse's theory has been strongly criticized.[4] Many biologists reject his view on normal species functioning. There is, they argue, an enormous amount of genetic variation within species and populations. Besides that, as is noted by Van der Steen and Thung: "Physiological functions change with the environment, so *there are no reference values simpliciter*. Reference values will have to be *context-dependent*. They are sensible only if they are related to the environment besides age and sex. Blood cell counts change with altitude, metabolic rates with temperature, and so on. Many conditions which are pathological according to Boorse's definitions may be biologically normal in some, and abnormal in other environments" (Van der Steen and Thung, 1998, p. 90). Many infections are species-typical reactions to pathogenic agents that enter the body. On Boorse's definition infections cannot be seen as diseases. However, they are painful and sometimes incapacitating. That is why they are regarded as diseases (Nordenfelt, 1987, pp. 30, 31).

More promising is the action-theoretical approach to health of Pörn and Whitbeck, as refined by Nordenfelt. Pörn and Whitbeck define a subject's health as (physical and psychological) ability to realize goals set by himself (Nordenfelt, 1987, p. 65). Nordenfelt prefers vital goals whose fulfilment is necessary and jointly sufficient for minimal degree of long term welfare (which he equates with happiness) instead of goals set by the agent himself, because according to Pörn's and Whitbeck's definition all persons that do not have any ambitions at all, such as mentally disabled persons and persons in PVS should be regarded as healthy (Nordenfelt, 1987, p. 78). I myself prefer to speak of basic needs in functioning normally in basic social roles as parent, householder,

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worker and citizen.[5] In the line of Pörn and Whitbeck, Nordenfelt distinguishes between several factors that can compromise health: diseases (which are bodily or mental processes), impairments (end-states of diseases), injuries (bodily or mental change or state, caused externally) and defects (congenital bodily or mental states). Diseases, impairments, etc. tend to compromise health. Whether they in fact do, depends on the nature of the vital goals.

I am now able to define the relation between health and happiness. Health – as the physical and psychological ability to fulfill basic needs in functioning normally in basic social roles – is a condition for happiness. Health belongs to the category of factors that generally contribute to happiness.[6] Health is, however, not a necessary condition for happiness. A man who is not very healthy, intelligent and rich, may succeed in realizing his life-plan because he has the good fortune of marrying a rich widow. In that case, that man's physical and psychological abilities did hardly contribute to his success. As we have seen, being healthy does not mean total absence of all diseases, impairments, etc. The impact of diseases, impairments, etc. on a subject's health is related to his life-plan. A star soccer player who loses his leg in a car accident will never again be able to play soccer on the same level as before the accident. A professor whom the same misfortune befalls, can usually, in spite of his impairment, continue to do what he did before, lecture and research.

A common observation in quality-of-life research is that quality-of-life is only weakly linked to objective conditions, such as age, gender, income, conditions of living and also health, but highly to social ones, such as the availability of social support, and psychological ones, especially personality traits as feeling of competence, ego-strength, feeling of having control over one's life, maturity, optimism, etc. (Campbell *et al.*, 1976, p. 496 vv.; Abbey and Andrews, 1985, p. 26). The conclusion of some authors is that quality-of-life is rather insensitive to all conditions, good or bad, and in particular to lasting states of adversity or fortune.[7]

Research on cancer patients supports that conclusion. Their satisfaction with life is unexpectedly high.[8] The long-terms effects of disease and impairment on satisfaction with life are highly dependent on a patient's coping abilities and his capacities to adjust his life-plan to new, more adverse circumstances. As shown in some investigations, many people who were (not) satisfied with their life before a treatment, were also (not) satisfied with their life after

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the treatment. There are authors who suggest that cognitive processes are responsible for the adjustment of expectations, due to which the previous level of satisfaction is restored. However, patients may *worry* about their condition and prospects, although they evaluate their life positively. Worries are negative affects regarding their situation. The relative independence of cognitive evaluation and affect is supported in research by Zajonc (1980, pp. 151–175; 1984, pp. 117–123). Formulated in terms of my conceptual framework: the satisfaction of patients with their life may become quite normal again. But their health problem probably will continue to influence their enjoyment level negatively.

VIII. CONCLUSION

Medical quality-of-life researchers study the impact of medical interventions on "quality-of-life" in order to improve the balance between the benefits and burdens of interventions. In their view treatments are desirable if, and insofar as, they contribute to the improvement of "quality-of-life." These researchers usually are interested in impact of interventions on normal functioning and satisfaction with life. Fragments of ideals of human excellence are sometimes present among the quality-of-life considerations which are used in making decisions about severely disabled newborns. The relevance of such considerations for making medical decisions is highly disputable.

The appearance of quality-of-life considerations in medical decisionmaking witnesses to, first, a growing awareness of the ambivalence of many interventions and, second, the change from a beneficence-centered to an autonomy-centered medical ethics. Judgments about the impact of interventions on normal functioning are meant to broaden the scope of medical decision making. Judgments about enjoyment and satisfaction with life are primarily first-person judgments. Such considerations represent the point of view of the patient in making decisions. It is not likely that quality-of-life considerations will disappear from the scene of medical decisionmaking. My main objection against "quality-of-life" is that it is a container concept which can cover quite diverse considerations. For the sake of clarity I would prefer to use distinct terms such as "normal functioning," "satisfaction with life" and "human development." However, if that should happen, we

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would lose a term which serves as a banner for all those who have certain reservations against the blessings of modern medicine and health care.

NOTES

[1] The first authors who – as far as I know – used the term "quality-of-life" in this connection were Ordway (1953), and Osborn (1957).

[2] There is still another context in which quality-of-life criteria are used, *viz.*, the context of decisions about the allocation of scarce resources within health care. Health care economists, especially, propagate the use of quality-adjusted-life-years to measure the outcome of different treatments for the same disease or of treatments of different diseases. A quality-adjusted-life-year is a year of survival with a correction for less than normal quality-of-life.

Jonsen, Siegler and Winslade have made a comparable analysis of the various meanings of the term "quality-of-life." They distinguish between quality-of-life as "subjective satisfaction by an individual with his or her personal life," as "an evaluation by an onlooker of another's life situation" and as "the achievement of certain attributes highly valued in our society" (1982, 109–138). I benefitted much from Edward W. Keyserlingk's *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*. In his view the issues raised by quality-of-life considerations are about the value of *treatments*, not about the value of a patient's *life*. He is right as far as the first two meanings of "quality-of-life" are concerned. Considerations of quality-of-life in the third meaning – that of level of human development – do refer to the value of a patient's life. Judgments about level of human development are not descriptive, but evaluative. The fully developed human being provides the standard. The use of considerations of quality-of-life in the third meaning is morally questionable. However I agree with authors such as Richard McCormick (1974, 175) that biological human life is a value to be preserved only insofar as it is a condition for realizing human values. The life of a human being in which the neocortical function is absent, has therefore no value.

[3] The more mildly mentally disabled persons do not function normally compared to the non-disabled and are not (completely) independent. However, they often do experience enjoyment and do regard their lives as satisfactory. The fact that one calls them "disabled" reveals that in our common thinking about the quality-of-life of disabled persons not only enjoyment and satisfaction count, but also more ideal-theoretical notions of complete human flourishing.

[4] Among others by Nordenfelt, 1987, ch. 2; Van der Steen and Thung, 1988, 81–91.

[5] That is the definition of Braybrooke, 1987.

[6] I agree with Nordenfelt (1993) on the nature of the relation between health and happiness. His concept of happiness as want equilibrium stands in the utilitarian tradition, and differs from mine.

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[7] See for references: Veenhoven, 1991, p. 16. He disputes the evidence for this conclusion.

[8] See for a discussion of that observation: De Haes and Van Knippenberg, 1985, 809–817.

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