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Update - January 1986

Loma Linda University Center for Christian Bioethics

LOMA LINDA UNIVERSITY
ETHICS CENTER
Volume 2, Number 1 January, 1986

Update

Endowment Effort Faces January Deadline

Dear Friends:

A fascinating chapter in our Ethics Center's young life will end at midnight on January 31, 1986.

The Center will receive $50,000 in challenge grants from a generous California family and the Loma Linda University Medical Center if by then we have raised all but that much of the $500,000 endowment.

As of this writing, we are within $200,000 of reaching the goal, an amount equivalent to what the Center received for all of its activities last Christmas season.

The Center's endowment effort has captured the imaginations of a small but extremely enthusiastic number of us with an amazing variety of backgrounds and orientations. But despite our other differences, we all believe that LLU should provide a place where thoughtful and prayerful people can help each other assess some of the most perplexing challenges humanity has ever faced. The endowment assures the Center's financial stability and integrity by insulating it from changing economic and political pressures.

Although I do hope that a number of us can give a thousand dollars or more again this year, every gift, no matter how large or small, endorses the project with a cheery vote of confidence.

Thank you for considering our January 31 deadline as you make your financial plans. And may 1986 be your best year yet!

Sincerely,

David R. Larson

David R. Larson
Associate Director

Symposia Discuss Abortion, Apartheid, and Nuclear War

The morality and politics of abortion, apartheid and nuclear war was and will be discussed at public meetings on the campus of Loma Linda University scheduled for the fall, winter and spring quarters, respectively.

Doctors Sidney and Daniel Callahan debated the issues surrounding abortion on Friday evening, November 22, at the Randall Visitors Center in Loma Linda. Doctor Sidney Callahan, a psychologist who teaches at Mercy College in Dobbs Ferry, New York, is a "feminist favoring life." Doctor Daniel Callahan, founder and Director of The Hastings Center at Hastings-on-the-Hudson, New York, is a "philosopher favoring choice." The Callahans, who have been married for 21 years, have six children.

Although they recently collaborated in the production of **Abortion: Understanding Differences** (New York: Plenum Press), the Callahans had not previously explored their differences before a live audience. "We have wondered for some time how to present both sides of the abortion issue in a single meeting that would not become too heated," stated David Larson, who coordinated the event, "so we were very pleased that the Callahans, who live together peacefully despite their differences, were able to be with us."

The second symposium, to be held in early 1986, will air conflicting sides of the South African apartheid debate. Charles Teel, Jr., the Ethics Center's specialist in social ethics, and Julie Ralls, a sophomore LLU medical student, are planning the discussion. The Ethics Center and the LLU chapter of the American Medical Students' Association are co-sponsoring the symposium.

A two-day examination of nuclear peacekeeping will be held May 16 and 17, co-sponsored by the Ethics Center and the University Church of Loma Linda. The planning committee consists of University faculty and students, University Church and Ethics Center staff, and non-Loma Linda persons. "I'd personally like to see us explore in some depth the major options available for thinking about nuclear war: pacificism, just-war theory, and democratic conservativism," comments Jim Walters, coordinator of the weekend discussion.

Audio tapes of the various discussions and printed copies of selected presentations will be available at a nominal cost through the Ethics Center.

Center Prepares First Book

A volume of essays on contemporary issues in bioethics is being edited by the Ethics Center staff for publication in mid-1986.

Although the core of the planned volume will consist of papers presented at a conference held earlier last year, other essays will be added. The scholarly contributions cluster around four topics: the ethical challenge of high-tech medicine, justice and health care, primate experimentation, and models for ethical thinking. "We don't see this volume proposing new ethical theories so much as providing fresh insights on critical medical challenges," comments James Walters, Assistant Professor of Christian Ethics at LLU, and co-editor of the volume with David Larson, Associate Director of the Ethics Center.

Update

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Letter to the Editor

Dear Editors:

Some of the discussants in your seminar (on organ transplantation) were concerned about the use of animal tissues and whether every minute detail was discussed with the patient's family. For years bovine cartilage was used (I have used it myself) for cartilage implants in humans. While we did explain what we were using, no detailed ethical issue ever arose, nor was its use by plastic surgeons ever questioned on an ethical basis. I feel some of the panelists were straining at gnats in their attitudes. Tendon tissues derived from animals have been used for years in plastic surgery.

What about surgical catgut sutures, made from the submucosa of sheep intestines for over a century? No one ever made an issue over their use nor required extensive briefing of patients, or ethical consultations.

I dare say that not one percent of the millions of women using the estrogen drug PREMARIN know that it is derived from the urine of pregnant mares—hence the name. This is an animal-derived substance. No ethical issue at all. Likewise with either porcine or bovine insulin.

The electronic media used the Baby Fae case as an issue and hyped it up out of all proportion. Those of us observing at a distance felt that Dr. Bailey conducted himself with conservatism and restraint and should be commended instead of criticized.

Lloyd Rosenvold, M.D.
Hope, Idaho

An Editorial

Religion and the Bioethical Enterprise

Given the fact that so many of our bioethical questions were spawned by the technology of the late 20th century, one should probably not expect very many helpful answers from religious traditions formalized long before anyone dreamed about genetic engineering, xenografts, in vitro fertilization, embryo transfer and fetal surgery. The Old Testament knows of surrogate parenting, but what of total life support, TPN, hemodialysis, pacemakers, ventilators, and when to start or stop them? What of health-care equity and cost-benefit effectiveness?

Institutionalized religion also has lost much of its traditional effectiveness as the repository and vehicle of moral values transmission. In disturbing ways each generation has tended to become **now** oriented, isolated from both the past and future. On these terms religion and bioethics might seem to have very little to do with each other.

It remains, however, that recognized or not, at least in the Western world, Judeo-Christian presuppositions do mightily inform such questions. The very existence of the biomedical science that poses the questions derives from Judeo-Christian premises. It is no accident that science flourished in that portion of the world most influenced by biblical monotheism. The "oneness" of reality and the sense of order that radical (in the sense of "roots") monotheism implies gave to science its philosophic foundations, including an optimistic affirmation of the world. The Creator had said, "It is very good."

That affirmation also conditioned man's attitude toward his fellow creatures. Humane treatment of animals, for example, even while granting priority to man (created in God's image and given dominion over the garden) is the logical development of a positive view of nature. Animal experimentation will always be a matter of serious ethical concern in such a conceptual setting.

Judeo-Christian ideas also permeate our efforts to understand what it means to be human and what it takes to nurture and protect personhood, and that, of course, is what the bioethical enterprise is ultimately all about. A conception of person as possessing the self-conscious capacity to control one's own behavior, to make choices, to determine one's destiny, to love, to interact socially, to be responsible, to be competent—qualities that distinguish human existence as more than merely being alive—qualities that are so pertinent to decision-making in matters of life at its beginnings and at its termination—derive from a biblical, Judeo-Christian way of looking at man. It is true that infusions of Platonic-Greek notions about the soul have muddied the waters of the abortion issue at the moment, but the fact that there is so great general agreement on other ethical matters in our society—much greater than our disagreements—is due to our common "religious" heritage.

Finally, for those who acknowledge that heritage, there is the motivation that faith brings to the bioethical task. Those who will care enough to be involved with such issues over the long haul will do so because they are motivated by higher concerns than mere professional role-playing.

Bioethics as an infant progeny of ethics has already largely taken over the house as infants are prone to do. Bioethicists are multiplying and new bioethics centers are appearing almost monthly. There is no question that these issues are fascinating. But the capacity for maintaining that interest through the perplexing years ahead is more likely to characterize those whose commitment includes faith. So much about the answers to these questions is related to one's ultimate purposes as over against this-worldly professional goals.

We would do well to admit it. If not our own religious beliefs, at least those of our fathers before us have created a context in the world where novel social and ethical burdens have been weighted upon us all. But they also give us the values and norms required to carry the load. It only makes sense that at least some of us should self-consciously consider these issues within the circle of the light that illumines our common past.

Jack W. Provonsha

What's A Little Church Like Ours Doing in Big Medicine Like This?

On April 19, 1985, the Ethics Center presented a public discussion of religion and medicine in Adventist life entitled "What's A Little Church Like Ours Doing in Big Medicine Like This?" at the Loma Linda University church.

Professors Dalton Baldwin (theology), A. Graham Maxwell (New Testament), Lawrence Longo (physiology and obstetrics-gynecology), and Richard Neil (health promotion and education) represented Loma Linda University. Miroslav Kis (ethics) represented Andrews University and Harrison Evans (psychiatry) spoke for the Adventist Health System. Roy Branson (ethics) and Douglas Hackleman (psychology) represented ***Spectrum*** *and* ***Adventist Currents*** *respectively. David Larson (ethics), Associate Director of the Center, moderated the discussion.*

The following excerpts, drawn from a transcript that is fifty pages long, illustrate the direction and demeanor of the conversation. For either the complete transcript or a video or audio cassette of the meeting, please contact Gwen Utt at the Center.

Larson: We are moving into an era in which health care delivery and medical research are becoming increasingly difficult to finance and increasingly difficult to administer. Some Christians are therefore suggesting that the time has come for their organizations to move away from health-care delivery and medical research, if they have not already done so. In just a few years Adventists themselves will have to be considering these questions very carefully. So, as an attempt to anticipate that discussion just a bit, we have gathered tonight.

From Water Cures to Organ Transplants: Have We Lost Our Way?

Baldwin: In order to answer that question we must first clarify what we mean by "our way." Four features of the Battle Creek water cure stand out in my mind as significant:

1. The Battle Creek water cure was on the growing edge of scientific advance. When leaders in water cure spoke about rational remedies they meant remedies in harmony with nature: that is, scientific remedies. John Harvey Kellogg was not content with merely meeting the requirements for his medical degree. He spent significant amounts of money paying for medical tutoring in a newly developing light therapy and electrical therapy in addition to his regular medical curriculum. Later, at great expense, he traveled to Europe to study with the greatest surgeons he could identify. He was excited about the research of Pavlov and set up a research institute to carry on similar work in America.

2. The way of water cure attempted to institutionalize science. Institutionalized science shares housing, instruments, and funding; it pools creative suggestions; it profits by mutual correction; and it avoids wasting time arguing about basic presuppositions where the institution is based on a common paradigm.

3. The way of water cure attempted to integrate science and religion. Larkin B. Coles in his **Philosophy of Health** had said that "it is as truly a sin against heaven to violate a law of life as to break one of the ten commandments." If we take Paul's position that the opposite of a choice for sin is a choice for faith (Romans 14:23), we conclude that a positive decision on a health principle is as much a matter of faith as a decision about a biblical principle. Later Ellen White summarized this integration of science and religion by saying that "rightly understood, science and the written Word agree and each sheds light on the other." With such presuppositions, the developing Seventh-day Adventist Church decided that institutionalized scientific medicine was essential because it would throw light on a right understanding of God's revelation.

4. The way of water cure attempted to institutionalize service. Kellogg was the moving spirit behind the founding of the James White Memorial Home for the Aged in 1891. The Chicago Medical Mission opened on the property of the Pacific Garden Mission in 1893. The Carolyn E. Haskell Home for Orphans was dedicated in 1894. The same year W. S. Sadler opened an evangelistic Lifeboat Mission on South State Street in Chicago. In 1896 a workingmen's home that could sleep from 300 to 400 was opened in Chicago.

We may summarize the way of the Battle Creek water cure in four ways: it was on the growing edge of scientific advance; it institutionalized science; it integrated religion and science; and it institutionalized service.

The ideals of the Battle Creek water cure were not easy to maintain. Too often the administrative brethren cut off Kellogg's funds and blocked his advances out of jealousy for his intelligence, power, and influence. Too often Kellogg countered by referring to ministers as men of "mediocre ability" who maintained their influence through the use of "psychological trickery."

But a good case can be made for the conclusion that Kellogg was dependent in a large measure for his success on the devotion and the support he received from his church. When all the employees worked for less than the going wage, from the physicians to the janitors, when there were many students who were working for semi-free labor, and when the church voted subsidies and encouraged donations, service had become institutionalized.

When Kellogg was severed from the church, he felt the loss severely. One by one, he had to discontinue his philanthropic enterprises: the retirement home, the orphanage, the Chicago Mission and the American Medical Missionary College were closed. Even though Kellogg lost the way

of institutionalized service and integration of religion and science, those who picked up the pieces and pressed on did not.

Healing the Sick and Preaching the Gospel: Is There An Essential Link?

Maxwell: Our understanding of the Gospel has everything to do with whether or not we see an essential link. One understanding of the Gospel—and admittedly the one most widely held for so many years—is preoccupied with what God has done to adjust our legal standing in His sight. In this more legal view, sometimes called "forensic," sin is seen as a breaking of the rules. Death is seen as imposed penalty. Now there's much talk of love, of course, but there is particular emphasis on such matters as justice, retribution, pardon, guilt, punishment, demands of law, satisfaction of justice, legal substitution, propitiation of wrath, expiation and atonement—not bad words, of course, in and of themselves. Everything depends on how they're understood. In the legal model atonement is seen as payment of the penalty and, to be candid, the bottom line in the more legal view is God's warning to His children, "Obey me or I'll have to kill you."

Now there is another model of the plan of salvation that understands the Gospel as the good news about what God has done—not to adjust our legal standing in His sight, but what God has done to heal the damage sin has caused. In this healing model sin is seen as a breakdown of trust. Death is seen not as penalty but as consequence. This view also speaks of justice and righteousness, of course, but it particularly emphasizes trust and truth and evidence and understanding and explanation, demonstration, freedom, maturity and, above all, reconciliation and healing as the specific meaning of salvation. Atonement is understood not as payment of penalty but reconciliation to unity and harmony and at-oneness with our God and with each other and at-oneness is the precise meaning of that word. And the bottom line in this healing model is not "Love me or I'll kill you," but "Let me save and heal you or else you'll die."

Now behind these two understandings of the Gospel there are two different pictures of God and they result in different understandings of the link between healing the sick and preaching the gospel.

If the healing model is correct, and I believe it is, there is no more eloquent and effective way to demonstrate the good news of the Gospel and the truth about our God than Christian medicine. Doctors do not kill their dying patients. But if they cannot win their patients' trust, it is very difficult to heal, and when patients die even doctors have been known to cry.

As I understand it, the words of our question were very carefully chosen. Surely most would recognize a general and desirable connection between healing the sick and preaching the Gospel. For example, skillful healing of the sick is good for the church's reputation. Besides, healing the sick is a good way to make contacts for the Gospel and help pay the freight. But is there an **essential** link? Is it possible that the meaning and purpose of healing and preaching the Gospel are essentially the same, that in essence they're not just linked but really one?

If this healing model of the Gospel is correct—and I would stake my life upon it based upon all sixty-six books of Scripture—then it is redundant to raise the question, "Healing the Sick and Preaching the Good News About the Healing of Salvation: Is There an Essential Link?" Of course there is. Why raise the question? But before these two lines of ministry can blend into one in the Seventh-day Adventist Church—a blending urged so frequently by the founder of this institution—there will have to be a restudy of the Gospel and a rediscovery of the truth about our God.

Adventist Institutions and the World: If Small Is Beautiful, Is Big Bad?

Branson: The issue is not size. The issue is purpose or purposes. If the Adventist Health System is achieving its purpose or purposes, the bigger it gets the better.

Now I've said "purposes" because one of the issues facing the Adventist Health System confronts the rest of corporate America. Should a corporation have one purpose and do it well or should it have several purposes on which it is judged?

One of my former colleagues at Andrews University has said in print what he said when I was there: "Look, if the only purpose of Adventist medical institutions is to provide excellent medical care, then perhaps the system should become independent of the church." We have had a lot of very vigorous discussion on that point because I believe such institutions can serve more than one purpose.

When Adventist health institutions were established they were expected to cure the sick and to be an entering wedge for the church. But they also were committed to trying to improve the health of this country. And if that is one of the purposes of Adventist Health Systems then being big is an opportunity because improving the health of the nation is an immense task.

If the Adventist Health System included as one of its purposes improving the nation's health, then it will have accepted a responsibility of the sort that large corporations accept, namely improving the community, and it will also be true to the church's heritage. Battle Creek was not simply a place where people were cured. Nor were they all brought into the church. Battle Creek was also a long-running seminar John Harvey Kellogg conducted for the leaders of this country to show them how the health of this nation could be improved.

What are some of the topics that an Adventist health system might address if it takes this third purpose seriously? You can list them as well as I can. Adventist institutions pick up the bodies of those mutilated by drunk driving. Should they be any less mad than Mothers Against Drunk Driving? Why not work with that group and other groups to eliminate or curtail advertising for alcoholic beverages? Several national groups that I know of in Washington, D.C., are working very hard right now to sustain the national excise tax on tobacco. They are being opposed by very powerful senators from North Carolina. If tobacco is, as the Surgeon General says, the greatest single preventable threat to health in this country, why isn't the Adventist Health System in the forefront of efforts to eliminate price supports for tobacco and maintain high excise taxes on it?

Take another possibility: Almost every Adventist hospital has an emergency room and must treat the results of violence. What are some of causes of violence?

Another is hand guns. In this very state (California), not even the churches were willing to take a stand on the question of hand guns a year or so ago. That's what we're here for, isn't it? To challenge certain problems and issues that others are not wiling to take up. Hand guns are a threat to the health of people in this society.

I'm suggesting things like national conferences held in

major cities sponsored or co-sponsored by the Adventist Health Systems to dramatize issues that desperately need the attention of the American people. I'm suggesting sponsorship or co-sponsorship of hard-hitting, tough television documentaries on issues where the public must be persuaded to take action to protect the health of the vulnerable in this country.

Certainly giving good medical care is admirable, and I'm as delighted as you are if people want to join the religious community that gives me meaning in my life. But beyond care for the sick and evangelism, Adventist medical institutions should also reflect the third purpose for which they were established: improving the health of this country.

The Adventist Health System: Are We Drifting Toward Another Battle Creek?

Evans: I think it is good for us to remind ourselves that our medical work, in spite of its faults, in spite of its shortcomings, has been carrying out the work for which it was intended—as the right arm of the message and as an opening wedge for the church.

The development of the Kettering Hospital is a marvelous story. George Nelson, who was a great missionary and educator, sold himself and the church to the Kettering family and community leaders, and they founded that marvelous institution. They have been able to raise a fine church and church school. The hospital is affiliated with Wright State School of Medicine, part of the Ohio system. This is an example of what "this little church" has been doing.

Another example: A few days ago I had the privilege of talking with Mr. Scoggins, Administrator of the Hackettstown Hospital which was started about thirteen years ago—a relatively new hospital. When the community learned that the Adventists were going to build a hospital, there was an atmosphere of hostility and distrust; but they went ahead, made contacts, influenced the people, even got community support. Now we have a lovely 106-bed hospital, full support of the community, and a fine church. The Adventists are well-known and loved.

Some ask, "Why should our church continue its medical work when other churches have decided they have no business in this enterprise?" Well, that decision was made a long time ago in many of the other churches. The central hospital of the Columbia Medical College, which is one of the great medical schools, is known as the Presbyterian Medical Center. But it is Presbyterian only in name. And this is true of so many of our other health institutions that were started by the Methodists or other denominations. But we have continued to maintain our interest in medicine because we feel that this is a way in which we can reach out and touch people's lives, influence them, and attract them not only to our church but to a better way of life.

The purposes of Adventists Health Systems are largely to help our various institutions in financial support, counseling and business guidance, providing skills and leadership, common purchasing, insurance, definition of church goals and objectives, marketing skills, education and rehabilitation programs. So this organization was established to support and maintain our institutions so that they can provide that entering wedge.

Kis: How big is too big? What makes big too big? Dr. Baldwin mentioned the initial importance of the institutionalization of science and of service. I have heard warnings about the liabilities and dangers of institutionalization. Could you make some comments about that?

Baldwin: It seems to me that institutions are vital. We need to have ways to put together those who provide funds, those who provide ideas, and those who provide work. We do this by cooperating, and the name of dependable cooperation is "institution." I think that the church is an institution and so I do not fear institutions. However, it is true that a good institution will have as part of its institutionalization a method for renewal.

Hackleman: The question whether we are drifting toward another Battle Creek is moot. We drifted past Battle Creek years ago on any number of criteria: size, medical technology, conformity to accrediting and regulatory agencies, debt, theology. What is important is not where we are vis-a-vis Battle Creek. What is important is that our pilots be alert to the rapids ahead and direct our bark through smooth water. Let me propose something constructive: Why not sprinkle a few prevention-oriented health and fitness centers around the country even if it means erecting fewer free-standing urgent-care facilities, popularly known as docs-in-the-box? Why not react quickly and creatively to a growing demand in this country and elsewhere for good health? Why not help **keep** man whole as well as **make** man whole? Wouldn't it be rewarding, some day, to hear the words, "When I was a burned out and surfeited yuppy, you provided me a wellness center?"

Why did Nathan Pritican have to crusade for what Adventists have believed for generations? Statistics demonstrate that even the average American vegetarian Adventist, whose diet is poor in other ways and who probably exercises minimally, usually outlives his or her nonvegetarian peers by several years. A wellness-oriented approach, along with our established hospitals, would be entirely consistent with our belief in the body as a living temple, the needs of our fellow humans, our desire to evangelize, and just plain, good economic sense.

Longo: If we're going to do it, whether it's clinical care, education or research then why don't we be first-rate?

When people really want to know about nutrition where do they go? Is it to Loma Linda? Probably not. More likely they'll go to MIT, which is one of the world centers in nutritional research. If they really want to know about smoking and health and environmental pollution do they come to Loma Linda? Well, perhaps for some very limited questions, but again more likely they'll go to Johns Hopkins. And, as Doug Hackleman has noted, if people really want to know about preventive medicine do they come here? Well, one would hope that they would, but perhaps it is more likely they would go to visit Dr. Pritikin's center.

I think we have to ask ourselves about our obligations either as members of this institution or as church members who support it. What are our responsibilities? What are the responsibilities for each of the schools in this institution, each of the departments, each of the divisions, and each of us as faculty and staff? Are we committed to scholarship? How can we as laborers in the work better fulfill the visions of Ellen White and Abraham Flexner?

Neil: The problem is that the church has certain goals and certain needs: the salvation of souls and the training of certain kinds of persons. Medicine also has certain kinds of needs. I'm not sure that those needs, motives, and goals are always the same, but I think they can work harmoniously.

I'm intrigued by the title, "What's a Little Church Like Ours Doing in Big Medicine Like This?" As I've listened, I've thought that we might even want to reverse it to "Why Does Big Medicine Like This Need a Little Church Like That?" Certainly the church does not need medicine. I'm talking about organizations now. Certainly, medicine does not need a church. So why should we have the two joined

together?

When the church links up with big medicine, with both of them trying to fulfill their own needs by utilizing the others' talents in a synergistic relationship, there's probably going to be a little lost from each. The question that I see facing this denomination and this panel is, How can we best accomplish both goals to the maximum without losing the essence of either?

As I read Ellen White and hear the invections against bigness, Dr. Branson, and as I look, Dr. Evans, at the Hackettstown Hospital, which in 1979 had about 12 percent of its staff as Adventists, my question is, Are there some dangers to bigness and what might those dangers be?

Larson: Not only is the number of Adventists relatively small in many of the medical institutions we run, but even when there are large numbers of Adventists, many of them might describe themselves as nominal Adventists—people for whom Adventism is more of a cultural heritage than a living, vibrant faith. Then there are those among us who are religiously illiterate, good faithful persons who really don't know what their church stands for or what it's trying to do. So if we think of the non-Adventists and the nominal Adventists and the religiously-illiterate ones, we have a real staffing problem.

Branson: First of all, isn't it important to remember that Ellen White was really concerned about concentration and proportion? Today no single Adventist institution, not even this one or Florida Hospital, can dominate the whole system.

Now, let me respond just for a second, if I may, Dave, to the question of very few Adventists. I think that this is a problem for one of our purposes—namely, providing care of the sort that Dr. Maxwell was talking about. If there aren't a lot of Adventists running around the halls, then how can we give distinctively Adventist care? I tried to suggest that our hospitals' mission does not depend simply on the quality of interpersonal relationships. It depends, to some extent, on institutional purposes and this doesn't require a certain percentage of Adventists walking around the halls. I'm not saying this isn't a problem, but it's a problem for just one purpose. Even if we had a small percentage of Adventists in the halls of Adventist hospitals, we still could have administrators who say, "Okay, but we're still standing for something in the community," and follow through on that.

Evans: I think Dr. Neil has touched upon a very sensitive and important area. How do we cope with the staffing problem and have Adventist leadership? Frankly, I don't have the answer to that. I think it's a real problem. Dr. Larson mentioned that in some of our hospitals there are nominal Adventists. I don't think that problem is confined to our hospitals, unfortunately.

Maxwell: My belief is that our greatest danger is not that we will grow too big, but that our conception of God and the Gospel and our mission is too small. If our conception of God and our mission is adequate, we can't do anything too big.

This church was given the opportunity to present the largest view of God the earth has ever heard and Ellen White had a great deal to do with it. She didn't make it up, she found it in all sixty-six books of Scripture. If our conception of God and our mission and the good news is adequate, we can grow as big as we want. But the danger is that we will follow the history of every other religious movement before ours, that we'll flourish in education and in the professions and the universities and professionals will all drift one way and the ministers and the administrators will all drift another.

Neil: I think that as the size of an institution increases, there's a certain amount of inertia that leads towards a depersonalization that must be consciously overcome. I think that's one of the disadvantages of bigness.

Larson: May I pursue that just a little bit further? I thought you might have been saying a little earlier that the Adventist church really doesn't need medicine. Did I understand that correctly?

Neil: No. This church does not need "**big** medicine." I'm using that in a corporate sense. What I see the church needing, and I would agree with Dr. Baldwin, I think, is an approach to restoring people to health that includes acute care, promotive and preventive medicine.

Kis: I would prefer the word "great" to "big." One doesn't need to be big to be great. I am thinking of Pierre and Marie Currie, the scientists in France, and H. M. S. Richards in his chicken hut. What is great about greatness is boldness, the unwillingness to be satisfied with any achievement, and maybe sacrificing for some ideal.

Branson: Is there some danger from the Adventist Health Systems to the denomination, perhaps? I would have thought that one danger might be that the people who run the Adventist Health Systems could begin to feel that the institutions are an end in themselves. It would seem to me a healthy exercise for the church, and perhaps for the leaders of the Adventist Health Systems, to ask themselves, "Is there something which would be worth losing a significant number of our Adventist hospitals for?"

Maxwell: While Roy Branson was speaking I thought I felt his grandfather stirring beneath my feet somewhere! The practice of the healing arts has a specific contribution to make to the unique and special mission of the Seventh-day Adventist Church. If we lose sight of that, one institution is too much.

Larson: If each of you had one wish that would be fulfilled regarding the medical ministries of our denomination, what would it be?

Neil: My one wish is that all of our good, well-intentioned, highly-motivated professionals dealing with health in whatever facet would work together in peace and harmony.

Longo: Well, David, I'd like to echo John Gardner's call for excellence, or that we strive to maintain superb quality and truly be the light set on a hill that Ellen White had as her goal for those of us in this institution.

Hackleman: As the health system becomes bigger and bigger business, we can hope that it will remember the biblical counsel that the greatest of these is charity.

Kis: Sometimes bigness is measured by money but Jesus said that some people would have a hard time to pass through the eye of the needle. So my desire is that as we grow big, we will become greater.

Evans: That each of us has a deeper commitment to Jesus and to the church, that we will be unselfish and sacrificing, and that the "bottom line" will not be the ultimate goal.

Branson: That something would take place in the Adventist Health Systems that resulted in a lowering of the mortality rate in this country.

Maxwell: I think what I'd like to see most is for the Seventh-day Adventist Church to take a new and larger view of God and the Gospel and the unique and special mission of the Seventh-day Adventist Church. I believe if we come up with the right and larger view, the role of the Christian practice of the healing arts will be seen to be of increased importance.

Baldwin: If I had one wish it would be that every individual who has anything to do with the health system would live a life of faith.

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Book Review

A Diagnosis of America's Sickness

Habits of the Heart: Individualism and Commitment in American Life. *Robert N. Bellah, Richard Madsen, William M. Sullivan, Ann Swidler, and Steven M. Tipton (Berkeley and Los Angeles, California: University of California Press, 1985), xiii plus 355 pages, $16.95.*

Far from being a dispassionate sociology of contemporary American life, this volume sounds a national alarm. Individualism—long a hallmark of American life—is rampant and "may have grown cancerous." At book's end the metaphor turns from individual disease to corporate catastrophe: spiritually-jaded America "hovers on the very brink of disaster."

Whether America is facing imminent demise is arguable, but a crisis of spirit among the middle class—identified as the trend setters—is well-documented here. Modern life is increasingly empty of personal meaning as individual success is achieved at the cost of social integration and internal coherence. These doctors of philosophy not only diagnosis America's sickness, but they offer a prescription: tradition—those pillars which have long sustained the American spirit. The clock cannot be set back, but a critical and deliberate reappropriation of tradition is mandatory. We have jettisoned too much and we now suffer the malaise of a widespread meaninglessness.

Practicing their preaching, the five social scientist coauthors do their sociological analysis through the prism of Alex de Tocqueville's 1830's classic, **Democracy in America.** This French social philosopher saw individualism as a threat to the lively young democracy. The stability of social class in European democracies was replaced by the innate volatility of individualism in America. The American experiment allowed individuals the heights of freedom and accomplishment, but even the most advantaged "seemed serious and almost sad even in their pleasures" because they "never stop thinking of the good things they have not got." Robust individualism, wrote Tocqueville, would smother American democracy without the country's countervailing and strong moral fabric: a combination of healthy family life, vital religious communities and popular political involvement. Bellah and company spent several years interviewing scores of Americans across the country, studying historical background and writing under their mentor's categories. Their Tocquevillian-prompted sense of an America adrift was confirmed. America's national ethos, her undergirding mores ensconced in family, religion and politics—what Tocqueville sometimes termed "habits of the heart"—are under unrelenting attack by modern individualism.

Through the relaying of a variety of selective biographical sketches the authors portray a country of individuals whose lives are as successful as they are empty and rooted in nothing deeper than their one-dimensional selves. A typical modern success story, the authors underscore, involves a person leaving home, severing religious association, and achieving success in a job which brings dubious personal satisfaction. (Whereas one's work used to bring satisfaction because of seen results in the lives of acquaintances, modern job satisfaction is minimal because today's society is faceless, intricate and complex. What once was a calling is now at best a career and at worst merely a job).

Individualism is at the core of American life—our deepest identity; and Bellah, the book's principal author, does not seek to undercut a healthy sense of selfhood. Biblical individualism and republican individualism, two strands of American tradition which are communally-based and deserve renewed attention, are contrasted with modern individualism. The latter, the authors indicate in one of several insightful historical asides, has roots in the philosophy of the 17th century English thinker John Locke, a powerful defender of individual rights who has been enormously influential in America. The tragedy of radical individualism, it is argued, is not only in its immediate futility, but its failure to perpetuate civility. The "empty self" (vs. the "constituted self") could be undercut from within unless it is sustained by more than itself. "What is at issue is not simply whether self-contained individuals might withdraw from the public sphere to pursue purely private ends, but whether such individuals are capable of sustaining either a public **or** a private life" (p. 143). Hence the book's apocalyptic foreboding.

Yet there is hope: a more equal community of commitment is possible. The American middle class throughout this century has sought freedom and meaning through the acquisition of income, status and authority only to become increasingly disillusioned. Our hope lies, say the authors in a too-brief final prescriptive chapter, in a pervasive change in national ethos—from our culture of separation to one of coherence. Just as such a massive public tide change regarding black Americans came in the Civil Rights movement, so a desperately-needed "moral ecology" movement could catch on. Economic democracy and social responsibility would replace private privilege and excessive reward. Our poverty of affluence would yield to a richness of mutuality in which personal failure and success are not so disproportionately rewarded. Needlessly to say, this is not a description of current events, but it is a relevant and imperative dream with roots in our best traditions.

James W. Walters

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