QUALITY OF LIFE - EVALUATION OR DESCRIPTION?

ABSTRACT. ‘Quality of life’ is part of many different discourses and has been used in a variety of meanings ranging from purely descriptive (as in some medical contexts) to distinctly evaluative meanings (as in some social science and political contexts). The paper argues that there are good normative reasons to make the concept as descriptive as possible at least in its medical applications and, furthermore, to reconstruct it in a thoroughgoing subjectivist way, making the reflexive self-evaluation of the subject him- or herself the ultimate standard. Attention is drawn to the fact that only few of the measures of quality of life applied in present-day medicine correspond to these requirements.

KEY WORDS: quality of life, medicine, social indicators, subjectivism

1. INTRODUCTION

Though the concept of quality of life is more than half a century old it still meets with a great deal of reserve. Reservations are directed primarily at its medical applications and primarily not for reasons of content but for reasons of social consequences. One reservation is that the concept seems to be inherently dangerous by encouraging a grading of individual lives according to their respective ‘quality’, with the uncanny prospect that some lives might be assigned a quality of life so low that they no longer seem worth living. A valuing of lives according to their differential ‘quality’ would, moreover, be in open contradiction to the egalitarianism embodied in the Kantian tenet that every human being has the same inherent dignity and that his life and freedom must be exempt from utilitarian trade-offs appropriate to non-human goods and commodities.

Another objection to the concept is that not only its potential use in valuing lives may be socially harmful but that already its present - largely professional - use is harmful by suggesting a shared definition of ‘quality of life’ that does not in fact exist. In this way - so the objection goes - the public is deceived about the tentative and highly subjective character of quality of life evaluations. On the one hand, ‘quality of life’ judgements are given an important role in medical regulations and decisions; on the other hand, they are not, and cannot be subjected to the same rigid standards of scientific objectivity as other diagnostic and prognostic procedures.
There seems to be a real dilemma. On the one hand, the concept is far too well-established in the social sciences, in medicine, and even in everyday language, to be simply discarded; on the other hand, it is part of too many different discourses and is meant to fulfil too many different functions to have anything like a fixed and unitary meaning. The question, then, is: Is it possible to fix its meaning in a way that is theoretically and practically satisfactory and neutralises, or at least diminishes, what is seen as dangerous in the concept?

2. **Quality of Life in Medicine**

‘Quality of life’ started on its career in the seventies, in politics and in the social sciences, as an antidote to the public intoxication with purely economic measures of social welfare. In the eighties, the focus of the concept passed to the medical context. Despite the differences in meaning and function implied by the change of topic, the motives of its introduction were similar: In the social sciences the concept was introduced from dissatisfaction with the traditional, exclusively economic indicators of social welfare; in medicine, the concept was introduced from dissatisfaction with the traditional, exclusively functional indicators of health-related well-being. Both concepts are implicitly critical not only of the categories and approaches of their respective sciences but also of the strategies which take these categories as their guiding principles. For far from being a purely theoretical device, the concept of quality of life functions in both of its principal fields of application as an alternative practical orientation. In politics, the social indicator movement grew out of the feeling that economics does not exhaust (and possibly not even touch) the essentials of personal well-being and that social policies should be explicitly oriented towards the improvement of social rather than economic indicators. Analogously, the quality of life movement in medicine was, among others, a symptom of the uneasiness about a medical system which judged its own merits and demerits exclusively in terms of functional aims like the restitution of organ function, the normalisation of blood values, improved mobility and prolonged life expectancy. In both disciplines the concept of quality of life was designed to substitute, or at least complement, the traditional indicators with their advantage of easy quantification and measurement and their disadvantage of corresponding only very imperfectly to the aims of their respective social practices. Just as a rise in income is a very poor indicator of a rise in happiness, survival rates, physiological functioning and incidence of symptoms are very imperfect criteria for the