The 3rd BESETO Conference of Philosophy
Session 16

Concept of Sustainable Well-being Based on Capability and Relational Intergenerational Ethics

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Abstract

Based on examination of healthcare, a definition of QOL is produced:

> A person's QOL at the moment of estimation is measured according to how wide the scope of choices available to the person is: the essential measure of a person's QOL is the person's actual capability at the moment.

Though in healthcare the physical and mental aspects of QOL are principally focused upon, we cannot separate those aspects from others, which are connected seamlessly or contiguously. When we measure QOL, the object of measurement is environment, in the sense in which environment is the set of all circumstances, people, things, and events around a person influencing her/his life.

The definition of QOL in healthcare can be generalized, based on which a general definition of well-being can be obtained:

> A person's well-being is measured as the integrated sum of her/his capability that is and will be actualized during a certain period of time.

By "relational ethics", I refer to the ethical viewpoint that ethical codes vary depending on the remoteness, or closeness, of relationship among the parties involved. The principle of '*live-by-helping-each-other*' is dominant among people in close relationship, while the principle of '*live-and-let-live*' among people in remote relationship. The two principles coexist in each human relationship.

Sustainability of well-being can be explained based on the two principles. Future generations are not like bands coexisting with us, but like those reproduced in a band and cared for by elder members of the band. Nevertheless, scholars have been discussing the intergenerational ethics based only on '*equity*', which is a conception belonging to the *live-and-let-live* principle. Introducing a complimentary conception '*generativity*', which expresses our positive attitude of caring for future generations under the *live-by-helping-each-other* principle, we shall be able to explain why, and how, we should seek the sustainability of human well-being.

Sustainable human well-being is one of the most popular topics in fields where social and natural sciences as well as technologies intersect and contribute to global policy lines. For instance, the

Kyoto Protocol,[1] which provides each nation with target values for the reduction of carbon dioxide emissions, has as its ultimate objective nothing other than preserving a good environment for future generations. The topic, however, has been hotly debated without clearly defining the concept of well-being; nor has the basis for its sustainability requisition clearly been shown. "Well-being" is often equated with welfare, while its sustainability is based on intergenerational equity. I shall presently argue about these points and offer a philosophical basis for the subject.

To be fair, I have not specialized in the study of the subject in question. My background is in clinical ethics, in which I have been engaged for many years as a scholar in philosophy and ethics, having dialogues with medical personnel and searching for a system of clinical ethics that is both theoretically sound and practically effective in medical practices. Accordingly I shall start by reporting certain conclusions I have arrived at in the field of clinical ethics, and approach the present issue through this lens.

1 Health status, quality of life, and well-being in terms of capability

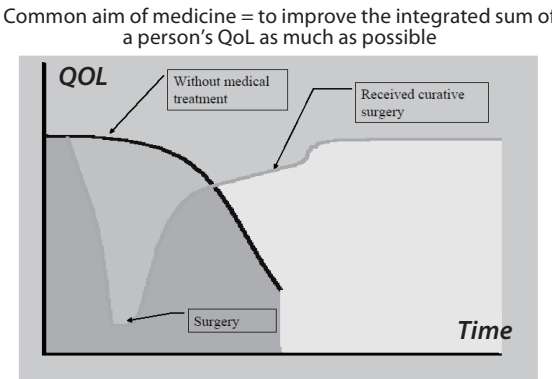
a. Examination in healthcare: human capabilities and environment

In having observed and described activities of medical personnel, I have produced a few definitions; I will offer these, starting with the one that concerns the concept of health and the purpose of medicine:

> Def. 1: A person's health status is measured as the integrated sum of her/his bodily (i.e., physical and mental aspect centered) QoL (quality of life) that is and will be actualized in the course of time from the moment of estimation until the end of life.

Definition 1 should become clearer if we examine what is the aim of healthcare (Picture 1). Picture 1 shows the predicted alteration of my QoL from here forth. Suppose I undergo a routine health examination and it is discovered that I have cancer somewhere in my body. The physician tells me that even though I myself do not notice any symptoms and my QoL seems fine at the moment, my actual health status is not favorable: as time advances I shall begin to notice symptoms, shall suffer from them, and I have a very short time to live—provided I do not receive medical treatment. The physician also tells me that there is a suitable, curative surgery available. If I choose this option, my QoL will be initially quite low, during the operation and for a while thereafter, as I shall be suffering or at least in an unpleasant situation. As time progresses, however, my health will be restored and I will be able to enjoy a longer life with quite high QoL. Thus what the medical intervention has done is to improve the integrated sum of my QoL as much as possible—which is exactly the common aim of medicine. This explanation is applicable not only to curative treatment, but also to palliative treatment, and even to terminal care.

1 United Nations. *Kyoto Protocol to the United Nations Framework Convention on Climate Change*. United Nations Environment Program, 1997.



[Picture 1]

Now, QoL itself should be defined, and my conclusion is as follows:

Def. 2: A person's QoL at the moment of estimation is measured according to how wide the scope of choices available to the person is; the essential measure of a person's QoL is the person's actual capability at the moment.

This way of defining QoL differs from that which subjectively evaluates QoL based on level of satisfaction, and also from that based on need. Presently I shall focus my attention only on the relationship between satisfaction and capability, although I believe a similar argument is possible on the one between need and capability.

Some scholars (Murray *et al*.) refer to the inconsistency between the use of the phrase "quality of life" in general and in health,[2] saying that in the former situation it is "a term that has been used widely in various social science contexts to refer to the overall, subjective appraisals of happiness or satisfaction experienced by individuals", while "in health, the term QoL has been used often in a more particular way to refer to a multidimensional construct relating to symptoms, impairments, functional status, emotional states and what we have labeled as health domains". In healthcare in Japan, however, most medical personnel as well as scholars, in thinking that QoL is a subjective measure, practice its measurement according to a multidimensional construct, but seem unaware of such inconsistency. In my view, the two usages are linked with each other as follows.

Most things are evaluated by our satisfaction when we use them: for instance, when we drink Brand X Japanese *sake* and we are satisfied, we say, "this *sake* is good"; when we are discontent, we say, "this *sake* is not so good". Likewise, when we drive a new car and are satisfied, we say, "this car is good", but if we are not satisfied, we say, "this car is not so good". When a salesclerk in a *sake* shop recommends Brand X to a customer and says, "this *sake* is good", it means, "if you try this one, I am

2 Murray CJL, Salomon JA, Mathers CD, and Lopez AD. "Conclusions and Recommendations." In *Summary measures of population health: Concepts, Ethics, Measurement and Applications*. WHO, 2002. pp. 731–756.

sure that you will be satisfied"—usually based on her experience with a given *sake*'s characteristics. As *Sake* is something to drink, its quality is evaluated by the satisfaction of those who drink it; and as a car is something to drive, its quality is evaluated by the satisfaction of those who drive it.

Moreover, as with the salesclerk recommending a particular kind of *sake*, with respect to most things that are basic in our lives, we recognize what characteristics a given thing needs in order to satisfy most people who would use it. Thus the two descriptions are compatible: the quality of a thing is evaluated by users' satisfaction, and the quality of a thing is evaluated by examining its characteristics.

Life itself is among such things, and it is something to live, therefore the quality of life is evaluated by means of living; that is, when we live our lives and are satisfied, life is good and its quality is high. Meanwhile, the "multidimensional construct relating to symptoms, impairments, functional status, emotional states" is nothing more than a list of life's characteristics appropriate for satisfying people from the perspective of health. Here note that although not all the characteristics that in fact satisfy some people are recognized to be appropriate, there must be a criterion by which certain characteristics are recognized to be components of QoL, while others are not.

The aforementioned criterion, which should be a common characteristic needed for people to be satisfied with their life, is *capability*. The items enumerated as elements of health-related QoL concerning symptoms, impairments, functional status, emotional states, etc. are the elements because of this common characteristic. For instance, pain is an element that makes the QoL low or worse, for pain attacks a person without her/his consent, despite her/his aversion; in this sense, pain binds her/him and lessens her/his capability or freedom. Again, pain strips opportunities from the person who has it: opportunities of reading books, of having a peaceful time with her/his family or friends. In this sense, the pain lessens her/his capability, or range of options.

Though in healthcare the physical and mental aspects of QoL are principally focused upon, we cannot separate those aspects from others, as they are connected seamlessly or contiguously. For instance, suppose a disabled woman who cannot walk by herself; if we focus solely on the physical aspect, we would say that she cannot move by herself and her scope of choices is narrow. We should, however, expand our field of vision and consider the numerous other circumstances around her; when a circumstance that she can use a wheelchair is set, she becomes able to do more things than before. Moreover, if roads, accesses to entrances of buildings and so on are set as barrier-free, her scope of choices will be widened even further. Thus, QoL, or actual capability at the moment of estimation, depends on circumstances in life, and not exclusively on physical and mental condition.

When we measure QoL, the object of measurement is the *environment*, in the sense that environment is the set of all circumstances including people, things, and events around a person influencing her/his life, including the ecosystem. Additionally, the conditions of one's body and mind are the most basic component of her/his environment. In sum, we can define QoL as follows:

Def. 3: By QoL, we measure how one's present environment makes one capable and widens one's scope of choices.

b. QoL and human well-being in general

The definitions shown above, which have been given in the field of healthcare, can be generalized

for use concerning the present issue. First, definitions 2 and 3 can be used here without revision, with only the proviso that here the physical and mental aspects are not privileged among other circumstances.

Secondly, as for the definition of well-being in general, seeing that people generally view their health as an important part of their well-being,[3] the relationship between evaluation of one's health and QoL expressed in definition 1 is suggestive: the latter is estimated at some moment, while the former follows the time course of the latter. We can use this idea also in formulating a definition of well-being in general, obtained as:

Def. 4: A person's well-being is estimated as the integrated sum of the person's QoL that is and will be actualized during a certain period.

And, combining definitions 2 and 4:

Def. 4′: A person's well-being is measured as the integrated sum of her/his capability that is and will be actualized during a certain period of time.

So far, the definition is the one of individual human well-being. But we can talk about a person's well-being in general, and not about a specific person's well-being, when we assess generally the circumstances, or environment, of a given person in a certain time period, and this is sufficient for the purpose of this paper.

2 Relational intergenerational ethics and sustainability of well-being

a. Sustainability of well-being

In the same vein of the famous concept of "sustainable development" presented by the Brundtland Committee (WCED, 1987) as "...development that meets the needs of the present without compromising the ability of future generations to meet their own needs", we might roughly define the present subject as:

Def. 5: Sustainable well-being is the well-being of the present that can be actualized without compromising the well-being of future generations.

or as:

Def. 5′: Sustainable well-being is a sufficient state in the integrated capability that is being actualized during a certain period in the present without unreasonably compromising the capability to be actualized in future generations.

3 The WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

How are the concept 'capability' and those definitions effective in the issue at hand? I shall address this point later, and now try to answer another question:

Why *should* our present well-being be sustainable?

A convincing reason for this will be provided based on a so-to-speak "relational view of ethics". By the term "relational", I refer to the characteristic that ethical codes vary depending on the remoteness, or closeness, of relationship among the parties involved. I have developed this idea in clinical ethics as follows.

b. Relational system of ethics

There are two elements in the codes of clinical ethics: the principle of closeness, or togetherness, and that of remoteness. The former seems to have originated in natural human relationships in primitive human bands, where collaboration and care, which are necessary for such bands to survive, make the members close and strengthen unity so that members are required by nature to collaborate with, and care for, each other. This requirement becomes the source of ethical codes among people in close relationships. The attitude of *live-by-helping-each-other* expresses this way of living in close relationships.

By contrast, the latter principle seems to have originated in invented agreements for peaceful coexistence among bands hitherto alien, or even hostile, to each other; human beings have discovered a reasonable way of reconciliation among interested groups: agreements involving the setting up domains for each group and establishing rules, including mutual non-aggression and noninterference in other groups' internal affairs. Such codes become ethical codes among people in remote relationships. The motto "*live-and-let-live*" refers to this way of living in remote relationships.

Since each human relationship has both of the two elements to varying degrees, the two types of ethical codes coexist there. For instance, in medicine, respect for autonomy would seem to belong to ethical codes of remote relationship, while caretaking and beneficence would fall under those of close relationship.

Consequently, the process of decision making in medicine should be taken as dynamic, where ethical codes vary depending on the relationship between medical personnel and the patient (and family). For instance, medical personnel should endeavor to maintain, or create, a closer relationship with the patient and family until the last moment, by continuing deliberation and seeking an agreement that can sufficiently balance two requirements: realizing the patient's best interest and respecting the patient's wills and wishes. When they cannot reach an agreement at the last moment, there is no alternative but to prioritize the patient's autonomy over their judgment regarding the patient's best interest, provided that the patient self-determination is not antisocial; here they are acting on the basis of codes of remote relationship.

There has been, however, a trend among ethicists toward one-sidedly basing judgments on ethics in remote relationships, by simply emphasizing the patient's autonomy or interpreting justice as fairness of distribution of goods. We now need to recognize the importance of ethics of close relationships, and make the two types of ethics codes compatible.

In addition, the preceding explanation of the two principles and origins of ethics is, as a result, an interpretation as well as an attempt to reconcile the ethics of care and ethics of justice. Carol Gilligan challenged Lawrence Kohlberg's theory of moral development, arguing that his theory is

male-dominated, measuring development from the viewpoint of ethics of justice, while the moral development of girls is different from that of boys, which one can recognize from the viewpoint of ethics of care. From my perspective, the ethics of care correspond to the ethics of close relationship, under which women have been traditionally expected to behave in and around their home, while the ethics of justice correspond to the ethics of remote relationship, according to which men have been expected to participate in public life outside the home.

Further, both closeness and remoteness are included in the essential design of a society: how balance is struck between the two is essential in the determination of the type of society in which we wish to live. Libertarians place major importance on remoteness, at least in terms of public affairs in society, while trying to minimize closeness and push it away to private space. In contrast, when liberals emphasize both individual freedom and reduction of economic and social disparities, they aim to make remoteness and closeness compatible.

Consortism, or symbiosis, if it is understood as simply a *live-and-let-live* system, is not sufficient here, though it might be consistent with the ethics of remoteness. What is needed in addition is an attitude of *live-by-helping-each-other*, which requires the ethics of togetherness and is compatible with the proper meaning of "consortism" (derived from the Latin *consors*, meaning "one who shares an inheritance").

c. Relational approach to intergenerational ethics

The sustainability of well-being can be explained based on the *live-by-helping-each-other* principle as well as on the *live-and-let-live* principle. The concept 'intergenerational equity' seems to belong to the latter. Future generations, however, are not like bands coexisting with us, but like those reproduced in a band and cared for by elder members of the band. Our generation is *responsible* for the existence, i.e., reproduction, of future generations, and for this reason we hope to leave an *appropriate* environment behind for future generations to live in; "appropriate" in the sense that such generations will be capable of promoting their lives with a wide range of choices. Inheritance of wisdom and of better circumstances, or environment, i.e., succession of capability, is the way our ancestors had done for subsequent generations up to our generation, and now what we are doing for the next generation.

This does not necessarily mean that we should maintain and leave, for instance, a particular characteristic (e.g., CO2 emissions) in nature. If we were to invent some way of managing under a high concentration of CO2, we could leave behind such knowledge instead of curbing CO2 emissions; in reality, however, we have not discovered such an alternative and consequently must try to drastically curb emissions. In other words, the capability which we are hoping to make sustainable consists of the inner (human) environment, including rational ability, and the external (physical) environment, including human physical conditions and many circumstances (e.g., the ecosystem and the CO2 concentration in it).

Again, that we are responsible for the appropriate capability of future generations does not mean that our capability and those of future generations should be even. We cannot compare the two; we cannot even compare the capability of our generation with that of past generations. What we can do is to try to pass down enough environmental resources and wisdom we have now, for the future generations to live.

Our positive attitude toward passing these things down is an act of caring for future generations, and is an expression of the *live-by-helping-each-other* principle in the context of intergenerational human relationships—an attitude which might be expressed by the word '*generativity*'. 'Generativity', a term coined by Erik Erickson in the field of psychology, refers to the concern in establishing and guiding the next generation; actions such as doing socially-valued work or training disciples are expressions of generativity. As defined by an ongoing research project at Northwestern University,[4] "Generativity is an adult's concern for and commitment to promoting the well-being of youth and future generations through involvement in parenting, teaching, mentoring, and other creative contributions that aim to leave a positive legacy of the self for the future." Thus we can appropriately use this term in the present issue by slightly widening its phrasing.

In sum, basing ourselves not only on equity, but also on generativity, we shall be able to explain why we should seek, or rather we are actually inclined to seek, the sustainability of human well-being.

Moreover, we can consider the well-being of the collective body of human beings who live now and will live in the future, based on the idea of togetherness between us and the people of future generations, and by applying definition 4 to this context, such as when we are talking about the following hundred years, we can define the well-being during this period as follows:

Def. 6: Human beings' well-being in the time a hundred years from now is measured as the integrated sum of our capability that is and will be actualized within the interim hundred-year period.

Conclusion

In this paper, I have tried mainly to propose two points: first, the concept of 'capability' is valid not only in healthcare, but also in our present issue; and secondly, we have to introduce ethics in close relationship, or ethics of care, into intergenerational ethics, together with ethics of remote relationship, or ethics of justice.

4 Foley Center, Northwestern University. (http://www.sesp.northwestern.edu/foley/research/generativity)