

The Therapeutic Contradiction

Suffering, Medicine, Providence, and the Practical Rejection of Redemptive Pain

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Central claim

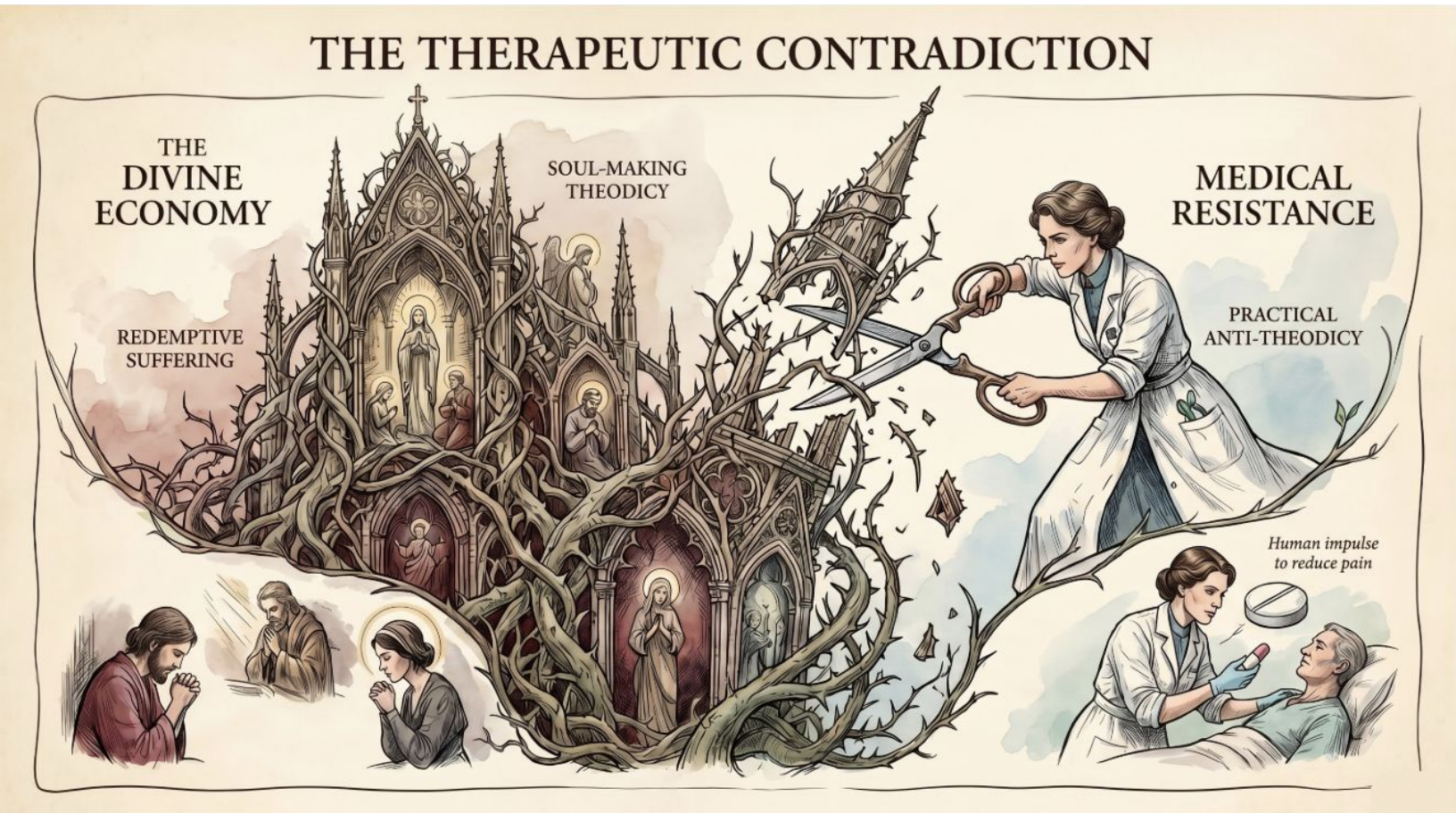
Christian medicine does not logically contradict theism, but it places a serious internal burden on any theodicy that justifies preventable suffering by goods that require the suffering. When believers rightly relieve the same condition without first protecting its alleged spiritual role, their practice supports the simpler judgment that the suffering is an evil to be opposed. A coherent theology may answer with a principled difference between divine and human duties or with redemption after suffering; medicine alone does not disprove a deity or every theodicy.

Preview: Relief tests what the explanation really claims

Theodical claim	Therapeutic norm	Missing bridge	Warranted result
Some suffering is justified because a divine good requires its occurrence or continuation.	Competent agents should normally prevent or relieve that suffering when expected benefit exceeds harm.	Why may a perfect deity preserve for a good what humans are right to remove, especially if a less harmful route was available?	Without a principled role difference, medical practice undercuts the justification; it does not by itself refute theism.

The target is the joint position, not every Christian account of suffering. The pressure is strongest when a positive theodicy says that a kind of preventable pain is needed for a greater good and the same community treats its removal as an ordinary moral duty.

Visual preview:



The left side depicts a divine economy in which suffering is assigned redemptive or soul-making work; the right side depicts medicine's practical commitment to relief. The scissors cut the claimed dependence between suffering and its alleged good, not religion itself: a treatment that removes pain without a comparable moral loss pressures the claim that this pain had to remain. The image identifies an explanatory burden, not a proof that no specified God-concept can exist or that every instance of suffering should be medically eliminated.

Abstract

Christian theodicies often place suffering within a morally sufficient divine purpose, while Christian medical practice treats preventable suffering as a condition to diagnose, reduce, or remove. These commitments are not formally contradictory merely because a deity and a human agent can have different permissions and duties. The practical tension becomes evidentially important, however, when the same kind of suffering is said to be justified by a good that requires its occurrence or continuation, yet believers correctly relieve it without first preserving that alleged good-producing role.

This paper distinguishes four claims commonly blurred in discussion: a defense that shows logical compatibility, a theodicy that proposes an actual justifying reason, redemption that brings good from an evil already present, and a therapeutic duty to oppose avoidable harm. It then develops an overlap argument. If a theodicy says that suffering is needed for a morally sufficient good, and proportionate medical relief frustrates that route, the joint endorsement of both claims requires a principled explanation of why divine permission and human intervention differ. Without that bridge, therapeutic practice undercuts the positive theodicy and favors the more modest judgment that suffering is an evil from which goods may sometimes be rescued.

Soul-making, punishment, providence, and skeptical theism each face a distinct version of this test. The strongest replies appeal to stable natural order, creaturely vocation, divine command, or limits on human knowledge. These replies can preserve consistency, but only by specifying the role difference, limiting what the theodicy claims to explain, and refusing to count every cure and every failure as equal confirmation of providence.

The conclusion is firm but bounded. Medicine is practical moral evidence against broad necessity-based rationalizations of suffering; it is not a deductive disproof of theism, a claim that every intervention is obligatory, or a rejection of every redemptive interpretation. The constructive alternative is therapeutic humility: relieve proportionately, distinguish redemption from justification, and do not infer a divine rationale for pain more confidently than one's own practice permits.

Keywords: problem of evil; theodicy; suffering; medicine; providence; soul-making; skeptical theism; palliative care

1 The Challenge in Its Strongest Form

The familiar contrast is vivid. A theology may describe illness, injury, grief, or vulnerability as a setting for discipline, moral formation, providence, dependence, or redemption. A clinic treats infection, hemorrhage, severe pain, and preventable disability as conditions calling for competent intervention. The temptation is to call these attitudes a contradiction. That label captures the pressure but not yet the logic.

There is no contradiction in saying that one agent may permit what another agent should prevent. A judge may permissibly authorize a sentence that a prisoner's friend has no standing to cancel. A parent may allow a child to struggle with a difficult task while a stranger should not manufacture the same difficulty. Roles, knowledge, authority, promises, and relationships can change duties. A Christian can therefore say that the deity specified by a traditional God-concept has reasons to permit suffering while human beings have a separate command to heal.

The relevant *God-concept* here means a specified conception of a deity: an omniscient, omnipotent, and perfectly good creator who governs or permits events while commanding human love of neighbor. The paper does not assume that every theistic tradition accepts that package. It tests a joint Christian position whose components are often affirmed together:

1. at least some severe, preventable suffering is morally justified by a good that depends on its occurrence or continuation;

2. ordinary human agents are normally right, and often required, to prevent or relieve that same kind of suffering when they can do so proportionately; and
3. both judgments express, rather than merely coexist within, the same account of perfect goodness.

The first claim is stronger than saying that good can emerge from suffering. It is a claim about permission: the good supplies a morally sufficient reason for allowing the harm. The second is not the reckless instruction to eliminate every unpleasant state. Medicine itself weighs benefits, burdens, consent, scarce resources, side effects, and the natural course of disease. The targeted norm is narrower: when a competent intervention is expected to prevent or relieve serious suffering without comparable harm or a stronger duty against it, relief is ordinarily favored.

That norm is not an invented philosophical abstraction. The World Health Organization describes palliative care as both prevention and relief of suffering and treats its integration into health systems as an ethical responsibility (World Health Organization 2018). The American Medical Association likewise states that physicians have ethical responsibilities to address pain and suffering throughout serious illness, including alongside disease-modifying treatment (American Medical Association 2025). These sources do not settle theology. They make explicit the practical moral judgment medicine already embodies.

The precise pressure

When suffering is justified by a good that requires it, successful relief appears to frustrate the stated route to that good. If relief is nevertheless the right response, the theology owes an account of why the justificatory reason applies to divine permission but not to human preservation. Without that account, the practice and the explanation pull in opposite directions.

2 Four Claims That Must Not Be Blurred

Arguments about suffering become confused when possibility, explanation, response, and duty are treated as interchangeable. Table 1 separates them.

Table 1: Four claims with different burdens.

Claim	What it says	What would support it	What does not follow
Defense	Theism and suffering could both be true because a possible morally sufficient reason is available.	A coherent scenario that removes a proposed logical inconsistency.	That the scenario is actual, probable, or the best explanation of this suffering.
Theodicy	A stated good is an actual or likely morally sufficient reason for divine permission of suffering.	A credible account of the good, its dependence on the harm, proportionality, distribution, and lack of a less harmful route.	That every instance of the same kind is justified or that contrary evidence is irrelevant.
Redemption	A good response transforms, defeats, or brings value from suffering that has occurred.	Evidence about the sufferer's good, agency, relationship, recovery, or later meaning.	That the suffering was needed, should have been caused, or should have been allowed.
Therapeutic duty	A human agent should prevent or relieve suffering when action is competent, proportionate, and not defeated by a stronger duty.	Clinical facts, expected benefits and harms, consent, justice, role, and resources.	That every discomfort must be removed or that no good can emerge from endurance.

Plantinga's free-will defense is a classic example of the first category: its central task is to answer a proposed logical incompatibility by showing how significant freedom and evil might coexist with a perfect creator (Plantinga 1974). Rowe and Draper represent evidential challenges that remain after logical possibility is granted. They ask whether the amount, kinds, and distribution of suffering make traditional theism less reasonable or less explanatorily successful than alternatives (Rowe 1979; Draper 1989). A defense can therefore succeed at its limited task while leaving the evidential question open.

A theodicy takes on more. Hick develops a soul-making account in which an environment containing danger and difficulty helps form morally mature persons (Hick 2010). Swinburne argues that natural evil supplies knowledge, meaningful choice, and opportunities for consequential responsibility, and he addresses the divine right to allow suffering within that economy (Swinburne 1998). Stump's Thomistic account uses narratives and second-personal goods to explain how suffering might be connected to a person's flourishing and union with the divine (Stump 2010). These accounts differ substantially, but each illustrates the extra explanatory work required when one moves beyond mere compatibility.

Redemption is different again. A person may acquire courage after an assault, solidarity after bereavement, or compassion after illness. Those goods can be real without making the assault, death, or disease necessary or permissible. If a lifeguard rescues a child from a negligently unguarded pool, the rescue is good; it does not retroactively justify the negligence. The distinction is crucial because religious speech often moves silently from "good came from this" to "this was allowed for that good".

Medicine belongs primarily to the fourth category. It responds to the person now at risk. Its practical success can also bear on the second category: if an alleged justificatory good remains available after the suffering is safely removed, then that good did not depend on the suffering in the claimed way. If no identifiable loss follows relief, the necessity claim has lost support.

3 The Therapeutic Overlap Argument

The strongest version of the argument concerns *overlap cases*: instances of suffering covered both by a positive theodical rationale and by an ordinary duty of relief. Consider severe postoperative pain. Suppose a defender says that such pain is justified because it produces patience or dependence. A clinician can safely provide analgesia without compromising healing, consent, or another serious good. Christian patient, family, and clinician agree that relief should be given. The question is not whether patience can grow during pain. The question is whether that possible growth justifies preserving the pain when it can be removed without a comparable loss.

The argument can be stated in ordinary language:

1. If suffering is justified by a good that requires its occurrence or continuation, then preventing or relieving the suffering blocks that stated route to the good.
2. In many ordinary clinical cases, proportionate prevention or relief is morally required.
3. Some theodicies apply their justifying rationale to kinds of suffering that include those clinical cases.
4. Therefore, anyone who endorses both the theodicy and the duty of relief owes a principled account of why divine permission and human intervention are morally different in the overlap cases.
5. Where no such account is supplied, medical practice undercuts the positive theodicy for those cases.

The conclusion is not that a formal contradiction has already been derived. Premise 4 identifies a missing bridge. A role difference could supply it. Nor does the conclusion infer that suffering has no possible value. It says that the defender may not use value produced through suffering as a justification

for permission while treating the suffering's removal as an uncomplicated good, unless the difference in agency is made morally relevant.

This pressure is especially strong when the proposed good can be secured after relief. Compassion does not require that a patient remain in agony; it requires recognition and fitting response. Courage can be exercised in treatment, rehabilitation, disclosure, caregiving, and advocacy. Dependence can be learned through receiving help without leaving symptoms uncontrolled. When the good survives the intervention, the necessity premise weakens. The clinician has not thwarted the good; the intervention has shown that the good was not tied to continued suffering.

Adams's focus on horrendous evils sharpens the proportionality issue. Some harms threaten to make a participant's life appear not worth living, so a successful account must address the good of the sufferer rather than merely add benefits elsewhere in the world (Adams 1999). Medicine makes the same person-centered demand in practical form: whose good is served, what burden is imposed, and was a less harmful route available?

4 Medicine as Practical Moral Evidence

Medical action does not begin from a complete theory of cosmic value. It begins from a person with a wound, infection, tumor, breathlessness, trauma, or pain. The clinician asks what can be known, which options are available, what the patient values, and what benefits and burdens each option carries. Relief is not automatic, but suffering supplies a reason for action rather than a presumption in favor of preservation.

This posture is philosophically important in three ways.

4.1 It reveals a stable first-order judgment

People may offer many accounts of why suffering exists, but competent care repeatedly returns to a practical judgment: serious avoidable suffering counts against leaving the situation unchanged. The judgment is defeasible. A painful procedure may prevent greater harm; a burdensome treatment may be refused; aggressive intervention may prolong dying without helping the patient. None of these qualifications turns suffering into a general theological asset. They show that medicine compares harms and goods rather than treating relief as absolute.

4.2 It tests claims of necessity

A necessity-based theodicy says more than "this pain might be used well". It connects the permission of pain to a good that could not be secured, or could not feasibly be secured, by a less harmful route. Successful relief can function as a local test. If pain is removed and the relevant agency, relationship, moral learning, or compassion remains available, then the intervention is evidence against the alleged dependence.

This evidence is local, not total. An anesthetic does not show that no hardship is ever needed for courage. It shows that this painful input was not obviously necessary for the goods named in its defense. The cumulative force comes from repeated cases in which prevention and relief are treated as gains without a corresponding moral deficit.

4.3 It exposes outcome capture

An explanation becomes weak when every outcome confirms it. If a treatment succeeds, success is called providential relief. If it fails, the suffering is called providential formation. If no reason is visible, mystery protects the account. Each description may be logically possible, but their unrestricted combination makes the world look the same whatever the hypothesis predicts.

Draper's comparative approach is useful here. Evidence supports a hypothesis when it is more expected under that hypothesis than under a serious alternative, not merely when the hypothesis can absorb it (Draper 1989). The natural history of medical progress is readily expected if embodied harms yield to observation, experiment, organized care, and technology. A providential account may remain compatible with that history, but compatibility alone does not show what explanatory work providence adds.

5 Soul-Making and the Anesthesia Test

Soul-making is among the strongest targets because it connects adversity to recognizable human goods. Courage requires danger or fear; patience requires difficulty; compassion responds to need; practical wisdom develops through consequential choices. Hick's account does not simply praise pain. It presents an environment suited to moral and spiritual development (Hick 2010). Swinburne likewise emphasizes opportunities for knowledge and responsible response (Swinburne 1998).

The medical challenge should therefore not be the crude question, "If suffering builds character, why use any anesthetic?" Some goods require effort, risk, or exposure to loss. A surgeon who removes pain may still preserve the challenge of recovery, the patient's agency, the caregiver's compassion, and the community's opportunity to help. The sharper anesthesia test asks:

1. Which exact good is alleged to justify this suffering?
2. Does the good require this kind, intensity, duration, and distribution of suffering?
3. Would proportionate relief actually prevent the good?
4. If not, what justificatory work was the suffering doing?

The test separates three claims. First, some people grow through adversity. This is credible. Second, a world with no challenge might omit important goods. This is defensible. Third, the actual preventable suffering in an overlap case is justified because it is needed for those goods. This is the demanding conclusion. The first two do not automatically establish the third.

Medicine also reveals substitution. If patience can develop through rehabilitation with pain controlled, if compassion can be expressed by relieving distress, and if responsibility can be exercised in prevention, then the goods are not lost; their route changes. The burden shifts to the defender to explain why a perfectly capable deity required the more harmful route when human agents rightly choose the less harmful one.

Stump's narrative approach rightly resists reducing a sufferer's life to an abstract unit in a global calculation (Stump 2010). Yet that strength increases the need for case sensitivity. A narrative in which suffering is ultimately defeated for the person is not a general license to assign that purpose to someone else's pain. The closer the account comes to the sufferer's particular good, agency, and relationships, the less plausible it is to infer justification from a generic possibility of growth.

6 Punishment, Consequence, and Providence

The punishment family requires careful distinctions. A theology may say that mortality and disorder belong to a fallen creation without claiming that each illness is an individually deserved penalty. It may also distinguish natural consequence from an imposed sentence. The therapeutic challenge applies differently to each form.

If a particular disease is treated as deserved punishment, healing appears to interrupt the penalty. A defender can answer that mercy is itself part of the divine purpose or that humans lack authority to administer the cosmic order. But then punishment no longer explains why this illness should continue,

and medicine's resistance is not resistance to justice. The account has moved toward permission followed by mercy, which still requires an explanation of the initial harm.

If illness is described as a consequence of stable natural order, intervention is easier to reconcile. Human beings may learn to manage lawful processes without opposing their creator. This response supplies part of the needed role asymmetry: the deity establishes or permits an order, while creatures exercise agency within it. Yet it does not by itself justify the order's particular costs. A stable system may be necessary for action and knowledge, but many stable systems are conceivable. The question remains why an omnipotent and perfectly good creator would select or permit one containing these intensities and distributions of suffering.

Providence offers the broadest reconciliation. Medicine can be described as one secondary cause through which divine care operates. On this view, the physician does not cut against providence; the physician participates in it. That claim is coherent. It also faces an evidential discipline: if successful treatment counts in favor of providence, what would count against the claim that the medical history is providentially ordered? A framework that invokes purpose in cure, purpose in failure, and unknowable purpose in ambiguity risks becoming outcome-insensitive.

Murray argues that a successful explanation of evil must do more than assert compatibility; it must remain credible in light of what we otherwise have reason to accept (Murray 2008). Therapeutic practice belongs in that evidential background. A providential explanation gains content when it identifies a difference we should expect, a limit it accepts, or a reason the agent asymmetry applies. Merely placing the word "providence" over the observed record does not yet explain the record.

7 Skeptical Theism and Practical Confidence

Skeptical theism cautions against assuming that, because humans see no justifying reason for a suffering, none exists. The central thought is epistemic humility: finite agents should not expect their grasp of value, possibility, and long-range consequence to match that of an omniscient deity (Bergmann 2009). This position can block an inference from "no reason is visible" to "there is no reason".

The medical case presses on the scope of that humility. A clinician who can stop severe, unnecessary pain must decide whether to act. If unknown goods are serious enough to defeat moral criticism of divine nonintervention, why do they not also defeat confidence in human intervention? Sehon develops this kind of moral-paralysis objection: sufficiently broad skepticism about hidden goods threatens ordinary moral judgment (Sehon 2010).

There are several replies. The skeptical theist can distinguish evaluating the deity's total reasons from acting on the limited reasons available to a human agent. One can be uncertain about cosmic outcomes while still following a known duty of care. A Christian can add that commands to love, heal, and protect give creatures action-guidance even when providential purposes remain unknown. This reply is important because it shows again why no simple contradiction follows.

Yet the reply carries a cost for positive theodicy. If humans are not positioned to identify the divine reason, they should not confidently name soul-making, punishment, or another specific purpose as the explanation of a case. Skeptical theism is strongest as a defeater of one inference; it is weaker as a license for detailed providential storytelling. The move from "there may be a reason beyond our view" to "this suffering forms souls" exceeds the modest epistemic claim.

The divine-command reply also must leave room for moral understanding. Lee argues that an appeal to commands alone can threaten the value-responsive love the religious life is meant to preserve (Lee 2025). In medicine, care is not simply behavioral compliance. It involves recognizing another person's distress as a reason, judging proportionately, listening to that person's values, and responding competently.

A theology that saves intervention only by declaring ordinary moral perception untrustworthy has protected action at the expense of its intelligibility.

The skeptical-theism fork

Either our moral perception of preventable suffering is reliable enough to guide care, in which case it remains relevant evidence when evaluating theodical claims; or it is too unreliable to criticize divine permission, in which case the basis for confident human relief needs an independent account. A command can guide action, but it does not automatically vindicate a positive explanation of the suffering.

8 The Strongest Reply: Different Agents, Different Duties

The best response to the therapeutic challenge is a principled role asymmetry. The defender may argue that divine and human responsibilities differ for reasons that are not available to ordinary agents:

- a creator may sustain stable natural processes while creatures repair harms within them;
- significant freedom may require limits on coercive prevention while human agents remain obligated to resist one another's wrongdoing;
- a deity may know all consequences and compensate sufferers in ways humans cannot;
- creatures may have an assigned vocation of care that does not mirror every divine permission; and
- direct divine prevention may alter the conditions for agency or relationship in ways a local medical intervention does not.

These possibilities matter. They show why the moral rule "if humans should prevent it, a deity must prevent it in exactly the same way" is too quick. They also resemble serious theistic accounts that appeal to freedom, knowledge, responsibility, compensation, or relationship (Plantinga 1974; Swinburne 1998; Stump 2010).

A useful asymmetry must nevertheless satisfy four constraints.

8.1 Relevance

The role difference must connect to the case at hand. General statements that a deity is mysterious or that creators have different rights do not show why this suffering, at this intensity, is appropriately left for human repair.

8.2 Proportionality

The good must be weighty enough for the burden imposed on the sufferer, and the account must address that person's good rather than merely benefits to observers. This is especially urgent for horrendous suffering (Adams 1999).

8.3 No less harmful route

If the same good could be achieved through a less harmful arrangement, the stated reason does not yet justify the more harmful one. Omnipotence does not mean doing the logically impossible, but it expands the comparison class beyond the options available in a clinic.

8.4 Predictive discipline

The account should not count relief, non-relief, preventable failure, and hiddenness as equivalent confirmation. If no possible pattern would weaken it, it may preserve compatibility while surrendering explanatory force.

Meeting these constraints would not make every premise certain. It would turn the reply into an argument rather than a label. The therapeutic challenge is therefore constructive: state the role asymmetry plainly, show why it matters, and accept the limits it places on positive claims about particular suffering.

9 Redemption Without Justification

The most promising reconciliation may be to stop asking suffering to do justificatory work it cannot bear. A redemptive account can say:

1. suffering is a genuine evil and supplies a reason for proportionate resistance;
2. persons and communities can still respond with courage, solidarity, wisdom, protest, care, or transformed relationship;
3. those goods may defeat part of suffering's damage for a person without making the suffering necessary; and
4. the possibility of redemption does not excuse preventable permission in advance.

This view preserves much of what religious practice values. It makes room for testimony that illness changed a life, that support deepened a relationship, or that hope survived loss. It also aligns those meanings with treatment. The clinician need not preserve pain to protect meaning; relief can itself become an expression of solidarity and love.

The distinction also protects sufferers from retrospective appropriation. Telling someone that an anguish was necessary for a spiritual good claims more than observing that the person later found meaning. The first assigns a reason to the permission of harm. The second recognizes the person's response. Respect for agency favors allowing sufferers to describe what, if anything, was redeemed rather than converting their pain into evidence for a general theory.

This is not the only possible Christian position. Adams and Stump offer richer accounts in which the good of the sufferer and relationship with the divine can ultimately defeat suffering (Adams 1999; Stump 2010). The therapeutic test does not refute those projects. It asks them to keep three claims separate: the suffering was permitted, the suffering was justified, and the suffering was redeemed. A theology may defend one without establishing the others.

10 A Therapeutic Consistency Test

Before using a suffering as evidence of providential purpose, a defender can apply the five questions in Table 2. The test is deliberately usable outside specialist philosophy.

Table 2: Five questions for testing a theodical explanation.

Question	What it tests	A strong answer supplies	A weak answer reveals
Would you preserve it?	Whether the claimed good really depends on the suffering.	A reason the good needs this burden or a clear admission that it does not.	Praise of suffering that disappears when action becomes possible.
Why do the agents differ?	The bridge between divine permission and human relief.	A morally relevant difference in role, knowledge, authority, relation, or consequence.	A double standard stated only as mystery or status.
Was a gentler route available?	Necessity and proportionality.	A comparison showing why less harmful routes would lose the relevant good.	Mere compatibility between suffering and some later benefit.
Is this justification or redemption?	Direction of explanation.	Clarity about whether a good licenses permission or repairs harm afterward.	A later good used to excuse an earlier avoidable evil.
What outcome would count against it?	Explanatory discrimination.	A pattern that would weaken the providential claim and evidence favoring it over alternatives.	An account that absorbs cure, failure, and silence equally.

The questions do not demand access to every divine reason. They demand proportion between what is known and what is claimed. A defense can answer modestly: “I do not know, but a reason is possible”. A theodicy must answer more: “this is the kind of reason that actually or probably justifies the permission”. The test prevents the modest defense from being presented with the confidence of a positive explanation.

The test also disciplines critics. A critic should not infer that medicine proves atheism, that all adversity is pointless, or that any use of suffering language is abusive. The relevant conclusion is narrower: when therapeutic action and theodical explanation overlap, the practice supplies evidence about which account of suffering the community itself treats as morally action-guiding.

11 Objections and Replies

11.1 Medicine is itself providence

This claim can reconcile action and belief: treatment is one means through which divine care occurs. The reply succeeds as a compatibility claim. It becomes explanatory only when it does more than relabel successful human action. It should clarify why access is uneven, how preventable failures fit the account, and what pattern would be less expected on providential governance. Otherwise it preserves theism without answering the therapeutic challenge to a positive theodicy.

11.2 Humans may relieve suffering even when a deity has reasons to permit it

Correct. This is the role-asymmetry reply, and it defeats any simple allegation of formal contradiction. The remaining question is whether the difference is principled and case-relevant. If the alleged good requires the suffering, why does human relief not frustrate it? If the good does not require the suffering, why did it justify permission? A coherent answer is possible, but it must supply the missing bridge.

11.3 Unknown consequences make intervention and nonintervention incomparable

Every medical decision contains uncertainty, yet rational action remains possible because evidence, competence, expected benefit, patient values, and foreseeable harm guide proportionate judgment. Unknown distant consequences do not normally cancel a clear duty to stop hemorrhage or relieve uncontrolled pain. If skeptical uncertainty is broadened until it does cancel those duties, the view

inherits the moral-paralysis problem. If it is limited so care remains rational, the same first-order judgments remain relevant when evaluating theology.

11.4 The argument assumes that pain has no value

It does not. Pain can warn of injury; burdensome treatment can be justified; chosen sacrifice can express agency; unavoidable adversity can become an occasion for growth. The argument targets the move from possible value to morally sufficient permission. It asks about necessity, proportionality, the sufferer's good, less harmful routes, and the action-guiding implications of the claim.

11.5 The argument judges divine action by human standards

Any problem of evil involving perfect goodness already uses some continuity between divine and human moral concepts. If "goodness" has no recognizable connection to preventing gratuitous harm, loving persons, or responding to suffering, then calling the deity good ceases to answer the moral problem. A defender may argue for differences in right and role without making goodness wholly equivocal. The therapeutic test asks for exactly that middle path.

12 Conclusion

The therapeutic contradiction is best understood as an internal evidential pressure, not a bare logical inconsistency. Christian medicine and palliative care normally treat serious preventable suffering as a reason for proportionate action. A positive theodicy may instead treat the same suffering as justified by goods that require it. Those commitments can coexist only when a principled bridge explains why divine permission and human relief differ.

The strongest cumulative reason for concern is not one anesthetic or one hospital. It is the repeated pattern: relief is celebrated without an identified loss of soul-making opportunity; compassion is expressed by removing rather than preserving pain; successful intervention shows that many goods remain available by gentler routes; and appeals to mystery are often reserved for explaining nonintervention rather than guiding action. Together these facts favor the modest judgment that suffering is an evil to oppose, even when good can later be made from it.

A coherent theology still has live options. It may specify a morally relevant agency difference, defend the necessity and proportionality of a particular suffering, limit itself to a logical defense, or shift from justification to redemption. What it should not do is move without notice among those positions, count every medical outcome as providential confirmation, or assign a purpose to another person's pain more confidently than its own practice warrants.

The requested intellectual change is therefore simple. Relieve suffering competently and proportionately. Distinguish good rescued from suffering from good that justified permitting it. When offering a theodicy, ask whether you would preserve the suffering for the same reason, why a perfect deity's duty differs, whether a gentler route was available, and what evidence could count against the explanation. Medicine does not settle the existence of a deity. It does expose which explanations of suffering survive contact with care.

A Formal Reconstruction of the Central Thesis

A.1 Plain-language reconstruction

- P1.** If a theodicy says that a case of suffering is justified by a good requiring the suffering, while proportionate human relief of that case is morally required, then the joint position needs a principled explanation of why divine and human duties differ.

- P2.** Where no such role-asymmetry explanation is supplied, the joint position has an unresolved justificatory gap.
- P3.** At least some necessity-based theodicies cover kinds of severe, preventable suffering that Christian medical practice treats as subject to a normal duty of proportionate relief.
- P4.** In at least some of those overlap cases, no principled role-asymmetry explanation has been supplied; general appeals to mystery, status, or providence do not by themselves explain the difference.
- P5.** Therefore, in at least some overlap cases, therapeutic practice undercuts the positive theodicy.
- P6.** This undercutting does not entail that traditional theism is false; a successful role-asymmetry account, a limited defense, or a redemptive rather than justificatory interpretation remains possible.

A.2 Symbols

s : A relevant case of severe, preventable suffering.

$T(s)$: A targeted theodicy says that s is morally justified by a good that requires the occurrence or continuation of s .

$R(s)$: Proportionate human prevention or relief of s is morally required.

$A(s)$: A principled, case-relevant role asymmetry explains why divine permission of s and human relief of s are morally compatible.

$U(s)$: Therapeutic practice undercuts the targeted theodicy in case s by exposing an unresolved justificatory gap.

Th : The traditional form of theism under examination is true.

A.3 Symbolic inference

The conceptual bridge is:

$$\forall s[(T(s) \wedge R(s) \wedge \neg A(s)) \rightarrow U(s)].$$

In plain language: for every relevant case, if the theodicy justifies the suffering, relief is morally required, and no principled role difference explains the two claims, then the practice undercuts that theodicy in that case.

The overlap premise is:

$$\exists s[T(s) \wedge R(s) \wedge \neg A(s)].$$

That is the substantive premise. It says that at least one real kind of case is covered by both the necessity claim and the therapeutic norm without an adequate asymmetry bridge.

From these two premises it follows:

$$\therefore \exists s U(s).$$

The inference is deductively valid: the universal conditional applies to the case asserted by the existential premise. The conclusion remains local. It says that at least one targeted theodical explanation is undercut.

It does *not* follow that:

$$\exists s U(s) \Rightarrow \neg \text{Th}.$$

Undercutting one positive explanation is not a deductive disproof of theism. The traditional God-concept could be defended by another account, by a successful $A(s)$, or by declining to claim knowledge of an actual justifying reason.

A.4 Validity and support

The displayed inference to $\exists s U(s)$ is valid if its premises are true. The first premise is conceptual: it states what follows when a necessity-based justification, a duty of relief, and the absence of a role bridge are jointly affirmed. The second premise is interpretive and partly empirical. It requires showing that an actual theodicy covers the relevant kind of suffering, that proportionate relief is genuinely required, and that the offered asymmetry is absent or inadequate. Clinical ethics supports $R(s)$ for many cases; theodical texts supply candidates for $T(s)$; philosophical analysis evaluates $A(s)$.

The conclusion is therefore not stronger than the body. It identifies an evidential and explanatory failure where the overlap conditions hold. It leaves open the truth of Th , the possibility that another case has a successful $A(s)$, and the distinction between saying that suffering is justified and saying that suffering can be redeemed.

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