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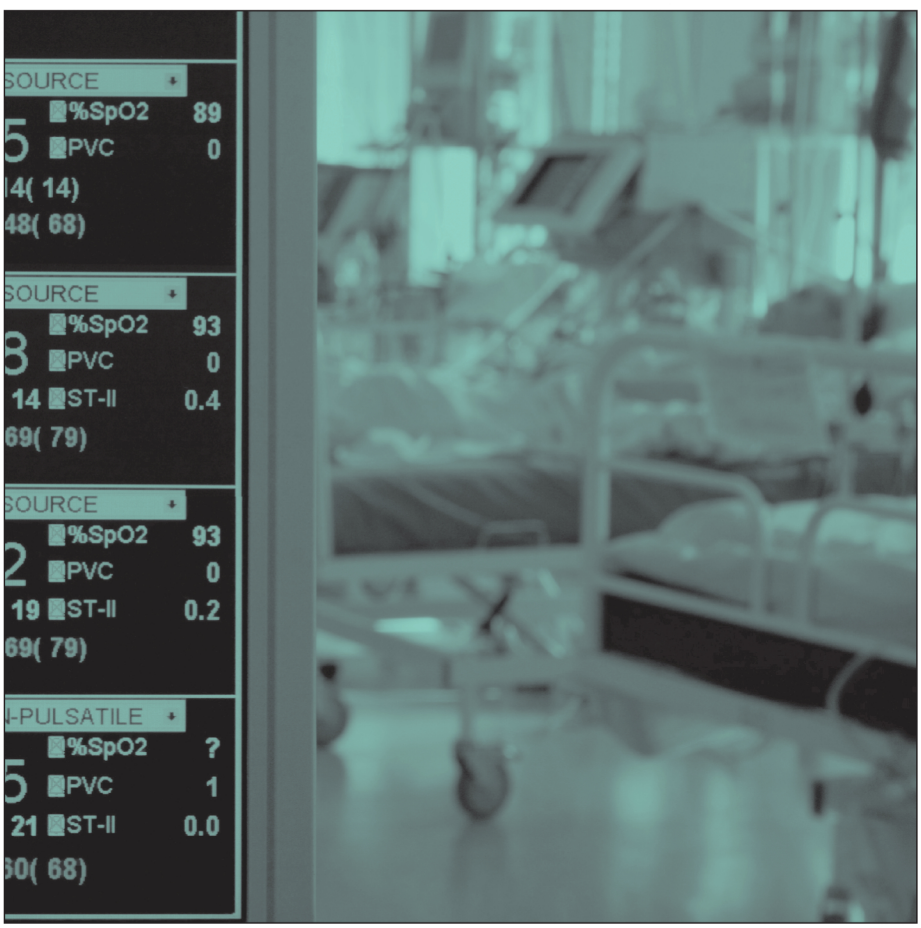
An International Journal of Bioethics



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EDITORIAL

HEALTHCARE AND THE *COMMON GOOD*

C. BEN MITCHELL, PHD

The U.S. healthcare system is by many accounts both the envy of the world and in very deep trouble. Some resist the word 'crisis' to describe the situation, suggesting such a diagnosis is too cynical. Others have predicted that the impact of Baby Boomers on the healthcare system will lead to the collapse of employer-provided healthcare (see William Styring and Donald Jonas, *Health Care 2020: The Coming Collapse of Employer-Provided Health Care).*

According to the Brookings Institute, healthcare spending in the United States now exceeds US $2 trillion annually (nearly 17% of all spending). If the current rate of spending continues to grow, the cost of family health insurance coverage will exceed $17,000 annually per family by the year 2011. Within five years many families will pay over $20,000 per year for coverage.

Depending on whose figures one cites, more than 45 million Americans are uninsured at least part of each year. Yes, some individuals step in and out of coverage because they change jobs. An inordinate number of illegal immigrants and their children are uninsured. There are ways to massage the numbers, but whatever the causes, those are still frightening statistics.

Healthcare funding has already played a part in the Presidential race and is likely to assume an even more prominent role, just behind the war in Iraq and the fuel crisis. The physician-patient dyad is now truncated by the health maintenance organization (HMO). The unintended consequence of which is what can only be described as 'adversarial medicine'—patients are wary of doctors, doctors carry exorbitantly expensive malpractice insurance, and no one trusts the HMOs to act in the patient's best interest.

Arguably, the 'common good' is the appropriate moral matrix for thinking about healthcare. The doctrine of the common good should not be confused with John Stuart Mill's utilitarian axiom: 'the greatest good for the greatest number.' The pursuit of the greatest good for the greatest number always ends up jeopardizing the minority for the sake of the majority. The common good serves the interests of the community viewed as a whole.

French philosopher and economist Bertrand de Jouvenel is not a household name these days even among academics; but we neglect his wisdom to our own peril. During the 1950s and 60s de Jouvenel was much better known than today. He lectured at Yale, Berkeley, and other prestigious universities. He was a respected public philosopher. In his book *Sovereignty* (1957), the second volume of his great trilogy on political philosophy, de Jouvenel has an extended discussion of the common good. Pursuit of the common good does not assert 'rights' and 'obligations', those being antithetical to the common good. Instead, a focus on the common good enables us to see that we are 'members one of

another' and arouses within us an awareness of the 'we' and the 'us' as opposed to the 'he', 'she', and the omnipresent 'me'.

Hippocratic medicine aims always to serve the patient's good, not the market's. We must think strategically and globally about how best to serve that good within the boundaries of markets, health services, HMOs, and other funding schemes, for the common good.

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GUEST COMMENTARY

HOW MUCH BRAIN DO I NEED TO BE HUMAN?

SCOTT B. RAE, PHD

Some time ago on a hospital ethics committee consult, the patient was an anencephalic child, born in the hospital's NICU. The physician had brought the case to the committee and held the view that no symptoms should be treated aggressively. One of the ICU nurses who was caring for this child was surprised that this case came to the ethics committee at all. In the course of the meeting on this case, she stated her view when she said, "She's not a person; let her die." Though the discussion did not go in the direction of organ donation prior to death, if the issue had been raised, this nurse would likely not have had a problem with that either.

The severely neurologically impaired, such as the anencephalic newborn, the PVS patient and the nursing home resident at the end stages of Alzheimer's, raise puzzling questions. They are alive, but do not have much of a life, when it comes to the narrative that distinguishes them from their mere bodily functions. Our intuitions tend to rebel against the notion that they are human beings like us, because they look and seem to us to be simply bodies that medical technology is sustaining.

These cases raise the question: "How much brain do you need to be human?" Or to put it more generally: "What kinds of capacities are necessary for one to be considered a person?" Underlying the former question is another criterion for personhood, that of consciousness/sentience. With the neurologically impaired, the question we are really asking is: "Can someone be a person without being conscious or sentient?" The question of brain activity then is related to how much brain activity is necessary to sustain consciousness/sentience, and is actually secondary to the more basic criterion of consciousness/sentience.

From the first discussions of the criteria for personhood in the 1970s with Fletcher[1] and Warren,[2] the emphasis was on consciousness and other related capacities, such as rationality, awareness of one's environment, and capacity for relationships. These were echoed by Michael Tooley[3] and were the basis for James Rachels' distinction between biographical and biological life.[4] They are taken to chillingly consistent conclusions by Peter Singer, who applies them to infanticide as well as abortion and euthanasia.[5] Some of the most widely read discussion in this area has come from philosopher/bioethicist Bonnie Steinbock in her book Life Before Birth: The Moral and Legal Status of Fetuses and Embryos.[6] She argues that having interests, on which moral status rests, depends on consciousness/sentience.

Ethics & Medicine, 24:3 (2008): 135-138.

Some evangelical Christians have also adopted a functional view of a person, based on the image of God[7] being more of a function than a status. For example, philosopher Robert Wennberg has concluded that the permanently unconscious patient has lost the image of God and is no longer a person. Wennberg states, "When an individual becomes permanently unconscious, the person has passed out of existence, even if biological life continues. There cannot be a person where there is neither the capacity for mental states nor even the potentiality for developing that capacity."[8] Similarly, theologian Robert V. Rakestraw comments, "[T]he spirit of the PVS patient has already returned to God… While the body has some kind of residual life, the person is dead… The Christian has a theological basis for distinguishing between the death of the body, with its residual movements, and the death of the person."[9]

As ethicists within the Judeo-Christian tradition, we should be careful about any view that distinguishes between biological and biographical life. Biological life, far from being irrelevant to one's status, actually undergirds the notion of having a life. It is true that there is a difference between being alive and having a life, but having a life is dependent on how one actualizes his or her capacities, and is irrelevant to one's value objectively and ontologically. Wennberg and Rakestraw are correct that it is acceptable to remove feeding tubes from the PVS patient, but not on the basis that they are no longer persons or that they have died. If that were true, then there would be no reason not to harvest their organs, perform experiments on them, or simply perform their funerals and bury them. The reason we do not bury them is that they are still living persons, even though they have lost the ability to actualize most if not all of their capacities that contribute to having a good life.

Rejection of an interest view of moral status, or other functional views of a person, would suggest that the PVS patient, or other severely neurologically compromised patients are still persons, and that their standing as persons is not dependent on their neuro-cognitive level of function. Consciousness/sentience is necessary to the experience of life, but it is not necessary for one to be a person. The PVS patient, the anencephalic child, the severely demented and the temporarily comatose are all persons with full rights to life, regardless of their level of cognitive function.

However, it does not follow from this that they must be offered every treatment to keep them alive. Just because a PVS patient is a person does not mean that the community must do everything, at all time and at all costs, to keep them alive. Nor does the sanctity of life mandate this. There is a growing consensus, reflected in the Cruzan decision, that medically provided nutrition and hydration are indeed forms of treatment that can be refused, if there is clear evidence that it is the patient's wish. In most cases feeding tubes are analogous to ventilator support; removal of feeding tubes is not starving a person any more than removing ventilator support is suffocating them. Further, to insist on a mandatory aggressive treatment based on the sanctity of life doctrine is to elevate earthly life to the status of the ultimate good. If the sanctity of life obligates us to do everything at all times to keep people alive, then we are making a dangerous theological assumption about earthly life being the highest good. From a Christian view of the world, earthly life is a penultimate good;

the ultimate good being our eternal fellowship with God. Moreover, with death being a conquered enemy, one thing that follows is that death need not always be resisted. It is acceptable to say "enough," including the removal of feeding tubes.

The Scripture is clear that a person's status and rights are grounded in the image of God. This sets human beings apart from animals and provides the essential basis for human dignity. The Bible teaches the continuity of personal identity through time and change. This is the central message of texts like Psalm 139 and Psalm 51, that the psalmist is the same person in the womb and as an adult. Psalm 139 actually extends that notion to the earliest stages of pregnancy, when the unborn child is an "unformed substance," which some lexicons translate as "embryo." This is echoed in the Incarnation account. The Messiah is first recognized as coming, not at Jesus' birth, but at his conception, when He was still in the embryonic stage, in the first few days of Mary's pregnancy. In philosophical terms, the Bible teaches that we are substances, with an internal, defining, and directing essence—the soul—that remains the same through time and change. That is, we are more than a collection of our parts and properties. Human beings are not "property-things," but substances. To be sure, souls must have bodies in order to maximize their capacities, even in eternity. But we are not our bodies, any more than we are our brains. We are body-soul unities to be sure, which is the emphasis in the Scripture, especially the OT, where different aspects of a person (heart, soul, etc.) are used as figures of speech for the whole person.[10] But this does not mean that human beings are not both body and soul ontologically.

So how much brain does one need to be human? Enough to be alive. Because to be a living human being is also to be a person. It does not follow that we must do everything to treat persons, especially those in a PVS. But neither consciousness nor sentience nor the ability to reflect the image of God are determinants of what constitutes a person. Those are all functions that are a result of being a person, not the determinants of it. Human beings function in the way we do because we are things of a certain sort—human persons created in God's image with dignity, moral status and rights to life.

Endnotes

1 Joseph Fletcher, "Indicators of Humanhood: A Tentative Profile of Man," Hastings Center Report 2 (1972): 1-4, and "Four Indicators of Humanhood: The Enquiry Matures," Hastings Center Report 4 (1974): 4-7.

2 Mary Anne Warren, "On the Moral and Legal Status of Abortion," The Monist 57:1 (1973): 43-61. She further refined these views in Moral Status: Obligations to Persons and Other Living Things (New York: Oxford University Press, 1997).

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6 Bonnie Steinbock, Life Before Birth: The Moral and Legal Status of Fetuses and Embryos (New York: Oxford University Press, 1992).

7 The Christian doctrine of humanity created in God's image is explicitly stated in Genesis 1:26-27; 5:1; 9:6.

8 Robert Wennberg, Terminal Choices: Euthanasia, Suicide and the Right to Die (Grand Rapids: Eerdmans/Paternoster, 1989), 159.

9 Robert V. Rakestraw, "The Persistent Vegetative State and the Withdrawal of Nutrition and Hydration," in David K. Clark and Robert V. Rakestraw, Readings in Christian Ethics: Volume 2—Issues and Applications (Grand Rapids: Baker Book House, 1996), 128-29.

10 The figure of speech is a synecdoche, of the part for the whole.

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GREY MATTERS

THE SYNAPSE AND OTHER GAPS

WILLIAM P. CHESHIRE, JR., MD

Gaps are among the most meaningful of nonentities. Despite their emptiness, they do not reduce to nothingness, for they are defined by their relationship to something else. A gap, depending on the context and one's viewpoint, might be regarded as a vacant breach or a bridgeable junction. Located just beyond the boundary of things tangible or discernible, gaps invite questions of possibility.

Consider the synapse. This narrow cleft between nerve cells constitutes a cellular discontinuity. The synapse forms a division between living cells. Its shape is the space between the edges of adjacent neurons which are anatomically and functionally distinct from one another. A molecule lingering within the synapse would lie outside the cell border in the narrow 20-40 nanometer void between one neuron's presynaptic membrane and another neuron's postsynaptic membrane.

The synapse is at the same time a nexus of potential continuity. Across its gap surge streams of encoded molecular signals. Highly specialized ion channels and receptors strategically positioned at the edge of the synapse coordinate a bustling flow of chemical messages from one neuron to another. Neurons then integrate excitatory and inhibitory information conveyed through their synaptic connections. From the collective activity of cerebral neurons – joined via synapses – emerge brain functions.

The word "synapse" derives from the Greek words meaning "to clasp together." Physician and physiologist Charles Scott Sherrington, who sometimes referred to the brain as an "enchanted loom," coined the term "synapse" in 1897. Sherrington reasoned that, since "there does not exist actual confluence of the conductive part of one cell with the conductive part of the other, … there must be a surface of separation," or a "nexus between neurone and neurone in the reflex arc."[1]

Meanwhile, also at the turn of the twentieth century, physician and neuroanatomist Santiago Ramón y Cajal was focusing his microscope on the fine structural details of individual neurons, which, stained with Golgi's silver chromate technique, could for the first time be clearly seen. Observing that the neuron at one end issues forth a long slender axon, and at the other end reaches out in many directions with finely arborizing dendrites, Cajal proposed that neurons communicate with each other unidirectionally across tiny gaps. Cajal was the first to postulate that the brain comprises billions of discrete neurons rather than being arranged as a seamless multicellular web.[2] Integral to what became known as the neuron doctrine was the discovery of the synapse.[3]

Ethics & Medicine, 24:3 (2008): 139-142.

The synapse itself would remain invisible for another half century. Although Sherrington inferred its existence from the electroconductive behavior of neurons, and Cajal extrapolated its dimensions from the filamentous outlines of almost-touching neurons, direct visualization of the synapse was beyond the optical resolution of the finest microscopes of the era. Definitive demonstration of the synaptic cleft came in the 1950s, once electron microscopy provided nanoscale magnification of intricate synaptic ultrastructure. Since then, numerous varieties of synapses have been described. The approximately 160 trillion synapses in the adult human cerebral cortex[4] vastly outnumber the 200-400 billion stars in the Milky Way galaxy.

Identification of the synapse closed a gap in scientific understanding while opening the door to investigation of the neuron. Knowledge about neurons has informed the scientific basis of neurology and greatly enhanced the ability to diagnose and treat patients with neurological disorders. Knowledge about the brain continues to grow by staggering proportions. Now that every detail of the brain has become accessible to empirical investigation, there is, in principle, no longer any structure within the brain too small to image or any neural circuit too subtle to trace out.

And yet, there are other cerebral explanatory gaps which persist and perplex. After the synapse, perhaps the greatest challenge today is whether neuroscience can bridge the gap between brain and mind. Each scientific discovery adding to the molecular understanding of neuropsychology draws closer to the ambitious goal of a complete understanding of the brain. Each functional brain imaging study correlating particular thoughts to alterations in metabolic activity in specific cerebral pathways tightens the apparent link between brain and mind.[5,6] One may wonder whether, once technology has brought the inner recesses of the brain fully within view, the mind laid bare will have yielded all its secrets to the scrutiny of neuroscience.

Somewhere within the narrowing gap between brain and mind is what Francis Crick, co-discoverer of DNA's double helix, has called his "astonishing hypothesis," which is "that 'You,' your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behaviour of a vast assembly of nerve cells and their associated molecules."[7]

Crick is correct, up to a point. If he had claimed that mental states "are represented by," or "correspond to," nerves and molecules, then his statement would have been germane to his field of molecular biology. With the words, "are in fact no more than," he has stepped outside the jurisdiction of science and proffered a philosophical assertion which argues that all that is true and can be known about human consciousness is ultimately reducible to matter and its quantifiable interactions.

The philosopher Patricia Churchland, who writes about the brain from the position of eliminative materialism, argues that, "The mind that we are assured can dominate over matter is in fact certain brain patterns interacting with and interpreted by other brain patterns."[8] Continuing, she writes, "In all probability, one's decisions and plans, one's self-restraint and self-indulgences, as well as

one's unique individual character traits, moods, and temperaments, are all features of the brain's general causal organization."[8]

There is much in the writings of Crick and Churchland that can be affirmed in regard to the relevance of recent scientific discoveries about the brain to higher cognitive functions. While the findings of neuroscience are necessary to explain the brain, it does not follow, however, that they are sufficient for a complete understanding of the meaning of human mental states that arise within the healthy brain. A thoroughly reductionistic model of the brain might require one to relinquish belief in personal agency, intentionality, moral knowledge of right and wrong, conscience, and recognition of the sacred, and resign oneself instead to the belief that matter is the supreme reality, and its accidental interactions humanity's sole source of guidance.

Much rhetoric is needed to paint over the cracks that appear in the articulation of materialistic worldviews. These cracks resist being filled with the stuff of materialism. What value can be placed on tenacious insistence in materialism, if insistence is in reality nothing more than a momentary rush of neurotransmitters? How can one validate as rational the assertion that free will is an illusion, if all thoughts, including the assertion and its assessment, are no more than the product of a chain of necessary causation involving molecules and elementary particles? Who could authenticate as truthful the claim that alternative explanations are false, if utterances are merely sounds heard from the mouths of human automata?

Philosopher Daniel Dennett asks, "But why should consciousness be the only thing that can't be explained?"[9] It matters, of course, what kinds of explanation are permitted and which are excluded. This is also a question that presupposes the existence of that which the question treats as hypothetical: explained to whom?

In attempting to close by abolishing the gap between brain and mind, Crick and others before him have exposed the yawning crevasse of materialistic reductionism. Churchland, to her credit, with the words, "in all probability," maintains at least an agnostic foothold on higher philosophical ground. A ceaselessly inquiring mind that recognizes when certainty is warranted and when provisional conclusions are appropriate is less likely to fall into reductionism's confines.[10]

Whereas physicalist interpretations of the mind-brain problem seek to reconcile brain processes with higher mental states, dualistic interpretations from Descartes to Aquinas face the problem of explaining how personal agency interacts with the material brain. Nonreductive physicalist anthropologies, which reject the possibility of an immaterial mind, nonetheless bear the burden of explaining how agency as a nonlocalizable emergent property can exert top-down causation on lower-level streams of material causation.[11]

The temptation common to all these approaches to understanding the brain is to close the explanatory gap prematurely. Some claim certitude from incomplete data. Others find their claims disproven once more data emerge. Others appeal to extraneous categories of knowledge. Still others reason

inconsistently or favor among available options those conclusions that seem to make fewer moral demands personally.

A similar error characterized "God of the gaps" apologetics, which invoked divine intervention as an explanation whenever gaps were found in the scientific evidence. One problem with this approach is that many of these gaps were eventually answered as science advanced, apparently displacing dependence on God. Another problem with this apologetic is the suggestion that God's influence can be seen only in what is not understood, or in competition with natural forces, rather than seeing God's sovereign hand in all of nature. This kind of "God of the gaps" reasoning is no longer accepted as valid within scientifically-informed Christian apologetics.

Gaps are an intractable feature of the landscape of knowledge. Betwixt and between the known and the knowable, gaps persist. A complete explanation of mind, matter and the universe remains persistently elusive to human inquiry. Some of these explanatory gaps are like holes in a jigsaw puzzle awaiting the addition of more scientific knowledge. Other gaps lie at the edge, above, or below the jigsaw puzzle. These gaps are open opportunities to look beyond the empirical patterns to larger answers.

Cajal allegedly quipped that his scalpel could never find the soul.[12] Taking for granted that his scalpel could rightly divide the neuron, this should come as no surprise. Cajal's postmortem brain specimens, dessicated and fixed onto a glass slide, were silver-stained artifacts of life and not life itself. Even the study of living brain cells with modern methods cannot be expected to prove or disprove the existence of the soul. Cajal's scalpel may not have touched the soul, but his pen wandered well into metaphor. In his memoirs, he wrote, "As the entomologist chasing butterflies of bright colors, my attention was seeking in the garden of grey matter, those cells of delicate and elegant forms, the mysterious butterflies of the soul, whose fluttering wings would someday—who knows?—enlighten the secret of mental life."[13]

Gaps, in conclusion, illustrate both discontinuity and continuity. The synapse where one neuron ends and another begins is a double membrane of structural and conductive discontinuity. That is not the whole story, for signals flowing selectively across those gaps create a nexus of informational continuity. Communicating in concert, the sum of synapses signify something greater than the parts.

Neuroscience now peers into the gap between brain and mind. This gap, like the synapse, may be thought of as both continuous and discontinous. The task of science is to seek to fill explanatory gaps. And yet, there are questions that science alone cannot answer with certainty. Though all of nature is subject to scientific investigation, not all that is true regarding the nature of things and minds can be apprehended through the scientific method. Science properly understood accommodates a creative tension between what can be seen and what is abstractly reasoned, between what is known and what can be imagined.

Gaps persist. They force us to seek answers more earnestly. Some answers come not as solved mathematical formulae but as wondrous epiphanies unwritable by equations but hintable through metaphor. Ignoring these gaps, one might measure the brain completely without fathoming the mind or contemplating its Maker.

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10 The habit of ongoing questioning and testing against reality required for productive scientific inquiry may be compared to Paul's admonishment in *1 Thessalonians* 5:17 to "pray without ceasing." (NKJ)

11 For further discussion of dualistic anthropologies, see: Green JB. *What About the Soul? Neuroscience and Christian Anthropology*. Nashville: Abingdon Press, 2004; Green JB, Palmer SL. *In Search of the Soul: Four Views of the Mind-Body Problem*. Downer's Grove, IL: InterVarsity, 2005; Moreland JP, Rae SB. *Body & Soul: Human Nature and the Crisis in Ethics*. Downer's Grove, IL:InterVarsity, 2000; Aiken DW. Why I am not a physicalist: a dialogue, a meditation, and a cumulative critique. *Christian Scholar's Review* 2004; XXXIII(2): 165-180.

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CLINICAL ETHICS DILEMMAS

THE RIGHTS AND RESPONSIBILITIES OF PREGNANT WOMEN

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Editor's Note: *The goal of this column is to address ethical dilemmas faced by patients, families and healthcare professionals, offering careful analysis and recommendations that are consistent with biblical standards. The following ethical analysis is a commentary on a legal case that has caused some controversy in the clinical ethics community.*

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Question

Is it ethically permissible for a woman to forego potentially life-saving treatment for her unborn child?

Case

Melissa Rowland, a 28 year old woman who had been pregnant with twins, was charged by the State of Utah in 2004 with murder and child endangerment for refusing to permit a timely cesarean section that resulted in the death of one of her twins. The story is complicated by the fact that Melissa had four other children (two of which were previously delivered by cesarean section): two were given up for adoption, and one was taken away by child protective services. She carried a diagnosis of oppositional defiant disorder and had been convicted of felony larceny, as well as endangerment of another child in the past. She apparently had traveled from Florida to Utah in order to give these twins up for adoption, and had sought no prenatal care.

In the three weeks prior to her eventual delivery, Melissa did contact two different hospitals in the Salt Lake City area. On December 25 she contacted one hospital by telephone complaining of no fetal movement and was advised to go to a hospital immediately. She did not. She was then seen on January 2 by a physician at another hospital who recommended an immediate cesarean section due to oligohydramnios (abnormally small amount of amniotic fluid), fetal growth retardation, and repetitive fetal heart rate decelerations, but Melissa left against medical advise stating that the scar would "ruin her life" (in spite of the fact that she had had two previous cesarean sections and was warned of the risk of death or brain injury to her twins if she refused treatment). She presented to another hospital on January 9 to see if her babies were alive; no heart rate could be found on one of the twins by external monitor, but again Melissa left against medical advice. Finally she returned to one of the hospitals on January

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13, and was delivered by cesarean section; twin A was a stillborn male infant, and twin B, a girl, was found to have cocaine and alcohol in her blood at birth. The medical examiner determined that the stillborn male had no congenital anomalies and had died about two days prior to delivery.

After being charged with murder and child endangerment, Melissa ultimately pled guilty to two counts of child endangerment. Her sentence of consecutive prison terms and fines were suspended in lieu of 100 hours of community service and 18 months of probation, including completion of outpatient mental health and substance abuse treatment, a rehab program, and a parenting skills class. Melissa, however, left the state and complied with none of her probation stipulations. Ultimately, her surviving child was removed from her home as well. The Utah district attorney declined to have Melissa returned to the state.

Discussion

This case generated a great deal of controversy in the court room as well as in the media. Charging a mother with murder for willfully contributing to the death of her unborn child was seen by many as an egregious violation of a woman's autonomy rights, as well as another step in the drive to undermine abortion rights by conferring the status of personhood on the unborn. In the December 2004 issue of Obstetrics and Gynecology there appeared two editorials written by prominent physicians and an attorney criticizing the charges brought by the State of Utah and delineating the ramifications for women's health and reproductive rights should such actions become a precedent.[1] Their position was reiterated by the American College of Obstetricians and Gynecologists (ACOG) in a Committee Opinion published in November 2005 entitled, "Maternal Decision Making, Ethics, and the Law."[2] In it, a "predominantly child-centered approach" to reproductive ethics that views the fetus as separable and independent from the mother was criticized as "paradigmatically adversarial" in its emphasis of the divergent rather than convergent interests of the mother and fetus. In spite of its emphasis on "shared interests," the article maintained that the autonomy and personhood of the woman (as opposed to the unborn child) is indisputable, and that informed consent from the mother for any intervention on the part of the fetus is an ethical obligation of the obstetrician, which must be respected and adhered to regardless of the consequences. The fallibility of physicians and of medical knowledge was cited as justification for such maternal right of refusal: "Criminalizing women in the face of such scientific and clinical uncertainty is morally dubious."[3] In their view, coercive and punitive policies with regard to pregnant women would adversely affect infant mortality rates by undermining the physician-patient relationship, and would create the potential to criminalize many types of otherwise legal maternal behavior (smoking, obesity, etc.).

These opinions, however, are based on the erroneous presupposition that autonomy is an absolute right which must be protected in all circumstances and at all costs. To the contrary, autonomy is not a "right" but a principle which is neither absolute nor inalienable. In its original sense, as developed by Kant and Hume, autonomy referred to social enablement of individual responsibility—to

empowering one to take responsibility for one's choices rather than making one's choice the standard of right and wrong. As such, autonomy is understood to be limited by one's responsibility towards others, especially when a potential for harm exists. Pregnancy, with its inherent maternal fiduciary and beneficence-based responsibility for an "other," is one circumstance in which individual autonomy is limited.[4,5]

Legal precedents for the prosecution of mothers for injuring their children in utero are equivocal and contradictory. There is no consistent message in state or federal courts regarding the liability of a mother for the death of a child in utero from failing to consent to medical treatment.[6] Both editorials noted above cited *McFall v Shimp* (10 Pa D&C3d 90, CP Ct 1978) as a precedent for their position that a woman not be required to undergo a cesarean section for the benefit of her unborn child. In *McFall v Shimp*, the courts declared that a man could not be compelled to donate bone marrow to his cousin, even though he was the only compatible donor. What the authors of the editorials fail to acknowledge in citing this case is that there is a vast difference between the relationship and responsibility of first cousins (as in *McFall v Shimp)* and that of a mother and unborn child. The maternal-fetal relationship is qualitatively unique in the realm of medical ethics. The maternal decision to carry a child to term creates a beneficence-based fiduciary obligation on the part of the mother (and physician) to act in the best interest of the unborn child, and to sacrificially care for and nurture that child, an obligation which does not exist between first cousins.[7,8]

It has been argued that the ruling of the Utah court invalidates the notion of "informed consent," depriving pregnant women of customary rights. In reality, the court simply held Ms. Rowland culpable for the death of her unborn child, as it would anyone who knowingly caused the death of another human being. Conversely, what is advocated by those who would oppose any interference with a woman's autonomous reproductive rights, is that pregnant women be granted a privileged status, one that would exempt them from the responsibility and culpability for their choices and actions, placing their "informed choice" beyond accountability—a responsibility to which we would hold any other competent individual. For example, while we allow people to choose to drink alcohol and to assume the responsibility of operating a motor vehicle, we prosecute them for driving while intoxicated, or for killing or endangering the life of someone by driving under such conditions. Why should pregnancy, a state of heightened responsibility, exempt women from accountability for irresponsible and illegal behavior? Was Melissa Rowland competent to make an informed choice? Interestingly, while the court did not directly address the issue of Ms. Rowland's competency, it did so implicitly by justly suspending her sentence while simultaneously sanctioning care.

The employment of a "slippery slope argument," evidenced in all of the above editorials, is a non sequitor. While tobacco abuse or excessive weight gain during pregnancy do have detrimental effects on the unborn child and are not ideal, they are not illegal; cocaine abuse and murder are. Such speculation does not offer a viable prudence-based objection.

Obstetrics has always been a uniquely privileged specialty where responsibility and care must be rendered for the needs of two individuals—two living human beings—simultaneously. Historically, those practicing obstetrics have been advocates for both mother and child, a fact which has always been ripe with both challenges and rewards; the "art" was finding the "win-win" solutions—the balance between autonomy and beneficence—to the dilemmas posed. Nevertheless, abortion advocates would now have us believe that the unborn child is not a person, and therefore not a patient separate from the mother, but merely a parasitic appendage to be cared for only with the mother's consent. In this perspective, taking the life of the unborn is not murder. (In Illinois, charges of murder do not apply unless the child is killed after the umbilical cord is cut and full separation from the mother has occurred.)9 Our failure as a culture to define "personhood" (and hence "rights bearer") on non-arbitrary grounds has resulted in a definition based on convenience—one that has led to such inconceivable devaluation of life. However, while we have chosen not to grant the at-term fetus the status of independent moral agent, it is still a patient, with beneficence-based rights, like any other dependent, non-autonomous living human being.[10] Regrettably, as the focus of responsibility in obstetrical care has thus shifted solely to the mother, no advocate for the unborn child remains in circumstances where their "interests" are divergent, a fact which is morally repugnant and intuitively unjust.

Minkoff and Paltrow stated that "the best protection for a fetus lies in the protection of the rights of the individual best positioned and most highly motivated to defend its interests: an informed and empowered mother."[11] Melissa Rowland was "informed and empowered" and yet unreasonable, displaying a "depraved indifference to human life." A vaginal birth in a woman with two prior cesarean sections, a twin pregnancy, oligohydramnios, fetal growth restriction, and abnormal heart patterns was certainly a choice, but not an evidence-based, medically indicated alternative by any criteria. The risk of maternal death in this situation was commensurate with, if not greater than, the maternal risk from a repeat cesarean section. Conferring the status of absolute right to maternal autonomy not only places it beyond accountability but threatens the integrity of our profession as well. As human physicians, our knowledge is imperfect, and we and our medical judgments are fallible; but they are made with prudence, without malice, and with the intent of balancing the interests of both parties, in accordance with our responsibility to "do no harm." Can we in good conscience allow our medical judgments—whether to fight to save the life of an unborn child or to sit idly by and watch it die unnecessarily—to be determined merely by the autonomous will of the mother?

As human beings, we are not independent, autonomous, self-sufficient monads but interdependent, social beings. Our existence, individually and corporately, is as dependent upon mutual responsibility as it is upon rights. We were conceived and born in the hopes, dreams, and desires of others and are bound together by duties of care, responsibility, and compassion. Unfortunately, we have been so blinded by the tyranny of autonomy that we no longer recognize the necessity for responsibility in our choices and behaviors. Likewise, in our

promotion of women's reproductive rights, we have divorced rights from their corresponding responsibilities and neglected the fact that pregnancy is more than a right; it is a self-sacrificial responsibility, one in which a mother gives of herself that another may live.

What kind of people do we wish to be? Do we wish to live in a society founded on mutual respect and responsibility, or one ruled by the tyranny of unbridled autonomy and self-centered irresponsibility? As a profession, we are in a unique position to positively impact our culture through respect, education, and compassionate concern for all individuals entrusted to our care, born and unborn alike. Nevertheless, there will continue to be tragic individuals and situations, such as Ms. Rowland, for whom we have no reasonable recourse in the exercise of our moral and fiduciary responsibilities except legal sanctions. Yes, women should be free to make "informed" choices in the context of their beneficence-based responsibilities, but such freedom should not exempt them from culpability when their autonomous decisions harm others.

Endnotes

1 Richard Berkowitz, MD, "Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense,", and Howard Minkoff, MD and Lynn Paltrow, JD, "Melissa Rowland and the Rights of Pregnant Women," *Obstetrics and Gynecology* Vol. 104, no 6 (December 2004): 1220-1221, and 1234-1236.

2 ACOG Committee Opinion, "Maternal Decision Making, Ethics, and the Law," *Obstetrics and Gynecology* Vol 106, No. 5 (November 2005): 1127-1137.

3 Ibid., 1133.

4 Mark S. Komrad, "Defense of Medical Paternalism: Maximizing Patient's Autonomy," *Journal of Medical Ethics* 9 (1983): 41.

5 Frank Chervenak, MD, Lawrence McCullough PhD, and Daniel Skupski, MD, "An Ethical Justification for Emergency, Coerced Cesarean Delivery," *Obstetrics and Gynecology* Vol 82, no 6 (1993) [journal on-line]" available from http://www.acog.org/publications/green_journal/1993-1994/BOG82!29.txt; accessed -01 February 2006.

6 Marshall L. Wilde, LL.M, "Rowland Case Illustrates Maternal-Fetal Conflict," [commentary on-line]; available at http://www.law.uh.edu.healthlawperspectives/Reproductive/040325Ro; accessed 28 April 2005.

7 Ibid.

8 Scott B. Rae, "The Unkind Cut of Forced C-Sections," [commentary on-line]; available from http://www.cbhd.org/resources/reproductive/rae_2004-08-13_print.htm; accessed 01 February 2006.

9 The People of the State of Illinois v. Elizabeth Ehlert, document no. 1-00-0273. (Illinois Appellate Court 2002) [database on-line]; available at http://www.state.il.us/court/Opinions/AppellateCourt/2002/1stDistrict/November/Html/10; accessed 10 April 2005.

10 Frank A. Chervenak, MD, and Lawrence B. McCullough PhD, "The Fetus as Patient," *Fetal Diagnostic Therapy* 1991; 6: 93-100.

11 Howard Minkoff, MD and Lynn Paltrow, JD, "Melissa Rowland and the Rights of Pregnant Women," *Obstetrics and Gynecology* Vol. 104, no 6 (December 2004): 1220-1221, and 1234-1236.

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COMPLICITY AND STEM CELL RESEARCH: COUNTERING THE UTILITARIAN ARGUMENT

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Once the principle of universal human rights and dignity is broken, the weak will always risk suffering at the hands of the powerful. It is a situation that we all should want to avoid.[1]

Introduction

The value placed on human life in all its stages of development constitutes a central aspect of a culture's moral thinking. When the 1973 U.S. Supreme Court decision in *Roe v. Wade* granted the right to unrestricted legal abortion to all American women, it established a dubious "right of privacy" as more fundamental than the intrinsic presumption of fetal personhood, as defined by the Fourteenth Amendment of the US Constitution. Today the debate over human embryonic stem cell research may set moral and legal precedents that will plow deep furrows in our nation's conscience, far more than *Roe*. The discussion has been heated and divisive because of the serious scientific, ethical, philosophical, and theological issues involved.

A neglected element in the current debate is that of *moral complicity*. If we assume the personhood of the embryo, and that killing an embryonic human being is a moral evil, then those who provide reason, circumstance, and means for the act share complicity with that evil. This paper will examine and critique a utilitarian argument that seeks to justify such complicity.

Background

Human embryonic stem cells (hES cells), derived from frozen embryos "left over" from *in vitro* fertilization (IVF) procedures, have the promise of curing a variety of human ailments. Because hES cells can act as "starter" cells to grow new nerve tissue, heart muscle tissue, or glandular tissue, many scientists are excited about potential treatments or even cures for heart disease, strokes, Parkinson's disease, diabetes, and many other disabling conditions. Yet producing hES cells requires the destruction of the embryos that contain them, entities that many pro-life Christians hold to be human persons with rights.

Current U.S. policy permits private companies to engage in hES cell research, but prohibits federal funding (e.g., through the National Institutes of Health), except for a limited number of stem cell lines from embryos that had already been destroyed.[2] At issue are two major themes. First is the sanctity of human life. Many object to the destruction of embryos to obtain hES cells, since they believe that embryos are human persons, and thus have basic human rights.[3-9]

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The second theme is the utilitarian rationale for the use of such embryos, since "they are going to be destroyed anyway."

The utilitarian argument has not received as much attention as the first, yet is an important key to justify hES research. If one assumes that frozen embryos are going to be discarded anyway, why not utilize them for research? Even if one is distressed by the destruction of an embryo, isn't it better if some good can come from it? The utilitarian argument seems to make some sense, and deserves a thoughtful response.

Notice that no one makes this argument unless, at least for the moment, he assumes that embryos are persons. In others words, why bother to justify a destructive action towards mere biological tissue? The utilitarian argument is based on the idea that one can assume embryos to be persons and still destroy them. Yet there are two questionable assumptions inherent in this approach: 1) eventual destruction of embryos is inevitable, and 2) those that benefit from embryo destruction are not complicit in that morally evil act.

Ethical Assumption #1: The Inevitability of Embryo Destruction

The first questionable assumption is that embryos are destined for destruction. However, just because embryo destruction is a possibility does not make it a certainty. In fact, there are at least five possible outcomes for unused frozen embryos. First of all, embryos may simply be implanted in the wombs of those who provided gametes for their creation. In fact, Christian physicians who affirm the conception view of human personhood often recommend that *only* those embryos that will eventually be implanted be created in the first place,[10] obviating the problem of "leftover embryos" that has led to the present debate.

Another alternative is to release frozen embryos for implantation into another womb. Such "embryo adoption" can provide childless couples the joy of having a baby, while at the same time acting on behalf of another.[11] Bevington is more to the point: "[Embryo adoption] will prevent a pre-born human being from being subjected to destruction at the hands of fertility clinicians or medical researchers."[12] Embryo adoption is readily available to those who wish to pursue this idea, and the success rate for achieving pregnancy and carrying a child to term is similar to that of routine IVF.[13] The Snowflakes Embryo Adoption Program is the best-known non-profit organization,[14] but some commercial centers offer this service as well. The federal government has even earmarked nearly $1 million to promote this idea,[15] with $500,000 of the grant going to Snowflakes.[16]

From a legal perspective, embryos are property, whose disposition is the sole prerogative of the "owners." Yet the law has been ambiguous, often claiming that embryos are "irreplaceable" and "unique."[17] The conflicting and arbitrary state of current law regarding IVF and the embryos derived from it has been discussed recently by Capron.[18] Of course any legal claim is specious if a prior claim of moral personhood can be established (cp. abortion, which would be morally wrong though legal).

So, setting the procreative options aside for the moment, the third option would be to leave frozen embryos in their current state of physical, moral, and legal limbo, with the parents / owners unwilling or unable to decide their fate. Of course, this sort of non-decision may lead eventually to the destruction of the embryos, but the limit of long-term storage of frozen embryos is not yet known.

The fourth choice, then, is to request that frozen embryos be destroyed. By far, this is the most common outcome for unused frozen embryos, *by explicit decision of the parents / owners*. In a recent survey of 1246 couples who had decided to no longer try for a pregnancy themselves, the great majority (89.5%) requested that their frozen embryos be destroyed, even though other options were available.[19] Another survey of over 3800 couples revealed that 9.1% would be willing to donate their embryos to another couple for adoption,[20] while a separate study of 509 couples revealed that about 10% would consider donating their embryos for stem-cell research.[21]

The fifth option, donating embryos for stem cell research, is therefore not the most common choice, and almost as many couples are willing to give them up for adoption. All five of these options are available for the couples who have legal control over them. Even though most might wish to have them destroyed, this is a conscious choice, and therefore *not inevitable*. Subtle factors related to clinician and fertility center biases have an enormous influence over the final outcome. If more centers actively supported and enthusiastically promoted the idea of embryo adoption, then this would surely be a much more frequent outcome. With this in mind, "inevitable destruction" becomes no more than a moral smokescreen for a utilitarian agenda.

Ethical Assumption #2: Moral Complicity

So if killing embryos is a moral evil, who participates? Does the moral blame reside merely with the laboratory technician who flushes the cryogenic canister down the drain, or does responsibility for the act include the physician or fertility center director who authorized this? What is the role of the owners of the embryos? Whether or not they are the biological parents, they have the legal power to make decisions about their fate. Should they be morally culpable as well? One may rightly ask, "Who benefits from the death of this embryo, and should that person bear some of the moral responsibility as an agent of its destruction?" This introduces the idea of *moral complicity*.

Moral complicity refers to the possible taint of moral guilt attached to a person by association with a moral wrong. For an example from law, an accomplice or accessory to a crime is just as culpable as the person who actually performs the deed.22 Speaking from a moral perspective, complicity requires that a person have some association with the act committed, even if she does not perform the deed herself.

As an example of the argument from complicity, consider the use of fetal tissue to develop and obtain vaccines for widespread use. Such was the case with the rubella vaccine, a live (though attenuated) virus developed in tissue

culture from aborted fetuses.[23] A number of other commonly-used vaccines have had a similar source, including Poliovax for polio, Havrix for hepatitis A, and Varivax for chickenpox.[24]

Alternative sources are available for all but three of ten commonly-administered vaccines currently in use.[25] Many would make a strong case against using vaccines derived from aborted tissue, because of the idea of complicity with the original unethical act:

> "Immediate material cooperation" is complicity in an action which one does not formally approve, but in which one is so closely involved that one shares its evil. The [vaccine] cell-line researchers were almost certainly immediate material cooperators. Pharmaceutical researchers made no effort to avoid the morally problematic cell line, and thereby spread the effect of the abortionists' evil intent.[26]

Vaccine *users* (physicians and their patients) are further removed from the original act, however. Even though some writers claim that physicians should not use them (as above), there seems to be a sense that the passage of time reduces complicity to a morally repugnant act.[27]

But the passage of time does not always help to "morally sterilize" an act. Consider the story of Eduard Pernkopf , a distinguished professor of anatomy who published his *Atlas of Topographical and Applied Human Anatomy* between the years 1933 and 1960. This is a four-volume masterpiece of 800 detailed watercolor paintings of human anatomy, used extensively by European medical schools in the latter part of the twentieth century. In February of 1997, the University of Vienna began an extensive investigation into the subjects used to produce the *Atlas*. Their conclusion: 1,377 persons put to death during the Nazi era had been delivered to the Institute of Anatomy, and very likely some of these victims were portrayed in the *Atlas*. Indeed, many of the artists were members of the Nazi Party, and Pernkopf himself was a fascist and a Nazi sympathizer. The *Atlas of Topographical and Applied Human Anatomy* has now disappeared from the libraries of many medical schools because of the moral taint associated with its production. (For a useful summary of the *Pernkopf Atlas* issue, see Seidelman.[28])

It seems curious that moral complicity appears to be assuaged by time in the vaccine case, whereas the passage of time does not help in the *Pernkopf Atlas* case. What determines the difference? Whatever it is, the reader should at least understand that moral complicity is multifactorial. (For an in-depth discussion of moral complicity from theological and scriptural perspectives, see Pura.[29])

Applying the concept of complicity to embryonic stem cell research, it appears that all parties—researchers, technicians, donor parents, and experimental subjects—are associated in some way with the destruction of the embryos, and therefore complicit in the original immoral act. At least in the case of certain parties, such as researchers and treatment subjects, this association also entails benefit, strengthening the sense of complicity. This should be seen as a powerful argument against hES research under any circumstances.

A Moral Analogy

The following moral analogy should help to amplify these criticisms of hES research. The reader should assume, for the sake of the argument, that the sanctity argument is true, i.e., that human personhood begins at the moment of conception. Also, please assume that complex legal matters can be resolved.

1. A six year-old girl is in a major car accident, and declared brain dead. Her loving parents anguish over the decision, but reluctantly agree to donate her liver. Your son, who has a rare liver disease, is the fortunate recipient. You are clearly morally justified in accepting the donated liver for your son.
2. Let us change the *agent* of the little girl's death. A drunk driver caused the accident. Even worse, that driver was the girl's father. But you are not morally responsible for the circumstances that led to the girl's death, and are still morally justified in accepting the donated liver for your son (this of course ignores the thorny issues of informed consent on the part of the donor's parents).
3. Let us change the *manner* of the little girl's death. The father, instead of being a drunk driver, is insane. He uses a handgun to shoot his daughter in the head. You are still not morally responsible for the circumstances that led to the girl's death, and could justify accepting the donated liver.
4. Let us change the *agent* of the little girl's death once more. You know that the girl's father is violently disposed towards his daughter, and that he plans to kill her. You reason, "He will kill her anyway, so my son may as well benefit from the girl's liver." You take a gun and kill the girl yourself. Now you are *clearly* on the other side of the moral fence. No reasonable person would argue that you are morally justified in doing this, even if, for some reason, the death of the little girl at the hands of her father is inevitable.
5. Let us change the *circumstances* of the little girl's death in another way. You decide not to kill the girl yourself. However, you pay the father $10,000 to pull the trigger, so that your son may benefit. No reasonable person would argue that you are morally justified in doing this, even though you did not commit the act yourself. You are just as morally culpable.
6. Let us change the *moral contract* between you and the father. No money changes hands. However, you plead with the father to kill his daughter, saying "Your daughter's liver is my son's only hope." Of course, you do nothing to prevent her death. No reasonable person would argue that you are morally justified in doing this (from a legal perspective, this would be conspiracy to commit murder).
7. Finally, let us now simply change the *age* of the little girl who dies to provide your son with a liver. Now she is no longer six years

> old. In fact, she is an embryo. Her father is willing to destroy her to provide stem cells to treat your son's liver disease. You are just as morally culpable (i.e., you are morally complicit in the evil) as the father if you accept this offer.

Note that the premises and the conclusions drawn follow directly from each other *if the sanctity argument is granted*. The analogy relies on commonsense ideas of a shared moral culpability, to reach the conclusion that there is *never* a justification to destroy embryos to benefit others, no matter what their supposed inevitable fate.

Some would claim that this analogy is unfair, in that embryo donors and stem cell recipients would never know each other personally. On this view, a moral distance also exists between the fertility clinics and the researchers that created the embryos through IVF. Yet each would *benefit* from the relationship, however tenuous and anonymous. Since a physical benefit may accrue to patients receiving hES treatments, and since academic or monetary benefits would accrue to those engaged in the research, it seems disingenuous to assert in either case that "a sort of moral autoclave will sterilize the tissue ethically so that it can be used without contamination by association with its method of supply."[30] It is this mutual benefit from an evil act wherein moral complicity lies.

Throughout this analysis we have made the assumption that the act of destroying embryos is a moral evil, because embryos are in fact human persons. Such an assumption is reasonable in order to examine the utilitarian argument for their destruction, *viz.* "they are going to be destroyed anyway." As pointed out earlier, personhood is implicit in making such a statement.

The analogy also makes one thing clear: this situation is *not* identical to that of using vaccines derived from abortions in the distant past. No passage of time can morally sterilize the act of embryo destruction, and thereby release the beneficiaries from complicity, because embryos are destroyed *for the purpose of* medical research or treatment. This immediacy in the use of stem cells from destroyed embryos should make the complicity of all parties easier to discern.

Conclusion

In the thirty-plus years since *Roe v. Wade*, utilitarianism has become a dominant ethical rationale, even among some conservative thinkers who honor the sanctity of human life from conception. This article has examined some of the hidden issues in the utilitarian argument, and has presented a moral analogy to clarify the idea of complicity. As utilitarian arguments gain ascendancy over Christian ethics in our society, a decline in the value of human life will surely occur. Respect for life demands foregoing practices that diminish human dignity and worth. Otherwise, human beings may lose sight of their identity as persons, made in the image of a loving Creator.

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AN ETHICAL ANALYSIS OF THE HARM REDUCTION APPROACH TO PROSTITUTION

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Abstract

Prostitution has been found to be a major factor in the global spread of HIV/AIDS, especially in Africa and Asia. Over the past several years, millions of dollars have been funneled into programs that seek to limit the spread of HIV/AIDS by providing condoms to prostitutes and increase their utilization through education and the 'empowerment' of prostitutes. Those following this approach, termed a 'harm reduction' approach to prostitution, continue to demand more funding for future programs in spite of the lack of an ethical basis for this philosophy. Alternatively, efforts to fight prostitution by others have been geared toward the elimination of prostitution in what could be termed a 'rescue and restore' approach to prostitution. Since prostitution is inherently a harmful activity, to seek reduction of harm rather than its elimination creates an ethical dilemma. An ethical analysis of the harm reduction philosophy as opposed to the rescue and restore philosophy will be performed using an accepted ethical framework for public health issues.

Introduction

In 2003, Congress enacted the "United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003".[1] This legislation authorized funding in the amount of fifteen billion dollars to fight the global spread of HIV/AIDS through what has become known as the PEPFAR funds (President's Emergency Plan For AIDS Relief). Unfortunately, this legislation has ignited a political firestorm in Washington over the issue of how funding may be allocated when groups are targeting prostitution in their anti-AIDS efforts. The Act specifically states, "No funds made available to carry out this

Act, or any amendment made by this Act, may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking."[2] The Bush Administration has come under attack for its enforcement of this provision, which espouses what will be labeled the 'rescue and restore' approach to prostitution. The rescue and restore approach seeks to remove men and women from prostitution and restore them to a lifestyle that is productive within society. An alternative view, known as the 'harm reduction' approach, believes that efforts to eradicate prostitution, while ideologically commendable, are often unrealized, and instead chooses to focus time and energy on reducing the various harms that are prevalent within prostitution. This attack was renewed recently when President Bush announced that he was asking Congress to approve an additional fifteen billion dollars to be

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spent fighting AIDS after the current funding expires in 2008.[3] The controversy centers on the fact that harm reduction techniques, such as the provision of condoms to prostitutes, often allow for the continuation of prostitution and its other related harms whereas a rescue and restore approach seeks to abolish prostitution and all its attendant harms. Strategies for reduction of harm in prostitution have been described.[4] Unfortunately, very little has been written on the ethical basis for promoting a harm reduction approach to prostitution, as opposed to a rescue and restore approach.

History of Harm Reduction

Harm reduction as a philosophy was developed in an effort to deal with the issue of illicit IV drug use and its association with the spread of HIV/AIDS. However, even within the drug abuse arena, there has been controversy as to whether the definition of harm reduction should encompass programs that were oriented toward abstinence. Narrow definitions of harm reduction excluded abstinence-oriented programs, while broader definitions were comfortable including them.[5] Lenton and Single chose to include abstinence-oriented strategies within their definition of harm reduction which had three necessary conditions: "1) the primary goal is the reduction of drug related harm rather than drug use *per se*; 2) where abstinence-oriented strategies are included, strategies are also included to reduce the harm for those who continue to use drugs; and 3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug-related harm."[6] The most common harm reduction strategy within illicit IV drug use is the provision of sterile needles and syringes to IV drug users for the purpose of reducing needle sharing.

This harm reduction approach was later adapted as a framework for dealing with the issue of prostitution and its involvement in the spread of HIV/AIDS. Within the field of prostitution, the task of harm reduction has been defined as follows: "To reduce existing vulnerability amongst sex work entrants; and to ensure that sex work does not introduce further vulnerability."[7] While harm reductionists in prostitution refuse to reject the ideal of the abolition of prostitution as an end point, in practicality, it is usually ignored. As this purpose statement clearly shows, the possibility of someone within prostitution continuing in that activity under a harm reduction program is not only possible, but actually expected.

Examining the ethical foundation for harm reduction in illicit IV drug use, Fry et al. pointed out that harm reduction in illicit drug use has been operating without an explicit moral framework and that the lack of development of ethical underpinnings for harm reduction has been to its detriment.[8] They point out that at a *macro-ethics* level, there are many questions regarding harm reduction within illicit drug use that remain unanswered and suggest an 'ethics engagement' through further dialogue on harm reduction ethics. This lack of a good ethical foundation within the harm reduction philosophy is also related to the fact that within public health in general, the discipline of ethics has been slow to develop.[9,10]

As might be expected, as harm reduction has transitioned from illicit IV drug use into prostitution, the poor development of ethical underpinnings that has characterized harm reduction continues in the realm of prostitution. A recent PubMed search entering the key words of 'harm reduction', 'prostitution', and 'ethics' yielded absolutely no results. In her commentary on the transition of harm reduction from drug use to prostitution, Cusick concludes that prostitution is a suitable arena for development of the harm reduction agenda, but fails to discuss any ethical justification for harm reduction in prostitution as opposed to the rescue and restore approach.[11] Cusick promotes a harm reduction approach to prostitution because she concludes that the harms associated with prostitution are related to vulnerability and are not inherent to the activity itself. Therefore, if vulnerability can be eliminated, it might be possible to completely remove all harm from prostitution. This overly simplistic approach incorrectly minimizes the harms that result to the self-esteem of every person involved in prostitution and wrongly assumes that vulnerability to sexually transmitted infections can be completely eliminated through condoms.

Ethics in Public Health

As new ideas and approaches are introduced into the field of public health, it is important that they be evaluated scientifically with all available empiric data. But the evaluation must not be limited to scientific evidence alone. It is critical that any new approach such as harm reduction be examined on an ethical basis as well. A framework for ethical analysis in public health has been suggested by Roberts and Reich [12] and will be used to analyze the harm reduction approach to prostitution as opposed to the only known alternative at this time, the rescue and restore approach to prostitution where it is legally prohibited. This suggested analytic framework includes the three philosophies of utilitarianism, liberalism, and communitarianism.

Utilitarianism

Utilitarianism evaluates a planned action on the basis of the consequences of that action. The action that promotes the greatest good for the most people is generally seen as ethically justified within the philosophy of utilitarianism. Though variations of utilitarianism exist, and there are controversies surrounding the issue of how to define 'good', it remains a useful philosophy to evaluate the two different approaches to prostitution.

The harms of prostitution have been reviewed,[13] revealing among other things that prostitution has an increased mortality rate,[14] with one report showing a 1% chance of being murdered while working as a prostitute.[15] Other reported harms of prostitution include violence,[16] increased sexually transmitted infections,[17] significant emotional disturbances,[18] and concomitant drug use.[19] Prostitution therefore must be viewed as a very dangerous activity for the vast majority of those who engage in it.

Approaching the issue of prostitution from a harm reduction perspective differs from the rescue and restore approach mainly by undertaking small interventions that reduce harm rather than seeking to remove all harm

in prostitution through its elimination. Utilitarianism would see both the reduction of harm and the elimination of harm as good, but could only justify harm reduction above elimination if the total good achieved in harm reduction was greater than the good achieved by the same amount of effort in a rescue and restore approach. In other words, the good achieved if one million dollars were spent to distribute condoms to prostitutes in the harm reduction approach would have to be greater than the good achieved if the same amount of money was spent to remove prostitutes out of prostitution. A recent evaluation of a harm reduction program in India focusing on prostitutes found that the intervention would only prevent 22-35% of new HIV infections among prostitutes if performed in a low transmission setting, and if the same intervention was performed in a high transmission setting, it prevented only 11-17% of all new HIV infections.[20] Therefore, harm reduction quantitatively reduces harm in the form of HIV spread in only a minority of those directly involved in the intervention. In addition, while reducing HIV spread is certainly viewed as a good, condoms would do nothing to eliminate the potential for violence and other harms associated with prostitution. It is in fact very possible for a prostitute to successfully negotiate condom use only to find the client being very abusive and inflicting significant physical harm during the course of the sexual encounter. In this case, one harm would be lessened, but the total harm incurred by that prostitute would not necessarily be significantly altered.

There are other harm reduction strategies that attempt to address the issue of violence in prostitution, such as education and empowerment, but none of these strategies is capable of completely removing the possibility of violence. By its very nature, prostitution will always have some risk since it involves two people with one person in a position of some vulnerability. In addition, education and empowerment may have an effect in reducing violence for a period of time, but these effects are often temporary and will require repeating since within the harm reduction paradigm, the person continues in the activity that exposes them to potential harm.

In the rescue and restore approach, one million dollars spent exclusively on removing men and women from prostitution will have a clear and definite good measured in the number of individuals successfully removed from prostitution. The potential harm for these individuals will not be reduced by just 35%, but will be totally eliminated. In addition, the harm will be eliminated, not only from a particular sexual encounter, but also from that point forward because the person is no longer working in prostitution. With the rescue and restore approach, therefore, there is a clearly defined consequence that is seen as good, the complete removal of all harm from prostitution for that individual. The quality of that good is strengthened by the fact that it is permanent rather than temporary. Through the lens of utilitarianism, then, because the good achieved through rescue and restore appears more complete and permanent than that achieved through harm reduction, rescue and restore appears to be the ethically superior approach to prostitution. Therefore, the onus is on harm reductionists to show the good achieved through their approach is greater than that achieved through the rescue and restore approach.

Liberalism

The second philosophical view in the framework of Roberts and Reich is liberalism. Here liberalism means to respect and maximize the rights of the individual and not use people as a means to another's ends, along the lines of the teaching of Immanuel Kant. A particular action or program is seen as ethically justified if it adequately respects the individual and does not overtly impinge on their individual human rights.

Prostitution itself, by its very nature, severely impinges on individual human rights since the vast majority of prostitution is pimp controlled.[21] As a result of being under the control of a pimp, the prostitute is often unable to negotiate condom use or the type of sex act performed. This control also includes financial exploitation. In addition to the client (John) who is benefiting from the act of prostitution, a third party outside the client is gaining financially from the transaction. The prostitute is often forced to give all or most of their proceeds to the pimp. The amount of financial gain for the pimp is directly related to the degree of exploitation of the prostitute, which further compromises the rights of that prostitute. This exploitation and lack of individual rights within prostitution is shown by the fact that in one study 92% of prostitutes stated that they wanted to leave prostitution immediately.[22] If over 90% of people working in a particular activity want to leave, the most ethical action would be to help them leave it, not simply reduce their harm within the activity. In fact, harm reduction may actually become unethical if as a result of reducing harm, the person being exploited is enabled to remain in an activity that is inherently unequal rather than being forced out completely as a result of the harms incurred.

In order for harm reduction to be ethically viable within the framework of liberalism, it must insure that all the rights of the prostitute are protected within their program. Since their program includes continued activity within prostitution, all the rights of individuals must be protected, not just those of confidentiality and autonomy. It is not enough to distribute condoms and educate prostitutes while maintaining confidentiality, and yet allow them to return to a highly exploitative environment. Liberalism by definition means an environment as free of exploitation as possible. Therefore, ethically harm reductionists should be working to remove all forms of exploitation found in prostitution, such as pimp control. Not only should efforts be geared toward removing exploitation, but safeguards would need to be established that effectively guarantee the ongoing rights of the prostitutes. Finally, it should be understood that removing all forms of exploitation within prostitution does not remove all harm since, for instance, the threat of sexually transmitted infection still remains.

The rescue and restore approach to prostitution would end all forms of exploitation because it is removing the person from prostitution. Since the removal would be permanent, there would be no need for additional resources to be devoted for the ongoing enforcement of human rights. In addition, with the rescue and restore approach, once again, all harms are removed, not just

those associated with exploitation. Until the harm reductionists have shown their ability to remove all forms of exploitation from within prostitution, the rescue and restore of individuals from prostitution appears to be ethically superior to harm reduction within the philosophy of liberalism.

Communitarianism

The third philosophy within the ethical framework of Roberts and Reich is communitarianism. Communitarianism draws from the teachings of Plato and Aristotle and seeks to promote activities that create a good society. What is good may be defined by the individual community or may be based upon universally agreed criteria, but in either case, good would be viewed as what is positive for the community. While prostitution may provide a means of income for those involved, it is rarely seen as a positive for the community at large. Even in locations where prostitution has been legalized such as in Amsterdam, there are resulting community problems, such as an associated increase in organized crime that has accompanied prostitution.[23] In addition, the negative effects of prostitution upon community businesses have been chronicled.[24] Another negative effect of prostitution upon the community is the spread of sexually transmitted infections to innocent parties within the community, such as the wives of the men who visit prostitutes. Harm reductionists assume that the spread of sexually transmitted infections can be minimized through a combination of condom use and regular STI testing of the prostitutes. This approach minimizes the fact that while condoms reduce the spread of sexually transmitted infections, they do not completely eliminate them. An NIH workshop on condom effectiveness concluded that there was insufficient evidence regarding the condom's ability to prevent the spread of chlamydia, gonorrhea in women, trichomonas, herpes, syphilis and chancroid.[25] The ability of the condom to prevent the spread of HIV/AIDS was estimated at 80% within the Cochrane database.[26] Finally, a regular HIV testing program within the adult film industry has already been reported as unsuccessful in the prevention of the spread of HIV/AIDS.[27] Therefore, all available evidence seems to point to the fact that regarding communitarianism, the most ethical action regarding prostitution when it comes to the community at large is rescue and restore, rather than a harm reduction approach that allows the activity of prostitution with its associated harms to continue.

Conclusion

In summary, though harm reduction as a philosophy has been used for a number of years within the field if illicit drug use, the ethical underpinnings of that philosophy are still being worked out. As harm reduction has transitioned from drug abuse to prostitution, very little attention has been given to the ethical basis for harm reduction in its application to the field of prostitution. When a proposed ethical framework for public health is applied to analyze the ethical basis of a harm reduction approach in prostitution compared to the rescue and restore approach to prostitution, the rescue and restore approach is found to be superior. Therefore, as funding is provided to groups interfacing

with prostitution in their efforts to fight the global spread of HIV/AIDS, the ethically superior approach of rescue and restore should be preferred until adequate ethical justification can be established for a harm reduction approach to prostitution.

Endnotes

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ZENOISM, DEPRESSION AND ATTITUDES TOWARD SUICIDE AND PHYSICIAN-ASSISTED SUICIDE: THE MODERATING EFFECTS OF RELIGIOSITY AND GENDER

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Abstract

A misfortune may be seen by a person as a singular event or may be over-interpreted as Zeno the Stoic did, as a "sign" of cosmic proportion (zenoizing). This tendency to "zenoize" paradoxically provides a meaning structure which may be missing in the individual's ordinary life-space. This paper presents two studies: Study One (n=233) investigating the moderating effects of religiosity and gender on zenoism, depression, demoralization and suicidality, and Study Two (n=137) investigating these same moderating effects on zenoism, fear of dependency, value of life and favorability towards physician-assisted suicide (PAS). Results indicate: 1) male respondents zenoize more than female respondents; 2) nonreligious respondents both zenoize more than religious respondents and are more generally favorable to PAS and more suicidal; 3) the tendency to zenoize is negatively related to depression, demoralization and value of life for nonreligious respondents and for men; 4) the tendency to zenoize is positively related to favorability towards PAS towards oneself and overall suicidality; and finally, 5) general and self-specific favorability towards PAS are distinct measures, but both are positively related to overall suicidality.

> But if he gives the signal to retreat as he did to Socrates, I must obey him who gives the signal, as I would a general. – Epictetus, *Discourses*, 1.29.
>
> Though He slay me, yet will I trust in Him. – Job, 13:15.

According to the ancient Greek chronicler Diogenes Laertius, Zeno, the founder of the Stoic school of philosophy, wrenched his toe on the way home from lecturing at the *Stoa* (porch) and subsequently voluntarily held his breath until he died (Diogenes Laertius, 7.28). Leaving aside the question of whether it is possible to commit suicide in this manner, the event as described above seems curious from a common-sense perspective. Why should Zeno kill himself after so seemingly minor an annoyance as wrenching his toe? The leap from wrenching one's toe to killing oneself seems monumental.

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Understanding Zeno's actions necessitates examining more closely the Stoic school of thought regarding suicide. Suicide must not be undertaken frivolously, "but if he (god) gives the signal to retreat as he did to Socrates, I must obey him who gives the signal, as I would a general." (Epictetus, *Discourses*, 1.29). In this quote, the contemporary writers, Droge and Tabor (1992, 29-39), find a precedent for "rational suicide," which has provided the justification for physician-assisted suicide (PAS). Voluntary suicide is condoned when it is necessary (Greek: *anangke*) and rational; it is condemned when it is irrational. A rational suicide is preceded by an apparently divine signal that the time to die is at hand. In other words, Zeno killed himself by holding his breath, not because he broke his toe, nor because he was in pain, nor even because he was depressed, but because he bought into the notion that the event of stubbing his toe represented the divine signal to depart (Droge and Tabor 1992, 31).

The Biblical figure of Job, in contrast, does not commit suicide despite being assailed by far more serious misfortunes. First Job is stuck by the loss of his great wealth, and then the deaths of all his children. He reaffirms his faith in God: "Naked came I out of my mother's womb, and naked shall I return thither; The Lord gave, and the Lord hath taken away; Blessed be the name of the Lord" (Job 2:21). Finally, he is inflicted with severe skin inflammations all over his body. He takes a potsherd to scrape his boils as he sits in ashes. And now, his wife urges him to blaspheme God and die (Job 2:9). Job rejects his wife's view: "What, shall we receive good at the hand of God, and shall us not receive evil?" (Job 2:10). Though he is deeply grieved, he reaffirms his relationship with his Creator. "Though He slay me, yet will I trust in Him" (Job 13:15).

The question remains, however, as to why Zeno interpreted wrenching his toe as a divine signal to depart when the Biblical figure of Job did not react similarly in the face of far greater misfortunes? It may well be that the tendency to find cosmic significance in a minor misfortune (i.e., the tendency we will call "zenoism"), as destructive as it proves for Zeno, may represent a coping strategy, which provides him with a meaning structure that is otherwise missing in his life. In a certain sense, it provides a sense of the heroic—Zeno is important enough to be called by the gods to depart. Although it is pale substitute of a life-affirming religious faith, zenoism may still represent an antidote against states of hopelessness and helplessness, without any redeeming sense of meaning. To be sure, zenoism is somewhat of a delusional coping mechanism, imparting meaning to an event where it does not really exist. Furthermore, in Zeno's case it centers the meaning on death and suicidality rather than on life. Yet at the same time, zenoizing may actually give Zeno a sense of the heroic and make him feel important and less depressed and hopeless. Zeno is aging and feels alone. He inserts meaning into his life through interpreting cosmic significance to his relatively minor misfortune. Interpreting his rather innocuous mishap as a divine signal to depart in effect provides him with permission to commit suicide (Plato, *Phaedo*, 62b-c, Cicero, *De Finibus*, 3.60-61). In this sense, his suicide is *rationalized* rather than *rational*, masking the underlying psychodynamic issues of gerophobia and loss of control. Job, in contrast, does not need this interpretive structure as he is in a relationship

with a Creator who gives his life intrinsic meaning. Job's meaning is to live and overcome his misfortunes. In the Biblical mind, God gives and takes away life, but this is not the same as searching for a divine signal that it is time to depart. Job is thus not pushed to interpret his far greater misfortunes as a sign to exit this world but as a test of his faith.

If this reasoning is correct, it would follow that the presence or absence of a religious sensibility would be a critical moderating influence on the relationship of zenoism towards depression, especially a sense of meaninglessness and demoralization, and ultimately toward suicidality. To begin with, we would expect that nonreligious respondents will show greater tendency for depression-meaninglessness, demoralization, and attitudes toward both suicide and physician-assisted suicide than will religious respondents. For example, Zenoism may be expected to reduce a sense of meaninglessness for nonreligious respondents and thus have appeal even though it may have lethal consequences (the "meaningful death" syndrome), while it should be unrelated to meaninglessness for respondents with a more traditional religious orientation and thus not have this same appeal.

The role of respondent gender may be important here. We would hypothesize that women are more naturally involved with the organic processes of life and would thus be less favorable to both suicide and physician-assisted suicide than would men. We can speculate that women may show less variance in religious sensibility than men and thus that differences between religious and nonreligious women with regard to both zenoism and suicidality and the relationship between the two will be less than that between religious and nonreligious men.

We report here two studies linking zenoism to the above variables. Study One examines the relationship of zenoism to depression, demoralization and suicidality. Study Two examines the relationship of zenoism to fear of dependency, value of life and favorability towards physician-assisted suicide (PAS), both generally and with regard to oneself. Each study examines the moderating role of respondent religiosity and gender.

Research Questions

Our first psychological question is whether the tendency to zenoize will be different for religious and nonreligious respondents. From the above discussion, we hypothesize that religious respondents will show a lower tendency to zenoize than will nonreligious respondents. We further predict that women will tend to zenoize less than will men.

A second question involves the effects of both respondent religiosity and gender on depression-meaninglessness, demoralization and suicidality (Study One), and on value of life, fear of dependency and favorability towards physician-assisted suicide (Study Two). We hypothesize that religious respondents and women will show less depression, demoralization and suicidality (Study One) and greater value of life, less fear of dependency and favorability toward physician-assisted suicide (Study Two) than will non-religious respondents and men.

A third question is whether the tendency to zenoize is positively or negatively related to depression, demoralization, and suicidality (Study One) and value of life, fear of dependency and favorability towards physician-assisted suicide (Study Two), and whether this differs for religious and nonreligious respondents. From the above discussion, we hypothesize that high zenoism might well diminish depression and demoralization (Study One) and be negatively linked to value of life (Study Two). This pattern should be especially true for nonreligious respondents as compared to religious respondents. The opposite pattern may hold with regard to value of life in Study Two. Zenoism should be negatively linked to value of life for nonreligious but not for religious respondents. This interactive effect should not emerge with regard to attitudes toward suicide and physician-assisted suicide. High zenoism should be positively linked to both high suicidality and positive attitudes toward physician-assisted suicide for both nonreligious and religious respondents.

A fourth question involves gender differences in this regard. Will respondent gender affect the relationship of zenoism to depression, meaninglessness and demoralization, and propensity towards both traditional suicide and physician-assisted suicide? We hypothesize that religiosity should be less important for women than for men in moderating the effects of zenoism on these suicide measures.

Study One: Zenoism, Depression and Suicide

Study One examines the moderating effects of religiosity and gender on zenoism and on its relationship to depression, demoralization and suicidality.

Methods (Study One)

Sample

Data was gathered from two sources: undergraduates at Wayne State University in Detroit, MI (n=142), and undergraduates at Aquinas College in Grand Rapids, MI (n=91). The overall sample (N=233) consisted of 177 females and 46 males, with 10 respondents not indicating their gender. Seventy-six participants failed to list their age in the combined data set. The average age of those who did respond to this question was 24.6 for the Wayne State sample and 20 for the Aquinas sample.

Procedure

Questionnaires were distributed in classes and students were asked to complete them in order to receive extra credit points from their instructors. In the relatively small number of cases of missing data, a missing score was replaced by the mean score of the subscale if 80% of the subscale had been filled out. If 80% of the subscale had not been filled out, then the missing item was left blank and treated as missing data. To adjust for multiple comparisons, we have employed Bonferroni corrections where appropriate.

Measures

In addition to the demographic measures obtained of age and gender of the respondents, five other measures were obtained: religiosity, zenoism, demoralization, depression, and suicidality.

Religiosity. Life Ownership Orientation Questionnaire (LOOQ) (Ross and Kaplan, 1993) measures religiosity in 14 items in a Likert-type format in which each statement is rated from 1 (*Strongly disagree*) to 4 (*Strongly agree*). Many traditional measures of religiosity tend to focus on extrinsic measure of religiosity, such as degree of attendance at a religious institution, degree of participation in a religious community, and observance of specific ceremonies and rituals of the religious community. The LOOQ, in contrast, measures the degree to which a participant feels that a Creator is involved with the events in her or his everyday life. Two subscales are measured in this construct by seven items each: a God orientation (e.g., "I believe God controls what happens to me.") and an individual orientation (e.g., "Only I am responsible for what is going on").[2] In the present study, we calculated an overall tendency toward religiosity by subtracting the individual-orientation score from the God-orientation score. The median value of this difference score was –1. Participants with difference scores of zero or above were categorized as religious (i.e., God-oriented), whereas participants with difference scores of -1 and below were categorized as non-religious (i.e., individual-oriented).

Zenoism. The Zenoism scale (Kaplan and Ficker, 2001) is comprised of 18 hypothetical misfortunes in six life domains (three events in each domain): relationships, health problems, daily responsibilities, career/academic pursuits, social issues, and artistic/athletic pursuits. Respondents are presented with two possible interpretations for a misfortune. For example, "Sara being upset because her husband has left her" can be interpreted in one of two possible ways: 1) a limited interpretation (Sara needs to look for a new partner), and 2) a zenoic interpretation (Sara should not be married). "Jim failing his midterm exam in a class important to his major course of study" likewise can have two interpretations: 1) a limited interpretation (Jim failed this particular exam but probably will do better next time), and 2) a zenoic interpretation (Jim could see this as a sign he should not be in school). Each interpretation is rated on a Likert-type scale from 1 (*Strongly disagree*) to 7 (*Strongly Agree*). Thus, two subscale scores are possible from the zeniosm scale: a zenoic score and a limited score. In both subscales the scores range from 18-126; higher scores indicating a greater tendency to engage in zenoic, generalized, or limited interpretations respectively.[3] We will focus only on the zenoic interpretation in the present study. Our measure of zenoism is simply the degree (1 to 7) with which one agrees with the zenoic interpretation.

Demoralization. The state of demoralization has been, "recognized throughout the centuries as existential despair, spiritual torpor, pointlessness, mopishness, or acidia" (Kissane and Kelly, 2000). This non-caring attitude towards life may easily be confused with depression, but there are subtle differences. Depressed people tend to view the world in a distorted, extremely

negative way, to look at themselves in an unrealistic, punitive, or self-critical way, and to generate a great deal of pessimistic emotional energy across multiple domains in their life. A demoralized person, on the other hand, simply becomes discouraged easily or feels that it is not possible to attain his or her goals, and thus may fail to set goals. A demoralized person's thinking is not necessarily distorted, but rather may be a function of facing actual obstacles in one's life leading to discouragement. The effect of this discouragement is that a demoralized person may continue to engage in life's activities and respond to his or her environment although lacking enthusiasm and appearing apathetic. The Demoralization scale (Butler et. al, 2002) is constructed of 28 statements rated in a Likert-type format, ranging from 1 (*Strongly Disagree*) to 5 (*Strongly agree*). Each item was carefully chosen to reflect one of the three aspects of demoralization, such as lack of hope ("When faced with a difficult challenge, I sometimes lose hope"), lack of significance ("I think my future dreams are not important") and discouragement ("Negative comments from others make me feel like I will not succeed").

Depression. Two indices of depression were employed in the present study. The first index is the Beck Depression Inventory-II (Beck, Steer & Brown, 1996), a 21-item inventory designed to measure a person's general depressive style without specifying a specific time referent (e.g. feeling sad, feeling like a failure, feeling guilty). It has been adapted from the BDI-I (Beck, 1967; Beck, 1985; Beck and Beck, 1972), which has been the most widely used self-report measure in English and has been translated and used successfully in many other languages. The BD-II is significantly convergent with clinical ratings of depression (.71) and divergent with clinical ratings of anxiety (.47). The second index of depression is a two-item scale specifically rooted in a concrete time period. It measures the participant's perceived state of depression over the past few months. The questions asked were very concrete. On a four-point scale ranging from "quite a bit" to "not at all" participants were asked to indicate: a) "Have you been depressed over the last few months?" and b) "Have you been feeling sad or blue over the past few months?" These two items showed a significant positive correlation ($\underline{r} = .72$, $\underline{p} < .001$). The correlation between the Beck measure of depression and the two-item concrete measure surprisingly was not significant. This non-relationship may be due to the fact that the Beck measure represents more of a participant's ongoing symptom pattern of depression, while the two-item measure explicitly probes for a participant's temporary state.

Suicidality. The Suicide Probability Scale or SPS (Cull and Gill, 1988) is a 36-item scale designed to measure four subscales: hopelessness (12 items), suicide ideation (8 items), negative self evaluation (9 items) and hostility (7 items). Each item is a statement, such as "I feel I need to punish myself for things I have done and thought" or "I have thoughts of how to do myself in." Each item is rated from 1 ("None or a little bit of the time") to 4 ("Most or all of the time"). An overall Suicide Probability score is calculated through summing the four subscales.[4]

Results (Study One)

Questions 1 and 2: Effects of respondent religiosity and gender on zenoizing, depression-demoralization and suicidality

To examine the first two research question, we ran a two-way Anova on the effects of participant religiosity and gender on zenoism, depression, demoralization and suicidality.

Main effects of religiosity. Table 1 presents the main effects of participant religiosity on these dependent variables. In confirmation of the first hypothesis, nonreligious (individual-oriented) participants tend to zenoize marginally more (52.9) than do religious (God-oriented) participants (48.6, $F = 3.35$, $p < .07$). Nonreligious participants also tend to show greater depression, both on the Beck index (6.6 versus 4.2, $F = 4.19$, $p < .05$) and the two-item index (5.2 to 4.9, $F = 3.46$, $p < .07$) and greater demoralization (53.5 versus 48.3, $F = 4.53$, $p < .05$). No significant effect of respondent religiosity emerges with regard to degree of suicidality or any of its component scores (hostility, negative self-esteem, suicidal ideation and hopelessness).

Table 1. Main effects of religiosity (Study One)

	Nonreligious (Individual-oriented)		Religious (God-oriented)		
	N	M	N	M	F
Zenoism	121	52.9	102	48.6	3.3†
Demoralization	123	57.1	102	51.3	4.9*
2-item depression	123	5.1	102	4.9	3.4†
Beck depression	121	6.6	102	4.2	4.2*
Hostility	115	10.7	97	9.9	1.7
Negative self-esteem	114	12.7	97	13.0	0.4
Suicidality	114	11.1	97	11.9	0.7
Hopelessness	114	15.6	97	15.1	0.2
SPS-total score	114	50.1	97	50.0	0.0

†$p < .10$ *$p < .05$

Main effects of gender. Table 2 indicates that participant gender also plays an important role. As can be seen in Table 2, males in our sample tend to zenoize more (54.3) than do females (47.2, $F = 8.97$, $p < .01$). At the same time, men tend to show less depression on the Beck index (4.1 to 6.6, $F = 4.49$, $p < .05$) and more negative self-esteem (13.5 versus 12.2, $F = 4.57$, $p < .05$) than do women, though gender did not significantly affect any other index of suicidality.

Table 2. Main effects of gender (Study One)

	Men		Women		
	N	M	N	M	F
Zenoism	46	54.3	180	47.2	8.9**
Demoralization	47	54.6	180	53.7	0.1
2-item depression	47	5.0	180	5.1	1.0
Beck depression	47	4.1	180	6.6	4.5*
Hostility	43	10.2	170	10.4	0.6
Negative self-esteem	43	13.5	169	12.2	4.5*
Suicidality	43	12.1	169	10.9	1.4
Hopelessness	43	14.9	169	15.9	0.8
SPS-total score	43	50.7	169	49.4	0.2

†$p < .10$ *$p < .05$ **$p < .01$

Religiosity x gender Interactions. The data reveal the following significant interactions of participant gender by religiosity. Figure 1 reveals that religiosity did not affect tendencies for zenoism for women but it did for men. Nonreligious males were significantly more zenoic (mean = 58.8) than were religious males (mean = 49.8) or than women whether non-religious (mean = 47.1) or religious (mean = 47.4, $F = 3.86$, $p < .05$). In other words, the non-religious (i.e., the individual-oriented) males are the odd group out, being more zenoic than any of the other three gender x religiosity groups.

Figure 1. Interaction of gender and religiosity on zenoism (Study One)

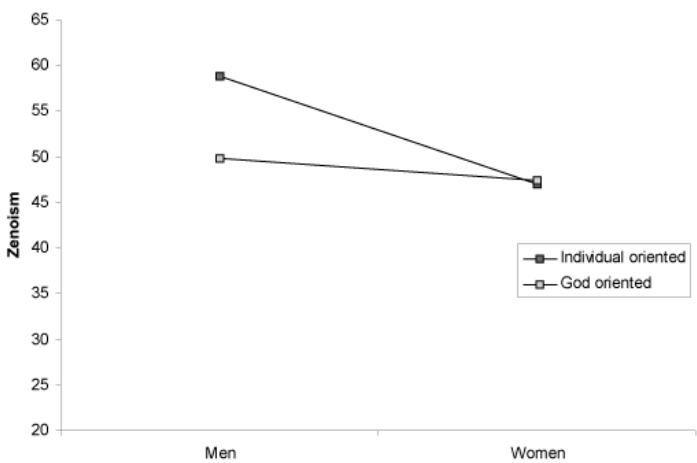
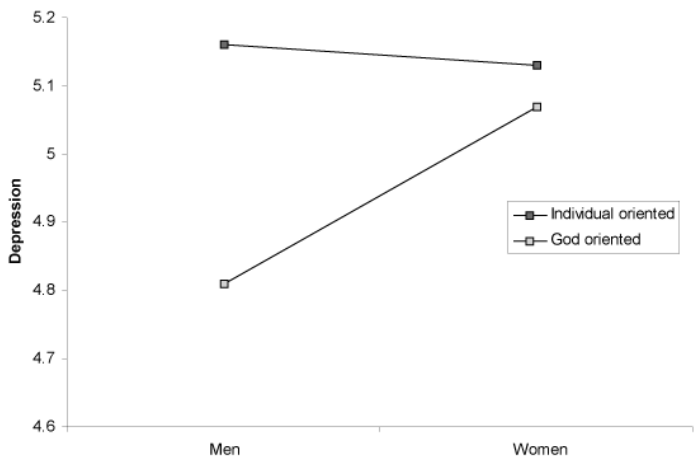


Figure 2 indicates a slight second interaction trend. The effect of religiosity on the two-item index of depression is centered on men and not on women ($F = 1.8$, $p < .20$). Religious males tended to be less depressed (mean = 4.8) than nonreligious males (mean = 5.2). No such difference emerges for females (the mean for both religious females and non-religious females = 5.1). Here it is the religious males who stand out. However this pattern fails to reach conventional significance levels and must be regarded as suggestive only.

Figure 2. Interaction of gender and religiosity on depression (Study One)



Questions 3 and 4: Effects of zenoism on depression, demoralization and suicidality: The moderating effects of religiosity and gender

To examine research questions 3 and 4, we examine the correlations between degree of zenoizing with indices of depression, demoralization and suicidality (see Table 3). First we report these relationships across all respondents, then nested within religious versus nonreligious respondents, within men and women, and finally within all four combinations: religious men, non-religious men, religious women and nonreligious women.

Table 3. Correlations of zenoism with depression, demoralization and suicidality (Study One)

	Depression (two-item)		Demoralization (total SPS score)		Suicidality	
	N	r	N	r	N	r
Total Sample	225	-.07	220	-.04	219	.18*
Religious Ss	102	-.02	101	-.05	97	.22*
Nonreligious Ss	121	-.15	119	-.23*	112	.14
Men	46	-.23	44	-.28	42	.21
Women	179	-.00	176	.03	168	.18*
Religious men	16	-.08	16	.04	14	.25
Nonreligious men	29	-.43	28	-.46*	27	.22
Religious women	84	.05	84	- .01	81	.20
Nonreligious women	92	-.06	92	-.03	85	.16

*$p < .05$ (Bonferroni correction)

Across the entire sample, zenoism is not significantly related to either depression or demoralization, though it is significantly related to suicidality ($r = .18$, $p < .05$). However, interesting differences do emerge when we examine the sub-samples discussed above.

The moderating effects of religiosity. For the religious sub-sample, zenoism is significantly related only to suicidaity ($r = .22$, $p < .05$) and is not significantly related to either depression or demoralization. A different picture emerges for our nonreligious sub-sample, however. Here zenoism is negatively related to both depression ($r = -.15$) and demoralization ($r = -.23$, $p < .05$), reaching significance levels for its relationship with demoralization. This tends to confirm our prediction as to the meaning-making function of zenoism for people who lack the anchor of traditional religious faith. The relationship between zenoism and suicidality does not reach conventional significance levels for this subsample.

The moderating effects of gender. Zenoism is negatively related to both depression ($r = -.23$) and demoralization ($r = -.28$), though the relatively small number of males precludes these correlations reaching conventional significance levels. No such relationship emerges between zenoism and depression/ demoralization for the women in our sample. In other words, zenoism tends to serve a positive function for the men but not for women in our sample. At the same time, zenoism is related to suicidality for both men ($r = .21$) and women ($r = .18$, $p < .05$), reaching conventional significance levels for the latter.

The interactive effects of religiosity X gender. The case becomes even more interesting when we examine correlations within the four gender by religiosity sub-groupings (see Table 3) Although zenoism is mildly though not significantly related to suicidality for all four subgroups (rs range from .16 to .25), it is strongly negatively related to depression ($r = -.43$) and demoralization ($r = -.46$, $p < .05$) only for the nonreligious men in our sample. This is the only sub-group where Zenoism is seen to have a significant positive effect—it may make nonreligious males less depressed and thus serves to counteract the meaninglessness in their life.

Discussion (Study One)

The results of Study One confirm the predictions of Hypothesis 1. Nonreligious respondents in our sample tend to show higher zenoism than do religious respondents. This trend is centered among the males in our sample. Likewise men tend to be more zenoic than women. Our results also indicate, however, that the effects of religiosity on zenoism only occur for men but not for women in our sample. Nonreligious men tend to zenoize more than religious men, but no such difference occurs between nonreligious and religious women. The nonreligious men actually show much higher tendencies toward zenoism than do the other three subgroups. Women may have a natural sense with regard to the intrinsic meaning of life whether or not they are religious. Thus, they have no real need to zenoize regardless of religion. On the other hand, nonreligious men may be quite susceptible to zenoic tendencies.

The predictions of Hypothesis 2 tend to be confirmed with regard to the effects of religiosity on depression and demoralization but not with regard to suicidality. Respondent gender does play a role, but not exactly in the predicted manner. Women actually show greater depression than do men. No gender difference occurs with regard to demoralization or overall suicidality, though men do show a greater degree of negative self-esteem, one subscale of the suicidality measure.

The predictions of Hypotheses 3 and 4 are largely confirmed. Zenoism is negatively related to depression and demoralization for nonreligious respondents and for men, but not for religious respondents or for women. Further, this effect seems centered primarily in the nonreligious male subgroup, religiosity being an unimportant moderating influence for women. The relationship between zenoism and suicidality, in contrast, is largely unaffected by religiosity or gender.

Zenoism, though remaining somewhat lethal with regard to suicidality, seems to serve a more positive prophylactic function for our male participants than for our women, especially for our non-religious males. Zenoism may make individual-oriented males less depressed, and may serve to substitute for the meaning in their lives, which may be provided by religion for males. Females do not seem to be similarly affected; women may not need to be heroic to feel that their lives are meaningful and worthwhile.

Study Two: Zenoism, Value of Life and Physician-Assisted Suicide

Study Two examines the moderating effects of religiosity and gender on zenoism, and on its relationship to depression, demoralization, suicidality, value of life, fear of dependency and attitudes toward physician-assisted suicide (PAS).

Methods (Study Two)

Participants

Data was gathered from Wayne State University in Detroit, Michigan. The overall sample (n=137) consisted of 81 women and 56 men.

Procedure

The same procedure was employed as that used in Study One. Questionnaires were distributed in classes and students were asked to complete them in order to receive extra credit points from their instructors. In the relatively small number of cases of missing data, a missing score was replaced by the mean score of the subscale if 80% of the subscale had been filled out. If 80% of the subscale had not filled out, then the missing item was left blank and treated as missing data. To adjust for multiple comparisons, we have employed Bonferroni corrections where appropriate.

Measures

In addition to collecting demographic measures, we presented participants with scales designed to measure the following constructs: religiosity, zenoism, fear of dependency, value of life, and favorability towards physician assisted suicide, both general and with regard to oneself. The measures of the religiosity, zenoism and overall suicidality are identical to those described in the Methods Section in Study One. The measures of fear of dependency, value of life, and favorability toward physician-assisted suicide (PAS), both general and specific to oneself, are presented below.

Fear of Dependency. The Fear of Dependency Scale (Kaplan et. al., 2004) consists of ten items designed to measure how much a person fears being dependent on other people because of physical and/or psychological losses with regard to independence. The scale employs a Likert-type format in which each statement is rated from 1 (*No fear at all*) to 5 (*Strongly fear)*.

Value of Life. Value of Life Scale (Kaplan et. al., 2004) consists of ten items designed to measure how much a person values his/her life giving a set of debilitating physical circumstances. The scale employs a Likert-type format in which each statement is rated from 1 (*No value at all*) to 5 (*Strongly value*).

Attitudes toward Physician-Assisted Suicide (PAS). The Attitudes toward Physician-Assisted Suicide Scale (Kaplan et. al., 2004) consist of two separate subscales: General Favorability towards Physician-Assisted Suicide (PAS) and Attitudes towards Physician-Assisted Suicide (PAS) for Oneself. PAS General: The subscale consists of ten items designed to measure a person's general attitude

towards Physician-Assisted Suicide (PAS) under a set of different circumstances. The scale employs a Likert-type format in which each statement is rated from 1 (*Strongly disagree*) to 5 (*Strongly agree*). PAS Self: The subscale consists of ten items designed to measure a person's specific attitude towards Physician-Assisted Suicide (PAS) for oneself under a set of different circumstances. The scale employs a Likert-type format in which each statement is rated from 1 (*Strongly disagree*) to 5 (*Strongly agree*).

Results (Study Two)

Questions 1 and 2: Effects of respondent religiosity and gender on zenoism, fear of dependency, value of life, favorability toward PAS and suicidality.

To examine the first two research questions, we ran a two-way Anova on the effects of participant religiosity and gender on zenoism, fear of dependency, value of life, favorability toward PAS, both as a general concept and specific to oneself, and overall suicidality.

Main Effects of Religiosity. Table 4 presents the main effects of participant religiosity on all these dependent variables. No differences emerged between religious and nonreligious participants with regard to Zenoism, fear of dependency and value of life. However, as predicted, nonreligious respondents tended to have more favorable general attitudes towards PAS (M = 29.4) than did religious respondents (M=26.3 $F=6.9$, $p<0.01$) and greater favorability toward PAS-self (M=16.9) than did religious respondents (M=14.2), but this difference was not significant. No difference emerged between religious and nonreligious respondents regarding overall suicidality.

Table 4. Main effects of religiosity (Study Two)

	Nonreligious (Individual-oriented)		Religious (God-oriented)		
	N	M	N	M	F
Zenoism	62	43.0	59	47.3	2.1
Fear of dependency	62	35.7	59	49.3	1.0
Value of life	62		36.5	59	36.8
0.0					
Favorability toward PAS-General	62	29.4	59	26.3	6.9**
Favorability toward PAS-Self	62	16.9	59	14.2	4.1*
Overall (SPS) Suicidality	62	51.9	59	51.9	0.0

*p < .05 **p < .01

Main Effects of Gender. Table 5 indicates that participant gender also plays an important role. As predicted in Hypotheses 1 and 2, men tended to zenoize significantly more (M=49.0) than women (M=41.4, $F=6.7$, $p<0.01$). Men also tended to be more favorable towards PAS with regard to themselves than did women (M=16.78 versus 14.2, $F=3.7$, $p<0.05$) and more suicidal overall (M=55.4 versus 48.4), though this latter effect failed to reach conventional significance levels. No gender effects emerged with regard to fear of dependency, value of life or general favorability towards PAS.

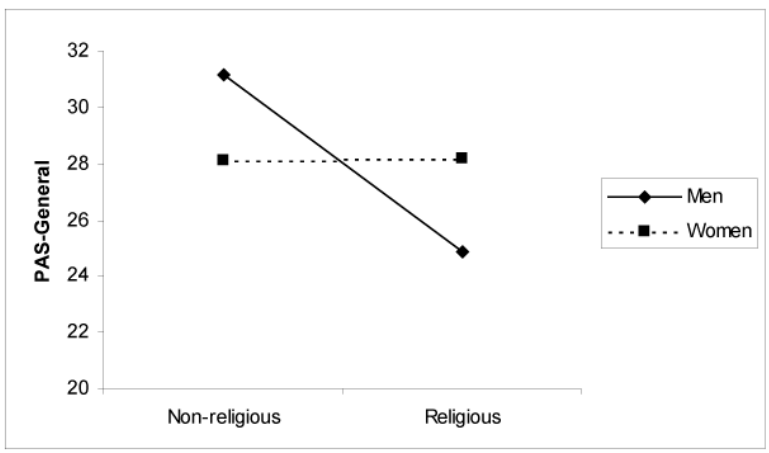
Table 5. Main effects of gender (Study Two)

	Men		Women		
	N	M	N	M	F
Zenoism	43	49.0	80	41.4	6.7**
Fear of dependency	43	35.7	80	36.2	0.3
Value of life	43	37.2	80	36.2	0.1
Favorability toward PAS-General	43	27.6	80	28.1	0.2
Favorability toward PAS-Self	43	16.8	80	14.2	3.7*
Overall (SPS) Suicidality	43	55.4	80	48.4	3.2

*p < .05 **p < .01

Gender x Religiosity Interactions. Figure 3 presents the one significant interaction between respondent gender and religiosity. Nonreligious men (M=30.8) tend to be much more generally favorable towards PAS than religious men (M=24.5). Women's attitudes toward PAS-general, in contrast, is unaffected by religiosity. Both nonreligious women (M=28.1) and religious women (M=28.2, $F=7.1$, $p<.01$) fall between the two male extremes.

Figure 3. General favorability towards PAS as a function of sex and religiosity (Study Two)



A second interesting and unexpected interaction emerges, though it fails to reach conventional significance levels. Nonreligious men (M=34.0) shows less fear of dependency than religious men (M= 37.5), while the opposite pattern emerges for women: nonreligious women (M=37.4) showing greater fear of dependency than religious women (M= 34.4, F=2.8, p<.10).

Questions 3 and 4: Effects of zenoism on fear of dependency, value of life, favorability toward PAS and suicidality: The moderating effects of religiosity and gender

To examine research questions 3 and 4, we examine the correlations between degree of zenoism with indices of fear of dependency, value of life and favorability toward PAS. (see Table 6). First we report these relationships across all respondents, then nested within religious versus nonreligious respondents, within men and women, and finally within all four combinations: religious men, nonreligious men, religious women and nonreligious women.

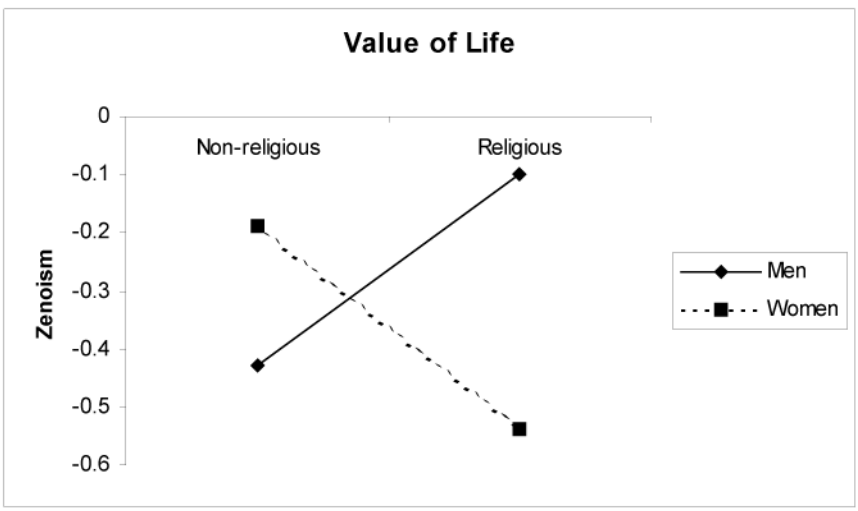
Across the entire sample, zenoism is significantly positively related to fear of dependency (r=.19, p< .01) and favorability toward PAS-self (r=.31, p<.001) and negatively related to value of life (r= -.32, p<.001). However zenoism was unrelated to favorability toward PAS-general for the entire sample. Though not part of our original hypotheses, it is interesting to report that value of life is significantly negatively related to both favorability towards PAS-general (r=-.20, p<.05), PAS-self (r=-.50, p<.001), and overall SPS suicidality (r=-.20, p<.05). Neither PAS measure nor overall suicidality was significantly linked to fear of dependency.

The moderating effects of religiosity. This pattern is fairly consistent across the religious and nonreligious sub-samples, for all variables except general favorability toward PAS and overall suicidality. Religious respondents show a positive relationship between zenoism and general favorability towards PAS (r=.15), while nonreligious respondents show a negative relationship between these two variables (r= -.21). Neither correlation reaches conventional significance levels, however. One other very important finding emerges. Religious respondents show a greater correlation between zenoism and overall suicidality (r=.54, p<.001) than do nonreligious respondents (r=.16). Favorability towards PAS-self is linked to fear of dependency for non-religious participants (r=.39, p<.001) but not for religious participants. No such relationship occurs between fear of dependency and general favorability towards PAS or overall suicidality.

The moderating effects of gender. The overall pattern regarding zenoism is unaffected by respondent gender except with regard to fear of dependency and overall suicidality. Zenoism is quite significantly related to fear of dependency (r= .34, p<.01) and for overall suicidality (r=.35, p<.001) in women. However, it is shows no such relationship for the men in this study for either fear of dependency (r=.04) or overall suicidality. The same pattern exists in the relationship between fear of dependency and favorability toward PAS-self. It is significant for women (r=.26, p<.05) but not for men (r=.05). No such effect occurs with regard to favorability toward PAS-general.

The interactive effects of religiosity X gender. The case becomes very interesting when we examine the predictive effects of zenoism within the four gender x religiosity subgroups. A striking interaction emerges with regard to the relation of zenoism and value of life and is presented in Figure 4. Religious women ($r = -.54$, $p < .01$) and nonreligious men ($r = -.41$, $p < .05$) show higher negative correlations between zenoism and value of life than do nonreligious women ($r = -.19$) and religious men ($r = -.10$).

Figure 4. Zenoism x value of life : The effects of gender and religiosity (Study Two)



Another fascinating pattern emerges with regard to the correlation between zenoism and general attitudes toward PAS. Religiosity plays a very important moderating role for men, zenoism being positively related to general favorability towards PAS for religious men ($r = .45$) and actually negatively related towards PAS for nonreligious men ($r = -.32$). No such big difference exists for women, zenoism only slightly positively related to general favorability for religious women ($r = .12$) and slightly negatively related ($r = -.09$) for nonreligious women. Further, no such striking gender x religiosity interactions occur with regard to the correlation of zenoism and either fear of dependency or favorability toward PAS with regard to oneself, or to any of the relationships between fear of dependency or value of life with either general of self-specific attitudes toward PAS.

The overall suicidality score was somewhat positively linked to favorability towards PAS-general ($r = .30$, $p < .001$), as well as towards PAS-self ($r = .26$, $p < .01$) across the entire sample. However, we should report that general and self-specific attitudes towards PAS are somewhat distinct variables ($r = .18$ for the entire sample) and within all of the religiosity x gender subgroup. In other words, it is one thing to consider the question of physician-assisted suicide in general, and quite another to consider it for oneself. The more general attitude

may be simply a social and political position, while the second self-specific attitude may have more personal existential ramifications—whether one personally is willing to die.

Discussion (Study Two)

The results of Study Two confirm some but not all of the predictions of Hypothesis 1. Nonreligious individuals tend to have more favorable general attitudes towards PAS-general than do religious individuals and also more willingness to consider PAS for themselves. No such difference emerges regarding tendencies to zenoism, fear of dependency, value of life or overall suicidality.

The results support the prediction of Hypothesis 2. Men tend to zenoize more than do women. Men also have more positive attitudes towards PAS with regards to themselves than women, and tend to be more suicidal, but do not differ in general attitudes toward PAS. These two findings suggest that (1) men may have a greater tendency to over-interpret a negative event than do woman, and (2) men become impatient when dealing with sickness. This may lead to greater propensity for physician-assisted suicide and greater overall suicidality. In addition, a significant interaction emerges between sex and religiosity with regard to general attitudes towards PAS. Religiosity affects general attitudes towards PAS for men but not for women. Nonreligious men tend to be more favorable towards PAS generally than do religious men. No such difference emerges for women. Women, whether religious or not, may have an intuitive sense that life has meaning, while men may not have this sense without a religious foundation. Perhaps a nonreligious male, lacking the inherent structure that religiosity provides, sees PAS as an attempt to gain some control and meaning out of his death.

The predictions of Hypotheses 3 and 4 are partially confirmed. Zenoism is positively related to favorability towards PAS with regard to oneself and overall suicidality. These relationships are unaffected by religiosity or gender. A more complicated pattern emerges with regard to the relationship between zenoism and general favorability to PAS. Zenoism increases PAS favorability for religious men but diminishes it for nonreligious men with no such big difference emerging between religious and nonreligious women.

Zenoism is negatively linked to value of life, but this relationship is affected by respondent religiosity differentially across gender. Zenoism is negatively related to value of life for religious women and nonreligious men. The question of causal direction of this relationship is important here. Does low value of life lead to zenoism, or does zenoism lead to low value of life? The former explanation seems to hold for nonreligious men, in an attempt to provide life value that the religious men already have. The less the inherent life-value, the greater the need to zenoize—hence the negative relationship. Yet the latter explanation seems to hold for religious women. They already are imbedded in the meaning structure of religion. For them the tendency to zenoize may actually decrease their value of life. Fear of dependency does not seem to play such an important role for men, but it does for women.

The role of religiosity is also important. Fear of dependency may play a more important role for nonreligious individuals than for religious individuals in shaping attitudes towards PAS. For nonreligious individuals there is a stronger relationship between fear of dependence and propensity toward PAS-self than there is for religious individuals. Fear of dependency does not seem to have the same lethal role for religious as nonreligious respondents. Religious people, in other words, do not seem to be so phobic regarding dependency.

Suicidality is linked to positive attitudes towards PAS. Overall suicidality is more positively related to favorability toward PAS-self than it is to favorability toward PAS-general. This trend is fairly consistent across sex and religiosity, though it seems to be stronger for women than for men and for religious rather than nonreligious individuals. This suggests that attitudes towards PAS, especially attitudes towards PAS-self, represent a component of suicidality and are not an independent constellation of variables. Finally, general and self-specific favorability towards PAS are clearly different variables. It is one thing to be express a general philosophy regarding PAS. It is quite another to consider it for oneself.

Conclusion

Our findings are striking and suggest a reason for the focus on death with dignity in ancient Greek and Roman Stoicism and in contemporary Western society. Our obsession on the way in which we die actually may serve to substitute for the lack of meaning in our lives. Our data suggests that belief in a personal Creator may anchor this meaning function for the men in our sample, though not necessarily for the women. Thus, religion may serve a stronger suicide-preventive function for men than for women. In the absence of such a religious foundation, men may be more susceptible to zenoize and to actually be helped in this regard.[5] Although it is death-centered rather than life affirming, zenoizing does provide a meaning-function, however delusional, in a person's life, and though pessimistic, may actually decrease a person's sense of helplessness. However, with an inherent meaning-structure such as that provided by Biblical religion, one need not over-interpret and catastrophize events in an attempt to feel less isolated and important. Without this inherent meaning structure, the tendency to zenoize may represent a continuing temptation, with its siren call of death with dignity.[6]

Endnotes

1 Wayne State University, University of Illinois in Chicago. Earlier drafts of this paper have been presented as Kaplan and Ficker (2001); Kaplan, Ficker, Dodge, Schatten, Thiel, Wallrabenstein and Folk, 2003; Kaplan, Dodge, Thiel, Wallrabenstein, Smith and Laird, 2004; and Kaplan, Thiel, Laird, Dodge, Wallrabenstein, Goodman, Shchesyuk, and Smith, 2005, at successive meetings of the American Association of Suicidology.

2 Previous research has shown the LOOQ-G subscale (Life Ownership Orientation to God) to have a reliability alpha of .88, and the LOOQ-I subscale (Life Ownership Orientation to the individual), a reliability of .67 and strong validity against the life-taking issues of abortion, suicide, doctor-assisted suicide, and capital punishment (Ross & Kaplan, 1993).

3 Preliminary analyses indicate a Chronbach Alpha of .70 for the limited interpretation subscale, and .83 for the zenoic interpretation subscale. The correlations between the three interpretive styles yielded both convergent and discriminate validity as follows below.

4 Cull and Gill report the following measures of reliability. Chronbach alpha coefficients were calculated on a sample

Table 6. Correlations of zenoism with value of life, fear of dependency, favorability toward PAS-general and PAS -self and overall suicidality

(Study Two)

	Fear of Dependency		Value of Life Towards PAS		General Favorability PAS for Self		Favorability Towards Suicidality		Overall (SPS)	
	N	r	N	r	N	r	N	r	N	r
Total Sample	123	.19**	121	-.32***	122	-.01	121	.31***	121	.29 ***
Religious Ss	58	.16	58	-.36**	58	.15	.58	.42**	58	.54***
Non-religious Ss	61	.32**	61	-.28*	61	-.21	61	.24	60	.16
Men	42	.05	42	-.25	42	.05	42	.32*	41	.13
Women	79	.34**	79	-.42***	79	.06	79	.25*	80	.35***
Religious men	18	-.26	18	-..08	18	.45	18	.51*	18	.42
Non-religious men	23	.30	23	-.45*	24	-.32	23	.29	22	-.06
Religious women	40	.37*	40	- .54***	40	.12	40	.31.*	40	.60 ***
Non-religious women	38	.26	38	-.18	38	-.09	38	.16	38	..32

*p < .05, ** P < 01, *** P<.001 (Bonferroni correction)

of 579 even-numbered cases and 579 odd-numbered cases. The alpha coefficients ranged from .62 for Negative Self-Evaluation to .89 for Suicidal Ideation. The estimated internal consistency of the total sample was even higher .93 for both scales). Split-half estimates of reliability yielded essentially similar results, the Spearman-Brown estimate of correlation ranging from .58 for Negative Self-Evaluation to .88 for Suicidal ideation, with a correlation of .93 for the total scale.

The SPS also demonstrates high validity, the SPS total and subscale scores being positively correlated with MMPI scales of depression ($\underline{r}$'s = .44 to .73, Cull and Gill, 1988) and significantly with both the Beck Hopelessness Scale and the Beck Depression Inventory in college students and adult psychiatric inpatients (D'Zurilla et. al., 1998). Finally, the SPS was standardized on an ethnically diverse group of adolescents and adults in the general population and compared with a group of psychiatric inpatients and suicide attempters (Cull and Gill, 1982). These four SPS subscales discriminated between three criterion groups: participants without suicidal tendencies (n = 562), psychiatric inpatients (n = 260) and suicide attempters (n = 336). For the clinical subscales, the *F* values ranged from 89.6 for negative self-evaluation to 282.4 for Hopelessness ($\underline{p} < .001$ for all subscales). The power of the total score to differentiate among the criterion groups was even more impressive ($F = 311.2$, $p < .001$).

5 The smaller number of men than women in these studies makes our results regarding men more suggestive than necessarily definitive. Future studies should attempt to sample a greater number of male respondents. In addition, future studies may find it useful to examine the relationship between zenoism and impulsivity, and to examine how impulsivity may correlate with religiosity and zenoism.

6 Such a person may also be inherently suicidal, searching for a meaning structure (a divine signal from the gods) that makes committing suicide permissible. Such a constellation might be useful in describing a suicide bomber in contemporary Islamism. He needs to find an acceptable mechanism to transform suicide (*intichar* in Arabic), which is forbidden, into a martyr's death (*intishahid*), which is honorable (Orbach, 2004, p.123).

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BOOK REVIEWS

Reformed and Always Reforming: The Postconservative Approach to Evangelical Theology

Roger E. Olson. Grand Rapids: Baker, 2007.

ISBN 0-8010-3169-9; 247 PAGES, PAPERBACK, $19.99

On the first page of his introduction, Roger Olson makes the aims of his work clear: 'This is a book about theology and not sociology, politics, or even ethics' (7). Those readers uninterested in the current state of evangelical theology can thus feel free to move on to the next review. For the rest of you, *Reformed and Always Reforming: The Postconservative Approach to Evangelical Theology* may be well worth your consideration. Though Olson's project is about theology and not ethics or politics, he views the aim of his project in the same stream as that of Jim Wallis, Ron Sider, and Tony Campolo, namely, to demonstrate how 'it is possible to be more evangelical by being less conservative' (7).

Olson argues that conservative evangelical theology, characterized by the writings of Carl F. H. Henry, Wayne Grudem, Tom Oden, and D. A. Carson, among others, has become too tied to tradition – either in the form of the 'ancient ecumenical consensus' or the 'received evangelical tradition' – to allow the Spirit to speak in a fresh way to the community of faith through new interpretations of scripture. However, instead of rejecting conservativism for liberalism, Olson explores the movement known as 'postconservativism', which embraces what is best about conservativism, such as reliance on and fidelity to scripture, without adopting conservativism's less palatable features, such as its perceived defensiveness, exclusivity, traditionalism, and dogmatism.

As paradigm examples of postconservative evangelicals, Olson discusses Stanley Grenz, Clark Pinnock, and Kevin Vanhoozer, among others. He begins by describing the common traits of the postconservative style represented by these theologians: a focus on transformation over information, a vision of theology as 'a pilgrimage and a journey rather than a discovery and conquest' (55), an uneasiness with the Enlightenment and its influence on evangelicalism, a view of evangelicalism as a 'centrifugal center of powerful gravity' rather than a set of 'outlying boundaries that serve as walls or fences' (60), an experiential rather than doctrinal emphasis, and finally, a respect for tradition without traditionalism. These common traits and others closely related become the topic of discussion for the bulk of the book.

Though Olson tries to keep the tone as amiable as possible, he is not known to pull punches when he feels that a position or theologian has been mischaracterized or treated unfairly. This is precisely what he feels has been the case with postconservativism and its proponents at the hands of their conservative critics. *Reformed and Always Reforming* is thus one part explication and one part polemic. For the most part this makes for a lively and provocative read, but there are points where Olson's allegiances may cause him to gloss over or even defend some of the weaknesses of the postconservative move in theology. For example, in his discussion of Nancy Murphy's postfoundationalism, Olson appears to endorse a coherentist view of truth over a correspondence view (though later he commends a correspondence view as well). But while coherence is certainly a helpful epistemological category, it will never be a more fundamental metaphysical criterion for truth than correspondence with reality, even granting the postfoundationalist critique of our epistemic limitations. Here, as elsewhere in the book, one wonders if adopting a theology influenced by postmodern philosophy is truly an advance over one influenced by modern or ancient philosophy.

Those who read *Reformed and Always Reforming* straight through may also find it to be a

bit repetitive at times. It almost reads as though each chapter is intended to stand on its own, despite the topical threads running throughout. On the other hand, Olson may feel it necessary to repeatedly drive home his point, given the way postconservatives have been misrepresented often to the point of slander. And for giving this new voice in evangelicalism a proper hearing, I believe that Olson has done Christian theology an important service worthy of a careful read.

Reviewed by David C. Cramer, MDiv, MA (Philosophy of Religion, cand.), who is an Adjunct Professor for the School of Religion and Philosophy at Bethel College, Mishawaka, Indiana, USA.

Ethics & AIDS in Africa: The Challenge to Our Thinking

Anton A. Van Niekerk and Lorette M. Kopelman, Ed. Walnut Creek, CA: Left Coast Press, Inc., 2005.

ISBN 978-1598740714; 222 PAGES, PAPERBACK, $24.95

It's refreshing to read a book containing so much with which those holding Bible-based values can agree. Written by a variety of authors from secular institutions in Africa, the UK and the US, *Ethics & AIDS in Africa* is the first comprehensive book devoted to the ethical dimensions of the epidemic. It is a compilation of essays, largely from a South African (rather than Western) viewpoint. Not surprisingly, the book raises and analyzes ethical issues about HIV/AIDS and its treatment. It then offers answers which are contrary to much of the traditional Western thinking and actions of the first quarter century of the AIDS pandemic.

After presenting data on HIV/AIDS in chapters 1, chapter 2 attacks the issue of the insufficiency and unreliability of much of the statistical data on the epidemic. This misleading data has helped leaders (especially in Africa) deny the scope of the problem as they fail to adequately address it. Next, an economic analysis and discussion of social arguments concerning highly-active anti-retroviral therapy (HAART) is presented. Nicoli Nattrass, a University of Cape Town economist, concludes, 'Once HIV-related hospital costs are included . . . the cost per HIV infection averted is lower in a treatment plus prevention scenario than in a prevention-only scenario' (39) and that use of HAART is constrained by political rather than economic realities. The insufficiency of a purely biomedical approach divorced from the social and political forces affecting action and the need to focus on what can be done immediately to respond to HIV/AIDS are stressed over waiting until an ideal, comprehensive solution to the problem can be found.

The book has few negatives, other than the fact that the data in its first chapter and its discussion of retroviral therapy need to be updated. However, these points reflect the date of publication and do not affect its ethical arguments. I recommend this text for discussion in groups addressing the AIDS crisis as well as for use in a case study of the history and wisdom of actual responses to HIV in Africa. Christians, as well as those from other religious communities whose faith based arguments and moral discussions are often excluded from the public square, will find it an excellent example of translating the concepts they support into medical, social and scientific arguments that secular communities must address.

Reviewed by Sharon A. Falkenheimer, MD (Aerospace Medicine), MPH, MA (Bioethics), who has many years of experience in international situations, has spoken and taught in over 15 nations, has formerly directed international medical training at the USAF School of Aerospace Medicine, and is an academician at the International Academy of Aviation and Space Medicine, a Fellow of the Aerospace Medical Association, and a Fellow at the Center for Bioethics and Human Dignity, USA.

Can a Health Care Market be Moral? A Catholic Vision

Mary J. McDonough. Washington, D.C.: Georgetown University Press, 2007.
ISBN 978-1-58901-157-1, 256 PAGES, PAPERBACK, $29.95

Despite the fact that the issue of health care has been drowned in the sea of election year rhetoric concerning the economy and war, Mary McDonough's book, *Can a Health Care Market be Moral?*, is timely and informative, yet inconsistent in the conclusions drawn. McDonough outlines the moral requirements of a health care system from the perspective of Catholic social thought, demonstrating that market systems are incompatible with such requirements. Yet her concluding proposal for a market organizational approach with governmental oversight is incompatible with her arguments and goals for health care.

McDonough lists six topics vital to justice: human dignity, social interdependence, the common good, obligations to the poor and vulnerable, stewardship, and a Christian interpretative framework of meaning. She then evaluates four market approaches to health care, finding them all wanting with respect to social justice. Quoting Edmund Pellegrino she concludes that 'market values have no place in health care (because) . . . the healing relationship cannot exist within the market model of distribution.' (203) A value dimension approach to health care is then explored, one which addresses the meanings of health, suffering, illness, and death that market approaches fail to do. Ultimately, McDonough determines that Daniel Callahan's Finite Model of medicine is the most compatible approach with Catholic social thought.

McDonough astutely diagnoses the etiology of our health care crisis—capitalism's emphasis on choice, control, and individualism combined with our overly broad definition of health—but her treatment plan doesn't address the underlying malady. She argues for universal access to health care, a goal she states is incompatible with market systems, yet proposes governmental oversight of a market mechanism that incorporates a value dimension approach as her treatment of choice. She justifies her inclusion of market mechanisms as a necessary means to contain costs, a rationale that contradicts her prior assessment that costs are driven by choice and desire—market forces. Additionally, she notes that the United States, with its market approach, has the costliest health care system in the world. With regard to quality, the only category in which the US leads other nations is in those over 80 years of age, a fact traced directly to the federal Medicare program. In the end, McDonough clings to Catholic understanding of health care as a basic human right while simultaneously noting that rights language is inconsistent with the notion of common good. But is health care a right (which involves entitlements, choices, and demands) or a responsibility that we, in our affluent society, have towards others in the name of justice? A focus on universal health care as a responsibility would ameliorate the individualistic notions of choice and desire that have driven the costs to astronomical levels, a possibility McDonough fails to entertain.

McDonough's instructive book provides a concise overview of the health care crisis and an evaluation of needed reforms from the perspective of Catholic social thought. Her conclusions, however, seem to be an accommodation to the cultural ethos and contradict her argument. A federal system of universal health care would be most consistent with the goals which she has outlined as essential, yet would also be politically incorrect and socially unpopular.

Reviewed by Susan M. Haack, MD, MA (Bioethics), FACOG, who is a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

Waiting With Gabriel: A Story of Cherishing a Baby's Brief Life

Amy Kuebelbeck. Chicago: Loyola Press, 2003.

ISBN 0-8294-1603-X; 174 PAGES, PAPERBACK, $17.95

This book is a celebration of life! Through her tears, the author opens the door to her family, giving the reader a rare and poignant glimpse of their struggle to deal with devastating news. The reader is granted an opportunity to share in the family's pain. One caution, though, the author's candor will evoke tears of compassion.

Kuebelbeck opens the narrative during her second trimester of pregnancy – when she and her husband learn that their baby has a severe heart defect. Subsequently, we learn the diagnosis is Hypoplastic Left Heart Syndrome (HLHS), fatal if untreated, but even when treated leads to a difficult and prolonged recovery with no guarantee of success. Mother and father elect to abandon medical intervention because of the severity of the prenatal condition as well as the difficulty with predicting medical outcome.

This is an account of and a guide to the people, prose, and prayers surrounding the family's pregnancy and the life of baby Gabriel. The author shares with us the painstaking process of researching the medical condition, speaking with expert medical personnel, and with families who have traveled a similar medical pathway. She recounts engaging clergy and counselors, and pondering the decisions placed before her family. In her story, Kuebelbeck makes the intriguing observation that while pregnant, she can protect unborn baby Gabriel – but after delivery, this shelter is shattered and the HLHS will declare its own unfettered medical course. Even after having arrived at the decision that they would not pursue life-sustaining medical treatment on behalf of baby Gabriel, several minutes after his birth and during the initial baby examination, a member of the medical staff still queries their decision to refuse medical intervention. Even experienced medical personnel may be ill-prepared for death without a medical fight.

'Two of the most primal parental instincts are to keep your child alive and to protect your child from unnecessary pain. Those instincts usually do not collide. With our baby, they did.' (11) Utilitarianism and allocation of resources have little meaning – or perhaps none – at the bedside of a child who is ill and dying. Mother and father chose to offer heart-felt love to baby Gabriel. A warm blanket and arms of love provided protection from the gadgetry of modern medicine.

Kuebelbeck's narrative does not deal with the existential questions of a baby's death. It offers practical advice for parents in pain during the pregnancy and anticipated birth of a child with severe neonatal defects. In so doing, it copes with death, but it celebrates life!

Reviewed by Ferdinand D. (Nick) Yates, Jr., MD, MA (Bioethics), who is a pediatrician and consultant on Pediatric, Adolescent and Neonatal Issues in Buffalo, New York, a Fellow at the Center for Bioethics and Human Dignity, and an Adjunct Professor of Bioethics at Trinity International University, Bannockburn, Illinois, USA.

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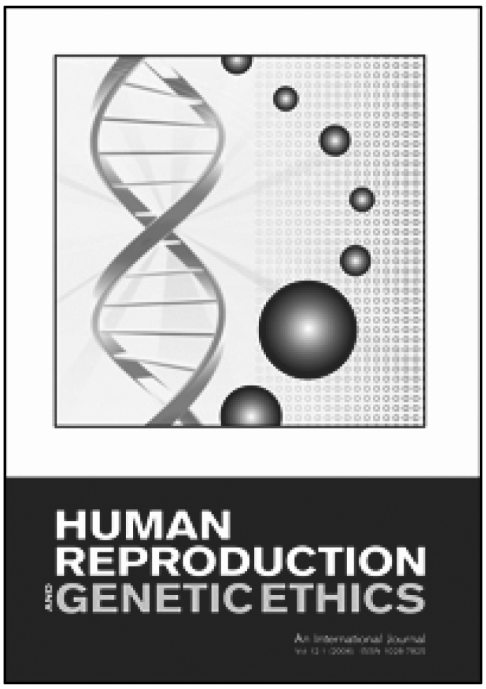

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- Privacy of Genetic Data and
- Screening
- Eugenics
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- Human Cloning
- Human Gene Therapy

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