Praying for a Cure

When Medical and Religious Practices Conflict

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Introduction

Peggy DesAutels, Margaret P. Battin, and Larry May

Three recent and sometimes conflicting trends have contributed to renewed public concern and debate over health-related religious practices. First, more and more people are acknowledging and even insisting on a patient's right to make his or her own health- and death-related choices. Second, there has been an increasing (though reluctant) acknowledgment by the medical community of the effectiveness of alternative approaches to healing, including religious approaches, for at least some types of people with some types of diseases. And third, the state has become increasingly involved in "protecting" vulnerable populations such as children, the elderly, and the disabled.

Because of increased recognition of a patient's right to refuse conventional medical treatments and to seek alternative healing methods, it is now widely accepted by medical ethicists and the courts that competent adults may refuse life-saving treatments on religious grounds. But can parents refuse medical treatment for their children? Although neither a legal nor an ethical consensus has been reached on this question, there has been increased public concern over (as well as state interference in) a wide variety of types of cases of apparent child neglect and abuse. Whether medical refusals for children are tantamount to child abuse has not yet been legally determined. In fact, in various cases across the country in which children have died as a result of their parents' exclusive reliance on a religious cure, the charges against such parents have ranged from no charges at all to neglect to child endangerment to manslaughter to murder.

This volume focuses the debate over the ethics surrounding conflicting religious and medical practices by examining the specific case of health-related choices made by and for Christian Scientists. Although there are several religious groups who refuse medical treatment or components of it, the

issues surrounding Christian Scientists' medical refusals are especially vexing and ethically complex. Many of us are vaguely familiar with the fact that "Christian Scientists are the ones who do not go to doctors," but few know much more about how a Christian Scientist's view of the world conflicts with that of the majority; nor do many of us know much about the substantive ethical issues surrounding a Christian Scientist's health-related choices.

There are several reasons for delving more deeply into the political, social, and ethical conflicts that arise from the practice of Christian Science. First, medical professionals in clinical settings are likely to encounter a variety of diverging cultures and worldviews that incorporate approaches to health and healing that clash with medical approaches. The culture and worldview of Christian Scientists is a good case in point. Second, our society must decide how tolerant it should be toward minority groups, religious or otherwise, with defining practices that challenge the moral convictions of the majority. Christian Science children's cases do tend, at least prima facie, to challenge one of our deepest moral convictions that children should not be allowed to suffer or die. And third, because Christian Scientists tend to be well-educated professionals who generally make rational, well-informed choices in their lives, their health-related choices cannot simply be dismissed as choices made by irrational fanatics. Rather, a determination of the rationality of their choices can only be made after an in-depth critical examination of their views and practices.

This volume addresses the issues surrounding the health-related choices of Christian Scientists in a rather unique way. It has a point-counterpoint format but contains three voices rather than the usual two. The three authors of this book are philosophers who work in overlapping areas of philosophy but take very different stands. Peggy DesAutels has published in the areas of medical ethics, moral psychology, and philosophy of mind. Peggy Battin has published in bioethics, aesthetics, health policy, professional ethics, and in particular on end-of-life issues. Larry May has published in philosophy of law, theory of moral responsibility, and professional ethics. Battin and May are not Christian Scientists; DesAutels was raised in this tradition.

High-Risk Religions and Informed Consent

In the first half of the book, Peggy DesAutels and Margaret P. Battin examine certain religious practices by drawing on concepts and norms from professional ethics, rational choice theory, and philosophy of science. The religious practices of concern to them involve the ways in which some religious institutions influence their members to make "high-risk" decisions.

More specifically, they address the following questions: Why do members of the Christian Science church uniformly take health-related risks that other people do not? And is the Christian Science church ethically irresponsible in the ways it influences its members' decision-making processes?

DesAutels and Battin differ over whether the Christian Science Church is ethically remiss for failing to supply healing success-rate statistics to its adherents. Battin claims that the Christian Science Church is morally culpable for publishing only anecdotal accounts of healing successes because its members are then unable to assess the risks involved in choosing a Christian Science approach to healing. She argues that the Christian Science Church systematically disregards the principle of autonomy and violates requirements of informed consent by providing to its adherents only selected accounts of successful cures. DesAutels, on the other hand, defends the practice of publishing only healing successes. She argues that the Christian Scientist's decision to pursue spiritual means for treatment does not resemble in structure the decision to pursue a particular medical treatment and that therefore cure-rate information is inapplicable to a Christian Scientist's decision-making process.

Christian Science in a Pluralistic Society

In the second half of the book, Peggy DesAutels and Larry May debate how to treat the seemingly harmful practices of a minority religion within a larger pluralistic, secular society. May considers the stalemate that can arise between Christian Scientists and medical professionals over the treatment of Christian Science children to be primarily a conflict of groups over authority within a pluralistic society. He takes a communitarian perspective on the question: In a pluralistic society such as ours, at what point should respect for a religious minority culture be tempered by concerns for the fundamental rights of children? May argues that neither the medical community nor the Christian Science community should be given exclusive purview in determining the best means for securing a child's right to health. Rather, the two groups should compromise. Christian Scientists should be socialized to be more open to medical diagnoses in order better to know when to seek medical help for their children in life-threatening situations, and medical professionals should be socialized to be more sensitive to patients as persons and more open to nonstandard approaches to health in non-life-threatening situations.

DesAutels responds by claiming that the conflicts that arise between Christian Scientists and medical professionals are best described not as a

conflict over authority but as a conflict over worldviews. She maintains that the fundamental disagreement between members of the two groups rests on the significant disparities between a religious idealist belief system and a secular materialist belief system. No compromise is possible between two such different worldviews. Because neither group intends that children suffer and both groups value the health of children, the two groups should simply respect each other's disparate worldviews and resulting health-related choices.

Practices, Beliefs, and Church Structure of Christian Scientists

Christian Scientists rarely, if ever, go to doctors. They usually choose instead to rely exclusively on prayer for healing. One major difference between a Christian Scientist's approach to praying for healing and that taken by more mainstream Christian denominations is that Christian Scientists do not attempt to "mix" prayer with a medical approach. They view the two approaches—prayer versus medicine—as incompatible. Christian Science doctrine does not *forbid* going to doctors. Rather, it is up to each Christian Scientist to decide whether to use a Christian Science prayer-based approach or a medical approach.

Because Christian Scientists choose to take such a radical stand on health-related issues and because they commit to a lifestyle so different from most, their choice to be Christian Scientists is usually a carefully considered one. They do not deem themselves to be Christian Scientists simply by virtue of their choice of church on Sunday. Even those whose upbringing included faithful attendance at a Christian Science church must eventually choose for themselves whether to make the significant commitment to a way of life that includes, among other things, daily prayer and study, no drinking, and no smoking.

The Christian Science view of prayer is different from that of some "faith-healing" religions. For Christian Scientists, it is an ongoing process of better understanding and demonstrating that there is a perfect spiritual order already in existence. They believe that when this order is felt and understood, suffering in human experience is overcome and eliminated. Thus prayer is not viewed as a petition to God to intervene by performing a miracle of some sort. Rather, prayer is a search for an increased understanding of spiritual reality—a search that, when successful, results in the exemplification of this reality in one's experience. When praying about a specific situation, Christian Scientists mentally affirm relevant spiritual facts and deny the ultimate reality of anything that appears to contradict these facts.

In philosophical terms, Christian Scientists are idealists. Mary Baker Eddy, the woman who founded Christian Science in the 1860s, reasoned that if God, infinite Mind, is All, then there is no matter. What is perceived by humans as a physical universe is, in reality, nothing more than the conscious and unconscious thoughts of mortals. As Richard Nenneman, a Christian Scientist and past editor of the *Christian Science Monitor*, explains it, the physical universe is "ultimately unreal, but it is, in terms of the human perception of it, also plastic—it is molded according to the thinking brought to bear on it by each individual."[1] In other words, for Christian Scientists, the experience of inharmonious physical conditions (e.g., disease) is illusory and temporary. Their view is that a better understanding of God's harmonious spiritual universe will cause an apparently unhealthy physical condition to change into a healthy, harmonious "physical" condition. Prayer, then, is not just an optimistic hope "in the patient's mind" but is, for Christian Scientists, a better grasp of the loving and good nature of ultimate reality. This better understanding is exemplified on the patient's body, since for a Christian Scientist, the patient's body is itself nothing more than an image in thought.

Christian Scientists refer to themselves as "Christian" because they study and attempt to follow the teachings and example of Jesus. But their conception of Jesus' relation to God differs from that of most other Christian denominations. The human Jesus is, for Christian Scientists, an exemplar and way show-er, but Jesus' relationship to God is seen as being no different from any other human's. Jesus merely expressed and demonstrated God's ever-presence more fully than any other human being has before or since. Thus, Christian Scientists think that anyone can heal just as Jesus did by emulating his way of life and better understanding his teachings.

The structure of the Christian Science Church also differs from that of many mainstream Christian denominations. There are no Christian Science ministers or clergy. Instead, church services are conducted by two "readers" who are elected from within each church's congregation to serve for two or three years. Sunday services incorporate readings from the Bible and the Christian Science "textbook," *Science and Health with Key to the Scriptures*, by Mary Baker Eddy.[2] Wednesday evening services also include time for members of the congregation to share recent healing experiences or thoughts on Christian Science. Rules for governing both the central or "Mother" church, in Boston, Massachusetts, and its branch churches throughout the United States and the world, are found in the *Church Manual*.[3]

When Christian Scientists desire assistance or guidance from other Christian Scientists, they have several options. If they would like someone to pray for them, they can call on a Christian Science "practitioner." Practitioners charge for their services and are listed in the *Christian Science Journal,* a monthly publication. They are well versed in the teachings of Christian Science and are required to submit evidence of healing effectiveness to the Mother Church prior to being listed. If Christian Scientists wish to learn more about how to practice the teachings of Christian Science in their day-to-day lives, they can apply for what is termed "class instruction." These two-week classes are taught by "teachers" of Christian Science. Practitioners who have been especially successful at prayer-based healing and have gone through an additional course from a current teacher of Christian Science are eligible themselves to become teachers. Trained Christian Science nurses are also available for those who need nursing services. Unlike practitioners and teachers, nurses do not pray for their patients and, unlike medical nurses, they do not administer any sort of medication. Instead, they assist with daily hygiene, dress wounds, and keep patients as comfortable as possible while the patient addresses the situation through prayer. Most major cities in the United States have several Christian Science churches (First Church of Christ, Scientist; Second Church of Christ Scientist; and so on). Many also have a Christian Science nursing facility.

As specific issues and controversies arise in the course of this volume's debate, additional details on Christian Science views and practices are brought to bear. However, the authors of this volume do not pretend to offer a complete exposition of either Christian Science theology or the Christian Science way of life. Instead, they hope to expand a new field within applied philosophy—one in which the ethics surrounding the views, values, and practices found within an organized religion are reflectively and critically examined by both those within the religion and those who stand outside it.

Notes

1. Richard A. Nenneman, *The New Birth of Christianity: Why Religion Persists in a Scientific Age* (San Francisco: HarperCollins, 1992), 155–156.

2. Mary Baker Eddy, *Science and Health with Key to the Scriptures* (1875; Boston: The First Church of Christ, Scientist, 1934).

3. Mary Baker Eddy, *Manual of The Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts,* 89th ed. (Boston: The First Church of Christ, Scientist, 1895).

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High-Risk Religion: Christian Science and the Violation of Informed Consent

Margaret P. Battin

In some of the more colorful groups on the American religious spectrum, the religious faith of believers involves a willingness to take substantial physical risks—risks to health and physical functioning, even the risk of death. In several of these groups, the risks a believer takes are indirect, as in refusing blood transfusions or other medical treatment; in others, the risks are direct and immediate, as in drinking strychnine or handling poisonous snakes. Christian Science, as the Church of Christ, Scientist, is informally called, is one of these groups: Its members refuse virtually all medical treatment for illness or disease, relying instead on Christian Science's distinctive practice of "healing."

We may think of these practices as extraordinary tests of religious commitment. A willingness to risk death seems to exhibit the extraordinary value religion can have for believers; indeed, willingness to risk death for religious reasons is often extolled as the highest test of faith. But this willingness also raises a set of disturbing moral issues concerning the ways in which religious groups encourage their adherents to take such risks.

In what follows, I want to take a closer look at the influence of religious groups on their adherents' choices, focusing on high-risk decision making that can result in death, particularly in Christian Science. The same sorts of issues arise for many other groups as well: Jehovah's Witnesses; the Indiana-based Faith Assembly; the serpent-handling, strychnine-drinking Holiness churches of the Appalachian Mountains; the Oklahoma-Colorado Church of the First Born; End Time Ministries in South

Dakota; the Pennsylvania-based Faith Tabernacle; the Oregon City, Oregon, group the Followers of Christ; and others.[1] I do not wish to suggest that the willingness of believers in these groups to risk death may not be sincere and devout; rather, I want to cast a morally inquiring eye on the way in which religious institutions engender these sincere, devout beliefs. Christian Science, I shall argue, is among the most problematic of these.

This characterization may seem to be at odds with the social position of Christian Science. It is sometimes claimed in defense of Christian Science that its members tend to be upper-income, well-educated, professional people who are stable members of society, nonusers of drugs, alcohol, or tobacco—solid citizens, reliable and trustworthy. This is not a group on the margins of society or one scrabbled together by taking advantage of unfortunates with serious social or psychological problems. Yet, I shall argue, the practices of the Christian Science church nevertheless constitute a continuing violation of one of the most basic ordinary and professional moral norms, the requirement of *informed consent* when individuals are asked or invited to take risks to their own health or lives.

Risk Budgets and Styles

How do people come to take risks? How may other persons and institutions influence someone to take risks he or she might otherwise not accept? Is there something distinctive (or troubling) about a religious group that encourages its members to take risks—risks with their health, risks with their lives? To pose the problem in a precise way, we can conceptualize the issue of high-risk religion as it might be addressed in the field of professional ethics. Drawing on issues concerning the formation and manipulation of choice, especially in medicine, we can approach this problem under the general rubric of *informed consent,* thus applying norms from professional ethics to practices within organized religion.

In everyday life, risks that a person voluntarily and knowingly takes can be described as the result of a prudential calculation, however rudimentary that calculation may be in practice, in which he or she elects a course of action hoping it will produce a gain or avoid a loss while recognizing that it may either concurrently or alternatively result in a (further) loss. This prudential calculation involves a survey of the range of possible outcomes of the action proposed, an assessment of the likelihood of the various possible outcomes (the decision is made *under risk* if the probabilities are known, *under uncertainty* if they are not), and an assessment of the relative desirability or undesirability of each of the possible outcomes. Typically, avoidance risk taking

weighs two or more projected negative outcomes against each other; gain-oriented, positive risk taking may weigh various positive outcomes against each other, or a positive outcome against both the cost of failing to achieve it and the cost of failing to take the risk. Whatever the specific context of the risk decision, the decision maker properly makes the calculation by multiplying the value of each possible outcome times the probability that it will occur, if known (or the best approximation to it), and then choosing the course of action promising the highest expected utility. That this calculation may be made in a completely intuitive, nonquantitative way does not obscure its nature: Conscious decision making under risk or under uncertainty always involves acting so as to produce some preferred outcome while recognizing that this action may instead produce a different, undesired result.

Each individual, Charles Fried has pointed out, has a distinctive *risk budget*—the degree and severity of risk he or she is willing to accept in order to avoid certain losses or to achieve certain gains.[2] The risk budget is a function of the possible courses of action the individual foresees, the probabilities he or she assigns to the various possible outcomes, and the utilities he or she attaches to each of these, influenced by any characteristic errors the person may make in performing the prudential calculation that indicates what course of action promises the greatest expected utility. Although the risk budgets of ordinary individuals in a culture appear to be fairly uniform with respect to the background risks of everyday life (e.g., in drinking the water in a given locality or in using electricity in one's home), there is considerable divergence in the willingness of individuals to accept specific higher foreground risks—for instance, in financial dealings or in high-risk sports like hang gliding or mountain climbing. This is just to say that some members of a culture take risks that other members of the culture won't.

Furthermore, each individual has a distinctive *risk style*—the degree of deliberation or abandon he or she exercises in making a prudential calculation under risk or uncertainty. Some people assess perceived risks with meticulous, painstaking care, regardless of whether the risks are mild or severe and the amount of information they have about the probabilities of various possible outcomes; other take both big and little risks in a comparatively cavalier way. Different individuals also process relevant information in very different ways. For instance, some are naturally optimistic, focusing primarily on the benefits to be gained; other are comparatively pessimistic, attending to possible losses, even when their estimates of the probabilities of the outcomes are the same. In processing information, some individuals may be more prone to characteristic errors of reasoning

in risk assessment than others. Like risk budgets, the risk styles of persons within a culture are relatively uniform with respect to background risks but may vary considerably among individuals with respect to certain more conspicuous risks. Some people make their choices about risks in ways that other people would regard as foolish.

The problem presented by the practices of Christian Science, as well as other high-risk religious groups, arises with an observation about risk budgets and styles. The members of a culture ordinarily exhibit broad commonalities in both risk budgets and styles with respect to background risks; they also typically exhibit a range of idiosyncratic, individual risk budgets and styles with respect to certain conspicuous, higher-risk decisions. However, the risk budgets and styles of the members of certain religious groups display striking uniformities not so much with respect to background risks but with respect to major, conspicuous foreground risks—direct risks to health, physical functions, and even risks to life. Furthermore, the kinds of risk characteristically taken by members of these groups often fall well outside the risk budgets and, in addition, violate the risk styles of most other members of society, even outside the quite broad range of individual variation in risk budget and style that members of the culture ordinarily display in their decisions. Put another way, the members of certain religious groups like Christian Science take risks other people do not and decide to do so in ways that other people would not, but they nevertheless do so in remarkably uniform ways. Nor are these trivial risks; some are potentially fatal ones.

These characteristic risk-taking patterns, each distinctive of a particular group, may seem to be just another element in the colorful spectrum of American religious diversity. But this diversity cloaks substantial moral issues about the ways in which religious groups influence and shape individual decision making among their members. It is not merely that these people take risks other people do not and decide to do so in ways other people would not; it is the very uniformity of these group-specific risk budgets and styles and the degree to which they fall outside the ordinary range of variation that invites scrutiny of the mechanisms by which they are produced. What we will find in these religious groups—including Christian Science—are systematic, doctrine-controlled violations of the principle of autonomy, that is, of the moral principle familiar in professional and ordinary ethics that requires both protection of an individual's capacity to choose and respect for the substance of that choice.

If there are violations of the principle of autonomy, they can be identified by locating the precise point at which they occur in the paradigmatic decision-making process, evident in varying forms in different religious

groups whose adherents regularly make choices that indirectly or directly expose them to risks of death. Are these choices *informed?* Do they involve *consent,* genuine consent that is voluntary and uncoerced? In answering these questions (questions that can be articulated more clearly in part because we are approaching the problem from the standpoint of professional ethics), we will come to see that at least some of the ways in which religious groups shape and control high-risk decision making are morally indefensible.

Risk Taking in Christian Science

The First Church of Christ, Scientist, takes the refusal of conventional medical treatment in favor of Christian Science healing as central among its practices and as indicative of faith.[3] According to Christian Science belief, what we (mistakenly) call "disease" is produced by a "radically limited and distorted view of the true spiritual nature and capacities of men and women."[4] "Illness" results from "human alienation from God,"[5] produced by fundamental misunderstanding. Disease is symptomatic not of physical disorder but of underlying spiritual inadequacy and a failure to understand one's true spiritual nature. A faithful member of the church who falls ill consults a Christian Science practitioner to seek treatment, which consists "entirely of heartfelt yet disciplined prayer."[6] The practitioner, who is often consulted by telephone (sometimes long distance) and need not make a bedside visit, has no medical training in either diagnosis or treatment. The practitioner does not physically touch or examine the patient. Rather, the practitioner assists the ill person in prayer, the objective of which is to relieve physical symptoms by promoting the correct and reverent understanding of the true nature of disease: In reality there is no such thing. Prayer is believed to be incompatible with conventional medical treatment, since a medical treatment presupposes the misleading assumption that there is such a thing as disease, that it is of physical origin, and that it can be treated by physical means. Properly, one cannot speak of *cure,* for there is no disease to be cured; rather, the relief of symptoms is a "demonstration" of the correctness of the principles upon which Christian Science is founded. Christian Scientists do generally use the services of dentists and oculists and sometimes have physicians perform what they call "mechanical" procedures not involving medication, such as setting broken bones; but other than this, no conventional medical procedures, either diagnostic or therapeutic, are used.[7] For services rendered in praying for and with the individual who is ill, the Christian Science practitioner receives a fee roughly comparable to the fees conventional physicians charge. This fee is reimbursable by many insurance companies (including

some Blue Cross/Blue Shield plans) and by some state and federal Medicare and Medicaid programs.[8] There are about 2,800 Christian Science practitioners who practice healing through prayer on a full-time basis and about 675 nurses listed in the *Christian Science Journal*.[9]

Frequently, the choice between Christian Science healing and conventional medical treatment does not constitute a subjectively recognized *risk* for the devout Scientist, since belief in the efficacy of Christian Science healing may be very strong. In such cases, the individual may be confident that Christian Science healing will provide relief from the condition that troubles him. Nevertheless, the choice to accept treatment from a Christian Science practitioner rather than a medical doctor, or not to accept treatment at all, resembles in structure any other prudential calculation under risk: Various possible outcomes—cure, continuing illness, incapacitation, and death—are foreseen under specific valuations and under more or less quantifiable expectations about the likelihood of their occurrence. Christian Scientists are, of course, aware of the availability of conventional medicine; medical treatment is a possible choice, but one that, on prudential grounds, the believing Christian Scientist does not make. The believing Scientist not only thinks he or she is acting in accord with the dictates or expectations of the faith but also that he or she will maximize the likelihood of achieving the outcome with the greatest expected utility, namely, a successful cure, by preferring Christian Science healing to conventional medicine. It is in this choice that the risk taking lies; the believing Christian Scientist, of course, sees it as a good risk.

Christian Science is not the only religious group whose high-risk practices challenge the principle of informed consent. Others include Jehovah's Witnesses, who refuse a single component of medical treatment—the transfusion of blood or blood derivatives into their bodies—on the basis of scriptural passages that prohibit eating or drinking blood; the Faith Assembly, a small fundamentalist group centered in northwestern Indiana, which at its height prohibited members from consulting doctors or using any medical treatment at all, including vaccination, assistance in childbirth, emergency treatment, prostheses, eyeglasses, or hearing aids; and the Holiness churches, widespread in the Appalachian regions of the southeastern United States, many of which practice serpent handling and strychnine drinking on the basis of biblical directives, and others named at the outset: the Church of the First Born, End Time Ministries, the Faith Tabernacle, and the Followers of Christ, all of which teach avoidance of medical care. But Christian Science is the one I want to focus on here, in part because its practices are particularly problematic.

Altering Risk Budgets

Even when the risk taker's prudential calculation is neither skewed by the imposition of coercively large costs for failing to take the risk nor made in an emotionally heightened condition, there are two further ways this calculation can be distorted. Like any other group, a religious group can influence the individual's estimate of the probability of the various outcomes he or she foresees, or it can change the evaluations assigned by the individual to these outcomes, or both. In both cases, the effect of the influence is not to coerce choice or to impair its quality by altering risk style but to alter the individual's risk budget.

Altering Assessments of Probabilities

A person reasonably conversant with the circumstances of the world knows certain facts: that malnourishment impairs health, that rattlesnakes are poisonous, that acute appendicitis can be fatal, and so on. These commonplaces are as familiar to the religious person as to the nonreligious; they are part of the common stock of background information shared within a culture. Hence, the religious risk taker, at least when the risks are understood to be common, physical ones, will have a fair amount of background knowledge about the risks he or she takes. A snake handler knows that rattlesnake bites can be fatal; that is what makes snake handling important and why it serves as a test of faith.[10] Similarly, Faith Assembly members know that hemorrhage in childbirth can be fatal; that is why it is a test of commitment to the church's beliefs to refuse treatment and why, in the controversial case of Sally Burkitt (a Faith Assembly member who bled to death during the delivery of her baby), assisted only by prayer and not by a midwife or physician, Sally pleaded for a doctor instead. Of course, in many cases religious risk takers will not know the precise degree of risk involved (as most of us do not know the precise risk from hemorrhage in childbirth or from untreated rattlesnake bites), but we all share a general conception of the relative dangers of these threats. It is against this background conception of general estimates of danger that religious risk taking occurs.

Yet it is possible to change an individual's estimate of the likelihood that various possible outcomes will occur. Given an array of evaluated possible outcomes, this may involve making specific positively valued outcomes seem more likely or making specific negatively valued ones seem less likely, or both, so that a recalculation of the risk would result in a different choice.

Take, for instance, the case of the Christian Scientist with acute

appendicitis who seeks relief. Like other members of contemporary society, he or she will have some background understanding of the likelihood of untreated appendicitis's resulting in death. Although this is by no means a scientifically rigorous conception, the person can say, for instance, that the likelihood of death is greater in untreated appendicitis than in, for example, untreated influenza. However, the teachings of the individual's church persuade him or her that although this background information is accepted by nonbelievers and correctly describes the probabilities confronting them, the probabilities are quite different for persons who understand the nonphysical nature of illness and disease, the power of Christian Science healing, and the true nature of prayer. The believer holds that achieving a correct understanding of "illness" and "disease" as resulting from defective mental attitudes will free him or her from them, even when the risks would otherwise be very high, and that the way to achieve this correct understanding is in prayer. Thus, the Christian Scientist will hold that the risk of death from acute appendicitis treated only with Christian Science prayer is, in fact, much lower than the shared cultural conception would insist; in fact, that it is actually lower not only than the risk from untreated appendicitis but lower than the risk in appendicitis treated with conventional medicine. Prayer, in this view, is the most effective treatment of all. This shared perception of risk explains why Christian Scientists exhibit similar, though unusual, risk budgets in medical choices of this sort; it also invites us to ask how this shared perception of risk is attained.

How does the believing Christian Scientist reach this still lower estimate of the probability of death? Let us look at the kind of evidence with which the believer is supplied and upon which he or she bases prudential calculations of risk; these involve alterations of risk budgets and styles.

Support for claims of the efficacy of Christian Science healing, following the pattern of assertions made in *Science and Health with Key to the Scriptures*[11] and other writings of Mary Baker Eddy, is provided largely by the testimonials of those who recount the ways in which they have been healed from disease or injury. These testimonials are typically quite detailed and fervently sincere in tone; they are direct, firsthand accounts of what is often an extremely powerful, faith-confirming experience. For example, a woman living in the Mojave Desert area of California writes: "On a warm afternoon last May while coming into our house through the laundry room (which is part of the garage), I felt a sharp pain in my right foot. Looking down, I saw what appeared to be a rattlesnake disappearing under the washing machine."[12]

She goes on to recount her fear, the assistance of the Christian Science practitioner in praying for her recovery, the development and eventual

subsiding of a discolored, numb swelling on her foot, and the confirming effects this experience had upon her faith.

This testimonial is typical of the handful published in each issue of the *Christian Science Journal,* a monthly periodical widely circulated among Christian Scientists and, like the weekly *Christian Science Sentinel,* a primary source of information about the church. The *Journal* asserts that "the statements made in these testimonies with regard to healings have been carefully verified,"[13] and that it retains on file the originals of testimonials together with the three written verifications or vouchers required for publication. Between 1900 and 1985, some 53,900 testimonials of healing had been published in the periodicals of the church; they are said to be "the most important body of evidence concerning Christian Science healing."[14]

A careful examination of testimonials published in Christian Science periodicals between 1971 and 1981, according to a First Church of Christ, Scientist, authority defending healing in the *New England Journal of Medicine,* shows "647 testimonies concerning illnesses that had been medically diagnosed, in some cases both before and after a healing . . . [including] leukemia and other neoplasias, both malignant and benign; diphtheria; gallstones; pernicious anemia; club feet; spinal meningitis; and bone fracture, among numerous others."[15] This figure includes 137 pediatric cases. Healing in such cases might seem to constitute an impressive record. But the record is wholly anecdotal in form, appealing simply to isolated cases without reference either to general patterns or trends or to comparisons based on control groups. The effect of this kind of information—independently of whether the claims are actually true—is to exacerbate one of the most common errors in decision making under risk.

Many kinds of error are possible in risk-taking choice. Objective errors include misidentification of the range of possible outcomes and assignment of faulty probabilities to possible outcomes (often as the product of subjective factors such as unwarranted optimism or pessimism), misidentification of the values one assigns to possible outcomes, inconsistent weightings of possible outcomes, self-deception, and so on. But there is a common, documentable error characteristic of rational choice, frequently discussed with reference to informed consent in medical situations. This is the tendency to overrely on case information and to underrely on base-rate information.[16] Ordinary patients in ordinary medical contexts do this: They tend to base decisions on anecdotal accounts, supplied by physicians, friends, personal experience, or other sources, including movies and TV, and to downplay or ignore information about the rates of incidence of specific conditions, side effects, self-limiting conditions, spontaneous recovery, and so on.

Whereas ordinary medical patients do this rather naturally, Christian Scientists in situations of medical risk are in effect *encouraged* to do so, since they are supplied with information that makes miscalculation inevitable. What are *not* available from the Christian Science church or from its publications are data that might counteract this tendency or could contribute to establishing reliable base-rate information: How often, given a specific medical condition, does Christian Science healing appear to be effective? This question is much easier to answer than, How often is Christian Science healing actually effective? But no data are available even for the easier question about apparent results.

Clearly, 647 documented cases over a ten-year period is sparse evidence, in view of the number of Scientists and the frequency within the general population of the conditions involved. There might, of course, be many undiagnosed, undocumented cases or a lower incidence of the conditions among the Christian Science population, but these conjectures do little to provide the Christian Scientist with a reliable sense of the frequency with which Christian Science healing, once attempted, is effective. Testimonials of failures, of course, are not published in the church's periodicals.

Yet there is at least some documented information available concerning failures. A study of child fatalities associated with religious groups opposing medical treatment examined the records of 172 children who died between 1975 and 1995 in which there was evidence that parents had withheld medical care because of reliance on religious rituals or teachings and there was sufficient documentation to determine the cause of death.[17] Of the 172 deaths, 140 were from conditions for which survival rates with medical care would have exceeded 90 percent, conditions like pneumonia, meningitis, aspiration, type 1 diabetes, dehydration, diphtheria, measles, appendicitis, and small bowel obstruction. Eighteen more had expected survival rates of over 50 percent. Although this study can be challenged on design grounds, since calculation of overall mortality rates is not possible and the cases were collected in a nonrigorous manner, as the authors recognize, nevertheless the cases do shed light on the importance of negative information. (Interestingly, in this study, Christian Science had a lower number of deaths in proportion to the size of its membership than other groups studied: the Church of the First Born, End Time Ministries, the Faith Assembly, and the Faith Tabernacle.)[18]

Furthermore, the lack of negative information made available to Christian Scientists is compounded by false positives—cases in which Christian Science healing is credited with the cure of a condition that was self-limiting or would have resolved spontaneously anyway—as when the cold

that vanishes after troubling a person for two weeks is taken as proof that Christian Science really works.[19] Even the account by the woman bitten by the rattlesnake under her washing machine should be seen in light of the fact that rattlesnake bites are comparatively seldom fatal, especially at distant sites on a limb (the woman was bitten on the foot); but this information was not provided. Yet it is only with adequate base-rate information, making it possible to calculate overall frequencies of success and failure in non-self-limiting conditions with given forms of treatment, that a person can rationally compare conventional medical treatment with Christian Science healing of the same condition, and make a choice in an informed way.[20]

To assert that Christian Science healing cannot be chosen on a rational basis is, of course, not to assume that Christian Science healing is in fact less effective than conventional medical therapy. This point must be conceded by critics of the group, given substantial rates of iatrogenic illness in conventional treatment and the fact that a very large proportion (variously estimated at 75 or 80 percent) of the "illnesses" initially seen by physicians are either self-limiting or psychogenic in origin. Rather, it is to point out that the basis on which a Christian Scientist makes a choice in seeking relief from symptoms is not rationally defensible. Christian Science healing might, in fact, be more effective than conventional medicine, but even the Christian Scientist would have no way of knowing this. Yet the church does claim to supply persuasive, empirical *evidence* for the efficacy of healing; this is part of the point of *Science and Health with Key to the Scriptures* and part of the point of providing testimonials at all.

But the issue is more complicated than it might appear. Nicholas Rescher takes the crucial distinction in risk assessment to be that between *realistic* and *unrealistic* appraisal.[21] Despite the fact that the individual Christian Scientist's choice to rely on Christian Science healing is not rationally defensible, it cannot be said to be unrealistic in a general sense. This is because the individual Scientist has not exaggerated, underestimated, misinterpreted, or otherwise misapprehended or distorted the available evidence. Given the evidence he or she has, the tools provided for assessing it, and the surrounding claim of a trusted institution that the evidence is compelling, he or she makes a subjectively realistic assessment; the fault is not the Scientist's, who is both a believer and a member of the church. In fact, the Christian Scientist characteristically believes that such a choice is a good, sound decision based on a large body of compelling evidence that, though ignored by non-Scientists, is rationally persuasive. As one Scientist wrote:

> My own family has relied on Christian Science for generations. I have never considered prayer a gamble. Please understand: I'm not speaking of some crude kind of "faith healing" that implores God to heal and says it was His will if nothing happens. I'm speaking of responsible spiritual healing practiced now over a century by many perfectly normal citizens and caring parents.
>
> I'm concerned about not being taken seriously—that nobody in the media . . . is really taking into account that these healings have been happening over many years. Not just in my family, not just my friends. I'm speaking of the massive, long-term experience in a whole denomination.[22]

If this believer's assessment of risk, although subjectively realistic, is in fact objectively unrealistic, any moral complaint must be directed not primarily against the believer, nor against church teachers and officials, since after all they too share the same set of assumptions with the church membership. Rather, blame rests with the institutional perpetration of the claim that the evidence is valid, and the complaint should point out how the encouragement of belief in the efficacy of healing rather than objective confirmation of it compromises the possibility of autonomous choice. Of course, there is fault on both sides. The medical establishment has been as uninterested in examining alleged Christian Science healings (being generally content to assert that either they were spontaneous recoveries, perhaps associated with the placebo effect, or they were inaccurately diagnosed in the first place) as Christian Science has been to provide well-documented evidence, in particular evidence scrutinized under contrary hypotheses.

But there is a further complexity to the risks Christian Scientists take in choosing healing over conventional medical treatment. Not all healing is successful; some people remain incapacitated, some are sent to Christian Science sanitariums or nursing homes, and some die. Christian Science teaching explains this at least in part as the result of a failure on the part of the patient to understand fully his or her own nature as a spiritual being or to pray adequately for release from incorrect attitudes; the devout Scientist believes that the risk of death from "disease" correctly understood and adequately prayed for is nil. But the Scientist, devout or otherwise, is not encouraged to assess, in making risk-taking choices, how likely it is that he or she will correctly understand and adequately pray for release from the condition. This crucially relevant factor in a prudential risk calculation under these religious assumptions is simply not brought into question or discussed, nor is any evidence bearing on it, anecdotal or otherwise, provided. How often does the explanation of a patient's failure to recover appeal to the claim that the patient failed to pray appropriately or had the wrong

attitude? This information too is of great relevance in risk-taking choices, yet it is nowhere forthcoming.

Furthermore (although there is some lack of agreement on this issue)[23] Christian Science generally holds that healing through prayer is incompatible with conventional medical treatment, since prayer consists in achieving an understanding of the nature of disease that contradicts the causal, physicalist assumptions of medicine. Stories abound of people being denied continuation of the services of a Christian Science practitioner if they also enter the care of a physician. Patients who enter Christian Science sanitariums receive care only from nurses who are members of the church and from church practitioners; the nurses are prohibited from doing anything "material" to evaluate or relieve disease and suffering.[24] Thus, although conventional physicians are quick to recognize the psychotherapeutic value of ordinary prayer by the patient, whatever advantages might accrue to the ordinary patient from a combination of medical treatment and religiously supported hope are not available to the Christian Scientist. Rather, the Scientist is forced to make a choice between therapies without knowing whether the chance of survival with both kinds of therapy is better or worse than with only one or the other. Christian Science periodicals do not print testimonials from persons who see doctors as well as healers, any more than they do from persons who see doctors alone.

The institutional practice of altering persons' risk budgets by providing only anecdotal information unaccompanied by base-rate data, as Christian Science does, and by ignoring the incidence of failed cases and of any special conditions that must obtain for the supposed course of action to be effective, fails to satisfy yet a third basic initial criterion for autonomous choice: Not only must it be voluntary and rationally unimpaired, as we've seen, but it must also be adequately informed. It is true that anecdotal information of the kind provided in Christian Science periodicals can be extremely effective in stirring faith and may be of great significance in a person's life. It may well produce a sizable placebo effect. And it is possible that Christian Science healing is actually efficacious, even in cases of non-self-limiting, serious illness. But insofar as merely anecdotal information is put forward as the evidence for claims of efficacy in healing and as a basis for refusing conventional medical treatment, it is clearly an inadequate basis upon which to encourage people to take such substantial risks. Neither their reliance on religious healing nor their refusal of conventional medical treatment meets the conditions for "informed consent." Hence, if we are to assess the practices of this church in the same way we would assess those

of medicine or other secular professions that encourage people to take life-threatening risks without granting them the right to give informed consent, we would be tempted to say that they involve manipulation, callousness, or deceit.

The analysis given here of evidentiary claims concerning the efficacy of nonmedical healing applies not only to Christian Science but to any religious group that appeals to alternative varieties of healing, whether the healing involves denominational practitioners, faith healers, or the assumed direct influence of a divine being. The Faith Assembly, for instance, regards Jesus as the sole physician, but (at least if the scant evidence available concerning this group is correct) relies on much the same persuasive structures (where it does not directly coerce) Christian Science uses to produce acceptance of its claim. So do individual faith healers of various sorts, groups such as the Church of the First Born and the Faith Tabernacle Congregation, and many of the contemporary "televangelist" preachers. Methods used to further beliefs about the efficacy of healing at such institutions as the Roman Catholic shrine at Lourdes might also bear inquiry, as well as the practices of groups that accept faith healing but do not reject conventional medical treatment, such as the Assemblies of God and certain charismatic subgroups of Catholicism and Anglicanism. Thus, although Christian Science may provide the most conspicuous example of a certain sort of religious intervention in high-risk decision making, it has many features in common with other groups; ethical censure, if it is appropriate at all, ought hardly be reserved for this group alone.

The Doctrinal Status of Risk Taking

To show that risk-taking religious conduct occurs in various forms and with various amounts of risk in various religious groups—including Christian Science—is not yet to reach a normative conclusion. It cannot simply be assumed that making a decision in which one risks death is wrong, nor can it be assumed that there is something wrong with the mechanisms that religious groups employ to influence people in making these decisions—however extreme the risks, however manipulative the manner of encouraging them, and however severe the consequences for both the risk taker and for others. These are the features that an examination of religious practices using professional ethics exposes; yet to identify features is not to establish that they are morally intolerable, since such conduct is governed not only by moral considerations but also by the doctrines, teachings, and authoritative pronouncements of the specific religious groups.

In my volume *Ethics in the Sanctuary,* I developed a typology to distinguish various levels of doctrinal assertions with respect to the ethical dilemmas involved.[25] The typology recognizes four distinct levels or orders of doctrinal assertions: 0-order or base-level doctrines, the fundamental imperatives of a group (often, though not always, stated in scriptural texts); first-order doctrines or teachings, which stipulate ways of putting basic imperatives into practice but characteristically generate new moral problems in doing so; second-order doctrines or teachings, which establish a position that attempts to resolve the ethical problems presented by first-order doctrines; and third-order doctrines or teachings, which function as excuses for residual moral problems. This four-level typology provides a basis for distinguishing the more fundamental religious imperatives of a group from dictates that, though they may have achieved similar doctrinal status, exhibit later historical or theoretical development within a tradition and are best viewed as "answers" to and "excuses" for the moral problems posed by the fundamental imperatives and the ways they are put into practice. Because of their derivative status, whatever doctrinal position they may enjoy, they are to be treated as initially more vulnerable to ethical review than the basic imperatives of the tradition within which they arise.

In surveying the huge variety of risk-taking practices evident among various Christian and Christian-influenced groups, this typology serves to differentiate between those risk-taking dictates that are more vulnerable and those that are less vulnerable to ethical criticism. Of course, since the risk-taking practices in these groups—including Christian Science—do not form a coherent, unified, single tradition but occur in a spectrum of denominations and sects with different histories, application of this typology will not be completely tidy or uniform. Nevertheless, it is possible to identify doctrines, directives, teachings, and other authoritative pronouncements at all four levels.

In these religious settings, some people take risks, including physical risks, and some of these risks eventuate badly: some persons suffer serious damage to their health; some die. The topology employed here reveals a further level of doctrinal, quasi-doctrinal, or authoritative claim, identified as third-order doctrine, that provides "excuses" for the residual moral problems generated by the practices in question. For instance, when a Christian Scientist practicing his or her beliefs by relying on healing refuses conventional medical treatment and dies, some account consistent with both the basic doctrinal imperative and with the first- and second-order teachings is needed to explain or justify the negative outcome.

Similarly, since serpent handlers act to honor the assertion in Mark 16 that "they will pick up snakes in their hands, and if they drink any deadly thing, it will not hurt them," the group's continued acceptance of the basic religious imperative depends in part on providing a doctrinally acceptable account of how snake bites and snake bite fatalities can occur, that is, an excuse for the negative outcome resulting from the risks a person takes in relying on the scriptural assurance that no harm will come from handling snakes.

These third-order teachings or excuses for failed risks are usually easy to identify, though they are not always encoded in official doctrine. When a Christian Scientist who refuses medical treatment and relies on prayer worsens or dies, the most frequent explanation is that he or she failed to pray adequately and hence failed to achieve the proper understanding of the nature of disease. Similarly, the Faith Assembly member who dies after refusing treatment is said to have lacked faith in Jesus' power to heal—an accusation so prevalent in this group that its founder, Hobart Freeman, extended it even to those who use automobile seat belts. The serpent handler who is bitten is sometimes said to have failed to be sure of being genuinely anointed before taking up the snakes.

Just as it is easy to identify these third-order teachings or excuses for the negative outcomes that a group's risk-taking practices have brought about, it is also easy to see a feature that is common to many of them: They explain the negative outcome as a result of a failure on the part of the individual harmed. This is true in the Faith Assembly, the Holiness Church, and Christian Science. In examining the excuses various groups encode in their doctrines, we can begin by considering whether excuses that lay the blame for unsuccessful risk taking at the feet of the risk taker are themselves morally defensible, or whether a defensible excuse must be of some other form.

In contrast, the Jehovah's Witnesses appear to offer no excuse when a Witness refuses transfusion and dies. However, under the reevaluation that is characteristic of Jehovah's Witness practice, there is nothing to excuse. The faithful Witness who dies because he or she refuses blood—according to the teachings of the group—nevertheless achieves salvation, which, under the reevaluation, is the maximally valued outcome the choice could yield. Consequently, for the devout, the death need not be excused. The issue, then, is whether Christian Science is like this, or whether Christian Science involves a pragmatic attempt to achieve cure: Does Christian Science involve praying for a cure, or praying for its own sake, believing—but not centrally intending—that this might also result in cure?

The Moral Evaluation of Risk Taking in Religion

Examining the practices of Christian Science and other groups suggests an immediate conclusion: that these practices involving risks cannot be morally defended, and, furthermore, that they should be denounced on moral grounds. In *Ethics in the Sanctuary,* I argue that the developed practices and teachings of religious groups, as distinct from their fundamental imperatives, are vulnerable to ethical critique. And when we now look at these practices in a variety of groups, including Christian Science, we see that they involve clear abuses of identifiable, uncontroversial moral principle. Examining issues in confidentiality in many groups, for example, Catholics, Mormons, and fundamentalist groups like the Collinsville Church of Christ, we find practices that variously involve lying, nonconsenting disclosure, manipulation, and allowing serious, preventable harms.[26] Thus risk taking in a variety of groups involves coercion, impairment of rational capacities, manipulation, callousness, and deception. No doubt we could look further and find more. But to identify these apparent moral abuses is not to establish that they are abuses *in religious contexts;* we have only seen them this way because we instinctively appeal to principles familiar in secular life. Even though we have established that certain religious doctrines and practices are open to ethical evaluation, we cannot simply assume that the principles presupposed by this catalogue of apparent abuses are applicable here.

Of the moral principles that these apparent abuses seem to violate, autonomy is central. This principle is highlighted by the strategy of using the apparatus of professional ethics to examine issues of religious risk taking, in particular, the concept of informed consent. The principle of autonomy, received in both its Kantian form and in the utilitarian version defended by John Stuart Mill, is seldom contested in either ordinary or professional ethics, though there certainly are continuing, vigorous debates about how it should be interpreted, about the degree to which individuals are capable of genuine autonomy, and about when, if ever, the principle may be overridden. This principle has been central in contemporary professional ethics. Here too disagreement virtually or nearly exclusively concerns the conditions under which paternalistic or harm-based exceptions to the principle are legitimate; there are few real challenges to the principle of autonomy itself.

Do these religious practices violate the principle of autonomy and thus undercut the possibility of informed consent? Though they are often explicated within professional ethics in more elaborate ways, the conditions for autonomous choice involve three criteria: (1) the decision must be

uncoerced, (2) it must be rationally unimpaired, and (3) it must be adequately informed. But, as we have seen, these are precisely the conditions that the practices of these various groups violate.[27] The Faith Assembly, at least on some occasions, coerces its members into refusing medical treatment. The Holiness serpent-handling groups encourage making potentially fatal decisions about handling snakes under extreme emotional impairment, calling that condition an "anointment" for taking the risk. Christian Science provides selective, anecdotal information only, without base or failure rates, in a way that is inevitably deceptive in influencing a high-risk choice. Nor is it apparent that these interferences in autonomous choice can be excused on the ground of limiting risks to third parties or for compelling paternalist reasons. Thus, since these practices are vulnerable to ethical critique and the infractions of the principle of autonomy are so clear, it would seem that moral conclusions could be drawn readily.

But I do not think this is so. Because our apparatus for evaluating religious practice is not yet complete, the principle of autonomy cannot be directly employed. Upper-level doctrines and practices are *candidates* for critique; but we have yet to establish on what basis the critique can be made. To condemn practices for violating conditions of autonomous choice involves an unwarranted leap in ethical evaluation, even though these criteria are well established in both professional and ordinary ethics. It is a leap we can make—in limited ways—only after our initial typology is supplemented with the appropriate critical principle.

The principle to which we shall appeal, the fiduciary principle, is a distinct moral principle not reducible either to that of autonomy or to those of nonmaleficence and beneficence. Most explicitly articulated in law, it is vaguely recognized in various forms in all of the secular professions. The fiduciary principle serves to identify the obligations of the professional vis-à-vis the client in professional contexts and, except for a few distinctive interpersonal relationships, it is usually thought to be limited to professional contexts.

To employ a principle adopted from professional ethics to examine organized religion is not to presuppose that religious functionaries are all professionals in the fullest sense. Clergy of the mainstream denominations have traditionally been regarded in this way, though cult leaders, evangelists, faith healers, gurus, and the like have not. Although the fiduciary principle has been developed in professional contexts, its scope is broader and provides a crucial distinction in assessing religious practice.

The fiduciary principle, which applies to all aspects of professional-client interaction, regulates practice by stipulating that it must be possible for the

client to *trust* the professional in the course of the interaction, even though the professional's own interests may conflict with those of the client. Put another way, the fiduciary principle prohibits the professional from taking advantage of the client—violating the client's rights or harming his or her interests—in the course of the professional relationship, though the professional's superior status, power, and knowledge would make it easy to do so. For example, the lawyer has fiduciary duties to the client; this means that the lawyer must use his or her professional skills to advance the client's interests or, at least, not to harm them. Similarly, the trustee, as fiduciary to the beneficiary of a trust fund, must refrain from usurping the beneficiary's interests in the fund, just as the director of a corporation must refrain from promoting his or her own interests at the expense of the corporation. The fiduciary principle may seem similar to the more general principle of nonmaleficence, but it has a specific application to the professional-client relationship and to the characteristic imbalance of power this relationship exhibits. It is broader in scope than the comparatively narrow principle of autonomy; it requires the professional not only to respect the client's autonomous choices and to protect the client's capacity to make them but also to ensure (and this does not rule out paternalistic intervention) that the client's interests are served. Thus, the principle is a complex one, with conditions often in tension between autonomist and paternalist demands, and it is not reducible to the simpler principles often cited in professional and ordinary moral discourse. To say, as Charles Fried does, that the fiduciary "owes a duty of strict and unreserved loyalty to his client"[28] is correct and makes it clear that the professional's primary obligation is to the client, not the professional's own interests, the institution, or others who might be involved. But the question of how the sometimes conflicting requirements of this complex principle are to be satisfied is left open.

Inasmuch as the fiduciary principle has autonomist components, the three conditions for the protection of autonomous choice identified above—noncoercion, freedom from rational impairment, and adequate informedness—can all be derived from it, though in some circumstances they may be in tension with paternalist components of the principle. In professional areas such as medicine and law, these three conditions protect the client from the professional in very specific ways. The client, it is assumed, consults the professional in order to advance his or her aims and interests; the protection needed is protection from possible dishonesty, manipulation, or greed on the part of the professional. For instance, when the patient consults the doctor for help in curing an illness, he or she occupies an unequal, vulnerable position in the relationship (the patient, after all, is

both sick and untrained in medicine) and must rely on the physician's obligations as fiduciary to keep from being made worse off, specifically, from being made worse off with respect to health. The legal client consults an attorney for help in protecting his or her rights and similarly relies on the attorney's fiduciary obligation to a client. Since the attorney is far more skilled in the law than the client, the attorney could easily jeopardize the client's rights. Professionals are also often in a position to jeopardize other interests of the client (both doctors and lawyers, for instance, can easily threaten a patient's or client's emotional, social, or financial well-being), but it is with respect to the specific interest or set of interests about which the client has consulted the professional that the fiduciary principle most directly applies.

Like other professionals, the religious professional, whether minister, priest, rabbi, pastor, evangelist, faith healer, or guru, is in a position to make individuals within the group either better or worse off. He or she can affect their emotional, social, financial, or other peripheral interests. The religious professional can also affect, either positively or negatively, the specific aim or interest for which they seek help in the first place; it is this fact that initially supports the appeal to the fiduciary principle made here. What the fiduciary principle requires is that the priest or the preacher not treat those who come as prey, even in the most subtle ways, or use them either for self-interested ends or other institutional goals but instead remain worthy of trust.

To construe the relation between the religious professional and member of the religious group in this way invites us to identify precisely what it is that the religious believer comes to the religious professional for, that is, what interests he or she hopes to serve in approaching the religious professional. Although this may be very difficult to do for a specific case, we can venture certain general observations. Consider, for instance, the reasons why the Christian Scientist or a member of the Faith Assembly has contact with the leaders of his or her group, as contrasted with the reasons why, for example, a member of a serpent-handling group might do so. The Christian Scientist calls a practitioner when he or she is ill and does so for help in restoring health. Similarly, the member of the Faith Assembly rejects medicine and relies on Jesus in order to get well, but he or she also acts to retain membership and avoid humiliation by the group. The serpent handler, on the other hand, attends a prayer meeting and handles serpents in order to satisfy the injunction he or she believes Mark 16 states; there is less evidence here of some particular external objective. Then again, the Jehovah's Witness appears to refuse blood in order to satisfy a biblical

commandment, much as the serpent handler does, but does so in order not to jeopardize his or her chances of salvation.

Of course, identifying reasons why people engage in religion is a murky business at best; a full psychological explanation of such behaviors is far more complex than can be treated here. Nevertheless, it is evident that strikingly different degrees of rational prudence, in the pursuit of self-interest, are exhibited by the members of various groups. The Christian Scientist seeks to get well, just as any ordinary patient seeing any ordinary doctor does; in doing so, the Scientist acts to promote one of his or her interests—health. The Scientist does not call the condition "illness" nor recognize its symptoms as those of "disease," nor does he or she understand the end state sought to be a "cure" but rather a "demonstration" of the truth of the principles of Christian Science. Indeed, the Scientist rejects the entire causal metaphysics of medicine. Nevertheless, he or she accepts, and the church promotes, a variety of external similarities, many dating from the earliest period of the church,[29] reinforcing the claim that what the believer seeks is what any ordinary patient seeks: help in regaining health. For instance, the Christian Scientist calls the practitioner only when he or she has discomforting symptoms (whether or not viewed as symptoms of "disease"). The practitioner can be found by looking in the Yellow Pages; an appointment is made; the practitioner's services are paid for at rates roughly comparable to those of a physician; and, in some states (Massachusetts, for instance) Blue Cross will pay the bill. To put it another way, Christian Science functions as an alternative health care system, though it denies medicine's metaphysics and makes no use of medical techniques; we can easily identify the professional institution to which Christian Science promotes itself as an alternative. But in doing so, the way in which Christian Science encourages risk taking is different from that of many other religious groups.

Not all risk-taking practices function as alternatives to secular professional institutions. The serpent handler, for example, does not so clearly seek to advance his or her interests by risking health or life but instead acts simply to obey an injunction he or she believes is what the Lord demands. There do not seem to be external similarities promoted by the group that would reinforce the claim that in handling snakes the believer attempts to further the same aims and interests that clients of other professionals do. Serpent handling is not an *alternative* anything; it is simply a practice of the group.

Noting these differences should allow us to see why the fiduciary principle, although vaguely asserted in the secular professions, is not dis-

cussed much there and why, in contrast, it is of particular interest in the religious sphere. The fiduciary principle prohibits the professional from violating moral principles in a way that would undermine those aims or interests for which a client seeks protection or advancement in using the professional's services. In medicine and law, as in other secular professions, this covers the entire range of cases: Patients and legal clients use the services of doctors and lawyers in order to protect and advance their own aims or interests, or those of organizations and causes with which they identify, and generally not for any other reason. They come to lawyers and doctors to protect their rights, broadly construed, or to get well. Since virtually all of the activities in which the professional engages with the client are initiated in response to such purposes on the part of the client, there is nothing distinctive in these areas of professional practice that the fiduciary principle might isolate and identify as protected under this principle. Of course, some clients do not voluntarily consult professionals but are delivered to them, such as the unconscious emergency patient or the impoverished defendant in the criminal justice system. But even in these circumstances the fiduciary principle applies by extension. On some occasions a client might consult a professional for purposes that do not appear to serve his or her self-interests, as, for example, when a person consults a doctor to donate a kidney to someone else. But even here the patient does so with the aim of protecting his or her interests as well as those of the recipient and does not ask the doctor to remove the kidney without regard for his or her own health. Even if the fiduciary principle is not particularly conspicuous in the secular professions, largely because it covers virtually all available cases, it will nevertheless play a central role in sorting out those cases in religion to which ordinary moral norms apply and those to which they do not.

The fiduciary principle functions in critiquing religious practice by identifying under what conditions upper-level practices and doctrines may be reviewed with the moral principles available in professional and ordinary ethics—such principles as autonomy, nonmaleficence, and beneficence. Although the working typology employed earlier makes it possible to distinguish between fundamental, 0-level imperatives and upper-level, developed doctrines and practices, it does not specify whether all of the latter are actually open to critique. The fiduciary principle functions as a second general principle, supplementing the earlier typology, and further limits the application of moral norms to religious practices. The fiduciary principle itself does not aid in sorting out conflicts and tensions between the demands of autonomy, nonmaleficence, and beneficence, either in general or

in specific cases; this is work for the applied professional ethicist concerned with organized religion, the "ecclesioethicist," to do. But the principle does tell us when the ecclesioethicist can get to work, by telling us under what conditions the basic moral principles can be applied to upper-level doctrines and practices. In religious contexts, the fiduciary principle asserts that *the developed practices, doctrines, methods, and teachings employed by religious professionals or their religious organizations must meet (secular) ethical criteria wherever the individual participates in these practices to advance his or her self-interests.* The fact that the religious professional is *religious* does not exempt him or her from treating clients in ways that are morally binding in the secular professions, as well as in ordinary morality, whenever the client approaches the religious professional for the same sorts of self-interest-serving purposes for which he or she would approach a secular professional—even if the client is also a believer and adherent of the group. For example, if the Christian Scientist seeks help from a Christian Scientist practitioner *in order to get well,* then he or she is entitled to the same freedom from coercion, from impairment, and to the same adequate information to which an ordinary medical patient would be entitled in seeking to get well. In a word, the religious believer, like the medical patient, is entitled to the protections of informed consent; the believer's status as a believer does not abrogate this right. However, if a believer approaches a Christian Science practitioner not to get well but in order to deepen his or her faith, as many devout Christian Scientists clearly do, then it is not so clear that these constraints apply. Many Christian Scientists conceive of healing not as an alternative medical system at all but as a process of prayer that is part of the effort to achieve a certain spiritual condition. A side effect of that process, though not its central purpose, may be the restoration of health.[30] It is indeed crucial whether the Christian Scientist is praying *for a cure* or praying for the sake of praying, though believing that cure may also result.

It may seem that the religious organization, or the religious professional within it, can have no such fiduciary obligation, inasmuch as neither the professional nor the organization has control over the reasons for which an individual approaches them. This is not so, of course, for the way in which a religious organization, including its officials, is approached is very much a function of the way in which it announces or advertises itself. After all, announcing or advertising an organization is an interactive process between the organization and the individuals who approach it. The process is not much remarked upon in the secular professions, since most secular professions announce themselves in uniform ways, but it is a process of

tremendous variability in religion. Christian Science, for instance, announces and promotes itself as an alternative healing system by the very fact that it distributes testimonials that recount favorable recoveries using Christian Science healing (even though these testimonials are described primarily as serving to give thanks to God) and by asking Blue Cross to cover the services it renders. In response to the way in which Christian Science announces and promotes itself, prospective users of the church approach it in kind, seeking to receive these services in order to further their aims and interests in getting well. The fact that prospective users of Christian Science healing, both members and prospective converts, seek to further their aims and interests in getting well leads the church and its officials to promote the church's services in this way. Similarly, for example, the Church of Scientology promotes itself as providing help in achieving psychological stability and growth; in this sense, it attempts to function as an alternative psychotherapeutic profession. As in Christian Science, Scientology's public stance is interactive with the aims and purposes for which prospective users of its services approach the church: It announces itself as able to provide psychological help and personality development, and people who seek these things turn to it.

In the secular professions, when we talk about a client's reasons for seeking a professional, we are saying as much about the professional and the background organization as we are about the client. Thus, to phrase the fiduciary principle in terms of what the client seeks is also to identify specific professional and institutional postures. In religion, since the fiduciary principle underwrites the application of standard ethical principles (for example, the bioethics canon of autonomy, nonmaleficence, beneficence, and justice) when adherents approach with self-interested aims, it thus also underwrites the application of these principles when the religious group and its officials announce themselves as available to help persons pursue their interests.

Of course, virtually all religious invitation may contain some appeal to self-interest. Insofar as a group makes such an invitation, however, under the interpretation of the fiduciary principle advanced here, it is obligated to protect and promote the aims and self-interests to which the invitation is directed. The church that announces itself as able to satisfy certain interests of persons who are attracted to the church in this way opens itself to *secular* moral critique of the practices and doctrines it employs in satisfying those interests. Not all of the upper-order practices in a religious group will be susceptible to ethical critique under the fiduciary principle; but many of those that have been traditionally protected by the notion of

religious immunity will be clear targets for ethical examination and can be assessed using the secular moral criteria developed in ordinary and professional ethics. (Curiously, the distinction between upper-level practices that are vulnerable to ethical critique and those that are not is reflected, though somewhat crudely, in the growing area of clergy malpractice insurance. Malpractice insurance is available in approximately those areas in which clergy do what other professionals do, especially counseling, but not for practices much less directly related to the satisfaction of individual self-interests, such as the performance of rites, the maintenance of beliefs, or the upholding of orthodoxy.) The distinction is not always clear; most groups give off mixed signals and are approached for mixed reasons. Nevertheless, the theoretical importance of this distinction is considerable.

I began with a discussion of the practices of various religious groups in encouraging their adherents to take risks, focusing particularly on Christian Science. In this discussion, appeal has been made to both general moral principles, such as autonomy, nonmaleficence, beneficence, and justice, and to their application in requirements such as informed consent. I argued that upper-level practices such as these, which encourage risk, are candidates for moral critique, but I did not demonstrate why critique is appropriate in these specific cases. Use of the fiduciary principle provides an answer. At least in the case of the Christian Science, Jehovah's Witnesses, and the Holiness churches, there is good reason to think that individuals consult religious professionals to promote their own interests and that these groups promote characteristic practices under a corresponding appeal to self-interest of the members of the group. Christian Scientists choose prayer over medicine in order to get well; the church promotes prayer as a means of healing. The Jehovah's Witnesses refuse blood to avoid precluding salvation; this church and its officials promote the practice of refusing blood at least in part with this rationale. If it turns out that the serpent handler does not act to obey the biblical commandment but simply seeks the heightened sensory or emotional experience provided by the dangerous thrill of handling snakes, then this too belongs under ordinary ethical scrutiny. After all, heightened sensory or emotional experience is available in ways that are less life threatening.

Applications of the fiduciary principle in organized religion are not likely to be easy in practice. The principle refers to the reasons for which people use religious services, as induced by the religious organization and vice versa, and these reasons may be multifarious and obscure. Nor can we assume that the reasons for which people consult religious professionals are as uniform as the reasons for which they consult doctors or lawyers.

Individuals go to church or see their ministers for an enormous variety of reasons, including relieving anxiety, coping with fear, preserving a marriage, restoring health, increasing security, dealing with grief, curbing aggressive or suicidal impulses, maintaining social standing, and so on. A very large part of what leads the religious believer to a religious professional involves the protection and advancement of interests like these; a very large part of the comforts that religious groups offer are directed toward the satisfaction of these interests. Self-interested religious behavior may be very difficult to distinguish from self-interested nonreligious behavior. However cumbersome applications of the principle might be in practice and, consequently, however poor a basis it might make for policy formation, it is an appropriate basis for distinguishing those religious activities and practices that are proper targets for ethical critique from those that are comparatively immune.

It is also a proper basis for scrutinizing the way that religious groups advertise themselves and their services, both in securing continuing commitment from their members and in attracting new ones. The televangelist groups and their leaders are particularly revealing targets for scrutiny. Oral Roberts, for example, makes a direct appeal to the financial interests of prospective contributors by promising immediate material reward. Roberts has sent multicolored prayer sheets to his "prayer partners" to be mailed back (together with a contribution) with a list of needs for which he can pray: "The RED area is for your SPIRITUAL healing; the WHITE area is for your PHYSICAL healing; the GREEN area is for your FINANCIAL healing. Check the needs you have and RUSH them back to me."[31] Roberts is by no means the only media preacher who announces his brand of religion as likely to enhance a believer's interests in material comfort and financial success. But because televangelists invite persons to approach them for the same sorts of reasons for which they might approach a secular financial counselor or investment firm, they are open to the same sort of ethical critique. In general, religious operatives promising satisfaction of their audience's financial interests provide a ripe field for further inquiry.

However, not all individuals approach religious professionals or organizations to promote their own self-interests. Consider, for instance, the person who sees a minister or goes to church in order to "strengthen my faith." This seemingly central religious purpose bears close scrutiny, for it must be asked why the believer wants to strengthen this faith. If, for instance, it is evident that the believer seeks assistance in strengthening faith to "be sure to go to heaven," the motive sounds very much like the kind of self-interest that other forms of rational prudence display. Once it is

assumed or believed that there is a heaven, then it is not so much a matter of *religion* to want to get there; it is a matter of rational prudence, especially if the only available alternative under this particular belief system is hell. Consequently, even the apparently religious purpose of strengthening one's faith in consulting a religious professional or participating in religious practices falls under the fiduciary principle just articulated. Hence, the professional's methods of providing these services and the established church practices that support them are subject to the same working moral criteria as other areas of professional ethics, at least if we assume that the religious professional is in any way capable of either advancing or undermining the interests a person seeks to advance.

This conclusion does not mean, however, that the same local principles or rules of professional ethics apply in religion as they do in medicine or law. Although the fiduciary principle may provide a basic moral standard for all areas of professional practice, including organized religion, it may be that specific applications of the principles derived from it, as well as local rules such as confidentiality and truth telling, differ from one area of professional practice to another. Thus, for example, principles governing the protection of autonomy in decision making under risk may differ from psychiatry to medicine to sports coaching to religion, but they must all satisfy the general fiduciary requirement that the professional be loyal to the client and not take advantage of him or her.

Although having one's faith strengthened in order to get to heaven may not be a distinctively religious purpose for consulting a religious professional, some purposes are. A person who initially expresses a desire for help in strengthening faith might explain that she seeks this help because God is supremely worthy of worship and therefore she wishes to worship God more fully—regardless of the impact this fuller worship might have on her. This kind of purpose in seeking assistance from a religious professional does not involve seeking to advance one's own interests, thereby putting oneself in a position vulnerable to the professional's influence. Consequently, it is not a purpose to which the usual strictures of professional morality under the fiduciary principle apply. For instance, some Christian Scientists, as perhaps some Faith Assembly members, Jehovah's Witnesses, Holiness Church members, members of the Church of the First Born, End Time Ministries, Faith Tabernacle, or others, may observe their church's teaching not to enhance their health or to secure salvation but simply because they believe it to be the word of God. As yet, we have no basis for applying secular moral criteria in cases like these, regardless of the nature of these practices and doctrines that have developed or the group's methods in promoting this

behavior. (This is not, of course, to say that they are justified.) However, these cases may be very few, and such people as rare as saints. If most religious behavior is actually the pursuit of self-interest under a special set of metaphysical assumptions, then the "professionals" who are the purveyors and caretakers of these assumptions in the form of religious doctrine, teachings, and practices are obligated, as in any fiduciary relationship, to protect persons in that pursuit. Christian Science is no exception.

Notes

1. This chapter is drawn from my book *Ethics in the Sanctuary: Examining the Practices of Organized Religion* (New Haven: Yale University Press, 1990). In this book, chapter 2, "High-Risk Religion: Informed Consent in Faith Healing, Serpent Handling, and Refusing Medical Treatment," originally dealt with four high-risk groups: Christian Science, Jehovah's Witnesses, the Faith Assembly, and the Holiness churches. Several additional groups are covered in Seth M. Asser and Rita Swan, "Child Fatalities from Religion-Motivated Medical Neglect," *Pediatrics* 101, no. 4 (April 1998): 625–629.

2. Charles Fried, *An Anatomy of Values: Problems of Personal and Social Choice* (Cambridge: Harvard University Press, 1970), 167.

3. See Thomas C. Johnsen, "Christian Scientists and the Medical Profession: A Historical Perspective," *Medical Heritage* (January–February 1986): 70–78, for a loyal account of the historical background; also see Robert Peel, *Spiritual Healing in a Scientific Age* (San Francisco: Harper & Row, 1987), for a loyal attempt to address scientific issues.

4. Arnold S. Relman, M.D., "Christian Science and the Care of Children," *New England Journal of Medicine* 309, no. 26 (December 29, 1983): 1639.

5. Nathan A. Talbot, "The Position of the Christian Science Church," *New England Journal of Medicine* 309, no. 26 (December 29, 1983): 1641–1644, esp. 1642.

6. Talbot, "Position of the Christian Science Church," 1642.

7. On the distinction between mechanical procedures and other medical treatment, see Arthur E. Nudelman, "The Maintenance of Christian Science in Scientific Society," in *Marginal Medicine,* ed. Roy Wallis and Peter Morley (New York: Free Press, 1976), 42–60; also see William E. Laur, M.D., "Christian Science Visited," *Southern Medical Journal* 73, no. 1 (January 1980): 71–74, esp. 73.

8. Rita Swan, "Faith Healing, Christian Science, and the Medical Care of Children," *New England Journal of Medicine* 309, no. 26 (December 29, 1983): 1640.

9. Also listed in the *Christian Science Journal* are churches, reading rooms, and Christian Science colleges and university organizations. Christian Science care facilities are not listed in the *Journal* but do advertise in church publications.

10. Members of the Holiness churches insist that serpent handling is not to be understood as a "test of faith" in the sense that reciting a creed might be but as a "confirmation" of God's word. Glossolalia, serpent handling, strychnine drinking, and similar practices are the "signs following" belief in God but are not evidence for it. See Robert W. Pelton and Karen W. Carden, *Snake-Handlers: God-Fearers?*

or Fanatics? (Nashville: Thomas Nelson, 1974), which provides a useful pictorial essay on these practices.

11. Mary Baker Eddy, *Science and Health with Key to the Scriptures* (1875; Boston: The First Church of Christ, Scientist, 1934).

12. Merrily Allen Ozengher, *Christian Science Journal* 101, no. 9 (September 1983).

13. A footnote that appears at the beginning of "On Christian Science Healing," a section of testimonials in each issue of the *Christian Science Journal.*

14. Talbot, "Position of the Christian Science Church," 1642; see also *A Century of Christian Science Healing* (Boston: The Christian Science Publishing Society, 1966) for the church's account of this history. The figure is from the Committee on Publication's 1989 paper "An Empirical Analysis of Medical Evidence in Christian Science Testimonies of Healing, 1969–1988," First Church of Christ, Scientist, 175 Huntington Avenue, Boston, Mass. 02115.

15. Talbot, "Position of the Christian Science Church," 1642.

16. See, e.g., Daniel Kahneman, Paul Slovic, and Amos Tversky, eds., *Judgment under Uncertainty: Heuristics and Biases* (Cambridge: Cambridge University Press, 1982).

17. Seth M. Asser and Rita Swan, "Child Fatalities from Religion-Motivated Medical Neglect," *Pediatrics* 101, no. 4 (April 1998): 625–629.

18. Asser and Swan, "Child Fatalities," 628, table 4.

19. Nudelman, "Maintenance of Christian Science in a Scientific Society," 49.

20. Base-rate and related information could presumably be accumulated if Christian Scientists as well as non-Scientists were routinely examined and diagnosed by physicians and if medical records of all procedures (as well as records of healing by prayer) were kept. Of course, this is not generally the case. Neither could the kind of persuasive evidence supplied by controlled clinical trials be obtained on the efficacy of Christian Science healing, since it would not be possible to *randomize* subjects into groups, one of which would (sincerely) perform Christian Science prayer while the other would not pray but would have confidence in conventional medicine alone. The closest approximation to designing such a trial would be (1) to randomize believing Scientists into groups that use prayer and those that, denied the services of a Christian Science practitioner, are offered only conventional treatment or (2) to randomize nonbelievers into those who use conventional medical treatment and those who go through the motions of prayer.

A study cited in the *Hastings Center Report* 19, no. 3 (May–June 1989): 2–3, reports a randomized, double-blind study of the effects of intercessory prayer on hospitalized patients ("Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population," *Southern Medical Journal* 81, no. 7 [1988]: 826–829). This study randomized patients who were prayed for by others, not patients who prayed for themselves; nevertheless, it did conclude that the prayed-for group exhibited fewer complications than the control group.

21. Nicholas Rescher, *Risk: A Philosophical Introduction to the Theory of Risk Evaluation and Management* (Washington, D.C.: University Press of America, 1983), 132.

22. Lois O'Brien, "Prayer's Not a Gamble," letter in *U.S. News & World Report,* April 28, 1986, 81.

23. Contrast the symposium articles in the *New England Journal of Medicine* 310, no. 19 (May 10, 1984): 1257–1260, with subsequent letters to the editor.

24. Rita Swan, letter to the editor, *New England Journal of Medicine* 310, no. 19 (May 20, 1984): 1260. Swan is the president of CHILD (Children's Healthcare Is a Legal Duty), a group that opposes exempting Christian Science from obligations to provide medical care for children.

25. I develop the typology over the course of several chapters, including the one from which this essay is drawn. Also see the commentary by Michael Steel, "Religious Practice, Divine Discourse, and Applied Ethics," thesis, Australian Catholic University.

26. The issue of confidentiality and the practices of these groups are discussed in chapter 1 of *Ethics in the Sanctuary.*

27. These explorations are conducted more fully in *Ethics in the Sanctuary,* chapter 2.

28. Charles Fried, *Medical Experimentation, Personal Integrity and Social Policy* (New York: American Elsevier, 1974), 33.

29. By the turn of the century, the medical establishment viewed Christian Science as an alternative (and bogus) school of medicine, not a religion. See Johnsen, "Christian Scientists and the Medical Profession," 72.

30. Johnsen, "Christian Scientists and the Medical Profession," 73. As Johnsen also notes, in 1898 a unanimous opinion of the Rhode Island Supreme Court affirmed that prayer in Christian Science could not be mistaken for the practice of medicine in any "ordinary sense and meaning" of the term.

31. Alan Brinkley, "The Oral Majority," *New Republic,* September 29, 1986, 31.

3

Put Up or Shut Up?

Countering the Defense of Christian Science

Margaret P. Battin

Christian Science, I've argued, raises compelling moral issues about the ways in which religious groups treat their members. To be sure, Christian Science is hardly alone in this respect—many religious groups raise troubling issues of this sort—but Christian Science presses the issue of "informed consent" in accepting and refusing medical treatment in a particularly acute way. I see this as a troubling ethical dilemma.

Peggy DesAutels, in her important, spirited reply to my charge, argues that this is not the problem I think it is. She claims that the worldviews of the Christian Scientist and the non-Scientist are at odds. One is "matter based," as it might be put, the other "spirit based." Thus, she argues, we cannot impose ordinary ethical expectations of informed consent on the church, on its practitioners, or on its believing members who seek help in easing or curing their illnesses by turning to Christian Science prayer.

I think DesAutels's argument fails. It fails because Christian Science still seems to want to have it both ways—to function both as a system of alternative medical treatment and, at the same time, as a religious system rooted in distinctive metaphysical beliefs about the nature of body and mind; this is the dual "pitch" made to long-term members and prospective converts alike.[1] But DesAutels's argument is so sensitive to the beliefs of practicing Christian Scientists that I'd like to try to draw out the consequences of what she says as a way of showing what the real dilemma is, as I see it, for Christian Science in the contemporary world. DesAutels undercuts her own argument, I believe, by treating it as the end of the conversation. Having argued that Scientists and non-Scientists are operating from two

different worldviews, she takes that to be the end of the matter; but I think that she instead introduces new, larger issues. Thus her remarks should be treated as the beginning of a further conversation, to be pursued here, not as the end of the current one.

Let me get right to the point. My challenge to Christian Science was, in essence, a "put-up-or-shut-up" one—either prove that Christian Science healing is effective or stop making the claim that it *is* effective and, furthermore, stop employing practical strategies (e.g., charging fees for healing and having Blue Cross pay the bill[2]) that suggest that it is effective. The ethical challenge posed to Christian Science requires that it face a practical dilemma that looks like this:

Christian Science must either

1. prove the effectiveness of Christian Science healing
2. or abandon all self-presentation that Christian Science healing is effective.

Not to do one or the other of these, I have argued, is a violation of what would in other areas be called professional responsibility and would in particular violate canons of informed consent. It is morally wrong to encourage people—either current church members or prospective converts—to use Christian Science healing in preference to conventional medicine to cure their ills if you cannot provide them with adequate information, specifically including information about the rates of effectiveness of the two forms of treatment, for making such a choice. It is wrong, in other words, to claim that prayer is a "more dependable form of healing"[3] if you cannot actually establish that this is the case. The church does attempt to present its views (for example by preparing videos for paramedics or other medical personnel who might come in contact with Christian Scientists), but this is a long way from providing testable, scientifically confirmable results.

DesAutels has argued that Christian Science does not face such a dilemma, since the objective of Christian Science practice is not primarily to cure disease but rather to attain a state of spiritualized consciousness from which healing then naturally flows. Indeed, to the believing Scientist this does not seem to be a dilemma at all, since the Scientist believes that attainment of this altered state of consciousness results in physical healing, indeed, *always* results in healing if this more spiritualized consciousness is really attained. But Christian Science cannot have it both ways: It cannot claim to be a religious system and, at the same time, base its appeal on

claims that it is effective in curing disease.[4] This leaves us with the dilemma set out above. Thus I would like to explore what Christian Science faces in pursuing one alternative or the other—to explore the routes DesAutels claims cannot and need not be taken. I see such exploration as the only way of preserving the church's moral integrity in the face of objections that it violates the basic canon of informed consent, a canon as essential in religious practice, I have argued, as in other areas of professional ethics. To look at these options is thus to pursue the conversation DesAutels incorrectly thought would come to an end with the assertion that Scientists and non-Scientists simply have different worldviews. They may in fact have different worldviews, but this is hardly the end of the story.

Two options are open to Christian Science. The first is to prove the medical claims. Suppose Christian Science elected to try to *prove* that its healing practices are effective. Doing so would necessarily involve comparative empirical studies of outcomes of Christian Science healing versus available alternatives. This is not to try to combine or blend medicine and healing, as would indeed be problematic if, as DesAutels claims, different worldviews are involved, but to look at the outcomes of each independent form of treatment.

Conducting comparative empirical studies would clearly constitute a different way of establishing efficacy than the ways now recognized by the church, which are limited to direct personal experience of one's own healings and first-person accounts by others. Christian Science could not continue to rely on its practice of giving testimonials, on its weighty record, *A Century of Christian Science Healing,*[5] or even on its own so-called empirical study, an ample collection and analysis of anecdotal reports of cases of healing between 1969 and 1988,[6] since such stories and accounts cannot establish base rates of illness and cure or provide any reliable comparative data. In particular, they cannot establish the sometimes tacit, sometimes explicit assumption that Christian Science healing is effective where conventional medicine is not, especially in the most serious cases, even though many Scientists have what they describe as extremely powerful, convincing experiences of such healings, sometimes occurring in cases in which there has been antecedent diagnosis and failed medical treatment.

What would be required to try to *prove* Christian Science's claims are rigorously designed studies comparing rates of illness and cure for those using Christian Science prayer, conventional medical treatment, and no treatment, and, perhaps, nonconventional or countercultural forms of medical treatment as well. Such studies can be either general—comparing, for example, lost work days, disability, or death rates for matched samples from

each group—or specific, comparing outcomes by identified condition, including, say, influenza, diabetes, breast cancer, hepatitis, or myocardial infarction. Comparative empirical studies of Christian Science treatment have been proposed in the past, including, for example, by Dr. Isabelle V. Kendig, then chief clinical psychologist at the National Institute of Mental Health, who in 1957 sought to compare the health records of a group of one hundred Christian Scientist inductees in the U.S. Navy with matched non-Scientist controls. (The study was blocked, according to Robert Peel, not by the church, which said it had no objection to the project, but by the government, apparently leery [in Kendig's words] of anything having to do with religion.[7]) But the church has opposed or failed to support most calls for rigorous comparative studies, usually arguing that randomization would not be possible, that treatment by prayer and by conventional medical procedure could not be offered in double-blind fashion, and that it would be destructive to the spirituality of believing Scientists to subject them to conventional medical diagnosis, even if they were not to be treated.

Nevertheless, one route open to the church is to work with conventional medical practitioners in designing studies that as far as possible overcome these obstacles and provide objective results about outcomes, both in general and on a condition-by-condition basis. This might require some ingenuity in study design; for example, comparisons could be based on symptom clusters rather than diagnosed conditions; or both Scientist and non-Scientist volunteers could be solicited to undergo diagnosis but not be informed of the results; or large populations could be followed under careful matching for all health-risk factors; and so on.[8] Furthermore, it would require some sensitivity to conceptual issues, for example, in stipulating what counts as morbidity, health, dysfunction, remission, and cure; and so on. Non-Scientists as well as Scientists might have to rethink their conceptions of medical benefit, risk, and outcome. Designing such studies may be less difficult for minor conditions than for major, life-threatening illnesses, or more difficult in conditio s that include psychiatric as well as physical illness. Nevertheless, I think it is possible to construct at least some informative, suggestive studies, at least if there is adequate cooperation between Scientists and non-Scientists in their design.

The second option that is open to Christian Science is to augment the religious claims and abandon claims to effectiveness. The alternative route for Christian Science would be to reinforce its identity as a *religion,* dropping practices (e.g., charging fees for healing and having Blue Cross pay the bill) that suggest it is essentially an alternative medical system. (Much of what DesAutels says suggests that it should be understood primarily in

this way, that is, as a religion rather than as an alternative medical system.) Doing so would be no easier than designing adequate controlled trials, since dropping these self-presentation features would involve departing from much of Christian Science's history and current practice. Among other things, this would mean dropping the practice of having testimonials about healing serve as a major part of Wednesday worship services, discontinuing the practice of printing testimonials of healings in church publications, and, of course, dropping reimbursement by Blue Cross. Worship services would focus on the achievement of enlightened consciousness, and the publication of testimonials by Scientists would serve to show how they came to achieve such consciousness. Prayer practices would not be initiated for the purpose of healing. Furthermore, prayer would not be primarily initiated in conditions of illness but would be engaged in for its own intrinsic value, without reference to its side effects in healing. Turning to prayer would no longer be the normal, institutionally supported response *in time of illness;* instead, prayer would simply be encouraged all the time (as it already is) but not redoubled or specialized for times of illness. Nor would the group maintain any further practice (though it is often insisted that this is not the case) of prohibiting or discouraging members from turning to conventional medicine in time of illness. In these ways, Christian Science would be transformed into a religious group more like, say, Buddhism in character, in which the central objective of practice is the attainment and maintenance of a nonmaterialist, spiritualist worldview. If Scientists also wished to believe that this spiritualized consciousness also results in physical healing, that would be their business; but the church would no longer encourage prayer or the quest for more spiritualized consciousness *in order to be healed,* either as a primary or a secondary effect.

Neither course of action would seem to preserve much of what we now think of as Christian Science; they may seem to be extreme and unrealistic. Furthermore, DesAutels has already offered objections to both of them: against the first, that the effectiveness of Christian Science healing is not open to empirical proof; and against the second, that Christian Science's self-presentation does not delude either current members or prospective ones, since its dedication to the achievement of a more spiritualized understanding is explicit or presupposed in all its presentations and practices, and healing is already understood by all as a by-product or secondary goal. But DesAutels's objections are both open to counterargument. To the first, it would be possible, though not perhaps easy, to actually test the efficacy of Christian Science healing practices in an unbiased way. To the second, Christian Science's current self-presentation can delude both current

members and prospective future ones. This is true whether or not their "worldviews" are different or similar to those of non-Scientists, that is, whether they do or do not have materialist outlooks. Rather, what counts here are the outcomes of the practices in question and their effects on people who engage in them, including long-term members, new members who convert in order to cure illness that medical science has been unable to treat, and, where decisions to pursue Christian Science healing rather than medical care have been made on their behalf, children. That leaves Christian Science facing the dilemma outlined above—either put up or shut up. Either *prove* that healing is effective (and not just by adding up anecdotal stories) or stop claiming that it is. Though these two positions may seem to be extreme ones, they are the only two ways to resolve the moral dilemma Christian Science now faces.

But this seems to suggest that the two routes, (1) to put up by proving that healing is effective or (2) to shut up by dropping claims that it is, are equally defensible as courses of action for the church. However, I do not think this is the case; in order to understand this, is it necessary to look at the relationship between the two.

Consider what might happen if the church pursued the first course of action: It would decide to "put up" by providing evidence and so would be willing to cooperate in the design and execution of the comparative studies described above. These would be three-armed trials of Christian Science healing versus conventional medical treatment versus nontreatment, including both general studies of outcomes across populations and targeted studies of specific conditions, and might even include additional arms for various nonconventional medical therapies. I harbor no illusions that it would be easy to construct a fully rigorous study acceptable to both Scientists and practitioners of conventional medicine, even with maximal good will and genuine commitment to open exploration on both sides, but I do think it would be possible for such a study or groups of studies to produce quite suggestive results.

But now consider what the results might be: There are three principal possibilities. First, comparative studies might show that Christian Science appears to offer no benefits, either in general or for specific conditions, over conventional medical treatment or nontreatment: Christian Scientists have more symptoms, more illnesses, more sustained illnesses, and they die sooner. Second, such studies might instead show that Christian Science produces better results than standard medical treatment, both in general or for specific groups of conditions: Christian Scientists have fewer symptoms, fewer illnesses, shorter illnesses, and live longer. Third, the results

might show that Christian Science offers benefit over nontreatment, but not over standard medical treatment, or benefit over standard medical treatment but not, at least in some conditions, over nontreatment, and so on. (At the moment, we have virtually no reliable data about any of these claims, except certain comparisons of outcomes of standard medical treatment and nontreatment.[9]) Nevertheless, regardless of the outcomes of these studies, Christian Science would risk little by cooperating in such studies, at least insofar as it identifies itself as a religion: Neither "good," "neutral," nor "bad" results can damage the central religious claim that the ultimate objective of religious life is to achieve a more spiritualized consciousness. This is the claim that, in DesAutels's view, should be taken as central, and it is right in concert with the assertion she quotes from Mary Baker Eddy that "the mission of Christian Science now, as in the time of its earlier demonstration, is not primarily one of physical healing." Thus far, Christian Science has little to lose; it is protected whichever way the studies turn out. Furthermore, even if the studies were to show that Scientist prayer has worse outcomes than conventional medicine or nontreatment, this would still not refute the claim that spiritualized consciousness always results in healing; it would merely undermine the claim that it is prudent to think one can attain such consciousness in an attempt to cure disease. Thus it would undercut the practice of seeking aid in prayer during times of illness in order to attain cure, though it need not discourage or preclude the practice of seeking aid in prayer not only in illness but at all times of one's life. Indeed, if the group is a *religious* group, this might seem to be a gain: Prayer would cease to be valued for extrinsic purposes and would be valued wholly for intrinsic ones. In the bargain, of course, this change would protect both loyal Christian Scientists and prospective converts from practices that would do them no good.

After all, the real test of whether Christian Science sees itself as a religious group rather than an alternative medical system is whether, as a group, it would continue to pursue spiritualized consciousness if it were demonstrated that attaining it did *not* result in healing. Thus cooperating in studies of the efficacy of Scientist prayer, as well as working to ensure that those studies were designed without bias and would yield intelligible results, would enhance Christian Science's self-understanding as well as reinforce its spiritual claims.

But suppose Christian Science, when faced with the dilemma outlined above, were instead to begin by pursuing alternative 2, to "shut up" by emphasizing only the religious claims and rejecting any attempt to prove the efficacy of Christian Science healing. It would thus retreat from all self-

presentation practices that might suggest that healing is effective, like the use of testimonials, the avoidance of conventional medicine, and the use of Blue Cross to pay bills for prayer. It would of course undergo substantial changes, as remarked above, in moving away from much of its traditional and current practice, as reference to health benefits dropped out of the picture. But this would be to reinforce the centrality of prayer designed to achieve a more spiritualized consciousness. Presumably, then, Christian Scientists, no longer pursuing prayer in order to achieve health, would come to use prayer for enhanced spiritual life but would probably rely on conventional medicine in times of illness, or perhaps turn to unconventional therapies or forgo any sort of treatment altogether.

As before, several different things could happen: First, Christian Scientists' health prospects could be improved; second, Christian Scientists' health prospects could remain about the same; or third, Christian Scientists' prospects could grow worse, depending, of course, on whether Christian Science prayer has actually turned out to be effective, neutral, or damaging in comparison to conventional or nonconventional medical treatment or nontreatment for various kinds of illness. *But Christian Scientists would have no way of knowing which was the case.* It could be that the church, in choosing to "shut up," that is, to cease making claims about the efficacy of healing, had elected a course of action that would make its members and prospective converts worse off, or it could be that they were better off (or worse off for some disease conditions but better off for others), but in the absence of the comparative studies considered above, neither the church, its members, nor anybody else would have any reliable way of knowing this. (This, of course, is the current state of affairs.) But insofar as the moral injunction the church must respond to in the first place is the accusation that it violates canons of informed consent by not making or attempting to make available to its members and prospective members the kind of information that will allow them to make prudent choices about their own lives, including whether or not to turn to Christian Science prayer in time of illness, this course of action *still* runs afoul of this injunction.

Thus it is not just an open option whether the church should pursue alternative 1 or alternative 2, whether it should "put up" or "shut up." Although the church may eventually be morally obliged to shut up if it cannot put up, it ought not merely shut up without some sincere attempt to provide concrete evidence concerning the efficacy of its practices, that is, to determine whether the healing practices it now employs may not be efficacious in some or all conditions. It already tries to do this (that is what its testimonies of healings and its own "empirical study" are meant to do,

provide evidence that prayer really works), but it does not try to do so in rigorously scientific ways. Yet not to try to establish the efficacy of prayer (or establish that it is not effective after all) is to shortchange not only believing members and prospective converts, but all other persons who now rely on conventional or unconventional medicine or who avoid treatment altogether.

There is another way to put this. If Christian Science knows a secret—or rather, as it believes, a "demonstrable science"—about what is conventionally labeled illness and disease, this is knowledge of paramount importance for everyone, not just Christian Scientists. After all, everyone is subject to illness and disease, and these conditions can cause immense suffering and loss in the lives of any person. Given the importance of any form of real knowledge about illness and disease, regardless of its origin, a group that had access to that knowledge would be morally obliged to explore whether its knowledge is in fact a reliable, trustworthy, genuine form of knowledge, indeed, a demonstrable "science," as it claims. To keep it as a secret for the religiously initiated would seem perverse, even if it might eventually turn out that the knowledge can be effectively used only by those who accept the background religious view. Of course, at the moment, neither Christian Scientists nor outside detractors can know whether its claims are true. To retreat before public criticism of its practices into a more insular religiosity would be the less morally defensible course, one that would make itself still more vulnerable to the initial moral objection brought against it; to try to explore the truths it believes would be the more defensible and principled one. After all, Christian Science, as I argued earlier, has little to lose (except its current indefensible ambivalence) by cooperating with medical science in exploring its claims. Even if its claims are not supported, Christian Science can still survive as a religious group with a commitment to prayer and the attainment of a nonmaterialist worldview, but it has a great deal to lose by *not* doing so.

To be sure, a comprehensive, well-designed set of studies could also have a great deal to say about the nature of self-limiting conditions, iatrogenic disease, and the placebo effect, and on these grounds alone would be of value. But it would also have a great deal to say about (religious) claims, which conventional medical science now simply ignores. Thus, in reply to DesAutels's interesting and sensitive remarks, I would encourage her not to treat the alleged difference in worldviews between Scientists and non-Scientists as a conversation stopper but to recognize that this is the beginning of a conversation that would do well for both Scientists and non-Scientists to continue.

Notes

1. See Joan C. Callahan's extensive exploration of this issue in "Christian Science Healings: An Alternative Health Care System?" *Journal of Social Philosophy* 26, no. 3 (Winter 1995): 105–111.

2. About twenty-five major insurance companies cover charges for Christian Science healing. For at least some Blue Cross plans, if Blue Cross is part of a required employee plan and the employer requires Blue Cross to provide some form of coverage for Christian Science treatment, Blue Cross will do so, but not otherwise.

3. Nathan A. Talbot, "Medicine and the Return to Christian Science," *Christian Science Sentinel* 94, no. 8 (1992): 29.

4. Callahan, "Christian Science Healings."

5. *A Century of Christian Science Healing* (Boston: The Christian Science Publishing Society, 1966).

6. Committee on Publication, "An Empirical Analysis of Medical Evidence in Christian Science Testimonies of Healing, 1969–1988," The First Church of Christ, Scientist, 175 Huntington Avenue, Boston, Mass. 02115.

7. Robert Peel, *Spiritual Healing in a Scientific Age* (San Francisco: Harper & Row, 1987), 188–189.

8. In particular, such studies would have to be designed to try to take account of Christian Science's concern that the conventional diagnosis and naming of disease tends to reinforce it, as well as the tradition's injunction against "numbering the people." "Numbering the people" was prohibited by Mary Baker Eddy in the context of measuring church growth, but it is sometimes understood to prohibit keeping statistics and other forms of data about individuals.

9. Asser and Swan's comparison of outcomes in children for whom medical treatment was not provided for religious reasons and standard survival rates (discussed in chap. 1 of this volume) is a case in point, but it involves limited and selected rather than randomized samples. Seth M. Asser and Rita Swan, "Child Fatalities from Religion-Motivated Medical Neglect," *Pediatrics* 101, no. 4 (April 1998): 624–629.

Conclusion: Agreeing to Disagree?

Margaret P. Battin, Peggy DesAutels, Larry May

In this volume, three philosophers concerned with the ethical issues that various forms of organized religion can raise have explored dilemmas posed by the beliefs and practices of Christian Science. One of us, Peggy DesAutels, was raised in the Christian Science tradition; the other two of us, Peggy Battin and Larry May, are not members of this tradition and hence view it from the outside, as indeed most critics do. But this is not a battle between adherents and critics; on the contrary, all three of us are trying to reach a conscientious, responsible, joint understanding of the difficult issues Christian Science raises and to recommend workable, sensitive, broadly acceptable social policies.

But it doesn't seem to be working. There are deep differences here, differences that appear to remain even after our extended discussions. Battin still thinks that Christian Science ought to provide base-rate data and other kinds of confirmatory evidence for the healings it claims to have accomplished; only with such evidence, she insists, can people (Scientists and non-Scientists alike) make informed choices about how to protect their health. The same sort of information, Battin thinks, is necessary for making informed choices about the health care of children. DesAutels rejects these demands for empirical study, insisting both that such information is irrelevant to the practice of Christian Science and that attempts to gather such information would impose the medical model of health and disease on Christian Scientists. Meanwhile, May still thinks a compromise is possible in the matter of medical treatment for children, if both Christian Scientists and medical professionals are socialized to respect each other's convictions; this would in general permit parents to seek Christian Science healing for their children most of the time but mandate medical treatment for problems that are severe or life threatening. Again, DesAutels rejects

this. Furthermore, Battin and May do not identify the same issues in Christian Science as the centrally problematic ones, though both agree there are problems that are not resolved by DesAutels's answers, sensitive and understanding though they may be. It looks as though we three have hit bottom, so to speak, in plumbing the depths of our disagreement. The civilized thing to do, it may now seem, is to "agree to disagree": To recognize that these differences are irreconcilable and to find some more or less makeshift way of accommodating public policy and practice to this huge gulf.

But do we really disagree? After all, we hold many points in common—matters of basic philosophical, political, and public policy commitment. How we can disagree about anything substantial if we agree about all these things? The following list displays just some of the things we do agree about:

- that people's religious beliefs should be respected
- that prayer may be meaningful and important to those who engage in it
- that state intrusion into religion should be minimized
- that ill health (whatever that is) is undesirable
- that people have the right to make their own health care decisions
- that Christian Science is a long-established, cherished tradition
- that Christian Science parents care deeply about their children
- that children ought not be abused, injured, or caused to suffer or die
- that children ought not be allowed to die when they can be saved
- that legal battles over how Christian Scientist parents may treat their children are undesirable
- that the state acts appropriately in protecting vulnerable parties from abuse
- that some medical treatment is followed by "cure"
- that some Christian Science treatment is followed by "cure"
- that some medical treatment fails to produce "cure"
- that some Christian Science treatment fails to produce "cure"

If there is disagreement, DesAutels claims, it is at a deeper level, not just about facts and values at any superficial level but about basic issues in metaphysics. Christian Science sees a person as an expression of divine Mind, not matter, and the human body as shaped by the comprehension of each individual; non-Scientists see the human body as flesh and blood, a mate-

rial substance animated by a nervous system and guided by intentions—an ordered, functioning organic system. For Christian Scientists, "disease" is misunderstanding; for non-Scientists, disease is physical disorder in an organic physical system. This is the conflict between religious idealism and secular materialism, twain that cannot meet.

But can we really disagree about the metaphysics of the human body? To be sure, the entire history of philosophy might seem to provide ample fuel for such disagreement: Plato, Berkeley, Kant, and Hegel are idealists or partly so, though in various ways; Epicurus and Lucretius, Hobbes, Marx, and Darwin are materialists, though of different sorts too, and they have radically different theoretical views about the human body. But does the practical disagreement that erupts for us in friction over foregoing conventional health care in favor of Christian Science healing, and especially over denying conventional health care to children, resemble that of the philosophers?

Certainly, the disagreement is at least in part the product of what each of us, as believers or nonbelievers, as patients, as parents, sees as "out there," in the world, or "in here," in us and of us. But do we really "see" and experience something different? Three philosophers are writing this book; two of them stretch out their hands and see skin, flesh, the structure of bone; the third does the same but attempts to see the idea of God that lies behind this apparent physical structure. Democritus would have claimed to see his outstretched hand as a collection of atoms; Plato would have seen his as an exemplar of an ideal Form; many others thinkers would claim to see theirs in a variety of ways, though G. E. Moore stretched out his own hand hoping to end what he viewed as nonsense: "Is this a hand I see before me?" he asked, insisting that the answer could not be anything but yes.

It is right here that the most basic challenges and disagreements may seem to arise. Is the difference in what the three of us see as we discuss Christian Science, stretching out our hands before us, an elective difference, if it is a difference at all? Do "idealist" and "materialist" accounts provide accurate descriptions of what we each see and experience? Can one "choose" to see one's own hand in these different ways? Could one change one's way of seeing? (If not, presumably it would be impossible to "convert" to Christian Science.) Is "practical idealism" really possible at all? Or do we all actually see our hands as physical structures of skin, flesh, bone, with some of us—those with certain religious commitments—then "reinterpreting" this phenomenon as a manifestation of divine Mind, just as some philosophers reinterpret it as assemblages of

atoms or instantiations of the Forms? Or perhaps is it the other way around; could we all be seeing our hands as projections of consciousness but reified by some of us as objects of flesh and bone? Of course there can be disagreements among people over all sorts of matters, including facts, policies, customs, beliefs, the requirements of morality, and many other things; but can there be genuine disagreements in practice, in everyday life, over metaphysics? Do we actually see and experience our own hands, our own bodies, in different ways, or do we merely live with different official commitments about how we will interpret them? Yet it is these very bodies, of which our hands are part, that are at issue in decision making about conventional medical treatment versus Christian Science healing.

If there are basic metaphysical disagreements, agreement may elude us. If there are not, we cannot "agree to disagree"; agreement itself is too near to let it drop. What might the agreement be, in practice, if we could reach it? Larry May suggests a compromise solution in which parents are free to employ Christian Science healing for their children's minor ailments but are expected to turn to conventional medicine for severe, life-threatening ailments, like Robyn Twitchell's intestinal blockage. Battin would accept this arrangement, provided that adequate base-rate and other data were available to show that conventional medicine outperformed Christian Science in severe, life-threatening ailments but not in minor ones, largely self-limiting ones, both for adults and children. Given such data, adults would be free as a matter of basic religious liberty to make whatever practical choices they wanted for themselves, even if it clearly meant a probable earlier death, but ought not make choices for their children that would likely mean death when recovery was otherwise possible. Could the Christian Scientist, DesAutels, agree? This might seem easy, since Christian Science can still flourish in the vast majority of cases in which the condition is not severe, iatrogenesis is a risk, outcomes are not known, or the condition is self-limiting; conventional medicine could be encouraged just in that minority of cases reliably known to be truly serious. But the Christian Scientist committed to an idealist conception of reality cannot agree without giving away the store; to agree to calling in conventional medicine for the most severe cases would be either to relinquish the claim that persons are "really" spiritual, idealist beings, not material ones, or to acknowledge that sometimes healing doesn't occur even in the best of attempts to see persons, including oneself, as ideal, spiritual beings. Of course, Christian Science already acknowledges that people are sometimes unable to fully understand the true nature of reality, and that hence prayer fails to achieve

healing in some cases; but if it grants this, then the wisdom of "praying for a cure" is open to challenge in every case.

To see the issue more clearly of whether we can "agree to disagree," we can also explore whether we can or cannot agree in a specific case, for example, the case of little Robyn Twitchell. Clearly, we agree about a great deal. We all agree that Robyn's parents desperately wanted what was best for him. We all agree that Robyn's symptoms were, to the nonprofessional (though perhaps not to the professional), difficult to interpret: symptoms of serious distress intermittent with symptoms of apparent cure, confounded by the fact that his older brother had had similar symptoms the previous week and had recovered without incident. We all agree that Robyn experienced at least some pain, that he vomited, and that he died. Yet we disagree about what Robyn's parents should have done in responding to this situation. Battin thinks that the Twitchells should have been informed, when they first sought Christian Science healing, of the approximate likelihood that this treatment would be effective, given the symptoms, compared to conventional treatment, just as they would or should have been informed of the likely benefits and risks of conventional treatment: They should have been told that with surgery for the blockage there was a good chance that Robyn could have been saved and that without the surgery—with or without Christian Science prayer—he would almost certainly die. May thinks that the parents and the Christian Science practitioner who was called should have been socialized to recognize that the case was a serious one, appropriate for conventional medicine, and that Robyn should have been taken to the hospital. DesAutels thinks Robyn's parents did the loving, religiously sincere, appropriate thing for their child. Are we disagreeing about the facts of the case here, or are we really disagreeing about its metaphysics? Are we all just talking about differing interpretations of the evidence about what was wrong with Robyn, or are we talking about different conceptions of what Robyn's symptoms represented and indeed, about what Robyn, as a human person and human body, was in himself? If it is the former—different interpretations of evidence—we can agree to agree and keep working until we have all the facts and values sorted out; if is the latter—different underlying metaphysics—we can only disagree and perhaps not even agree on whether to do so or not. It may not even be easy to say what differences these alleged metaphysical differences would make, if any at all. There is no easy way to resolve these issues; it is what makes them so interesting, and it is why ethical issues in the practice of organized religion are so compelling, an area of philosophical reflection we all believe will grow.

Personal Note from Peggy Battin

In March 1998, distinguished clarinetist Christie Lundquist died. This is not a fictional story and this is not a made-up name; Christie Lundquist, first clarinetist of the Utah Symphony, was a clarinetist of national reputation, "legendary" in the words of one of her colleagues. I spoke with Christie only twice about her practice of Christian Science, but I had been watching for years from my balcony seat at the symphony. Over the years, she had grown thinner and a little gaunt, and the color of her skin had shifted from normal Caucasian flesh tones to a yellower, greener cast. Her colleagues in the symphony said that she missed many rehearsals, that she was often ill. We surmised that it was liver disease, ineluctably advancing.

A medically trained friend was with me at the symphony one evening and found her symptoms so pronounced that they could be diagnosed from the balcony. "She won't live six months," said the friend, but in fact Christie lived another three years; she was fifty-one when she died. Whether she would have lived longer (or not) with conventional treatment I do not know. A friend said that she had contracted hepatitis in Mexico twenty years earlier and that the national symphony with which she was playing had made her see a doctor; but of course she did not see a doctor and would not consider it. Her colleagues in the symphony were furious; she was a brilliant player as well as a remarkable athlete and a wonderfully witty human being. They loved her and they respected her, even though she seemed to have no conception of her disease or its potential consequences. Indeed, they said, among the woodwinds, she was always grabbing people's mouthpieces and trying them out.

Watching the progression of her disease from the balcony, performance after performance over a long period of years, cost an immense effort of will to try to summon respect—genuine respect, not superficial tolerance—for her beliefs and for her way of living. I too was angry: angry that her beliefs should lead her to die, destroying a remarkable talent, robbing the symphony of a brilliant player, and robbing herself of life. More than once, I wanted to rush down to the stage from the balcony and shake her, to say, "Christie, quick, go to a doctor before it's too late. Don't just let yourself die."

But when I talked with her, just once, and once again—seeing at close range the real deterioration of her skin, its many small lesions, the yellowed filaments in her eyes—she spoke so movingly of the importance of her beliefs that I could not bring myself to say words like "liver failure" or "see a doctor," which seemed not only rude and invasive but somehow irrelevant. She lived in a different world, I think, one in which these expressions would

have made little sense. She told me at length how much her beliefs in Christian Science had contributed to her playing of the clarinet, and she seemed not at all afraid of whatever future she was facing. When she talked, I felt an odd sense of awe.

Those who spoke to Christie in the Christian Science nursing home in which she spent her final days said she was upbeat, very upbeat. She cheered them up when they called, they said, not the other way around, even though she knew she was dying.

Did Christie and I ever talk, really talk? Could she have conveyed to me at any real level what she believed or why she believed it? After all, I couldn't seem to talk to her about my own comparatively "materialist" conception of the universe or of the human body and its functions, and I couldn't seem to say the things I believed about her. I wanted to say, I can see that you are very ill; you should seek real medical help soon, before it is too late; it is stupid to waste your life this way. But I just couldn't do it. I do not know whether we could have ever really talked in any way that we both could have understood, in any way that would have resolved disagreement; but I know that it is too late now. I'm left with the anger—and the sense of awe. If there is a paradox and a deep gulf of understanding in approaches between those who believe in Christian Science and those who do not, this is it—that feeling of both intimacy and unbridgeable distance in this conversation between a nonbeliever who would go on living and a believer about to die.

Personal Note from Larry May

A doctor I know, perhaps the most open-minded and sensitive doctor I have ever known, was one of only two physicians on our hospital ethics committee to side with me in thinking that Christian Science children should not be forced into medical treatment. He and I often talked about how important it was to avoid paternalism in these matters. But one day things changed for him. Here is the story he told at one of our monthly ethics committee meetings. He had come to know a Christian Science child with cystic fibrosis who was referred to him by a doctor who had treated her since infancy. He eventually developed a "working relationship" with the family, agreeing never to discuss the child's medical condition with her and to do minor examination of her in her home every week. At least as he told the story, and I have no reason to disbelieve him, there was mutual respect between himself and the parents. When the girl improved he didn't see her for a few months, by mutual consent.

One day, the parents summoned him because the girl was not gaining weight and was breathing hard. At her bedside he detected a distinct blueness to her skin—she desperately needed more oxygen. He informed the family that she was seriously ill, slowly suffocating to death. He said he couldn't help her anymore in the restricted way they had been proceeding. He recommended immediate hospitalization. The parents refused.

He contacted our ethics committee and the hospital lawyer. He told us that he was beginning the process necessary to get a court order to force her parents to bring her into the hospital. He was clearly emotionally drained by the last few days, having had little sleep and worrying constantly. In our meeting, I argued with him (I was the only one), but my heart wasn't in it. For whatever reason, the doctor didn't pursue the court order, and the girl died several days later. Even though he did what I thought, at the time, was best, I'm still haunted by this story, as is he. The tragedy of the situation overwhelms me.

Personal Note from Peggy DesAutels

I could respond to the previous personal notes by describing cases either of Christian Scientists recovering from medically incurable conditions or of non-Christian Scientists suffering and dying while under medical care. I will do neither. I will simply add that I rejoice when others experience good in their lives and that I too am saddened when others suffer and die. Unfortunately, neither medicine nor Christian Science has found a way to eliminate suffering and death from human experience. All that any of us can do is attempt to find insight, health, and healing by turning to the sources we most trust.

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