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DO JUSTICE, LOVE MERCY: THE INAPPROPRIATENESS OF THE CONCEPT OF JUSTICE APPLIED TO BEDSIDE DECISIONS

Discussions about the allocation of scarce resources to individual patients have frequently been based on the concept of justice. I am going to argue that it is usually not appropriate to ground individual treatment decisions on ideas of justice. Compassion and mercy are the moral concepts better suited to the inequalities and individual differences of the sick.

Understanding justice in the context of medical care is made more difficult by several common confusions. First, medical care is primarily concerned with the care of the sick and not with health. Seond, the origins of national health insurance programs (which are, of course, sickness insurance programs) have more to do with decreasing the costs to the state of poverty, disease, disability, and premature death than concern with the individual sick person. Third, attempts to apply principles of justice at the individual bedside falter for a number of reasons, both symbolic and factual. Fourth, invoking principles of justice in the setting of individual sickness denies the reality and potency of individual differences as well as denying the existence of fate.

Let me first address the fact that medical care is primarily about the care of the sick and not about health. While it is certainly true that pneumonia is an impediment to helath, not having or recovering from pneumonia is an insufficient criterion for health. But, preventive medicine, as conventionally discussed and practiced, is concerned with the prevention of disease, not primarily with the promotion of health. The word 'helath' is often used in the United States as a euphemism to conceal the presence of 'sickness', That is the case, much as the Hospital for Special Surgery was originally called the Hospital for the Ruptured and Crippled. Sterility clinics became fertility clinics and contraceptive clinics became family planning clinics. Another example is a program being funded by a prominent foundation for the 'health impaired elderly'. Those words are a euphemism for the old and the sick (which is what they call themselves). Euphemisms are fine until they begin to fool their users. The euphemism works because most people put health and disease at the opposite end of the same spectrum. That understanding, however popular, will probably not withstand critical examination – especially in view of the difficulties of finding a definition of health. Whether or not health and disease are more than passingly related to each

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other, it *is* the case that medical care is overwhelmingly the care of the sick. The distinction is important because it seems easier to decide whether, in a just society, a sick person should receive care regardless of the ability to pay, than to decide whether a person has a right to health – whatever that may be.

Now for the second confusion. At first glance, it would seem that health insurance programs, or national health care systems, are really an extension of human activity that stretches back into antiquity – charity to the sick. What seems new in this century is the idea that all sick persons should have an equal right to medical care independent of their ability to pay. In that context, the word 'charity' is often considered onerous. It may be pertinent, however, to remember that national health insurance programs have their historical basis not primarily out of concern for the individual sick person but, rather, out of concern for the burdens of the state. Edwin Chadwick, who had been secretary to Jeremy Bentham ([6], pp. 32 ff), published his 'Report on the Labouring Classes of Great Britain', in 1842 [4]. The investigations that formed the basis for that publication grew out of ferment for reform of the 'poor laws' of Great Britain. Chadwick showed systematically how much more disease, disability, and premature death were to be found among the poor than among the comfortable. Whatever his humanitarian conerns, his basic argument for removing that disease burden by sanitary reform was that the poor were poor (and a drain upon the state) because they were sick (Chadwick's observation that the poor have more sickness than the comfortable has been repeated generation after generation and remains true today in the United States and even in Great Britain). What Chadwick proposed was pure Bentham utilitarianism. The legislation that created Britain's National Health Service was a direct descendent of the poor law reform of the mid-19th Century. In view of the history of National Health Insurance, its fundamental objectives, and its philosophical foundations, questions of distributive justice are entirely appropriate, as are discussions of a right to medical care. But the focus of the concern remains, not the care of a particular sick person, but that person's needs in relationship to the needs of others and in the light of the resources of the state.

But the debate about justice and medical care has gone further: Now we ask what are the limits of the equal distribution of medical services (regardless of ability to pay) and, more, how are scarce resources to be allocated? This is often symbolically phrased: Which of several patients with end-stage renal disease should get 'the kidney'? At first glance, the sick-room appears to be an appropriate place to examine the concept of justice. The sick seem

an apt reminder of why the concept must first have arisen. The idea of justice is a response to the plight of persons subject to a power over which they have little control and injured by that power beyond anything they deserve. They have not been rendered to as was their due (if I may draw on one of the earliest definitions of justice).

In the beginning, and in most discussions, the concept 'justice' is employed in opposition to the concept of 'injustice'. If that is the case, justice may not be the appropriate concept when illness is considered because, when those terms are used, human agency and interest is involved (even in the derivative words applied to God, the community or the state). However, the sick are not sick because of human agency and intent but overwhelmingly because of the action of fate. Fate is called fate precisely because it is without human intent – fate cannot be unjust nor can it be just. The category of justice is simply not relevant. It has become fashionable to displace fate by speaking as though the sick have largely made themselves ill by their ways of life, that illness comes because of someone fouling the environment. But both ideas are naive because, ultimately, everybody sickens and dies no matter what their life style and no matter how clean the environment. Even habits which are known to be illness-producing, such as cigarette-smoking, produces sickness in only a minority of their habitués. Even when sick persons do things which seem (inexplicably) calculated to make themselves worse, it is almost never because the sick actively wish to be sicker. Such behavior merely testifies to the complexity of the state of illness and of the human condition.

An example, albeit over-simplified, of a situation often discussed which employs the concept of justice might be helpful: Two sick persons lie in adjacent beds – one is poor and one is rich, but both are in severe pain. As the doctor goes by, he or she gives pain relief only to the patient who can pay. Would we characterize the doctor as unjust, or would we say he is cruel, without mercy, has no pity, or lacks all compassion? Another example: two persons are dying of diseases similar in absolutely all respects. There is medicine (or a kidney, a treatment, a machine) to save only one. Who shall get the medicine? The question has been repeatedly argued on the basis of principles of justice. One that basis, I find no answer satisfactory. If the younger, more productive, smarter (use what criteria you wish) receives the treatment, you may argue the justice of the solution because he or she was due more. But the other patient died – was that also his or her due? Even by lottery, justice is not served because one must die. Indeed, we resort to lottery where no just solution appears possible. One might say that the

lottery is the only fair way out of the difficult situation. Despite Rawls's usage, not all that is fair is just and not all applications of justice are fair. They are not equivalent concepts. It seems to me that none of these decisions need introduce the language of justice. Justice is not the relevant criteria, for no other reason than there can be no just solution – a solution in which each person receives his or her due.

Perhaps this is where the actions of a state and an individual are quite disparate. Justice may be the applicable term when the state is faced with the treatment of its sick citizens and where resources are limited. However, public policy and individual actions may differ in their moral basis, although apparently sharing the same goals.

Applying the concept of justice to individual decisions made at the bedside has additional difficulties. Addressing the question of which patient shall get the life-saving treatment (where there is only enough for one), some have suggested that the person who has in the past or can be expected in the future to contribute more to society, has the greatest claim to be saved. The paradox often present below the surface in discussions of justice at the bedside is revealed to some degree by that belief. There, the patient is being considered as a means towards the ends of the community or state, something which, at least in other circumstances, may be considered wrong. From the state's point of view, it is perfectly reasonable to save the person who will contribute the most to the state. Others believe that personhood is, in itself, sufficient to make all patients equal in that situation of scarcity. Those who hold this latter position want this fateful decision to be made solely on relevant 'medical' criteria. Who the patient was, is, or will be is not, for them, relevant. But, perhaps, people who want such awful decisions made solely on 'medical' grounds, would also like to see patients treated as persons. And they are correct in that desire because we have all become aware of the problem of an overly technical medicine – physicians who care more about diseases and technology than about patients. Treating patients as persons is not only ethically warrented, but better medical practice. That is because the nature of the person cannot be separated from diagnosis, treatment, or prognosis, except artificially or in a trivial sense ([1, 3]). The obvious paradox is not easily resolved. The symbol of justice is a blindfolded woman who holds a technical device, the scales, with which to weigh all the relevant details without regard to the person of the disputants who stand before her. That has not been, at least until quite recently, an appropriate symbol for medicine. Indeed, the concept that applies in the symbol of justice is the political concept – equal before the law.

But in no other respect except the fact of their personhood are people equal. Here, equal is no longer a political term but applies to the biological, psychological or social factors involved in sickness. Some persons are taller, some smaller, heavier, smarter, with more or less hair, light-skinned and dark, strong or weak, and with personalities and dispositions that differ quite considerably. These differences are observable at the subcellular level as well as in the behavior of the family. The methods of modern science have been devised to reduce the impact of individual differences so that generalizations become possible upon which scientific advance can be made. But the fundamental fact of individuals is not sameness but particularity. Kenneth Schaffner [8] has pointed out how necessary it is for medicine to begin to understand how to go from the general to the particular. Not merely because physicians treat individual patients – in the full sense of the word individual [5] – but because those individual differences from the subcellular level to the family, have a profound effect on the diagnosis, treatment and outcome of an illness.

The fact is that in the political system, as in medicine, we just do not know what to do with problems caused by individual differences. Consequently, we may pretend that they do not exist or that they are the result of some human wrong which, when made right, will erase the differences. It is in the nature of Nature that most human differences result from the operation of chance. We have become so successful in overcoming the handicaps imposed on people by fate (driven by our fundamental political belief in equality) that we have come to believe not only that all persons are equal in all respects, but that fate is fiction. Much current malpractice litigation seems primarily intended to compensate patients whose illnesses had an unexpected adverse outcome. This view assumes, falsely, that if something goes wrong, *somebody* must be at fault. There, a system of justice intended to protect people from being wronged by other people is used to indemnify them against the action of fate – a non-human agency.

What, then, is to be the moral basis of behavior toward the sick – especially when painful decisions must be made? Love of humanity, compassion, and mercy, *not* justice, are the appropriate concepts to guide actions at the bedside. The logo of the New York Hospital is not blindfolded justice, but the Good Samaritan. The obvious truth of what I have suggested has become obscured. (That otherwise superb work the *Encyclopedia of Bioethics* [7], has a number of entries devoted to justice, but there are *none* about compassion or mercy, I hasten to point out.)

The process by which we in the Western world have forgotten that the

sick among us are cared for out of love of humanity, compassion, and mercy, is duplicated in the education of medical students. Applicants to medical school learn, even before their interview, not to say that they want to be doctors because they like to help people, although that is often the case, because it sounds too sentimental. They are given an intense (and necessary) scientific education that ultimately provides them with an incredibly complex set of recipes for the treatment of disease and an equally complex and effective system for deciding what recipe to apply in a given instance. By the time seven or eight years have passed, they may not even remember, not to mention publicly acknowledge, why they chose medicine in the first place. In recent years, with the recognition that medicine is a moral (or moral-technical) profession [2], courses and discussions dealing with ethical problems have been included in the medical school curriculum [9], but the degree of intellectual power and systematic training given to the moral side of medicine nowhere approaches what is given to the technical.

Justice is defined in the *Oxford English Dictionary* as "the quality of being just or righteous; the principle of just dealing; the exhibition of this quality or principle in action." Mercy is " the forebearance and compassion shown by one person to another who is in his power and who has no claim to receive kindness; kind and compassionate treatment in a case where severity is to be expected." (Definition 7 describes mercy as "acts of compassion towards suffering fellow creatures.") Compassion is "the feeling or emotion that comes from being moved by the suffering or distress of another and the desire to remove it, pity that inclines one to spare or to succor." Note the difference in the use of terms expressing feeling in these definitions. Such words are virtually absent in definitions of justice.

Compassion and mercy are old-fashioned notions. But their hold on us has not been diminished solely by the advance of science. Those words smack of the benefaction of the strong towards the weak. There have been times when the pious application of these ideas has excused the worst oppression of the poor and downtrodden. Perhaps the paternalism inherent in the corruption of those virtues had to be overcome in order to achieve the political freedoms we now enjoy. Indeed, many things merely paternal, compassionate, or merciful, extended towards the sick by care-givers, are still called paternal*istic* – as though those virtues cannot be exercised honestly without the intent to oppress, demean, or coerce.

It is strange how little we know about these virtues. They are related to interactions between persons in situations of unhappiness, pain, suffering, and tragedy – the condition of being sick. They have to do with aspects of

personhood that are neither political nor psychological but based, instead, on the moral claims members of the human community have on one another. In this era more is known about the political and psychological than the moral. But how are those virtues to be applied to the allocation of scarce resources to individual patients? And how will they be used to decide who shall survive? Their application is the stuff of wisdom, and wisdom, we are told, cannot be taught. But surely wisdom is learned more quickly where it is valued. It will be most valued when we recognize that compassion and mercy must guide us in difficult decisions. Knowing that, we must begin to give them the thought and analysis that has been given to justice in the last few centuries. I am suggesting two quite distinct things. First, moral awareness does not exist in all persons at all times. In many individuals, not only physicians, the compassion necessary for the care of the very sick is simply atrophied through disuse. Moral awareness must be specifically awakened, shown to be appropriate to the physician's act, and then made manifest. Only then can moral awareness take its place alongside scientific training and clinical experience. It is often said that people (specifically physicians) cannot be taught to be compassionate – they either are or are not. Where is the evidence for that claim? Who has tried and failed and how did they try? Which leads to the second suggestion. We must study compassion in order to understand it and its applications if it is to be effectively taught. If that sounds excessively mechanistic, it is only the current habit of thought that makes it so. We did not arrive at the present sophisticated understanding of justice merely by having lived, but rather because of the active reflection on the concept, and its continual refinement. The same possibility exists for concepts like compassion and mercy. They are fruitful areas for study. It might sound odd to ask a student: 'On what basis would you extend or deny compassion to this patient?' But it is not so odd (or dangerous) as having somebody extend or deny compassion without giving it any thought. We would not wish to be judged solely on the untrained intuitions of those who must judge.

One final point remains to be discussed. For all its faults, no society has ever, in the world's history, been as just as ours. Equality before the law is fundamental to the principle of justice. Justice is, therefore, the moral precept that acknowledges the fundamental equality of all persons. But compassion and mercy arise out of human need. They are moral qualities that acknowledge fundamental differences between persons. Recognition of inequality before nature, sickness, and fate is basic to a compassionate society. Perhaps, in the absence of a just society, compassion could be conceived as an instrument

of oppression. But justice without compassion, without recognition of the fundamental differences between persons, is also oppressive.

In this essay, I have attempted to show that justice is not the most appropriate concept for guiding actions at the bedside of the sick. Compassion and mercy are far more appropriate. The issue is not simply one of realizing the necessity for change, but one of recognizing that compassion and mercy, like other virtues, must not only be awakened in but also taught to future physicians.

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