



Scientific Contribution

Suffering and the goals of medicine

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Abstract. Taking as its starting point a recent statement of the Goals of Medicine published by the Hastings Centre, this paper argues against the dualistic distinction between pain and suffering. It uses an Aristotelian conception of the person to suggest that malady, pain, and disablement are objective forms of suffering not dependent upon any state of consciousness of the victim. As a result, medicine effectively relieves suffering when it cures malady and relieves pain. There is no medical mission to confront the spiritual condition of the patient.

Key words: Aristotle, dualism, goals of medicine, malady, pain, suffering

In its issue of November–December 1996, the Hastings Centre Report published a special supplement setting out the findings of an international consultative group into the goals of medicine. Faced with new pressures including those arising from new technologies, the needs of developing nations, and ageing populations, it was felt that the basic objectives of medicine needed to be rethought. The four goals that were identified by the group were:

1. The prevention of disease and injury and the promotion and maintenance of health
2. The relief of pain and suffering caused by maladies
3. The cure and care of those with a malady, and the care of those who cannot be cured
4. The avoidance of premature death and the pursuit of a peaceful death.¹

The second goal identified by the Hastings Centre mentions both pain and suffering. It distinguishes them as follows:

Pain refers to extreme physical distress and comes in many varieties: throbbing, piercing, burning. Suffering, by contrast, refers to a state of psychological burden or oppression, typically marked by fear, dread, or anxiety.²

And the authors go on to point out that pain and suffering are not always associated: one can experience pain without suffering, and one can suffer without feeling pain. One might have a toothache but not be distressed or disturbed by it, especially if one understands its origin and has a plan for dealing with it, or one can be suffering from mental distress or anxiety related to

illness without actually experiencing pain. The authors go on to castigate the medical profession for often failing to take seriously the psychological suffering and anxiety that can accompany disease and which can, indeed, be present even when disease is not. But the research group was not of one mind as to the extent to which medicine should go in the relief of suffering. It recognised that suffering can be related to such ‘spiritual or philosophical’³ questions as the meaning which the patient attributes to their pain and illness. But it urged doctors to exercise empathy and sensitivity as one human being in the presence of another in dealing with such suffering. While palliation can be offered for pain, in the presence of psychological suffering, medicine as such would seem to have reached a limit.

This is wise counsel, but it does raise the philosophical problem of dualism. Pain is understood to be associated with physiological insult, while suffering is the mental distress occasioned by this pain. This distinction between pain and suffering corresponds to the distinction between body and mind which has been challenged in recent times on the ground that it discourages a holistic conception of the patient and encourages clinicians to think of the body in reductive terms. The so-called biomedical model is dualistic in that it focuses on the body conceived of just as a physiological system and isolates it from the psychological distress of the patient (and thereby threatens to ignore the latter). Eric Cassell has argued that medicine falls short of its mission when it focuses just on pain conceived of physiologically while neglecting the suffering which the patient is undergoing.⁴ This contrasts with the Hastings Centre document’s reticence as to how far medicine should go in address-

ing the problem of suffering. Could it be that this disagreement arises from making the pain/suffering distinction in the first place and of seeing suffering in purely psychological terms? Perhaps pain and suffering should not be distinguished so readily in a way that corresponds to body/mind dualism.

My hypothesis is that suffering is the more fundamental concept of the two and that pain is one of several possible forms of suffering. I will also argue that malady is a form of suffering and that being sick is a form of suffering. I will then argue that, understood in this way, it becomes self-evident that the relief of suffering should be one of the goals of medicine, but that not all kinds of suffering should be the explicit object of medical interventions.

Teleology and suffering

My theses are offered in the context of a holistic conception of the human person derived from the philosophy of Aristotle. Aristotle identified four 'parts of the soul' as making up the full human being. These were the vegetative, the appetitive, the deliberative, and the contemplative.⁵ In modern parlance these parts of the soul could be thought of as a person's biological functioning, their emotional and desiring functions, their practical and rational lives, and their sense of the meaning of their existence. Perhaps we could illustrate the best way to understand the relationship between these four aspects of our being with an image. Imagine a large sphere made of white glass and with a hole in the bottom. Now imagine that a yellow light globe is inserted into the sphere and turned on. The glass of the sphere will now glow with a yellow light. Now imagine that a blue light globe is inserted into the sphere and turned on. The sphere will now glow with a green light. Thirdly, a red light globe is inserted. The colour of the sphere will now be a muddy or brown sort of colour. Fourthly, let us imagine a white globe being inserted and switched on. The colour of the sphere will now become lighter. Now, let this sphere represent a person and let each of the four coloured globes represent the functioning of a 'part of the soul' or an aspect of that person's being. What emerges as life is lived is a new colour or mode of being as each part of the soul becomes operative. It is no longer possible to identify the functions of each level of our being separately, and their expressions are always combined into a whole. Moreover, this image shows us that the parts of the soul or functions of our being project themselves outwards into the world and form the dynamic wholeness of a person as they do so. Each aspect of our being colours and modifies the whole. We create our own wholeness or self as we project ourselves into the world and

into relationships with others. Our sense of the well functioning of our bodies infuses our whole being, as do our desires, our practical tasks, and our ultimate commitments.

These four aspects of our being are teleological in the sense that they tend to their own distinctive fulfilment. The fulfilment of the biological level of our being is the basis of health, while the fulfilment of the appetitive or conative part of us is a feeling of satisfaction, wellbeing, and zest for life. The deliberative or practical aspect of our lives is fulfilled when we perform our tasks as well as we are able (whether or not we are successful), while the fulfilment of the contemplative aspect of our being is our having a sense of the meaningfulness of life. The combination of all these levels of our existence is our wholeness and integration as persons.

My first thesis is that suffering is to be understood as the frustration of the tendency towards fulfilment of these various aspects of our being.

Malady

We can suffer in a variety of ways. For example the biological or vegetative level of human existence tends to the health of the body. Malady is the frustration of this functioning. This becomes clear as we consider the definition of malady offered by the Hastings Centre document:

The term "malady" is meant to cover a variety of conditions, in addition to disease, that threaten health. They include impairment, injury, and defect. With this range of conditions in mind it is possible to define "malady" as that circumstance in which a person is suffering, or at an increased risk of suffering an evil (untimely death, pain, disability, loss of freedom or opportunity, or loss of pleasure) in the absence of a distinct external cause.⁶

Malady is the form of suffering constituted by the frustration of the internal goals of the biological or vegetative aspect of our being. Malady is vegetative or biological suffering. It is literally true that we suffer disease.

This point presents an immediate challenge to dualism. Persons can be said to be suffering in this physical way even when they are not aware of it. It follows from this that suffering is not a function of consciousness, or a mental epiphenomenon which supervenes on malady. The malady by itself constitutes suffering. My second thesis then is that malady is an objective form of suffering.

Although it will not be possible to explore all the implications of this idea in this paper, it is worth

noting that this notion of an objective form of suffering applies to organisms that are not persons or of which the status as persons might be in question. It follows, for example, that animals can suffer whether or not they are capable of self-awareness. It also follows that fetuses and neonates can suffer and that comatose patients can suffer. The bioethical implications of these points will be considerable. If my conception of objective suffering constitutes an expansion of the notion of suffering beyond that which is accepted in ordinary language, I believe these bioethical implications serve to justify such an expansion. The role of philosophical theory is to provide just such ethically challenging revisions of our ordinary language concepts.

But to return to my analysis of malady. If this analysis were to be confined to the bodily level of our existence, I would fail to acknowledge the wholeness of our being. Even though my analysis is focused on the physiological level, malady can frustrate our existence at all levels. At the conative or appetitive level of our being, malady constitutes suffering in that it frustrates our enjoyment of our desires and alters our sense of relationship with the world and with our own bodies. We no longer feel at home in the world and in our own body. Even the things that we normally enjoy doing such as listening to music or conversing with friends lose their lustre when we are ill. The world seems to have a pall cast over it and our relationship to it is vitiated. If the inherent goal of this aspect of our being is an inchoate form of enjoyment and rapport with the world, then malady destroys this relationship. In healthy life, our bodily existence is taken for granted and our functional relationships with the world constitute an inchoate level of enjoyment to which we do not consciously allude. Drew Leder has called this 'the absent body'.⁷ When malady strikes, this preconscious harmony in our being is altered and our bodily existence becomes a centre of attention and concern. This is a frustration of an inherent tendency of our being which can lead even to a threat to our sense of self. It is through this preconscious sense of enjoyment of existence, as Levinas has argued,⁸ that we gain a sense of the power and vigour of our own being so as to enable us to experience our own agency and autonomy in the world. It is from the basis of this sense of ourselves as agents that we venture out into the world, take on projects, establish relationships, and form our identities as persons. This existential project of self-making has its roots in the sense of being at home in the world and the vigour which is given us by our health. When malady strikes, this basis is threatened and our sense of security in our own identity is in jeopardy. It may be that this is what Cassell means when he says that suffering involves a sense of threat to one's own integrity.⁹

Moreover, at the conative level of our existence, our seeking to form relationships with others is as basic an existential concern as is our project of self making.¹⁰ It is just as basic in our inner most being to seek to form and maintain a rapport with significant others as it is to create and maintain our own identity. But when malady strikes, the balance between caring for others and self-project is altered. At such times we normally become overly concerned and preoccupied with ourselves and our states of illness. Our relationships with others can be maintained with extra effort and commitment, but our primary inclination will be to attend to our own being. In this way too, the interpersonal dimension of our being will be frustrated by malady, whether this malady is episodic or chronic. In so far as our relationships with others are constitutive of our identity, so malady will be a pre-intentional threat to that identity. As Cassell has suggested, this is constitutive of suffering. My account differs from his, however, in that it requires no conscious awareness on the part of the victim. It is enough that the inherent tendency of our being to sociability is actually frustrated by the malady. Suffering is an objectively present condition of the person.

In the deliberative dimension of our existence malady leads to suffering in that it prevents many of our actions from being fulfilling for us, or even from being embarked upon. There are at least two ways in which this is so. First, there is the failure of our actions to achieve their external goal. It may well be that our malady prevents our projects from achieving success. And this will clearly lead to the sort of disappointment which constitutes suffering. But this form of suffering is not central to my analysis. It can be avoided by taking on only tasks of which we know ourselves to be capable despite our malady. After all, should we be foolish enough to try to fly through the air without special equipment, we would fail. This would disappoint us. But it would not be valid to describe such disappointment as suffering. Rather, it is a case of foolishness because it involves taking on what we know we cannot achieve. As in life generally, our deliberation does not need to be frustrated if it takes our malady into account and if we take on only tasks which are achievable within our reduced powers. However, taking on a limited range of tasks will be a limitation imposed on our being by our malady and this is a further way in which our practical and deliberative being can be frustrated. This limitation of the range of projects we can take on constitutes a diminution of our being and is thus constitutive of suffering. But even more importantly, the sense of enjoyment in work and activity that comes easily to the healthy person and which Aristotle describes as the internal goal of doing a task well, will often be frustrated by malady in ways

that constitute suffering. Even when our capacity is not affected, being ill will often reduce our enjoyment of our work.

At the contemplative or integrative level of our existence suffering arises from frustrations of the spirit that maladies can bring. A failure to answer the perennial question of the sick person: *why me?* can lead to suffering, as can a sense of injustice or meaninglessness attaching to the malady. It will be constitutive of suffering if victims of malady cannot absorb what is happening to them into a broader conception of their lives or into some overarching meaning. There will be a number of examples of this. The first is the diagnosis itself. Knowing what the malady is, knowing what the disease is that is causing the symptoms, knowing what the source of the pain is, are all ways of relating the malady to a broader story or theory. One source of suffering in those afflicted with malady is not knowing what the problem is. It is the fear of an unknown future or threat which frequently constitutes suffering. Patients will often express relief and will stop suffering in this way when they are given the diagnosis of their illness,¹¹ especially, but not exclusively, when the diagnosis turns out to disclose a non-serious malady. In cases where the malady is serious, the tendency of the contemplative part of our souls will be to understand it as ordained by providence or fate, as a punishment for sin, as a sacrifice with salvific power, or as meaningful in some other way. In each case the meaning that the malady is given arises from a belief in transcendent or ultimately important realities greater than the individual. The tendency of the contemplative part of the soul in the face of malady is to create a faith powerful enough to overcome the despair and fear which the malady would bring with it. Suffering at this level is the frustration of this tendency.

We must also consider the internal, existential goal of the integration of our lives which I map onto Aristotle's model as the tendency to achieve the wholeness of the four aspects of our being and of our relationships with others. In a healthy person this goal is usually achieved pre-intentionally and without further thought. A healthy person's very embodiment is the expression of their interests and commitments. One feels the vigour of health in so far as one enjoys happy relationships with others, feels at home in the world, is engaged in tasks that hold reasonable promise of success and which have a meaning in one's larger conception of life. Anything that frustrates the tendency to create this wholeness in one's life will constitute suffering. Malady clearly causes such frustration. As already pointed out, malady brings the body into the foreground in one's life in a way that undermines this wholeness. The body is absent, as it were, in an integral life and its foregrounding by malady

destroys integrity. As Cassell has pointed out¹² the body comes to be seen as an alien thing or even as an enemy in the life of a person who is ill. A sick person frequently feels at odds with himself in that his body will not cooperate with his projects. He can lose self control or find that his body will not obey his will. Moreover, chronically ill persons often seek to withdraw from the world and break off their relationships with others because of the shame and embarrassment which their illness brings them in the social world.¹³ These events are not only frustrations of the inherent tendency to sociability which is part of the appetitive part of our being, it also destroys the integration of our being and is thereby constitutive of suffering in a further way.

Just as all the lights mingle in our analogy of the sphere, so the suffering of malady suffuses our whole being. Nevertheless, malady is primarily a form of suffering that can be analysed in terms of the vegetative part of the soul in Aristotle's model of the human person.

Pain

In the same way, pain is a form of suffering that can be analysed primarily in terms of the appetitive part of the soul. Pain is an unpleasant sensation of the body. I leave aside such metaphorical usages as 'the pain of bereavement' or 'being pained by an insult' for which the term 'suffering' is more apt. I understand pain as a physical sensation. Even when physicians can find no bodily cause, the sensation is still experienced as located somewhere in the body. While there are many qualitative differences and differences of intensity between pains, they all have in common that they are hurtful and unpleasant to some degree. For this reason they are the opposite of sensual pleasure and should be analysed primarily as frustrations of our inherent desire for pleasure and comfort. As such, they are a species of suffering focused in the appetitive aspect of our being.

My third thesis is that pain is a form of suffering. By this I mean that pain is to be counted as suffering because it is a case of the frustration of the inherent appetitive goals of the person who is its victim. It is not the case that pain causes or gives rise to suffering because it is unpleasant, as if the pain and the suffering were two distinguishable phenomena. Rather, the unpleasantness of the sensation of pain constitutes a frustration of the inherent tendencies of our being; especially the tendency of the appetitive dimension of our being to secure pleasure and the satisfaction of desire. As such, pain just is this suffering. As with malady, pain can constitute suffering in a variety of

ways through frustrating a variety of the tendencies of our being. But the most obvious way in which it does this is by being unpleasant and hurtful. The appetitive aspect of our being is directly and immediately frustrated by this experience. It is pre-eminently in this way that pain is a form of suffering.

Now, this would seem to counter the point made by the Hastings Centre paper that pain and suffering are distinct. There it is argued that there can be pain from which the victim does not suffer, as when people ignore their toothaches and get on with their lives, and there can be suffering without pain, as when people fear illnesses when they are not diseased. I can accommodate these points by distinguishing the various kinds of suffering associated with the different aspects of our being identified by Aristotle. Pain constitutes suffering at the appetitive level of our being, but, like malady, it can also occasion suffering at the other levels. But it constitutes suffering in these other aspects of our being in a way that is more contingent and in a way that the victim can overcome. If the person in pain can cope with their pain in such a way that most of the internal goals of their being are not frustrated, then pain will not constitute suffering at the other levels of their being. If the body still works well despite the pain (and pain has positive functions within the workings of the body), then there need be no biological suffering. If most of the person's desires are still real and attainable and if she feels at one with the world and with others despite the pain, then she will undergo but little conative suffering. If the person in pain can get on with the job and achieve satisfaction in performing activities well and thinking clearly, then there need be no suffering at the deliberative level of our practical lives. If the person in pain has an understanding of ultimate things that allows her to understand her pain as part of the scheme of things (and having a medical diagnosis may serve this purpose just as well as having a theory about God's providence), then she may not suffer at the spiritual dimension of her existence. And if the pain is not such as to destroy the unity of a person's life and the integration of the aspects of his being, then again it will not constitute suffering of this kind. The overarching being of the victim can absorb the particular suffering of pain into a life stance which is not one of suffering. In these ways we could say of a person in pain that she was not suffering. In this way I can explicate the distinction between pain and suffering made by the Hastings Centre paper (and by Cassell), but also posit an essential unity between them in the conative or appetitive dimension of our being.

The sick role

The sick role is also a frustration of our being and, as such, it constitutes a form of suffering. In this case the frustration occurs primarily at the practical or deliberative dimensions of our being. Our practical lives are disrupted and, with the sanction of others, we adopt the role of a sick person. This is a strategy for coping with the frustration of the inherent goals of our lives as practical people and the suffering which is constituted by this frustration. The sick role is a suffering role in which the focus of analysis falls on the deliberative and practical aspect of our being. Further kinds of suffering occur, as I have already noted, when sick persons cannot give their malady, pain, or debilitation a meaning, or integrate it into their lives.

Spiritual suffering

From what has been said above, it will be clear that my Aristotelian framework allows me to distinguish, within the whole of a person's existence, a form of suffering which relates to the contemplative or integrative aspect of a person's being. Whether we call this form of suffering 'spiritual' or 'existential', the central idea is that it is constituted by a frustration of the tendency of persons to seek integration and meaningfulness in their lives. If I cannot integrate my malady, pain, or disability into my existence by seeing it as part of a meaningful narrative of my life or by relating it to a reality greater than myself, then I will suffer from psychological distress. It is at this level of our existence that religion can often provide comfort, but in our secular age other sources of relief and equanimity must be sought and developed. It is beyond the scope of this paper to explore this challenge further.¹⁴ It is enough to note that this form of suffering often takes the form of the experience of a meaninglessness attaching to malady, or a disintegration of one's life in the face of it.

In this way, spiritual suffering might be related to clinical depression. If such depression is caused neurologically, then we would have a case of malady manifesting itself in the contemplative aspect of our being. If it is not so caused, but is a purely existential or psychological condition, then the suffering would be analysed as focused more fully in this aspect. The forms of suffering that are associated with mental illness constitute a separate problem which also lies beyond the scope of this paper.

The goals of medicine

We have now seen that my Aristotelian conception of the person allows us to identify a number of forms of suffering corresponding to the 'parts of our soul' only some of which the victim may be aware of. This solves the problem of dualism in the Hastings Centre paper. Rather than seeing suffering as a psychological reaction to pain or malady, pain or malady are themselves forms of suffering. And they also constitute further forms of suffering in the deliberative, contemplative, and integrative aspects of our being. But although we can use Aristotle's model to distinguish these forms analytically, the light globes in a sphere analogy should remind us that, wherever it is focused, suffering suffuses our whole being.

So what should medicine do about suffering? It is clear that it should cure maladies, relieve pain, and rehabilitate the sick to the extent that it is able. In this it focuses upon the bodily existence of patients. However, the Hastings Centre document, Cassell, and other commentators are right to suggest that medicine should not ignore the other aspects of human existence. The question is just how these further aspects should be given their due regard.

In accordance with the third goal above, medicine should seek 'the cure and care of those with a malady'. In so doing it would remove suffering at at least the first three dimensions of our being and usually the fourth. Helping a person in such a way that the fulfilment of the internal goals of their being is not frustrated, whatever that may involve in a particular case, is what a health worker does by attending to the needs of the body. But in doing so the health worker is in effect relieving suffering. This means that the doctor does not have to do anything extra. Curing malady just is relieving suffering. Similarly, if pain is understood as suffering in the appetitive dimension of our being, then the relief and palliation of pain already is the relief of suffering. Relieving pain relieves the phenomenal form of suffering which belongs to the bodily and appetitive dimensions of our being. Further, if the sick role is understood as suffering at the deliberative level of our being, then curing the malady and removing the need for adopting the sick role will relieve suffering. A doctor does not need the skills of a psychologist or social anthropologist in order to relieve suffering. She needs only to be a good physician.

My objective concept of suffering also justifies the first goal of medicine identified by the Hastings Centre discussions: that of preventing malady. In my analysis, people who are experiencing health threatening conditions such as lack of education, poverty, unhygienic living conditions, addictions of various kinds, poor diet, dangerous working conditions, and so forth, are

actually suffering even though they may not be aware of it or feel their lives or integrity threatened. The tendencies of their being are actually being frustrated and in this sense they are suffering. The call to relieve suffering thus translates into a call to alter social and material conditions of life so as to enhance health.

Whether suffering at the spiritual dimensions of our being can be relieved by curing malady, relieving pain, rehabilitating the sick, or preventing disease and injury is a contingent matter. Certainly malady and pain will be the most immediate occasion for appetitive, deliberative, and even contemplative forms of suffering and their removal will relieve suffering. But the issue is whether the spiritual suffering of the patient, occasioned by the malady or pain, can be relieved by the physician even while the malady or pain continues. It doesn't help to say that these forms of suffering will disappear when the malady or pain is relieved. The challenge is to explore whether the physician might do anything to relieve them as part of the process of health care even while malady and pain persist. It is here that the Hastings Centre paper is wise to suggest that a patient's inability to get on with their lives or to make sense of their affliction is a problem which can be approached only with the greatest diffidence by a physician.

My theses do not imply a return to the biomedical model. I am not arguing that the kind of medical practice which has been rightly criticised in recent times for being mechanistic and insensitive to the human dimension of the patient should be endorsed. What I am arguing is that the professional focus of medicine and other health professions should be upon the biological and conative levels of human existence. Effecting cure or palliation at these levels will reduce suffering. The kinds of suffering that occur at the deliberative and contemplative levels of human existence and that are implicated in breakdowns of the integration of aspects of human living, are not within the scope of the healing art as a part of its explicit project.

But they are within the scope of the healing arts as a potential for problems. Insensitivity to suffering at these levels would add to that suffering. It is part of the traditional Hippocratic calling of doctors that they must not cause suffering. The principle of non-maleficence demands the same. The recognition of suffering at the higher levels of human existence that I have identified does not raise for health workers the responsibility to relieve suffering at these levels. Rather, it raises the responsibility to not add to suffering at these levels. The curative regimens that doctors institute should disrupt the practical lives and relationships of patients as little as possible. If hospitalisation is required, there should be minimum disruption to the forms of life of the patient and to his ability to

maintain relationships with others. The meanings that patients give to their lives should not be threatened by the curative process. The hospitalisation should not be in an institutional context where the belief system is at odds with that of the patient. The doctor-patient relationship should be fully interpersonal and rich, rather than objectifying, routinised, and bureaucratised. All of the failings of the current biomedical regimen have the potential to add to the suffering of patients in the non-bodily dimensions of their being. It is because of this that the doctor should take note of them and avoid them. But it will not be possible for a doctor to relieve all of the patient's suffering. When all is said and done, a malady, especially in the form of chronic illness, is a tragedy that cannot be made good. It can only be ameliorated. Whatever medicine may achieve in the way of the cure of malady, the relief of pain, the rehabilitation of the sick, the prevention of disease and injury, and the avoidance of spiritual suffering arising from its procedures, suffering can remain a problem at the integrative level of our being.

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Notes

1. Daniel Callahan et al. *The Goals of Medicine: Setting New Priorities*, Special Supplement to *The Hastings Center Report*, November–December 1996: S9–S13.
2. See reference 1: S11.
3. See reference 1: S12.
4. Eric J. Cassell 'The Nature of Suffering' in his *The Nature of Suffering and the Goals of Medicine*, New York: Oxford University Press, 1991: 30–47.
5. Aristotle, *The Nicomachean Ethics*, 1102b4–1103a10.
6. See reference 1: S9.
7. Drew Leder, *The Absent Body*, Chicago: The University of Chicago Press, 1990, passim.
8. Levinas, Emmanuel, *Totality and Infinity: An Essay on Exteriority*, translated by Alphonso Lingis, Pittsburgh: Duquesne University Press, 1969, pp. 110–115. See also my use of these ideas in my 'Health and Subjectivity' *Health* 1997; 1: 23–36.
9. In "The Nature of Suffering: Physical, Psychological, Social, and Spiritual Aspects" in Patricia L. Starck and John P. McGovern, editors, *The Hidden Dimension of Illness: Human Suffering*, New York: National League for Nursing Press, 1992: 3, Eric Cassell defines suffering thus: 'Suffering is the state of distress induced by the threat of the loss of intactness or the disintegration of personhood – bodies do not suffer, persons do.'
10. See my *Caring: An Essay in the Philosophy of Ethics*, Niwot: University Press of Colorado, 1995, chapter 4.
11. See reference 4: chapter 7.
12. See reference 4: 57.
13. See reference 4: 54.
14. See this author's, 'The Meanings of Suffering' forthcoming in *The Hastings Center Report*.