Cambridge Quarterly of Healthcare Ethics (2025), 1–12
doi:10.1017/S096318012400080X

CAMBRIDGE UNIVERSITY PRESS

RESEARCH ARTICLE

How Much Does Suffering Matter?

Brent M. Kious

Department of Psychiatry, Huntsman Mental Health Institute, University of Utah, Salt Lake City, Utah, USA
Email: brent.kious@hsc.utah.edu

Abstract

Ethicists frequently suppose that suffering has special moral significance. It is often claimed that a main goal of medicine—perhaps its primary goal—is the alleviation of human suffering. Following Eric Cassell and others, this essay considers suffering understood as the experience of distress—negative emotions—in response to threats to something that one cares about. It examines whether, on this value-based account of suffering, we should accept the claim that suffering has special moral significance. It argues that we should not: suffering does not add significantly to the value of other human interests and rarely changes our moral obligations itself; it merely seems to have strong moral relevance because it often attends to interests that matter. This is because negative emotions themselves have only limited moral significance, which is due to the fact that their primary mental role is to indicate to us the relative importance of non-emotional goods.

Keywords: caring; Cassell; distress; emotions; suffering

Introduction

It is common to suppose that suffering has special moral significance. Appeals to suffering are often used to motivate us to donate to charities, take political action, change the kinds of things we eat, avoid war, etc. One might think of suffering as a general-purpose moral thing-to-fix. Michael Brady has said that we generally assume that "suffering is intrinsically and prima facie bad.…[T]he fact that one is suffering gives someone (and perhaps others) a prima facie normative reason to do what she (and they) can to alleviate her suffering."[1] Others, such as Roberto Andorno and Cristiana Baffone, have even argued that the prevention of suffering is the fundamental justification for the existence of human rights. They write that there is a *prima facie* duty to prevent suffering:

> Assuming that the first moral principle, from which all others are derived, is that good is to be done and evil avoided, and admitting that suffering is an intrinsic evil, it is reasonable to conclude that there is a moral duty to prevent human suffering.[2]

The moral significance of suffering is particularly evident in medicine: it is sometimes said that physicians' primary obligation is to alleviate suffering, where treating illness matters because illnesses produce suffering. Eric Cassell writes: "The relief of suffering…is considered one of the primary ends of medicine by patients and the general public."[3] That alleviating suffering is a key medical goal might be especially true in my own field, psychiatry, where the focus often seems to be on alleviating negative emotions; negative emotions, like fear and sadness, are often part of the illness being treated.[4]

I have argued elsewhere[5] that the term "suffering" is used in three interrelated ways: a use that makes suffering a matter of unpleasant sensations, so that pain, nausea, itches, and other unpleasant sensations are instances of suffering (the sensation-based view); a use that treats suffering as equivalent to a failure to

flourish (objective or flourishing-based suffering); and a use that regards suffering as a matter of a person's distress in response to threats to things she values (value-based suffering).

Here, I want specifically to explore the moral significance of value-based suffering. I take Eric Cassell's famous account of suffering to be a species of value-based view.[6] According to Cassell, suffering is the experience of severe distress in response to a perceived threat to the integrity of a person. Earlier, I have suggested that, the idea of a person's integrity being quite murky, we should assume that what Cassell had in mind was really *distress in response to a perceived threat to something one cares about*, where caring about something is a matter of having any of an array of positive, motivationally significant attitudes towards it: loving, desiring, valuing, and so on.[7]

I will also assume that *distress* is a matter of having negative emotions—emotions that are intrinsically unpleasant or aversive. Distress might therefore include anger, sadness, anxiety, fear, hopelessness, regret, shame, guilt, grief, and a number of other typically aversive, unpleasant emotional experiences. So, on this view, and on Cassell's, a person who grieves the death of his teenage son is suffering, a person who feels rage because he has been fired from his job is suffering, a person who is anxious about dying from cancer is suffering, and a person who feels guilty because she has relapsed with drugs after working to stay sober is suffering. In each case, the negative, aversive feeling is necessary for the suffering—indeed, we might wonder whether negative emotions themselves constitute suffering *independent of perceived losses*, thereby bringing the value-based view more into line with the sensation-based view. The examples above also suggest that suffering can come in degrees; a person can suffer a little or a lot, or somewhere in between. This will depend on the intensity and variety of negative emotions they experience, which partially depends on the extent to which they care about what has been lost or threatened.

Finally, it should be noted that on the value-based view, a person can suffer in reaction to her own desires, values, emotions, feelings, beliefs, and other mental states, since it is possible for her, in a meta-cognitive fashion, to care about what those are like. A person can suffer because she is craving heroin and wants not to crave heroin.[8] Another person might feel guilt, a sort of first-order suffering, but also have second-order suffering because she feels ashamed of feeling guilty. This phenomenon is common in persons with depression, anxiety, and certain personality disorders. I frequently have patients who feel sad because of something happening in their life (losing a job, for instance) but also despair because they believe that they ought not feel sad in such a way. The avenues of suffering are as convoluted and diverse as desire itself.

With the value-based view in focus, I will argue below that suffering does not matter quite as much as we think. It is usually a mistake to accord great importance to the alleviation of value-based suffering *itself*. On the value-based view, if suffering has moral significance, it should reside in some way in the moral significance of distress. At the same time, the moral significance of distress is complicated: it is relatively weak when compared to other human concerns, so that it is often subordinate to such concerns and bears on our moral duties only when other considerations are balanced or irrelevant. This is, ultimately, because the primary function of distress is to alert us to *other* reasons we have to do things. Thus, suffering itself does not matter much, if at all, more than the losses that occasion it already do.

Taking distress seriously

Before examining the limits of the moral significance of distress, it is worth pointing out that distress could matter in at least three distinct general ways.

First, distress could have *instrumental* significance, such that too much (or even too little) distress, of the wrong type, at the wrong time, etc., could make it hard to achieve our goals. Distress can reduce our ability to function in a wide variety of domains, especially if it is prolonged, severe, and pervasive; this is especially true (almost by definition) for distress that qualifies as a psychiatric illness. Distress can also increase the risk of psychiatric illness. Traumatic experiences make their victims more likely to be depressed,[9] to have nightmares, to make impulsive decisions, to be irritable and angry, to abuse substances,[10] to develop schizophrenia,[11] to self-harm,[12] and to die of suicide.[13] Distress also has adverse physical effects. Football fans might be more likely to have heart attacks after their team loses.[14] Chronic

stress—which at least involves feeling *distressed* even if there is more to it—increases your risk of heart disease,[15] stroke,[16] diabetes,[17] dementia,[18] and other negative health outcomes.

Second, distress could have subjective moral significance. That is, people might care about distress, see it as something bad (or good), or see it as giving moral reasons. Indeed, it is obvious that people *do* see distress as having moral significance, if only through the guise of suffering. What I want to explore, however, is whether we *should* see distress as having moral significance.

Third, distress could have *intrinsic* moral significance. I will not offer a theory of intrinsic moral significance here and will also assume, against skeptical arguments, that intrinsic moral significance is possible. If distress has intrinsic moral significance, then whether an individual is experiencing distress matters for our moral obligations. If distress has intrinsic moral significance, people ought to care about it from a moral standpoint; it gives them moral reasons. Throughout this paper, the focus will be on whether a person's distress *itself* gives others moral reasons, changes their obligations, or helps determine what is right and wrong.

Although it will be later argued that distress does not have much intrinsic moral significance, it should be acknowledged there are a number of intuitively appealing reasons for thinking that it does. First, the fact that distress has clear subjective moral significance might imply that it has intrinsic moral significance. Perhaps people tend to care about it because they *should* care about it? People dislike being afraid, sad, anxious, and even angry. People are generally motivated to avoid distress *per se* and take this motivation to be reasonable. They do what they can to avoid and minimize distress. Indeed, many applications of psychiatry and psychotherapy are intended primarily to alleviate distress. We also regard the prospect of distress as a reason to choose some options over others: if you need to take some medication to treat a medical condition and there are two options, and both are equally effective and identical in their side-effect profiles except that one would have no effect on your emotions, while the other would make you have constant, low-grade anxiety, it would be reasonable to choose the first medication over the second—and it would be hard to understand anyone who regarded them as equivalent. Perhaps most compellingly, people frequently make tradeoffs against their non-psychological interests to avoid or reduce distress. It is common, for instance, to choose against a particular career because one thinks it would be too distressing. Such choices are often regarded as reasonable and even praiseworthy.

Second, most of us assume that bodily pains are morally significant. Presumably, this is because they are typically unpleasant. But distress does not seem to be relevantly different from pain with respect to unpleasantness. A key aspect of unpleasantness is aversiveness. Pain is intrinsically aversive in that we are typically motivated to avoid it. Distress also seems to be intrinsically aversive: consider the way that fear motivates us to avoid a threat. So, if pain is bad because it is intrinsically aversive, then distress, which is also intrinsically aversive, is presumably also bad. One might even think of distress as a sort of psychological pain. Indeed, many of the same brain areas that participate in the experience of pain's painfulness are activated when we experience emotional distress.[19] Should be endnote?

Third, it is clear that intentionally causing emotional distress is sometimes morally wrong. Imagine the following case, which we can call *Faux Robbery*. Suppose Sigmund does not like Aaron and wants to make things hard for him. Sigmund contrives to terrify Aaron by putting on a ski mask and pulling a gun on Aaron while he is walking home from work, making Aaron think that he is about to be shot. Even assuming no other risks are imposed (e.g., there is no risk that Aaron will be physically hurt), this would clearly be wrong. At first blush, the morally significant thing, the thing that makes *Faux Robbery* wrong, is Aaron's terror.

One might object that what makes *Faux Robbery* wrong is not Aaron's distress but the fact of Sigmund's deception. But this would be incorrect. Consider a somewhat different case, *Ultrasonic Attack*. Rather than simulating a mugging, Sigmund has developed an ultrasonic emitter that can remotely stimulate the amygdala, causing overwhelming terror, and uses this on Aaron from across the street in a clandestine fashion. That is clearly wrong, too, no matter what Aaron might think about what is happening, and even though he has not been deceived. Moreover, it is clearly more morally objectionable than if Sigmund used the ultrasonic emitter to make Aaron feel relaxed or happy; while there may still be moral objections to such uses—perhaps the fact of making someone feel an emotion that is not fitting, or

the fact that imposing the emotion violates Aaron's freedom of thought—the extra wrong of *Ultrasonic Attack* is evidently that Aaron is made to experience *distress*.

Fourth, it is clear that it can sometimes be wrong to fail to alleviate distress when it is present. If one of my patients starts to have a panic attack—and surely this represents a sort of suffering!—it would be wrong for me to do nothing, unless perhaps doing nothing was the best way to help him in the long run. Likewise, if a surgeon does not attend to her patient's fear before the surgery, or to his sadness afterward, we might think that she has failed him, at least partially.

How much does distress contribute to moral wrongs?

In *Faux Robbery* and *Ultrasonic Attack*, causing someone to have emotional distress seems to have decisive moral significance: the actions in both of these cases seem to be wrong because they cause distress (without good reason). But it is not obvious that the infliction of emotional distress always increases the wrongfulness of an action. One familiar sort of case is *White Lie*: Imagine that Lisa has purchased an outlandish new hat—for quite a bit of money—and asks Zac, a friend, whether he thinks it looks good. He does not. Zac correctly assumes, however, that if he is honest with Lisa, it will make her feel quite distressed. Supposing that it will not otherwise matter for Lisa, Zac, or anyone else what Zac says, how much Lisa's likely distress should determine what Zac may do is unclear. Some may think that her distress is not decisive—Zac should tell the truth, even though Lisa will be distressed. Others might think that because telling the truth will distress Lisa, and because very little else is at stake, Zac is *obligated* to lie. Between these views, one could imagine that Zac is permitted to lie but not obligated to do so. I am not sure whether Zac should not lie or is permitted to lie if he likes, but the idea that he could be *obligated* to lie is troubling, suggesting that this position gives too much moral weight to Lisa's distress.

More generally, we might ask when, if ever, the fact that an otherwise permissible action would cause another person to experience distress makes that action wrong. One difficulty in constructing such cases is to identify instances where the emotional distress does not track some other interest. For instance, we might wonder whether the fact that it would make his wife very anxious makes it wrong for Wilhelm to go skydiving—but the problem, here, is that his wife may have other interests with respect to whether Wilhelm goes skydiving that are also morally significant, so that the apparent moral significance of his wife's distress is simply down to other factors. Another difficulty is that in cases where ordinarily permissible behavior causes a person severe distress, the distressed person may have, or is even *likely* to have, some unusual susceptibility. But then if we think that their distress has no or only very little moral significance, this may be due to ideas about when accommodation for abnormal susceptibility is necessary.

One way to get around these difficulties is to examine contrast cases, where we can ask if the addition of emotional distress makes a moral difference compared to a similar case where there is no distress.

With this in mind, consider a case, *Motorcycles*. Imagine that Leda and Melanie both want to buy motorcycles, which they plan to ride together. Doing so would generally be morally permissible. But both of them separately have 18-year-old children whose interests will be somewhat adversely affected if they buy the motorcycles—motorcycle riding is risky, and their children remain financially dependent. However, Leda's son, Jacques, is himself a motorcycle enthusiast and will not be distressed if she buys the motorcycle. In contrast, Melanie's son, Erich, does not like motorcycles and thinks they are foolish. If Melanie buys the motorcycle, it will make Erich briefly very anxious, though he will get over it after a few months. Assuming that it is permissible for Leda to buy the motorcycle and that Melanie and Leda are in all the other morally relevant ways the same, does Erich's anxiety make it wrong for Melanie to buy the motorcycle? Readers may have conflicting intuitions about whether or not Melanie may buy the motorcycle, but most of those who think she should not would probably also concede that Leda should not do so, either. In any case, Erich's distress does not alter the moral terrain in any significant way.

A similar issue is whether causing emotional distress adds significantly to the wrongness of actions that would clearly be wrong otherwise. Consider a case we might call *Actual Robbery*. Imagine that Konrad intends to mug two people—Martha and William. Konrad will threaten them with a gun, pistol-

whip them, and then take their money. He does this, but without thinking at all about how his victims will feel. Perhaps because of previous experiences, or perhaps because of his genetic vulnerabilities, William is terrified by the incident, though his terror quickly abates without long-term consequences. In contrast, Martha is dispassionate. Has Konrad wronged William more than he wronged Martha? It does not seem so; the wrong in both cases is the same. Indeed, I am inclined to think that if Konrad was going to choose to rob either William or Martha, but not both, knowing that William is more vulnerable to terror, and simply dismissed this as a consideration (perhaps he flips a coin), it would be no worse for him to rob William than to rob Martha. To be sure, though, it *would* be worse if he actively chose to rob William *because* he wanted to terrify him. There is obviously something perverse about persons who exult in others' suffering.

It also seems clear that distress does not detract from established moral obligations. Suppose, to modify a frequently used example in moral philosophy, that we are in Nazi-occupied France and that we have been providing refuge to a Jewish family, who are hiding in our attic. Suppose our neighbor learns that we are helping the family, and this makes him very anxious, because he is afraid he will be implicated if we are caught. Does this alter our moral obligations? It would seem not, even though his anxiety is reasonable.

Does distress lead to greater moral claims?

Another way to examine the moral significance of emotions is to consider how they contribute to our obligations to aid others: does distress increase these obligations? Again, consider some cases. Let us call the first *Heart Attacks*. Imagine that you are an emergency room physician—the only one on hand at the moment—and two people (Sigmund and Aaron, again)—arrive in your emergency department at the same time, both having heart attacks. To simplify things, suppose that Sigmund and Aaron are indistinguishable in nearly every respect except one: Sigmund is extremely fearful because of his heart attack, while Aaron, who has practiced mindfulness meditation for years, is not; he is in pain, and he is at risk of death and disability, but he is not afraid. Assume, too, that Sigmund's fear is not going to change his prognosis or have any other sequelae. While your attention might be drawn more strongly to Sigmund's predicament—one function strong emotional expressions serve is presumably to attract help—does his fear give you a stronger reason to treat him than you have to treat Aaron? If so, how much stronger? Suppose that you determine that both patients urgently need cardiac catheterization and angioplasty, but there is only one catheter lab in the hospital. Should Sigmund, who is fearful, be prioritized, or should you make the decision about who goes first (remember, again, that they are identical in all other respects) by flipping a coin?

One might initially feel that Sigmund, the fearful patient, should be prioritized. After all, he is worse off than Aaron, the mindful patient, and that seems to matter. He is certainly suffering more. If suffering had some special, extra moral weight, the ER doctor would have a greater reason to treat Sigmund than to treat Aaron. That is not the case, however. Although Sigmund is suffering, I want to claim this does not necessarily add anything to the reasons the physician has to aid him; barring some special circumstances, both Sigmund and Aaron have the same claim on treatment, largely because of the moral significance of their diagnoses and what these mean with respect to life, bodily integrity, functioning, and other non-emotional interests.

To see this, consider that Aaron, who is not particularly self-sacrificing despite his mindfulness, might reasonably complain if the ER doctor prioritized Sigmund: "It does not seem fair that I am being denied an equal chance to get a scarce, life-saving resource just because I happen to be less fearful." He might even object that he is being penalized for the long-term consequences of efforts to improve himself, at least as he understands "improvement." The point here does not depend on the moral merits of Aaron's mindfulness practice. Suppose he is just constitutively someone who has less emotional tone. Or suppose that he has already taken a benzodiazepine and so is not anxious. Here, too, he might still reasonably complain that his relative lack of suffering does not reduce the reasons we have to provide him with care.

To extend this intuition, imagine that Sigmund's fear and anxiety will not be lessened by the treatment. Sigmund is fearful and suffering, but his fear has taken on a sort of free-floating character, so that it will not get better even if the heart attack is treated. Should he have priority in receiving the treatment compared to his less anxious competitor? Here it seems even clearer that he should not—it should be, in effect, a coin flip. So, if his distress does give him any greater claim in the first case, it is presumably only because there is some chance that the intervention will alleviate that distress.

One might say, however, that the case of free-floating anxiety misses the point, because in the conventional way of thinking about things, any extra moral weight that suffering conveys—when it gives us extra reason to address some underlying loss or threat of loss—depends on the suffering being causally dependent on the loss, which is presumably not true for the case as it is described. But I doubt that causal dependence is especially important. Consider a case we might call *Back Pain*. Suppose two people come to our ER with severe back pain. The first rates her pain as 7/10. She is very anxious about the pain, and her anxiety is 8/10. The second patient has the same back pain (still 7/10) and is *also* very anxious (still 8/10), but she is not anxious because of back pain. Instead, she is anxious about the fact that her husband has lost his job, and the family's finances are under threat. Both patients are suffering both have back pain, and both are suffering with anxiety, but the second is not suffering with anxiety because of the back pain. For either patient, the back pain can be alleviated by diazepam (Valium), a benzodiazepine that acts as a muscle relaxant and which is also extremely helpful for acute anxiety. The diazepam will do nothing for the husband's lost job, of course. Unfortunately, our pharmacy has just informed us that we are down to our last dose of diazepam, and there are no alternatives available. Other things equal, to whom should we give it? Again, it seems to be a wash: we should, other things equal, flip a coin. If that is true, however, then the fact that emotional distress is caused by some (perceived) threat to what a person cares about does not have any special significance with respect to what we should do to alleviate that distress, except perhaps in cases where the connection signals a greater expected effect for our efforts.

You might imagine that the conclusions reached above depend on specific duties related to the medical context, but we can find similar non-medical examples. Consider the following case, *Pit Bull*: you are walking down the street, and you happen to see two children, of similar age, both being threatened by a raging pit bull. If you do not intercede (let us note that interceding will take considerable bravery on your part!), it is likely that both will be severely mauled, perhaps killed. Both of the children look afraid, but one is clearly more afraid—he is shaking, crying, etc. Both of the children are suffering, but one is suffering more. Do you have any more reason to save the more fearful child than the less fearful one? It does not seem so to me. If, horrifyingly, you could save only one of them, the fact that one is fearful does not mean that he should have priority. Here, the first more fearful child's distress does not add any moral weight.

One might imagine that our intuitions in the cases above—*Heart Attack, Back Pain*, and *Pit Bull*—are driven in part by the fact that they involve some sort of emergency or by the fact that there are very strong interests—death or dismemberment—at stake. The concern, of course, is that even though distress does not have moral significance that is on a par with a person's life, we should not conclude that it has no moral significance at all. But we can also see that distress does not have additional moral significance in non-emergent cases where the competing interests are much less significant. Consider *Grade Inflation*: you are a professor in a philosophy class. Two students, Kay and Carl, have done equally poorly on their final papers. Because of your school's requirements, you must maintain a rigid grade curve, and so you must assign one student a "C" and one a "C+". You know that Carl is much more anxious than Kay and will be more distressed if he gets the "C" than Kay will be. Should you give Carl the "C+" instead of Kay? As in the earlier cases, my intuition is that this should be a wash: Kay is, despite her lack of distress, just as deserving of the higher grade. Moreover, it seems clear that we should not consider how Carl might feel about his grade when assigning the grade—how he feels is irrelevant.

For a similar example, consider *Layoff*: Imagine that you are a manager in a tech firm, and because the firm's newest product has flopped, you need to lay off one of your employees. Emil and Virginia have both been working for you about the same amount of time, are from that standpoint equally eligible for being laid off, and have demonstrated similar—adequate but not especially good—performance. Imagine, though, that Virginia is much more emotionally sensitive than Emil, so that you expect that

if you lay Virginia off, she will have several weeks of relatively severe (but not functionally significant) sadness and grief. Should this tilt your decision in favor of laying off Emil? Again, it does not seem so.

Another concern you might have about many of the cases above is that distress imagined—especially in *Heart Attack, Back Pain, Pit Bull, and Grade Inflation*—is relatively temporary, which should tend to reduce its expected moral significance (we might assume that the moral significance of distress will be roughly proportional to its severity and duration). Even protracted distress, however, does not always provide strong moral reasons. But consider a case we might call *Minor Amputation*: Viktor and Irvin have both presented to your battlefield surgery with injuries—both have damaged, in identical ways, the smallest toe of the left foot. If you do not operate immediately, both will lose the injured digits. Suppose that you know, however, from genetic testing of all the soldiers in your unit, that Viktor is very likely to develop mild lifelong anxiety if he experiences any lasting combat injuries. The anxiety will not impair him functionally but will be moderately unpleasant. Immediate surgery would greatly reduce the likelihood of this anxiety. In contrast, Irvin is relatively resilient and will not develop anxiety. Thus, if you operate on Irvin, Viktor will lose his little toe and be slightly more anxious than otherwise, while if you operate on Viktor, Irvin will only lose his little toe. On whom should you operate first? As with our other comparative cases, it seems to me that you do not have any particular reason to prioritize Viktor; his risk of a little extra anxiety—which, again, should not affect any of his substantive interests—does not add anything to the moral terrain, so you should assign both patients the same priority and choose by flipping a coin.

The relatively small moral significance of Viktor's anxiety might be easier to see if we suppose that Irvin's injury and its long-term sequelae without treatment will be just marginally worse than Viktor's injury. Imagine that Viktor has injured only the last five millimeters of his small toe, while Irvin has injured 10 millimeters. Neither injury will have any functional significance, and the pain involved is the same, but Viktor remains at much higher risk of moderate long-term anxiety. Here, it is clear that Irvin has the greater claim to treatment. Thus, if Viktor's anxiety matters, it is only very little.

We can, of course, imagine variations of this case where Viktor's anxiety weighs more heavily. Suppose that, rather than a slight increase in anxiety, Viktor will suffer long-term severe anxiety—he will be much more fearful, much more of the time, and it will greatly lower his quality of life. In this case, we might think that Viktor should, if we can know his vulnerability, have a greater claim to treatment than Irvin. Where Viktor is experiencing severe, protracted anxiety, however, it may not be the case that his emotions themselves are bearing moral significance, since we should expect that severe anxiety will have measurable functional relevance, too. If we try hard to imagine—and it is admittedly difficult to imagine—that Viktor has severe anxiety but also that it has no meaningful separate effect on his life, so that how he lives and what he does is not changed, then the moral significance of his anxiety is lessened.

Other considerations

There are other reasons to doubt that distress has significant moral weight. One is that, much of the time, feelings only matter to us while they are happening. Consider *Shrub:* suppose I get out of bed in the middle of the night, stumbling into the kitchen to get a drink of water, and think that I see a burglar in my living room. I am suddenly charged with fear, anger, and indignation. I flick on the lights. I realize that the burglar is only the new shrub my wife had purchased earlier that day. I am relieved, and my fear abates. If you then asked me whether my fear was a problem, I would say, "no, it is no big deal." Has my life gone less well because of the fear? Not really. Though it seemed to have mattered in the moment, in the clear light of the kitchen, my distress did not matter at all. In a similar vein, consider that in cases where a person's distress is demonstrably disconnected from anything else that matters—as when they feel fear from watching a horror movie or feel sad from listening to Barber's *Adagio for Strings*—we do not suppose that their life has gone less well at all. Indeed, we may even suppose that in virtue of this negative emotional experience, their life has been richer and more worth living.

Another thing to consider is that we often do not regard our emotions as giving us reasons themselves. Consider a variant on *Shrub* (call it *Baseball Bat*). Suppose that, as above, I stumble into my kitchen and I

am alarmed by the shrub, which looks like an intruder. I grab a baseball bat to fend off the intruder, which I keep on the side for just such a purpose. Then I flick on the lights and realize my error. I have an apparent reason to attack before I turn on the lights, though no objective reason—though I take myself to have a reason, I am in error. Note, however, that my fear does not add to that apparent reason. Moreover, my fear certainly does not give me anything like an objective reason, even if it persists after I realize my mistake.

Consider, for comparison, a somewhat less acute example. Suppose that my boss has said that I will lose my job if I do not increase my productivity. I like my job, so I am understandably anxious. Obviously, I have a strong reason to increase my productivity. Do I have *more* reason to increase my productivity because I am anxious? Presumably not. And if I stop being anxious after a day or two, simply because of habituation, even though the threat from my boss persists, do I suddenly have less reason to improve my productivity? Again, no. Here, my anxiety indicates the reasons that I have, but does not add to or modify them.

Finally, note that in some cases—we see this especially often in psychiatry, perhaps—people think that there is something problematic about trying to alleviate distress that is appropriate to a situation. For instance, a patient of mine who was being treated for depression and alcohol dependence recently learned that his sister had died in a car accident while he was in treatment. We had been helping him with antidepressants, and he had been improving, but after learning of the death, he was reasonably concerned that the antidepressants would impair his ability to feel appropriate grief (which, fortunately, they did not). It also often happens that patients worry that their antidepressants are *ineffective* because they feel distress in situations where most people would feel distress—their marriage has ended, they have lost a job, a parent has died. Most mental health providers will try in such cases to reset expectations: antidepressants do not necessarily prevent one from feeling bad in such cases, but that is *okay*. More broadly, there is a great deal of concern that psychiatry overmedicalizes some forms of ordinary sadness, such as grief.[20] Presumably, doing so is bad because there are some forms of distress that we *ought* to feel —i.e., forms of distress that we do not have reason to avoid, once their usual conditions have obtained.[21]

A compromise position

The above considerations point to a sort of dilemma about the moral significance of suffering, where this depends on the moral significance of distress. On the one hand, distress clearly has some moral significance—it is wrong to inflict it wantonly, wrong to neglect it if we can readily do something about it, and clear that we have some reasons to prevent it when possible. On the other hand, there are many cases where distress seems to add little or nothing to our reasons for action, or where the reasons it gives us are readily overridden by almost any other reasons. How can we reconcile these observations?

The claim here is that we should regard the intrinsic (as opposed to instrumental) moral significance of distress as derivative or "indicative": while distress *can* have independent moral significance, this moral significance is typically outweighed by the moral significance of almost all other human goods. We should only regard distress *per se* as having moral significance when other kinds of considerations are balanced out or not at stake.

To be clear, my view is not that distress can have no moral weight. It is just that what weight it has does not add to the moral weight of the losses that cause it. If someone is anxious, I have some reason to help her. I certainly have strong reasons to avoid making others anxious unnecessarily. But if someone is anxious because of cancer, my reasons for treating her are not increased by her anxiety; they simply amount to the reasons I have to treat her cancer.

On this view—the indicator theory—to observe that someone is suffering is to make an important rhetorical move: it catalogues and reminds us of the other reasons we have to help them. But it does not change what those reasons are. Cassell and others who claim that the goal of medicine is to alleviate suffering therefore have it partially wrong: the goal of medicine should actually be to alleviate the problems that cause suffering, where suffering just indicates that they are problems that matter.

The indicator is not without precedent. Something similar is evident in many philosophical views about happiness. The problem with hedonic versions of utilitarianism, many think, is that they seem to argue for the maximization of pleasure and satisfaction at the expense of human interests that, though perhaps less subjectively satisfying than other pursuits, are more *important*. This, of course, is why John Stuart Mill strayed from Jeremy Bentham's insistence on maximizing pleasure to the idea that we should promote more enlightened interests or "higher pleasures": poetry over pushpin, and so on.[22] A similar point is made by Robert Nozick in his writing about the experience machine (wherein one has the option of leading a highly satisfying but purely simulated experience) many of us think it would be better to live a less satisfying life full of *real* accomplishments and failures than to spend all of our time having extremely satisfying but simulated experiences.[23] Both of these ideas suggest that the emotional experience of happiness is not as important as a life well lived. My point about suffering is similar: in medicine and elsewhere, it is much less important that we alleviate the distress that constitutes suffering than that we promote our patients' interests—where their suffering indicates what those interests are.

Similarly, many of us think that it is often wrong or at least misguided for people to curtail their own ambitions and goals in order to avoid suffering. The Buddhist idea that we should try to avoid desire in order to avoid suffering is correct in some respects: it does not make sense to get on the hedonic treadmill and to cultivate desires (like buying a Humvee or being extremely wealthy) that exceed those that help constitute a good human life. But it may also be a mistake to avoid developing desires and ambitions or to kill off desires one already has simply because one is afraid they will be disappointed. A person who eschews goals simply to avoid anxiety or disappointment has not lived well; indeed, they have lived badly. And often, they seem to misunderstand the significance of their distress. The person who refuses to let himself fall in love (if he can manage such a trick) simply because he does not want to run the risk of grieving that love if he loses it, mistakes the relative values of love and grief.

The indicatory theory is also consistent with the view of distress expressed by many psychotherapies (though not necessarily consistent with why people choose to pursue psychotherapy in the first place). Many of these approaches to mental illness—dialectical behavioral therapy[24] and acceptance and commitment therapy[25] in particular—ask us to *accept* our distress, to avoid putting judgment on it, to see it as something that is not necessarily bad even if it is painful, and to focus much more on substantive goals like having relationships and pursuing meaningful projects than on simply trying to feel less bad.

In summary, then, the distress that constitutes value-based suffering has moral significance in some respects but not in others. It can give us strong instrumental reasons, which are dependent on other reasons we have for action. It can also give us indicative reasons—when the distress reflects the reasons that we have otherwise, often making them more salient to us. Indicative reasons are, however, predicated entirely on the other reasons we have and do not add anything to them. Finally, distress can give us direct, intrinsic reasons for action that are reflective of its intrinsic badness. But these reasons are typically weak and subordinate to the more substantive reasons that they tend, as a class, to indicate.

Moral double counting: should we care about how we feel?

The indicator theory has implications for how we should treat ourselves. But there is a problem. As suggested above, the distress that constitutes value-based suffering does not add significantly to the moral significance of losses or threats to what we care about. This implies, plausibly, that caring about things can (at least under certain circumstances) give them value. But what if we happen already to care about how we feel, such that feeling less distress has itself become a project for us? Then, how we feel should have the same moral significance as any other thing we (happen to) care about.

In fact, the answer is "no": even if we happen already to care about minimizing emotional distress, we should not regard distress *itself* as having great intrinsic non-subordinate moral significance that is on a par with our other values. This is because taking distress seriously would involve a sort of moral double-counting. If I am distressed because I am losing my job, then to regard my sadness as giving me some additional reason for action beyond the ways in which losing my job itself gives me reasons for action is to

take myself to have two reasons to do something (e.g., fight to keep my job). When those reasons align and there are no competing goals about which I care as much at stake, no problem arises. But if my distress is not proportionate to my values, or if I happen to value things that are sometimes in conflict, then regarding my distress as itself reason-giving, as opposed to being merely a somewhat unreliable indicator of my reasons, entails that I may more often act in ways that do not correspond to what really matters to me.

A related problem is that double-counting involves a risk of making ourselves into a sort of utility monster.[26] If I care about some project but also care about the distress that is associated with threats to that project and so experience additional distress, and *then* also care about that additional distress, and then care about further resulting distress, and so on, any time I experience distress, it will tend to greatly distort my assessment of my reasons for acting. Something similar can happen interpersonally: the person who happens to feel more distress and to have meta-emotional values (who cares about her own distress) will invariably appear to have a greater claim on others' help than those who feel less distress and do not care much about their own distress. This seems problematic, especially if whether or how much she cares about her distress is up to her. Although it may be that individuals who experience more distress and greater negative utility are more deserving of succor than others, there is something wrong—unfair, even—about making ourselves more vulnerable to distress than we must be.

Objections

To recap: the conclusion to this point is that neo-Cassellian, value-based suffering does not have strong independent moral significance, over and above the moral significance of the losses that underpin it, because the distress that constitutes suffering has only indicative and, sometimes, instrumental moral significance. Before embracing this conclusion, however, we should consider some objections.

One initial objection is that if we do not regard value-based suffering as having independent moral significance, then we inadvertently detach compassion—the emotional resonance we experience when we witness others' suffering—from moral decisionmaking. This could be a problem in several respects. First, from a practical, psychological standpoint, compassion could be necessary, or at least extremely helpful, for effectively attending to others' concerns, making it easier for us to recognize what morality requires of us or to motivate ourselves to follow its dictates.

The objections are largely beside the point. The claim here has been that, from the standpoint of accurately and completely tallying the reasons we have for acting, counting suffering itself in is largely mistaken. But I have already allowed that attending to suffering is important because suffering is indicative of other reasons related to whether a person's life is going well or not. From a psychological standpoint, I am fully prepared to accept that compassion in the face of others' suffering is helpful in recognizing the reasons we have and moving us to act on them.[27]

One might instead argue that compassion is *conceptually* necessary for acting rightly—that an agent who does the right thing simply because he recognizes it as the right thing, without also responding compassionately to the suffering of others, is morally disabled and not really acting rightly—in something like the way a person who follows the rules only because he is afraid of getting caught is not really acting morally. This is similar to Bernard Williams's "one thought too many" worry: there is something wrong with someone who can alienate himself from personal concerns in the way that a purely rationalist approach to morality requires.[28] The best response here, however, might simply be to distinguish two forms of compassion: *empathic* compassion, where one feels what the other person feels, or at least responds to their feelings, and *sympathetic* compassion, where one takes the interests and concerns of the other person to matter without any emotional resonance.

To emphasize this point, consider one more comparative case, *Starvation*. Suppose that you are touring a site of humanitarian disaster, and you encounter two people, Anna and Hans, who are almost equally ravaged by malnutrition and associated disease. But Anna is ever so slightly more malnourished and ill. It happens that severe malnutrition produces apathy. While Hans is still nourished enough that he can still just barely experience distress, Anna is not; she has reached a stage of complete apathy because

of her malnourishment. So, even though she is a bit more unwell than Hans, she is not distressed. Is Hans more deserving of help than Anna because he is experiencing distress? It would seem not; indeed, if one is more deserving than the other, it is Anna. Now returning to the objection, presumably we can treat Anna and Hans with equal compassion—and respond virtuously to their plights—even though Anna is not herself experiencing distress and there is no possibility of empathic compassion for her.

Conclusions

I have argued, controversially, that a certain kind of suffering—what I have called value-based suffering, which involves experiencing emotional distress in response to a loss—does not itself have strong independent moral significance. This is because distress (negative emotions) itself has limited moral significance—its significance is primarily indicative or instrumental, and its indicative significance is subordinate to non-mental reasons for doing things. According to the indicator theory, distress only matters in its own right when other, material interests are not at stake or are balanced against each other.

If my argument is correct, it implies something rather surprising for bioethics: that the goal of medicine should *not* be to alleviate suffering. Instead, it should be to promote other human interests as they are impinged upon by medical problems.

The fact that suffering *qua* distress does not have much intrinsic moral significance has implications for questions in bioethics, such as the ethics of medical aid in dying (MAID). The justification for MAID is often taken to be suffering—typically, suffering that cannot otherwise be alleviated. My view implies that suffering itself does not justify violating strong moral duties like the duty not to kill, so that the attempt to justify medical aid in dying through the alleviation of suffering falls flat. And if it does, we might be without any compelling justification for MAID. But this is a mistake. It is true that the feelings a person has as a result of some loss/threat to integrity do not themselves justify MAID. But if those feelings reflect a reasonable appraisal of the individual's situation, and the individual is in a position such that it is reasonable to conclude that their life is, given what matters to them, not worth living, then their suffering is indicative of their reasons, and there may still be sufficient justification for MAID.

Notes

1. Brady MS. *Suffering and Virtue*. New York: Oxford University Press; 2018:21.
2. Andorno R, Baffone C. *Human rights and the moral obligation to alleviate suffering*. In: Green RM, Palpant NJ, eds. *Suffering and Bioethics.* New York: Oxford University Press; 2014:182–3.
3. Cassell EJ. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 1982;**306**(11):639–45.
4. Kious BM, Nelson RH. Does it matter whether a psychiatric intervention is "palliative"? *AMA Journal of Ethics* 2023;**25**(9):655–60.
5. Kious BM. Three kinds of suffering and their relative moral significance. *Bioethics* 2022;**36**(6):621–7.
6. See note 3, Cassell 1982.
7. See note 5, Kious 2022.
8. Frankfurt HG. The importance of what we care about. *Synthese* 1982;**52**(2):257–72.
9. Mandelli L, Petrelli C, Serretti A. The role of specific early trauma in adult depression: A meta-analysis of published literature. *European Psychiatry* 2015;**30**(6):665–80.
10. Levin Y, Lev Bar-Or R, Forer R, Vaserman M, Kor A, Lev-Ran S. The association between type of trauma, level of exposure and addiction. *Addictive Behaviors* 2021;**118**:106889.
11. Popovic D, Schmitt A, Kaurani L, Senner F, Papiol S, Malchow B, et al. Childhood trauma in schizophrenia: Current findings and research perspectives. *Frontiers in Neuroscience* 2019;**13**:274.
12. Zetterqvist M, Lundh L-G, Svedin CG. A comparison of adolescents engaging in self-injurious behaviors with and without suicidal intent: Self-reported experiences of adverse life events and trauma symptoms. *Journal of Youth and Adolescence* 2013;**42**(8):1257–72.

13. Angelakis I, Gillespie EL, Panagioti M. Childhood maltreatment and adult suicidality: A comprehensive systematic review with meta-analysis. *Psychological Medicine* 2019;**49**(7):1057–78.
14. Lin L-L, Gu H-Y, Yao Y-Y, Zhu J, Niu Y-M, Luo J, et al. The association between watching football matches and the risk of cardiovascular events: A meta-analysis. *Journal of Sports Sciences* 2019;**37**(24):2826–34.
15. Wirtz PH, von Känel R. Psychological stress, inflammation, and coronary heart disease. *Current Cardiology Reports* 2017;**19**:1–10.
16. Truelsen T, Nielsen N, Boysen G, Grønbæk M. Self-reported stress and risk of stroke: The Copenhagen City Heart Study. *Stroke* 2003;**34**(4):856–62.
17. Hackett RA, Steptoe A. Type 2 diabetes mellitus and psychological stress—A modifiable risk factor. *Nature Reviews Endocrinology* 2017;**13**(9):547–60.
18. Stuart KE, Padgett C. A systematic review of the association between psychological stress and dementia risk in humans. *Journal of Alzheimer's Disease* 2020;**78**(1):335–52.
19. see, for example, Decety J. Empathy, sympathy and the perception of pain. *Pain* 2009;**145**(3):365–66. See also Kross E, Berman MG, Mischel W, Smith EE, Wager TD. Social rejection shares somatosensory representations with physical pain. *Proceedings of the National Academy of Sciences* 2011;**108**(15):6270–5.
20. Horwitz AV, Wakefield JC. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford: Oxford University Press; 2007.
21. For more on this, see note 1, Brady 2018. See also Brady, MS "Why we should be experientialists about suffering", this Special Section.
22. Mill JS. *The Collected Works of John Stuart Mill*. Toronto: University of Toronto Press; 1991.
23. Nozick R. *Anarchy, State, and Utopia*. New York: Basic Books; 1974.
24. Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press; 1993.
25. Hayes SC, Strosahl KD, Wilson KG. *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change*. New York: Guilford Press; 2011.
26. Chappell RY. Negative utility monsters. *Utilitas* 2021;**33**(4):417–21.
27. My point here is similar to some of the claims that Paul Bloom makes about empathy. Bloom distinguishes empathy and compassion; here, I'm using the term "compassion" to describe what he might call "empathy." I am not sure which term is ultimately the right one, but it matters little for present purposes. The central issue is whether being a good moral agent depends on being *directly* responsive to others' distress, as opposed to responding to the things that cause the distress. Bloom P. *Against Empathy: The Case for Rational Compassion*. New York: Random House; 2017.
28. Williams B. *Moral Luck: Philosophical Papers 1973-1980*. New York: Cambridge University Press; 1981.

Cite this article: Kious BM (2025). How Much Does Suffering Matter? *Cambridge Quarterly of Healthcare Ethics*: 1–12, doi:10.1017/S096318012400080X