The value and quality of life

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ABSTRACT – A medical view on 'the value of life' can be inferred from medical accounts of the quality of life: a life has value if it embodies certain qualities. Scales have been developed to quantify quality of life.

While the term 'quality of life', is used frequently in everyday discourse, perceptions of what it might actually mean differ greatly and are often incompatible. This incompatibility can be illustrated through an examination and development of the Greek myth of Sisyphus. The different models that the author explores rest on 'significant toil', 'choice', 'happiness or well-being', or 'social factors' being the prerequisite for quality of existence. These models are incommensurable and, as intangible concepts, cannot be quantified. Decision-making in medicine does not require a complex evaluation of quality of life: it consists of the doctor's offer of treatment based on the best evidence, and the patient's consent to, or refusal of, that offer. Apart from the need to obtain consent, the main ethical constraint on the doctor is equity.

Doctors do not write much about the value of life. But they do write a great deal about the quality of life, and it is through discussions of the quality of life that we can discover a medical view of the value of life. In short, a typical medical view of the value of life seems to be that life, or a life, has value to the extent that it exhibits certain qualities. Indeed, in their enthusiasm for this position researchers have developed elaborate scales to quantify quality of life, and by implication the value of life. Against all this I wish to argue: first, that while at an everyday level it is harmless enough to think of the value of life in terms of characteristic human qualities, it is not possible to develop a single coherent model from these commonsense ideas, and hence attempts to quantify them inevitably fail. Second, I wish to argue that questions of the value or the quality of life are in any case quite irrelevant to treatment decisions. Many people will regard this as a highly controversial, not to say counter-intuitive stance, but I shall try to make it more plausible by arguing, third, that the theoretical basis of treatment decisions is in fact much simpler than complex quality of life scales suggest. This, of course, is not to say that treatment decisions are simple – it is just the theory behind them which is.

The value of life seen in terms of certain qualities

Quality of life issues are often discussed in medical contexts in terms of emotionally charged cases, such as those involving withholding and withdrawing treatment in the demented elderly or brain-damaged neonates, or in terms of experimental therapies. In such discussions it is difficult to see the wood for the trees. I shall therefore use a very different type of scenario in the hope that I can present quality and value of life issues more clearly because 'writ large'. The example I would like you to consider is the Greek myth of Sisyphus.

In Greek mythology Sisyphus was King of Corinth. For reasons not entirely clear Sisyphus fell into disfavour with Zeus. His punishment was that he had to push a boulder up to the top of a mountain in Hades. When he had just reached the summit the boulder would roll to the foot creating huge clouds of dust which obscured the light. Coughing and cursing, Sisyphus had to repeat the procedure through all eternity. Many writers, such as Camus, have taken this to be the paradigm of an entirely valueless life.

Let us now develop the myth to bring out some points relevant to our discussion of quality of life. We shall suppose that the demi-god of medicine, Asklepios, decides to become the newly fashionable 'patient's advocate' and pleads with Zeus to have some changes made in the punishment. First, he arranges that the boulder will no longer cause huge clouds of dust. As a result there are improvements to the lungs of Sisyphus and his health improves. We therefore have one obvious factor in a good quality of life – health. Second, Asklepios arranges for some friends to visit Sisyphus to comfort him, wipe away the sweat, and so on. His quality of life has again been improved, because loneliness diminishes quality of life and friends improve it. Third, Asklepios persuades Zeus to transfer the place of punishment, from the fearful environment of Tartarus to a Scottish mountain. He is still pushing the boulder, but in beautiful scenery. Once again, there is an improvement. Fourth, the myth stresses the pointlessness of Sisyphus' activity. Let us suppose that Asklepios manages to modify the punishment further, so that Sisyphus now carries up different boulders and eventually succeeds in building a cairn, or even a shelter, at the top of the mountain. The activity now has a point, a minor creative purpose, and immediately we can say that there has been an improve-
ment in quality of life. Fifth, it is further agreed that Sisyphus will be allowed to abandon his boulder-pushing to help climbers whenever they get into difficulties on the mountain. He now has an outlet for some skills and moral capacities, and we could perhaps claim that an outlet for moral qualities seems to improve quality of life. Sixth, let us suppose that Sisyphus is allowed the occasional remission from his punishment – he is given every second weekend off or the like, during which period he can do other things. Once again we have an important factor in a good quality of life – some leisure and the possibility of varied activity.

Finally, and most controversially, let us imagine an essential change. The original punishment was to go on through all eternity. Suppose that Asklepios pleads with Zeus about the everlasting nature of the sentence, and Zeus says, ‘Okay, I will allow him to die after one more year!’ Does this improve his quality of life? Opinions might differ here. Some people might say that life is good whatever the quality. Indeed, if the life of Sisyphus has been improved under the six headings just mentioned, some people might say that it cannot possibly constitute a further improvement that this life will come to an end. Others might say that, whatever its quality, human life by its very nature is a transient affair. Indeed, it can be argued that what makes the very idea of quality possible, is that death comes to us all in the end; death supplies the framework or the parameters within which we can talk of value and quality. Let us assume the latter position for the moment because it enables us to bring to a close one particular type of analysis of ‘quality of life’. We shall call it the ‘significant toil’ model of quality of life, and it makes clear why such a life might be considered valuable or worthwhile.

Why is this model plausible? The answer is that it taps into an important and widespread set of assumptions about human life, assumptions which go back to Greek mythology and are still present in all of us. They are, that we all have something which can be called an essential human nature, and that it can be developed or realised or educated, granted the appropriate conditions. These assumptions, originally Greek, passed into Christian thought, where they were reinforced by the idea of God creating human beings in the divine image, that is, with an essential nature. Despite the plausibility of the ‘significant toil’ model, however, it is open to some serious objections which can give rise to rival models of the value and quality of life. These rivals are also part of our commonsense picture of the world.

Choice

The origins of the first objection can be found in the philosophy of Kant, and the Enlightenment more generally. It is that our description of the life of Sisyphus, even as improved by Asklepios, lacks one important ingredient, some would say the vital ingredient, for a life of good quality – choice. Sisyphus is compelled to push his boulder and the modifications of his punishment are all arranged on his behalf through the advocacy of Asklepios; he is totally without any choice. For many people this would be a fatal flaw in the ‘significant toil’ model. Their view would be that it is the ability to choose which gives human life its distinctive value. In health care ethics this point of view is strongly held and is expressed via the concept of autonomy. The rhetoric of autonomy is all-pervasive in health care ethics, patients’ movements, and the like, so let us consider the implications of seeing the value or quality of life in terms of autonomy.

Suppose that Zeus decides to release Sisyphus after many years of punishment and gives him a sum of money to help him back to ordinary life. Sisyphus proceeds to spend this money on whatever is the mythological equivalent of gambling machines, lottery tickets, scratch cards etc. Let us say he is successful, and makes an income from gambling. Has his quality of life been improved from the point at which he was pushing boulders to build shelters at the top of a pleasant mountain with his friends etc?

If it is said that the single most important factor which gives life value is an individual’s own preference expressed through choice, then it must follow that this life does have a better quality than the other, because in terms of this model to be a self just is to be able to choose. This is the post-modern view of quality of life; agents are the only authorities on their own quality of life, and it is this capacity for choice which gives human life value. The particular health care exemplification of this view occurs when patients are seen as the only authorities on their treatments, regardless of effectiveness or cost. Patient autonomy is the single overriding value. This is a widespread view, but it does not lie comfortably with the ‘significant toil’ view.

Happiness or well-being

A second criticism of the ‘significant toil’ model is that it does not mention the happiness of Sisyphus (‘well-being’ is the term more frequently used in health care writings but the problems are similar with both terms). According to this criticism, people’s quality of life just is their happiness or well-being. The term ‘happiness’ is ambiguous but the dominant sense in contemporary culture is that we are happy if we are in certain states or moods in which pleasant feelings dominate. These moods have many variants or subsets, but common to all are powerful subjective feelings of pleasure. For example, let us return to the myth of Sisyphus and imagine that Asklepios puts Sisyphus on a course of pills – Prozac or the like. We can imagine that Sisyphus is still undergoing his original punishment of pushing his boulder up the dusty mountain to be faced eternally with the futility of what he is doing. The myth describes him as groaning and cursing the gods. He is then put on the pills and as a result he becomes euphoric and brimming with nice feelings which totally divert him from the unending futility of his activities. Has his quality of life been improved? If happiness consists of nice feelings,
regardless of their causation, and if quality of life consists of happiness in this sense, then the Prozac (or whatever) has indeed vastly improved quality of life. And it would follow that the quality of life of all of us might be improved if there were a drug which enhanced our feelings regardless of the grim reality of our actual situations.

In health care the situation described in the myth is far from uncommon. For example, imagine the many cases such as that of the single mother living in damp housing in an area of multiple deprivation. The temptation for a GP to prescribe an antidepressant must be overwhelming. If we accept this as a valid account of 'quality of life', then quality of life can be improved even though the life lived remains exactly as it was before. It is simply the patient's feelings which have changed. It is easy to see here how doctors can be described by unsympathetic socialists as 'agents of social control'. They are providing opiates for the masses which blind the poor to the reality of their social situations. Nevertheless, it is often said that your quality of life just is how you happen to be feeling. This view of quality is a rival to the first two models, for according to this view no self-development or choice is necessary for a good quality of life. Indeed, self-development and choice might interfere with the nice feelings of which this kind of quality of life consists.

Society and material needs

All three models of quality of life so far discussed could be criticised as being too individualistic. It might be said to be unrealistic economically, politically, culturally and even in terms of our human natures, to base an account of quality of life simply round the individual. For example, take the opportunity costs. If a society puts a lot of money towards the problems of one person or one group of patients, then, by the same token, it has so much less to spend on other persons or groups, or on important other problems such as housing or education. Moreover, there is also a temporal dimension. Society is an entity which continually evolves through time, and the actions of one generation have a bearing on those of another. The material satisfactions of the future lay a claim on the political spenders of the present. And this is to say nothing of the cultural needs of a society which may have little to do with material needs but none the less are important in the quality of life of that society, and give value to it.

If we think of quality of life in this way, then we are stressing human inter-relatedness or solidarity, and the quality or the worthwhileness of the life of one person has a bearing on that of another. In health care, in particular, this is relevant in view of the huge costs involved. The ethical concept which should govern the supply of our health needs in this respect is equity, a social concept. I am arguing that a full and adequate discussion of quality of life seen in a social perspective cannot be divorced from consideration of equity.

Incommensurability and scales

The different ways of looking at quality of life, and therefore at what gives value to life, can yield very different conclusions in different situations of health care, as well as in a broader social perspective. For example, the sufferer from Alzheimer's disease who is clean, fed and watered may do well on the 'happiness' model of quality of life, but very badly on the 'significant toil' or 'choice' models. Again, a fetus does badly on the choice model because, lacking any autonomy, it has no rights at all, even on the eve of its birth; and a non-autonomous patient may well suffer because autonomous relatives insist on a certain kind of care which suits them but is not in the best interests of the patient. My point in all this is not to take sides on any of these issues but to point out that these incompatible positions follow from what can seem plausible accounts of the value of life derived from ordinary conceptions. As soon as we go beyond the platitudes on which we can all agree, these ways of looking at the value of life – all of which are implicit in our ordinary thinking – can be seen to be in conflict with each other.

This makes it impossible to combine all the models into a single measure for evaluating health care, still less any wider social dimensions. For a scale of any kind to be meaningful there must be an agreed unit of measurement. In other words, scientific measurement is inherently reductivist – concerned with one type of entity only – whereas quality of life is multifactorial, and the factors are inherently incommensurable, no matter how complex the mathematics. Hence, the attempt to produce 'quality of life scales' is bound to fail.

The impossibility of producing meaningful scales in qualitative research has not deterred researchers from trying to create such scales. The attempts are inspired by the belief among medical researchers that nothing is truly scientific unless it involves measurement. Hence, there has been a widespread attempt to quantify qualitative research. Let us take an example of such an attempt. Suppose a researcher is interested in the quality of the interaction between doctor and patient. If this quality is to be quantified, then the researcher must pick some characteristics of the interview which are countable. Let us suppose that the researcher decides on, say, eye contact. No doubt, eye contacts can be counted (and perhaps someone has devised an eye contact scale!). But what would that show? Some patients might think it a good thing if their doctor keeps looking at them, but others might feel embarrassed or frightened. And the more discerning may become irritated at becoming the object of non-spontaneous behaviour, learned perhaps at a course on communication skills. The point is that doctor–patient interviews ought to be holistic – one person responding to another in whatever way each is comfortable with – whereas whatever is quantifiable must be reductivist – in terms of specific characteristics, such as the angle of the chair, the respective levels of interviewer and interviewee, eye contact, and so on. But holistic human relation-
ships cannot be reduced to a set of learned, measurable behaviour patterns.

If this is true of professional-patient interviews, it is all the more true of much wider concepts such as quality of life. Quality of life is a holistic concept, so that whatever a researcher measures it would still be open to a patient to say 'What you have measured has nothing to do with my quality of life'. The upshot of this is that quality of life, as that concept is used in medicine, attempts to combine in one concept basically incompatible ingredients. Ideally it should be discarded. If you are in doubt about this simply consider the tortured mathematics of quality of life scales.

A simple basis for decision-making

A much simpler basis for decision-making in medicine can be substituted, based on two different sorts of evaluation. First, the doctor must decide what is the appropriate medical treatment, or whether the treatment being used is showing any medical benefits to the patient. This is a technical judgement, concerned with a medical good. Second, when this technical judgement is fully explained, the patient must give informed consent or refusal to the treatment. This offers a very simple dual-aspect basis for treatment decisions, and one which simply omits the complexity of quality of life considerations.

To soften the stark simplicity of this basis for decision-making I shall amplify it a little. First, I said that the doctor offers the treatment based on a technical evaluation of the medical evidence. I see no objection to a patient's participation here. If the patient has treatment suggestions, then, provided the doctor can endorse them, we have a joint consultation which will harness the great healing powers of the patient's beliefs. This can only be beneficial. Second, I am assuming that the informing of the patient and any subsequent treatment, or palliation, take place in a humane context. Third, and much more controversially, the doctor's treatment decisions should not be entirely technical; there is an essential ethical dimension. Doctors have large amounts of the taxpayers' money at their disposal, and it seems to me to be of the first importance that their decisions on treatment should be based not just on the technical medical good which may be the outcome but on considerations of equity. Many doctors are extremely resistant to this, taking the view that medical ethics is exclusively concerned with the doctor-patient relationship. Hence, they are willing to dispose of large sums for small benefits for their patients. But the ethics of fairness seem to me to have priority over small medical benefits for some patients. It is an insistence on this, rather than any complex judgements about the value or quality of life, which is of importance for contemporary medical decision-making.

In sum I have been arguing that:

- The value of life is construed in medicine in terms of the quality of life.
- Quality of life can be seen in terms of several models, which are individually plausible but cannot be combined into a single model.
- Quality of life scales inevitably fail.
- The basis of decision-making in medicine is theoretically simple: the doctor's technical decision on the best evidence-based treatment and the patient's consent or refusal of that treatment.

References

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