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An Essay

## Beyond Justice

by Robert D. Orr

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*Bioethicists have generally looked after the contractual and fiduciary obligations of health care professionals to patients by their adherence to and insistence on the principles of ethical action — autonomy, nonmaleficence, beneficence, and justice. But these principles, while necessary, only serve the best interests of people already recognized as patients. If we truly want to help vulnerable populations — those who fall outside the margin — then we need to go beyond justice to embrace the theological principles of mercy and grace; that is, we need to rely more completely on the way medicine was before secularization and commercialism. Competency and compassion intertwine in western medicine.*

**Y**ou see them on the news, or even more commonly, on the television news-magazines — people living in poverty, disabled individuals, ethnic minorities, disenfranchised citizens, undocumented aliens, sometimes even children and elderly individuals. They are in the news because they are vulnerable — they lack a voice; they lack power; they may lack the necessities of life such as adequate food and housing; and — they very often lack access to adequate health care. To the majority of North Americans, these individuals and groups are invisible (Boyle 1992). The press wants to render them visible, wants to make the “haves” feel guilty about the “have-nots.” But guilt is not enough. The media pleads for justice. But I maintain: justice is not enough.

### Does Bioethics Address the Needs of Invisible Individuals?

The greatest contribution of contemporary bioethics has been the recognition of, and advocacy for, the principle of autonomy. The battle cry of the last thirty years has been “the patient has a right to self-determination.” Using this principle, bioethicists and ethics committees have often helped the disenfranchised or inarticulate patient or family achieve its goal despite apparent conflicts with the medical establishment. This emphasis has

focused on the contractual nature of the patient-doctor relationship. Enforcement of the contract by the bioethicist helps the individual by leveling the playing field. But this works only if that

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individual is already a patient in the health care system and someone recognizes the ethical issue and requests assistance. Autonomy is necessary but not sufficient to give the powerless a voice.

Although autonomy is a dominant ethical principle, it is not the only principle employed in modern bioethics. Bioethicists recognize, teach, and even preach, the ancient principles of nonmaleficence and beneficence. Health care professionals must do no harm to their patients

and always seek that which is good. These principles focus on the service aspect of the professional relationship. Bioethics has served many vulnerable patients by asking "is this treatment plan in the patient's best interest?" But again, this assistance is available only to patients.

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It does not help individuals who remain outside the health care system. Even added to autonomy, nonmaleficence and beneficence are not enough.

Justice, the fourth major principle of modern bioethics, would seem to have the best chance of helping invisible individuals, because it is different from the other principles. While the first three principles focus on the individual patient, the principle of justice raises our sight to patients and society as a whole. The justice argument is that "like patients should be treated alike."

Most bioethicists will argue that two patients with valvular heart disease should be treated the same, even if one's heart valve was destroyed by rheumatic fever and the other's, from chronic intravenous drug abuse. Some professionals, however, and even some bioethicists, may argue in the name of justice, that the "innocent" patient with rheumatic heart disease is more deserving of treatment than the "guilty" drug abuser.

Notwithstanding these opinions, let us accept that bioethics often takes an advocacy role for some invisible individuals in the name of justice. In these circumstances, the bioethicist, emphasizes the fiduciary aspect of the patient-doctor relationship. The issue is to achieve more than a level playing field. The physician, having greater knowledge and authority than the patient, must be trustworthy,

and is obligated to act in the best interest of the individual patient.

But still, these individuals have to be in the health care system to have their needs met and their positions defended. It is the rare bioethicist who goes out on the street, seeking the homeless mother and child, or the drug-abusing young man sleeping under a bridge, to advocate for their welfare. No, justice as envisioned by modern bioethicists, even when added to autonomy, nonmaleficence, and beneficence, is inadequate to meet the needs of many invisible individuals in our society.

### The Principle of Justice

Before we move beyond justice, we should pause to give it a fair hearing since it does seem to have promise. There are many theories of justice that might be pertinent to addressing the needs of invisible individuals. Beauchamp and Childress (1994) provide the following examples:

- to each person an equal share,
- to each person according to need,
- to each person according to effort,
- to each person according to contribution,
- to each person according to merit, and
- to each person according to free-market exchanges.

Applied to health care, the first two theories may help the plight of vulnerable individuals, but the remainder might actually hurt them.

The plurality of theories notwithstanding, the principle of justice usually means treating like patients alike; similar persons deserve to be treated the same. We must be careful here, recognizing that "deserve" is a value-laden term and the definition of "person" is still under intense discussion.

It is fairly straightforward for bioethicists to argue that two patients with the same condition and same needs should be treated alike, even if the two patients are of different races or socioeconomic status. Yet some have argued, incorrectly in my

estimation, that the productive citizen deserves more in the way of health care than the unemployed, the miscreant, or the undocumented alien. Some utilitarian reasoning may occasionally be justified when dealing with an absolutely scarce resource (Orr et al. In press), but it is not justifiable in most allocation, access, or cost issues.

Considering the multiple meanings and vagaries of "justice," we must either modify and solidify our understanding of justice in bioethics or admit that the guiding principle of justice is not sufficient to address the care of invisible individuals.

### Beyond Justice

If our current usage of justice is inadequate, how can we move beyond it? What is there beyond justice that we should seek? After all, "liberty and justice for all" is the American way. These questions bring to mind a sermon I heard many years ago in which the speaker defined three theological terms: "justice" is getting what you deserve; "mercy" is not getting what you deserve; and "grace" is getting what you do not deserve. Perhaps we need to incorporate into bioethics the theological principle of mercy or even grace. Once these principles are developed and accepted in relation to health care, then bioethicists can enforce them.

But therein lies a problem. Shakespeare told us that this ploy would not work; it is impossible to force someone to be merciful. In *The Merchant of Venice* (Act IV, Scene I), Antonio, a wealthy merchant, has a cash-flow problem because his funds are tied up in his goods and ships at sea, so he seeks a short-term loan. Since he has no collateral at hand, Shylock, the moneylender, demands a promise of "a pound of flesh" if he should default. Antonio promises. Tragedy strikes. All of his ships sink. Shylock takes him to court demanding justice; he wants his pound of flesh. Portia, acting as judge, lends wisdom to the justice/mercy question:

**Portia:** Do you confess the bond?

**Antonio:** I do.

**Portia:** Then must [Shylock] be merciful.

**Shylock:** On what compulsion must I? Tell me that.

**Portia:** The quality of mercy is not strained;  
It droppeth as the gentle rain from heaven  
Upon the place beneath. It is twice blest;  
It blesseth him that gives and him that takes . . .  
But mercy is above this sceptered sway,  
It is enthroned in the hearts of kings,  
It is an attribute to God himself;  
And earthly power doth then show likest God's  
When mercy seasons justice. Therefore, [Shylock],  
Though justice be thy plea, consider this,  
  
That in the course of justice none of us  
Should see salvation; we do pray for mercy,  
And that same prayer doth teach us all to render  
The deeds of mercy.

In summary, mercy is better than justice; no one can be forced to be merciful; mercy is not inherent in human nature, but is a divine quality.

The divine source of justice and mercy can be seen in ancient Jewish teachings. Dorff and Mackler (1999) assess that, in both *halakhah* and theological reflection, the provision of health care is a communal obligation. The definition of "community" and the extension of the obligation

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continues to be debated in modern society and can also gain guidance from Jewish tradition. Dorff and Mackler point out that the provision of health care to vulnerable, invisible individuals not only involves funding, but also the provision of time and caring.

How, then, does this caring come into modern medicine? Some of the elements of mercy and grace

are contained within the principles of nonmaleficence and beneficence. But I believe these sources are incomplete. Caring and compassion are aspects of mercy and grace that are often lacking in modern medicine and bioethics. They have been part of the practice of medicine for centuries, yet now they are listed among scarce resources. And these divine

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aspects are particularly important in regard to caring for vulnerable individuals because sometimes they are difficult to care for. It goes against our selfish human nature to reach out to those who smell bad, behave irresponsibly, or appear ungrateful — and much easier to render them invisible.

### **Caring and Compassion**

What does “care” mean in medicine? It is interesting that the terms, “treatment” and “care” are often used interchangeably, as in intensive care, long-term care, and palliative care. This linguistic phenomenon has its positive side, perhaps best intoned by Francis Peabody when he said that “the secret of caring for the patient is in caring for the patient” (Peabody 1927). But replacement of the word “care” for “treatment” can also have a negative implication. For example, when a decision is made to withdraw life support from a patient who is irreversibly dying, we sometimes talk about “withdrawing care.” Wrong. We may withdraw treatment, but we should never, never stop caring.

When we pause to think about the meaning of the word “compassion,” we often stop at the easier definition of “with feeling.” And certainly we should offer health care to all patients with feeling. But I would encourage us to look at the more difficult definition, “to suffer with.” No one, including me, likes to suffer. But surely we cannot adequately address the health care needs of the invisible, the outcast, the marginalized in our society, unless we are willing to suffer with them.

When did compassion and caring — real caring — become part of the practice of medicine? Medical historian, Al Jonsen, capsulizes the western medical ethos as competence and compassion. In analyzing the evolution of this ethos, he deduces that the “Hippocratic principle of competence” laid the foundation 2,500 years ago. But it was the addition of the “Samaritan principle of compassion” from Christian teaching which completed that foundation (Jonsen 1990). For centuries, it was often the priest who ministered to both the soul and the body. And it is from religious terminology that we have conceptualized the practice of medicine as profession, mission, or covenant, as opposed to the more recent secular concepts of a contractual or fiduciary relationship.

The Samaritan ideal of compassion, though practiced and modeled for centuries, was formally incorporated into medical teaching by John Gregory (1772) in the first virtue-based treatise on medical ethics. Gregory focused on the moral sense of sympathy, which, he argued, was the sine qua non for a professional relationship between physician and patient.

Pellegrino and Thomasma (1993) include compassion in their enumeration of virtues that are basic in medicine, such as fidelity, compassion, phronesis, justice, fortitude, temperance, integrity, and self-effacement. To this list, they subsequently added the three Christian virtues of faith, hope, and love (Pellegrino and Thomasma 1996).

Winslow (1994) has said that the metaphors we use in medicine reveal our values and help to shape them. He makes the interesting observation that, over the years, medicine has used a progression of

metaphors first from the ministry (ministering to the sick on the surgical service), then to the military (disease is an enemy that invades and is combated with a drug armamentarium, by house officers), later to law (patient advocacy, consent, rights), and most recently to industry (managed care, competition, human resources).

I must be cautious not to overinterpret this association of medicine and religion. I don't recall that Marcus Welby, that fictional paragon of competence, caring, and compassion, voiced any particular religious motivation. And countless nonfictional health care professionals, without claiming a religious motivation, have volunteered for service in the Peace Corps or have worked for reduced salaries at government sponsored clinics for the underserved because they were truly altruistic. Even secular health care institutions almost always have altruistic mission statements.

Historically, however, the majority of individuals and organizations who offer care to invisible individuals, have been religiously motivated. The prime modern example is Mother Teresa, who cared for individuals dying in the streets of Calcutta, but thousands of other unknown individuals have shown mercy and grace to those in need based on their religious beliefs and convictions. The Salvation Army has been reaching out to invisible individuals for 135 years. Hundreds of rescue missions and inner city health clinics have been operated by religious groups or individuals. A significant percentage of hospitals began as religious charities. Some retain the religious affiliation in their names, though they are thoroughly secularized. A smaller number retain their religious mission.

But if caring and compassion, mercy and grace, are divine qualities that were incorporated into medicine centuries ago, and even if they have been adopted by altruistic nonreligious health care professionals, where have they gone? As Winslow implies, health care was first secularized, and more recently commercialized. This commercialization has continued to emphasize competence, but has substituted competition for compassion. Today our

"caring" terminology includes such words as providers and consumers, market share and capitated lives, product lines and bottom lines. It

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is very difficult for medicine to remain a mission when it is so concerned about financial margins. And those in our society clearly fall outside the margin.

If the professions of medicine and bioethics are truly to care for these outsiders, we must recall and resurrect our altruistic, if not our religious, roots. We must reread the parable of the Good Samaritan (Luke 10:30-37) and use it as an example in our own lives (DuBose 1999). I am not advocating that religion take over either health care or bioethics. What I am encouraging is that the mercy and grace aspects of caring, the divine aspect, the humanly unnatural altruism, be reclaimed by individuals in these professions.

## References

- Beauchamp, Tom L., and James F. Childress. 1994. *Principles of Biomedical Ethics*, Fourth ed., New York: Oxford University Press.
- Boyle, Philip J. 1999. "Rendering Visible the Invisible." *Park Ridge Center Bulletin* July/August: 2.
- Dorff, Elliot N., and Mackler, Aaron L. 1999. "Responsibilities for the Provision of Health Care." *The United Synagogue Review* Spring: 18-19.
- DuBose, Edwin R. 1999. "The Call of the Good Samaritan." *Park Ridge Center Bulletin* July/August: 9-10.

- Gregory, John. 1772. *Lectures on the Duties and Qualification of a Physician*. London: W. Straham. Reprinted in Larry B. McCullough, ed. 1998. *John Gregory's Writings on Medical Ethics and Philosophy of Medicine*. Dordrecht: Kluwer, pp. 161-244.
- Jonsen, Albert R. 1990. "The Good Samaritan as Gatekeeper." *The New Medicine and the Old Ethics*. Cambridge, MA: Harvard University Press, pp. 38-60. Luke 10:30-37. *Holy Bible*.
- Orr, Robert D., Joyce K. Johnston, Stephen Ashwal, and Leonard L. Bailey. In press. "Should Children with Severe Cognitive Impairment Receive Solid Organ Transplants?" *Journal of Clinical Ethics*.
- Peabody, Francis W. 1927. "The Care of the Patient." *JAMA* 88:877-882.
- Pellegrino, Edmund D., and David C. Thomasma. 1993. *The Virtues in Medical Practice*. New York: Oxford University Press.
- . 1996. *The Christian Virtues in Medical Practice*. Washington D.C.: Georgetown University Press.
- "The Merchant of Venice." *The Complete Works of William Shakespeare*. Roslyn, NY: Walter J. Black.
- Winslow, Gerald R. 1994. "Minding our Language: Metaphors and Biomedical Ethics." *Loma Linda University Update* 10(4): 1-6.