

High-Risk Religion*

Margaret Pabst Battin

Among some of the more colorful groups on the American religious spectrum, the religious faith of believers seems to involve a willingness to take substantial physical risks—risks to health, to physical functioning, even the risk of death. These groups include several in which the risks a believer takes are indirect (as in refusing blood transfusions or in refusing all medical treatment), and a few in which the risks are immediate and direct (for instance, in handling live poisonous snakes). We may think of these practices as extraordinary tests of religious commitment, or we may think of this willingness to risk death as a demonstration of the extraordinary value religious goals can have for believers. Indeed, willingness to risk death for religious reasons is often extolled as the highest test of faith. But I also think that the willingness of the members of religious groups to risk death reveals a set of disturbing moral issues, issues concerning the ways in which religious groups “bring it about” that their adherents are willing to take such risks. In what follows, I want to take a careful look at the influence of religious groups on their adherents’ choices, focusing on high-risk decision making which can result in death. To address these issues is not to suggest that a religious believer’s willingness to risk death may not be sincere and devout, but rather to cast a morally skeptical eye on the way in which these sincere, devout beliefs are engendered by the religious institutions within which they arise.

Risk Budgets and Styles

Let us put the problem in a somewhat more precise way. To do so, we can conceptualize the problem as it would be seen within the field of professional ethics; here, it would be treated under the general rubric of *consent*. This conceptualization will provide an approach to the problem, and will permit us to employ analytic techniques from both ordinary apparatus and professional ethics.

In everyday life, risks which a person voluntarily and knowingly takes can be described as the result of a prudential calculation on his part, however rudimentary that calculation may in practice be, in which he elects a course of action which he hopes will produce a gain or avoid a loss, though he also recognizes 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 considered, an assessment of the likelihood of these various possible outcomes (the decision is made “under risk” if these probabilities are known, “under uncertainty” if they are not), and an

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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, or a positive outcome against both the costs of failing to achieve it and 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 choosing that with 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 despite recognition that this action may instead produce a different, undesired result.

Each individual, Charles Fried has pointed out, has a distinctive "risk budget": this is the degree and severity of risk he is willing to accept in order to avoid certain losses or achieve certain gains.¹ This "risk budget" is a function, of course, of the possible courses of action the individual foresees, the probabilities he assigns to the various possible outcomes, and the utilities he attaches to each of these, influenced by any characteristic errors he may make in performing the prudential calculation which indicates to him what course of action promises the greatest expected utility. But while the risk budgets of ordinary individuals in a culture appear to be fairly uniform with respect to the background risks of everyday life (for example, 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 which other members of that culture won't.

Furthermore, each individual has a distinctive "risk style": this is the degree of deliberation or abandon he exercises in making the prudential calculation in which risk-taking consists. Some people size up 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; others take both big and little risks in a quite cavalier way. Individuals also process relevant information in quite different ways: for instance, some are naturally optimistic, focusing primarily on the benefits to be gained; others are comparatively pessimistic, attending to the 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 cul-

ture are relatively uniform with respect to background risks, but may vary considerably among individuals with respect to certain more conspicuous risks. This is just to add that some people make their choices about risks in ways that other people would reject.

Now the problem which the practices of certain religious groups present arises with an observation about risk budgets and styles. With respect to both risk budgets and styles, we observe broad commonalities among the members of a culture with respect to background risks, and we also note a range of idiosyncratic, individual risk budgets and styles with respect to certain conspicuous, higher-risk decisions. However, when we observe the risk budgets and styles of the members of certain religious groups, we notice striking uniformities not so much with respect to background risks, but with respect to major, conspicuous, foreground risks—direct risks to health, physical functioning, even to life. Specifically, what we notice is that the kinds of risks 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 which members of the culture ordinarily display with respect to their decisions. To put the observation which introduces the problem in another way, we see that the members of certain religious groups take risks other people don't, and they decide to do so in ways other people wouldn't, but they nevertheless do these things in remarkably uniform ways. Nor are these trivial risks; some are potentially fatal ones.

These characteristic risk-taking patterns, each distinctive of a different group, may seem to be just another element in the colorful spectrum of American religious diversity. But I think this colorful diversity cloaks substantial moral issues about the way in which religious groups influence and shape individual decision making among their members. It is not just that these people take risks other people don't and decide to do so in ways other people wouldn't; 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 us to look at the mechanisms by which they are produced. What we can expect to find are systematic, doctrine-controlled violations of the principle of autonomy, that is, of that moral principle familiar in professional and in ordinary ethics which requires both protection for an individual's capacity to choose and respect for the substance of his choice, and we will be able to identify these violations by locating exactly the precise point at which they occur in the paradigmatic decision-making process.

We shall look at these mechanisms by examining in some detail the practices of four quite different religious groups whose adherents regularly make choices which indirectly or directly expose them to risks of death. We will do this in order to consider whether some of the

ways in which religious groups shape and control high-risk decision-making are morally indefensible, and I will argue that this is the case. However, I will also argue that this is not true of all of the ways in which high-risk decision making is influenced—even among the four groups isolated for discussion here—and it will be part of my project to develop a general criterion for distinguishing morally indefensible practices in shaping decision making in religion from those practices which may be morally defensible. This criterion will serve in concert with a typology of doctrinal claims to be discussed briefly below to allow us to fix more precisely the range within which we can discern and address *ethical* issues generated within organized religion.

Three of the groups we shall examine participate in practices which impose varying degrees of indirect risk of death by refusal of medical treatment or some component of it—Christian Science, Jehovah's Witnesses, and the Faith Assembly. The practices of a fourth group impose in addition a direct threat of death—the serpent-handling, strychnine-drinking groups within the Holiness Church. Two of these, the Faith Assembly and the Holiness Church, are generally regarded as cults or fringe groups; the other two, Christian Science and the Jehovah's Witnesses, occupy intermediate positions somewhere between the fringe and the mainstream of American religious groups. That these are all Christian denominations should not suggest that similar moral issues do not arise in other world religions, but only that the issues of high-risk decision making in religious commitment are particularly prominent ones in certain strands of the Christian tradition.

Risk Taking in Four American Religious Groups

1. *Christian Science.* The 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.² According to Christian Scientist 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"³; illness results from "human alienation from God,"⁴ 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. When a faithful member of the church falls ill, he or she consults a Christian Science practitioner to seek treatment which consists "entirely of heartfelt yet disciplined prayer."⁵ 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—i.e., that in reality there is no such thing. Hence, prayer is believed to be incompatible with conventional medical treatment, since 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. Scientists do generally use the services of dentists and oculists, and sometimes have physicians perform such “mechanical” procedures as setting broken bones, but other than this no conventional medical procedures, either diagnostic or therapeutic, are used.⁶ For services rendered in praying for and with the individual who is ill, the Christian Scientist practitioner receives a fee, roughly comparable to the fees conventional physicians charge, which is reimbursable by many insurance companies (including some Blue Cross/Blue Shield plans) and by some state and federal Medicare and Medicaid programs as well.⁷

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 these cases, the individual may be quite confident that Christian Science healing will provide relief from the condition which troubles him. Nevertheless, his choice to accept treatment from a Christian Scientist practitioner rather than an M.D., or to accept no treatment at all, resembles in structure any other prudential calculation under risk, where various possible outcomes—cure, continuing illness, incapacitation, or death—are foreseen under specific valuations and under more or less quantifiable expectations concerning the likelihood of their occurrence. Christian Scientists are of course aware of the availability of conventional medicine, at least in part because so much of Christian Science teaching involves warnings against resort to it. Thus, conventional medical treatment is a possible choice, but one which, on prudential grounds, the believing Christian Scientist does not choose. This is because the believing Scientist not only thinks he is acting in accord with the dictates or expectations of his faith, but also thinks he will maximize the likelihood of achieving that possible outcome with the greatest expected utility—namely, successful cure—by preferring Christian Science healing to conventional medicine. It is in this choice that the risk-taking lies, though for the believing Christian Scientist, of course, it will be seen as a good risk.

2. *Jehovah's Witnesses.* Jehovah's Witnesses refuse a single component of medical treatment, the transfusion of blood or blood derivatives into their own bodies. They do so on the basis of a variety of scriptural passages, especially *Genesis 9:4* (“...you must not eat the

flesh with the life, which is the blood, still in it...”), *Leviticus* 17:12 (“...Therefore I have told the Israelites that neither you, nor any alien settled among you, shall eat blood...”), *Deuteronomy* 12:23-25 (“...you must strictly refrain from eating the blood, because the blood is the life...”), and *Acts* 15:28-29 (“...It is the decision of the Holy Spirit, and our decision, to lay no further burden upon you beyond these essentials: you are to abstain from meat that has been offered to idols, from blood, from anything that has been strangled, and from fornication.”); they believe that the scriptural prohibition of eating or drinking blood prohibits any form of taking the blood of another into one’s own body, including by transfusion.⁸ Although they will accept infusion of nonblood solutions to expand blood volume, faithful Witnesses consent to surgery—even major surgery—only under the understanding that it be performed without additional blood.⁹ They will not accept blood in emergency situations or accidents, and relatives are asked to refuse consent on behalf of those who are unconscious. Nor will they accept blood or blood derivatives in treatment for diseases of the blood, such as anemia or leukemia. In a series of cases, the courts have generally upheld the right of competent, adult Jehovah’s Witnesses to refuse blood transfusions, even where the risk of death is very high, provided that the patient has no obligations to dependents which cannot otherwise be met.¹⁰ However, the courts have generally not permitted pregnant women to refuse transfusions, nor parents to refuse transfusions for their minor children.

For Jehovah’s Witnesses, the situations in which these choices arise are comparatively rare, though when such situations do arise they may be extremely serious or life-threatening. Frequently, too, such decisions must be made in conditions of extreme urgency, as for accident victims, where exsanguination is an immediate, life-threatening risk. Despite the urgency, however, such choices also conform to the risk-taking paradigm: the two principal possible outcomes—survival with transfusion, vs. death without transfusion, are foreseen under evaluations assigning great weight to obedience to church belief and the highest value to an expected salvific afterlife, versus a great but comparatively lesser value to continuing physical existence. These are avoidance choices in risk taking; it is not possible to avoid taking the risk. But as in all risk taking, that option believed to promise greater utility under the valuation assigned is the one which the prudent, rational Witness will choose.

3. *The Faith Assembly*. The Faith Assembly, a fundamentalist group of several thousand members centered in northeastern Indiana, prohibits its members from consulting doctors or from using any medical treatment at all, including vaccination and other preventive treatment, assistance in childbirth, emergency treatment, prostheses, eyeglasses, or hearing aids. This group was founded in the mid-1960’s by Hobart Freeman, a former Southern Baptist minister who had been dismissed

from the faculty at a fundamentalist theological seminary for failing to conform to its beliefs. Freeman started the church in his basement, moved it to a rural barn (the "Glory Barn"), and after a dispute with the owner, moved the church again to its present location in Wilmot, Indiana. Freeman taught the members of the fledgling church to shun doctors and rely on prayer and faith for healing, a teaching which stiffened into a rigorous anti-medical policy enforced with threatened expulsion from the group. Freeman also claimed that he would never die.

In the spring of 1983, two reporters from the *Fort Wayne News-Sentinel* investigated evidence of 52 deaths attributed to the group's prohibition of medical treatment.¹¹ The dead included 28 babies whose mothers refused prenatal care, seven children with untreated illnesses and injuries, ten adults with untreated illnesses, and seven mothers with complications of childbirth. These reporters also identified a living five-year-old child with a basketball-sized tumor of the abdomen whom they expected to become the 53rd. But they also found evidence that compliance with the group's policy of refusing medical treatment was by no means universally voluntary. They documented the existence of an "underground" network via which mothers were taking their children to physicians in neighboring cities, so that they could receive medical treatment without fear of exposure, punishment, or excommunication for themselves or the children. They also described in detail the case of Sally Burkitt, a 27-year-old woman who hemorrhaged following the unassisted delivery of a child: medical attention was denied her and she bled to death 56 hours after the delivery—despite her explicit, repeated pleas that a doctor be called. ("We'll get the best doctor there is," her husband had promised, but what he meant was Jesus.)¹² By late 1985, at least 90 deaths had been attributed to the practices of the group, and by 1988 the figure had reached 100. Hobart Freeman had been indicted in connection with the death of a 15-year-old girl, but in December of 1984 he himself had died—with advanced heart disease, gangrene in one foot, pneumonia, and possible diabetes, having refused all treatment. Legislatures in the midwestern states with sizeable Faith Assembly populations began to enact a number of laws mandating medical care for children.¹³

4. *The Holiness Churches.* Serpent handling is a practice found in many cultures, including those of certain southwest American Indian groups, but it is particularly widespread in the Appalachian regions of the southeastern United States. It was apparently introduced in 1906 in Grasshopper Valley, Tennessee, by a man named George Went Hensley, who carried a rattlesnake in his hands down from a ridge where he had been bitten. Hensley evangelized throughout Appalachia; his legacy includes many of the small, independent Holiness Churches found in this region. While not all Holiness Churches prac-

tice serpent handling and while it is illegal under state law in Kentucky, Virginia, and Tennessee and under municipal ordinances in North Carolina, the practice is nevertheless found in rural areas in much of Appalachia.

Serpent handlers base their practices on a literal interpretation of *Mark* 16:17-18:

And these signs shall follow them that believe: in my name shall they cast out devils; and shall speak with new tongues. They shall take up serpents; and if they drink any deadly thing, it shall not hurt them; they shall lay hands on the sick, and they shall recover.

At the Scrabble Creek Church of All Nations (about 37 miles from Charleston, West Virginia) prayer meetings are held in a small, one-room building with benches or pews and an open area at the front. The meeting is attended by members of all ages, including infants and children, and sometimes by visitors as well. Meetings may last four to six hours, two or three times a week, and consist of hymn singing, preaching, foot washing, healing, and personal testifying of increasing emotional intensity. Participants dance, sing, shriek, shout, crouch or lie on the floor, and may exhibit glossolalia and motor automatism including spasms, jerks, and seizures. At the climax of these meetings, live poisonous snakes (usually rattlers or copperheads collected in the nearby mountains) are produced from a box or wicker basket and passed among those who wish to handle them. Some participants simply touch or hold the snakes, while others coil the snakes around their arms, heads, or throats.¹⁴ The purpose, participants say, is to "receive the Holy Ghost" or to "confirm the word of God" in *Mark* 16. Bites do occur, but although one source claims that George Hensley said of his forty-six years with the Dolley Pond Church that he'd been bitten four hundred times, "till I'm speckled all over like a guinea hen,"¹⁵ bites are not particularly frequent. Most members also refuse medical treatment if bitten, claiming that the bite provides a further test of God's will.

Many serpent handlers claim that "I'm afraid of snakes like anybody else,"¹⁶ but that they lose this fear when they are "annointed" to handle snakes and enter an ecstatic condition. Said Sister Eunice Ball of Newport, Tennessee,

When the annointing's on me, I'm not afraid of the serpents. Other times I'd run. I've taken up as many as six serpents at one time—five copperheads and a large rattler. I've not ever been bitten. There's something there that you know without a doubt that it won't harm you. My hands don't get stiff. I can move my hands, but the feeling's still there."¹⁷

Serpent-handlers variously believe that they will not be bitten, or that if bitten they will not die, that recovery from snakebite is a miracle

wrought by God, and that those snakebite deaths which do occur are signs wrought by God "to show the scoffers how dangerous it is to obey His commandments."¹⁸ Detractors' claims that the snakes have been de-venomed, drugged, or otherwise deliberately rendered harmless are clearly false, and naturalistic explanations such as that grasping snakes by their midsections produces cataplectic reactions in the snakes or that human body heat or motion disturbs their reflexes also seem inadequate.¹⁹ Between 1910 and 1977, there were approximately forty deaths from religious serpent handling and nonfatal bites numbered in the hundreds if not thousands.²⁰ Some of these groups, especially in West Virginia, also engage in the drinking of strychnine (sometimes called a "salvation cocktail") from which fatalities are also reported.

Religious Risk and Freedom of Religion

Of course, to show that risk-taking conduct occurs in various forms and with various degrees of potentially fatal risk in different religious groups is not yet to reach a normative conclusion; it cannot simply be assumed that risk taking is wrong, however extreme its consequences for the person who takes the risk. Quite the contrary, it is plausible to defend risk-taking conduct in religion under the general principle of autonomy, regarding religious choice as one among the kinds of choices to which an individual is entitled by his right of self-determination. Indeed, since religious belief may be at the heart of an individual's identity and since action in concert with these beliefs may be central to the individual's securing of his identity in the world, religious choice—even where it involves serious, potentially disabling or fatal risks—may seem to be particularly worthy of protection and respect. Of course, some religiously committed individuals may not perceive their behavior as involving risks, nor, for that matter, as involving any sort of choice or decision at all. Indeed, it may be the most firmly committed who take themselves to have no options, in that they feel bound to do whatever God, or the specific religious group requires. Some may even believe that they cannot do otherwise, not only in a normative sense but in a metaphysical sense as well. Ultimately, they believe, God determines both what shall happen and how they shall act. Still others may recognize only a single antecedent choice—for instance, the choice "for Jesus" or "for God"—but hold otherwise theodeterminist views. Nevertheless, many religious believers do recognize the distinction between subjective and objective risk, and even if they feel that their personal commitments oblige them to make certain choices rather than others, nevertheless recognize that in many sorts of religiously relevant situations it would be possible for them to perform any one of a variety of alternative actions, each of which would yield differently valued outcomes and incur different

degrees of risk. The principle of autonomy defends all these varieties of high-risk choice in religion, at least where choices are voluntarily and knowingly made — that is, where the criteria of informed consent are met — even when the outcome may be death.

A principal objection to the view that autonomous risk-taking conduct in religion should be respected, and the only one with legal standing, appeals to the harm principle by citing the social costs of such behavior. Under this principle, risk-taking religious conduct may be morally condemned, as well as restricted or prohibited under law, where it imposes harms or substantial risk of harms to other persons. For instance, emotional and financial costs for immediate family members or others dependent on a person may be severe if the risk that person takes eventuates badly. Whether a parent dies because he has undergone surgery without blood, or was fatally bitten in a serpent-handling prayer meeting, or died after refusing medical treatment for a curable illness, the consequences for a dependent child, for instance, are the same. Some legal cases appear to restrict religious risk taking on grounds of obligations to dependents, as in the Jehovah's Witnesses cases, though this remains a much-disputed issue.

Religious risk taking may also be restricted if the risk envelops not only the individual who voluntarily assumes it but bystanders or dependents as well. For instance, in *Swann v. Pack*, a 1975 case, the Tennessee Supreme Court outlawed serpent handling on the grounds that it constitutes a public nuisance. In this case, a prayer meeting of the Holiness Church of God in Jesus Name was described by the prosecution as involving the

...handling of snakes in a crowded church sanctuary with virtually no safeguards, with children roaming around unattended, and with the handlers so enraptured and entranced that they were in a virtual state of hysteria...²¹

though the defense presented further evidence to show that the snake handling was performed on a stage in front of the audience and that the area was roped off with guards stationed at intervals to prevent any snakes from escaping. While laws explicitly prohibiting serpent handling have been passed in only a handful of states, observers suggest that in many other states such practices would most likely be construed as constituting a public nuisance.

The costs society must absorb for those who are injured, incapacitated, or killed in religious risk taking may of course be considerable. However, a general analysis which focuses on the social consequences of religious practices must surely cut the other way: a great deal of the behavior encouraged by religious groups is strongly risk-reductive, especially where nonviolent, continent lifestyles are required, and results in social savings rather than costs. Methodists and Mormons do not drink; Seventh-Day Adventists avoid food additives, stimulants, and meat; Quakers do not go to war. Catholics, like those in

most Christian groups, are forbidden to commit suicide. The Amish avoid motor vehicles and power appliances and tools, and have a correspondingly lower accident rate. Most Christian-based groups discourage premarital and extramarital sexual activity and violent lifestyles, thus reducing the risks of injury, pregnancy, and sexually-transmitted disease. Where these prohibitions are effective, they lower risks to health and life considerably, and clearly vastly outweigh the social costs of increased risk taking by those who refuse medical treatment and the handful of snakehandlers in rural Appalachia. Of course, appeal to the harm principle introduces the extremely interesting question of whether a religious group ought to encourage or require its members to consider the potential impact of their own risk taking on other persons prior to their taking such risks, and if so, just how this impact ought to weigh in their choices, but this question is subsidiary to the more central moral issue to be explored here. This more fundamental issue directly concerns the ways in which members of religious groups come to take risks like these in the first place.

In assessing the ways in which our four specimen groups, Christian Science, Jehovah's Witnesses, the Faith Assembly, and the Holiness Church, elicit risk-taking behavior, we are assuming that their practices do in fact increase the risks of ill health, disability, or death. Reliable figures on the actual rates of risk or on the frequency of negative outcomes is available for none of them, however, and for some of these groups information which might help to establish precise assessments of increased risk is either not collected or very closely guarded. Of course, there are some scattered data on which to base our assumption. As we've seen, by 1988 a hundred deaths had been attributed to the practices of the Faith Assembly in its two decades of existence. A joint study by the Indiana State Department of Health and the Center for Disease Control in Atlanta calculated that in Elkhart and Kosciusko counties, Indiana, where many Faith Assembly members live, mothers in the sect were 100 times as likely to die from complications of pregnancy as other women in Indiana, and babies up to one year old three times more likely to die.²² About 40 deaths, we saw, had been reported by 1977 among snake handling groups. The coroner of King County, Washington, did a retrospective analysis of deaths of children in the years 1935-1955, and found 11 deaths where 1) there was no medical treatment; 2) the child could have been positively treated and almost certainly would not have died; and 3) the parents were Christian Scientists²³; in this county, the average longevity of Christian Scientists was very slightly lower than the average longevity of the non-Scientist population.²⁴ Case-by-case data on deaths of children in religious groups which reject conventional medical treatment is available from CHILD, Inc.²⁵ However, rigorous statistical analyses of morbidity and mortality patterns are in general not available for any of these groups.

The few figures which are available are altogether inadequate to establish reliable estimates of the increase (or perhaps decrease) of risk in these religious behaviors. No figures are available, for instance, on the number of Jehovah's Witnesses who have died as a result of refusing blood transfusions, though certain individual cases can be documented from court or medical records. On the contrary, Jehovah's Witnesses often claim that surgery without blood, or with only nonblood volume expanders, may offer equal or better results than surgery with blood transfusions, partly because of the risks of disease transmission in transfusion and partly because of the greater degree of surgical caution and skill employed by the surgeon who must operate without resorting to blood.²⁶ Nevertheless, it is believed that many Witnesses are denied surgical treatment by surgeons not willing to assume the risks of operating without blood. For instance, it was rumored some years ago that one of the busiest trauma hospitals in Dade County, Florida, had a blanket policy of refusing to treat Witnesses,²⁷ although accurate figures are not available. As surgical techniques improve for operating without blood and as recognition for Witnesses' firmly established legal right to refuse blood becomes more widespread, however, the risks for Witnesses may be declining, though they still remain higher than for persons receiving competently performed surgery with blood where needed. (In fact, the use of transfusion is no longer virtually automatic in major surgery even where religious belief is not an issue, and some attribute this to better surgical and laser techniques, as well as volume expanders, developed in response to the dilemmas which operating on Jehovah's Witnesses had presented for surgeons.) Similarly, there has been no controlled study of the morbidity and mortality of Christian Scientists compared with persons accepting conventional medical care. That their religious practices increase the risks of ill health or death would of course be heavily disputed by Christian Scientists, and perhaps by the Faith Assembly and Holiness Church as well. Nevertheless, given the absence of persuasive evidence to the contrary and the presence of good reason to think that the risks are in fact substantially elevated in all these groups, we shall continue to assume so here.

Altering Risk Behavior

That the members of these four religious groups exhibit distinctive commonalities in risk budget and style which fall well outside the risk budgets and styles of most other persons in society is evident enough; but these commonalities do not all arise in the same way. Indeed, if we examine practices and policies of these four groups more closely, we shall see that they exhibit four quite different mechanisms by which these commonalities are produced, each of which involves autonomy-compromising interference with the paradigmatic decision-

making structure at a different point. It is the differing nature of these interferences that renders the practices of each of these groups subject to a different point of moral critique, and that, in the end, will allow us to distinguish between those sorts of interferences which are morally defensible and those which are not. In the actual world of religious practice, of course, none of the mechanisms ascribed to each of these groups occurs in isolated form, and each of the groups has some of the features of the others (as do many other religious groups besides these four). But the mechanisms which we shall somewhat artificially isolate here are clearly those most prominent within and distinctive of these groups.

1. *Coercion.* One way in which a religious group (or any group, for that matter) can alter the risk-taking behavior of its members is by coercion. Within the Faith Assembly, for instance, although some members voluntarily accept its policy of refusing medical treatment, others—if we may believe the accounts of the two Fort Wayne newspaper reporters—do so only under threat of other sanctions. These include public humiliation, repudiation by spouses, friends, and other members of the group, and expulsion from the group altogether. Coercion operates by introducing a new outcome variable into the calculation that the risktaker makes. Not only must the risktaker weigh the probabilities and costs or benefits of possible negative or positive outcomes, but also a very large cost which will be imposed if he refuses to take the risk at all. It thus in effect suppresses the possibility of the initial choice. The force of the coercive measure is a function of the perceived costs to be imposed and the likelihood that it will actually be imposed, weighed against the costs and benefits of the risk itself. However, such sanctions are typically viewed as virtually certain to be imposed—especially those which involve not only institutional discipline but humiliation and rejection within the group. A number of religious groups, especially among the cults and new religions, are said to use coercion in securing compliance with fasting, socialization, and work regimens, expressions of loyalty and group commitment, and contribution of one's financial and other resources to the group: the Oakland Family of the Unification Church and the Hare Krishna are often cited in this regard, and Jonestown is said to provide the most horrifying example. Within the Faith Assembly, these sanctions are comparatively mild, but still strong enough to produce compliance in many cases where the risks apparently would not have been voluntarily sustained.

2. *Altering Risk Styles.* A second way in which a religious group can alter the risk-taking conduct of its members is by altering the risk styles they employ. For instance, a group may work to make its members consider certain choices more carefully than they ordinarily might, often to the individual's ultimate advantage. This, for example, may be the effect of a good deal of the pastoral marriage counseling

that many mainstream and other religious groups provide: counseling encourages the individual not to leave a marriage impetuously or in temporary anger, but only after sustained reflection, thought, and prayer. However, some religiously induced changes in risk style appear to work in the other direction, towards less considered, less cautious styles of taking risks, and it is these which present deeper moral issues.

Among serpent-handling groups, for instance, individual choices to touch or hold a snake appear not to be coerced; there is no sanction, either official or informal, during the service or afterwards for declining to handle snakes. Nor are snakes thrust upon people; those who choose to handle them must come forward to do so. Many members of the Holiness Church attend prayer meetings on a regular basis but never handle snakes. In fact, the teachings and traditions of this group explicitly encourage members to handle snakes only when they feel called or moved—i.e., “annointed”—to do so, and urge them not to do so otherwise. Persons are not blamed or chastised for failing to become annointed or for not handling snakes. Thus, serpent handling in the Holiness Church appears to be free of the kind of coercion characteristic of Faith Assembly refusal of medical treatment.

However, serpent-handling meetings involve a very high degree of participation by the members present. Services consist not only in singing and preaching, but in moving about the room, touching, shouting, and shrieking; this very high level of activity is sustained over a number of hours. These factors tend to produce an extremely heightened level of emotionality, which in turn invites the trembling, tactile hallucinations, glossolalia, and physical convulsions which members believe are the identifying signs of becoming “annointed” to handle snakes. But, according to the teachings and practices of this group, it is in precisely this (abnormal) condition that an individual’s choice to handle serpents on this specific occasion must be made. One cannot decide in advance to handle snakes; one must wait to be “called.” Reverend Robert Grooms described his first annointing, which occurred at the Holiness Church of God in Jesus Name, Carson Springs, Tennessee, in 1970, in the following way:

It was like a bucket of water pouring over me. I was tingling all over. I was so anointed with the power that I was just shouting....It’s sort of like feeling the heat from a light bulb. It’s tremendous. It came over me in such a fantastic way. I felt it through my whole body. I just went plumb out in under the power. But I knew exactly what it was for. God was telling me to take up the serpent.²⁸

This is the condition which the prosecution in *Swann v. Pack* called “so enraptured and entranced” that worshippers in it can be described as in a “virtual state of hysteria.” It is in this agitated condition, then, that the risk of sudden death is undertaken.

While it is easy to point out the moral deficiencies of coercive alterations of risk budgets or styles, alterations brought about by producing heightened emotionality may be somewhat harder to assess. Under the principle of autonomy, recognized by both ordinary morality and professional ethics, self-harming choices ought not be honored where emotionality is heightened, at least not if it is heightened enough to impair the capacity for autonomous choice, and paternalistic intervention may be necessary to protect autonomy where the individual's decision-making capacity is impaired. Nevertheless, we do in practice respect many sorts of risk-taking decisions made in emotionally heightened conditions, for instance, those made in love, in patriotic fervor, in moments of altruistic self-sacrifice, in "gutsy" sports adventures, in emergency rescues, and so on. Thus, we have rather ambivalent antecedent standards for impairment in risk-taking choices. It is not properly the actual risk involved in serpent handling that should arouse our moral suspicion (especially since the risk of death from snakebite may not be greater than in certain dangerous sports, such as hang gliding), but rather the way in which these groups engender a highly charged emotional climate and then require that risk-taking choices be made in this impaired condition.

Of course, the antecedent choice to attend a serpent-handling prayer meeting is not made under the same conditions, and thus is not subject to the same ethical reservations. However, participants claim that they do not know in advance whether they will in fact be appointed to handle snakes at a given meeting; they do not decide in advance to handle snakes, but rather simply to attend the meeting. Of course, to decide to attend the meeting is to decide to expose oneself to the risk of deciding to take the risk, but it is not a decision made in confrontation with the snakes or in the volatile surroundings of the prayer meeting. The specific decision to handle snakes is not made during any earlier, calmer, or presumably more rational moments—namely, those moments of which serpent handlers say "I'm afraid of snakes like anybody else," but only at the meeting under the extraordinary conditions which occur there.

3. *Altering Risk Budgets.* Even where the risktaker's prudential calculation is neither skewed by the imposition of coercively large costs for failing to take the risk nor is made in an emotionally heightened condition, there are still two important respects in which this calculation can be distorted. Like any group or individual, a religious group can 1) influence the individual's estimates of the probabilities of the various outcomes he foresees, or 2) change the evaluations he assigns to these outcomes, or perhaps 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.

a. *Altering assessments of probabilities.* A person reasonably conversant with the circumstances of the world knows certain facts about it:

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 risktaker—at least where the risks are understood to be common, physical ones—will have a fair amount of background knowledge about the risks he takes. A serpent handler knows that rattlesnake bites can be fatal; that is what makes snake-handling important, and why it serves as a test of faith.²⁹ 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 Sally Burkitt pleaded for a doctor instead. Of course, in many cases religious risktakers will not know the precise degree of risk involved—as, indeed, most of us do not know the precise degree of risk from hemorrhage in childbirth or from untreated rattlesnake bites—but we all share some 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 from this condition. Like other members of contemporary society, he will have some background conception of the likelihood that untreated appendicitis could result in death, and while this is by no means a scientifically rigorous conception, he will still be able to say, for example, that the likelihood of death is greater in untreated appendicitis than in, say, untreated influenza. However, the teachings of his church persuade him 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, the power of Christian Science healing, and the true nature of prayer. The believer holds that achieving a correct understanding of illness as resulting from defective mental attitudes will free him from illness—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, the risk of death from acute appendicitis treated only with Christian Science prayer is in fact much lower than the shared cultural conception insists. Indeed, he holds, it is lower not only than the risk from appendicitis not treated at all, but lower than the risk in appendicitis treated with conventional medicine. Prayer, in

his view, is the most effective treatment of all. This shared perception of risk explains why members of this religious group exhibit similar though unusual risk budgets in medical choices of this sort; but 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 he is supplied, and upon which he bases his calculations of risk.

Support for claims of the efficacy of Christian Science healing, following the pattern of the assertions made in *Science and Health With a Key to the Scriptures* and other writings of Mary Baker Eddy, is provided largely by testimonials of those who recount the ways in which they have been healed from diseases or injuries they have suffered. These testimonials are typically quite detailed and fervently sincere in tone; they are direct, first-hand 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...³⁰

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 homey testimonial is quite typical of the half-dozen to dozen published in each issue of the *Christian Science Journal*, a periodical widely circulated among Christian Scientists and 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,"³¹ and that it retains on file the originals of testimonies together with the three written verifications or vouchers required for publication. Since the turn of the century, approximately 50,000 testimonials of healing have been published in the periodicals of the church; these are said to be "the most important body of evidence concerning Christian Science healing..."³²

According to a First Church of Christ, Scientist authority defending healing in a recent issue of *The New England Journal of Medicine*, careful examination of testimonials published in Christian Science periodicals between 1971 and 1981 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."³³ This figure includes 137 pediatric cases. Healing in cases of these sorts

might seem to constitute an impressive record. But we must notice that it is wholly anecdotal in form, appealing simply to isolated cases without reference to general patterns or trends, or to comparisons based on control groups. If we look at the effect of this kind of information—independently of whether the claims are actually true—we see that it exacerbates what is one of the most common, frequent 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 like 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, especially vigorously discussed with reference to informed consent in medical situations. This is the tendency to over-rely on case information and under-rely on base rate information.³⁴ 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, and downplay or ignore information about the rates of incidence of specific conditions, side effects, self-limiting conditions, spontaneous recovery, and so on. But while ordinary medical patients do this rather naturally, Christian Scientists in situations of medical risk are in effect encouraged to do it, since they are supplied with information that makes this miscalculation inevitable. What is not available from the Christian Science church or from its publications is any data that might counteract this tendency or contribute to establishing reliable base rate information: how often, given a specific medical condition, does Christian Science healing appear to be effective? This is a much easier question to answer than "How often is Christian Science healing actually effective?" But even for the easier question about apparent results no data is available. Clearly, 647 documented cases over a ten-year period is quite sparse evidence, in view of the number of Scientists and the frequency within the general population of these diseases. There might of course be many undiagnosed, undocumented cases, or a lower incidence of such conditions among the Christian Scientist 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 are, of course, not published in the church's periodicals. Furthermore, lack of this information is compounded by acceptance of a vast number of what we might call 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.³⁵ 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, especially at distant sites on a limb (the woman was bitten on the foot), are comparatively seldom fatal; but this information was not, of course, 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 his choice in an informed way.³⁶

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 (a point possibly conceded by some opponents of the group, given substantial rates of iatrogenic illness in conventional treatment and the further fact that a very large proportion of the "illness" initially seen by physicians is either self-limiting or psychogenic in origin), but only to point out that the basis on which the Christian Scientist makes his choice in seeking relief from his 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 A Key to the Scriptures*, and part of the point of providing testimonials at all.

Nicholas Rescher takes the crucial distinction in risk assessment to be that between *realistic* and *unrealistic* appraisal.³⁷ But 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 evidence available to him. Given the sort of evidence he has, the tools he is given for assessing it, and the surrounding claim of the institution in which he trusts that this evidence is compelling, he makes a subjectively realistic assessment; the fault is not his, given his antecedent status as a believer. In fact, the Christian Scientist characteristically believes that he is making a good, sound decision, based on a large body of compelling evidence—evidence which, 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.³⁸

If this believer's assessment of risk is 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 as members of the church. Rather blame should be directed primarily against the institutional perpetration of the claim, in the guise of belief, that this evidence is good, and the complaint should point out the way in which this compromises the possibility of autonomous choice. Of course, there is fault on both sides of the fence: the medical establishment has been for the most part as uninterested in examining alleged Christian Science healings (being generally content to assert that either they must be spontaneous recoveries, perhaps associated with the placebo effect, or have been inaccurately diagnosed in the first place) as Christian Science has been to provide well-documented evidence for them, especially 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 own nature as a spiritual being or to pray adequately for release from his incorrect attitudes; the devout Scientist believes that the risk of death from disease correctly understood and adequately prayed for is nil. But what the Scientist, devout or otherwise, is not encouraged to assess in making his own risk-taking choices is how likely it is that he will actually correctly understand and adequately pray for release from his 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. Just 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 greatest relevance in risk-taking choices, yet nowhere forthcoming.

Furthermore, although there is some lack of agreement on this issue³⁹, Christian Science appears to hold that healing through prayer is incompatible with conventional medical treatment, since prayer consists in achieving an understanding of the nature of disease which contradicts the causal, physicalist assumptions of medicine. Stories abound of people being denied continuation of the services of a

Christian Science practitioner if they enter the care of a physician.⁴⁰ Patients who enter Christian Science nursing homes are required to sign a statement saying they will not seek the services of a physician.⁴¹ 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; yet he is not supplied with any evidence concerning whether the chances of survival for those who accept both kinds of therapy is better or worse than for those who rely solely on 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.

Altering persons' risk budgets by supporting claims recommending nonconventional treatment with anecdotal information unaccompanied by base-rate data, as Christian Science does, and by ignoring the incidence of failed cases and of any special conditions which must obtain for the supposed course of action to be effective, fails to satisfy the third of the basic initial criteria for autonomous choice: not only must it be voluntary and rationally unimpaired, but it must 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 sizeable placebo effect. And it is of course possible that Christian Science healing is in fact efficacious, even in 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. Their consent to reliance on religious healing is not "informed," nor is their refusal of conventional medical treatment informed either. In assessing the character of Church policies which perpetuate this state of affairs, we shall be tempted to say that they involve deceit.

The analysis given here of evidentiary claims concerning the efficacy of nonmedical healing applies not just to Christian Science alone, but to any religious group which appeals to alternative varieties of healing, whether it 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) to produce acceptance of this 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 "televange-

list" preachers. One might also want to inquire into the way in which beliefs about the efficacy of healing are furthered at such institutions as the Roman Catholic shrine at Lourdes, as well as into the practices of groups which accept faith healing but do not reject conventional medical treatment, such as the Assembly of God and certain subgroups of Catholicism and Episcopalianism. Thus, while Christian Science may provide the most conspicuous example of a certain sort of religious intervention in high-risk decision making, it will have many features in common with other groups, and ethical censure, if it is appropriate at all, ought hardly be reserved for this group alone.

b. *Altering evaluations of outcomes.* In addition to altering assessments of probabilities, risk budgets can be altered by changing the evaluations that the risktaker assigns to various possible outcomes. Since the prudential calculation the risktaker makes is the product of his assessments of the probabilities of the various outcomes times the value he assigns to them, changing evaluations will alter risk behavior as effectively as altering estimates of probabilities.

Jehovah's Witnesses, who refuse blood transfusions although they accept other components of medical treatment, accept a risk of death which is as serious as that taken by serpent handlers, Christian Scientists, and members of the Faith Assembly. However, the prudential calculation which the Jehovah's Witness makes has quite different ingredients. Whereas the Christian Scientist seeks a cure for his illness (though he does not call it a "cure" nor recognize his condition as an "illness") and makes his decision whether to accept conventional medical treatment or to rely on Christian Science healing based on a calculation concerning the efficacy of the two forms of treatment, however ill-informed it may be, the Jehovah's Witness, in contrast, does not seek a cure at all. To be sure, he hopes to get well, and hopes not to die. But his primary commitment is to honor a prohibition he believes to be divinely mandated, *whatever* the costs to him in health or life, in order to ensure his own eventual salvation. Of course, the Jehovah's Witness will be party to the culturally shared background information concerning the likelihood of death in whatever medical condition he is suffering, whether it is acute appendicitis or intestinal hemorrhage, but his church makes no attempt to alter his assessments of these probabilities. What the church does instead is supply him with a reevaluation of outcome states.

The Jehovah's Witness suffering an intestinal hemorrhage, for instance, will have at least a general awareness (sometimes intensified by an unsympathetic surgeon) that the chances of surviving with both surgery and blood transfusion are good, but that the chances of surviving with surgery alone, without blood, are markedly reduced, though they are not so low as the chances of surviving without any treatment at all. His church does not disguise these facts, nor does it encourage him to base his choice on anecdotal information in the

absence of base rate data. But there is something new in the picture here, not much evident in the Christian Scientist's choice between medicine and healing as the better risk for staying alive: the Jehovah's Witness sees the choice as one for maximizing his hopes of eternal rather than temporal life. Clearly, he does not want to die; otherwise, he would not consent to surgery at all. But he wants something else still more. He obeys the divine command because, he believes, to fail to do so might end his hopes of salvation. Thus, although his prudential calculation is in structure just like the calculations made by the serpent handler, the Christian Scientist, and the member of the Faith Assembly, its scope includes a wider set of possible outcomes. This range of outcomes believed possible is expanded by the teachings of the church, which supplies not only the claim that there is such a condition as salvation, but a set of conditions for attaining it, and it specifically identifies in its doctrines a particular act (accepting blood) which would preclude reaching this state at all.

To expand the range of possible outcomes a person foresees in this way has two associated consequences: it forces that person to reassess the disvalue he has assigned to the possible loss or adverse consequences previously expected, and it forces him to reassess the value of the previously expected probable benefit or gain. Reassessment typically takes the form of diminution of the extreme values assigned to the previous best and worst outcomes, though they remain possibilities within the schema; for them are substituted distinctively religious outcomes, which now assume the most extreme values. These altered value rankings are so strongly bipolar and so extreme that the one, salvation, acquires complete priority over the other, damnation, and over all intermediate outcome states as well. Life and death become trifles in the face of these new outcomes, so that they play only a subsidiary role, if any at all, in risk-taking choices.

It is this double substitution in value rankings of outcomes that is characteristic of religious recommitment and conversion, and it is the adoption and maintenance of these value rankings that is central to much religious education and proselytism. (It is also this feature of reevaluation which distinguishes this type of risk-budget alteration from simple coercion, discussed earlier; there, additional sanctions were added to the individual's perceived range of outcomes, but this did not produce reevaluation of the initial possible outcomes foreseen.) A reevaluation of outcomes of this sort would have quite evident effects on the risk-taking calculation: virtually any risk that might secure salvation would be worth it, whether it cost one's life or anything else, provided only that failure in the risk would not preclude future chances of achieving salvation after all. Similarly, virtually no risk of damnation could conceivably be ventured, however attractive the intermediate gain.

But of course this starkly bipolar conception of an afterlife is too

rigid and primitive for many more liberal, contemporary forms of religious faith; heaven and hell in a hereafter are not the outcomes envisioned by every religious consciousness, and many religious groups (or at least the more liberal elements within them), especially among mainstream Protestants and some Catholics, are discarding traditional notions of the afterlife. But this does not diminish the capacity of these more liberal religious groups to alter their members' evaluations of outcome states in risk-taking situations. For some modern groups, "heaven" and "hell" are taken to apply to this-world conditions, and there is no life after death; "heaven" and "hell" label states of human consciousness, but are equally strongly to be sought or avoided. These states are not to be confused with pleasure and pain or happiness and unhappiness. Borrowing Catholic terminology, they might best be called "beatitude" and "sin," though a conception of them is by no means confined to Catholicism. They are distinctively *religious* conditions, though they may on occasion coincide with positive and negative hedonic states. These more contemporary interpretations of traditional afterlife notions exhibit a second way in which religious groups can alter evaluations of outcomes in risk-taking calculations: they can divert the individual's assignment of maximal value from secular states of happiness, pleasure, or utility generally defined to the distinctively religious condition of this-world beatitude.

Now this might seem to be a merely terminological change, if the individual is simply to switch his risk-taking strategies from maximizing utility in the secular sense to achieving this-world beatitude: it is still the state he most strongly prefers. But while secular states of pleasure or happiness are by and large identifiable both by the agent and, though less reliably, by external observers, it is the religious group and tradition behind it which stipulates what counts as beatitude. It is also the religious group which defines the conditions for identifying it. Thus, the religious group both promotes achieving the state and urges adherents to be willing to risk all to gain it, and yet at the same time identifies what that state is and provides instructions ("discipline") for how to attain it. For some strains of Catholicism, for instance, this-world beatitude seems to be identified with "the beauty of suffering": what one should want most is to be like Christ and to feel the full measure of His sacrifice.⁴² In other strains of the same tradition, it is identified with humility, or with mystic transport, or with complete self-sacrificing charity. In still other traditions, particularly those influenced by eastern religions, the maximally valued state (often called "enlightenment") is stipulated as egolessness, detachment, or perhaps complete obedience to the Master. The range of this-world conditions which are identified as maximally valued possible outcomes may vary widely from group to group, but we must notice that in each case it is the religious group and its tradition which identifies the condition and assigns it both its preeminent status in the believer's

values schema and its capacity to reevaluate or eclipse ordinary value rankings. It is in this way that a religious group alters the risk budgets and hence the risk behavior of its members, first by stipulating what sorts of outcomes they should be willing to risk death to attain, and then by urging them to take the risk.

If we look back at the three forms of intervention in high-risk decision making we have previously described, it is easy to see where the moral analysis gains a foothold. The Faith Assembly methods involve clear-cut coercion, at least on some occasions. The Holiness Church avoids coercion but fosters a kind of circumstantial manipulation resulting in impairment of decision-making capacities. And inasmuch as Christian Science practices involve providing only partial, misleading information wholly inadequate for the sort of choice to be made, they involve deception. Coercion, manipulation and deliberate impairment, and deception are all familiar themes in moral analysis. But risk encouragement by reevaluation of outcomes, as among the Jehovah's Witnesses, may prove a difficult matter to assess via ordinary moral analysis. There are two principal reasons for this difficulty. First, since encouraging risk taking in this way does not seem to involve coercion, deception, or impairment of the individual's reasoning processes, at least not to the same conspicuous degree as in the three previous groups we have examined, it does not appear to violate the conditions of autonomous choice. Secondly, the reevaluation of values is a familiar, accepted strategy for behavioral change, and is characteristic of many other enterprises: education, psychotherapy, moral training, discipline and criminal justice, and so on. In each of these areas, reevaluation proceeds by persuading the individual that his old goals, aims, fears, objectives, and so on were unsophisticated, immoral, or foolish, and by encouraging him to accept new, better, healthier ones. These new goals then assume preeminent status, and as the older ones are completely eclipsed or recede into triviality the reevaluation is achieved.

Although reevaluation may make use of a variety of specific techniques, moral objections to deliberate alteration of an individual's valuation of outcomes, where it does not involve coercion, deception, or impairment of reasoning processes, typically attach not to the fact or methods of reevaluation but to the altered valuation itself. Regardless of its methods, we object when an institution—say, a school—attempts to turn a humanitarian into a bigot, for instance, but are much less likely to object when a similar institution using similar methods seeks to reverse the process. By and large, we take the reevaluation to be a salutary one when it assigns greater importance to rationally defensible value rankings such as happiness over unhappiness, pleasure over pain, beauty over ugliness, health over illness, and so forth, both for the agent and for those affected by his actions. However, as we've seen, in religious contexts like that of the Jehovah's

Witnesses, the reevaluation can move outside the range of rationally defensible value rankings to assign preeminent status to distinctively religious conditions.

It is this that makes it difficult to evaluate some forms of risk taking in religion and to assess the means by which some religious groups elicit such behavior. The sort of altering of risk budgets by reevaluation of outcomes which characterizes Jehovah's Witness practice should, presumably, be critiqued by assessing the actual moral value of the outcomes which come to be assigned highest rank in the individual's new evaluative scheme. But of course it is not possible to supply morally objective, non-faith-based assessments of these outcomes, nor indeed objective, non-faith-based evidence for the reality or attainability of such outcomes, since they are distinctively religious conditions. The Jehovah's Witness may be quite willing to risk death by refusing blood transfusions in order to attain salvation, but he has only faith-based "evidence" that there is such a thing as salvation or that keeping the commandment to avoid blood will be instrumental in attaining it. Similarly, the traditional Catholic who seeks beatitude in suffering has only faith-based evidence, supplied by the doctrines or teachings of his church, to assure him of the intrinsic superiority of this condition over pleasure, happiness, or other secular states. Non-believers will of course be quite sceptical of both such claims, and hence quite ready to say that these (erroneously) expected outcomes do not warrant the risks made in their names. Consequently, these sceptics will further argue, the institutional church which promotes risk taking in order to achieve these outcomes has no warrant for controlling the behavior of its adherents in this way. It may be one thing to hold or even teach beliefs of this sort. But it is quite another, the sceptics will add, to encourage or require persons to make high-risk personal decisions based on these beliefs, especially when it may cost them their lives. Where religious risk taking is elicited by reevaluation of outcome states in a way that deviates from rationally defensible rankings of outcomes, there is in principle no rationally defensible way of providing moral justification for such practices, since we evaluate such practices on the basis of outcome values but these religious outcomes cannot themselves be assessed. Thus risk encouragement by reevaluation cannot be attacked in the direct way that risk encouragement can be attacked when it proceeds by coercion, impairment, or deception, but it cannot be granted a clean bill of ethical health either.

It is now also possible to see why it is often difficult, in the sorts of religious situations we are concerned with here, to distinguish between decisions under risk and those under uncertainty. In many or most of these decision situations, the individual has very little, if any, knowledge of the actual probabilities of the outcomes he can foresee; objectively speaking, his decision is made under uncertainty. But in

most cases his religious group supplies him both with a general conception of the likelihood of the various outcomes and a conception of what the range of possible outcomes is, though these conceptions are likely to be conveyed by trading on hopes, conveying promises, supplying assurances, discounting counterevidence, and so on. Significantly, the religious group typically supplies him with a conception that the probabilities are very strongly in his favor ("Since Jesus loves you, mere serpents cannot harm you."), though he has little or no objective evidence that this is so. Thus the individual *believes* he knows the probabilities of the possible outcomes, and hence subjectively speaking makes his choice as a decision under risk, though to an external view it is a decision made under uncertainty of the most complete sort.

The Doctrinal Status of Risk Taking

To show that risk-taking religious conduct occurs in various forms and with various degrees of risk in various religious groups is not yet to reach a normative conclusion. We cannot simply assume that the making of decisions in which one risks death is wrong, nor can we simply assume that there is something wrong with the various mechanisms which religious groups employ to influence people in making these decisions—however extreme the risks, however manipulative the manner of encouraging them, and however severe their consequences both for the risktaker and for other persons. These are the features that the examination of religious practices from the vantage point of professional ethics exposes for us, but simply to identify these features is not yet to establish they are morally intolerable. After all, such conduct is governed not only by moral considerations, but also by the doctrines, teachings, and authoritative pronouncements of these specific religious groups.

Elsewhere,⁴³ I have developed a typology which distinguishes various levels of doctrinal assertions with respect to the ethical dilemmas involved. This 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 the basic imperatives into practice but which in doing so characteristically generate new moral problems; second-order doctrines or teachings, which establish a position attempting 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 typology provides a basis for distinguishing the more fundamental religious imperatives of a group from dictates which, 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, we treat them as initially more vulnerable to ethical critique than the basic imperatives of the tradition within which they arise.

If we survey the huge variety of risk-taking practices evident among various Christian and Christian-influenced groups, we may use this model to differentiate among those risk-taking dictates which are more vulnerable and those which are less vulnerable to ethical critique. Of course, since the risk-taking practices we have described do not form a coherent, unified, single tradition, but occur in a spectrum of quite different denominations and sects with quite different histories, we must expect that application of this model will not be completely tidy, nor uniform across these groups; nevertheless, it is possible to identify doctrines, directives and other authoritative pronouncements at all four levels.

This identification is most difficult at the 0-order, base level, since most Christian groups do not point to a single, explicit statement of a risk-taking command in their scriptural texts in the same way that they point, for instance, to scriptural commandments to confess. There are of course suggestive Biblical passages: the Parable of the Talents, for instance, might be interpreted to commend those servants who took risks by investing the money with which they were entrusted, but condemn the servant who took the safe but unproductive course of burying his talents in the field. Yet we hardly wish to interpret such stories here, nor is it clear how this one is to be extended beyond financial investment, and in any case we could hardly suppose that such stories yield a clear, fundamental, unmistakable imperative. Nevertheless, even in the absence of explicit Biblical texts stipulating the taking of risks, it is fair to characterize Christianity, with its history of heroism, persecution, and voluntary martyrdom, as a religion of personal commitment and sacrifice: it is a religion in which one must be fully committed and "risk one's all" for God. As one contemporary fundamentalist writer portrays the characteristic expression of this commitment, "I'd risk anything for the Lord. My whole life is a risk for Jesus." Of course, Christianity also offers comforts, including assurances of divine benevolence and of eventual personal salvation, but these comforts are available only to those who are willing to risk themselves for the faith. Christianity, at least in its earlier forms, is not simply a religion of gradual, confident, relatively automatic self-development and unfolding, but a religion in which one's future is always at stake: one is dared, so to speak, to put one's faith in God, even when doing so will invite hardship, sacrifice, penalty, or death from a persecuting state. This feature of Christianity is particularly evident when it is compared with, say, Hinduism,

Buddhism, or other eastern traditions.

If this central challenge to risk oneself in religious commitment constitutes the fundamental imperative underlying religious risk taking—that is, the making of high-risk decisions by opting for taking the risk—we shall expect the emergence of first-order doctrines stipulating *how* one is to take this risk. Here we observe two divergent developments, developments which become increasingly distinct in later, post-Reformation periods of Christian history. In some groups, teachings emerge which interpret risks as a matter of faith or belief, and do not promote physical risks to health or life at all: it is coming to *believe* certain things that, in these traditions, constitutes the risk one must take for God. Risk lies in the “leap of faith,” not in the danger of bodily harm. This tendency, to treat the risks of religious commitment as wholly mental, emotional, or spiritual, is characteristic of the Protestant tradition and of some recent contemplative, eastern influenced Christian groups as well. Catholicism, with its traditional emphasis on fasting, mortifications of the flesh, celibacy, pilgrimage, crusade, and martyrdom, has not always interpreted the risks of religious commitment in a wholly mentalized way, though contemporary Catholicism—except perhaps in its monastic communities, political activist groups, and such organizations as Opus Dei—may now much more closely resemble Protestant practice.

At the other extreme from a wholly mentalized conception of risk which governs first-order mandates, the groups we have been examining here understand the risks which religious commitment poses as primarily physical ones, though of course the distinction is not sharp and psychological risks may be intertwined with these. No doubt many members of groups which construe risk as largely mental would say that they are prepared to risk their lives and physical selves as well, should the occasion demand it; but they do not belong to groups which have adopted high-risk behaviors *as practices* of the group. It is this latter feature which is central to the groups we are considering here. Thus the crucial distinction at this first level of doctrinal development concerns institutionalized risk-taking practices stipulating how the fundamental imperative is to be honored: are they institutionalized primarily as mental or as physical risks? In turn, the institutionalization of risk-taking practices as involving physical risk brings with it a set of new, explicitly ethical problems. (The institutionalization of practices involving mental risk may well generate similar problems, but for economy's sake they remain outside our scope.)

These schematic claims raise a problem of relativism: how can we reliably identify 0-level imperatives? The historical account given here of the general relationship between the fundamental Christian imperative to risk one's all and derivative, upper-order practices interpreting these as mental or physical risks remains, I think, an accurate one; yet the four groups discussed here do not seem to fit this model very

well. This might seem to undermine our typology, but I think it does not. The reason these groups do not seem to fit the typology is that they are not broadly representative of the full scope of developed practice we might expect to find associated with this fundamental imperative. Were we to include the practices of Catholic and mainstream Protestant groups in our discussion of risk, a much broader range of the spectrum would be included; these are the groups that interpret risk taking, as we said, in a way that is primarily mentalized. Furthermore, some possibilities for interpreting risk-taking in a physicalized way are simply not represented by extant groups at all, or perhaps only by groups about whose doctrinal claims and associated practices we know comparatively little: we might find an example in the Penitentes of the U.S. southwest, who practice ritual self-crucifixion. We have not chosen a range of groups to represent the broadest variety of possibilities for expression of a fundamental imperative well-distributed across a spectrum, but rather groups which exhibit similarities and differences within a much tighter range.

Of the groups discussed here, Christian Science fits most nearly into the broad category of groups which honor an underlying, fundamental Christian imperative to risk oneself for God, though I think the Scientist would understand this to be a mental risk rather than a physical one: the believer's risk involves shedding one's materialist conception of the world in favor of a spiritualized view, and relying on healing rather than traditional medicine is simply a consequence of that altered view. In contrast, Jehovah's Witnesses and the serpent-handling groups function in a way characteristic of fundamentalist groups: they take as 0-level a specific Biblical passage, literally interpreted and, they claim, rigorously obeyed.

Nevertheless, even for the fundamentalist groups, we can differentiate upper-order, developed practices from the basic 0-level doctrines, even though the groups claim to be observing the scriptures perfectly faithfully. Of course, this is always a somewhat Procrustean exercise, since sensitive identification of a group's teachings and practices requires sustained, detailed examination, and they do not always fit neatly into a tidy schema. Roughly, however, we can suggest that while for the serpent-handling groups *Mark 16* is clearly the 0-level imperative, their first-order, developed practices center around the handling of serpents at religious services (about which *Mark 16* says nothing). This, of course, involves handling serpents in an identifiable location, the church; doing so in the presence of observers; doing so on a more or less predictable, scheduled basis; and so on. The commandment to handle serpents is put into practice by handling serpents *at religious services*, though it could of course be done in other ways (e.g., solo, in the woods, only when one comes upon a snake). But the developed first-order practice of handling serpents at these prayer meetings poses very obvious moral problems, among them those of

voluntariness and of danger to participants and observers. To "answer" these moral problems, second-order doctrines and practices emerge: those recognizing the distinctive condition of "anointment" and holding that it is prerequisite for handling snakes; those discouraging criticism of churchmembers who do not handle snakes, those precluding offering snakes to visitors or to children, and so on. These are all ways of minimizing the physical and emotional damage the practice can create.

For Jehovah's Witnesses, we can also identify the 0-level imperatives the group observes by inspecting its teachings: *Genesis 9:4* and similar passages are those relevant here. This group's developed practices are those which involve interpreting these Biblical passages as applying to blood transfusions (which, needless to say, are not explicitly mentioned in the Bible) and the structures of religious education and reinforcement which promote this interpretive teaching. Here, obviously, it may be difficult to distinguish the development of a practice from the development of an interpretation; but in all groups, the development of a practice goes hand in hand with the emergence of a doctrinal interpretation. The distinctive nature of the Jehovah's Witness interpretation-and-practice based on *Genesis 9:4* and other texts can be more clearly seen by contrasting it with that of Judaism, where the same texts prohibiting eating or drinking blood are interpreted as dietary laws, and develop together with an extensive code of kosher slaughtering, food preparation, and food serving.

In all the sorts of cases we've examined, some risks eventuate badly: some persons who take these physical risks suffer serious damage to their health, and some of them die. The typological model we are employing predicts the emergence of a further level of doctrinal, quasi-doctrinal, or authoritative claim, which we've called third-order doctrine, serving to provide "excuses" for the residual moral problems which the practices in question generate. For instance, when a Christian Scientist practicing his beliefs by relying on healing refuses conventional medical treatment and dies, some account consistent both with the basic doctrinal imperative and the first- and second-order teachings is needed to explain or justify this negative outcome. Similarly, since serpent handlers act to honor *Mark 16's* assertion that "they will pick up serpents, 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 snakebites and snakebite 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 quite 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, as observed earlier, is that he 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 Hobart Freeman even extended to those who wore automobile seat belts. The serpent handler who is bitten is sometimes said to have failed to be sure he was genuinely anointed before taking up the snakes: for instance, in an informative cautionary tale circulated among serpent handlers, the story is told of a woman who *planned* to display her powers to handle snakes at a prayer meeting the following Sunday. Indeed, she kept a snake in a jar for this very purpose. But when she took out the snake at the announced time she was bitten and died—clearly, so the tale holds, because she had failed to wait for the appropriate anointing by God. Not long before receiving a bite on the toe, Reverend Clyde Ricker of Hot Springs, North Carolina, offered a slightly different explanation:

I'd say that if I get bit, and I swell up, that's not a sign that I denied the faith, or that I wasn't anointed...God was just using me to prove to somebody that the serpents have teeth, and to show what snakes can do to you.⁴⁴

Not only is it easy to identify these third-order teachings or "excuses" for the negative outcomes that a group's risk-taking practices have brought about, but it is easy to see a common feature 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, and even Clyde Ricker's attempt to explain the bite on his toe as "God using me to prove that serpents have teeth" is preceded by an attempt to defuse the usual institutional explanations—that he denied the faith, or wasn't anointed. Thus, in examining the "excuses" various groups encode in their doctrines, we can begin by considering whether excuses which lay the blame for unsuccessful risk taking at the feet of the risktaker 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. But notice that under the reevaluation which is characteristic of Jehovah's Witness practice, there is nothing to excuse. The faithful Witness who dies because he refuses blood nevertheless (according to the teachings of the group) achieves salvation, even if he loses his life. But achieving salvation is, under the reevaluation, the maximally valued outcome the choice could yield, whereas losing one's life under this reevaluation assumes much lesser importance. Consequently, for the devout, the death need not be excused.

The Moral Evaluation of Risk Taking in Religion

In looking at the practices of our four specimen groups, it has been tempting to draw the immediate conclusion that these practices cannot be morally defended—and, indeed, that they should be denounced on moral grounds. After all, we have already established that the developed practices and teachings of religious groups, as distinct from the fundamental imperatives, are vulnerable to ethical critique, and when we now look at these practices, we see that they involve clear abuses of identifiable moral principle: coercion, impairment of rational capacities, and deception. 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, though these principles may have no purchase in religious contexts. Even though we have established that certain religious doctrines and practices are indeed open to ethical critique, we cannot simply assume that the principles presupposed by this catalogue of apparent abuses are applicable here.

Of the moral principles these apparent abuses appear to violate, that of autonomy is central, the one highlighted by our strategy of considering issues in religious risk taking in light of professional ethics' 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 not itself contested in either ordinary or professional ethics, though there are of course 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 particularly vigorously applied in contemporary professional ethics; here too, disagreement virtually exclusively concerns the conditions under which paternalistic or harm-based exceptions to this principle are legitimate, and there are no real challenges to the principle of autonomy itself.

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) the decision must be rationally unimpaired; and
- 3) the decision must be adequately informed.

As we have seen, these are precisely the conditions which the practices of these groups violate. The Faith Assembly, at least on some occasions, coerces its members into refusing medical treatment. The Holiness Church serpent-handling groups encourage making potentially fatal decisions about handling snakes under extreme emotional impairment, calling that condition an "annointment" for taking the risk. Christian Science provides selective, anecdotal information only, without base or failure rates, in a way which is inevitably deceptive in

influencing a high-risk choice. Nor is it apparent that these interferences in autonomous choice can be excused on grounds of risks to third parties or compelling paternalist reasons. Consequently, 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 readily be drawn.

But I do not think this is so. Our apparatus for critiquing religious practice is not yet complete, and because of this, the principle of autonomy cannot be directly employed. As we said, the upper-level doctrines and practices are *candidates* for critique; but we have yet to establish on what basis the critique can be made. To try to condemn these practices for violating the 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—and then only in limited ways—only after we have supplemented our initial typology 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-a-vis the client in professional contexts, and is usually thought to be limited to these contexts and to a few distinctive interpersonal relationships; it is not usually said to be applicable across the board in ordinary morality.

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 of course cult leaders, evangelists, faith healers, gurus, and the like have not. But while the fiduciary principle has been developed in professional contexts, its scope, as we will see, is broader, and it provides the crucial distinction we require in assessing religious practice.

The fiduciary principle, which applies to all the aspects of professional-client interaction, regulates these by stipulating that it must be possible for the client to *trust* the professional in the course of this 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—that is, violating the client's rights or harming his interests—in the course of the professional relationship, though of course the professional's superior status, power, and knowledge would make it easy for him to do so. For example, the lawyer has fiduciary duties to the client; this means that the lawyer must use his professional skills to advance the client's interests, or at the least not to harm them. Sim-

ilarly, 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 own interests at the expense of the corporation's. The fiduciary principle may seem to be similar to the more general principle of nonmaleficence, but it has specific application to professional-client relationship and 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 autonomous choices on the part of the client and to protect the client's capacity for autonomous choice, 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, but one which makes clear that the professional's primary obligation is to the client, rather than to his or her own interests, to the institution, or to other parties who might be involved. As Charles Fried puts it, the fiduciary "owes a duty of strict and unreserved loyalty to his client."⁴⁵

Inasmuch as the fiduciary principle has autonomist components, the three conditions for the protection of autonomous choice identified above—noncoercedness, freedom from rational impairment, and adequate informedness—can all be derived from it, though of course 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 serve to protect the client from the professional in very specific ways. The client, it is assumed, consults the professional in order to advance his own aims and interests, and the protection he needs is protection from professional dishonesty, manipulation, or greed which might undermine them. For instance, when the patient consults the doctor for help in curing his illness, he finds himself in an unequal, vulnerable position in this relationship (he is, after all, both sick and untrained in medicine), and must rely on the physician's obligations as fiduciary to keep from being made still worse off—and specifically from being made still worse off with respect to his health. The legal client consults the attorney for help in protecting his rights, and similarly relies on the attorney's fiduciary obligation to him, for since the attorney is far more skilled in the law than he, the attorney could easily jeopardize those rights. To be sure, professionals are also often in a position to jeopardize other interests of the client (both doctors and lawyers, for instance, are easily able to threaten a patient's or client's financial wellbeing), but it is with respect to that specific interest or set of interests the client has consulted the professional in order to promote that the fiduciary principle most directly applies.

Given this, we may now notice that, like other professionals, the religious "professional," whether minister, priest, rabbi, parson,

evangelist, faith healer, guru, or leader in a cult, is also in a position to be able to make the individuals within his group either better or worse off. He can affect their financial, social, or other peripheral interests; but he can also affect either positively or negatively that specific aim or interest for which they come to him in the first place, and it is this fact which initially supports the appeal to the fiduciary principle we are making here. What the fiduciary principle requires is that the priest and the preacher not treat those who come to them as prey, even in the most subtle ways, or use them to serve their own self-interested or other ends.

To construe the relationship between religious professional and member of the religious group in this way invites us then to identify precisely what it is that the religious believer comes to the religious professional for, that is, what interests of his own he hopes to serve by approaching the religious professional, and although this may be very difficult to do in any specific case, we may nevertheless be able to venture certain general observations. Of course, we need not suppose that the reasons for which religious believers make use of the services of religious professionals are anywhere nearly as uniform as those of patients consulting doctors or clients seeing lawyers, and individuals may go to church or see their ministers or priests for reasons ranging from relieving anxiety, coping with fear, dealing with grief, preserving a marriage, curbing aggressive or suicidal impulses, restoring health, maintaining social standing, studying a tradition, or enhancing and deepening their faith. But despite this enormous range of purposes for which people may make use of religious services, we can still identify comparatively clear aspects of the relationship between religious professionals and the believers or adherents of the group which allow us to make the further distinction required.

Consider, for instance, the reasons for which the Christian Scientist or a member of the Faith Assembly has contact with the leaders of his group, as contrasted with the reasons for which, say, a member of a serpent-handling group might do so. The Christian Scientist calls a practitioner when he is ill, and he does so for help in restoring his health. Similarly, the member of the Faith Assembly rejects medicine and relies on Jesus in order to get well, but he also acts to retain his 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 believes *Mark 16* states; it is less evident that there is some particular external objective that he wishes to achieve. Then again, the Jehovah's Witness appears to refuse blood in order to satisfy the Biblical commandment much as the serpent handler does, but does so in order not to jeopardize his chances of salvation.

Of course, identifying reasons for which persons engage in religion is a murky business at best, and a full psychological explanation of

these various behaviors may be much more complex than we can sketch here. Nevertheless, we can still perceive the rather strikingly different degrees of rational prudence, that is, pursuit of self-interest, exhibited in the various cases. The Christian Scientist seeks to get well, just as any ordinary patient seeing any ordinary doctor does; in doing so, he acts to promote one among his interests, namely health. To be sure, he does not call his condition "illness," nor recognize his symptoms as those of "disease," and he does not understand the end state he seeks as "cure," but rather a "demonstration" of the truth of the principles of Christian Science. Indeed, he rejects the entire causal metaphysics of medicine. Nevertheless, he accepts, and his church promotes, a variety of external similarities, many dating from the earliest period of the church,⁴⁶ which reinforce the claim that what he seeks is what any ordinary patient does: help in regaining his health. For instance, he calls the practitioner only when he has discomfiting symptoms (whether or not he views these as symptoms of *disease*). He can find the practitioner by looking in the Yellow Pages. He makes an appointment; he pays for the practitioner's services at rates roughly comparable to those of a physician; and, in some states (Massachusetts, for instance) Blue Cross foots 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, and we can easily identify that professional institution to which Christian Science promotes itself as an alternative. The serpent handler, in contrast, does not so clearly seem to seek to advance his interests in risking his life, but seems to act rather to obey the injunction he believes. At least, there seem to be no external similarities promoted by his group which reinforce the claim that in handling snakes he seeks to promote the same sorts of aims or interests that clients of other professionals do, and we cannot readily identify any professional institution which promotes the sorts of aims or interests that serpent handlers satisfy in risking their lives as they do. Serpent handling, as we might say, is not an alternative anything; it is simply a practice of the group.

Observing these differences may also allow us to see why the fiduciary principle, while vaguely asserted in the secular professions, is not much discussed there, and why in contrast it should be of particular interest in the religious sphere. The fiduciary principle prohibits the professional from violating moral principles in such a way as to undermine the aims or interests of the client who makes use of the professional's services in order to protect or advance these aims or interests. But in medicine and law, as in the other secular professions, this covers the entire range of cases: patients and legal clients use the services of doctors and lawyers primarily 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 rea-

son. They come to lawyers and doctors in order to protect their rights, broadly construed, or in order to get well. Since virtually all the activities in which the professional engages are initiated by this intention on the part of the client, there is nothing in these areas of professional practice which the fiduciary principle might distinguish from them. (To be sure, some clients do not voluntarily consult professionals on their own, but are so to speak delivered to them: the unconscious emergency patient, the impoverished defendant in the criminal justice system; but even in such circumstances the fiduciary principle by extension still applies.) Of course, on some occasions a client might consult a professional for purposes that do not appear to serve his own self-interests—say, when a person consults a doctor in order to donate a kidney to someone else—but even here the patient does so with the aim of protecting his own interests as well. He does not after all ask the doctor to remove the kidney without regard for the health of the donor; his own interests are to be protected as far as possible even in altruistic donation.

If, then, the fiduciary principle is not particularly conspicuous in the secular professions, largely because it covers virtually all the available cases, it nevertheless will play a central role in sorting out those cases in religion to which ordinary moral norms apply and those in which they do not. It provides a criterion for critiquing those upper-level practices and doctrines we have already distinguished from 0-level imperatives, by telling us under what circumstances these upper-level practices and doctrines can actually be critiqued with the moral principles available in professional and ordinary ethics, i.e., such principles as autonomy, nonmaleficence, and beneficence. It thus functions as a second general principle, complementing our working typology, developed earlier, which shall govern the application of ordinary moral norms to religious practices. The fiduciary principle does not in itself aid us in sorting out conflicts and tensions between the demands of autonomy, nonmaleficence, and beneficence, either in general or in specific cases like those of Faith Assembly members or Marian Guinn; 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 in what circumstances the basic moral principles can be applied. Specifically, the principle holds that the developed practices, doctrines, methods, and teachings employed by religious professionals or their religious organizations must meet secular moral criteria whenever the individual participates in these practices in order to advance his own aims or interests. Depending on the specific aims and interests the individual brings to this interaction, different specific moral principles will be particularly relevant. To use the example developed here, where the aims and interests of the individual are met with developed doctrines and practices promoting high-risk decision making,

these practices are to be assessed particularly under the principle of autonomy. This, of course, is what we've instinctively already been doing, and we've found that under this principle, most of the practices we've examined are morally indefensible.

To put the fiduciary principle in another way, we may say that the fact that the religious professional is *religious* does not exempt him from treating his clients in ways which are morally required in the secular professions wherever the client approaches him for the same sorts of self-interest-serving purposes as he would approach a secular professional. If the Christian Scientist seeks help from a Christian Scientist practitioner *in order to get well*, then he 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. If he approaches the practitioner instead as a matter of expressing and deepening his 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 simply as part of the process of prayer and the effort to achieve a certain spiritual condition—of which a side effect, though not the central purpose, may be the restoration of health.⁴⁷

Now 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 the individual approaches. But of course this is not so, for the way in which a religious organization, and consequently its officials, are approached is very much a function of the way in which it announces or advertises itself. This is an interactive process between the organization and the individuals who approach it, a process not much remarked upon in the secular professions, since most secular professions announce themselves in quite uniform ways, but a process of tremendous variability in religion. Christian Science, for instance, announces and promotes itself as an alternative healing system by the very fact of, among many other things, distributing testimonials which recount favorable recoveries using Christian Science healing (even though these testimonials are described primarily as serving to give thanks to God), and asking Blue Cross to cover the services rendered. In response to the way in which Christian Science announces and promotes itself, prospective users of Christian Science approach it in kind, seeking to receive these services to further their aims and interests in getting well. At the same time, 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 these services in this way. Similarly, for example, Scientology promotes itself as providing help in achieving psychological stability and growth, and in this sense

functions as an alternative psychotherapeutic profession; but this stance is interactive with aims and purposes for which prospective users of its services approach Scientology. When we talk about what a client comes to the professional for, we are saying as much about the professional and the background organization as we are about the client; hence, to phrase the fiduciary principle in terms of what the client seeks is also to identify specific professional and institutional postures. In religion, then, the fiduciary principle permits the application of standard ethical principles when adherents approach with self-interested aims, and thus when the religious group and its officials announce themselves as available for adherents to do so.

Of course, it may be that virtually all religious invitation contains some appeal to self-interest. But insofar as a group makes such invitation, under the interpretation of the fiduciary principle advanced here it is obligated to protect and promote the aims and self-interests to which this 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 thus opens itself to *secular* moral critique of practices and doctrines it employs in satisfying these interests. Curiously, this distinction is reflected in a somewhat crude way 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, the upholding of orthodoxy, and so on. Not all of the upper-order doctrines of a religious group will be susceptible to ethical critique; but many of those which have been traditionally protected by the notion of religious immunity will be seen to be clear targets for ethical examination, and can be assessed using the secular moral criteria developed within ordinary and professional ethics. To be sure, things are by no means as tidy as this distinction may make it sound; most groups give off mixed signals, and are approached for a mixed bag of reasons. Nevertheless, this untidiness in practice by no means undermines the significance of the distinction in sorting out what can and cannot be critiqued.

Thus, we can now see that it has been appropriate after all to engage in the kind of morally evaluative discussion we have of the practices of our specimen groups. At least in the cases of the Faith Assembly, Christian Science, and Jehovah's Witnesses, there is good reason to think that individuals consult religious professionals to promote their own interests, and that these groups promote their 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, and the practice of resorting to prayer is promoted by the church as a way to achieve this end. Jehovah's Witnesses refuse blood

in order not to preclude salvation, and the practice of refusing blood is promoted by the church and its officials at least in part with this rationale. Members of the Faith Assembly submit to coercive measures in refusing treatment in order to maintain their membership in the group. And if what the serpent handler seeks is 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 may be available in other less life-threatening ways.

Applications of this criterion, based on the fiduciary principle, are not likely to be easy to make in practice. After all, the principle refers to the reasons for which persons use religious services, as induced by the religious organization and vice versa, and these reasons may be multifarious and obscure. In any given case or group of cases, we would need to inquire into the purposes for which an individual or group of individuals consults a religious practitioner, and such inquiry may seem both unwieldy and quite unlikely to be reliable. People participate in religious practices like confession, counseling, faith healing, and so on for an enormous variety of reasons, including restoring their health, relieving their anxieties, preserving their marriages, increasing their security, dealing with grief, and so on. Indeed, a very large part of what leads the religious believer to approach the religious professional seems to involve the protection and advancement of interests like these, and a very large part of the comforts that religious groups offer are directed towards interests like these. Self-interested religious behavior may be very difficult to distinguish from that which is not. But 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 which are proper targets for ethical critique from those which are comparatively immune. It is also a proper basis for scrutinizing the way in which religious groups advertise themselves and their services, both in securing continuing commitment from their members and in proselytizing new ones. Perhaps in part because of the difficulty of distinguishing among kinds of religious practice, our tendency in the past has been to let them all slip by, and to retreat to the traditional notion of the immunity of religious matters generally from moral critique. But just as it would be indefensible to subject all religious doctrine and practice to ethical scrutiny where there is no warrant for doing so, it is indefensible to protect from scrutiny those religious practices which deserve it.

However, not all approach by individuals to religious "professionals" or organizations is made for reasons of promoting self-interest. To determine the obligations of the religious professional in any given case, we need to examine the reasons for which a specific person or group of persons seeks religious services; not all of these may involve

self-interest. Consider, for instance, the person who describes his reasons for seeing his minister or going to church as wanting to "strengthen my faith." This seemingly central religious purpose bears close scrutiny, and it must be asked why or for what purpose the believer seeks this service. If, for instance, it is evident that the believer seeks to have his faith strengthened "so I can be sure I'll go to heaven," his motive sounds very much like the kind of self-interest which 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, particularly considering that the only available alternative under this belief system is hell. Consequently, even the apparently purely 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 which 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 capable of either advancing or undermining the interests a person seeks to advance.

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

But while having one's faith strengthened in order to get to heaven may not be a distinctively religious purpose for consulting a religious professional, we can imagine purposes which are. A person who initially expresses his desire for help in strengthening his faith might, in contrast, explain that he seeks this help because God is supremely worthy of worship and hence he wishes to be able to worship God more fully—regardless of the impact this fuller worshipping might have on himself. This kind of purpose in seeking assistance from a religious professional is not one in which the person puts his own self-interests in a position in which they are vulnerable to the professional's influence, and consequently it is not one in which the usual strictures of professional morality under the fiduciary principle apply. For instance, some Christian Scientists, as perhaps some Faith Assembly members and some Jehovah's Witnesses, may observe their

church's teaching not in order to enhance their own health or secure their own salvation, but simply because, as they believe, it is the word of God. In these cases the methods of the religious professional and of the group's religious practices are not subject to the three criteria outlined above, and we have no immediate basis for saying that coercion, impairment of rationality, deception, or fraud cannot be morally allowed. (This is not, of course, to say that they are justified.) However, these cases may be very, very few, and such people as rare as saints. If most religious behavior by most persons is really 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 these persons in that pursuit.

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Notes

- ¹ Charles Fried, *An Anatomy of Values: Problems of Personal and Social Choice*, Cambridge, Mass.: Harvard University Press, 1970, p. 167.
- ² See Thomas C. Johnsen, "Christian Scientists and the Medical Profession: A Historical Perspective," *Medical Heritage* Jan/Feb. 1986, pp. 70-78, for a loyal account of the historical backgrounds.
- ³ Arnold S. Relman, M.D., "Christian Science and the Care of Children," *The New England Journal of Medicine* 309 (26):1639 (Dec. 29, 1983).
- ⁴ Nathan A. Talbot, "The Position of the Christian Science Church," *The New England Journal of Medicine* 309 (26):1641-44 (Dec. 29, 1983), p. 1642.
- ⁵ *Ibid.*
- ⁶ 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, pp. 42-60, esp. pp. 45ff. Also see William E. Laur, M.D., "Christian Science Visited," *Southern Medical Journal* 73:1 (January 1980), 71-74, esp. p. 73.
- ⁷ Rita Swan, "Faith Healing, Christian Science, and the Medical Care of Children," *The New England Journal of Medicine* 309 (26):1936-41, p. 1640.
- ⁸ See the pamphlet supplied by the Watch Tower Bible and Tract Society of Pennsylvania, "Jehovah's Witnesses and the Question of Blood," 1977.
- ⁹ Some Witnesses will also accept closed-loop extracorporeal recirculation of their own blood during surgery and in hemodialysis.

- 10 See e. g. J. Skelly Wright's decision in "Application of President and Directors of Georgetown College," 311 F.2d 1000 (D.C. Cir.), certiorari denied, 377 U.S. 978 (1964).
- 11 Jim Quinn and Bill Zlatos, series of stories beginning May 2, 1983, in the *Fort-Wayne News-Sentinel*, Fort Wayne, Indiana.
- 12 Quinn and Zlatos, story dated May 5, 1983, p. 1.
- 13 In part spurred by the organization Children's Healthcare Is A Legal Duty, Inc. (CHILD), Box 2604, Sioux City, Iowa, 51106.
- 14 Robert W. Pelton and Karen W. Carden, *Snake Handlers: God-Fearers? Or, Fanatics?* (Nashville: Thomas Nelson, 1974), provides a useful pictorial essay on these practices.
- 15 *Swann v. Pack* 527 S.W.2d at 105. This case also notes that Hensley died of a diamondback rattler bit during a prayer meeting in 1955.
- 16 Nathan L. Gerrard, "The Serpent-Handling Religions of West Virginia," *Transaction*, Vol. 5, No. 7 (May 1968), p. 23.
- 17 Pelton and Carden, *op. cit.*, p. 12 of appendix.
- 18 Gerrard, p. 23.
- 19 Weston La Barre, *They Shall Take Up Serpents. Psychology of the Southern Snake-Handling Cult.* Minneapolis, University of Minnesota Press, 1962, pp. 19-20.
- 20 Findlay Russell, *Snake Venom Poisoning* (Philadelphia, Toronto: J.B. Lippincott, 1980), p. 527.
- 21 *Swann v. Pack* 527 S.W.2d at 100.
- 22 *Fort Wayne News-Sentinel*, June 2, 1984, p. 6A.
- 23 Swan, personal communication.
- 24 Gale E. Wilson, "Christian Science and Longevity," *Journal of Forensic Sciences*, Vol. 1, Oct. 1956, pp. 43-60.
- 25 CHILD, Children's Health Care Is a Legal Duty (Box 2604, Sioux City, Iowa 51106), was founded by Rita and Doug Swan, former Christian Scientists whose young son died of meningitis after receiving only Christian Science healing. The stated purpose of the organization is to "oppose child abuse and neglect associated with religious practices," and it opposes all religious exemptions from parental duties in providing health care for children. CHILD publishes an extensive newsletter describing specific cases of denial of treatment to children.

- ²⁶ See J. Lowell Dixon and M. Gene Smalley, "Jehovah's Witnesses: The Surgical/Ethical Challenge," *Journal of the American Medical Association* Vol. 246, No. 21 (Nov. 27, 1981), pp. 2471-72.
- ²⁷ Dixon and Smalley, *op. cit.*, p. 2472.
- ²⁸ Pelton and Carden, pp. 29-30.
- ²⁹ Members of the Holiness churches insist that serpent handling is not to be understood as a "test of faith" in the sense that, say, reciting a creed might be, but that it is a "confirmation" of God's word. Glossolalia, serpent handling, strychnine drinking, and similar practices are the "signs following" belief in God but not evidence for it. See Pelton and Carden, *op. cit.*
- ³⁰ Merrily Allen Ozengher, *Christian Science Journal*, Vol. 101, No. 9, Sept. 1983.
- ³¹ *Ibid.*, footnote appearing at the beginning of the "On Christian Science Healing" section of testimonials in each issue of the *Journal*.
- ³² Talbot, *op. cit.*, p. 1642; see also *A Century of Christian Science Healing* (Boston: The Christian Science Publishing Society, 1966), for the church's account of this history.
- ³³ *Ibid.*, p. 1642.
- ³⁴ See e. g. Daniel Kahneman, Paul Slovic, and Amos Tversky, eds., *Judgment Under Uncertainty: Heuristics and Biases*, Cambridge Univ. Press, 1982, *passim*.
- ³⁵ Nudelman, *op. cit.*, p. 49.
- ³⁶ 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 medical records were kept—which, of course, is not generally the case. However, the kind of persuasive evidence supplied by controlled clinical trials would not be possible to obtain concerning the efficacy of Christian Science healing, for the simple reason that it would not be possible to *randomize* subjects into groups which believe (and hence, presumably, can perform Christian Science prayer) and those who do not believe but have confidence in conventional medicine. The closest one could come in designing such a trial would be to randomize believing Scientists into groups which used prayer and those which, denied prayer, used conventional treatment, or to randomize nonbelievers into those which used conventional medical treatment and those who went through the motions of prayer.
- ³⁷ Nicholas Rescher, *Risk. A Philosophical Introduction to the Theory of Risk Evaluation and Management*, Washington, D.C.: University Press of America, 1983, p. 132.
- ³⁸ Lois O'Brien, "Prayer's Not a Gamble," letter in *U.S. News & World Report*, April 28, 1986, p. 81.

- ³⁹ NEJ; but also see Laur, p. 73.
- ⁴⁰ See Rita Swan case.
- ⁴¹ Reference in letters replying to *New England Journal of Medicine* articles, 1984.
- ⁴² See e. g. the works of Teilhard de Chardin.
- ⁴³ This typology is developed at length in Chapter I of my *Ethical Issues in Organized Religion* (to be published in 1989 by Yale University Press) of which this essay will form Chapter II, and it has also appeared in my "Applied Professional Ethics and Institutional Religion: The Methodological Issues," *The Monist* vol. 67, no. 4 (1984).
- ⁴⁴ Pelton and Carden, last page of appendix.
- ⁴⁵ Charles Fried, *Medical Experimentation, Personal Integrity and Social Policy* (New York: American Elsevier Publishing Co., 1974), p. 33.
- ⁴⁶ Note that by the turn of the century, Christian Science was viewed by the medical establishment as an alternative (and bogus) medical school, not as a religion. See Johnsen, *op. cit.*, p. 72 and *passim*.
- ⁴⁷ Johnsen, *op. cit.*, p. 73. As Johnsen also notes, a unanimous opinion of the Rhode Island Supreme Court affirmed in 1898 that prayer in Christian Science could not be mistaken for the practice of medicine in any "ordinary sense and meaning" of the term.