

Edited by  
Christopher Cowley

# Reconceiving Medical Ethics

Continuum Studies in Philosophy



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**Allison Ross** is an independent scholar. She has taught philosophy at Roehampton University and professional ethics at the Centre for Professional Ethics at Keele University. Her research interests include various topics within what can broadly be called virtue ethics. In particular, she is interested in the development and deformation of character and in the role played by practical rationality in good moral decision-making. She has recently been working with Nafsika Athanassoulis on a series of papers which aim to develop a virtue ethics approach to the moral assessment of risk-taking.

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# Introduction

Christopher Cowley

This anthology comprises a modest challenge, sometimes direct, sometimes implicit, to the mainstream Anglo-American conception of the discipline of medical ethics. It does so not by trying to fill the gaps with exotic topics of minority interest, but by re-examining some of the fundamental assumptions of the familiar philosophical arguments, and some of the basic situations (including the *descriptions* of the situations) that generate the issues.

The most important of such situations is the encounter between the doctor and the suffering patient. Before asking the mainstream question 'what are the doctor's obligations to the patient?', we believe that there are more important questions to ask first, such as: 'what is suffering, exactly, and how does it generate moral claims?', 'How does the suffering affect the patient's understanding of her own life?', 'How does the suffering enter into the relationship between patient and doctor?', 'What does the patient expect from the doctor, and when are such expectations legitimate?', 'What does the doctor need to do in order to understand the patient appropriately?', 'What exactly gives the doctor the right to touch the patient, to insert a needle into her?', 'What is the doctor's appropriate place in society?', 'How do doctors understand the prohibitions placed on them by their own profession and by the law?' Many of these questions will already have clear answers in non-philosophical terms, e.g. in terms of physiology, of psychology, of convention. Many of these questions will also strike mainstream philosophers as being trivial. It might seem obvious, for example, that medicine is a service like any other: the customer brings his defective property to the expert for repair, and it is the customer's free and informed consent that justifies the entire transaction. Several of the contributors challenge the view of medicine as a service, the view of the body as property, the view of consent as providing ultimate justification, and the view of the encounter as isolated from the rest of the patient's and doctor's lives.

In trying to answer these questions, some of the contributors will be making use of the work of philosophers often described as Continental or European. This will be a secondary purpose of the anthology: to reveal the



relevance of Husserl, Heidegger, Merleau-Ponty, Foucault and Ricoeur in reconceiving the central problems that characterize the discipline of medical ethics. It is interesting that none of these authors were mentioned at all in the two major reference works that appeared in the last five years: Steinbock's *Oxford Handbook of Bioethics* (2009) and Singer and Viens's *Cambridge Textbook of Bioethics* (2008). Indeed, it is rare for any of these philosophers to make more than a token appearance on the curricula of the Anglo-American philosophy department. And yet these philosophers have advanced sophisticated ideas about embodiment, power, narrative, self-understanding and other-understanding.

With the above in mind, it is worth spelling out what we will *not* be doing in this volume. Most mainstream anthologies in bioethics or medical ethics are compilations of “-isms” and “issues”. The first section might have a series of ethical theories such as utilitarianism and key concepts such as justice. The second section then collects together the big journalistic topics such as abortion and euthanasia and lays them out with arguments for and against. There is nothing wrong with this approach, but the existence of the *Oxford Handbook* and the *Cambridge Textbook* has obviated the need for another such volume, at least for the next few years. So this anthology is not aiming to provide a broad mainstream introduction to the discipline; it is written for a general reader already familiar with most of the -isms and the issues, most of the big newspaper debates and government policy disagreements. Nor does this anthology aim to provide the ‘latest developments’ in the mainstream fields, even if some of the authors will survey some of the latest developments in their own approaches.

Second, this is a book of *medical* ethics, which means that it is narrower than bioethics and omits topics such as animals, the environment, and research ethics. It also means that it is narrower than ‘healthcare ethics’ in that it is not primarily concerned with other healthcare professionals (nurses, physiotherapists, psychologists, social workers or hospital managers) – although many of the conclusions could be adapted without much loss to other professions.

Third, since we are focusing more on the ordinary encounter between doctor and patient, we will be avoiding some of the favourite topics of mainstream medical ethics, that is, those that comprise very abstract ideas or those that arise from very rare situations. This means that, with a couple of exceptions, we will not be discussing the following in any detail: resource allocation at the national or international level; the dilemmas brought forth by advanced technological developments such as stem cells, pre-implantation

genetic diagnosis, or xenotransplantation; the abstractions and applications of ethical theories or of the Four-Principle accounts made famous by Beauchamp and Childress (2009).

Fourth, we will be restricting our discussions to modern Western societies, and especially those with a national health service such as in the UK and in most of Europe. Some points of comparison will also be made with the American context where relevant.

## Summaries of the Contributions

### **Part I. The suffering patient, the suffering body.**

We begin with the simple human experience of suffering, and more particularly of suffering localized within a part of one's body. The person is aware that something is wrong and this is the reason to go and see the doctor. But in order for the person to understand what it means to suffer from a broken leg or a chesty cough or chronic abdominal pain, we first need to understand what it means for one's experience of the world to be essentially embodied and for those experiences themselves to be situated within an on-going life. Sometimes in stark contrast to the person's own conception of her body and of her suffering body is the scientific or mechanistic model of understanding: the body as governed by myriad interconnected causal processes, more or less known, more or less predictable; the body as very much part of the natural world. Some of these processes contribute to healthy function, others inhibit it, and the doctor-scientist wields a variety of tools to diagnose and treat as best she can.

Alastair Campbell opens with a discussion of the 2001 Alder Hey scandal in Britain, when it was revealed that organs of dead children had been routinely removed and retained by the Alder Hey hospital pathologists over many years without informing the children's parents. According to one popular conception of the body in philosophy and in medicine, the body is just a machine, and so the dead body is a useless abandoned machine: the Alder Hey parents' furious reaction is therefore at best incomprehensible, at worst, selfish for hindering scientific progress. Indeed, Campbell cites philosopher John Harris's bewilderment. However, what Harris fails to understand, according to Campbell, are the *meanings* which the human bodies, living and dead, possess in human lives. We cannot simply ignore or abandon these meanings by declaring the body to be no more than a vehicle for transporting persons around. At the same time, to understand the body

as meaningful is not to deny the reality of death: a husband kissing the brow of his dead wife is expressing his love, in a completely natural way, even if he does not expect her to acknowledge his kiss (p. 17). Campbell then considers the degree to which one's body, one's blood and one's internal organs can plausibly and coherently be considered as one's property. The concept of property involves a range of implications, and one's ethical views of the treatment of dead bodies and their organs, as well as the full meaning of any donation or organs or bodies, will depend on which of these implications are seen as most relevant.

Paul Ricœur is justly famous for his work on interpretation and narrative, some of which has found its way into medical ethics through the recent interest in the narrative aspect of illness and suffering (for example, Brody 2002). However, Gaëlle Fiasse explores other crucial aspects of Ricœur's ethics and his work specifically on medicine, above all his emphasis on the encounter between physician and patient. His analysis of this relationship helps to ground an ethics that precedes the norms and duties characteristic of the Kantian mainstream. Even though norms and precepts should be taken into consideration, argues Ricœur, they presuppose the face-to-face relationship, as well as the Golden Rule and the use of Aristotelian practical wisdom. In every 'pact of care' (*pacte de soins*), different aspects of solicitude are at stake in spite of the asymmetry between the medical worker and the suffering patient; and only by properly *attending* to the other can this asymmetry be somewhat corrected. This attention involves the physician's attempt, by a more faithful 'translation' of the patient's words, to better understand the specific nature of the patient's fragility, as well as the nature of the physician's own fragility. Such translation is an integral part of the proper mode of being with that other.

While normative moral theory has developed into a stable set of debates between consequentialism, deontology and virtue ethics, the third has only been applied to medical ethics by a handful of philosophers, some of them cited by Kristin Zeiler in her contribution. The advantage of virtue ethics approaches is that they can take into account the character of the doctor and its development – for better or for worse – through medical school and subsequent professional life. It is all very well discussing the right or best thing to do in a given situation, but if the doctor can't perceive it, cannot deliberate about it properly, and does not feel the appropriate emotions in response, then she may be unable to choose that action. In her contribution, Zeiler takes this virtue ethics work further by applying it in conjunction with Merleau-Ponty's phenomenology of bodily skill development. For Zeiler claims that there is a bodily dimension to ethical learning as well, and that

the acquisition of virtues-as-skills can have a direct effect on perceptual and emotional engagement.

## **Part II. When high-tech medicine fails: old age, dying and mental illness**

Medical ethics tends to share the prejudice of television medical drama: there is a lot of attention to high technology and to high-stress life-and-death decisions. And yet both ignore the huge number of patients with much less glamorous ailments. First, medical ethics tends to ignore the ordinary slow business of growing old. Part of growing old, of course, is to suffer a stroke or a cardiac arrest, but most of it involves a tediously gradual decline in function, and a slow increase in dependency that is usually managed by occupational therapists and social workers rather than doctors. By far the main problems with old age are not medical but social and spiritual. However, when doctors do intervene, the temptation is to fix the mechanical problem and then send the patient away, rather than seeing the intervention as an integral part of a wider, imperfect attempt by society to meet the needs of the increasing numbers of elderly. With a few notable exceptions, noted by Eric Matthews in his piece, medical ethics also tends to ignore the elderly other than as contingent bearers of interesting conditions.

One essential aspect of old age is dependency. But as Matthews explains, this dependency comprises more than a mere loss of skill and function (mirroring the accumulation of skill and function in childhood and adolescence): for the loss is exacerbated by the responses of others, who will sometimes talk down to the elderly in the same way as they talk down to children. It might seem that the solution to this tendency is to reaffirm the importance of individual autonomy. However, this is often problematic with the elderly because their autonomy seems compromised by their increasing dependence, and, in the case of dementia, by their loss of continuity with their earlier self. Using the work of George Agich and Maurice Merleau-Ponty, Matthews proceeds to re-examine the concept of autonomy in order to suggest a dialogical rather than confrontational model, where such dialogue can accommodate dependency, and open greater possibilities for the young – including young doctors and carers – to understand the old.

If the lack of attention in medical ethics to the ordinary business of ageing is surprising, given the fact that the vast majority of us will grow old, then the lack of attention to the ordinary business of dying is even more surprising. By dying, I mean the terminal phase of life where scientific medicine can do no more except provide pain relief. Once again it is tempting to think that since medicine has given up, so too should medical

ethics: all the difficult ethical decisions have been made. But palliative care and hospice care are nevertheless important parts of life precisely because this is a time when patients can organize and reflect on their lives. This is not just a matter of enjoying the good memories, tidying up one's affairs, and saying one's goodbyes: more importantly, it is a matter of making sense of one's life from a more objective, detached perspective. Finally, a discussion of palliative care is crucially important for medical ethics since it is the main alternative to euthanasia. Too often the euthanasia debate – perhaps the largest and most complicated debate in medical ethics – assumes that it is a matter of permitting or prohibiting in response to the patient's competent request. But too often that request is made in fear of a slow and undignified decline with poor palliative efforts, and those who would prohibit euthanasia might not sufficiently acknowledge their responsibility to make the alternative more palatable.

Rien Janssens and Guy Widdershoven provide an overview of the history of palliative and hospice care in the past half century, together with some of the justifications for it in the face of surprising social and medical resistance. Part of the problem with its acceptance and funding, they argue, have been some conceptual tensions and ambiguities. One such ambiguity is the place of death in discussions with the patient: how openly should the doctor or hospice worker mention it, especially when the patient is afraid? As in Matthews's piece, another ambiguity surrounds the concept of autonomy, and Janssens and Widdershoven outline some principles of 'hermeneutic ethics' (p. 79) to better characterize the nature of the relationship between doctor and patient, and the relationship between moral philosophy and the hospice situation. The most important principle of hermeneutic ethics is that the theoretical impetus has to be tempered by particular knowledge of the situation and by the understandings that the practitioners themselves have of the situation.

The ordinary business of ageing and dying is the most common example of the failure of high-tech medicine. Another is mental health, and the third and fourth chapters are about this. The first thing to realize is that a lot of mental illness is also pretty ordinary: low-grade depression and age-related senility are hardly rare. The second thing is that only a small portion of it is treatable by the standard tools of medicine, and such treatments are often pretty clumsy, merely controlling the symptoms rather than curing. Most mental illness involves suffering that is very different in kind from somatic suffering. As Steve Ramplin and Julian Hughes put it, there is something 'shocking' about mental illness (p. 84), perhaps because at a deeper level it undermines our own confidence in our grip on reality. This

means that mental illness has the ability to ‘change the conversation’ in medical ethics, as they put it. To explore the difference between mental and somatic illness and the impact on medical ethics, they invoke two notions. The first is the Heideggerian notion of ‘being-with-others’ (together with the specific type of caring involved in such being, ‘solicitude’). The second is the theory of ‘values-based medicine’ (VBM), most comprehensively developed by K. W. M. Fulford (2004). One of the reasons that mental illness poses such a challenge to medicine, argue Ramplin and Hughes, is precisely because it seems to undermine the value structures normally shared by patient and doctor.

Cowley considers the famous 1991 Dutch *Chabot* case, in which a somatically healthy 50-year-old woman, Mrs. Bosscher, asked psychiatrist Dr. Chabot to assist her to commit suicide. Dutch legislation permits physician-assisted suicide (PAS) and voluntary euthanasia in the event of ‘unbearable and hopeless suffering’; the vast majority of requests come from competent patients with advanced cancer. Mrs. Bosscher claimed to be unbearably and hopelessly depressed after a bad marriage to an abusive alcoholic and after the deaths of both her sons (the first from suicide); Dr. Chabot believed her, and helped her to die, and his decision was essentially upheld by the Dutch Supreme Court. For the purposes of the article, Cowley accepts the legality of PAS as a response to somatic suffering, and accepts that Mrs. Bosscher’s depression was ‘justified’ (to use George Graham’s (1990) term), but argues that such mental suffering was of such a different kind that it could not justify suicide under Dutch procedures. This is because of the difficulty of demonstrating genuine hopelessness without corroboration from general disease statistics: every depression is unique in a way that every cancer is not, and so there is no way to predict the future course of a particular depression.

### **Part III. Autonomy and autonomous decision-making**

The four chapters in this part pick up on the preceding discussions of autonomy. If there is one part of the ethics of medical practice that has changed enormously in the past half century, it is the attitude of the profession to patient consent. As a corrective to the paternalistic tendencies of those with excess power and knowledge, this is of course to be welcomed. However, there are still outstanding philosophical questions to ask about the nature of the patient’s consent. Again, it is too simplistic to understand patient consent along the lines of the customer’s consent to a service such as dry cleaning, not only because there are very few services that are as

intrusive and dangerous as medicine, not only because the medical 'customer' often has so little idea of what medicine does and of what impact it will have on her, but mainly because there are few services which are the subject of such urgent and genuine need.

D. K. Levy begins this part by using the issue of autonomy to illuminate a facet in the disagreement between two views in ethical theory, consequentialist and deontologist. Roughly, consequentialists assess moral judgements about actions based on those actions' consequences, while deontologists assess those judgements with reference to duty. For example, judgements about medical treatments can be assessed, ranked, regarded as impermissible, etc. using the differing considerations central to these viewpoints. A commonplace of contemporary medical ethics is that considerations of autonomy must also weigh in the assessment of medical treatments. Levy argues that considerations of autonomy *cannot* be considered within the consequentialist viewpoint. Therefore, if autonomy is central to medical ethics, the presumption must be against assessing treatments from a consequentialist perspective. This conclusion is defended notwithstanding Levy's acknowledgement that there is a seemingly natural fit between medical ethics and consequentialism because of how consequentialism conceives all ethical challenges as practical problems. Certainly, consequentialism is well-suited to some practical problems, especially collective problems like allocating scarce resources. However, with individual patients, consequentialism is unable to take account of a patient's autonomous perspective. It must regard a patient as a constituent of a state of affairs, as the locus of contingent future welfare, which welfare is marshalled or conserved with indifference to who does the marshalling or conserving. The consequentialist viewpoint of an individual thereby precludes forms of attention – like pity or respect – that are intrinsically related to perceiving another's autonomy. In some cases, mercy, writes Levy, may even require a doctor to 'act contrary to what is indicated, e.g. by the patient's stated desire or by clinical best practice' (p. 115). Examples like mercy also show that there will be limits to the weight medical ethics should give to autonomy.

In the same way that medical ethics has often accorded only a grudging customer-service respect of patient autonomy, it has also accorded reluctant respect to autonomous wishes and refusals based on the patient's religious convictions. It is too easy for a doctor to say: 'human bodies are human bodies, religion has nothing to do with it'; just as it is too easy for a doctor to summon the hospital chaplain when the discussion becomes too spiritual for her liking. Surely the doctor has herself reflected on the big questions of life and death, even without the specific idiom of a religious doctrine and

cosmology, and in that respect is perfectly qualified to engage with the patient's religious and spiritual concerns. This question should be distinguished from two others; first, from the striking but relatively rare cases such as the competent adult Jehovah's Witnesses legally refusing blood transfusions, knowing that their earthly life will end.<sup>1</sup> Second, it should be distinguished from the contributions to the *Cambridge Textbook* such as 'Hindu approaches to bioethics', which summarize specific *doctrinal* approaches to ethical questions separately, from a secular perspective. Instead, it is always worth bearing in mind how much so-called secular perspectives are often suffused with religious notions. Even the very idea of 'healing' is importantly ambiguous in this sense.

David Albert Jones begins his discussion of these questions by examining the claims of the Secular Medical Forum, who explicitly attempt to reduce the allegedly pernicious influence of religion on the optimal practice of scientific medicine. Such opposition is nothing new, as Jones traces its historical roots back at least 200 years. One reaction to this secular assault has been to argue that religion can do no harm and might actually benefit the suffering patient – but this, writes Jones, would be to misconstrue the place that religious beliefs have in people's lives. Indeed, 'Christianity may require actions that are a burden to mental health and which may have an adverse effect on the believer's subjective experience of well-being' (p. 140).

The third and fourth chapters in this part deal with the question of patient autonomy and consent indirectly, by examining the importance of the patient's particular understanding and appreciation of risks, and especially the risks posed by genetic illness. It is one thing to present a risk in terms of an inductive generalization of similar cases in the past: it is another for the patient to decide that something is too risky for her to undertake. Nafsika Athanassoulis and Allison Ross discuss (p. 149) the example of 60-year-old Thanos, who is diagnosed with stage 2 prostate cancer. Surgery offers the possibility of a cure, but also the risk of incontinence and erectile dysfunction. Although the likely progress of the cancer can be statistically predicted based on past cases, the precise meaning of the cancer in Thanos's life will be unique to him. This does not mean that 'anything goes' or that Thanos cannot be mistaken, since close friends and family can still *advise* him on the best course of action, given who Thanos is and what is important to him. But this notion of the 'best' is very different from some objective medical understanding. This 'personal' aspect of risk is to be contrasted with the 'public' aspect of risk and reasonable behaviour that is presupposed by the legal concepts of negligence and recklessness. On the boundary between the personal and the public is the thorny question of whether, in the context



of a public healthcare system, to somehow hold smokers responsible for their smoking-related health problems.

With genetic conditions, there is a different kind of risk at stake because the patient might not yet have any symptoms. Does patient autonomy include the right ‘not to know’, or would this be irresponsible to oneself and to one’s dependents? Ruth Stirton begins with questions such as these, and the way that they challenge the general assumption that more information is always a good thing. Part of the problem is the essentially familial nature of genetic illness, so that knowledge of my own condition will sometimes reveal something about my sister’s or cousin’s condition, thereby generating a new dilemma. In addition, there is the question of whether such information should be relevant to reproductive decisions. These will again be very personal decisions for the people involved, and Stirton is interested in the way such people make sense of the problems and of what might be ‘for the best’. She goes on to argue that philosophical engagement with the patient’s experience is fundamental to our understanding of genetic illness. She illustrates how phenomenology has been, and could be used to further explore the meaning of genetic illness to the individual patient. This becomes increasingly important as these inherently personal cases are to be contrasted with such public questions of whether health insurance companies (especially in the American context) and employers have a right to use predictive genetic information.

#### **Part IV. The law, the profession and ethics**

The first three parts have focused more on the patient, and this last part focuses more on the doctor (and to a certain extent on other healthcare professionals). But instead of asking what the legal, professional and ethical duties of the doctor should be, it asks what doctors *make*, and ought to make, of the duties placed upon them, and how they fulfil such duties in practice. There is also the question of the relationship between the three kinds of duties.

Richard Huxtable looks at the confusions in English law revealed by the case of Charlotte Wyatt, born in 2003 with severe organ problems. On several occasions she was given a very bleak prognosis, and the medical team wanted to implement a Do-Not-Attempt-Resuscitation (DNAR) order. But each time her parents would not agree, so the matter was repeatedly submitted to the courts. While the law is fairly clear in describing the relevant ethical factors, it is less clear in determining the precise content and relative weight of those factors. In Charlotte’s case, it was not clear what her ‘best interests’ were,

whether her situation was sufficiently ‘intolerable’, when the presumption in favour of life has been ‘rebutted’, or how much weight her parents’ wishes should have. The courts vainly hoped that the medical team could resolve the matter by ‘discussion’ with the parents, without it being clear enough how such a discussion (or rather persuasion) would transpire. Through this all, Charlotte continued to live, and as of 2009 had been out of hospital for two years. Huxtable uses this case and others to ask what can be reasonably expected from the law, both by the public and by doctors; he detects inherent ethical and thus legal indeterminacy and so his cautious suggestion is to make more use of clinical ethics committees.

Cliona McGovern examines the Codes of Ethics that all professions have voluntarily adopted (in particular she looks at medicine and physiotherapy). Such codes have a curious status. They are not law, nor are they part of the legal system; indeed McGovern gives us examples where the courts explicitly returned an issue to the profession for adjudication. Codes of Ethics are not normally considered to be among the body of rules and standards that serve to define the profession, although they approach the implicit standards of professionalism. But because of this ambiguity, there are many professionals who regard them as mere window-dressing. But this status is changing in interesting ways, writes McGovern. In a recent Irish case, two doctors were deemed professionally incompetent for failing to meet expected standards (the so-called ‘Bolam test’), but the case examined whether this should have happened at all. The judge found that if the Medical Council had wanted to sanction the doctors, then they should have used the ‘moral turpitude’ test. At the same time, McGovern describes one area of medical training where the Code of Ethics is flouted with dangerous impunity. Despite the code’s explicit requirement to seek the patient’s full informed consent, there is enough evidence of anaesthetized patients being used by medical students – at their consultant’s behest and pressure – to practice intimate examinations.

Mark Wicclair considers the position of doctors and pharmacists who refuse, for reasons of conscience, to authorize or perform or provide a lawful service, for example, for abortion or emergency contraception. At first glance, such refusals are curious: unlike military conscripts, these professionals all volunteered for training and for work, and they knew well that these services were lawful. And even within the medical profession, there are plenty of jobs (dermatology, pathology) that do not come close to abortion. Doctors and pharmacists are expected to perform other unpleasant tasks and to overcome other kinds of objection, for example those based on nausea or racism. So why the special exemptions granted to conscientious objectors? Why the absence of something like the ‘alternative service’ that is required from

objecting military conscripts? And what happens when there are not enough willing colleagues to cover the demand in sparsely-populated areas? While respecting claims of conscience, Wicclair examines some of the available responses to these questions and elaborates specific limits to refusals.

As a profession, medicine involves clear standards of skills and knowledge that have to be achieved in order to pass through the various stages of the career. Throughout, it is very clear what it means to say that a doctor possesses a certain expertise that a layperson does not. In addition to that expertise, the doctor gradually acquires experience, and some of them acquire good clinical judgement; they can regularly draw correct conclusions more quickly and from less evidence than a junior doctor would require. When we turn to the subject of ethics, the nature of good ethical judgement is much more obscure. For a start, not just doctors but all people are expected to acquire basic ethical 'skills' and 'knowledge' (if indeed that is what they are) long before they enter medical school. At the same time, there is no formal training course with exams that students could fail and resit. While a lot of good clinical judgement can be corroborated by scientific tests (at the extreme, by a post mortem), it is not clear what 'corroboration' of a good ethical judgement would amount to. Most controversial of all is whether medical students can be taught a basic degree of good ethical judgement via seminars in medical ethics. Julian Hughes and Steve Ramplin compare clinical and ethical judgement, and their acquisition at medical school, but they also argue against the strict dichotomy: in many cases, clinical judgements *are* a type of ethical judgements. It is not that one should make a clinical decision and then contemplate the ethical aspect of it and its consequences.

## Conclusion

It is hoped that the enclosed contributions will stimulate the mainstream reader into new and unfamiliar directions in medical ethics. At the very least, each contributor has sought to define his or her position in relation to others writing on similar themes, more or less abstractly, so there should be plenty of further reading for those with piqued interest. I would like to thank all the contributors, not only for their pieces but also for the further elaborations and clarifications I requested from them. I have myself learned a lot in the process.

Christopher Cowley  
Dublin, June 2011 Ricœur

## Part One

# The Suffering Patient, the Suffering Body

