

*Justice and Ethics: A Levinasian Perspective on Healthcare*

Nelly Jebran

**Abstract**

This essay applies the philosophy/ethics of Emmanuel Levinas to healthcare, looking particularly at his work in *Totality and Infinity* and its sequel *Otherwise than Being*. It emphasises the necessary relationship between what is generally considered “ethics” and “politics” to examine the state of healthcare as one wherein individuals are understood to be part of a “totality” and mere resource-users. The dangers of a culture of totality as described in Levinasian language are evident in the area of healthcare and, particularly, in the care of especially demanding Others, of whom infants with cognitive impairments are but one example. What is required is an understanding of justice that *re*-cognises and underscores the ethical foundations of all political structures.

Keywords: Emmanuel Levinas; healthcare; cognitive disability; justice; ethics; politics

Annie's death has led us to question the policies and practices related to the care provided to infants born with certain genetic conditions related to disabilities . . . We believe the care Annie received was different from the care received by other babies without certain genetic conditions, especially those related to cognitive delays . . . Subsequent to the undertaking of exhaustive research related to the ethics, legal and health policy issues of the matter, we have come to the conclusion that there appears to be good reason to be concerned about the systemic treatment provided to infants with certain genetic conditions, especially those related to disabilities for which prenatal testing and termination are available. (Spirit of our Time, 2009)

—Barbara Farlow, mother of Annie Farlow. Annie was born with Trisomy 13 in 2005 and died at 80 days in a leading Canadian children's hospital where, her parents claim, she received inadequate care.

Why would I deny Katya a medical intervention that was needed if I wouldn't deny Gemma, my older daughter, or Caleb, my son—they're not developmentally delayed—why would I discriminate against her? . . . There were plenty of opportunities to do it [perform lifesaving cardiac surgery], but apparently no parent had at that point been aware, and we could easily see why: the wool is pulled over the eyes of the parents and they're encouraged to basically dispose of these kids that are going to be burdens to the system. (Wilson, 2008)

—Sam Sansalone, father of Katya Maria Sansalone. Katya was born with Trisomy 13 in 2001; the Sansalones fought extensively with a Canadian hospital over the care of their daughter.

Ground-breaking biomedical technologies that dramatically increase the chances of life for critically ill patients are placing intense ethical and economic pressures on modern healthcare systems. A dilemma between provision of treatment and resource rationing is but one effect of the pressures confronting healthcare today. Using the philosophical framework provided by Emmanuel Levinas in his central works, *Totality and Infinity* and *Otherwise than Being*<sup>1</sup>, this paper critiques a notion of justice in healthcare that has eclipsed the primary ethical relation at the heart of Levinas's philosophy. The critiqued justice reflects an attitude of indifference indicative of what Levinas calls "totality". Totality, for Levinas, is a way of encountering the world that totalises the other person. Levinas compellingly describes the totalising logic as one that objectifies the Other: "To be sure, most of the time the *who* is a *what*. We ask 'Who is Mr.

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<sup>1</sup> I focus here on *Totality and Infinity* and *Otherwise than Being* as they are Levinas's principal works on ethics and politics. Other relevant works include *Time and the Other*, *Ethics and Infinity*, and *Entre Nous: On Thinking-of-the-Other*.

X?’ and we answer: ‘He is the President of the State Council,’ or ‘He is Mr. So-and-so.’ The answer presents itself as a quiddity; it refers to a system of relations” (Levinas, 1979, p. 177). I argue that healthcare systems have come to embody such a totalising logic, turning the *who* into a *what*, where the patient counts primarily as a user of scarce resources.

Levinas’s project — situated within continental philosophy as a critique of ontology’s primacy over ethics — is an interruption of totalising philosophies/institutions that negate the ethical relation between persons. He responds with an ethics of responsibility through which the subject remains unique among plural others in its responsibility *for* its neighbour. Levinas introduces the “face-to-face” as the primary ethical relationship: “To the question *who?* answers the non-qualifiable presence of an existent who *presents himself* without reference to anything, and yet distinguishes himself from every other existent. The question *who?* envisages a face” (Levinas, 1979, p. 177). It is important to stress that what Levinas means by “the face” cannot be a categorisation of the Other. In *Ethics and Infinity* (1985), Levinas famously states: “The best way to encounter the Other is to not even take notice of the color of his eyes. . . . The relation with the face can certainly be dominated by perception, but what is meant *specifically* by the face cannot be reduced to the perceptual” (p. 85). The face, then, is not physicality, so that, in encountering the Other, we are not taking account of traits, classifying the Other as a *what* (as a woman, as Black, as disabled, as elderly, as poor), but as a *who*. Furthermore, the face-to-face can never be a utilitarian or reciprocal relationship. Reciprocity implies a system of exchange and tradeoffs and this dangerously implies the fungibility of persons (Diamantides, 2000, p. 8). It is crucial to note that Levinas’s emphasis on the face-to-face is not a negation of politics, but a call for a transformed politics wherein the primary responsibility prompted by the encounter of

the face is irreducible to totalisation. The ethical relation of the face-to-face must always inform the social and political order (Veling, 2010, p. 51).

Part of Levinas's project, and an initiative I take up here, is to re-assert the relationship between the ethical and the political—to recapture the ethical in the political and recognise the already-political in ethical relations. In the context of healthcare, I focus on one particular instance where the dilemmas of rationing are experienced in the care of infants with genetic abnormalities or cognitive impairments;<sup>2</sup> such moments of tension at the patient level are crucial because they reflect a political and ideological attitude of totality. The implications are much wider than the patient-physician interface; these micro-level experiences emerge in a wider socio-political context and signal an overarching culture where the political overshadows the ethical. Specifically, I stress the political nature of the ethical relationship that occurs at the patient level between caregiver and patient; in Levinasian terms, the face-to-face has political relevance and does not exist in isolation of “the third” person. This “third” person is what bridges the ethical to the political. The Levinasian understanding of justice relies on the recognition that beyond—and at the same time as—the ethical responsibility of the one person for the other, there is a responsibility to other Others. The “‘I-thou’ forgetful of the universe” is insufficient for Levinas (1979) since “the *thou* is [always] posited in front of a *we*” (p. 213). In this vein, I emphasise the ethical relation as one that must be reaffirmed at the level of policy and decision-making, specifically in the rationing of health resources. While healthcare systems are

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<sup>2</sup> My understanding of intellectual disability, which I believe to be qualitatively different from physical disability in that the humanity and personhood of individuals with severe intellectual impairments is more readily put into question (for example in the work of philosophers Peter Singer and Jeff McMahan), leading to attitudes that support the disposability of such individuals, is framed mainly by the work of Eva Feder Kittay, Licia Carlson, and Simo Vehmas. See Carlson, L. (2010). *The faces of intellectual disability: Philosophical reflections*. Bloomington: Indiana University Press; Kittay, E. F. (1999). *Love's labor: Essays on women, equality, and dependency*. New York, NY: Routledge; Kristiansen, K., Vehmas, S., & Shakespeare, T. (2009). *Arguing about disability: Philosophical perspectives*. Milton Park, Abingdon, Oxon; New York, NY: Routledge.

political institutions, they are not strictly political—healthcare *systems* cannot be separated from the ethical relation that requires *care* for the patient-Other.

The two cases mentioned above (Annie Farlow and Katya Maria Sansalone) are Canadian examples representative of the oversight of ethics in politics. Laudably, publicly funded healthcare plans—such as the Canadian one—seek to address the vulnerability of the poor and alleviate inequality by removing socio-economic status as a barrier to access to healthcare, but that is only *one* form of inequality they address. Under public systems, treatment for children with severe intellectual disabilities is “cost-inefficient” and is frequently deemed “futile.” Perhaps the problem of resource rationing is put into relief in publicly funded systems because distribution decisions must still be made—but on what basis? Triage and resource distribution decisions—if not based on a patient’s ability to pay for services—must then be based on other criteria. In the cases of Annie and Katya and other children born with severe cognitive limitations, *they are the vulnerable*, except their vulnerability is defined by something other than poverty. The vulnerability of children like Annie and Katya is based (usually not openly, but justified in the language of futility) on their cognitive disability, which is also ultimately related to their minimal potential to become socially “productive” individuals. In this sense, our universal Canadian healthcare is not really universal; it remains exclusive and makes some of its most vulnerable members disposable. That said, I do not intend to critique Canadian healthcare, per se, but any healthcare scheme—publicly funded or otherwise—that forgets the face of the individual patient; this can happen in any provision of healthcare that is detached from the responsibility of the one-for-the-Other. Levinas demands from us an even greater responsibility to the vulnerable, be they the poor or the cognitively disabled.

**Justice: From Ethics to Politics and Back**

I summarise Levinas's understanding of justice as the following: *justice is the political in the ethical and the ethical in the political*. In undertaking a Levinasian analysis of healthcare, I begin with the following premises:

1) *There is a direct relationship between healthcare policy and economic utilitarianism in medical practice*. This relationship is fuelled by biomedical production and its accompanying technologies, as well as the perception of limited resources (actual or not, the perception is what ultimately matters in decision making) and the need to ration them. As such, healthcare cannot escape some form of economic utility. I suggest this is “the tyranny of politics left to itself” wherein the exchangeability of human beings becomes the norm. The rhetoric of “distributive justice,” which is idealised in healthcare systems, is influenced by utilitarian thinking and a calculative attitude toward the delivery of health as a product. In healthcare “systems,” patients are exchangeable resource-users of precious health services. Ultimately, cost-effectiveness has become essential in highly strained healthcare schemes, bringing about a totalising attitude that regards patients as anonymous consumers.

2) *Conclusions about medical futility may be influenced by economic calculations of resource rationing, leading to discrimination against particularly demanding Others*. Under a utilitarian mindset, healthcare systems directly or indirectly promote the dispensability of particularly burdensome resource-users. The Other—especially the cognitively impaired infant whose continued existence threatens to tax what is considered an already overwhelmed system—is especially at risk of “healthcare politics left to itself.” Working with limited health resources, healthcare practitioners must make distributive decisions as to “who gets what.” This is an element of politics and justice – the presence of the third party requires that responsibility to the particular Other (who, in this case, is a patient) is limited; on its own, this is not problematic, but

is a necessity of societal existence, healthcare included. There is cause for concern, however, when justice is “formalised” and “indifferent” – the individual becomes merely a nameless/faceless unit of consumption competing for resources with other patients. In what I refer to as the “utility/futility dilemma”, utility-based arguments are used to justify resource-rationing; providing treatment to the “disabled” Other is deemed futile, where the decision to refuse treatment may be motivated by cost-saving impulses – that is, resources are better spent on more capable, more productive, and less-burdensome Others.<sup>3</sup> Increasing cases of dispute between parents and physicians about the care of critically ill infants capture a representative concrete implication of the utility/futility dilemma encountered in healthcare. Parents stress economic utility as a basis for the denial of treatment for their children; physicians emphasise medical futility where resource allocation is a concern. Using Levinas’s concepts, I suggest that such critical moments of dispute about the care and treatment of infants with cognitive impairments are a telling empirical example of “totality” and what can happen in the political when it is left unsupervised by the ethical.

This is not to say that ethics is Levinas’s only concern. Levinas may be interpreted as overlooking the political and overemphasising the ethical, suggesting that his ethics is self-sacrificing, impractical, and even impossible in the “real world” of social and political interaction. My application of Levinasian ethics to the field of healthcare, nonetheless, proposes that not only is Levinasian ethics practical, but it is necessary – though currently deficient – in the health-related care for others. In their foreword to Levinas’ essay “Peace and Proximity” in the *Basic Philosophical Writings* (1996), Peperzak, Critchley and Bernasconi maintain the significance of politics in Levinasian ethics:

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<sup>3</sup> Rationing health care to the elderly, for example, is based upon a cost-benefit analysis that views the elderly as poor investments per healthcare dollar and whose treatment will procure limited returns (Smith, 2002, p. 46).

Far from a blind spot in Levinas's work, one finds—and with an increasing insistence—an attempt to traverse the passage from ethics to politics . . . Levinas endeavors to build a bridge from ethics, conceived as the nontotalizable relation with the other human, to politics, understood as the relation with the third party . . . that is, to all the others that make up society. (p. 161)

Justice emerges *within/at the same time as* the ethical relation in recognition of the “third” who is the source of politics and society; the political is *always already present with* the ethical. The “weighing, thinking, calculation, and comparison of the incomparable” (Levinas et al., 1996, p. 168) – that is, the realm of politics – is not external to the ethical relation between the Same and the Other since the Same and the Other do not exist in isolation. Applying this to healthcare, the ethical relation between the caregiver and the patient cannot be viewed in isolation—the patient Other exists alongside other patient Others who likewise make demands. Justice in healthcare, then, demands “taking account of” the third person. But this justice *begins in* the ethical and, therefore, a true understanding of politics does not lose sight of its ethical core:

In the measure that the face of the Other relates us with the third party, the metaphysical relation of the I with the Other moves into the form of the We, aspires to a State, institutions, laws, which are the source of universality. But politics left to itself bears a tyranny within itself; it deforms the I and the other who have given rise to it, for it judges them according to universal rules, and thus as in absentia. (Levinas, 1979, p. 300)

When politics *forgets* its ethical foundation (when it is “left to itself”), it “bears a tyranny” and “deforms the I and the other who have given rise to it.” As Diamantides (2000) argues, a false understanding of justice is one “reduced to those principles which allow for the preservation, measurement and calculation of our meaningful and conflicting desires to be ‘with’ [as opposed to ‘for’] each other” (p. 67). In other words, justice/politics that is purely calculative has forgotten ethics and remains but a residue of the *fullness* of the *political in which is contained the ethical*. As Peperzak, Critchley, and Bernasconi reaffirm, Levinas “wants to criticize the belief that *only* political rationality can answer political problems and to show how the order of the

state rests upon the irreducible ethical responsibility of the face-to-face relation” (Levinas et al., 1996, p. 161). In the delivery of healthcare, measurement/calculation that takes into account the existence of the third is indispensable, but “comparison” must remain attentive that it is acting on the *incomparable*—that is, when *unique* individuals become interchangeable units in a healthcare system whose primary function is the calculation of costs and benefits (where individuals become *comparable*), the political, at this point, is hollowed of its ethical core.

### **Politics Left to Itself Bears a Tyranny Within Itself: Healthcare and the Treatment of Children with Cognitive Impairments**

Echoing the previous section, a justice that is purely political is totalising. The political, absent the ethical, bears a tyranny within itself. How does politics become tyrannical and totalising? How does justice become unjust? Within the purely political totality, relationships are reciprocal and utilitarian; reciprocity suggests the exchangeability of individuals “making exploitation or worse justifiable” (Diamantides, 2000, p. 8). “Politics left to itself” is reflected in the work of justice all too commonly performed in courts of law where politics has itself as its sole concern rather than the well-being of individuals and society. Politics becomes trapped in its own processes, preoccupied with its internal intricacies and operations (Veling, 2010, p. 50). In a similar criticism, Diamantides locates the tyranny of politics in the formalisation of justice wherein justice is understood to be immune from the “emotional state of being-for-each-other” (p. 23). The “liberal pathos” of the West, he argues, promotes a “being-*with*-each-other” whereas we ought to “be-*for*-each-other” and “anarchically, gratuitously – for nothing” (p. 15-16). As a result, the individual in this state is “different but not unique,” is a “‘non-object’ of moral, political and legal *indifference*; it is an individual ‘entity’ – a member of a totality – but no longer unique Face” (Diamantides, 2000, p. 150-51). When the ethical – that reveres the

uniqueness of the individual and *sees the Face* in the crowd – is disregarded, politics becomes dangerous. “Thou shall not kill” is a powerful commandment in proximity and in the confrontation of the Face; in totality, where human beings cease to have a Face, where “the *who* is a *what*”, and where “the ultimate meaning alone counts,” the gravity of this commandment is diminished. As a consequence, healthcare normalises the purging of especially demanding Others.

In the context of budget constraints, limited resources pit the interests of one patient against those of another or against the resources of society as a whole. On the ground, this affects caregivers’ behaviour toward patients (Mehlman & Massey, 1994, p. 299) and is reflected as a reduction in “the quality of personal care for patients due to a consequentialist aim of maximizing human welfare” (Norvedt, 2003, p. 26). The problem of utility and futility that emerges as a result is a symptom of the “totality” that Levinas criticises. I use “utility” to refer to rationing principles under healthcare arrangements and “futility” to refer to a medical judgment about the effectiveness of a *particular* treatment on a *particular* patient. My understanding of utility and futility is supported by the definitions provided in Jecker and Schneiderman (1992): “Whereas rationing indicates a priority *between* scarce resources, futility implies that a *particular* medical intervention produces a low likelihood or quality of effect.... Futility refers to the treatment of a single patient; rationing involves a communal decision about many patients” (p. 194-5). Utility is derived from the principle of utilitarianism<sup>4</sup> whose objective is the achievement of “the greatest possible balance of value over disvalue for all persons affected” (Mack, 2004, p. 16). With reference to healthcare, Mack notes, “utilitarian thinking would stipulate that whenever there is a choice between different but equally efficacious methods of

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<sup>4</sup> Pertaining to the specific case of infants with cognitive impairments, my understanding of utilitarianism is influenced by Simo Vehmas’ concept of bioutilitarianism (Vehmas, 1999, p. 37).

treatment, patients' benefits should be maximised and the costs and risks minimised" (p. 16). He adds that a health-related understanding of utilitarianism replaces "pleasure and happiness" with "length and quality of life" (p. 16) and requires that, when resources are limited the goal is to maximise the health of the population as a whole. I argue that, in the interest of the "whole," the individual has been neglected. In other words, the ethical relationship of the *one-for-the-other* that ought to found politics is forgotten in healthcare policies and attitudes that seek "the greatest good for the greatest number."

In the context of care for infants with cognitive impairments, the conflation of economic utility with medical futility as a basis for treatment/non-treatment decisions is problematic. Physicians facing limited resources and undeniable pressures may be inclined to make cost-effective decisions in the language of medical futility (Mehlman & Massey, 1994, p. 291). In the case of critically ill infants, conflicts arise when parents—attuned to warnings of resource scarcity in harsh economic times – perceive non-treatment recommendations by physicians as purely economic and put into question medical futility arguments and the system that appears to provoke them. The treatment or non-treatment of critically ill infants – particularly those with cognitive impairments or developmental disabilities—concretises the broader structural dynamic in healthcare policy and the pervasive "totalising" attitude shaping healthcare.

Jecker and Schneiderman (1992) put forth a number of telling questions that capture part of this problematic: "Are futility and rationing merely two different words to describe the same impulse, the desire to cut costs? Is the idea of futility nothing more than a subterfuge for rationing? Is rationing inappropriately invoked when making judgments about medical futility? Are they both ominous signs that society is seeking covert ways to dispose of unwanted persons" (p. 189)? With rising healthcare costs and technological advances in medicine, physicians are

pressured by “competing loyalties to enter into a decision mode of one versus many” (Mack, 2004, p. 12). At the political level, government administrations have avoided the establishment of clear-cut guidelines to govern these decisions (Brown, 1993, p. 116). In this vacuum, futility becomes a handy concept, when upfront discussions of cost concerns are avoided:

In the area of rationing, in particular, the tendency is to make choices by not making them. . . . This may explain, in part, why futility sometimes functions as a convenient subterfuge for allocation decisions. It is easier for a physician to tell a patient that medical care is being withheld because there is nothing that can be done, than it is to say that medical care is unavailable because it is costly. . . . Yet careful observers are aware that our society already has made choices about both rationing and futility by not making them. . . . [C]ritics should realize that covert tactics are ironically a more convenient way to dispose of unwanted persons than an open policy debate. (Jecker & Schneiderman, 1992, p. 195)

Taking Jecker and Schneiderman’s general assessment to the patient level, Barbara Farlow (mother of Annie Farlow), states poignantly:

We recognize resources are finite, so the question becomes not if, but how we ration. Openly, transparently, democratically and with careful consideration for the rights of the vulnerable? Or quietly, without debate and behind closed doors? . . . No one wants to be seen as the person that started the conversation on who we exclude from universal health care . . . But we’re already excluding people like my daughter in other subtle ways, so the time to talk is now. (As cited in Vogel, 2011, p. 1242-43)

Considering the Canadian context, Brown (1993) states that “dispassionate macro-rationing decisions throughout the healthcare system indirectly influence micro-rationing decisions at the clinical level [utility], which in extreme cases involve highly emotive and value-laden choices about which patients shall, or shall not, receive vital healthcare services [where futility arguments can be inserted]” (p. 101). Yet, is utility *necessary* in healthcare systems? Brown argues that “the realities of resource scarcity necessarily temper Medicare’s goal of providing ‘free’ access to comprehensive health care for all Canadians” (p. 105). Practically, this means that rationing is based on “triage”; Brown points out that “when health resources are inadequate to meet all demands for health services, resources are explicitly or implicitly ranked

and rationed by the degree of ‘need’ for effective health care” (p. 108). Cost-effectiveness, a utilitarian element that attempts to attain the greatest benefit for each dollar spent, has become central to the functions of healthcare (McGregor, 2003, p. 433). Under state-run systems of healthcare, “justice implies equal treatment of equals under comparable circumstances. However, it is questionable what ‘equal treatment’ exactly means” (Breyer, 2009, p. 401). Breyer rightly questions the meaning of “equality” in justice, but assumes “comparability.” Comparability further indicates the interchangeability of persons and allows for the seemingly seamless translation from patient-care to cost-utility. The death of Annie Farlow is a case in point.

### **Annie**

An interesting tension appears at the interface of the minimization of individual suffering and the exclusion of individuals whose lives would be less than perfect. . . . In many cases, however, repeated and socially sanctioned choices form patterns, which can become coercive without anybody intending to make them so. Prenatal genetic screening for undesirable traits is quite possibly a case in point. Initially solitary decisions to exclude individuals with disabilities can surreptitiously become policies, and these can have social consequences which are mostly ignored in bioutilitarian argumentation. (Hayry, 2007, p. 61)

I recount the story of Baby Annie as a case that indicates a possible translation of patient-level decisions into dangerous society-level policies, covertly or openly. Annie’s story warns of the “real-life” effect of the dispensability of persons when they count only as “one of a number of others.” Annie was born in 2005 to Barbara and Tim Farlow with Trisomy 13, a chromosomal anomaly associated with developmental and physical impairments ranging from manageable to severe. At the age of two months, Annie was taken to Toronto’s Hospital for Sick Children in respiratory distress due to pneumonia. The attending physicians at the time of her admittance made no suggestion, according to her parents, that Annie was in grave danger; however, Annie died twenty-four hours after her admission to the hospital. While the coroner’s report attributes the death to complications of Trisomy 13, Annie’s parents suspect that her “death may have been

hastened and question whether there exists at the hospital a culture that prevents seriously ill and disabled infants from receiving life-saving treatment” (Boyle, 2010). The Farlows claim that a DNR order was placed without their consent and believe there is evidence to suggest that a narcotic was given to Annie to hasten her death. Commenting on the case, Dick Sobsey, professor of Educational Psychology at the University of Alberta and Director of the John Dossetor Health Ethics Center and the JP Das Developmental Disabilities Center, states

There is a disconnect between what the public thinks goes on in hospitals and what really goes on. Most infants and children who die in hospital critical care units die because of a decision to withhold or withdraw care . . . not in spite of all efforts to ensure their survival. Many die because of a decision based on someone’s idea of what their future quality of life would be and not because they are inherently close to death. (Boyle, 2010)

The implications of the decision-making referred to in this statement are unambiguous: decisions to withhold or withdraw care from critically ill infants cannot be taken as isolated occurrences; instead, they must be examined in the context of healthcare as an ethico-medical-political domain that reflects a totalising culture where persons are mathematical terms that either do or do not fit into the equation. When rationing healthcare resources is a priority, decisions are made about who gets treatment. In the case of children like Annie – children whose existence is guaranteed to further tax an already strained system – the question of rationing based on “quality of life” judgments and cost-effectiveness inevitably arises and prompts us to pause in concern for the causes and effects of such attitudes toward vulnerable Others.

### **Totality and Indifference**

Control and domination are almost natural within the attitude of indifference when, as Welie (1999) comments, we are moral strangers to one another:

Egalitarian ethicists have stressed the essential equality among human beings and the necessity of thinking about justice from behind the veil of ignorance lest we discriminate; in other words, we should neutralize any kind of familiarity that is likely to bias our

judgment, considering others (and ourselves) as unknowns instead, as moral strangers. (p. 12)

Diamantides (2000) offers a related criticism of the moral indifference found specifically in the medical and legal contexts. First, it is evident in medical science, which has suppressed its “appetite for compassion:” physicians are asked to “disengage” and emotionally detach themselves from the suffering of the patient – they act only to cure and, if that is not possible, the patient remains valuable only as an experimental source of medical knowledge (p. 93,107). Second, indifference is also embedded in the legal-political context framing medicine and healthcare. Diamantides calls this “the modern state’s . . . legal institutionalisation of ethical indifference” (p. xii). He adds that, on one hand, medico-legal doctrine pits the doctor and patient in a position of indifference to one another where suffering becomes “*meaningful* and *calculable*” (p. 21), while, on the other hand, judges are also abstracted from the suffering of the Other and the judge becomes merely “an incorrigible calculator of harm and benefit, rights and interests [where] he or she cannot be moved by the other’s incomparable, absurd suffering” (p. 87). The ethical proximity missing in medico-legal practice as well as healthcare reflects a lack of ethical proximity in broader contexts, such as the liberal pathos Diamantides critiques. He warns, “[T]his attitude implies a certain legal view of humanity and subjectivity: both are linked to the ability of being to be-for-itself [as opposed to being-for-the-other] . . . subjectivity supposedly no longer matters to the law [or medicine, or healthcare]: it is a matter of (law’s) indifference” (p. 32-33). Levinas’s philosophy, however, makes it clear that the face-to-face encounter is and always ought to be the basis of all social institutions (Clifton-Soderstrom, 2003, p. 448). Certainly healthcare, which is especially contingent on the face-to-face encounter with the Other’s suffering, ought never to forgo this foundation.

**Infinity: Love Must Always Watch Over Justice**

Justice emerges from love. This is not to say that the rigours of justice cannot turn against love understood as responsibility. Politics, when left to itself, has its own determinism. Love must always supervise justice. (Levinas, as cited in Diamantides, 2000, p. 13)

In response to the totality and the tyranny of politics left to itself, Levinas urges that love – the ethical relation of the for-the-other – from which justice originates, must never be forgotten in the realm of politics. Veling (2010), who refers to Levinas’s concept of love in the language of “mercy,” stresses that ethics “is not simply a countermeasure or complement to justice; rather, mercy ‘watches over justice’ . . . to ensure that our practices of justice are never conducted solely according to calculation and measurement, but are also weighed or motivated by mercy and love” (p. 10). Levinas (1991) reminds us that “justice is born out of charity” – that politics originates in the ethical relation – and that “[i]n no way is justice a degradation of . . . the for-the-other [ethics]” (p. 159). That is, despite its requirement for weighing and calculation, in light of justice’s “presence” in the ethical, the demands of justice in no way diminish the demands of the primary ethical relation. Justice, as such, is inseparable from ethical responsibility: “Justice is born out of charity. [That, even though] the two can appear strangers when one presents them as successive stages, in reality, they are inseparable and simultaneous” (Levinas, as cited in Diamantides, 2000, p. 12). While Levinas speaks of justice *and* ethics, both are mutually implicative and contemporaneous (Groenhout, 2004, p. 87). “Charity” – that is, ethics understood as the being-for-the-other and responsibility for *each and every unique other* – is a condition for justice (Diamantides, 2000, p. 12).

Justice is often epitomised in the image of “Lady Justice”, blindfolded and holding a set of scales, representing impartiality and equality and keeping order with perfect equilibrium (Veling, 2010, p. 17). The impartiality of justice as it is typically understood in the Western philosophical-political tradition serves to “de-face” persons – only in the absence of the face can

notions of impartiality, neutrality, and equality be maintained since comparability and measure depend on “likeness” as opposed to “uniqueness.” Levinas points us to the dangers of this impartiality; essentially, impartiality translates to *indifference*, which, I would argue, is the greatest of sins. Indifference means silencing the Other’s demands, quieting the Other’s call for my responsibility – in front of “indifference” (in front of a faceless being), the command not to kill crumbles. Levinas’s conception of justice, in contrast, is *partial* – it is partial to the *uniqueness* and the alterity of the Other, it allows the Other to speak and make demands – only in front of “the face” can the commandment not to kill hold sway.

The difference between “being-*with*” and “being-*for*” as brought up by Diamantides (2000) is helpful to understanding what Levinas means by an ethical justice. Politics left to itself encourages an attitude of being-*with* one another, evoking notions of “tolerance” – a “putting up with” the Other (and Others) who disturbs my existence. In being-*with* and tolerating the Other, in fact, I do not allow him to disturb me – a safe distance is maintained wherein he cannot affect me (as such, I am indifferent). In contrast, Levinas confirms that the Other *does disturb* my existence: “In a sense nothing is more burdensome than a neighbor. Is not this desired one the undesirable itself? The neighbor who *could not leave me indifferent*” (Levinas, 1991, p. 88, emphasis added). *The Other is there precisely to intrude on my being and my being is there precisely for welcoming this intrusion*. Justice requires that the ethical relation be maintained between me and all Others that confront me, not as a being-*with* in political society as “fellow-members of the human species nor as fellow citizens, but as the ‘anyone,’ the one usually passed-by with indifference, . . . *the one for me and my responsibility*” (Diamantides, 2000, p. 10). While the existence of the third and the consequent requirements of justice expose the face-to-face relation to thematisation, justice must nonetheless incessantly reject a plurality that

designates “additive ‘multiplicity’ of interchangeable humans” and relentlessly maintain a plurality that upholds uniqueness and *non-comparability* (Diamantides, 2000, p. 10-12, 53-54). Society, Diamantides says, is “the term for the infinite number of unique *encounters* or events of ethical proximity” (p. 14). What this Levinasian perspective then means for the domain of healthcare and the treatment of patients as *unique individuals* is substantial.

### **Love Must Always Watch Over Justice in Healthcare**

But in responsibility for the other for life and death, the adjectives *unconditional*, *undeclinable*, absolute take on meaning. (Levinas, 1991, p. 124, emphasis added)

As suggested, healthcare—as a social institution—has come to reflect totality and unethical (in the Levinasian sense of ethics) politics. Levinas (1979) proclaims, however, that the “collectivity in which I say ‘you’ or ‘we’ is not a plural of the ‘I’” (p. 39). “We” in healthcare, then, are not a multiplicity of faceless, nameless resource-users. To re-begin ethically in the realm of healthcare is first to maintain the unique individual in the collectivity of healthcare systems. While Levinas offers little in terms of concrete social structures that can safeguard the uniqueness of the individual (Groenhout, 2004, p. 94), my suggestion is that a Levinasian perspective can guide the ethical *back into* the strictly political-formal-detached experience that healthcare has become. Groenhout proposes that a Levinasian outlook “offer[s] us the resources to articulate and live out a conception of human life that recognizes limitations on the range of lives that can be considered good ones . . . and that rejects social policies that allow individuals to be defined as worthwhile or not on the basis of their genetic makeup” (p. 185). Levinas’s philosophy points out a truth that is fundamental to healthcare; “*that justice must be tempered by concern for the concrete other person*” (Norvedt, 2003, p. 25). In order to do this, decision-makers must always “‘mark’ the patient with ‘an identity of uniqueness’” (Diamantides, 2000, p. 173) and maintain the primacy of the suffering individual ahead of concerns for cost-

containment. While justice might require calculation in the distribution of health resources, this cannot become the overpowering function of healthcare. When healthcare is thought of primarily in terms of its distributive value and its maximisation as a societal product, the essence of “care” that ought to be its core is threatened; “The other is reduced to a number, and ethics becomes economy” (Norvedt, 2003, p. 31).

Several thinkers have conveyed Levinas’s “love watching over justice” and how it might apply to the area of healthcare. Norvedt’s understanding of Levinasian ethics demands that individual human suffering be responded to: “The tears of the other must never be forgotten within the realm of a social policy and its claim for just allocation of resources” (p. 31). Clifton-Soderstrom (2003) stresses the centrality of the human and the extremely personal face-to-face encounter in medicine, which makes healthcare a primarily ethical labour (p. 455-56) whose foundations are unmistakably communicated in Levinas’s language of ethical proximity. Gillett (2006) adds that Levinas’s reference to the command “Thou shalt not kill” is especially compelling in the decision-making process for critically ill patients “such that the very idea of ending a human life should always give us pause even where we are sure that sufficiency of the powerful considerations in favour of ending a life ought to guide our decision” (p. 253). And, finally, Diamantides (2000) refutes calls for impartiality in medical progress and the assumption that “professional” and “scientific” medicine is incompatible with being-for-the-other (p. 88).

I expand upon Diamantides’s critique and put forth a parallel request in medicine, public policy and societal attitudes that comprise our healthcare systems today. What they are crucially missing is *the watch of love over the administration of justice* – a re-cognition of the foundational ethical relationship that shapes human existence and, especially in healthcare, the *asymmetrical* responsibility for the unique and fragile Other. This is of even greater significance

when the Other is *uniquely* vulnerable, as in the case of infants with cognitive disabilities, and when the vulnerable Other's suffering places even greater demands on me. Rather than responding in magnitude to the greater demands made by more vulnerable Others – as the “hemorrhage’ of the for-the-other” (Levinas, 1991, p. 74) – healthcare systems (including the field of medicine, public policy, as well as general attitudes toward a “healthy society”) have instead attempted to silence these demands and even prevent them from being made: the widely acceptable “termination” of foetuses with genetic anomalies and the questionable deaths of babies like Annie are alarming examples. Unable to state it more gracefully myself, in the words of Diamantides (2000) drawing on Levinas:

I am suggesting the possibility that proximity itself is accomplished through *individuated acts of compassion* . . . relationships between carers and the ill [are and ought] to be based on [approaching] the other-as-*unique* (“unique” independently of, not in spite of, the absurdity of one’s health circumstances) in the form, *not of empathy with*, but of “*substitution*” of the one for the other who suffers “passively” and “absurdly” (despite oneself), through “insatiable but disinterested compassion”. (p. 8, emphasis added)

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