Pull Up a Chair  

By Douglas Brown, Ph.D.

That's the way I imaged the “yes, welcome” I received a year ago from Dr. Brody and his colleagues at the Center for Ethics and Humanities in the Life Sciences. With a measure of trepidation, I had inquired about any opportunities for me to gain from them a stronger philosophical context for the various clinical ethics projects with which I had become involved within the University of Michigan Ob/Gyn Department. The Center faculty not only offered their guidance. They surprisingly invited me to tutor them a bit as a theologian! This essay is a preliminary interpretation of our experiment with expanding their secular discourse to include a theological “second opinion.”

I continue to ponder the invitation to “pull up a chair,” attentive to subtle clues about the discussion of ethical dilemmas into which the fourteen-year battle my first wife (d. 1987) waged against multiple sclerosis had plunged me. --- “The Center's medical ethics discussions have been quite productive without me. In fact, no place had previously been reserved for a theologian” --- “They clearly are not making room for someone whose vocabulary, methodology, and reflection would effectively conceal any theological distinction.” --- “Yet, they seem open to testing afresh the possibility that theological reflection might offer input not available by other means.” --- “Perhaps they have realized, from their leading efforts to relocate ethical reflection nearer the patients and health care professionals, that ‘religion’ must be treated as more that a private matter inappropriate for societal discussions.” --- “I doubt that they have concluded, with Berger and Luckman that a scientific way of seeing existence is no more true (or false) than a religious one. I haven’t.” --- “Maybe they have found their way to Pascal's thoughts: Reason's most important discovery is reason’s limits.”

My immediate response to their invitation was a quick,”thank you, I would be glad too.” After all, I could come out no worse than with a very impressive C.V. entry. However, surely a theologian should rise above such impurity of heart.

(Please see Brown on page two)

Medical Neglect: Equity For All Children

By William B. Weil, Jr., M.D.

Freedom of Religion is one of our country’s greatest rights. While the Constitution guarantees the right of an individual to believe whatever he or she wishes, it does not allow one to use those beliefs to bring harm to others. Parents who deny needed medical care to their children because the parents believe that prayer, or some other religious practice is more efficacious are harming their children.

Parents have many prerogatives in the rearing of their children. However, in exchange for the opportunity to raise their children as they desire, the parents also have certain obligations to these children: to feed them, to clothe them, to see that they are educated, to keep them free from harm, and to provide for their medical care. To assure that our children do receive these benefits, we, as a society, have mandated through law that this will occur. We have school attendance legislation to insure that a child is educated, child labor laws to prevent children's exploitation before they are mature, and child neglect and abuse laws to assure freedom from harm and the provision of food, clothing, housing and medical care.

(Please see Neglect on page seven)
Could I, with integrity before the Center faculty and before my community of religious faith, join this invitation? For some participation would be hypocritical. The barrier-secularization. My “sitting down” to the Center discussions implies confidence that “secular” and “theological” need not be mutually exclusive. Let me explain.

Secularization happens when a social unit (from family to nation) breaks down into two spheres—“sacred” and the desacralized. In the West’s story, the transportation of the ancient Roman Empire into the “Holy” Roman Empire occurred without this break-down. The occasionally-cycled idea that ancient Rome and today’s society are equivalent illustrations of a secular society misses the mark. Whether ancient or medieval, day-to-day life continued at least in theory and form to be grounded in a blanket of “sacred”.

From Constantine forward for a millennium, “sacred” meant “Christian.” Then came the scholastic educational method, the Church’s frustration with youthful universities determined to be free, Henry VIII’s refusal to continue underwriting Rome, the breach between Protestants and Catholics, the radical proposal to separate church and state, lay acquisition of church property, decapitation of royalty. Secularization was a cultural phenomena waiting to be conceptually recognized and systematically channeled toward every vestige of Christendom’s “sacred.” Mixed in with economic maneuvers and political self-interest was talk of freedom, critical inquiry, and common sense. A gestational period stretching from Descartes’ “I think (doubt), therefore I am” to Kant’s “coming of age” finally began delivering newborn nations.

Catholics, Protestants, and Puritans as a rule sought desperately to protect the old theocracy with its accent of falleness, revelation, and subjection. Seventeenth-century latitudinarians and pietists, eighteenth-century deists, and nineteenth-century liberals proposed innovative ways both to promote empirical inquiry and to continue thinking of God as present. However, the disturbing new category of “innocent suffering,” the frightening potential for evil within the human heart, and scientific successes with the grammar of nature reduced the sacred to temporary presence in the dwindling number of gaps we could not manage alone.

Freedom of religion now meant freedom from religion. “Sacred” receded to private opinion. Public discourse, bounded by reason alone, forged ahead though severed (like cut flowers, in my judgment) from a transcendent “commons.” Notice on either side of this divide the determination to “walk” by sight.

Secular discourse has for several decades been backing away from unchecked confidence in empirically verifiable reason alone. I am among those theologians who have been backing away from the prima facie expectations to “see” (at least from within a circle of faith) God as present. In the ancient story of Job, this expectation distinguishes the conception of God maintained by the people around Job who victimized their former foe. I have accepted the nudge from the story’s narrator to make “God as absent” the expected result of observing human existence.

Jewish and Christian communities of faith have a steady, though oft-neglected, place in their long histories for theological formation as “before God without God” (Bonhoeffer). “Absence” permits both cynical and patient thoughts. The way we say, “Where have you been?” quickly communicates more than an inquiry to a spouse, a child, a friend. This oral interpretation also occurs when we ask, “If God is, what has He been doing?” A secular believer finds within the story retold by the community of faith ways to recover patient thoughts about “God as (by observation) absent.” For instance, I accept that for most members of a technological/scientific society God is absent as a necessity for explaining life experiences. To relegate God’s presence to an insurance form’s “act of God” explanation for some event not yet unraveled is hardly compelling. However, God’s absence as a necessity opens rich reflection on gratuitousness. (How many times have we accepted a gift with, “You didn’t have to do this,” only to be reminded, “That’s not why I did it.”) I find similar theological possibilities in considering God’s absence as a creation of/invitation to freedom, as the subtlety of a suitor, as a judgment against societal exploitation, as an opportunity to ponder our insignificance to the well-being of the cosmos, as a sign that God is clearing a path ahead of presently futile circumstances.

This “God as absent” theology provides me the point of contact with the Center’s secular discourse about medical ethics. “God as absent” roughly correlates with what is treated as sacred within secular discourse—the principle of criticism. And so I sat down to seminar discussions of maternal-fetal conflict, gynecological care for difficult-to-examine women with mental retardation, resource allocation, and the perceptions of women with gynecological cancer. Incorporating a theological angle seems to have “cash value” in at least eight ways. First, a theological participant can shed light on the religiously committed patients and health care professionals involved in clinical decision making. Second, she can clarify the understanding of ancient religious terms and stories (e.g., the good Samaritan) that remain on loan in secular discussion. Third, she can identify the set of convictions what establish the...
alternatives to theological faith depended upon by each participant in the secular discourse. Fourth, he can keep attention on what is at stake when a secular society neglects human spirituality. Fifth, she can prod the discourse beyond “Surely this is not the way it ought to be” to “Surely, this is the way it ought to be.” Sixth, he can introduce metaphors and stories from within her community of faith (e.g., a full life, a just society, compassion, quality of life, a time to die, rights, forgiveness, covenant). Seventh, he can assure that our paradoxical capacity for radical good and radical evil is not forgotten. Eighth, she can constructively call attention to the classical comedy inherent in the effort to stretch human wisdom so as to master life’s surprises and follies.

I must once more express my gratitude to the Center for the invitation to “pull up a chair.” We are all members of many communities. I regard the Center faculty and staff to be among my penultimate associations. The benefits have been decidedly on one side to my advantage. But such is the stuff of education.

Case Study: Christian Science, the Government and the Clash Over the Spiritual Healing of Children

David and Ginger Twitchell are a thirtyish, married Christian Scientist couple both of whom are descended from several generations of Christian Scientists. In 1986 they lived in the Hyde Park District of Boston with their two sons. That year, during five days in April, their youngest son, Robyn, displayed varying flu-like symptoms. The Twitchells, in conjunction with a Christian Science practitioner and a Christian Science nurse, treated the boy with spiritual healing, which ultimately failed. The child died of a bowl obstruction due to a rare congenital birth defect. Four years later, in May of 1990, the Commonwealth of Massachusetts brought charges of involuntary manslaughter against David and Ginger Twitchell for failing to seek conventional medical care for their son. They were convicted and sentenced to ten years probation and are required to take their children to a pediatrician regularly. The case is presently on appeal.

First Commentary: Jennifer Walters, D. Min.

The Twitchell case is commonly understood as a conflict between the individual’s right to freely exercise one’s religious beliefs and the government’s duty to protect vulnerable citizens, particularly children, from harm. As faithful Christian Scientists, Ginger and David Twitchell based decisions about health care for their ill son, Robyn, on their belief in a “divine power that makes ‘the healing presence of God’ a ‘practical reality.’” For them the teachings and practice of their faith were not restricted to worship but incorporated into a world view which shaped their opinion about acceptable options for healing their son’s illness. That they loved and grieve for their son has not been questioned. As his parents and medical/legal guardians they acted with good faith to heal his sickness according to Christian Science health principles and practices. However, in the opinion of the Commonwealth of Massachusetts, the Twitchells failed to protect their child with conventional medical treatment.

The Twitchell’s case represents not only a conflict involving religious practices, but also fundamental differences in approaches to health and healing. There are many cases in which individuals and communities have adopted an unconventional philosophy of health or medicine. The Twitchells’ medical choices were made on the basis of religious faith; many AIDS and cancer patients reject conventional medicine (or aspects of it) in favor of homeopathy, Chinese medicine or creative visualization on the basis of their assessment that modern medicine’s offerings are profoundly limited, at least in their situation.

The belief in spiritual healing in the Christian Science tradition arises from a desire to make a way for a “higher power” (God) to work in a person’s life. Of course, spiritual healing in this sense is not unique to Christian Science or even to Christianity or organized religion. Spiritual healing rituals and traditions extend back into ancient history and appear in nearly all cultures. This approach is not so foreign as the Twitchell case might make it seem and conventional medical practice includes
referral to some spiritual healing programs. Physicians commonly refer patients to Twelve-Step programs such as Alcoholics Anonymous and Narcotics Anonymous which are successful (and credible) group-oriented addiction treatment programs which base recovery and healing in a spiritual theory and practice. Some forms of individual or group psychotherapy and support acknowledge the role of spirituality in physical healing. Current research on the effect of mental states on the body's immune system (psychoneuroimmunology) and healing process has the financial support of the National Institutes of Health. "Mind/Body" programs which teach techniques for altering one's mental state and using spiritual and emotional resources to reduce stress have been developed at institutions such as the Beth Israel and Deaconess Hospitals in Boston. Patients with a diagnosis and a prescription from their physician can bill these--often expensive--programs to their health insurance carrier. Spiritual healing, while not widely accepted, is a growing part of conventional medical practice. Medical and legal authorities will acknowledge spiritual healing, but only as part of a prescribed medical program, carefully supervised by the physician.

The American Hospital Association's, "A Patient's Bill of Rights" states, "The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action." This is generally interpreted in conventional medical settings to mean that a patient may decline initiation of any medical procedure, even those that have proven efficacy and minimal risks. Parents, as legal guardians, have the right to decline treatment or preventive measures, such as vaccinations, on behalf of their children. Many states have laws which protect parents who have religious beliefs which prohibit conventional medical practice, from prosecution for child neglect in these situations. In these cases, and the Twitchell's, the parents have not only refused conventional medical treatment, they have refused to enter into the doctor-patient relationship. They have said, "My child will not be a patient." It is neither their religious faith nor their spiritual healing practices alone which are unacceptable to the State; it is their refusal to relinquish control of their children's health and welfare to conventional medical authorities. Conventional medical practice can admit the potential efficacy of spiritual healing to the extent that it can be monitored and controlled. Unfortunately, individuals, especially parents, who step outside these boundaries are at risk for State-intervention.

When apparently rational, intelligent persons make choices that defy accepted conventional (and often experimental) medical practice--even at the risk of one's life--the temptation is to "teach them a lesson". Western culture's faith in medical technology (surgery, drugs, diagnostic tests) is so strong and so complete that anyone whose actions display a 'dangerous' disbelief or distrust in its' power and authority to heal, may be subjected to state-sponsored attacks on their rationality and their autonomy. And yet, health professionals know that healing does not often conform to a recipe and life and death are equally unpredictable despite their ability to test for it. The Twitchells were prosecuted not only on the basis of their religious beliefs, but because they did not "buy" the Western medical product. They chose another way and, not so unlike the results of other conventional medical treatments, their son happened to die in spite of their best efforts.

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Second Commentary: Thomas Black

Dr. Leonard J. Weber in the Fall 1990 issue of Ethics in formation writes: "Active listening to others, including those who disagree, is at the heart of ethics education; it involves us in reflection on our own positions and on the adequacy of those positions."

The recent prosecutions of several Christian Scientist parents have prompted a great deal of ethical reflection among Christian Scientists, for whom the practice of spiritual healing has been a way of life from many decades. Obviously--or perhaps not so obviously, in light of the court cases--the aim of this practice is healing not harm to those we love and least of all harm to children. The death of a child is as unbearable to Christian Scientists as to others, as must have been evident to those who witnessed the anguish of the parents in court. A death that might possibly have been prevented by other means of care presents ethical questions as serious and troubling to us as, for instance, the death of a child through a medical mistake would raise for the doctors involved.

We are not made of stone. Christian Scientists would never--even on the basis of religious freedom--defend laws permitting spiritual healing for children if we felt that such deaths were the "norm" or unusually frequent in practicing Christian Scientist families. Or if there had not been extensive and significant healings in our own experience (including frankly, healings when medical care itself has been ineffective). It is because of this broader experience of healing, and all that it has meant to us, that we feel the "active listening" Dr. Weber refers to needs to involve genuine two-way dialogue and some recognition of the ethical complexity of this issue--not merely an unquestioning assumption that all the right is on one side or the other.

The complexities have often simply been filtered out in the atmosphere of recrimination surrounding the court cases. In regard to the Twitchell case in Boston, for example, it is striking how many of the facts have been widely misreported and how much has gone largely
(Black commentary)

unreported. Consider:

*Dr. Lawrence Tribe, Tyler Professor of Constitutional Law at Harvard, has said that the judge’s instructions to the jury were “fundamentally flawed,” that her refusal to allow the jury to be polled was “unfair,” that the result was a “fundamentally unfair conviction,” and that in the trial the state showed itself to be “acting cynically.”

*Perhaps one reason Professor Tribe has made these characterizations is that the Massachusetts legislature specifically placed a law on the books of the Commonwealth of Massachusetts to prevent this kind of prosecution. A similar defendant was convicted in Massachusetts in 1967, the only other prosecution of a Christian Scientist parent in the history of the Commonwealth. In discussions with various state authorities after this conviction, there was broad consensus that criminalization of such a parent was inappropriate, particularly since the prosecution represented a reversal of a long history of public policy. As a result, the legislature in 1971 amended the law to accommodate spiritual healing. The attorney General issued a formal opinion stating that the new law would “preclude criminal liability.”

*Despite the fact that the law as designed to apply precisely to such cases, the prosecutor in the Twitchell case repeatedly asserted that the amended law had no bearing. Since the trial, several jurors have publicly stated that they felt they were not fully informed and that their decision to convict was contrary to their present fuller understanding of Massachusetts law. As this case goes through the appeal process, it is expected that these issues will be addressed.

*Discussion of the medical aspects of the case has been equally one-sided and often inaccurate. It simply isn’t true, for instance, that the child was “force fed” or that he was “almost constantly vomiting,” as a Michigan doctor recently alleged in a newspaper column. Nor does the full evidence indicate that the child was in constant pain through the illness, as the prosecution suggested in its effort to obtain a manslaughter conviction. As the church’s official response to the initial inquest commented: “The pathos of Robyn Twitchell’s death is evident to all involved in this case. It is not increased by gratuitously... magnifying the symptoms of his illness; by maximizing the appearance of suffering while minimizing apparent signs of improvement or intermittent relief; by citing the doctors’ general testimony on the possible symptoms of a condition as if it were specific factual testimony on Robyn’s case...”

Medical fact supportive of the defendants case have rarely been published. Without examining the particulars of the case, most doctors have automatically assumed that the condition that led to the child’s death—an intestinal obstruction—was “easily treatable” (as the same Michigan physician put it) and would have been routinely corrected under medical care. But medical testimony in the trial on this point was divided, and there is considerable evidence to suggest that it was not merely a routine case.

The specific complication of Meckel’s diverticulum that caused the obstruction has been described in medical literature as the most “lethal” complication of this condition and the form least amenable to surgical correction. The condition was previously asymptomatic and, in real life as distinct as from theory, the diagnosis is by no means as certain and unequivocal as it was presented in court. (A similar obstruction that caused the death of actress Heather O’Rourke in 1988 was not properly diagnosed despite extensive medical contact.) Even presuming accurate diagnosis, there is no scientific or moral justification for the kind of assertion made by one physician at the inquest, that the cure of such a condition under medical care—a cure involving major surgery on a two-year old—is “100%” sure.

Points such as this do not “answer” the basic ethical questions raised by cases like the Twitchells’, but they illustrate the medical double standard that often tends to preclude serious two-way discussion of Christian Scientists’ healing practice. In real life, again, the answers are rarely black-and-white, and responsible physicians offer no guarantees. While this does not justify an “anything goes” approach in public policy in regard to health care, it does call into question the premise that “standard medical care” should automatically be considered the only acceptable form of care.

Ultimately, the ethical issues are inseparable from those relating to what might be termed the credibility of spiritual healing. Many in contemporary society see spiritual healing as a fantasy and prayer, or at best as a placebo. From this perspective, the only credible means of addressing physical illness is through medical techniques, and possible evidence for spiritual healing is dismissed a priori.

Christian Scientists respect the right of others to hold this point of view. But we also feel that in a pluralistic society there should be room for other points of view, especially since there is massive evidence of healing -- whatever the correct explanation for such healing -- in Christian Scientists’ experience. No one disputes that the scientific questions regarding this evidence need to be examined more thoroughly. Christian Scientists would contend that the whole phenomenon of spiritual healing needs to be examined far more thoroughly than has been possible either in the court room or in polemics that have approached the subject with the purpose of debunking it.

There is no easy resolution of differences on these matters, but perhaps what has been said can help to open rather than to shut off dialogue. A recent letter to the Journal of the American Medical Association -- a letter that JAMA declined to publish -- might provide a starting point for two-way listening:

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"In the late twentieth century, it's obviously highly unusual to find a significant number of educated people in the mainstream of society consciously choosing reliance on religious healing rather than medical care...it may be difficult for others to understand why Christian Scientists make this choice, and why we feel so deeply about the compassionate ideals behind it. Whatever the ultimate answer on the complex policy issue of how society can do right for children in general, those ideals don’t...lessen our commitment to our own children's health and well-being...Rather, those ideals point to what makes every human life so much more than its biology.

It may be easier for medical professionals to dismiss Christian Scientists as hopelessly old-fashioned religious obscurantists than to consider seriously the implications of the broad range of healings in their experience...This mindset deserves rethinking as physicians grapple with the problems of a medical system that has often undervalued man's spiritual resources and with technologies that increasingly dehumanize even as they are intended to heal."

Third Commentary: Tom Tomlinson, Ph.D.

This case is both a personal tragedy for the Twitchell’s and a complex problem for any public policy that wants both to protect children from injury and death and to protect a diversity of religious beliefs.

Not having knowledge of sufficient facts in the Twitchell case, it would be presumptuous of me to make a judgment about these parents, for reasons I will explain. My comments must be limited to what I see as the important and difficult problems which face development of policies for handling parents' religiously-motivated decisions not to employ orthodox medical science in the care of their children.

To uncover these difficulties, let's assume as a baseline principle that all parents are obligated to act in the best interest of their child, and that the State should be authorized to intervene when the parent is clearly acting against his child's best interest. This is a working principle that applies readily and uncontroversially to cases of gross child abuse or neglect, when the parent is acting out of malevolence or indifference toward the child; but the principle is not so easily translated into action in cases where devoted parents are acting in what they sincerely believe to be their child's best interest, from within a developed religious framework.

We must first of all ask whether we can neatly separate two questions, asking first what is in the child's best interest, and then asking whether the parents' religious views are contrary to the child's interests. What, for example, should we think of a case in which the Jehovah's Witness parents of a ten-year-old with metastasized osteosarcoma are refusing any treatment requiring blood transfusions, including surgery to remove the primary tumor? On the medical view, such treatment offers the only hope for survival, but the chances of success against this disease are very low, and treatment is itself hazardous, involving amputation and intensive chemotherapy. In calculating the "child's best interests," should some account be taken of the love and support that only these parents can give to a child who is probably doomed, if the alternative of forced treatment is likely to undermine the perspectives and rituals of faith through which this family provides comfort and strength to its members, including its children? If the answer is "Yes," then the child's best interest, even from a thoroughly secular perspective, cannot always be thought of as something separate from his parents' religious convictions.

Another problem concerns which parental behavior is to be judged by the best interest standard: a specific act of refusing or not seeking standard medical care; or the decision to apply a religious doctrine of healing to the care of their child. These are separate questions. Parents can consistently apply a religious doctrine in caring for their child, and never make any decisions which are harmful to them, as evidenced by throngs of healthy adults raised under Christian Science roofs. The danger for policies in this area is that the one judgment slides over into the other. This danger is illustrated by the Twitchell case.

Robyn Twitchell died from a bowel obstruction. The expert medical testimony was that prior to his death, he probably was feverish, vomiting, and in obvious (abdominal) pain. The Twitchell's testified that he showed none of these symptoms until the night before his death, but let's set that aside, and assume that his symptoms were generally as the doctors testified. If the judgment to be made is whether the Twitchell's acted in violation of Robyn's best interest by not seeking standard medical care, then the question before the jury is whether they acted in a manner grossly different than any other prudent, concerned parent, regardless of their motives or reasons. Did Robyn's symptoms resemble closely enough the symptoms of what is often called the "stomach flu," which many prudent parents would expect to resolve in due course without a visit to the doctor? What other concerned parents would do in the same circumstances is the sensitive question of fact on which a judgment about the Twitchell's actions should turn.

The danger is that a judgment about the prudence of the Twitchell's actions will be based on judgments about the truth or wisdom of the beliefs on which those actions were based. Thus, the question of whether his parents acted in his best interest in not seeking medical
care becomes the question of whether, all things considered, it was in Robyn's best interest to have parents who apply Christian Science teaching to his care. The first is a narrow question, the second is a broad one that presumes to judge the balance of benefits of a specific religious upbringing across the whole spectrum of a child's life, and in so doing relies on the assumption that the theology in question is mistaken. There is some indication that this is the turn taken in the Twitchell case. In handing down his sentence following their manslaughter conviction, the judge not only put the Twitchell's on ten years' probation, but made it a condition of that probation that they arrange regularly-scheduled medical care for their three other children, presumably believing that only under this condition could the best interest of these children be adequately protected. But this belief implies the theological judgment that whatever spiritual benefits Christian Science can offer in the raising of children are outweighed by the very small medical risk to which these three children would be exposed. Its effect is to rule out reliance on any religiously-based health beliefs in the raising of children.

Perhaps the American people no longer believe in any unique spiritual powers for healing, and no longer believe religious upbringings provide children with spiritual benefits which offer any meaningful compensation for risk. If so, they need to explain the case for their worship of high school football.

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A child who is not fed, clothed, kept from harm, educated, or provided necessary medical care, suffers the same degree of harm whether the harm is the result of parental ignorance, lack of resources, disinterest, intent to harm, or various belief systems of the parents. All children deserve to have their basic needs met, regardless of the attitudes or beliefs of their parents. That is an obligation our society has determined to be one of the hallmarks of a just and caring people. The vast majority of parents provide these basic needs for their children, and in the occasional situation when this does not happen, our judicial system intervenes on behalf of the child.

Because of legislation passed over fifteen years ago, Michigan, along with some other states, has one exception to the ability to assure our children that their basic needs will be met. In the regulations pertaining to child abuse and neglect, section 14 reads "A parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone, shall not be considered a negligent parent or guardian." That section, and others like it in other states, has led to the death of children across the country from diabetes, meningitis, bowel obstruction, and other illnesses that are fatal if not given prompt medical attention. On April 17, 1990, the U.S. Supreme Court, in a ruling on a case from Oregon, stated "We have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law." That statement, combined with previous decisions that freedom of religious belief does not allow one to harm others, makes it clear that our state legislature should repeal section 14 if we are to provide the basic needs of childhood to all children in Michigan.

In a number of cases from Massachusetts to California, criminal charges of manslaughter have been affirmed against parents who allowed their children to die while pursuing religious healing in lieu of medical care. Certainly, these parents bear the responsibility for their decisions. Freedom of religion also implies that parents, as adults, have the freedom to modify their views if they believe they may bring harm to others, such as their children. These are the kinds of choices we all must make in the adult world. How one should respond to the adult who chooses to adhere to beliefs that may bring harm is a difficult question. Whether the onus for these kinds of decisions should be extended to those who promulgate, reinforce, or attempt to coerce such decisions is an even more difficult question, because these individuals may, too, be acting on behalf of their own strongly held views. How far the culpability for decisions that bring harm to children should be extended is a matter which deserves careful consideration.

This year the Board of Trustees of the American Medical Association in Resolution H (A-90) stated under the heading of Legal Issues: "The constitutional guarantee of freedom of religion is a cherished right, but the Board has recognized that its preservation is not limitless and does not sanction harm to others. Laws may not interfere with mere religious beliefs and opinions, but they may interfere with practices. Reynolds vs. United States, 48 U.S. 145 (1989)." And later: "The AMA also recognized the need of the public to be aware of the basis upon which all practitioners, including religious healing practitioners, make their claims, and all such practitioners should be held accountable for asserting misleading, false or deceptive claims with respect to their practices."

The purpose of generating these remarks is to inform those that are interested in these issues that there will be introduced into the legislature in 1991, several bills that are designed to protect the interests of children and assure for all of our children equal protection under the law and equal access to their basic needs, including medical care when they are seriously ill. This is the least we can do for this most vulnerable segment of our society. Letters to your legislators supporting these efforts will be an excellent way to wish all children a healthy and loving New Year.

-7-
Intensive Summer Ethics Institute

Due to the enthusiastic response of the participants in last August's Intensive Summer Ethics Institute, the Center for Ethics and Humanities in the Life Sciences will be offering a similar program this coming summer, August 10 through the 16. The Institute will be staffed by nationally known faculty including Professor James Childress, Ph.D., of the University of Virginia Rebecca Dresser, J.D., of Case Western Reserve, James Nelson, Ph.D., of the Hastings Center, David Doukas, M.D., of the University of Michigan, Leonard Weber, Ph.D., of Mercy College, as well as the staff of the Center: Howard Brody, Ph.D., M.D., Tom Tomlinson, Ph.D. and Leonard Fleck, Ph.D. The Institute is designed to meet the educational needs of members of institutional ethics committees, faculty in colleges of medicine and nursing, and hospital administrators. Topics will include informed consent, treatment refusal, withdrawing life-sustaining treatment, confidentiality, ethical issues in neonatal care, reproductive rights issues, AIDS-related issues, "gatekeeper" issues and health policy. But the primary emphasis of this Institute will be skill-building, especially skills needed to engage in productive moral conversation. Hence a substantial amount of time will be spent in small groups.

Because of a desire to improve accessibility to the Institute by out of state residents the location will be moved from Shanty Creek Resort to the Kellogg Center in East Lansing. A brochure with complete details will be available by April 30. For further information, call 517-355-7550 or write to the Center, C-208 East Fee Hall, Michigan State University, East Lansing, MI 48824-1316.
An Update on Recent Activities at the Center

The Center Welcomes Dr. Douglas Brown as a Visiting Fellow

The Center for Ethics and Humanities has been pleased to welcome Dr. Douglas Brown as a visiting fellow for the academic year 1990-91. Dr. Brown is Associate Professor of Theology and Ethics at the Harding University Graduate School of Religion in Memphis, Tennessee, and has been instrumental in developing medical ethics teaching programs at Harding. He has also been actively involved both with the University of Tennessee Medical Center in Memphis, and more recently with the University of Michigan Department of Obstetrics and Gynecology, in joint research efforts in a variety of issues in medical ethics.

Dr. Brown began to explore fellowship possibilities with our Center as a way of deepening his understanding of contemporary medical ethics as seen from a secular, philosophical perspective. The Center receives by having Dr. Brown as a visiting fellow, and having the opportunity to share a theological perspective with us on ethical issues that are not represented within the expertise of our present faculty.

The fellowship has been designed as a series of four presentations. Prior to each, Dr. Brown submits a paper on a topic of mutual interest in medical ethics, and supplies a set of readings that approach the topic from a theological perspective. The Center faculty then respond by suggesting several readings that address the same issue from a more secular, philosophical perspective. The seminar itself then takes the form of an active give-and-take between the two perspectives on medical ethics. A particular focus of each session is to try to identify a level of understanding which is provided by a theological view, which may be lacking from a purely philosophical or analytic approach.

The two seminars presented so far this year have been on the subjects of maternal fetal conflict and on health care for persons with mental retardation. A third, upcoming seminar will be on the allocation of scarce medical resources. The topic of the fourth seminar has yet to be determined. Any faculty at Michigan State interested in participating in these seminars may contact the Center’s office.

Selected Speaking Engagements By Center Staff

Leonard Fleck will be speaking on April 19, along with Daniel Callahan, at Aquinas College in Grand Rapids at a conference addressing issues on health care financing. The conference is sponsored by the Gerontology Society and other organizations.

Howard Brody will be leading a panel discussion on various issues concerning Dr. Jack Kevorkian and assisted suicide at the Bloomfield Township Library on May 1.

Location and Date Set for Annual MERN Meeting

The Medical Ethics Resource Network of Michigan will be holding its annual meeting at the Harley Hotel at 3600 Dunckel Road in Lansing (take the Jolly road exit off 496) on May 3 and 4. Friday’s keynote speaker will be Donald Murphy, M.D., Associate Professor in the Division of Geriatric Medicine at George Washington University, Washington, D.C. The title of his paper is “Allocating Resources Across the Clinical Spectrum.” Saturday’s speaker will be Scott Vander Linde, Ph.D., Assistant Professor of Economics at Calvin College in Grand Rapids, Michigan. His paper is entitled “Medical Ethics and Economics: Irreconcilable Differences?”

For further information please contact Matthew Wies, D.O., M.P.H., Program Chairman (313) 762-4236.

A Message From Howard Brody

During February and early March, the Center’s office received inquiries following rumors of my ill health, which, I regret to report, were not greatly exaggerated. I had emergency back surgery on Feb. 8 following spontaneous rupture of two discs and was discharged on Feb. 26 following a somewhat prolonged period of physical therapy and rehabilitation. I was left with some residual nerve damage and muscle weakness, which ultimately should clear up completely although the process may take some months. I began to get back to work part time in early March and expect to be basically on a full-time schedule with the start of spring term. I’m deeply grateful to those who visited, phoned, sent cards or flowers, or otherwise expressed their concern and good wishes.