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Andrews University

School of Education

IDENTIFICATION OF SEVENTH-DAY ADVENTIST  
HEALTH CORE CONVICTIONS: ALIGNMENT  
WITH CURRENT HEALTHCARE PRACTICE

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Randall L. Haffner

June 2006

UMI Number: 3234102

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HEALTH CORE CONVICTIONS: ALIGNMENT  
WITH CURRENT HEALTHCARE PRACTICE

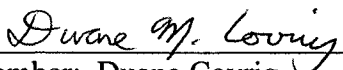
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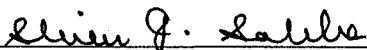
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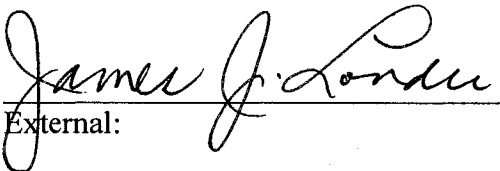
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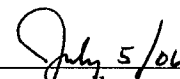
  
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ABSTRACT

IDENTIFICATION OF SEVENTH-DAY ADVENTIST  
HEALTH CORE CONVICTIONS: ALIGNMENT  
WITH CURRENT HEALTHCARE PRACTICE

by

Randall L. Haffner

Chair: Shirley A. Freed

## ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: IDENTIFICATION OF SEVENTH-DAY ADVENTIST HEALTH CORE  
CONVICTIONS: ALIGNMENT WITH CURRENT HEALTHCARE PRACTICE

Name of researcher: Randall L. Haffner

Name and degree of faculty chair: Shirley A. Freed, Ph.D.

Date completed: 2006

### Purpose

The prevailing literature suggests that organizations can sustain their vitality and longevity by preserving their core ideology. The purpose of this study is to define and articulate the core convictions of Seventh-day Adventist healthcare and then investigate how the leaders' and employees' cognitive understandings, behaviors, and affective attachments align at Florida Hospital in Orlando, Florida.

### Method

This two-phased sequential exploratory study utilizes qualitative research to define the core convictions of Seventh-day Adventist healthcare through historical literature review, analysis of official Church publications, four commissioned scholarly



papers, and one-on-one interviews with seasoned healthcare administrators. These findings are then used to develop a questionnaire administered at Florida Hospital to determine the perceptual gaps and alignments with the core convictions of Seventh-day Adventist healthcare.

## Results

The core convictions of Seventh-day Adventist healthcare are: Wholeness, Healing Ministry of Christ, Health Principles, Honoring the Beliefs of the Seventh-day Adventist Church, Image of God, and Community Service. In testing these core convictions, full alignment was determined between the senior leaders and middle management in cognitive understanding, behavioral application, and affective connection. Statistically significant differences exist between senior leaders and middle management compared to employees in four of the six core convictions. The Health Principles and the behavioral dimension are fully aligned across the segmented groups. Full alignment is also determined for the Christian-based religions across all six core convictions.

## Conclusions

The institutionalization of the core convictions of Seventh-day Adventist healthcare must be further incorporated into the sensemaking paradigm of Florida Hospital in order to protect the ongoing confessional identity.

To my loving wife Cindy and our three precious daughters Bailey, Kennedy, and Hadley. Your grace and sacrifice are the sustenance that enables me to thrive.

To my parents, for raising me in love.

To my colleagues at Florida Hospital; may the healing ministry of Christ be extended by our daily service.

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## CHAPTER ONE

### INTRODUCTION

The purpose of this chapter is to provide information on the background and identification of the problem. This chapter will also address the purpose of the study, research questions, research methodology, theoretical framework, significance of the study, assumptions, definitions, and delimitations and will conclude with the organizational framework for the study.

#### **Background of the Problem**

The prevailing literature suggests that organizations can sustain vitality and longevity by preserving core convictions and promoting adaptive innovations (Collins & Porras, 1994; Finke, 2004). In 17 of the 18 most successful companies whose performance was evaluated over a 50-year period, research demonstrates that these companies were guided by an ideology that is deeply rooted in meaningful values that transcends mere profitability (Collins & Porras, 1994).

Collins (1995) writes, "A deeply held core ideology gives a company both a strong sense of identity and a thread of continuity that holds the organization together in the face of change" (p. 83). Collins and Porras (1994) define core ideology as the combination of core values and organizational purpose (p. 73). According to the authors, core values can be defined as "the organization's essential and enduring tenets – a small set of general

guiding principles; not to be confused with specific cultural or operating practices; not to be compromised for financial gain or short-term expediency” (p. 73). They further define purpose as “the organization’s fundamental reasons for existence beyond just making money – a perpetual guiding star on the horizon; not to be confused with specific goals or business strategies” (p. 73).

The concept of core ideology is not a recipe that can be replicated from company to company. Collins and Porras (1994) write, “Our research indicates that the *authenticity* of the ideology and the extent to which a company attains consistent alignment with the ideology counts more than the *content* of the ideology” (p. 67, italics in original). The authors further build on the unique nature of core convictions by stating:

A very important point: You do not ‘create’ or ‘set’ core ideology. You *discover* core ideology. You get at it by *looking inside*. It has to be authentic. You can’t fake an ideology. Nor can you just intellectualize it. Core values and purpose must be passionately held on a gut level, else they are not core. (p. 220, italics in original)

The concept of core ideology has been branded by many descriptors over the years. Some have used the idiom “culture” (Peters & Waterman, 1982), “shared vision” (Senge, 1990), “moral purpose” (Fullan, 2001) and “collaborative purpose” (Odomirok, 2001) to depict this same phenomena. Regardless of the descriptor utilized, the principle is the same, indicating that organizational performance is enhanced through a set of articulated convictions that are incorporated throughout the enterprise.

Senge (1990) provides additional insight to this concept of “shared vision” and its relationship to purpose and values as he writes that “a shared vision changes people’s relationship with the company. It is no longer ‘their company,’ it becomes ‘our

company.’ A shared vision is the first step in allowing people who mistrusted each other to begin to work together” (p. 208). According to Senge, shared vision “creates a common identity” (p. 208).

Fullan (2001) writes, “Businesses are realizing more and more that having moral purpose is critical to sustainable success” (p. xi). In this regard, the sustenance of vitality is not a destination but rather is an ongoing journey (Jones, 2000). On this journey, Collins and Porras (1994) remind us that “ultimately, the *only* thing a company should *not* change over time is its core ideology” (p. 82, italics in original).

Core ideology is more substantive than simply having stated their collective vision and values. Wheatley (1999) suggests, “Values, vision, ethics – these are too soft, too ethereal, to serve as management tools” (p. 58). Wheatley clarifies that if people are guided by a compelling purpose, the whole system can create a greater coherence that becomes more orderly even without a controlling management culture. In other words, while vision and values are compelling, it is the more essential elements of purpose and core convictions that provide the *raison d’être* for an organization.

Miller (2002) suggests that faith-based organizations maintain vitality by “reaffirming traditional beliefs while continuously adapting their expression to environmental conditions” (p. 446). Given the fact that industries will mutate and evolve, Collins and Porras (1994) suggest that it is the core ideology that functions as a “bonding glue and guiding force that holds a visionary company together” (p. 68). They further state that “the visionary companies don’t merely declare an ideology; they also



take steps to make the ideology pervasive throughout the organization and transcend any individual leader” (p. 71).

Kim and Mauborgne (2005) remind us that industries “never stand still” (p. 6). Furthermore, their research indicates that there has never been a “perpetually excellent company or industry” (p. 12). As operations improve and markets expand, it is incumbent that companies and industries continue to reinvent themselves, looking for new markets and opportunities. Given these market conditions, the question is poised, How companies continue to compete without losing their ideology and core convictions?

### **The Problem**

The vast majority of higher education and hospital entities in the United States of America were founded as faith-based institutions by a religious order or sponsoring church entity. In addition to core convictions, these institutions also were founded with a confessional identity reflecting the spiritual ontology of their religious patron sponsor. However, the confessional identity that was instrumental in the initial establishment of these institutions has often been discarded over an extended time period for a variety of practical and philosophical reasons (Burtchaell, 1998; Marsden, 1994; Starr, 1982). Although these institutions have sustained their existence, the confessional identity and certain core convictions have been virtually abandoned. Choo (1998) writes, “More than ever, organizations are keenly aware that their ability to survive and evolve is determined by their capacity to make sense of or influence their environments and to constantly renew meaning and purpose in light of new conditions” (p. 66). Given the uncertain and

ambiguous environment, the ability to make sense and construct meaning is therefore subjected to different interpretations (Choo, 1998).

From the very origin of the Seventh-day Adventist Church, an emphasis on health has been an integral component of the ministry and outreach. In many ways, the Seventh-day Adventist view of health is intertwined with the fundamental doctrine and practice of the Church. The initial healthcare message of health reformation inspired the creation of Sanitariums where individuals came to be “made well” through therapeutic treatments and to “stay well” through education (Schwarz, 1970, p. 62). With various scientific and technological advancements, the sanitarium model has evolved into acute care hospitals that are impacted by various pluralistic influences, including reimbursement methods, a diverse workforce, and a healthcare model based on disease and illness rather than health.

While the original health reformation message was clearly applicable to the sanitarium model as initially developed, the confessional identity of Seventh-day Adventist healthcare in the environment of 21st-century medicine has not been fully evaluated. Furthermore, an understanding of the current perceptions and practice within Seventh-day Adventist healthcare institutions compared to the original confessional identity of Seventh-day Adventist healthcare has yet to be empirically tested.

### **Purpose of the Study**

For Seventh-day Adventist healthcare, the confessional identity has been inextricably connected to the core convictions over the 140 years since its founding. This fact of antiquity, however, does not guarantee that the confessional identity of yesteryear

will be preserved into the future. The purpose of this study is to determine and articulate the confessional identity and core convictions of Seventh-day Adventist healthcare and then investigate and describe how the leaders' and employees' cognitive understanding, behaviors, and affective attachments align at Florida Hospital.

### **Research Questions**

The research questions to be answered in this study are as follows:

1. What are the theological and philosophical core convictions that comprise the Seventh-day Adventist health message?
2. To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?

The four corresponding null hypotheses to the second research questions are as follows:

Null Hypothesis 1: There is no difference between senior leaders, middle management, and employees' perceptions across the six core convictions.

Null Hypothesis 2: There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

Null Hypothesis 3: There is no difference between religious groups across the six core convictions.

Null Hypothesis 4: There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

The research questions are set on the backdrop of the following propositions that will be explored in this study:

1. For an organization to preserve its confessional identity, current actions must align with the stated core convictions. If misalignments or gaps exist between the stated core convictions and current practice, a dissonance exists. To bring consonance, either current practice will be brought into alignment or the core convictions will be compromised which may jeopardize the confessional identity.

2. Institutionalism in and of itself cannot guarantee ongoing compliance to the confessional identity. Despite institutional qualities, individuals will enact their plausible interpretations by means of the sensemaking paradigm.

### **Research Methods**

This mixed methods research study utilizes the sequential exploratory strategy. As described by Creswell (2003), the sequential exploratory strategy is a two-phased approach wherein the initial phase will gather qualitative data that are utilized to develop a questionnaire, which is then administered in the second quantitative phase. Within this strategy, priority will be given to the qualitative aspects of the study.

The qualitative phase is comprised of four complementary activities including a historical analysis of Seventh-day Adventist healthcare through published literature, a

survey of the official published guidelines from the General Conference of Seventh-day Adventists, the commission of four original “white paper” manuscripts based on current research by some of the foremost contemporary academic scholars, and one-on-one interviews with 11 seasoned Adventist healthcare administrators. The second phase features the quantitative findings from a questionnaire administered at Florida Hospital to determine the perceptual gaps and alignments with the core convictions identified through the qualitative phase. An analysis of the survey results outlines the areas of statistical difference between the various stratified groups.

### **Theoretical Framework**

The theoretical underpinning of this study features cognitive dissonance theory (Festinger, 1957), sensemaking (Weick, 1995, 2001), and institutional theory (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Scott, 2001; Selznick, 1957). Cognitive dissonance theory states that individuals cannot productively function in an environment where their personal beliefs are inconsistent with their actions (Festinger, 1957). As explained by Choo (1998), “Sensemaking is a continuous, social process in which individuals look at elapsed events, bracket packets of experience, and select particular points of reference to weave webs of meaning” (p. 70). According to sensemaking theory, the “result of sensemaking is an enacted or meaningful environment, which is a reasonable and socially credible rendering of what is taking place” (Choo, 1998, p. 70). Institutional theory is defined by Selznick (1957) as organizational practices that “*infuse with value* beyond the technical requirements of the task at hand” (p. 17, italics in original). In this framework, “organizations do not so much create values as embody

them. As this occurs, the organization becomes increasingly institutionalized” (p. 20). Therefore, “institutional survival, properly understood, is a matter of maintaining values and distinctive identity” (p. 63).

### **Significance of the Study**

The significance of this study is the clear articulation of the confessional identity and core convictions of Seventh-day Adventist healthcare. In addition to the theological and philosophical expression ascribed in the confessional identity and core convictions, a questionnaire investigated the current alignment with the emerging core convictions at Florida Hospital in Orlando.

Therefore, the potential long-term functional significance of this study is twofold. The first is the opportunity for continued preservation of Seventh-day Adventist healthcare to its confessional identity based on this focused review. The second lasting effect is a questionnaire that can assist an organization in understanding the current alignment and gaps between the ideal standard and actual practice.

### **Assumptions**

The following assumptions are made in reference to this study:

1. The preservation of the confessional identity within healthcare institutions is important to the Seventh-day Adventist Church.
2. The preservation of the Seventh-day Adventist healthcare confessional identity is contingent upon the embracement of its core convictions at all levels of the organization.

3. The preservation of institutional values is tied to leaders' and employees' sensemaking paradigm.

### **Definitions**

The following terms are defined as used within the context of this study:

**Confessional Identity:** The spiritual ontology of an organization; the sacred ideology upon which the institution was founded.

**Core Convictions:** The essential elements of an organization that sustain the confessional identity; the essence, nature, essential properties, and purpose of an organization.

**Florida Hospital:** References to Florida Hospital specify the seven-campus system based in the greater Orlando metropolitan market.

**Wholistic:** A unique Seventh-day Adventist derivative of the word "holistic." Whereas "holistic" is defined from a secular view as the interdependence of the parts to make a whole, Seventh-day Adventists view wholistic with a Christ-centric aspect of the mind, body, and spirit.

### **Delimitations**

Although the core convictions and confessional identity of the Seventh-day Adventist health message articulated herein are the result of an exhaustive research effort, it should be noted that no official acceptance of these convictions has been formally adopted by an authoritative Church entity. Furthermore, the alignment and gaps identified herein represent the condition at Florida Hospital in Orlando, Florida, at this

given point in time and should not be construed to represent any other Seventh-day Adventist healthcare institution or the condition of Florida Hospital at any other point in time either historical or in the future.

### **Organization of the Study**

This mixed-methods study is divided into six chapters as follows. Chapter 1 provides the background and problem statement related to the confessional identity and core convictions of Seventh-day Adventist healthcare. The purpose of the study, research questions, research methodology, theoretical framework, significance of the study, assumptions, definitions, delimitations, and organizational framework for the study are also conferred.

A review of the theoretical literature is provided in chapter 2, covering the fields of institutional theory (Selznick, 1957), cognitive dissonance theory (Festinger, 1957), and sensemaking (Weick, 1995), along with a corollary on higher education.

Chapter 3 describes the sequential exploratory mixed methodology (Creswell, 2003) utilized in this study. A detailed description of the strategy, research questions, the population and sample, data gathering instruments, and the plan for analyzing the data for each phase of the study is presented.

Chapter 4 presents the findings of the qualitative phase of the study. Within this chapter, the articulation of the six core convictions of Seventh-day Adventist healthcare is presented. Chapter 5 exhibits the quantitative findings from a questionnaire administered at Florida Hospital to determine the perceptual gaps and alignments with one of the identified core convictions.



Chapter 6 summarizes the findings from this study, discusses conclusions, and recommends areas for further research.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Introduction**

This chapter reviews the relevant literature on the three theoretical bases for this study. Prior to the theoretical analysis, the chapter begins with a corollary from the literature, examining the systematic loss of confessional identity in higher educational institutions in order to provide a relevant context. The first theory base explores institutional theory followed by cognitive dissonance theory and sensemaking. Following the institutional theory section, a discussion on a rapprochement of the theories is developed.

#### **A Corollary on Higher Education**

The tension that exists in many organizations in preserving the confessional identity while adapting to the changing environment is untenable. Within the United States of America, the vast majority of hospitals and institutions of higher learning were created by religious orders and churches. However, through the years, the vast majority of these institutions have severed all formal relationships with their founding church entities. For many institutions of higher learning, the sanctity of holding on to the core religious heritage that was formative in the early years was ultimately disregarded for a

variety of reasons (Allen, 1999; Burtchaell, 1998). The first section will outline the systemic loss of the founding confessional identity that has occurred in numerous institutions of higher learning followed by a section featuring the handful of universities and colleges that have successfully sustained their confessional identity through a strict adherence to certain fundamental core convictions.

### The Loss of Confessional Identity

In a meticulous historical review, Burtchaell (1998) outlines the gradual disengagement of the various colleges and universities previously associated with the Congregationalist, Presbyterian, Methodist, Baptist, Lutheran, Catholic, and Evangelical denominations. Although there is no singular pattern of disengagement, there are general themes and similarities in both their founding as well as their disengagement from their confessional identity.

In tracing the historical origins of these institutions of higher learning, the common beginnings were orchestrated by clergy who determined the need for enhanced higher learning in order to create a stable new nation. Marsden (1994) chronicles the close tie between the development of the United States of America and the role of higher education. The belief within the newly constituted country was that the establishment of a civilized society would be closely correlated with the presence of educational opportunities. Marsden writes, "Next to religion, education was the best means of taming an unruly populace and assimilating diverse peoples into a common culture with shared ideals. Education would develop the individual sense of duty and a national conscience" (p. 85).

These educational opportunities were established through various sectarian Protestant and Catholic churches. Remarkably, only six years after the founding of the first Puritan settlement in Massachusetts, the Puritans began the necessary work to establish an educational entity that would eventually become Harvard University. In the first century of existence, the majority of Harvard graduates were trained as clergy (Marsden, 1994).

With the importance of education to the establishment of a civil society, the challenge became the reconciliation of sectarian belief with secular interests. At first, there was comfort that secular and sacred interests could reside collectively and peacefully within the university setting. However, in the 18<sup>th</sup> century, Thomas Jefferson led an effort to separate control of America's universities from specific sectarian church organizations. At this juncture, the issue was not so much the involvement of religious organizations in higher education, but rather the particular sectarian theologies of specific denominations being propagated within the colleges and universities with "public" monies. This conflict was ultimately heard before the United States Supreme Court wherein the court ruled for the immunity of charitable corporations from state control. Governmental funding continued in many parts of the country until early in the 19<sup>th</sup> century despite denominational affiliation (Marsden, 1994).

Despite the denominational ties of the college or university, students were welcome regardless of their faith professions. In the early years, the university President was required to be a member of the sponsoring denomination. The relationship between the university and the church usually entailed the provision of students and financial

means to sustain the operations. However, as students not associated with the denomination enrolled in these universities and other funding sources became available, the dependence on the sponsoring denomination were marginalized. Burtchaell (1998) explains that “for some colleges, effective emancipation came in the form of a sudden, large benefactor” (p. 823).

In concert with newfound funding options, the alumni assumed more leadership on the Board of Trustees away from clergy and church leaders. Concomitantly, the President and faculty felt increasingly “confined, stifled or trivialized by their church” affiliation (Burtchaell, 1998, p. 827). As the faculty developed their expertise within given fields, their primary devotion was pledged to their career rather than their institution and its confessional identity. Over time, the faculty devolved from active membership in the church to intolerance as they perceived that their religious affiliation was prohibiting unadulterated freedom to search for academic truth. In essence, the core conviction of academic truth precluded their confessional identity.

The influences of the scientific community’s interest in such theories as Darwinism challenged the fabric of many universities’ biblical declarations. With the intent to pay reverence to the scientific authority of academia, the empirical attributes of positivism soon became incongruous with religious teachings. Benne (2001) writes, “To the academic elite, these Christian enterprises seemed to be atavistic throwbacks to a bygone world. They seemed to be clinging to a way of understanding the world that had been surpassed by a new and more successful faith” (p. 28). The first victim was straightforward sectarian teachings. In other settings, moral philosophy replaced

theology as the primary curriculum for principled scholarship. Thereafter, the natural course was a “methodical secularization” (Marsden, 1994, p. 156).

In various universities, it was progressive professors who ultimately challenged the religious connection within the university setting, stating that such beliefs created constraints against “academic freedom” and claiming that “intellectual freedom is honored far above orthodoxy” (Marsden, 1994, p. 296). Marsden further explores this tension in writing:

The fatal weakness in conceiving of the university as a broadly Christian institution was its higher commitments to scientific and professional ideals and to the demand for a unified public life. In the light of such commitments academic expression of Christianity seemed at best superfluous and at worst unscientific and unprofessional. Most of those associated with higher education were still Christian, but in academic life, as in so many other parts of modern life, religion would increasingly be confined to private spheres. (p. 265)

Contributing to these internal scholastic aspects were various external factors. Peripheral funding sources, including governmental and private foundations such as the Carnegie Foundation for the Advancement of Teaching, contained specific prohibitions of church influences in order to be eligible for grants and financial support.

In retrospect, it was common for the church to express concern about the path to secularity a decade after it had already functionally occurred. As Burtchaell (1998) explains, “Later, worship and moral behavior were easily set aside because no one could imagine they had anything to do with learning” (p. 842). With the necessary monies and students being attracted independently of the church, these higher educational institutions allowed their relationship with the church to “atrophy” into a more “principled indifference” (p. 844).

### The Preservation of Confessional Identity

In stark contrast to this disengagement of faith from learning is Baylor University in Waco, Texas. In their 10-year vision document entitled *Baylor 2012* (Baylor University, 2002a), the President and Chief Executive Officer, Robert B. Sloan, Jr., boldly declares, “We aspire to what few institutions, if any, have ever achieved – recognition both as a top tier university and as an institution committed to Christ” (p. 1). Baylor University seeks to reverse the very basis and assumptions that led to the separation of some of the most respected universities and their sponsoring churches. Baylor (Baylor University, 2002b) states, “It is a legacy of modern thought to believe that the pathway divides between the uncompromised pursuit of intellectual excellence and intense faithfulness to the Christian tradition” (p. 3). They further proclaim, “We believe that the highest intellectual excellence is fully compatible with orthodox Christian devotion. Indeed, the two are not only compatible, but mutually reinforcing” (p. 3).

Recognizing the challenges that others have encountered toward this end, Baylor (Baylor University, 2002b) is careful to establish “that all truth is open to inquiry” (p. 2). Acknowledging the sectarian challenges in the past, Baylor affirmatively states:

Because the Church, the one truly democratic and multicultural community, is not identical with any denomination, we believe that Baylor will serve best, recruit more effectively, and both preserve and enrich its Baptist identity more profoundly, if we draw our faculty, staff, and students from the full range of Christian traditions. (p. 2)

In the 2 years since its adoption of their strategic initiative of *Baylor 2012*, Baylor has taken significant steps toward achievement of its vision. Each new hire is assessed for his or her Christian commitment. Distinguished Christian scholars have been recruited,

and frequent seminars and dialogue are orchestrated. However, the implementation has not been void of challenges and opposition. It has taken nearly 2 years for the Faculty Senate to officially adopt the plan (Benne, 2005). The President and Chief Executive Officer, Robert Sloan has recently resigned under intense pressure, drawing some to question if *Baylor 2012* will ultimately be successful in establishing the viability of the dual aspiration of excellence in academics within the Christian context (Litfin, 2005).

Benne (2001) highlights six colleges and universities that have challenged disintegration with their sponsoring church entity and have held onto their confessional identity. In examining the characteristics of these higher educational institutions, the three themes that must be publically relevant were the institution's vision, ethos, and Christian persons who would carry the vision and ethos. Benne's reference to vision is defined in similar fashion to what has been defined as confessional identity in this paper, which is an organizations' core ideology. The reference to ethos is the daily activities, symbolism, and rituals that reinforce the vision. When pressed to summarize the reason that so many church-founded colleges and universities broke from their sponsoring religious entities, Benne replies:

A short and flippant answer to these questions is simply this: an adequate number of persons—board, administrators, faculty and students—with a firm understanding of and commitment to the vision and ethos of each school's sponsoring heritage was not available to either school or church at the necessary times to translate that heritage into the school's life in a pervasive manner. Not enough committed and competent persons were present at crucial times to insist that the sponsoring heritage be publicly and fittingly relevant in all facets of college life. That is the crux of the matter. (p. 19)

Without principled intention, Seventh-day Adventist healthcare may follow the well-traveled path of higher education whereby the necessities of the Church are found to



be more problematic than beneficial. To subvert this reality, the leaders and employees must define and defend the vision and ethos of Seventh-day Adventist healthcare. The sensemaking paradigm of the leaders and employees must be in sync and in balance with the institutional values if Seventh-day Adventist healthcare is to stay grounded in the professed confessional identity.

### **Institutional Theory**

The first theory base to be explored is institutional theory. This section begins with definitions of institutionalism followed by an exploration of new institutional theories and concludes with the process of deinstitutionalization.

#### **Institutionalism Defined**

One of the first and most influential theorists of institutional theory is Philip Selznick (1957) who defines institutionalism as organizational practices that “*infuse with value* beyond the technical requirements of the task at hand” (p. 17, italics in original). In this mode, “organizations do not so much create values as embody them. As this occurs, the organization becomes increasingly institutionalized” (p. 20). Therefore, “institutional survival, properly understood, is a matter of maintaining values and distinctive identity. This is at once one of the most important and least understood functions of leadership” (p. 63). As organizations develop and become “*infused with value,*” the leaders’ primary focus is to ensure the continuity of these values. These values help the organization to create a distinct identity and character through the

adaptation and infusion of these values throughout the organization. In reference to the importance of values in institutionalism, Selznick (1996) writes:

Values do have a central place in the theory of institutions. We need to know which values matter in the context at hand; how to build them into the organization's culture and social structure; and in what ways they are weakened or subverted. (p. 271)

Through value installation, "institutionalization promotes stability: persistence of the structure over time" (Scott, 1987, p. 494).

An organization does not automatically progress to institutional status. Neither is institutionalism a standing that is conveyed with immediacy. Selznick (1957) recognizes this wherein he writes:

Institutionalization is a process. It is something that happens to an organization over time, reflecting the organization's own distinctive history, the people who have been in it, the groups it embodies and the vested interests they have created, and the way it has adapted to its environment. (p. 16)

Although Selznick (1948) emphasizes that organizations are "rationally ordered instruments for the achievement of stated goals," he also recognizes that organizations must be "adaptive social structures" (pp. 25-26), which are open systems that relate and respond to the realities of the marketplace. Therefore, organizations acclimate not only to the internal environment but also interact with the values of society. Cooptation then becomes the strategy whereby an organization incorporates elements from the external environment into the institutional process in order to build legitimacy and resilience.

The degree of institutionalism depends on a variety of factors including the frequency and quality of group interaction. However, the more "precise an organizations' goals" as well as "the more specialized and technical its operations," the

less likely it is that environmental and social factors will affect the organizations' development (Selznick, 1957, p. 16). In essence, Selznick embraces the principle that effective leaders not only define but defend the institutional values of an organization (Scott, 1987).

Institutional theory examines the function of social stimulus and influence to determine the related impact on organizational actions (Scott, 1987). Berger and Luckmann (1967) develop the concept of a "social construction of reality" (p. 15) based on the notion that social reality is a consequence of humans interacting with one another. They propose that it is through the establishment of knowledge, belief, and "shared history" (p. 54) that repeated actions of meaning are stimulated rather than through norms or rules. The formation of common meaning systems which ultimately leads to institutionalization occurs in the following three stages: *Externalization* is the creation of symbolic structures by social interaction whose meaning is shared by the participants; *Objectification* is the process whereby these "institutions, as historical and objective facticities, confront the individual as undeniable facts. The institutions are there, external to him, persistent in their reality, whether he likes it or not" (p. 60); and then *Internalization* is the process "by which the objectivated social world is retrojected into consciousness in the course of socialization" (p. 61). In essence, the social construction of reality is through the process of taking action together (externalization), interpreting our actions as separate from ourselves (objectification), which is then internalized by each of us personally (internalization).

Oliver (1997) writes that “from an institutional perspective, firms operate within a social framework of norms, values, and taken-for-granted assumptions about what constitutes appropriate or acceptable . . . behavior” (p. 699). Of greatest interest are those values such as confessional identity because “there is no obvious economic or technical purpose because their perpetuation cannot be explained by rational choice frameworks” (p. 699).

On a macro organizational level, the concept of institutionalism is built on “cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior. Institutions are transported by various carriers – cultures, structures, and routines – and they operate at multiple levels of jurisdiction” (Scott, 1995, p. 33). In like fashion, Barley and Tolbert (1997) define the institution as “shared rules and typifications that identify categories of social actors and their appropriate activities and relationships” (p. 96). On a more micro organizational level, institutional members function based on the shared meaning systems that develop over time. DiMaggio and Powell (1983) offer the concept of “organizational fields” which they define as “those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products” (p. 148). Therefore, even though healthcare as an industry has “cognitive, normative and regulative structure” that affects this study, by working within the “organizational field” of Seventh-day Adventist healthcare, we are able to appreciate institutional factors at both a macro and micro level.

### New Institutionalism

The works of Berger and Luckmann (1967), Knauff, Berger and Gray (1991), and Meyer and Rowan (1977) in combination with DiMaggio and Powell (1983) create the underpinning for new institutional theory. Whereas Selznick (1957) defines the *characteristics* of institutions, the premise of “new” institutional theory (also called neo-institutional theory) is to examine the *process* by which organizations become institutions.

DiMaggio and Powell (1983) argue that organizations are similar because they want to attain legitimacy in their environment. To that end, they have suggested that this change and development occurs through the three isomorphic processes of coercive, mimetic, and normative. Institutional change occurs through the mechanisms of *coercive isomorphism* wherein regulations and laws dictate actions; *mimetic processes* wherein uncertainty encourages imitation of structure or methods within the industry; and *normative pressures* where cultural expectations determined by professional training and networks encourage conformity and similarities. Legitimacy occurs through these three processes interacting among organizations. In reality, it is unlikely to separate these three categories of isomorphism in that they operate simultaneously even though they are distinct processes.

Meyer and Rowan (1977) purport that “rationalized myths” are part of the framework within which organizations operate – where their actions may only partially conform to the norms of rationality, but their actions become rational as everyone believes them to be. As structure and processes become accepted as social standards,

social legitimacy is established as the organization adapts to align with those standards. An underlying assumption throughout institutional theory is that organizations are open systems that are strongly influenced by the social environment within which they exist (Scott, 2001).

Scott (2001) categorizes the various perspectives of new institutional theory into three pillars: regulatory, normative, and cultural-coercive. The regulatory pillar concentrates on the role of institutions that guide behavior through the regulatory process of “rule-setting, monitoring, and sanctioning activities” (p. 52). The influences of “force, fear, and expedience are central ingredients of the regulatory pillar” (p. 53) which advance organizational conformity. The normative pillar focuses on how institutions guide behavior by defining what is expected or appropriate. The third pillar is the cultural-cognitive which stresses that compliance occurs “because other types of behavior are inconceivable; routines are followed because they are taken for granted as ‘the way of doing things’” (p. 57).

Whereas values, moral frames, and norms are the key construct of cognition in the original institutional version (Selznick, 1957), routines and taken-for-granted scripts are the cognition in the new institutional perspective (Zucker, 1987). Barley and Tolbert (1997) explain that institutions are “suspended in a web of values and norms, rules, beliefs and taken-for-granted assumptions that are at least partially of their own making” (p. 93). With open systems comes the unstable reality that even within institutionalized systems that “multiple pressure points providing inconsistent cues or signals, opening the possibility for idiosyncratic interpretation and either deliberate or unwitting variation in

practices” (Greenwood & Hinings, 1996, p. 1029). From a confessional identity standpoint, it is imperative that these socially constructed templates have the necessary social relations and embedded interpretations to sustain ongoing interactions.

### Deinstitutionalization

Once an organization embeds an institutionalized value set, certain actions are taken for granted as “the way things are done around here” (Scott, 1987, p. 496). Despite the plethora of writings and research on institutional theory, there is a paucity of attention devoted to the “antecedents of deinstitutionalization” that may determine the likelihood that institutionalized organizational processes and behaviors will be vulnerable to erosion or rejection over time (Oliver, 1992, p. 563). Oliver defines deinstitutionalization as the “delegitimation of an established organizational practice or procedure as a result of organizational challenges to or the failure of organizations to reproduce previously legitimated or taken-for-granted organizational actions” (p. 564). The premise of deinstitutionalization is that under certain specific conditions, the institutional perspective, habit, and tradition that historically created value congruence are “vulnerable to challenge, reassessment or rejection” (p. 564).

Oliver (1992) hypothesized that three factors lead to deinstitutionalization: political, functional, and social, which will be further detailed. The rate of institutionalization is moderated by organizational entropy, which accelerates the process of deinstitutionalization and inertial pressure, which tends to impede the deinstitutionalization process. The deinstitutionalization model developed by Oliver is depicted in Figure 1. Collectively, these five pressures will “determine the probability of

dissipation or rejection of an institutionalized organizational practice” (p. 566). The method of “dissipation” of institutional practices occurs by either “atrophy” or “rejection” (pp. 566-567). Atrophy refers to the gradual process wherein “accepted practices or activities are no longer continually reproduced or reenacted over time” (p. 567). Rejection refers to the direct assail and discontinuation to an existing norm.

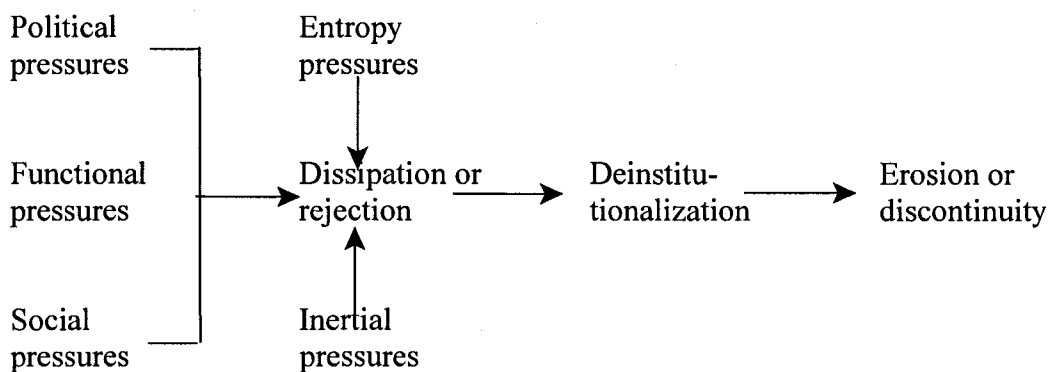


Figure 1. Pressures from deinstitutionalization. From “The Antecedents of Deinstitutionalism,” by C. Oliver, 1992, in *Organization Studies*, 13, p. 567.

### Political

Oliver (1992) suggests that political conditions such as a mounting performance crisis and conflicting internal interests will likely call into question the utility and/or legitimacy of institutional practices. In particular, the two political deinstitutionalization mechanisms are environmental and intraorganizational factors. In times of performance crisis, the “validity of organizational procedures that have traditionally served the organization’s interest effectively” (p. 568) are in doubt and questioned. In the corollary on higher education cited earlier, the intraorganizational factors were clearly motivating



forces as the internal interests of the faculty for freedom of intellectual pursuits conflicted with the institutional values.

### **Functional**

As defined by Selznick (1957), institutionalism is organizational practices that “*infuse with value* beyond the technical requirements of the task at hand” (p. 17, italics in original). Building on Selznick’s definition, several theorists note that institutionalized practices are often inefficient and ineffective from a pure performance consideration (Meyer & Rowan, 1977; Selznick, 1957; Zucker, 1987). Since institutionalism tends to flourish in conditions of goal ambiguity and technical uncertainty (Galaskiewicz & Wasserman, 1989; Selznick, 1957), an increase in an organization’s technical and professional advancement will foster deinstitutionalization tendencies. During times of “innovative pressures” and “performance problems,” the functional value of institutional practices will be evaluated for instrumental value and allowed to atrophy if its “perpetuation is no longer rewarding” (Oliver, 1992, p. 571). As cited in the corollary on higher education, once the respective church entity was no longer required for either funding or for the provision of students, the functional utility of the sponsoring entity was no longer regarded as valuable.

### **Social**

In contrast to political and functional mechanisms, the social deinstitutionalization process is usually not proactively precipitated by intention. According to Oliver (1992), normative fragmentation such as organizational changes,

including high turnover or succession, mergers that change the organizational continuity, changes in laws or expectations by society or other environmental changes can “disaggregate collective norms and values” (p. 575). As noted in the corollary on higher education, efforts were exerted by Thomas Jefferson and others first through the legal system and later by societal pressure to discontinue the sectarian influences of these colleges and universities.

The danger to deinstitutionalization of the Seventh-day Adventist healthcare confessional identity is that “the web of values, norms, rules, beliefs and taken-for-granted assumptions” (Barley & Tolbert, 1997, p. 93) change over time based on the political, functional, or social features in the environment. As suggested by Tolbert and Zucker (1996), practices are not necessarily equally institutionalized depending on their *longevity* or based on their *acceptance levels*. This would suggest that having a clear understanding of the “values, norms, rules, beliefs and taken-for-granted assumptions” is absolutely necessary to ensure *longevity*. The *longevity* of Seventh-day Adventist healthcare will be fortified through the historical and current identification of the confessional identity and core convictions in the first phase of this study. Furthermore, a clear understanding of *acceptance levels* of the “values, norms, rules, beliefs and taken-for-granted assumptions” is also a critical imperative to the preservation of an organization’s confessional identity. The *acceptance levels* of the Seventh-day Adventist healthcare core convictions will be ascertained through a questionnaire in the second phase of this study with results reported in chapter 5.

### **Cognitive Dissonance Theory**

Psychologists have long believed that the desire for consistency between belief and action is a central motivator for behavior (Festinger, 1957; Heider, 1946; Newcomb, 1953). This desire for consistency can be used as a “highly potent weapon of social influence” which can cause individuals to act in ways that are demonstrated to be contrary to one’s own best interest (Cialdini, 2001, p. 54). Even when faced with irrefutable physical evidence, once a commitment to a belief has been expressed, it is highly unlikely that one will change their position (Festinger, Riecken, & Schachter, 1964).

Festinger (1957) developed cognitive dissonance theory to explain the psychological balance that individuals will seek between their thoughts and actions. Given inconsistencies between beliefs and actions, an individual will seek to avoid or reduce this dissonance by changing beliefs, attitudes, or actions to produce a perception of consistency. The degree of dissonance will vary based on the intensity, importance, and degree of the given discrepancy. Given cognitive dissonance, Festinger suggests two general ways that individuals will employ to reduce this dissonance. The first way is to increase the consistency, or “consonance,” between cognitive elements. The second method is to reduce the importance of the issue from which the dissonant cognitive elements evolve.

In a similar vein, Festinger (1954) also developed the Theory of Social Comparison, which states that people have a basic need to evaluate their ideas and beliefs to ensure that they are correct. Festinger further specifies that “correct,” as it relates to

beliefs and social behavior, is highly subjective, which is defined by “social realities” rather than “objective absolutes” (as cited in Zimbardo & Leippe, 1991, p. 55). Weick (1995, 2001) advanced Festinger’s cognitive dissonance theory and developed an interpretive approach to studying the sensemaking process during uncertain environmental conditions that create cognitive dissonance.

### **Sensemaking**

Within this section, the theory of sensemaking is defined and developed. After the definition, the connection between sensemaking and cognitive dissonance theory is explained. The remainder of this section will report the distinguishing characteristics of sensemaking followed by a framework and sensemaking applications.

### **Definitions**

In this section, a collection of definitions for sensemaking is provided in order to build a conceptual framework of understanding. It should be noted that various authors use either the term “sensemaking” or “sense making” to reference and represent the same body of knowledge.

Throughout organizations, people are constantly and consistently trying to understand the environment around them. In order for the organization to create a collective strategy or plan of action, it is first necessary to make sense of what is happening in their environment (Choo, 1998). According to Weick (1995), sensemaking is a “developing set of ideas with explanatory possibilities, rather than as a body of knowledge” (p. xi). The development of sensemaking has been significantly influenced

from the robust framework of ethnomethodology (Czarniawska-Joerges, 1992; Gephart, 1993) and dissonance theory (Chatman, Bell, & Staw, 1986; Festinger, 1957; Weick, 1993). The sensemaking process involves cognitive, emotional, and behavioral components (Volkema, Farquhar, & Bergmann, 1996).

Weick (1995) proffers that “the concept of sensemaking is well named because, literally, it means the making of sense” (p. 4). He further writes that sensemaking “should be understood literally, not metaphorically” (p. 16). While “the word *sensemaking* may have an informal, poetic flavor, that should not mask the fact that it is literally just what it says it is” (p. 16, italics in original). Sensemaking entails making sense of various stimuli extracted from the environment and determining an appropriate cognitive framework or mental map to derive meaning and ultimately to initiate behavior (Starbuck & Milliken, 1988). In a very comprehensive definition, Choo (1998) writes:

Sense making is a continuous, social process in which individuals look at elapsed events, bracket packets of experience, and select particular points of reference to weave webs of meaning. The result of sense making is an enacted or meaningful environment, which is a reasonable and socially credible rendering of what is taking place. The central problem in sense making is how to reduce or resolve ambiguity, and how to develop shared means so that the organization may act collectively. (p. 70)

Thomas, Clark, and Gioia (1993) depict sensemaking as “the reciprocal interaction of information seeking, meaning ascription, and action” (p. 240). The key to understanding the essence of sensemaking is to appreciate that sensemaking is a process and not a construct. As a result of sensemaking, managers are able to create and utilize knowledge (Menon & Varadarajan, 1992), structure the unknown (Waterman, 1990), and

comprehend, understand, explain, attribute, extrapolate, and predict (Starbuck & Milliken, 1988, p. 51).

### Connection With Cognitive Dissonance Theory

Weick (1995, 2001) further develops Festinger's (1957) cognitive dissonance theory and provides an interpretive approach to study the construction of a social reality in situations that create cognitive dissonance. According to Festinger, people are assumed to be rational and pragmatic who make decisions based on calculated comparisons regarding the merit of each alternative. While Weick (1995, 2001) would agree that people are goal-oriented, he emphasizes the social nature of the populace. One of the premises of Weick's sensemaking model is that meaning is determined through a social process and, therefore, there are no true private thoughts that are not developed in a social sense. According to Festinger (1957), a perceived reality is the realism that psychological elements relate to. Weick (1995, 2001) furthers this thought by suggesting that perceived reality, or socially constructed reality, is authentic because people believe it is and behave accordingly (as cited in Hsiung, 2004).

The connection between commitment and enactment is straightforward. In most circumstances, when people act, their reasons are either "straightforward or uninteresting," especially when such actions can be "undone, minimized, or disowned" (Weick, 2001, p. 229). However, when actions or statements that are public, irreversible and volitional, a commitment has been created that will prompt consistent justification (Kiesler, 1971; Salancik, 1977). Commitment is therefore the link between cognitive dissonance and sensemaking, which makes "explicit behavior irrevocable" (Weick, 1995,

p. 156). Weick (2001) completes the tie between individual actions and organizational values within the context of cognitive consonance as he writes:

People continue to act in ways that create value and give meaning to their action. Here that process occurs when people engage in important, public, irrevocable, volitional acts that compel a search for justifications. When those justifications are found, they tend to persist and be defended. Hence, people act their way into their values, which paves the way for groups to act their way into their identities, which paves the way for organizations to act their way into their missions. (pp. 3-4)

The connection of sensemaking to cognitive dissonance theory is that people will be most astute in creating meaning around those actions to which their commitment is exceedingly significant. It is through commitment that one can connect sensemaking to binding actions. The implication is that one can understand how people make sense of the world by connecting “binding actions” with the “acceptable justifications” that were available at the time of such decisions (Weick, 1995, p. 156).

Within sensemaking, individuals develop scripts that provide predictions of event sequences and outcomes. Louis (1980) argues that when these scripts fail to explain the anticipated outcome, the individual will engage in sensemaking to retrospectively review and explain “why the actual outcomes occurred and why the predicted outcomes did not” (p. 240). In reference to Festinger’s (1957) theory of cognitive dissonance, Louis explains that the retrospective analysis involved with sensemaking will seek to resolve the tension and restore cognitive equilibrium (p. 240).

#### Distinguishing Characteristics

Weick (1995) identifies seven distinguishing characteristics that “set sensemaking apart from other explanatory processes such as understanding, interpretation and

attribution” (p. 17). The seven distinguishing characteristics are (a) grounded in identity construction, (b) retrospective, (c) enactive of sensible environments, (d) social, (e) ongoing, (f) focused on and by extracted cues, and (g) driven by plausibility rather than accuracy. Each of these seven distinguishing characteristics is further developed in the following sections.

### **Grounded in Identity Construction**

Sensemaking originates with a sensemaker (Weick, 1995). Establishing a consistent and positive identity of self is central in sensemaking. The sense a person makes within a given situation is influenced by their sense of who they are in that setting, which will have a direct impact on their perception of the situation. “Thus the sensemaker is himself or herself an ongoing puzzle undergoing continual redefinition, coincident with presenting some self to others and trying to decide which self is appropriate” (p. 20). Therefore, sensemaking is self-referential.

Given that the first premise of sensemaking is that the act of sensemaking starts with a person who is attempting to make sense of the given environment and situation, sensemaking is grounded in an individual identity (Weick, 1995). However, the individual is also representing an organization. Chatman et al. (1986) reconcile this thought:

When we look at individual behavior in organizations, we are actually seeing two entities: the individual as himself and the individual as representative of his collectivity. Thus, the individual not only acts on behalf of the organization in the usual agency sense, but he also acts, more subtly, ‘as the organization’ when he embodies the values, beliefs, and goals of the collectivity. As a result, individual behavior is more ‘macro’ than we usually recognize. (p. 211)



The establishment of identity is therefore both a personal act and a corporate endeavor. Bolman and Deal (2001) recognize that when leaders “have lost touch with their own souls, who are confused and uncertain about their core values and beliefs, [they] inevitably lose their way or sound an uncertain trumpet” (p. 11). This is an important concept in connecting the role of a leader with the confessional identity within a faith-based institution.

### **Retrospective**

The world that we perceive is conceptualized subsequent to its occurrence (Weick, 2001). In essence, people cannot know what they are doing unless the act has already been committed. As Weick (1995) explains, “Only when a response occurs can a plausible stimulus then be defined” (p. 26).

According to Weick, the focus on retrospective analysis is “perhaps the most distinguishing characteristic of the present conceptualization of sensemaking” (p. 24). The concept of retrospective sensemaking originated with Schutz’s (1967) analysis of “*meaning* of a lived experience” (p. 73, italics in original). The significance of this statement is that “lived” indicates that meaning occurs after the experience has transpired and “*meaning*” is not an external independent attachment but reflects the individual attention that is directed to the experience.

### **Enactive of Sensible Environments**

Through enactment, how an individual or organization makes sense of a given event or circumstance encountered will affect how that event will unfold (Weick, 2001).

Enactment is the connection between action and cognition in that “people act their way into explanations” (p. 176) and as “the activity of making that which is sensed” (Weick, 1995, p. 30). The basic premise is that the only reality that has meaning to people is the reality that people can perceive. In essence, enactment represents the “making” portion of sensemaking since individuals are active in creating their own realities. In choosing the enactment terminology, Weick (1995) highlights the close parallel between the process of legislature and management, which creates reality through “authoritative acts” (p. 31) indicating the ability to legislate our own realities. Therefore, for Weick, sensemaking is less about discovery than it is about enactment in which the actor creates facticity by rendering the subjective into something corporeal.

### **Social**

At first glance, sensemaking can give the impression that it occurs at an isolated individual level. However, Weick (1995) clearly states that “sensemaking is never solitary because what a person does internally is contingent on others” (p. 40). Walsh and Ungson (1991) define the social reality of an organization as “a network of intersubjectively shared meanings that are sustained through the development and use of a common language and everyday social interaction” (p. 60). As Weick (2001) points out, “sensible meanings tend to be those for which there is social support, consensual validation, and shared relevance” (p. 461). The implication is that when a person intends to change their meaning, they will seek a different social context.

**Ongoing**

Sensemaking, like experience, is a continuous flow and is fully appreciated only as we impose artificial boundaries around specific events to contain a portion of the flow. It is impossible to determine at what point sensemaking starts and at what point it will ever end. Weick (1995) writes, “To understand sensemaking is to be sensitive to the ways in which people chop moments out of continuous flows and extract cues from those moments” (p. 43).

**Focused on and by Extracted Cues**

As Weick (2001) explains, “If sensemaking is about nothing else, it is about the resourcefulness with which people elaborate tiny indicators into full-blown stories, typically in ways that selectively shore up an initial hunch” (p. 462). Smircich and Morgan (1982) underline that “leadership lies in large part in generating a point of reference, against which a feeling of organization and directions emerge” (p. 258). The process of noticing is different from sensemaking. Starbuck and Milliken (1988) distinguish noticing as activities of filtering, classifying, and comparing whereas sensemaking refers to interpretation and determination of what the various cues mean. They further state, “Sensemaking focuses on subtleties and interdependencies, whereas noticing picks up major events and gross trends” (p. 60). Therefore, noticing will determine the environmental events that are available for sensemaking.

### **Driven by Plausibility Rather Than Accuracy**

In sensemaking, people act in a pragmatic manner. Therefore, they favor plausibility over accuracy in the decision-making process (Weick, 1995). Sensemaking need not be sensible or accurate as long as it is plausible, coherent, and reasonable. Weick writes, “Sensemaking is about the embellishment and elaboration of a single point of reference or extracted cue. Embellishment occurs when a cue is linked with a more general idea” (p. 57). Considering that sensemaking is based on remembering (“retrospective”) and biased perception of selected cues (“focused on and by extracted cues”), the concept of plausibility is a natural consequence.

#### A Sensemaking Framework

For the sustenance of a confessional identity to be perpetuated, Weick (2001) suggests that “what needs to be borrowed are ideas and directions that can be embellished in the context of idiosyncratic local particulars” (p. 360). Thus far, the descriptors have focused on describing *what* sensemaking is without fully developing *how* sensemaking works. Daft and Weick (1984) developed a circular model depicted in Figure 2 which starts with “scanning,” followed by “interpretation” and then “learning” (p. 286). From the learning phase the cycle can repeat back through a feedback loop to either of the two previous steps referenced. These three aspects of the model will be further developed in the following paragraphs.

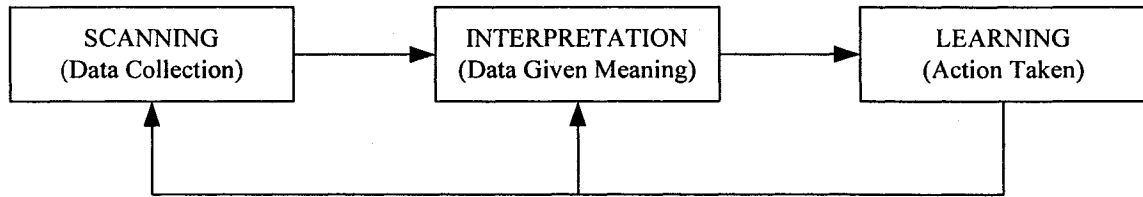


Figure 2. Relationships among organizational scanning, interpretation, and learning. From "Toward a Model of Organizations as Interpretation Systems," by R. L. Daft and K. E. Weick, 1984, *Academy of Management Review*, 9(2), p. 286.

Scanning entails information gathering and is usually an antecedent to interpretation and actions or decisions (Daft & Weick, 1984). In other models, scanning has been likened to noticing (Starbuck & Milliken, 1988), searching the internal and external organizational environments (Thomas et al., 1993) and problem sensing (Kiesler & Sproull, 1982). Kiesler and Sproull (1982) note that scanning can be prone to error due to the potential that managers will (a) ignore overly discrepant information, (b) assume events are correlated when they are only similar, (c) assume events are causal through a false association of events, and (d) assume that events did not occur when they did but were irrelevant to the situation. Starbuck and Milliken (1988) underscore the importance of scanning as they write, "Noticing determines whether people even consider responding to environmental events. If events are noticed, people make sense of them; and if events are not noticed, they are not available for sensemaking" (p. 60). Context is an important factor in that it can affect the extraction of cues from the environment, which may significantly influence the plausibility of the sensemaking (Weick, 1995).

The next stage is interpretation wherein managers assign meaning to the various stimuli. Daft and Weick (1984) define organizational interpretation as “the process of translating events and developing shared understanding and conceptual schemes among members of upper management. Interpretation gives meaning to data, but it occurs before organizational learning and action” (p. 286). Thomas et al. (1993) write: “Interpretation involves the development or application of ways of comprehending the meaning of information; it entails the fitting of information into some structure for understanding and action” (p. 241). Weick (1995) is deliberate in noting that interpretation is a much different process than sensemaking wherein he writes:

The key distinction is that sensemaking is about the ways people generate what they interpret. The concept of sensemaking highlights the action, activity, and creating that lays down the traces that are interpreted and then reinterpreted. Sensemaking is clearly about an activity or a process, whereas interpretation can be a process but is just as likely to describe a product. A focus on sensemaking induces a mindset to focus on process, whereas this is less true with interpretation. (p. 13)

In essence, interpretation is a sub-process within sensemaking in that sensemaking is much broader and more inclusive than interpretation.

The third stage of this process is learning which is differentiated in Daft and Weick’s (1984) model by the concept of action being taken. Learning should only occur after the scanning and interpretation have occurred. Thomas et al. (1993) define action as “any significant change in the ongoing organizational practices such as a substantive alteration in product or service offerings” (p. 242). It is through learning that cognitive theories are set into action (Argyris & Schon, 1978; Hedberg, 1981). As noted earlier, this framework is part of a feedback loop such that learning now can provide new data

for interpretation and provide a new perspective for scanning (Daft & Weick, 1984). It is through this process, including the feedback loop, that sensemaking occurs.

### **Rapprochement of Theories**

According to Weick (1995), “Sensemaking is the feedstock for institutionalism” (p. 36). Weick supports this claim by noting that the socially transacted organization becomes a world that “constrains actions and orientations” (p. 36). In essence, social constructions are institutionalized into the modus operandi of an organization, thus bringing the sensemaking paradigm into conformity with institutional theory. Weick continues that organizations are “loosely coupled systems” (p. 134) of individuals who are personally and collectively trying to interpret the “equivocality” (p. 92) of information about the organization’s environment. Furthermore, the underpinning of sensemaking is based on a relativistic platform whereby each individual is allowed to make sense of environmental cues and is left to enact their understandings within the organization.

It has been only since the early 1990s that researchers started to apply a more holistic view to the sensemaking process. Thomas et al. (1993) were among the first to apply an empirical approach to understand the systematic process of sensemaking. The juxtaposition of sensemaking with institutional theory has only recently been considered (Weick, Sutcliffe, & Obstfeld, 2005) with works just recently published (Jennings & Greenwood, 2003) and unpublished (Weber, 2003).

In evaluating institutional theory, detractors cite various issues of concern including that institutional theory is “static, reificatory, too macro, and without

hermeneutic appreciation” (Westwood & Clegg, 2003, p. 184). Barley and Tolbert (1997) note the top-down dominancy and orientation in institutional theory literature. Weick (2003) further states that “institutionalists are faulted for positing free-floating reified social facts that mysteriously constrain what people do and mean” (p. 191). In essence, institutional theory is criticized for its apparent inability to explain factors such as interests, power, agency, and organizational change. In like fashion, sensemaking and enactment have been criticized as lacking in “context, agency, structure, and mediated causality” (Jennings & Greenwood, 2003, p. 203). Since institutional theory is largely derived and developed from the field of sociology, the spectrum of this view has a macro vantage. In similar fashion, sensemaking is built from the field of psychology and, therefore, contains a micro orientation. In order to perform at the organizational meso level, the sociology and psychology must harmonize. Therefore, the necessity seems to exist to facilitate a “rapprochement” (Westwood & Clegg, 2003, p. 184) between the two theory bases, even if only on limited segments.

Whereas sensemaking is more micro in focus and predominately based at an individual level, institutionalism is primarily macro in orientation with interorganizational basis. Whereas both theories work with feedback loops, sensemaking operates in a much briefer model providing the ability to adapt and enact on a more expedited fashion. Whereas sensemaking is based on a relativistic individual basis, institutional theory recognizes the necessity and benefits of organizational values.

Institutionalism recognizes the importance of a value base in an organization. However, the process of ongoing value-based infusion at an individual level appears to



be lacking. DiMaggio and Powell (1983) write: “The theory of isomorphism addresses not the psychological states of actors but the structural determinants of the range of choices that actors perceive as rational and prudent” (p. 149, footnote 5). This isolated examination without significant consideration for the “actor” is problematic unless one can guarantee that the “actor” will always follow the institutional script.

Jennings and Greenwood (2003) flatly state that “enactment and institutional theory can never be completely combined” (p. 203). While this statement may be correct, it does not suggest that *components* of the two theories cannot exist in harmony. While this analysis might suggest incompatible polarity in the whole between sensemaking and organizational theory, the paradox for Seventh-day Adventist healthcare is that the preservation of its confessional identity will likely require a rapprochement of these theories at some level. According to cognitive dissonance theory, in order to fully and productively function, the behavior of the organization must be in consonance with its stated values. The value basis of Seventh-day Adventist healthcare has to inform the sensemaking paradigm in order for the leaders and employees to enact the stated organizational mission and purpose. As demonstrated in the higher education corollary, a short feedback loop is necessary to prevent the atrophy of the confessional identity that was not discovered by the university Board of Directors for 10 years, by which time it was far too late. However, the individual cannot be allowed to enact their own individual relativistic interpretation without an institutional value compass.

For an institution to preserve its confessional identity, current behaviors and actions must align with the stated core convictions. People will make sense of their environment and enact their plausible understandings on the given situation. If there is dissonance between an organization's confessional identity and the ongoing sensemaking of an organization's leaders and employees, the dissonance will likely be resolved by compromising the confessional identity.

While at first glance the relativistic platform of sensemaking seems incongruous with the valued principle basis of institutional theory, it would seem feasible to take aspects from both theories in order to create a *structured sensemaking* model. The premise of this model draws on the positive mechanistic aspects of institutionalism with the organic approach of sensemaking in order to proliferate the values of an organization but also to embed sensemaking at an individual level to secure that an organization is able to protect the confessional identity into the future. It is not sufficient to simply create institutional statements of values, it is also necessary that these values are understood and enacted by the "actors" within the organization. Meyer and Rowan (1977) write, "Institutionalization involves the processes by which social processes, obligations, or actualities come to take on a rulelike status in social thought and action" (p. 341). Meyer and Rowan argue that structures that are created by rationalized myths may not buttress the practical activity necessary to maintain institutional values. Therefore, "a stable solution is to maintain the organization in a loosely coupled state" which may be "at odds" (p. 360).

According to Pfeffer (1982), traditions such as confessional identity provide some of the most interesting content for sensemaking as well as a point of linkage with institutional theory (p. 239). Shils (1981) describes tradition as something that was created, was performed or believed in the past, or believed to have existed or to have been performed or believed in the past, and that has been or is being handed down or transmitted from one generation to the next (pp. 12-13). To qualify for tradition status, a pattern must be handed down at least twice over the course of three generations (p. 15).

The continued sustenance of the Seventh-day Adventist confessional identity tradition will require the rapprochement of the macro mechanistic value systems of institutional theory with the micro level enactment of sensemaking in order to ensure that ongoing challenges and dissonance will be resolved consistent with core values. In essence, institutional theory must provide the context and values not only at the organizational level but also to the individual to ensure that the organizational confessional identity can be preserved. The organic processes of sensemaking must be mechanized beyond the individual through institutionalistic means in order to create alignment between stated purpose and daily activity. The rapprochement of these two theories provides the lens by which this study is to be viewed.

## CHAPTER THREE

### METHODOLOGY

#### **Introduction and Research Questions**

The purpose of this chapter is to outline the procedures utilized in obtaining the data for this study. The methodology and data are collected in order to study the research questions and associated propositions as restated herein:

1. What are the theological and philosophical core convictions that comprise the Seventh-day Adventist health message?
2. To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?

The four corresponding null hypotheses to the second research question are as follows:

Null Hypothesis 1: There is no difference between senior leaders, middle management, and employees' perceptions across the six core convictions.

Null Hypothesis 2: There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

Null Hypothesis 3: There is no difference between religious groups across the six core convictions.

Null Hypothesis 4: There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

The research questions are set on the backdrop of the following propositions that were explored in this study:

1. For an organization to preserve its confessional identity, current actions must align with the stated core convictions. If misalignments or gaps exist between the stated core convictions and current practice, a dissonance exists. To bring consonance, either current practice will be brought into alignment or the core convictions will be compromised, which may jeopardize the confessional identity.

2. Institutionalism in and of itself cannot guarantee ongoing compliance to the confessional identity. Despite institutional qualities, individuals will enact their plausible interpretations by means of the sensemaking paradigm.

The chapter begins with a discussion of the overall mixed-methods research strategy. Following this general discussion, the remainder of the chapter will be segmented into two sections. The first section will explore the qualitative aspects of this research and in particular will discuss the following: (a) strategy, (b) research questions, (c) the population and sample, (d) data-gathering instruments, and (e) the plan for analyzing the data. The second section will explore the quantitative aspect of this research and likewise will discuss the following: (a) strategy, (b) research questions, (c)

the population and sample, (d) data-gathering instruments, and (e) the plan for analyzing the data. The chapter will then conclude with a discussion regarding overall reliability, validity, and generalizability.

### **Overall Research Strategy**

This study utilized a “mixed methods” approach in which qualitative and quantitative research methods are conducted in a single study to understand a complex phenomenon or issue (Creswell, 2003; Tashakkori & Teddlie, 1998, 2003). A mixed-methods approach was determined to be the most appropriate due to its exploratory nature, the grounding of the research questions within a particular set of theoretical assumptions, and the opportunity to combine complementary methods that would address the research questions most fittingly.

At one point, many researchers subscribed to the “Incompatibility Thesis,” which states that quantitative and qualitative paradigms cannot coexist. In spite of this thesis, the mixed-method field has grown in significance and acceptance. The fundamental principle of mixed research is to collect multiple sets of data or a combination of methods to create a mixture that has “complementary strengths” and “nonoverlapping weakness” (Johnson & Christensen, 2004, p. 411). Onwuegbuzie and Teddlie (2003) boldly assert that “mixed method data analyses offer a more comprehensive means of legitimating findings than do either qualitative or quantitative data analyses alone by allowing analysts to assess information from both data types” (p. 355).

From a philosophical standpoint, mixed-methods research is based on pragmatism which Onwuegbuzie and Johnson (2004) define as the “search for workable solutions in

the practice of research” (p. 10). In coining the term “pragmatism,” Charles Pierce of Harvard University established the basic tenet that “the meaning, truth, or value of an idea depends on the practical results of its use” (Stevenson, 2002, p. 210). In consideration of the diverse, expansive, and practical nature of the research questions detailed in this study, the mixed-method philosophy would seem to correspond appropriately.

In particular, a “sequential exploratory strategy” (Creswell, 2003, pp. 215-216) was the research design. As described by Creswell, the sequential exploratory strategy is a two-phased approach wherein the initial phase will feature the collection of qualitative data and analysis that will subsequently be utilized to develop a questionnaire to be administered in the quantitative phase. Within this strategy, the priority was given to the qualitative aspects of the study. Creswell affirms that “the primary focus of this model is to explore a phenomenon” (p. 215). Stated succinctly by Johnson and Christensen (2004), “if the purpose is development, then a sequential design is needed” (p. 424).

### **Phase One: Qualitative**

The first phase of this study utilized qualitative methods to collect the research data. This section begins with a personal biography followed by the strategy, research questions, the population and sample, data gathering instruments, and how the data were analyzed.

Merriam (1998) states that “qualitative research is designed to inductively build rather than test concepts, hypothesis, and theories” (p. 45). One of the distinctive attributes of qualitative research is the relationship of “*self as an instrument*” (Eisner,

1998, p. 33, italics in original). By this statement, Eisner defines the role of the researcher as one who “engages the situation and makes sense of it” (p. 34). There is an interesting connection between Eisner’s description of qualitative research and the sensemaking theory base previously discussed.

### Personal Biography

Creswell (2003) notes that “one cannot escape the personal interpretation brought to qualitative data analysis” (p. 182). Since the qualitative researcher is actively engaged in interpretation, Marshall and Rossman (1995) suggest that it is appropriate to include a personal biography.

In that spirit, my biography will be shared as it may influence the interpretation of this research data analysis. I am a fourth-generation Seventh-day Adventist having been born to a Seventh-day Adventist ordained minister and to a Registered Nurse who worked the majority of her professional life in Seventh-day Adventist healthcare institutions. In like fashion, my sister is also a Registered Nurse trained in the discipline of Seventh-day Adventist healthcare settings and two brothers who trained for the Seventh-day Adventist ministry. From first grade through college, my education was entirely within the Seventh-day Adventist system, including 8 years within the dormitory setting.

My entire professional career has been spent with Florida Hospital in Orlando, which is the largest Seventh-day Adventist hospital in the world. In 16 years at Florida Hospital, I have served in a variety of capacities from administrative resident, Chief Executive Officer of a 97-bed joint-venture hospital, to my current capacity as Chief



Operating Officer of the Orlando campus. In addition to specific titles and duties, I have also led various germane initiatives such as the Centennial Steering Committee, which studied the ancestry of Seventh-day Adventist healthcare in an effort to create the vision for Florida Hospital's centennial celebration scheduled to occur in 2008.

The resounding message from this biography is that I have had significant experiential influences throughout my life that contribute a personal insight and fervor to Seventh-day Adventist healthcare. The historical literature, review of the official Church guidelines, scholarly papers, and one-on-one interviews with my colleagues are very comfortable terrain. That being said, I will endeavor to allow the voice of those interviewed, the voice of those in the literature, and the voice of the scholars to speak for themselves. Clandinin and Connelly (2000) assure that "voice, and dilemmas created by the consideration of it, are always sorted out by the exercise of judgment" (p. 147). As such, I will use my best judgment to allow each participant to speak for themselves without abdicating my responsibility as the qualitative researcher.

### Strategy

The qualitative phase was comprised of four complementary and reinforcing activities. The activities include a historical analysis of Seventh-day Adventist healthcare through published literature. The official Seventh-day Adventist published guidelines for healthcare institutions were also explored. In addition, qualitative inquiry through one-on-one interviews were performed with 11 seasoned Adventist healthcare administrators to explore their experiences and perspectives on the confessional identity

and core convictions based on their vast experiences within the Seventh-day Adventist healthcare arena.

The fourth and final input to the qualitative aspect of this research is the commission of four original “white paper” manuscripts based on current research by some of the foremost contemporary scholars of the Seventh-day Adventist Church. These white papers were authored by Fritz Guy, Ph.D., of LaSierra University, Richard Rice, Ph.D., of Loma Linda University, Alden Thompson, Ph.D., of Walla Walla College, and Harold Koenig, M.D., of Duke University. The papers were presented at a Centennial Visioning Retreat on March 5 and 6, 2004, at Celebration, Florida, to the senior leadership of Florida Hospital.

Guy (2004) authored a paper based on the following inquiry: What are the philosophical and theological underpinnings that define faith-based healthcare? What are the essential elements of a faith-based provider?

Rice (2004) authored a paper based on the following inquiry: What are the core convictions of Adventist healthcare? What are the unique contributions that Adventist theology can contribute to a model of healthcare (defined as promoting health and providing care) in the 21<sup>st</sup> century?

Thompson (2004) authored a paper based on the following inquiry: Are there enduring values within our heritage that can sustain Seventh-day Adventist healthcare? How can we keep the heritage of Adventist doctrine and belief vibrant in the context of technological and sociological changes of the 21<sup>st</sup> century?

Koenig (2004) presented a summary of the research that has either been completed or is in process to give perspective on the following inquiry: How should the whole-person healing ministry of Christ inform and challenge Florida Hospital's operations today?

### Research Questions

The purpose of the qualitative analysis is to explore and describe the core convictions as contemplated in the first research question, which reads:

1. What are the theological and philosophical core convictions that comprise the Seventh-day Adventist health message?

### Population and Sample

Onwuegbuzie (2003) puts the issue of qualitative sample size in perspective by stating, "Just as quantitative researchers hope that their sample size is representative of the population, qualitative researchers hope that the sample of words is representative of the truth space" (p. 400). Stated succinctly, in qualitative analysis the issue is to ensure the correct population is queried who are able to proffer the representative insight of the "truth space." In the initial phase of research, a purposive sample of 11 individuals was selected and interviewed based on their personal experience and commitment to Seventh-day Adventist healthcare. Criteria for the subjects included in the study were Seventh-day Adventist members who have served in a leadership role(s) within a Seventh-day Adventist healthcare institution(s) for at least 20 years.

At least 2 weeks prior to the interview, each participant received a packet of information including a copy of the “Research Protocol,” “Informed Consent Form,” and “Research Questions,” which are attached in Appendix A. These same forms were submitted, reviewed, and approved by the Institutional Review Board (IRB) of Andrews University. The “Informed Consent Form” was signed by the participant and collected prior to each interview.

### Data-Gathering Instruments

In the first phase of research, four qualitative research techniques were employed, including historical literature review, review of the official Church guidelines for healthcare institutions, personal interviews, and the commission of original scholarly research. The interviews were conducted one-on-one and face-to-face. The objective of this phase, for all four separate techniques, was to establish a clear understanding and statement articulating the confessional identity and core convictions of Seventh-day Adventist healthcare.

Since this research involved human subjects, appropriate review and approval was obtained by the IRB of Andrews University prior to the interviews being conducted. The following four questions as approved by the IRB were utilized in the personal interviews and for the scholarly papers:

1. What are the essential elements of a Seventh-day Adventist hospital?
2. Are there enduring values within our heritage that can sustain Seventh-day Adventist healthcare? How can we keep the heritage of Adventist doctrine and belief vibrant in the context of technological and sociological changes of the 21<sup>st</sup> century?

3. What are the unique contributions that Adventist theology contributes to healthcare institutions?
4. How should the whole-person healing ministry of Christ inform and challenge Florida Hospital's operations today?

The interview and the scholarly presentations were audiotaped and a verbatim transcript was subsequently produced. In addition, actual transcripts of the scholarly papers were rendered by the authors.

#### Plan for Analyzing Data

Merriam (1998) describes qualitative data analysis as “the process of making sense out of the data” (p. 178). It is through this process of analysis that “categories and patterns emerge from the data rather than being imposed on data prior to data collection” (McMillan & Schumacher, 2001, p. 462). Creswell (2003) describes this coding process as organizing the data into chunks of material with specific meanings (p. 192).

In the qualitative phase, the interviews were recorded and transcribed verbatim to ensure data integrity. As an additional measure of intention, each of the interviewees was provided a copy of the transcript for their review and approval. Each of the interviews was then coded for meaning to capture the individual responses. The process of coding categorized common themes together, allowing associations and patterns to emerge from the data. Tashakkori and Teddlie (1998) developed the concept of *quantitizing* which involves converting qualitative data into numerical representations with the data (as cited in Johnson & Christensen, 2004, p. 425). The purpose of quantitizing is to prevent “overweighting” or “underweighting” the evolving themes.

Sandelowski (2001) further states that in reducing qualitative data to categories or themes, the researcher is using the “numbered nature of phenomena for their analysis” (p. 231).

The most significant statements from the interviews are placed in a grid to show the frequency of responses proffered for the various articulated core convictions. Based on the frequency of similar responses, emerging themes were triangulated between the interviews to determine the most significant convictions. Each interview transcript was coded on three separate occasions to ensure that the individual integrity of the responses was maintained while also decompressing the responses into “meaning codes” and ultimately into “emerging themes.”

In a similar analysis conducted with the interviews, the scholarly papers were analyzed and coded for meaning. For each of the corresponding questions, a grid was created for each of the scholarly papers recording the specified core convictions. The emerging themes from the scholarly papers are overlaid with the interview grid to determine similarities and differences. This analysis offers another opportunity to triangulate between the interviews and the scholarly papers to determine the significant emerging themes.

The themes from the interviews and the scholarly papers were then compared with the existing historical literature. This literature considers both the founding values of the church in antiquity, as well as the current articles of belief. Through this historical literature review, the emerging themes are tested for accuracy, completeness, and appropriate articulation.

## **Phase Two: Quantitative**

The first phase of this study utilized qualitative methods to determine the core convictions of Seventh-day Adventist healthcare. The second phase of this research builds from the core-conviction attributes collected from the qualitative inquiry to develop a questionnaire exploring the levels of engagement with these core convictions among the leaders, middle managers, and employees at Florida Hospital. This section begins with the strategy, followed by the research questions, the population and sample, data-gathering instruments, and the plan for analyzing the data.

### **Strategy**

The second phase of this research utilized the core convictions and specific attributes of those core convictions defined through the qualitative research phase to determine the alignment and/or gaps in actual practice at Florida Hospital. This is accomplished through the administration and quantitative analysis of the data produced through a questionnaire. This questionnaire was administered at Florida Hospital in Orlando, Florida, from January 30 through February 20, 2006, through an electronic survey. The results are segmented by senior leadership, middle management, and employees at Florida Hospital. Further analysis is segmented “Seventh-day Adventist” members, “Protestant Christian,” “Roman Catholic,” “Other,” and “None.” In addition, analysis was conducted to differentiate between the cognitive, behavioral, and affective components of each of the core convictions.

## Research Questions

The purpose of the quantitative analysis was to determine and describe the second research question, which is:

2. To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?

The four corresponding null hypotheses to the second research question are as follows:

Null Hypothesis 1: There is no difference between senior leaders, middle management, and employees' perceptions across the six core convictions.

Null Hypothesis 2: There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

Null Hypothesis 3: There is no difference between religious groups across the six core convictions.

Null Hypothesis 4: There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

## The Population and Sample

To access the names of individuals to receive a questionnaire, an electronic file of all senior leaders, middle managers, and employees with 5 or more years of service was provided by the Human Resources Department at Florida Hospital. The list was reviewed and altered to remove any known biases such as those individuals involved in



the development of the survey. Also excluded were individuals being carried on the Human Resources system but who are no longer actively involved at Florida Hospital. The faculty and leadership at the Florida Hospital College of Health Sciences were also excluded since they are not technically involved in the ongoing operations of Florida Hospital.

After altering the list, the names were manipulated into the format that Microsoft Outlook would recognize since many times the legal name in the Human Resources system is different from the preferred name listed in Outlook.

The entire population of 43 senior leadership individuals was provided a questionnaire. Senior leadership is defined as those individuals at Florida Hospital who are members of the President's Council. By title, these individuals hold positions, or equivalent positions, as President, Executive Vice President, Senior Vice President, Vice President, Associate Vice President, and Assistant Vice President. Although I personally qualify for this category, my name along with Sy Saliba, Ph.D., as a dissertation committee member, and Josef Ghosn, Ed.D., who assisted in the development and analysis of the questionnaire, were eliminated from the list in order to protect the integrity of the data. The response rate for this segmented group was 95% ( $n = 41$ ).

The entire population of middle management was also provided a questionnaire. Middle management are those individuals who attend Leadership retreats and are not senior leaders as previously defined. Within the Florida Hospital Human Resources system, these individuals are in a position of grade 70 and higher. By title, these individuals hold positions, or equivalent positions, as Administrative Director, Director,

Assistant Director, and Nurse Manager. The population in this category is 292 individuals. The response rate for this segmented group was 74% ( $n = 215$ ).

A random sample of 1,000 employees who have at least 5 years of employment with Florida Hospital was also provided a questionnaire. Those employees identified as senior leadership and middle management were excluded from this category. The 5-year criterion is necessary to ensure sufficient exposure to Florida Hospital and Seventh-day Adventist healthcare. A random number was assigned to each of the 6,265 employees who met the 5-year criteria. The employees were ranked based on their random number, and the sample was selected in numerical order. From the randomized list, the names were matched against the Florida Hospital Outlook system. In total, 1,304 random names were tested in Outlook to ultimately create a distribution list of 1,000 employees. The response rate for this segmented group was 40% ( $n = 397$ ), which is sufficient representation for a 95% confidence level with a 5% margin of error.

The faith backgrounds included in the analysis are Protestant Christian ( $n = 272$ ), Seventh-day Adventist ( $n = 173$ ), Roman Catholic ( $n = 153$ ), No Religion ( $n = 35$ ), and Other Religion ( $n = 15$ ). Within the survey, those who chose Other Religion were given the opportunity to type in their specific religious faith. Such added phrases as Baptist, Born Again Christian, Christian, Episcopal, Evangelical, Lutheran, Methodist, Non-Denominational Christian, and Southern Baptist were reclassified to "Protestant Christian." Those who remained in the Other Religion include Judaism ( $n = 5$ ), The Church of Jesus Christ of Latter-day Saints ( $n = 4$ ), Buddhist ( $n = 2$ ), Hindu ( $n = 1$ ), Jehovah's Witness ( $n = 1$ ), Quaker ( $n = 1$ ), and Rastafarian ( $n = 1$ ).

### Data-Gathering Instrument

As recommended by Dillman (2000), a number of techniques were utilized in the development of the questionnaire and methodology to reduce sampling error, measurement error, and non-response error. The population chosen to receive a questionnaire was selected to reduce sampling error. A respondent-friendly questionnaire was developed through the use of pre-sampling and focus groups to ensure appropriate understanding of word content and meaning to reduce measurement error. Four points of contact, including a pre-notice letter, the questionnaire, reminder letter, and thank-you letter, were electronically sent to each participant to reduce a non-response error. A total of 3 weeks was allowed for survey completion.

The research tool is an original survey instrument formulated from the core convictions and attributes of those core convictions as fully developed in chapter 4. The questionnaire was developed through a series of reviews and testing. At first, face validity was tested with the market research team at Florida Hospital. Following this exercise, selected individuals were asked to review the questionnaire and then interviewed to determine levels of understanding to determine alignment with intent. Once the survey instrument passed these rigors, six employees completed the survey with subsequent analysis of the data to determine survey performance. The questionnaire was then reviewed and approved by the Dissertation Committee and thereafter submitted to and approved by the Andrews University Institutional Review Board (IRB) and the Florida Hospital IRB for approval to use on human subjects.

The questionnaire is formatted around the six core convictions starting with a definition of that specific core conviction followed by a series of statements. The survey participants then rated their level of agreement with those statements based on a Likert scale from (1) Strongly Disagree, (2) Disagree, (3) Undecided, (4) Agree, (5) Strongly Agree with the option to select (N/A) for Unknown. The questionnaire gathered only basic demographic information pertinent to this research, including years of service and religious faith background.

Embedded within each of the core conviction sections are specific questions probing the cognitive beliefs (18 questions), behaviors (17 questions), and emotional attachment (9 questions). An index is provided in Table 1 to link the individual survey questions to their cognitive, behavioral, and affective dimension.

Table 1

*Questionnaire Index to Cognitive, Behavioral, and Affective Questions*

Core Conviction	Cognitive	Behavioral	Affective
Wholeness	Questions 1, 2	Questions 3, 4	Questions 5, 6
Healing Ministry	Questions 1, 2	Questions 3, 4	Questions 5, 6
Health Principles	Section 3, Questions 1 - 8	Section 4, Questions 1 - 8	—
Honor SDA Beliefs	Questions 1, 2	Question 3	Questions 4, 5
Image of God	Questions 1, 2	Questions 3, 4	Question 5
Community	Questions 1, 2	Questions 3, 4	Questions 5, 6

The questionnaire was administered between January 30 and February 20, 2006, online utilizing the Zoomerang ([www.Zoomerang.com](http://www.Zoomerang.com)) online platform. A copy of the questionnaire is provided in Appendix B.

### Data Analysis

The quantitative phase of this study involved a descriptive analysis of the data utilizing the Statistical Package for Social Science (SPSS) computer software to compute the mean, standard deviations, probability testing utilizing ANOVA, and post hoc analysis as necessary. For post hoc analysis purposes, Tukey's Honestly Significant Difference (HSD) test is utilized when equal variances are determined and Tamhane's T2 is utilized when equal variances are not determined. To ensure accuracy of the post hoc analysis, the results of the Tukey HSD were checked against the results of the Ryan-Einot-Gabriel-Welsch Range when equal differences were determined and Tamhane's T2 was verified by testing with the Games-Howell post hoc where unequal variances were determined. The determination of statistical significance was the same regardless of post hoc technique utilized.

For each ANOVA, the effect size for each variable available through SPSS is the partial eta squared ( $\eta_p^2$ ). For interpretive purposes in this research, the guidelines established by Green and Salkind (2004) are used wherein 0.01 is a small effect, 0.06 is a medium effect, and 0.14 is a large effect.

The data were analyzed and are presented by core conviction according to positional levels to determine if any differences exist between the segmented groups.

The data are also considered according to religious affiliation, and are also differentiated between the cognitive, behavioral, and affective dimensions.

If a respondent selected either N/A or left a question blank, a score of 9 was assigned and was given a missing data value so that it would not be added to the scoring on the 5-point Likert scale. Therefore, the sample size on some questions was different even among the same population and group. Across the entire population, the range of N/A and/or blanks per question ranged from 0 (on two questions) to as high as 29 (on three questions).

### **Reliability**

Merriam (1998) defines reliability as “the extent to which research findings can be replicated” (p. 205). The difficulty with reliability in the social sciences is that “human behavior is never static” (p. 205). The assumption underlying perfect reliability is that there is a single fixed reality that will result in identical findings in multiple studies. In dealing with social sciences, this is a problematical assumption. For this reason, Merriam suggests that a different standard apply to the social sciences. In particular, she suggests that, given the same data, an independent researcher would conclude the same results thereby creating a level of consistency and dependability (p. 206). Therefore, for the purposes of the qualitative research, the interviews and scholarly papers are available in verbatim transcript for independent review. Because this study is of great interest to Florida Hospital, multiple individuals and collective groups have reviewed and interacted with the data on a variety of occasions. Although the ultimate

findings are reflective of myself as the researcher, the findings have certainly been influenced by a confluence of perspectives and reviews.

As it relates to the reliability of the questionnaire, Cronbach's alpha was utilized to determine the correlation between the individual questions within a given core conviction construct. According to Nunnally (1978), psychometric instruments with an alpha of 0.70 or higher demonstrate sufficient reliability. In evaluating the entire survey, the alpha was 0.93, demonstrating whole scale reliability. As shown in Table 2, the alpha for each of the six core conviction constructs ranges from 0.76 to 0.87, demonstrating reliability for each of the core convictions.

Table 2

*Core Conviction Means, Standard Deviations, and Reliability Indices*

Core Conviction	Number of Items	<i>N</i>	<i>M</i>	<i>SD</i>	Alpha
Wholeness	6	609	3.99	0.97	0.79
Healing Ministry	6	612	4.32	0.89	0.83
Health Principles	16	596	4.42	0.82	0.87
Honor SDA Beliefs	5	612	4.17	0.92	0.81
Image of God	5	623	4.2	0.98	0.79
Community	65	604	4.15	0.94	0.76

As demonstrated in Table 3, when the questions are isolated by those testing cognitive, the alpha is 0.87, the behavioral is 0.85, and the affective is 0.84, demonstrating reliability for each of the three constructs.

### Validity

Eisner (1998) writes, “One of the persistent sources of difficulty for those using qualitative methods of research and evaluation pertains to questions about the validity of their work” (p. 107). The “validity of qualitative design is the degree to which the interpretation and concepts have mutual meanings between the participants and the researcher” (McMillan & Schumacher, 2001, p. 407).

Table 3

*Means, Standard Deviations, and Reliability Indices for Cognitive, Behavioral, and Affective Constructs*

Construct	Number of Items	<i>N</i>	<i>M</i>	<i>SD</i>	Alpha
Cognitive	17	561	4.55	0.65	0.87
Behavioral	18	565	4.04	0.96	0.85
Affective	9	624	4.11	0.96	0.84

Johnson and Christensen (2004) state, “In mixed research, you will need to establish the trustworthiness of your data by demonstrating evidence of a combination of these validity types” (p. 426). One such validity type is data triangulation, which “uses



multiple sets of data to cross-validate and corroborate findings” (p. 426). To increase the level of validity within this study, the qualitative phase utilized multiple triangulation techniques. Four separate qualitative data sources were utilized in defining the core convictions of Seventh-day Adventist healthcare including the most recent publications of the General Conference of Seventh-day Adventists, a historical review of the literature, the commission of four scholarly papers, and 11 interviews with seasoned hospital administrators.

Many additional techniques were utilized to increase the validity of this research. Eleven interviews were conducted rather than a small handful, thereby increasing the quality of inputs. The same questions used in the interviews were also utilized in the commission of the scholarly “white papers.” The scholarly papers were then evaluated and rebutted by an administrative member of Florida Hospital. The transcripts of the interviews and the scholarly white papers were coded and then evaluated against existing literature to ensure high levels of validity.

In addition, Merriam (1998) suggests the use of member checks, which involves “taking data and tentative interpretations back to the people from whom they were derived and asking them if the results are possible” (p. 204). Since the interviews were conducted with my colleagues at Florida Hospital who share a significant interest in this research topic, the interview data have been shared, confirmed, and discussed on multiple occasions and settings. The result of these interactions has brought further clarity and a furtherance of the data validity.

Based on the qualitative methodology as herein described, the validity of the questionnaire comes from the construction of the instrument. Since the questionnaire builds on the core convictions and specific attributes as defined from a triangulated qualitative methodology, the survey is a product of that validity.

### **Generalizability**

“The question of generalizability has plagued qualitative investigators for some time” (Merriam, 1998, p. 207). Eisner (1998) defines generalization as “transferring what has been learned from one situation to another” (p. 198). As stated in the delimitations, the results of this research have not been approved by any official church entity. Although outside the scope of this study, the true test of generalizability would be the official adoption of the confessional identity and core convictions within the Adventist Health System. In the absence of official adoption, the rigorous methodology employed should provide sufficient comfort that the findings of this study could be generalized to Seventh-day Adventist healthcare at large.

Based on the questionnaire methodology and results, the generalizability of the survey results can be ascertained across Florida Hospital. Within the confines of 95% confidence interval with margins of error of 5% for employees, the results of this survey can be generalized across the full population at Florida Hospital.

## CHAPTER FOUR

### QUALITATIVE RESULTS

#### **Introduction**

In this chapter, the findings of the qualitative research are explored and detailed. The purpose of this qualitative inquiry is to explore and describe the core convictions as contemplated by the first research question, which queries: “What are the theological and philosophical core convictions that comprise the Seventh-day Adventist health message?” To accomplish this, four separate sources of information are considered and processed. The first source considered is the historical literature and the events in connection with the establishment of the Seventh-day Adventist health message. Next, the official published guidelines from the General Conference of Seventh-day Adventists outlining principles for healthcare institutions are reviewed. The next two sections highlight the Seventh-day Adventist core convictions as explored in original commissioned scholarly papers and insights from one-on-one interviews with 11 seasoned Seventh-day Adventist healthcare administrators. With reflection from all the various sources contemplated, a synthesis of the most salient and fundamental core convictions of the confessional identity of Seventh-day Adventist healthcare is presented.

The chapter concludes with a reflection of these core convictions within the context of institutional and sensemaking theory.

### **Historical Sketch of Seventh-day Adventist Health**

Although significant detailed accounts exist outlining the historical events and circumstances leading to the establishment of the Seventh-day Adventist health message (Johns & Utt, 1977; Reid, 1982; Robinson, 1965; Schaefer, 1977; Schwarz, 1970; Van Dolson & Spangler, 1975; Walton & Nelson, 1948), for the purposes of this study, an abbreviated historical sketch is provided in order to supply the necessary context and perspective to ascertain the core convictions of Seventh-day Adventist healthcare. This historical sketch frames the health issues prior to 1866, the health visions of Ellen G. White, a vignette on the Battle Creek Sanitarium, and then a summary of the originating health principles.

#### **Health Issues Prior to 1866**

To fully appreciate the establishment and development of the first Seventh-day Adventist health enterprise in 1866, it is important to understand the environmental health conditions during this time. At the turn of the 19<sup>th</sup> century, the understandings of health and healing were primitive at best and many times the prescribed remedies were harmful. The philosophy in this age of uncertainty was that “a doubtful remedy is better than none at all” (Schaefer, 1977, p. 6). The prevailing care plan was “heroic medicine,” which assumed that any active therapy that produced a gross change in symptoms was affecting the disease itself (Reid, 1982, p. 29). Unfortunately, this theory was lacking in

scientific validity and many people with minor ailments suffered as a result. George Washington, the first President of the United States of America, was literally bled and drugged with calomel resulting in his death in a vain attempt to cure a case of laryngitis (Johns & Utt, 1977).

The physicians of the day could obtain a Medical Doctor degree in as little as 6 months of “training.” Drugs such as mercury and opium were considered among the most important remedies available and were not regulated by any governmental or scientific body. In 1850, the average American life span was 39.4 years with 17% of newborns failing to reach their first birthday (Schaefer, 1977).

As the Seventh-day Adventist Church was being developed, one of the pragmatic motivations for a health focus was that many times a majority of ministers and executive members was unavailable for service due to illness (Robinson, 1965). James White, the first President of the General Conference of Seventh-day Adventists, suffered a series of strokes that prevented his full participation in the administration of the newly developing church.

Given the dire health status and dearth of wholesome alternatives, a variety of health reformers emerged. Three particular hydropathic physicians had a significant influence on the Seventh-day Adventist health movement. Although not Seventh-day Adventists themselves, Drs. Joel Shew, James C. Jackson, and Russell T. Trall each offered specific perspectives in addition to hydrotherapy, which were ultimately incorporated into the Seventh-day Adventist health message. Shew placed special emphasis on a vegetarian diet and abstinence from drugs, tobacco, tea, coffee, grease, and

fats. Jackson stressed adherence to natural law. Trall taught that the state of the mind has significant influence over the body. Trall also taught that abundant fresh air, light, water, food, temperature, exercise, rest, clothing, ablutions, and controlled mental states were fundamental to a healthy existence (Reid, 1982). While these teachings are widely held today, at the time these teachings were foreign and radical.

In *How to Treat the Sick Without Medicine*, Dr. James C. Jackson outlines many of the health principles that were consistent with the health visions of Ellen G. White and would ultimately be officially adopted by the Seventh-day Adventist church. Jackson writes: “I have used in the treatment of my patients the following substances or instrumentalities: first, air; second, food; third, water; fourth, sunlight; fifth, dress; sixth, exercise; seventh, sleep; eighth, rest; ninth, social influence; mental and moral forces” (as cited in Robinson, 1965, p. 34). James and Ellen White visited Jackson’s water cure treatment center in Dansville, New York, on two prolonged occasions.

Another health reformer who had significant impact on the development of the Seventh-day Adventist health message was Sylvester Graham who is credited with ultimately changing the eating habits of America. Graham, a Presbyterian minister, advocated a return to the “natural way” of health and diet (Reid, 1982, p. 38). As such, Graham was a staunch advocate of a meatless diet and the abstinence of dairy products. Like Jackson, Graham advocated rest, exercise, water, proper dress, but also advocated cleanliness, sleeping in well-ventilated rooms, and eating only two meals per day (Numbers, 1992). It was Graham’s teachings that most influenced and had the greatest

impact on the Seventh-day Adventist health message due to the comprehensive nature of his message.

#### The Health Visions of Ellen G. White

During her lifetime, Ellen G. White received over 2,000 visions (Schaefer, 1977). While many of these visions contained issues related to health, the major components of the Seventh-day Adventist healthcare message were revealed in five specific visions. In the visions of 1848 and 1854, specific reform measures were outlined. In the vision of 1863, the broad principles of the Seventh-day Adventist health message were revealed. The vision of 1865 provided explicit instruction that the Seventh-day Adventists should develop their own health treatment center, which led to the development of the Western Health Reform Institute. In the vision of 1871, a warning was rendered that the health message as revealed was not being adhered to by the Seventh-day Adventist members. These visions are further detailed in the following paragraphs.

In the autumn of 1848, a vision was given to Ellen G. White that revealed the harmful nature of tobacco, tea, and coffee. A vision in early 1854 revealed the importance of cleanliness and specific issues of diet. In particular, unhealthy rich and greasy foods were to be avoided. Instead, foods with simple, coarse, and wholesome ingredients were to be encouraged (Robinson, 1965, p. 71).

On June 6, 1863, 2 weeks after the official formation of the church, Ellen G. White received a vision that provided an indivisible connection between physical health, spiritual well-being, and holiness. White writes:

I saw that it was a sacred duty to attend to our health, and arouse others to their duty. . . . We have a duty to speak, to come out against intemperance of every kind – intemperance in working, in eating, in drinking, in drugging and point them to God’s great medicine, water, pure soft water, for diseases, for health, for cleanliness, for luxury. I saw that we should not be silent upon the subject of health, but should wake up minds to the subject. (as cited in Reid, 1982, p. 102)

Health was clearly expressed to be a religious duty at both the individual and institutional level. The church was charged with “the duty to speak” against all manner of violations to health and to promote the natural laws of health in order to prevent illness and disease. In one of the most famous quotations from Ellen G. White (1948a), she affirmatively declared in 1867: “The health reform, I was shown, is a part of the third angel’s message and is just as closely connected with it as are the arm and hand with the human body” (p. 486). The “third angel’s message” is a reference to Rev. 14:9-10, which is a fundamental Seventh-day Adventist doctrine announcing the eventual second coming of Jesus Christ. Given this religious duty, the health message became central to the fabric of the church mission. In essence, the life of Christ was a healing ministry. In like fashion, the work of the Seventh-day Adventist church is a gospel that recognizes the intrinsic relationship between health, healing, and holiness.

Based on the vision of 1863, the Adventist believers began to appreciate health reform as integral to the third angel’s message announcing the return of Jesus Christ. Equipped with this new understanding, any transgression of the health principles was viewed as a violation of the natural law and would have a direct impact on one’s spirituality. In essence, health was elevated to a sacred duty in this third and decisive vision. Health became a critical duty in preparation for the second coming of Christ.



Toward this purpose, the vision of 1865 revealed that the Seventh-day Adventist believers should develop the necessary institutions to carry this health reform message to not only Seventh-day Adventists but to the entire world. In the words of Ellen G. White (1948a):

Our people should have an institution of their own, under their own control, for the benefit of the diseased and suffering among us, who wish to have health and strength that they may glorify God in their bodies and spirits which are His. Such an institution, rightly conducted, would be the means of bringing our views before many whom it would be impossible for us to reach by the common course of advocating the truth. (pp. 492-493)

The vision in 1871 further emphasized the importance of the health message to the third angel's message and the preparing of a people for the second advent of Christ. The necessities of correct health habits were further punctuated by White as she writes, "It is impossible for men and women, with all their sinful, health-destroying, brain-energating habits to discern sacred truth" (White, 1948b, p. 162). Further and specific guidance was provided that the Western Health Reform Institute's purpose was "to relieve the afflicted, to disseminate light, to awaken the spirit of inquiry and to advance reform" (White, 1948b, p. 165).

These health visions outlined the fundamental framework for the Seventh-day Adventist health message and provided the impetus to create health-related institutions. Beginning in 1863, Ellen G. White spoke widely on the topic of health and wrote prolifically on the subject in various books, articles, and pamphlets. However, it was in 1905 that White's (1942) quintessential work on health entitled *The Ministry of Healing* was published. The theme of *The Ministry of Healing* centers on the life of Christ and how the "Great Physician" and "Master Healer" devoted more time to healing than any

other activity. In healing, Christ focused on the wholistic health of an individual to include physical, mental, and spiritual matters in an effort to provide full restoration to a person. This book was written to provide direction and counsel to physicians, caregivers, and health educators on how the example of Christ focused on improving the status of the community of people around Him. In healing, the responsibility is not only to heal the immediate physical issues but to also educate the health principles necessary to stay well. Even though White signed a personal loan to fund the publishing for this book, all proceeds were pledged to the fledgling sanitariums to pay down their debt.

Although Ellen G. White is clearly regarded as the predominant leader in the development of the Seventh-day Adventist health message, there was a general health reform movement occurring throughout the United States of America and Europe. Based on exhaustive research, Numbers (1992) claims that the health principles as recorded by Ellen G. White were not original inspired works but rather were adaptations from the works of Drs. Shew, Jackson, and Trall. While some may argue that the reliability of the Seventh-day Adventist health message hinges on the debate of originality and inspiration, the purposes of this research do not require a resolution of this debate. Even if Numbers's assertions are valid, the themes that are explored within this paper can ultimately be traced to biblical sources or are reflections of natural law that have been verified through scientific research. The Seventh-day Adventist health message was clearly stimulated through the "visions" and writings of Ellen G. White and is, therefore, appropriately explored within this paper. However, the focus of this study is to explore the sustenance, transference, and maintenance of the Seventh-day Adventist healthcare

core convictions, thus making the question of originality or inspiration beyond the relevance of this study.

### The Battle Creek Sanitarium

The Western Health Reform Institute opened its doors in Battle Creek, Michigan, on September 5, 1866, with a staff of two physicians, one nurse, three or four helpers, and two bath attendants (Schaefer, 1977, p. 54). John Harvey Kellogg, M.D., joined the staff of the Western Health Reform Institute in 1875. He reluctantly agreed to serve as Medical Director in 1876 for a 1-year appointment, which ultimately lasted for 67 years until his death in 1943 at the age of 91 (Butler, Thornton, & Stoltz, 1994, p. 7).

Kellogg later unilaterally renamed the Western Health Reform Institute to the Battle Creek Sanitarium. The “Battle Creek Idea” that drew thousands to the Sanitarium was “a rational, scientific medical method of health building and training.” Dr. Kellogg brought together “in one place and under unified control, all the resources that modern medical science has developed” to heal the sick and to prevent future illness by educating the guests in the “methods of healthful living” (Butler et al., 1994, p. 10).

The Battle Creek Sanitarium was dedicated to the belief that true health incorporated the whole person, including the body, mind, and spirit as demonstrated through the healing ministry of Christ. A premise that was institutionalized was that every patron and employee was created in the image of God and worthy of the best care available. The Battle Creek Sanitarium provided “the combined features of a medical boarding house, hospital, religious retreat, country club, tent Chatauqua and spa” (Gerstner, 1996, p. 3).

James White was a central figure in the development of the Battle Creek Sanitarium, serving as the Chairman of the Board in addition to his duties as the President of the General Conference. James White was devoted to the pursuit of excellence and insisted that the facilities and services rendered be the best available in the world. Recognizing that the Sanitarium would only be as good as the quality of the physicians who provided service, White hand selected Dr. Kellogg to go through medical school training. While Kellogg initially received his Medical Doctor degree, having completed a 20-week course, he continued his training with an additional year at the University of Michigan and another year at Bellevue Hospital Medical School in New York City, which was regarded as the finest in the country at that time. Kellogg further perfected his skills by traveling throughout the United States and Europe to learn from the most prolific surgeons of the day. During the first 10 years in operation, there were only 10 fatalities among the 2,000 admissions. The level of expertise at the Battle Creek Sanitarium became world renowned. On occasion, physicians would accompany their most difficult patients that they might observe and learn from Dr. Kellogg and the Battle Creek Sanitarium (Robinson, 1965).

Kellogg coined the phrase “biologic living” to sum up the system of healthful living espoused at the Battle Creek Sanitarium. By biological living, Kellogg heavily promoted a vegetarian diet comprised of fruits, vegetables, grains, and nuts. Throughout his life, he promoted the health counsels of Ellen White and the other most sensible health reformers of that era, including the health principles of exercise, sunlight, fresh air, rest, trust in God, and exercise. In an effort to help people stay well and prevent disease,

Kellogg taught obedience to natural law as a moral duty in order to enjoy optimal physical and mental health (Schaefer, 1977, p. 60).

The sanitarium had the reputation of being among the most scientific in the world, both in technique and equipment. Although medications were administered when necessary, the overall health philosophy was an emphasis on a simple natural life and intelligent diet. “The institution’s philosophy was that many diseases are caused by a violation of nature’s laws and that the best way to prevent such disease is to obey those laws” (Schaefer, 1977, p. 58). One of these laws was the human need for rest, which was accomplished through Sabbath observance in which normal sanitarium activities ceased.

In addition to technique and equipment, Kellogg viewed the Battle Creek Sanitarium as a platform for education on the health principles. Every Monday evening, Kellogg entertained the guests by pulling from the “Medical Question Box” and addressing the inquiries of the patrons. Kellogg traveled extensively to speak and was also the editor of several health journals and authored more than 50 books on nutrition and health. The health status of the community was a continual concern and motivation including the establishment of a charity hospital for those unable to afford the services offered at the Battle Creek Sanitarium.

Kellogg was “a lover of innovation” and held numerous patents for the development of nutritional products and exercise equipment. The Battle Creek Sanitarium Equipment Company was founded in 1890. Some of Dr. Kellogg’s exercise equipment was installed in such notable locations as Buckingham Palace and on board the Titanic. Although Dr. Kellogg was one of the inventors of the flaked cereal and other

popular foods, he did not wish to profit from these products. Neither did he take any professional fees for the 22,000 surgeries that he performed, nor did he receive a salary from the Sanitarium. He supported himself and his household of more than 40 adopted and foster children with the royalties from his books and publications (Butler et al., 1994, p. 14).

A central premise was to educate and serve the largest population of the community in order to impact the health status throughout the United States. By 1885, the Battle Creek Sanitarium was “the largest of its kind in the world.” In 1926, it had a service staff of 1,800 with accommodations for over 1,500 patients. By 1938, the Sanitarium facilities were comprised of 32 buildings on 27.5 acres of land with a dining room that could seat 800 guests for each meal (Schaefer, 1977, p. 56).

The unfortunate reality of the Battle Creek Sanitarium is that it could serve as a case study for deinstitutionalization. Dr. Kellogg led a purposeful and systematic separation from the confessional identity that was foundational to the original establishment of the Western Health Reform Institute. Although Kellogg advocated a Christian ministry, he stood steadfast that the Sanitarium should be operated as a nondenominational entity outside the purview of the Seventh-day Adventist Church. Kellogg became increasingly disenchanted with the church leadership over personal health practices and a more conservative view on Sanitarium expansion plans. In the process of wresting control of the Battle Creek Sanitarium from the Seventh-day Adventist Church, Kellogg wrote:

When we say undenominational, we mean that this work is doing those things which are not simply for the purpose of advancing the interests of the Seventh-day

Adventist Church, but which will help forward the Christian religion, and help forward the general welfare of humanity. . . . These things are to be done, as stated by our charter, in the interests of the public; not in the interest of any church or any set of men, but for humanity (as cited in Robinson, 1965, p. 328).

The separation of the Battle Creek Sanitarium from the Seventh-day Adventist church was one step toward the demise of this once preeminent health facility. Without access to mission-minded medical, nursing, and therapy personnel along with some level of financial backing from the church, the Battle Creek Sanitarium was in a precarious position. In building the twin tower expansion, which opened in 1928, \$4,000,000 of debt had been incurred. The Great Depression of 1930 resulted in a significant decline in patient census, which plummeted from 1,400 patients daily to a mere 300. With interest payments accruing at \$500 per day, and without support from the Seventh-day Adventist church, the Sanitarium went into receivership in 1933, reorganized in 1938, and was ultimately sold to the federal government in 1942 for \$2,251,100 (Gerstner, 1996, pp. 74-75).

### Summary of the Originating Core Convictions

From the very origins of the Seventh-day Adventist Church, the healing ministry of Christ has been imbedded into the fabric of the church's beliefs and teachings. The health focus was closely tied "as the arm to the human body" with the third angel's message announcing the second coming of Jesus Christ (White, 1948a, p. 468). With the fervency of a reformation commission, the young church created a philosophy of wholeness that recognized that human beings are more than physical; they are also mind and spirit and highly affected by social influences. This reformation message centered

around the eight health principles as recorded by Ellen G. White (1942), which are “pure air, sunlight, abstemiousness, rest, exercise, proper diet, the use of water, trust in divine power – these are the true remedies” (p. 127).

In addition to wholeness, the healing ministry of Christ, and the health principles, the core convictions that were clearly motivating forces in the originating days of Seventh-day Adventist healthcare were community outreach, excellence, health education, honoring the beliefs of the Seventh-day Adventist Church, and treating every individual as creations formed in the image of God. As stated, there was clearly a ministry motive to prepare the way for the three angels’ messages and the second advent of Christ.

Through the application of the health principles, the Battle Creek Sanitarium became the preeminent health destination, gaining popularity as the place to be “made well” and then educated on how to “stay well” (Schwarz, 1970). In a tragic case of deinstitutionalization, the Battle Creek Sanitarium severed all ties with the Seventh-day Adventist Church, which ultimately resulted in the demise of this once distinguished center of health.

### **Official Church Guidelines**

The Communication Department of the General Conference of Seventh-day Adventists has published a composite of official church positions on various topics in a publication entitled *Statements Guidelines & Other Documents* (Communication Department of the General Conference, 2005). In a chapter entitled “Health-Care Institutions” (pp. 51-53), 10 “Operating Principles” are detailed as follows:



1. As Christ ministered to the whole person, “the mission of the Seventh-day Adventist Church includes a ministry to the whole person – body, mind, and spirit.” Other aspects of Christ’s ministry include “teaching the positive benefits of following the laws of health” and “the interrelationship of spiritual and natural laws.”

2. As a “functional” and “integral part of the total ministry of the church,” healthcare institutions are expected to follow the standards of the church to include the honoring of the “sacredness of the Sabbath.” Also referenced is the promotion of an “ovo-lactovegetarian diet” and abstinence from alcohol and tobacco.

3. In recognition of the “dignity of man,” Seventh-day Adventist healthcare institutions “give high priority to personal dignity and human relationships.” This manifests itself through “appropriate diagnosis,” “treatment by competent personnel,” a “caring environment,” and “education in healthful living.” This also includes “support” for the family and patient during the dying process.

4. In policy and through procedure, a “high regard of human life” should be reflected.

5. Seventh-day Adventist healthcare institutions “operate as part of the community and nation in which they function” and are responsible for the health status of that community.

6. Clergy of all creeds are welcome to visit with their parishioners.

7. The mission of Seventh-day Adventist healthcare is delivered through “compassionate, competent staff” who deliver care in accordance with the “practices and standards” of the Church.

8. Each institution is to “operate in a financially responsible manner.”
9. “Primary prevention and health education” are to be an “integral part” of the healthcare institution.
10. Seventh-day Adventist healthcare institutions are to function in consultation with the Health and Temperance Department of the General Conference of Seventh-day Adventists.

### **Scholarly Papers**

To complement the historical literature and advance the understanding of the core convictions of Seventh-day Adventist healthcare, the next stage of query involved the commission of four original “white paper” manuscripts based on current research by some of the foremost contemporary scholars of the Seventh-day Adventist Church. These white papers were authored by Fritz Guy, Ph.D. (2004), of La Sierra University, Richard Rice, Ph.D. (2004), of Loma Linda University, Alden Thompson, Ph.D. (2004, of Walla Walla College, and Harold Koenig, M.D. (2004), of Duke University. Although Dr. Koenig is not a Seventh-day Adventist, he is widely published and regarded as one of the leading experts on the inclusion of spirituality into healthcare through a wholistic-based care model with integrated elements of mind, body, and spirit. The papers were presented at the Centennial Visioning Retreat on March 5 & 6, 2004, at Celebration, Florida, to the senior leadership of Florida Hospital.

While it would be preferable to reprint each of these white papers in its entirety within this section, pragmatic considerations prevail and they are, therefore, included in the appendices. In an attempt to represent the key thoughts in summary form, the

authors' exact words are used wherever feasible without quotation since it is fully disclosed herein to be their work. A summary of the key elements of their papers is presented in the following sections.

#### Guy: Theoretical and Philosophical Underpinnings

Dr. Fritz Guy, Professor of Theology and Philosophy at La Sierra University, Riverside, California, is widely known for his contribution to Seventh-day Adventist thought from the perspective of Systematic Theology. Guy has served as a pastor, theologian, and university president. Guy (2004) authored his thoughts based on the following questions: What are the philosophical and theological underpinnings that define faith-based healthcare? What are the essential elements of a faith-based provider? The complete manuscript is available in Appendix C.

The consideration of a theoretical and philosophical expression of Seventh-day Adventist health starts with a careful consideration of what it means to be human. Guy develops the thesis that "human being" is a multilayered interactivity of four very different kinds of reality – *body, mind, world, and God*. Within this context, human being is to be understood as the human way of being and existing rather than as a person. The definition of body in this context is referring to the sheer physicality of existing in a material basis as a human being. The description of mind is consciousness, cognition, centeredness, agency – the entire complexity of understandings, deliberations, values, purposes that express the particular self. World is defined as the totality of relationships, knowledge, and values that constitute the context of reality. God is defined as the Ultimate Reality who is the originator of all existence, meaning, and value.

Although humans exist within the context of a body, Guy captures the Seventh-day Adventist belief that a human being is both body and more than body. The dualistic philosophies of Descartes, Plato, and Augustine suggest that mind and body exist in two separate realities. This dualistic philosophy is widely accepted in the dominant Western theological traditions. However, Christian theology has increasingly acknowledged that the idea of an immortal, separable human soul comes more from Platonic thought than from biblical sources (Stendahl, 1965). Therefore, the proper Christian view of “human being” is a multidimensional unity of mind, body, and spirit (Tillich, 1963). While the Seventh-day Adventist view rejects the dualism of mind and body, the Adventist view also rejects a materialistic reductionist, deterministic view of the human being.

The Seventh-day Adventist approach to healthcare is founded in this view of humanity. Since intrinsic worth is defined by our human being as created in the image of God, no human institution or social construct can redefine this worth. The physicality of a human being means that caring for the human body is thus honoring a creation of God. This is true if caring for oneself or another being. With the vulnerability of our human bodies, it becomes incumbent to care for oneself and for others. Because the mind and body are mutually influential, sufficient care for each is of utmost importance. Following this logic, since the mind and body are not identical, a care plan for each is necessary because it is possible for one to be effectively healed while the other is not.

Another important aspect of understanding the human being is to appreciate the aspect of social construction. The wholeness of personhood is contingent on the relational contexts in which individuals participate. Therefore, in addition to the physical

and mental status, another world of social and cultural aspects is significant. The practical implication of this premise is that Seventh-day Adventist healthcare will either influence or be influenced by the social culture.

The final aspect of Guy's premise is to understand that the human being is of divine interest. As avowed in one of the most famous sentences in the history of Western thought, the human being is "created both by and for God, and the human heart is restless until it rests in God" (Augustine, 1991, p. 3). Therefore, the human being is an object of divine interest which motivates concern with the healing and restoration in all spheres including physically, mentally, and socially. In this way, the human being is made whole.

#### Rice: Core Convictions

T. Richard Rice is Professor of Theology, Philosophy, and Religion at Loma Linda University. Rice earned his Ph.D. from the University of Chicago Divinity School. Rice's (2004) white paper was prepared based on the following questions: What are the core convictions of Adventist healthcare? What are the unique contributions that Adventist theology can contribute to a model of healthcare (defined as promoting health and providing care in the 21<sup>st</sup> century)? The complete manuscript is available in Appendix D.

From its origin, the hospital has always been a Christian institution. The care for the sick was one of the features that set Christians apart from their contemporaries and contributed to the rapid proliferation of the gospel in the Mediterranean world. Within the Seventh-day Adventist Church, this extensive involvement in healthcare expresses a

distinctive theological vision. From the very beginnings of the Seventh-day Adventist Church, the driving force has been eschatological. The second most prominent theme is the Sabbath. As the most *distinctive* feature of Adventists, the Sabbath brings the assurance of God's love for His people who were created in His own image.

The expression "present truth" occupies an honored place in Seventh-day Adventist tradition. It was the title of the earliest Adventist periodical and reflects the perspective of the early faithful. While Adventists acknowledge the learnings of the past, the belief exists that not all insights have been discovered or are yet fully understood. In a rare mixture of innovation and tradition, Adventists seek to understand God through a vibrant understanding of biblical truths and to be attuned to what God is yet to reveal in the current day. The concept of present truth is demonstrated by Jesus in the Sermon on the Mount wherein He affirms the teachings of the past but reveals a new understanding of these same principles (Matt 5:17, 21, 22).

One of the central characteristics of the Greeks was their tendency to view issues in relationship to the whole. Likewise, Adventism has the tendency to have an expansive and integrative perspective, holding contrasting ideas in a creative tension.

Etymologically, the words "holiness" and "healing" stem from a single root, conveying the idea of wholeness (Porter, 1997, p. 84). This concept of human wholeness which embraces not only the physical but also the mind and the spirit is the basis for the Adventists' interest in healthcare. Wholeness emphasizes the complex, multifaceted nature of our composition. But wholeness must exist in balance whereby each factor in our existence has its ideal place and lives in harmony with all the other aspects.

Wholeness, therefore, involves the emphatic rejection of dualism in all its forms. From a wholistic perspective, humans are not “composite” beings. They are not a combination, or conjunction, or two sorts of entities – one physical, the other mental or spiritual; one mortal, the other immortal; one material, the other immaterial. In other words, a human being is not the union of a body and a soul, as traditionally understood. There is nothing non-physical, such as a “soul,” “mind,” or “spirit,” that inhabits the body and continues to exist after the body dies. To the contrary, human life is inherently physical, or corporeal, in nature. Human beings exist in bodily form, or they don’t exist at all. Consequently, when physical life ends, the person in its entirety ceases to exist. Nothing human is inherently immortal.

The soul was what the body became when it was animated by the breath, or spirit, of God. In its basic biblical sense, then, the word “soul” refers to the organism as a whole, not to some part of it. A wholistic view of humanity affirms all the essential elements that make us human – physical, mental, emotional, social and spiritual – and a wholistic view of our actual existence acknowledges that every aspect of our humanity is unfulfilled and damaged by sin.

A wholistic account of humanity must tell the “whole” truth about human existence, and the whole truth includes the sad admission that we are not whole. To account for human existence, we must acknowledge the diminished sinful condition in which we find ourselves. We were not only created in the image of God, we are also sinners. As sinners, we are no longer whole. Rather, as sinful creatures we live in the resultant conflict with God and our fellow man. Due to sin, we are unable to fully see the

true worth of human beings. Sin is wholistic in that it affects us physically, mentally, and separates us from the spiritual.

Wholistic health is the ideal state of human existence. Health is the original condition of human creation and the ultimate goal of the healing process. However, people do not always receive physical, emotional, and spiritual healing simultaneously.

To care for people spiritually, we must likewise attend to their physical needs. In essence, healthcare not only has a place in religion, but religion has an important place in healthcare. Therefore, healing and ministry belong together as one comprehensive endeavor. Rice coined the term “*ministry-healing*” to express the conviction that healing and ministry belong together, not as two separate activities, but as two facets of one comprehensive enterprise.

The way that Jesus cared for others is noteworthy. Jesus not only cared *for* the whole person, He also cared *with* His whole person. Jesus’ commitment to ministry-healing encompassed His entire life. He poured Himself into service and ministry. Every aspect of His person was devoted to serving others. Physically, spiritually, emotionally, and socially – Jesus drew on every facet of His life to bless and benefit others. He identified with the objects of His care so completely that He became one with them. Their suffering became His, and His suffering became their means to salvation.

Healing *with* our whole person is fundamentally a calling. To participate in the healing ministry of Christ, caregivers will have to draw on all facets of their humanity – physical, emotional, spiritual and social – in order to care for the wholeness of others. Ultimately, to deliver wholistic care requires wholistic caregivers.



### Thompson: The Healing Ministry of Christ and Adventist Heritage

Alden Thompson is Professor of Biblical Studies at Walla Walla College.

Thompson earned his Ph.D. from the University of Edinburgh in Old Testament and Judaic studies. Thompson (2004) authored a paper based on the following questions: Are there enduring values within our heritage that can sustain Seventh-day Adventist healthcare? How can we keep the heritage of Adventist doctrine and belief vibrant in the context of the technological and sociological changes of the 21<sup>st</sup> century? The complete manuscript is available in Appendix E.

In the first section of his paper, Dr. Thompson summarizes Jesus Christ's vision of health and healing. In his review, Thompson concludes that the New Testament provides very little basis for separating the physical and the spiritual. In the healing ministry of Jesus Christ, the separation of the physical (healing of the body) from the spiritual (healing of the mind and/or soul) is possible only on a superficial level. Jesus modeled a wholistic ministry by affirming the link between sin and sickness (paralytic [Matt 9:1-8, Mark 2:1-12, Luke 5:17-26]); man at the pool of Bethesda [John 5:1-18], but also by denying the link between sin and sickness (the man born blind [John 9:1-12]). Likewise, when describing the way to eternal life (the rich young ruler [Matt 19:16-22, Mark 10:17-22, Luke 18:18-23] and Zacchaeus [Luke 19:1-9]), the link with the spiritual was emphatic. The redemptive ministry of Christ links the physical with the spiritual in ways which define "wholistic." The way that Jesus cared for the physical in the here and now was also in preparation for the eternal.

In looking at the defining moments, turning points, and summarizing statements in the life of Jesus Christ, a clear affirmation of a wholistic blending of the physical and the spiritual becomes apparent. These occasions are:

1. As recorded in Luke 4:18-19, Jesus defined the purpose of His ministry with a text from Isa 61:1-4 to bring “good news to the poor,” “release from the captives,” “sight to the blind,” and freedom to the “oppressed.”

2. In healing Peter’s mother-in-law of her fever, casting out evil spirits and “cured all who were sick,” Matt 8:17 connects with Isa 53:4 as follows: “This was to fulfill what had been spoken through the prophet Isaiah: ‘He took our infirmities and bore our diseases’” (NRSV). Within this context, the salvation prophesied by Isaiah referred to the healing ministry of Christ.

3. In reporting to an imprisoned John the Baptist, Jesus sends a report that concentrates entirely on the physical: “The blind receive their sight, the lame walk, the lepers are cleansed, the deaf hear, the dead are raised, and the poor have good news brought to them” (Matt 11:5 NRSV).

4. In an analysis of the five healings performed on Sabbath, Jesus communicates that the Sabbath is not only a *spiritual* occasion but also an appropriate day of *physical healing* as well (Brunt, 1981).

5. The “good news” that the disciples were commissioned to take to all the world (Matt 24:14, 28:19-20) can be either defined as a spiritual eternity or concern with a better life in the here and now.

6. In determining what will be commended or condemned in the time of judgment, the physical outreach deeds are referenced: “I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me” (Matt 25:35-36, NRSV).

To examine these six noteworthy events, all but the “good news” includes the physical in relation to the spiritual realm. As such, it would seem justifiable that the “good news” is a message which makes people whole both in body and spirit, enhancing the quality of their life in the here and now as well as pointing to the coming kingdom of God.

It is through an appropriate understanding of God’s law that one can fully understand the wholistic ministry of Jesus Christ. Initially, Seventh-day Adventists simply viewed the law as a requirement for salvation (1840s), but then came to see it as a gracious guide to life (1860s). But even the gracious gift was often a heavy burden, until Adventists learned that true obedience cannot earn salvation but is the result of salvation (1880s). Finally, God’s law of love came to be seen as the foundation for every aspect of life, including our relationship with others (1900s).

With an understanding that God’s law is manifested in loving grace with one’s fellow man, many tension points can be more fully appreciated and working models can be developed. Sociologically, we come to understand that we must integrate and cooperate with society while at the same time living according to God’s will. Biologically, a joyous simplicity should be sought that does not oversimplify to an

ascetic denial nor lavishly pursues every hedonistic pleasure. Theologically, the tension of human freedom of choice versus God's sovereignty will likely not be resolved on earth, but an understanding of each perspective is imperative. Anthropologically, despite the unique beliefs of the Seventh-day Adventist faith, an open, inclusive community of faith is the necessary forum to share God's healing love. The wisdom of God is necessary to fully and effectively resolve these tensions.

The tendency of Western thought is to categorize and systematize into causal relationships. However, many tensions and paradoxes exist. The "either/or" frameworks many times are best understood as "and/both." The essence and uniqueness of the Seventh-day Adventist view of health is in the way that beliefs and practices are integrated within a wholistic understanding of humanity. The tensions that we face can be resolved through a more wholistic appreciation and discernment. Through the example of Christ, we have seen that we are physical and spiritual. We are mind, body, and spirit.

#### Koenig: Whole-Person Care

Harold Koenig, M.D., M.H.Sc., is co-director of the Center for Spirituality, Theology and Health at Duke University Medical Center, a Professor of Psychiatry and Behavioral Science and Associate Professor of Medicine at Duke University. Koenig has published over 250 scientific peer-reviewed articles and has written or contributed to 29 books. Koenig is regarded internationally for his Christ-centered perspective on whole-person medicine. The following material (Koenig, 2004) is based on the inquiry: How

should the whole-person healing ministry of Christ inform and challenge Florida Hospital operations today?

When Jesus healed people, He healed the whole person – mind, body, and spirit. Clinical experience and scientific research confirm that the mind, body, and spirit do not function separately. The spirit influences the mind. The mind influences the body. The body influences the spirit.

The spirit influences the mind through a variety of ways. Religious faith influences the ability to cope with stress associated with an illness, with emotional well-being, with social support, health behaviors, with psychological and social functioning. In an exhaustive analysis of 574 scientific research studies published prior to the year 2000, 438 of these studies confirmed a positive relationship between religion and health (see Koenig, McCullough, & Larson, 2001, for full details). In particular, the vast majority of studies revealed a positive correlation between religion and mental health in terms of substance abuse (98 of 120 studies), well-being, hope and optimism (91 of 114 studies), purpose and meaning in life (15 of 16 studies), depression and its recovery (60 of 93 studies), suicide (57 of 68 studies), marital satisfaction and stability (35 of 38 studies), social support (19 of 20 studies), and delinquency (28 of 36 studies). Only in the category of anxiety and fear (35 of 69 studies) were the results less than a vast majority.

The body influences the mind in that physical illness is associated with fatigue, tiredness, depression, fear, and anxiety. The mind influences the body through depression, anxiety, stress, and negative emotions which all impact the immune,

endocrine, cardiac, and vascular functions. The physiological manifestations are infections, malignancy, heart attacks, arrhythmias, hypertension, renal disease, and stroke.

The spirit influences the body through psychological well-being, stress levels through personal decisions, social support and function, and health behaviors. In another exhaustive analysis of the available literature, the correlation between religion and physical health has been demonstrated in the vast majority of scientific studies. In particular, better immune/endocrine function (6 of 6 studies), lower mortality from cancer (5 of 7 studies), less heart disease (7 of 11 studies), less stroke (1 of 1 study), lower cholesterol (3 of 3 studies), less cigarette smoking (23 of 25 studies), more likely to exercise (3 of 5 studies), lower mortality (11 of 14 studies published between 1995 – 2000), and clergy mortality (12 of 13 studies) were all scientifically demonstrated. Only in the singular category of lower blood pressure (14 of 23 studies) was less than a vast majority demonstrated (Koenig et al., 2001).

The practical implications for the practice of medicine in the 21<sup>st</sup> century is that healthcare practitioners need to expand their assessment and responsibilities to include the entire spectrum of a patient's condition. In addition to a thorough physical examination, an emotional, social, and spiritual assessment should also be conducted. As appropriate, spiritual interventions should be made available including prayer, pastoral care counseling, provision of spiritual resources, connecting with a faith community, addressing any expressed needs, and follow-up to ensure that needs are met.

### Synthesis of Scholarly Papers

At the conclusion of the Centennial Visioning Retreat, the participants and authors participated in an exercise to synthesize the core convictions based on the scholarly papers and professional experience. The core convictions are numbered for the sake of clarity:

1. The Seventh-day Adventist view of “Health and Healing” begins with what it means to be “human.” By human, the belief is that we are a whole person inclusive of mind, body, and soul as one reality.
2. Another perspective of being human is that we are created in the image of God. This reality creates a moral imperative that Seventh-day Adventist healthcare will be inspired to serve as a spiritual calling.
3. Health and healing are two sides of the same coin.
4. A whole-person care approach is inclusive physically, spiritually, socially, and emotionally.
5. To pursue whole-person care requires a wholistic organization. Healing requires the whole person.
6. With the significance of its size and influence, Florida Hospital can and should impact healthcare policy.
7. Seventh-day Adventists hold polarities in balance recognizing truth within the paradox of episodic care vs. community care, caring for a patient vs. caring with, healing vs. health, stability vs. investment, and business vs. ministry.

8. As we deal with change in the 21st century, “Love to God & Love to Man” is the bedrock construct for Seventh-day Adventist healthcare.

9. Sin does not separate, it distorts.

Along with these definitive statements of core convictions, there were a number of questions posed for consideration and processing for another occasion. The questions posed are as follows:

1. How does Florida Hospital deliver “Adventist Care” with a vast majority of non-Adventist healthcare providers? When we speak of spiritual care, do the employees of Florida Hospital understand and experience this care?

2. How should Florida Hospital relate to medical doctors who have little interest in spiritual matters?

3. Is there enough evidence and belief to the value of whole-person care for Florida Hospital to pursue aggressively in practice? Is wholistic care a romantic concept or a reality in practice?

4. How should Florida Hospital involve the Seventh-day Adventist Church, various faith groups, physicians, and caregivers in the development of a whole-person care approach?

5. What are the next steps in this process? How should Florida Hospital preserve and advance this process?

### **Interviews**

Eleven interviews were conducted during the time period of October 2003 to May 2005 with seasoned Seventh-day Adventist healthcare administrators chosen for their



unique experiences and professional backgrounds. The inclusion criterion was to have served at least 20 years within a Seventh-day Adventist healthcare leadership capacity. A brief profile of those interviewed is detailed in Table 4.

The ages of those interviewed ranged from early 40s to late 70s and included 10 males and one female. Of those interviewed, three are retired from active service with the remainder still in leadership positions within the Adventist Health System. The background of these individuals includes a medical doctor, a registered nurse, a chemist, an ordained minister, with the remainder being trained in one of the fields of business administration. The majority were born and raised as Seventh-day Adventists with only one joining the Seventh-day Adventist membership in his adult years. Each of the interviews lasted approximately 1 hour and occurred either at Florida Hospital in Orlando, Florida; Florida Hospital Waterman in Eustis, Florida; or at the Adventist Health System corporate office in Winter Park, Florida. A verbatim transcript of the interview was provided to those interviewed to ensure accuracy and provide opportunity for additional comments.

Each of the interviews was conducted with research approval through the Andrews University Institutional Review Board to ensure protection of the human subjects. A "Research Protocol," "Informed Consent Form," and "Research Questions," as attached in Appendix A, were provided prior to the interview with the "Informed Consent" being collected at the time of the interview. In addition to basic demographic inquiry, the questions utilized during the interview were as follows:

Table 4

*Interview Participant's Profile*

Interviewee	Title	Years of Service
Mardian Blair	President Adventist Health System (Retired)	41
Don Bradley	Vice President, Florida Hospital (Retired)	50
Des Cummings, Jr., Ph.D.	Executive Vice President Florida Hospital Division	21
Connie Hamilton, R.N.	Chief Patient Care Officer Florida Hospital	31
Ted Hamilton, M.D.	Vice President of Medical Missions Adventist Health System	20
Lars Houmann	Chief Operating Officer Florida Hospital	21
Don Jernigan, Ph.D.	President Florida Hospital Division	23
Ken Mattison	President Florida Hospital Waterman	30
Terry Shaw	Chief Financial Officer Adventist Health System	20
Tom Werner	President Adventist Health System	30
Bill Wilson	Assistant to the President Florida Hospital (Retired)	45

1. What are the essential elements of a Seventh-day Adventist hospital?
2. Are there enduring values within our heritage that can sustain Seventh-day Adventist healthcare? How can we keep the heritage of Adventist doctrine and belief vibrant in the context of technological and sociological changes of the 21<sup>st</sup> century?
3. What are the unique contributions that Adventist theology contributes to health care institutions?
4. How should the whole-person healing ministry of Christ inform and challenge Florida Hospital's operations today?

Although not identical, these are similar to the questions utilized in the commission of the four scholarly papers already referenced.

Whereas the four questions query different aspects of institutional values and theological philosophy, in a collective sense, they comprise the various angles necessary to articulate the confessional identity and core convictions of Seventh-day Adventist healthcare. Therefore, the following compilation of interview statements on core convictions will convey both the individual voice but also the collective themes over the course of the four questions during the 11 interviews.

#### Collective Interview Statements of Core Convictions

As detailed in Table 5, a total of 19 different themes were referenced during the 11 interviews. Of these 19 themes, 8 were referenced by the majority of those interviewed. Every person referenced wholeness on at least one occasion while all but one made reference to the healing ministry of Christ and the health principles (or the CREATION model). Sabbath rest was the fourth most referenced theme, and community

outreach was fifth. The necessity for an Adventist Leadership and Team was also referenced by seven individuals. The “image of God” and overall service environment were each referenced by six of the interviewees. For those themes referenced during four interviews or more, the following sections will describe these themes in the words of those interviewed. Although the case can be made that the themes emerging from the interviews should be consolidated, some sub-themes are presented in order to provide a thick descriptive representation of the interviewees’ thoughts and intentions.

### **Wholeness**

During the course of all 11 interviews, the concept of wholeness was referenced by every executive. In fact, wholeness is the *only* theme referenced by every single individual. Although often referenced with the exact terminology of “wholeness,” on other occasions this concept was also referenced as an interest in the “mind, body, and spirit” and also as the process of “restoration.”

Don Bradley was born at the Florida Sanitarium in 1928 and dedicated his entire 50-year career at Florida Hospital, serving in a variety of administrative capacities. In addition to his father spending the majority of his career at the Florida Sanitarium, Don’s son is now the administrator over one of the campuses at Florida Hospital. When asked to articulate the essential elements of a Seventh-day Adventist hospital, his immediate answer was “dealing with the whole person.”

Terry Shaw, Chief Financial Officer of the Adventist Health System, continues this thought to suggest that the Seventh-day Adventist faith has “a very unique way of

Table 5

*Collective Themes From the Interviews*

Collective Themes	Reference Frequency
Healing Ministry of Christ	10
Health Principles/CREATION	10
Sabbath Rest	9
Community Outreach	7
Adventist Leadership and Team	7
Image of God	6
Environment and Service	6
Love	5
Excellent Clinical Care	4
Nature of Man	4
Prayer	4
Honor SDA Beliefs	3
Hope	3
Faith	2
Ministry Motive	2
Institutional Calling	2
Three Angels' Message	1
Truth	1

treating an individual from not only the physical aspects but their mind and spirit as well.” Shaw summarizes the Adventist view on wholeness when he states, “we uniquely believe in an intersecting mind, body, spirit model that has the three rings intersect in a way so that there is influence across the three.” As Don Jernigan, Ph.D., President of Florida Hospital notes, “The inseparability of mind and body is how we can have a health emphasis which isn’t idolatrous.” Whereas some pursue health in order to be “buff” or “pumped up,” for Adventists the rationale is that the soul and body are inseparable and is how one connects and serves God. In essence, health is a spiritual endeavor. For Jernigan, wholeness is “philosophically and theologically the absolute most authentic base to minister because it is biblical. It is the biblical model of who people are.”

Des Cummings, Jr., Ph.D., who serves Florida Hospital as an Executive Vice President of Business Development, has the unique distinction of having worked in all three aspects of Christ’s life as a minister, educator, and healthcare executive. Cummings suggests that one of the reasons that the Seventh-day Adventist health message embraces wholeness is because of the significant role that women played in establishing the Church and the health message. According to Cummings, women are more instinctively wholistic. In addition to Ellen G. White, among the original five students sponsored to go through medical school, two of the five were female.

Another perspective on wholeness was offered by Tom Werner, President of the Adventist Health System, who views one of the essential elements of Seventh-day Adventist healthcare as the restoration of man into a closer resemblance of our intended creation. Werner states:

God is in the business of restoring. Restoring us from a health perspective. Restoring us in our relationships with each other. And restoring us in the relationship with Him both here on this earth but more importantly in the hereafter. And if we do that well, then we are truly Seventh-day Adventist Christian hospitals.

Although wholeness is most often used to connote the perspective of mind, body, and spirit, the concept of restoration to wholeness to a closer resemblance of our original creation is a more fundamental perspective.

Ted Hamilton, M.D., Vice President of Medical Missions for Adventist Health Systems, suggests that wholeness can be viewed in a variety of ways. The first is in terms of understanding man as a being comprised of mind, body, and spirit. Another view is through the CREATION model; that in addition to the mind, body, and spirit, there are within and around each person these elements that contribute to the whole of existence. These elements are *Choice, Rest, Environment, Activity, Trust* in a divine power, *Interpersonal relationships, Outlook and Nutrition*. The third view is through the lens of a lifetime from birth to cessation. Wholeness should be viewed longitudinally throughout each of the stages of life. Hamilton suggested the fourth view of wholeness is the “community of man.” This concept motivates Seventh-day Adventists to serve the community, both local and worldwide, because of the belief that we are wholistically connected as children of a loving God.

Seventh-day Adventist hospitals are the only faith-based health system that has a theological basis for wholeness. Whereas many other health systems are coming to appreciate the necessity for integrating the mind and spirit into the physical aspects of healthcare, the spiritual component will not be an integrated component without a systematic theology to match.

Cummings believes that the force of chronic disease will expose the limitations of our current acute care health model and its emphasis on only the physical aspects of care. Research shows that 75% of healthcare costs are spent on chronic diseases oftentimes at the late stages of life. Cummings provided a paper written by Ralph Snyderman, President of Duke University, which reads in part:

Much of today's delivery of healthcare fails to acknowledge the components of healthcare that go beyond science alone. The problem lies in the modern western tradition of medical education. While many healthcare providers are trained to treat the body, few are trained to address the matter of the mind and soul. Components that are arguably as critical as the physical when it comes to getting and staying well. And the fact that so many consumers are now looking beyond body only healthcare makes it even more important for the medical community to be in the know about integrative medicine.

This sentiment is in sync with the wholistic view of Seventh-day Adventist healthcare. What Duke is attempting to put into their curriculum are the necessary components of mind and spirit to complement the physical training that has characterized Western medicine as currently practiced. From this Duke example, Cummings believes that secular institutions will be challenged to define the spiritual framework of a wholistic model. The advantage that the Seventh-day Adventist health system has is an integrated view that is based on a sound theological basis such that all three aspects of mind, body, and spirit can be approached in a wholistic manner.

Cummings continues that "our biggest threat is that we profess whole-person care and other people will practice it." The golden moment exists where the legacy system that has been established to respond to acute problems is being crippled by the chronic nature of diseases. Cummings articulates a clear vision that the reconciling factor between the acute system and chronic disease is a care path built on wholistic principles



that consider not only the physical aspects but also the emotional and spiritual factors as well. Lars Houmann, Chief Operating Officer of Florida Hospital, would agree that based on all available scientific data, the patient treatment plan must determine the spiritual and emotional gaps in order to determine their potential physical plan of care.

Whereas the first three questions evoked clear and definitive answers from each of those interviewed, it was this fourth question which pressed on how the “whole-person ministry of Christ” should inform current operations at Florida Hospital in the current day that caused many to pause and pose questions of their own. Those that were proffered included: “Do we have a model of management that supports whole-person care?” “Have we all agreed on definitions of whole-person care?” “Have we embedded whole-person care into our priorities, resources, capital, leadership development, incentives and bonuses?” and “To what degree does our culture enable or mitigate against wholeness for executives, doctors, and managers?”

Ted Hamilton affirms that Adventist healthcare has certainly “embraced a spiritual dimension of healthcare.” However, Hamilton is “not clear that we have continued to sustain and refresh that idea of wholeness as it relates to modern medical care in a tertiary institution.” While Hamilton would avow that “wholeness could well be a part of our worldview” and that “when you cut us, we probably bleed wholeness,” the opportunity exists to assess how the principles can be translated into practice in the daily modern sense.

### **Healing Ministry of Christ**

The healing ministry of Christ was referenced by all but one individual. To Jernigan, the core essence of a Seventh-day Adventist Hospital is carrying out a Christian ministry. Jernigan states that healthcare provides “the most intimate, most critical care to people that is imaginable in the human sense and you are not doing that as a humanistic endeavor. You are doing that to carry on the very work that Christ did when He was here on earth.” In a direct link to sensemaking, Jernigan further states that it is important that everyone recognize the reason for their actions and that the behaviors exhibited be Christ-like. While Jernigan’s first reference was to Christian ministry, the second essential element is to honor the beliefs and doctrines of the Seventh-day Adventist church. However, Jernigan quickly points out that “you can be as pure as the driven snow about your Sabbath policies and if you are not Christ-like in your care, being an Adventist hospital in that sense would be an abomination.”

Werner would agree that a Seventh-day Adventist hospital should “model our lives and the work of our institutions after the life and work of Jesus Christ.” Werner shared the personal experience of the death of his mother from a cerebral aneurism in a “large well-staffed, well-equipped teaching hospital” in Seattle. The physicians were well trained in their field, the nurses were caring, and all medical and personal needs were attended to. However, there were no mechanisms in place to deal with the spiritual needs of his mother or their family. Werner is clear from this experience that a large part of extending the healing ministry of Christ involves being “intentional about creating ways of dealing with the spiritual needs of families.”

The sentiment expressed throughout the interviews clearly conveys the theme that they serve the health needs of others because that is the example given by Jesus Christ. To serve the health needs of others is simply to walk in the footsteps of the Lord and Savior. Ted Hamilton simply states that we need a “disciple’s commitment” to follow in the example of Christ. Connie Hamilton, Senior Patient Care Officer at Florida Hospital, references the healing ministry of Christ as the “purpose” of Seventh-day Adventist healthcare. Hamilton notes that the ministry of Christ was “very relational, very heart-to-heart, people-to-people, both physical and spiritual.”

Contained within the mission statements of both the Adventist Health System and Florida Hospital is the statement that “we exist to extend the healing ministry of Christ.” The challenge is to institutionalize this value into the sensemaking paradigms of every employee in order to embed this value into the organization. Wilson notes that to suggest that “we extend the healing ministry of Christ” is to proclaim that our daily actions will be Christ-like. At the core, the motivation must be to act in absolute harmony with the will of Christ. Although he was careful to suggest that he has not seen this occur at Florida Hospital, Wilson did make mention that healthcare may become simply a job rather than a calling. With the decision in 1987 to depart from the Seventh-day Adventist Church pay scale, Wilson sees the possibility that healthcare careers will be pursued for monetary potential rather than mission inspiration. In the past, you could not hire for money, and, therefore, the motivation for service was more clearly differentiated.

Jernigan states: “I honestly believe that Adventist healthcare is unique in the United States in terms of promoting Christ-centered healthcare ministry.” This ministry

is likely to continue into the future because “we have created a management model that encourages all kinds of young people to commit to healthcare as a vocation early in life and make it a lifelong ministry which can be a ministry of medicine, a ministry of nursing, a ministry of management” along with various other disciplines.

Ken Mattison, President of Florida Hospital Waterman, reflects that when a patient leaves a Seventh-day Adventist healthcare facility, if they have not grown spiritually in some way, then an opportunity was missed. Mattison states, “This is a Christian organization where Christian values are lived every day and it is affecting the way that we provide care.” In the end, the ministry of Christ was based on individual relationships, meeting people where they were, and helping them heal into the restored potential of wholeness. The concept of Christian faith-based healthcare should have an advantage over other healthcare because of the compassion and the example of Christ that drives healthcare workers to do a better job because they want to honor God and follow the example of Christ.

Shaw notes that with shorter hospitalizations and an increasing use of outpatient services, the healing ministry of Christ as practiced in the Seventh-day Adventist facilities will need to change in order to accommodate these trends. Shaw points to the parable of the sower and the seed as detailed in Matt 5. The meaning of the parable to Adventist healthcare in the current situation is to not concentrate on the soil conditions upon which the seed may land; rather the focus must be on purposefully dispersing seed and allowing the Holy Spirit to impress beyond that. The challenge for Seventh-day Adventist healthcare is to determine those modes and means that can successfully

accomplish the dispersion of the healing ministry of Christ within the realities of the current environment.

### **Health Principles/CREATION**

The health principles were identified as core convictions by 10 of those individuals interviewed. The eight principles of health, as recorded by Ellen G. White (1942), are “pure air, sunlight, abstemiousness, rest, exercise, proper diet, the use of water, trust in divine power – these are the true remedies” (p. 127). In crafting the original health reform sanitariums, these elements were the essential product and provision of services rendered. With the conversion of the sanitarium model to the acute care hospital after World War II, the applicability of the health principles within this environment is less obvious.

In an adaptation of the original health principles articulated by Ellen White, Des Cummings, Jr., and Monica Reed, M.D. (2003), have reframed the eight principles into the acronym CREATION in response to explain the Seventh-day Adventist philosophy of health from strictly biblical sources. According to this model, the principles of health are *Choice, Rest, Environment, Activity, Trust in divine power, Interpersonal relationships, Outlook, and Nutrition*.

Within Seventh-day Adventist healthcare circles of the 20<sup>th</sup> century, the name Mardian Blair is certain to be referenced. With a career spanning over 40 years including presidencies at Hinsdale Hospital, Portland Adventist Medical Center, Florida Hospital, and as the Chief Executive Officer of Adventist Health System from 1984 to 2000, Blair is respected as a foundational leader of Seventh-day Adventist healthcare. According to

Blair, an Adventist hospital should be the place where the health principles are “proudly displayed and exhibited.”

Bill Wilson, who has worked in Seventh-day Adventist healthcare in various administrative roles since 1944, would agree and further suggest that a healthy lifestyle is comprised of diet, exercise, and a vibrant spiritual life. Mattison appreciates that the purpose of Seventh-day Adventist healthcare is to aid in the restoration of health. He states that the hospital setting is “a great opportunity to talk to people about the consequences of choices to exercise and diet.” As such, there should “always be a link between an Adventist hospital and teaching good principles of health.”

God reaches man through healing but also through health. Blair is clear that every Seventh-day Adventist healthcare institution should be involved in healthful living education. Although the level of involvement can be debated, the health principles should be a certain and available educational component. Bradley recounts that Florida Hospital was among the first hospitals in the area to offer smoking cessation seminars, stress management classes, and weight control support groups. Although Wilson does not think that the devotion to mission has been affected, when the decision was made to serve caffeine products and meat at the Florida Hospital cafeteria, the health message was marginalized.

Houmann not only acknowledges that the health principles are a part of our history and legacy, but they are also a “critical part of our future.” Houmann has a rich personal history within Seventh-day Adventist healthcare being the son of two Seventh-day Adventist physical therapists who were trained at Skodsborg, Denmark, and whose

father later became a family practice physician serving as a medical missionary in Ethiopia and later at the Washington Sanitarium in Washington, D.C. Among Houmann's immediate family is a nurse, an anesthesiologist, a dentist, and a sister who is married to a hospital administrator. Houmann recognizes that only a modicum of the health message has survived within the hospital setting over the past 40 years, but given the chronic nature and health status in America today, the need clearly exists and will likely be an essential element not as a historical symbol, but as a practical answer for the health challenges to come.

The limitations of the current acute care model are becoming more fully appreciated both inside the industry and beyond. Rather than relying on patching people back together after an acute event, the alternate and preferred tact is the understanding and engagement of healthy preventive practices. Houmann suggests that we need to reclaim our health principles because of the value that they still offer for a better life. Whereas in the past, the health principles were reduced to a dogma, they now represent a superior model that should be revitalized to answer the needs of the communities served.

### **Sabbath Rest**

As identified by nine individuals, one of the essential tenets to the Seventh-day Adventist faith is the seventh-day Sabbath as a day of rest to connect with God in worship. Blair comments: "The Sabbath is critical to our faith and should never be disregarded or scoffed upon in any way." Wilson notes that the Sabbath rest is a unique philosophy that no other healthcare institution offers.

The Sabbath is so essential and core to the Seventh-day Adventist belief system that it must be honored as part of the confessional identity. Jernigan notes that it is fundamental that the Sabbath will be honored in a Seventh-day Adventist hospital. Werner notes that the importance of Sabbath is that it communicates that God wants to have a special connection on a special day in order to develop a loving relationship. This special day should be a blessing for all those within a Seventh-day Adventist hospital including the patients, physicians, and staff alike.

For Cummings, the theology of Sabbath is the capstone of what the Seventh-day Adventist Church has to contribute because it is the celebration of a whole life. Sabbath demonstrates that it is insufficient to have only those physical aspects fashioned in the first six days of creation. It is the gift of love which is imbedded in humans and celebrated in Sabbath worship. Cummings suggests that the creation story can be compared to Maslow's hierarchy of needs. At the base is security, which can be likened to Sabbath rest. Rest is the assuredness of knowing that the battle is already won. At the next level is belonging, which can be equated with the Sabbath blessing. At the top of the pyramid, rather than being self-actualized, we are actualized in God. The abundance of life can only be appreciated through a relationship with God and fulfilled through relationships with others.

Cummings further highlights that, for Jesus, the Sabbath was the day for healing as a celebration of health as in His original plan. In John 9, while healing the blind man outside the temple on Sabbath, Christ proclaims that work must be done while the light is here. Sabbath in its original plan was the day to celebrate health and enjoy love. In His



redemptive plan, it was a day for healing, which was to restore health and restore love. And the best thing for love to do in a world of brokenness, on the day of the Lord, is to do the Lord's work of putting people back together again.

Shaw notes that Seventh-day Adventist healthcare has the unique opportunity to "reach the masses" on the "dynamic benefits of one day of rest" in a way that the conventional church never will. The Sabbath is a day of healing *and* a health benefit. The Sabbath is a unique blessed approach and tremendous opportunity to present to a world in need of rest.

### **Community Outreach**

On seven occasions, specific and distinct statements on the importance of community were expressed. There are two distinct perspectives expressed in regard to community outreach. The first perspective rendered by Mattison is the heritage of Seventh-day Adventist healthcare being concerned with the health status of the community served. The definition of community in this situation is both local and world wide. For instance, Mattison is personally involved in efforts in his local community to serve those in need but also is personally involved in an annual mission trip overseas to spread the mission of health and love.

The second perspective discussed by Blair concerns the representation of Adventism to the community. Since more community members are exposed and come into contact with Seventh-day Adventism through the healthcare ministry than any other branch of the church, the institutional values of the church should rightfully be exhibited and on full display.

The legacy of Seventh-day Adventist healthcare should not be limited to the bedside or within the four walls of a facility. For Jernigan, this means the sponsorship of well-designed initiatives that will address the needs of people in new and exciting ways, whether this is mission trips, local initiatives aimed at the underserved, or even the recently commissioned publishing arm at Florida Hospital that seeks to take the health message to a broad audience through the medium of print.

One of the key underlying principles of community outreach is relationships. Houmann says, "I think our theology is clearly a relationship theology with our God, our Creator. And that means a relationship with those that He's given us to live with and minister to." This relational view will translate into an experiential ministry. Shaw suggests that "at the end of the day, most people who are getting care want somebody who is doing it from the heart." The motive of care is certain to be discernable by a patient in need. The love for one's fellow man is a powerful premise to care for the needs of the community.

### **Adventist Leadership and Team**

Seven references were made on the importance of having an adequate representation of Seventh-day Adventist members both in leadership positions and among the employee base. If the Adventist belief is to remain vibrant into the future, Shaw suggests that hiring as many Seventh-day Adventist graduates from all walks of life will be necessary in order to have "a pipeline of people who are going to sustain the mission and ministry for the future." Having said that, Shaw is quick to note that "I am under no illusion that we will ever have just Seventh-day Adventists work in our

organization.” The challenge is to find people of the Christian faith who are called to be “grace ambassadors” and continue the healing ministry of Christ.

According to Houmann, one essential element of a Seventh-day Adventist hospital is an “unwavering leadership commitment to Seventh-day Adventist Christian principles.” Blair would agree and further suggest that the senior leadership should “be essentially 100% Seventh-day Adventist Church members. Leaders who understand Adventism and our health message” are of critical importance. Blair noted that while there have been and will continue to be leaders of other Christian faiths within Seventh-day Adventist healthcare facilities, the importance of having the vast majority of leadership being of the Adventist faith is of utmost importance. Blair also made special mention that the clinical team should be comprised by a “significant portion of Adventist nurses.” In reference to chaplains, Blair stated that they should neither be “secular” nor “timid.” The Seventh-day Adventist principles should be on display through each of the leaders, nurses, and chaplains alike.

Bradley shared that from the opening day in 1908 through 1954, every employee of Florida Hospital was a member of the Seventh-day Adventist Church. Bradley personally hired the first non-Adventist as a pharmacist who worked mostly in the back recesses of the hospital. Bradley indicated that this was a significant decision at the time fearing that the precedent would lead to a secularization of the workforce and a compromise of the health message. To guard against these fears, a hiring principle was established to create a screening process that applicants should “be spiritual or that they have our same concepts.” It is interesting to note that as of this date, this same

pharmacist is still an employee at Florida Hospital. Also noteworthy, only 13% of the Florida Hospital workforce in 2004 hold membership in the Seventh-day Adventist Church.

Shaw notes that “we have insisted that the individuals running our institutions are grounded in the Seventh-day Adventist faith and that be an experiential basis.” In essence, Shaw is raising the bar from a simple membership requirement to one of personal experience, understanding, and meaning through their association with the Church. Referring to hospital leaders, Werner adds to this thought in saying that the Seventh-day Adventist belief system should be “an inherent part of who they are.” Werner continues that a nucleus of Seventh-day Adventists in leadership positions and “a good quantity throughout the organization is exceedingly helpful.”

In order for the heritage and values to perpetuate into the future, Werner suggests that it ultimately comes to having “people in the organization who have internalized those principles and beliefs into their own life.” This means living both generally accepted Christian principles and those Seventh-day Adventist beliefs that may be unique. In terms of heritage and values, Blair would suggest that one of the key responsibilities of an administrator within a Seventh-day Adventist healthcare institution is to share the stories and the values that tell the health principles in a positive light. These values should be assimilated through each of the leaders on the entire team. In essence, the healthcare leader is a Church leader and needs to represent in both word and action the beliefs of the Seventh-day Adventist Church. This preservation of heritage is

an attempt to institutionalize the values by influencing the sensemaking paradigms throughout the members of the organization.

Bradley recalls hiring a nurse in the early 1960s who returned to his office after only 3 or 4 days on the job with her resignation. Upon inquiring the reason, the nurse clearly had come to understand that her language would not be acceptable to her co-workers at the Florida Sanitarium. This story demonstrates one example of how a sensemaking paradigm of acceptable behavior will guide daily interactions. The issue here is not regarding the hiring of Adventists. The issue is about having a vast majority of the team who not only understand the intended principles, but are living those values in such a way that all those around will fully appreciate what the Seventh-day Adventist core convictions are intended to be.

### **Image of God**

On six occasions, those interviewed express the importance of the concept that we were created in the image of God. Among the spectrum of Christian faiths, a common tenet is that we are a creation of God fashioned in His likeness. As masterfully stated by Ted Hamilton, the “Image of God” within Adventist theology is the:

cosmic scope of creation’s intent, redemption’s purpose, and eternity’s realization. There is this image of God who created us for His delight, who redeems us by His love and in eternity fulfills this relationship that had its beginnings a long time ago. So, it’s the image of a loving, creative, merciful, redemptive, persistent God.

Because we are God’s child, we also have the opportunity to serve other children of God in the form of every patient who comes for care.

Jernigan highlights that as we traverse down the road of technology and science, there will be abundant ethical dilemmas that can only be answered through a fundamental definition of what it means to be human. “Human beings aren’t an accident. They are not a collection of biological and physical mechanisms. But, they are living souls created in the image of God.”

Werner suggests that when you fully appreciate the concept of being created in the image of God, then every patient who occupies one of the hospital beds is treated as if God the Father is the one in need of care. In this light, Connie Hamilton recognizes that even the most difficult interaction with an unruly person must be viewed through the lens that God loves this person as much as He loves me. This places a different perspective on how we relate to our fellow man.

### **Environment and Service**

For six individuals, reference was made to the overall environment and expectation of service. Blair is clear that there should be “a pervasive atmosphere” that is distinctly and clearly identifiable as “palpably Christian.” Furthermore, this environment should be “where Seventh-day Adventism is proudly displayed.” The first way that this should be felt is by the way people are treated. This means that patients appreciate that they are being cared for in an abundant Christian environment of care and compassion. This also means that employees and physicians are treated as unique creations of God. Overall, Blair would suggest that there is “a spirit of the place” that is obvious and pervasive.

Houmann suggests that a Seventh-day Adventist hospital should be “an expression” of the Seventh-day Adventist principles “in clear unveiled terms.” Such expressions would take on the form of worship services, devotional thoughts, and an “organizational commitment to act in dedication to God and His work.” Shaw would suggest that this environment also includes an understanding that the technology and facilities are among the finest available.

Werner suggests that as technology becomes more pervasive in our society and certainly within the healthcare industry, that Seventh-day Adventist healthcare must be very intentional about meeting the human and spiritual needs of the patient and their families. This ability to meet the human and spiritual needs will likely distinguish “Christian and Seventh-day Adventist Christian hospitals from all the others in a way that will be just remarkable.”

From a nursing perspective, Connie Hamilton notes that changing bedpans and administering shots are very task oriented, however, it is the “enrichment of the experience and interaction of serving” that is the Christian ministry opportunity that exists within healthcare. She further reflects that “healthcare providers are allowed to be present in someone’s life at horribly sacred moments in their passage, most of which they don’t ever even want to be part of.” But in these moments of passage exists an openness for true service not only to the physical but especially to the spiritual. From the celebration of birth to the final chapter of death, these are sacred passages that occur within the healthcare setting and provide a supreme opportunity to serve. It is when this

service is motivated by Christian love that the mission of Seventh-day Adventist healthcare is ultimately provided.

### **Love**

Love was referenced on five separate occasions by five different individuals. Mattison states, “I believe that an Adventist hospital should be a place where people can be introduced to a God who loves and cares for them deeply.” In the course of conversation with Werner, the history of the Church and its unique and peculiar beliefs were discussed. Whereas in the past, a great deal of energy was consumed trying to live by the letter of the law, the current focus is on living a grace-filled life that communicates the love of Christ to the patients and communities that are served.

When God reduced Himself to one word, the descriptor chosen was love. Cummings suggests that love is the “energy force of the universe.” Cummings suggests that love emanates light and power. When Christ was asked to distill the greatest commandment, the simple direction was to love your neighbor as yourself. Therefore, within the context of an Adventist hospital, by providing loving care to patients, the ministry of Christ is being lived through those caregivers.

### **Excellence in Clinical Care**

On four occasions, excellence in clinical care was referenced during the interviews. From the earliest days of Seventh-day Adventist healthcare, there has been a mandate for excellence in patient care. During his interview, Mardian Blair’s comments echoed the sentiments of James White in the early days of the Western Health Reform



Institute. Blair states that the first and foremost element of an Adventist hospital is the quality of healthcare provided. For Blair, as for James White, it is inconceivable to have the Seventh-day Adventist name on any healthcare facility that stands for anything less than the highest quality of medicine and service.

During his interview, Cummings quoted A. G. Daniels, President of the General Conference of Seventh-day Adventists, who stated in an address to the dignitaries gathered for the opening of a new wing at the Battle Creek Sanitarium in 1888 that the Battle Creek Sanitarium was the “finest healthcare on earth. If one were to look for better solutions to health problems, they would have to go to a different planet.”

Ted Hamilton was quick to segment the level of excellence as reflective of “the state of the local art.” Hamilton is referencing that within given markets, a community standard is established according to resources and expectations. The belief is that whenever the level of quality falls to a second tier within a community, that an Adventist hospital is no longer correctly portraying the essence of Seventh-day Adventist healthcare. This standard was set from the earliest days of the founding and must be an essential element into the future.

### **Nature of Man**

The nature of man was referenced on four occasions. Ted Hamilton describes the Seventh-day Adventist belief that the nature of man is “flawed, finite and forgiven.” It is flawed in the sense that we are not whole. It is finite in that there is a limit to our days on earth. And it is forgiven because our flawedness and finiteness have been dealt with through the blood of Jesus Christ.

Houmann references the Seventh-day Adventist understanding of death as a “sleep state” of rest until the resurrection, which will occur during the second advent of Jesus Christ. While this understanding provides the consistent philosophical platform for the wholeness principles, it also allows for the dynamic possibilities of hope. This hope of a resurrection provides a vital perspective that transcends the mere provision of healthcare.

### **Prayer**

The sacred use of prayer was referenced as an essential element of Seventh-day Adventist healthcare on four separate occasions. Bradley recounts one zealous nightshift nurse who was waking the patients in order to pray with them. Although this was a bit more ambitious than appropriate, Bradley recounts in the early days of the Florida Sanitarium that prayer was utilized for many issues and crises that arose. On one occasion in the early 1960s, Bradley recalls struggling through the inability to attract nurses for employment. Having exhausted all earthly options, Bradley knelt next to his desk and prayed with an earnest heart as never before. Within 30 minutes, a nurse knocked on his door saying that she was driving by and felt impressed to stop and inquire about employment opportunities.

Prayer continues to be a powerful tool in the current age as well. Wilson shared an experience that happened that week whereby he felt compelled to visit an employee. When he approached her, she indicated that she had been praying for the opportunity to speak with him.

Mattison reflects that when assuming his current responsibilities, he was met with a skeptical and caustic medical staff. At the first Medical Executive Committee, an underlying environment of distrust and hostility was clearly evident. Prior to the next committee meeting, Mattison asked the medical staff president for permission to pray before the next meeting. The entire tone of the meeting and the ongoing relationship has changed based in part to this deeper connection made possible through prayer.

#### Interview Observations

One of the interesting things to note is what was referenced as *not* being one of the core convictions of Seventh-day Adventist healthcare. On three occasions, the issue of converting people into the Adventist belief and fellowship was referenced as not being the specific purpose of Seventh-day Adventist healthcare. While many examples were provided where people have been brought into the fellowship of the Seventh-day Adventist church, for many the point was made that this was *not* one of the core convictions.

In reviewing the interview transcripts after the writing of this section, I searched the manuscripts for pithy statements of value that could summarize the confessional identity and core convictions of Seventh-day Adventist healthcare. In the words of Tom Werner:

God is in the business of restoring. Restoring us from a health perspective. Restoring us in our relationships with each other. And restoring us in the relationship with Him both here on this earth but more importantly in the hereafter. And if we do that well, then we are truly Seventh-day Adventist hospitals.

Another underlying theme articulated by Mattison is that an Adventist hospital should be a place where “people can be introduced to a God who loves and cares for them deeply.”

As Shaw states, “There are very few health systems that have the theological underpinnings that truly understand the intersection of mind, body, and spirit the way we do.” It is this integrated theology of wholeness that provides the undergirding for the Seventh-day Adventist health message.

### **A Synthesis of Seventh-day Adventist Health Core Convictions**

Through the review of the historic literature, a context for the core convictions has been set. Through the review of the General Conference publications, the official guidelines have been considered. Through analysis of the philosophical and theological scholarly papers, the formative doctrine has been reviewed. In considering the view of practicing healthcare administrators, the pragmatic insights have been voiced. The synthesis of each perspective is herein pulled together into the fundamental core convictions that comprise the confessional identity of Seventh-day Adventist healthcare. Each of these core convictions will be discussed after a statement of Adventist theology and philosophy.

#### **Adventist Theology**

According to Reid (1982), “no well-qualified Adventist theologian” has ever developed a theology of health for Seventh-day Adventist healthcare (p. 127). Although this study discusses the theological basis of Seventh-day Adventist health, a thorough and complete analysis is beyond the scope of this study.

In considering the traditions of confessional identity, “the first word” will determine what follows (Martey, 1983, p. 12). For the Seventh-day Adventist Church, the “first word” is captured in its name. The seventh-day Sabbath along with the third angel’s message of a second advent of Christ as recorded in the biblical book of Revelation is the “first word.” Seventh-day Adventist believers have positioned health teachings within the eschatological understanding wherein the end of time, man is restored to God’s likeness in perfect form. In essence, healthful living is to be considered a Christian obligation toward restoration to be fully completed upon the return of Christ (Damsteegt, 1977, p. 229).

In examining the 28 fundamental doctrines of the Church (Ministerial Association, 1988), 17 of these doctrines are integrated and influence the Seventh-day Adventist health message. The 17 doctrines are: (a) the word of God, (b) creation, (c) the nature of man, (d) the great controversy, (e) the life, death, and resurrection of Christ, (f) the experience of salvation, (g) the church, (h) the remnant and its mission, (I) spiritual gifts and ministries, (j) the gift of prophecy, (k) the law of God, (l) the Sabbath, (m) stewardship, (n) Christian behavior, (o) Christ’s ministry in the heavenly sanctuary, (p) the second coming of Christ, and (q) death and resurrection (Jacobs, 1993).

Within the Adventist tradition, the understanding of the body as the temple of God is an important belief worth noting since it has been referenced but not fully developed. As recorded in 1 Cor 6:19-20, we are instructed:

Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honor God with your body.

And further recorded is 1 Cor 3:16-17, which states: “Don’t you know that you yourselves are God’s temple and that God’s Spirit lives in you? If anyone destroys God’s temple, God will destroy him; for God’s temple is sacred, and you are that temple.” The significance of the body being God’s temple is further perpetuated in Rom 12:1-2 which states:

Therefore, I urge you, brothers, in view of God’s mercy, to offer your bodies as living sacrifices, holy and pleasing to God – this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is – His good, pleasing and perfect will.

Lastly, the counsel of 1 Cor 10:31 provides specific direction: “So whether you eat or drink or whatever you do, do it all for the glory of God.”

The doctrine that the body is God’s temple is important to Seventh-day Adventist thought in that it ties together a variety of teachings. In particular are two teachings: the indwelling of the Holy Spirit along with the principle of stewardship that all things belong to God, which man is to oversee. The stewardship of people for their body places a responsibility that is important since this is the vehicle wherein the Holy Spirit provides guidance and comfort (Reid, 1982).

The Seventh-day Adventist Church has not claimed to be the first to recognize the need for health reform. However, Adventists hold the unique distinction to have integrated their health beliefs into their theology, doctrine, and practice. The connection of health with the third angel’s message provides a unique institutionalization of sacred values (Damsteegt, 1977, p. 222). While many of these doctrines are not unique to the Seventh-day Adventist Church, the noteworthy feature is how the doctrine integrates the

health message in such a wholistic fashion. No other denomination can replicate the health message as the Seventh-day Adventists because of this unique understanding and integration of doctrine.

### The Philosophical Core

Although the visions of Ellen G. White provided detailed guidance on healthy living, the philosophical core of Seventh-day Adventist healthcare can be traced back to ancient times. The “nature of man” can be traced to the Hebrew tradition and the “unitary constitution of all nature” is attributed to the Greeks. In addition, the expectant theory of healing which relies on the restorative agency of nature originated with Hippocrates along with rational influences from Galen. Each of these ancient philosophies establishes the framework on which the Seventh-day Adventist health foundation is built (Reid, 1982).

Seventh-day Adventists believe in a loving and personal God who created man in His image. Within creation is a divine law that is melded into nature. Based on the free will of man, the human race has fallen into a sin-plagued existence whereby natural law is continuously violated. The process of restoration is an act of God’s grace provided through the self-sacrifice of Jesus Christ which is thereafter accepted by faith. Our guidance and understanding, therefore, come from the life of Jesus Christ and through God’s revelation, through the Bible, and the natural law of the universe. In this all-inclusive world view, health is a spiritual issue that seeks a restoration through adherence to natural law and the life of Jesus in preparation for the advent of Christ (Reid, 1982).

### The Core Convictions of Seventh-day Adventist Healthcare

In an effort to condense and analyze the abundance of information presented in this chapter, Table 6 presents the themes as considered from the four sources of the historical literature, the General Conference guidelines, the scholarly papers, and the interviews. To provide a synthesis of these themes, where theological and philosophical connections naturally exist, the themes have been collapsed to incorporate sub-themes. In particular, “Love” and “Relationships” is viewed as a sub-theme of the “Healing Ministry of Christ,” “Sabbath” and “Adventist Leadership and Team” are sub-themes of “Honor SDA Beliefs,” and the “Nature of Man” becomes a sub-theme of “Wholeness.” Therefore, all themes and sub-themes that were referenced by at least three of the four sources of qualitative data will comprise the final synthesis of core convictions either as a theme or sub-theme.

The six core convictions of Seventh-day Adventist healthcare are “Wholeness/Nature of Man,” the “Healing Ministry of Christ,” the “Health Principles,” “Honoring the Beliefs of the Seventh-day Adventist Church,” the belief that we are created in the “Image of God,” and “Service to the Community.” A cogent description of each core conviction is hereafter provided followed by the my observations.

#### **Wholeness/Nature of Man**

In each of the 11 interviews, wholeness was expressed and developed by each of the Seventh-day Adventist healthcare administrators. Ted Hamilton, M.D., suggests that wholeness, through an understanding of the nature of man, is such an integral



Table 6

*Analysis of Themes by Source*

Theme	SDA Guidelines	Historical Literature	Scholarly Paper	Interviews
Wholeness	X	X	X	X
Healing Ministry of Christ	X	X	X	X
Health Principles / CREATION	X	X	X	X
Honor SDA Beliefs	X	X	X	X
Sabbath Rest	X	X	X	X
Community Outreach	X	X	X	X
Image of God	X	X	X	X
Excellent Clinical Care	X	X		X
Nature of Man		X	X	X
Relationships	X		X	X
Love	X		X	X
Adventist Leadership and Team	X	X		X
Environment and Service	X			X
Financially Responsible	X			
Competent Staff	X			
Clergy of all Creeds	X			
Prevention Education	X	X		
GC Oversight	X			
Institutional Calling			X	X
Prayer				X
Hope			X	X
Faith				X
Ministry Motive		X		
Three Angels' Message		X		X
Truth				X

component of the Seventh-day Adventist healthcare worldview that if “you cut us, we probably bleed wholeness.”

Ellen G. White brings the clear connection of wholistic medicine into acute specificity wherein she writes:

The relationship which exists between the mind and the body is very intimate. When one is affected, the other sympathizes. The condition of the mind affects the health of the physical system. If the mind is free and happy, from a consciousness of right-doing and a sense of satisfaction in causing happiness to others, it creates a cheerfulness that will react upon the whole system, causing a freer circulation of the blood, and a toning up on the entire body. The blessing of God is a healing power, and those who are abundant in benefiting others will realize that wondrous blessing in both heart and life. (as cited in Van Dolson & Spangler, 1975, p. 5)

As noted by Fritz Guy (2004), the Seventh-day Adventist wholistic view regarding the nature of man is the philosophical basis for the health message. The wholistic view of man created as inseparable physically, mentally, and spiritually is a fundamental philosophy that permeates the health approach of Seventh-day Adventists. The Seventh-day Adventist discernment of the nature of man is the glue that holds the various individual components of the health message together. Van Dolson and Spangler (1975) write that “the nature of man is basic to our philosophy of health. . . . In this view man does not *have* a body; he *is* body” (p. 59, italics in original).

As Richard Rice (2004) declares, wholeness involves the “emphatic rejection of dualism in all its forms. From a wholistic perspective, humans are not composite beings.” The wholistic view of humanity being created as inseparable physically, mentally, and spiritually is a fundamental philosophy that permeates the health approach of Seventh-day Adventists. This view stands in direct opposition to the Hellenistic and Cartesian belief that separates the body from the soul and the corollary immortal soul

theory. The Adventist belief is akin to the mortal man view of Hebrew tradition wherein body and soul subsist within a given individual that exists only as long as a person has breath (Reid, 1982). James White referenced 1 Thess 5:23 which reads: “And the very God of peace sanctify you wholly; and I pray God your whole spirit and soul and body be preserved blameless unto the coming of our Lord Jesus Christ” (KJV) as the connective proof that man is to pursue wholeness on earth in order to be saved whole (Damsteegt, 1977, p. 236).

In Hebrew, the word for being whole and healthy is *shalom* which also signifies peace. This connection in Hebrew thought suggests that a healthy body and peace of mind truly represents wholeness, which is a God-given gift to His people (Van Dolson & Spangler, 1975). In like fashion, Seventh-day Adventist theology is wholistic in nature such that the whole system of belief is called into question when any particular belief is considered.

As one comes to understand wholeness in its entirety, the implications are significant. Healthful living is not merely a pursuit of a physical dimension but also a spiritual endeavor. It is understood that unless healthful living is elevated into the religious experience, the church members will not fully comprehend and accept the integrated nature of wholeness (Damsteegt, 1977).

Adventists believe that the ultimate solution to human problems is within the spiritual realm (Reid, 1982). A significant implication of wholeness for Seventh-day Adventist healthcare is to integrate spirituality into the core process of patient care within the hospital setting. Rather than being viewed as an ancillary chaplaincy service, the care

of spiritual matters must be given an equal emphasis in the care process. Unless the clinical care process reflects the same integrative nature commensurate with the Seventh-day Adventist wholistic philosophy, the risk of deinstitutionalization is considerable. In other words, if spirituality is a separate process to the core patient-care practice, then the spiritual aspect can be decommissioned in practice without intention to effectively dismantle the spiritual aspect of care.

Within the current healthcare environment, significant attention has been given to “mind, body, spirit” or “holistic” medicine. The differentiation in spelling between “holistic” and the Adventist term “wholeness” is noteworthy in that many others are approaching a “mind, body, spirit” methodology from different world view perspectives. Seventh-day Adventists have distanced the more secular “holistic” form from the Christ-centered concept of “wholistic” (Olsen, 1984). As Des Cummings articulates, the Seventh-day Adventist church is “the only Christian faith that has a wholistic theology.” As others attempt to integrate holistic methods into their practice, Cummings believes they “will be unable to actually integrate into a wholistic system because they will not have a pattern of protocols for the spiritual.” In essence, the spiritual will be undefined and, therefore, without context to manage within the realm of clinical protocols.

Although there continues to be significant interest in health promotion within the Seventh-day Adventist Church today, the concentration seems to be focused on the physical benefits rather than the spiritual advantages that were core when health reform was first introduced. Furthermore, the connection of health reform with the three angels’ message does not appear to be fully understood or appreciated. Therefore, a new health

reformation is necessary to reengage the true motivation and bring clarity for practicing wholistic healthcare.

### **The Healing Ministry of Christ**

According to Ellen G. White, Jesus spent more time healing than preaching (1940, p. 350). The book *The Ministry of Healing* by Ellen G. White is the landmark expression of Seventh-day Adventist health philosophy. In this classic book, the healing ministry of Jesus Christ is recounted and then health principles are outlined for modern application. The essence of the healing ministry of Christ is a message of love that seeks to relieve the affliction and bring full restoration to man.

Mark 2:5 recounts the story of a paralytic lowered from the ceiling because the house in Capernaum was so filled with those seeking to hear Jesus speak. Rather than simply addressing the physical paralysis, Mark records that Jesus recognized their faith and stated, “Your sins are forgiven.” In essence, Jesus was demonstrating that not only did Christ have the power and interest in physical healing but also spiritual healing as well. This connection between faith and healing is repeated in the healing of Bartimaeus (Mark 10:52; Luke 18:42), the woman who was healed by touching Jesus’ cloak (Matt 9:22; Mark 5:34; Luke 8:48), and the single leper who returned to thank Jesus (Luke 17:19) wherein each was told that his or her “faith has made you well.”

Brunt (1981) states that the words associated with healing have a variety of translations which include the expected “to heal from disease” but also include “to rescue” and “to save” in a spiritual sense (pp. 20-21). According to this understanding, Jesus was telling those healed that their faith not only restored their physical issues but

also brought spiritual salvation. As Christians, “we are to engage in whatever brings our thoughts and bodies into the discipline of Christ, who desires our wholesomeness, joy and goodness” (Ministerial Association, 1988, p. 278).

As noted by Richard Rice (2004), one of the features that has distinguished Christians from the earliest days in the Mediterranean world was their care for the sick. As demonstrated by Alden Thompson (2004), this is true in large measure because the very ministry of Christ cared for the physical and spiritual, demonstrating that the two are inseparable. The ministry of Christ is a calling to follow in His footsteps by caring for the whole person with care and compassion. By caring for the physical and spiritual needs of our community, we are extending the healing ministry of Christ.

### **Health Principles**

According to the 21<sup>st</sup> doctrine of the Seventh-day Adventist Church: “We are called to be a Godly people who think, feel and act in harmony with the principles of heaven” (Ministerial Association, 1988, p. 278). The eight principles of health as recorded by Ellen G. White (1942) are “pure air, sunlight, abstemiousness, rest, exercise, proper diet, the use of water, trust in divine power – these are the true remedies” (p. 127). These principles are commonly referenced within Seventh-day Adventist circles by the acronym NEWSTART (a trademark of the Weimar Institute of Health & Education) which stands for Nutrition, Exercise, Water, Sunshine, Temperance, Air, Rest, and Trust in divine power. These eight principles are defined utilizing the official manuscript of the Seventh-day Church describing doctrinal convictions entitled *Seventh-day Adventists Believe . . .* (Ministerial Association, 1988, pp. 281-286):

*Nutrition:* The original diet established by God in the Garden of Eden consisting of grains, fruits, nuts, and vegetables provide the entire nutritional values necessary for optimum health.

*Exercise:* To obtain and maintain optimal physical and mental health, a regular physical exercise program is necessary.

*Water:* In addition to the therapeutic and hygienic properties of water, consumption of six to eight glasses of pure water per day is vital for healthy well-being.

*Sunlight:* As recorded in Gen 1:3, light is essential to life. Sunlight promotes health and healing through the natural human process.

*Temperance:* The abstinence of harmful stimulants such as caffeine, alcohol, tobacco, and drugs will result in a more healthy and robust existence.

*Air:* The abundance of fresh air both in nature as well as inside buildings is necessary to maintain optimal mental and physical functioning.

*Rest:* In addition to the necessity for rest through sufficient sleep, physical and mental health is also a function of a Sabbath rest whereby all the duties and responsibilities are set aside on a weekly basis for 1 day to connect with God and man.

*Trust in Divine Power:* A personal spiritual relationship with God will assist in dealing with daily challenges in a more productive and healthy fashion.

In an adaptation of the original health principles articulated by Ellen G. White, Florida Hospital has reframed the eight principles into the acronym CREATION in response to explain the Seventh-day Adventist philosophy of health from strictly biblical sources. According to this model, the principles of health are *Choice, Rest, Environment,*

*Activity, Trust in divine power, Interpersonal relationships, Outlook, and Nutrition* (Cummings & Reed, 2003). Although the CREATION model is different in nomenclature, the philosophy is absolutely consistent and mutually reinforcing with the models previously referenced.

As demonstrated by the voluminous scientific studies on the health benefits of the Seventh-day Adventist health lifestyle, the health principles are not only spiritually relevant, they are fundamental to a healthy life. Regardless of the preferred acronym, the message is essentially important to wholeness and vitality.

### **Image of God**

At creation, God spoke man into being in His image, in His likeness (Gen 1:26-27). From a health standpoint, this would seem to motivate two responses. The first is the sense of duty to maintain our bodies and our entire being in as pure and healthy manner as possible. The second implication is that as we consider our fellow man, it is our sacred trust to be afforded the opportunity to serve others in recognition that they are also an image of God.

As written by Van Dolson and Spangler (1975): “The great goal of health is not health for health’s sake, but sanctification – the restoration of man even in this life to the image of God, physically, mentally, socially, and spiritually” (p. 55). It is this restoration of health, restoration of relationships and a restoration with God that Tom Werner spoke about as being the fundamental purpose of Seventh-day Adventist healthcare.



### **Honoring Seventh-day Adventist Beliefs**

In the words of Mardian Blair, an Adventist hospital should be a place “where Seventh-day Adventism is proudly displayed.” Alden Thompson (2004) succinctly stated that the “name Seventh-day Adventist carries the true features of our faith in front, and will convict the inquiring mind.” Therefore, in addition to the third angel’s message announcing the second advent of Christ, the one that seems to be the most sacred to understand and protect within healthcare is the doctrine of the Sabbath.

In examining the New Testament, the vast majority of references to the Sabbath are in conjunction with one of the healing miracles performed by Jesus. In an attempt to protect the gift of Sabbath, the religious leaders of Jesus’ day had created a laborious set of rules to stipulate appropriate behaviors in a multitude of situations. In this legalistic environment, the significance of the Sabbath had been misrepresented and fundamentally obscured (Brunt, 1981).

There are five separate miracles of healing on the Sabbath recorded in the Bible: the healing of a man with a withered hand (Matt 12:9-14; Mark 3:1-6; Luke 6:6-11), a crippled woman with a stooped back (Luke 13:10-17), the man suffering from dropsy (Luke 14:1-6), the man at the pool of Bethesda (John 5), and the man born blind (John 9). In looking at these five miracles, Brunt (1981) highlights the common themes and learnings that emerge from an examination of these five Sabbath miracles. Interestingly, Jesus performed these miracles on Sabbath for the distinct purpose of communicating a different perspective about Sabbath. Of these five miracles, each was performed for chronic conditions rather than acute suffering. Specifically, the Bible reflects that the

woman with the stooped back had this condition for 18 years. The blind man had been born that way and the man at Bethesda had been there for 38 years waiting for his opportunity to slip into the pool when the healing angel ruffled the waters. Whereas Jewish law allowed for healing on Sabbath in acute life-threatening situations, chronic conditions as just described were to be deferred to the end of Sabbath. Furthermore, Jesus took the initiative to heal in each of these five occasions proactively without being requested. The final emerging theme is that Jesus ensured that each of the miracles were performed in a very public way and used the occasion to teach about the Sabbath.

The learning that Jesus was intent upon conveying is to show the purpose of Sabbath. Clearly, Sabbath was being defiled by the Jewish leaders through the reduction of these sacred hours into a listing of rules and prohibitions. The fact that Jesus chose to teach about the Sabbath through the act of healing is noteworthy. Throughout His ministry and healing miracles, Jesus connected physical healing with spiritual healing. By performing these miracles on Sabbath, the three aspects of spiritual restoration, physical healing, and Sabbath become connected. Through a relational connection with God and man, the gift of Sabbath allows for a salvific restoration and wholistic healing (Brunt, 1981).

An underlying premise is that in order to preserve and protect the beliefs of the Seventh-day Adventist Church, the vast majority of leadership positions and a critical component of the hospital team should be members of the Church. While other Christian faiths will certainly be necessary and appropriate to extend the healing ministry of Christ,

there are certain sacred beliefs such as the Sabbath that can best be understood by those that hold and practice such a belief.

### **Service to the Community**

While at first the health reform message was directed primarily at Seventh-day Adventist members, Ellen G. White professed clear guidance that the health reform message and health facilities were for the purpose of helping all mankind to appreciate the benefits of the health principles. The health reform message was viewed as cultivation to prepare the masses to accept the third angel's message of the second coming of Christ (Damsteegt, 1977). In referring to the need to establish the first health facility, Ellen G. White (1948a) remarked that "such an institution, rightly conducted, would be the means of bringing our views before many whom it would be impossible for us to reach by the common course of advocating truth" (pp. 492-493).

In the words of Des Cummings, the most natural interface between the church and the community is through healthcare. However, the work of health reform should never be limited to hospitals and health facilities. As noted by Don Jernigan, every Adventist hospital has a responsibility to extend beyond their walls to care for the health status of the community. Furthermore, the message of wholeness is a mantra that cannot be contained to a hospital setting but is fully applicable to all facets of life.

### **Researcher's Observations**

In concluding the listing of the core convictions, it is necessary to survey not only those items listed but also to account for those not cited. In considering those core

convictions listed in Table 2, there are several observations worth noting. Whereas the furtherance of the third angel's message was a clear motivating force in the early health reformation days, during the interviews it was expressly stated that Seventh-day Adventist healthcare should not be considered an evangelistic ministry. From my vantage, this issue is worth noting, but does not represent a denigration of the Seventh-day Adventist health message.

If John Harvey Kellogg, M.D., were to reemerge to the current scene, I think he would scream for Seventh-day Adventist healthcare to reestablish the curiosity of inquiry and innovation to unearth present truth. Rather than simply following the acute care practices institutionalized throughout all hospitals, the spirit of inquiry and healthy practice should be reengaged.

In regard to the health principles and a wholistic orientation, these are clearly stated as core convictions but may be lacking in practice compared to the days of Ellen G. White. While the degree of current alignment and gaps will be further determined in chapter 5, an underlying factor to the success of the health principles and a wholistic orientation is a focus on education. In the early days, significant resources and energy were devoted to the education of the community regarding healthy living practices; the current evidence would suggest that the Seventh-day Adventist Church devotes its current resources and energy to the provision of acute care medicine. While I do not think that education is a core conviction, the reformation zeal has clearly been tempered by the lack of funding for health education. That being the case, health education is a natural part of our heritage and should continue to be an ongoing focus.

Being that the majority of funding for our Seventh-day Adventist hospitals comes through reimbursement from governmental sources, one could easily question if the health message needs to establish its position in religious liberty and the separation of church and state. While this is a worthy question, in my opinion it does not rise to the level of a core conviction.

In the final analysis, the six core convictions as stated are believable and defensible. It is prudent to also consider those issues around the periphery. While the confessional identity is the sacred ideology, there are many other issues as herein referenced which must also be monitored and protected to ensure the sustenance of Seventh-day Adventist healthcare. However, it is my premise that the core convictions of Seventh-day Adventist healthcare are “Wholeness/Nature of Man,” the “Healing Ministry of Christ,” the “Health Principles,” “Honoring the Beliefs of the Seventh-day Adventist Church,” the belief that we are created in the “Image of God,” and “Service to the Community.”

### **The Institutionalization of the Core Convictions**

Ellen G. White (1948a) provides a firm warning to the leaders at the Battle Creek Sanitarium to remain firm in protecting and promoting the vision of health and its connection to the gospel of Christ wherein she writes:

The health reform is a branch of the special work of God for the benefit of His people. I saw that in an institution established among us the greatest danger would be of its managers departing from the spirit of the present truth, and from that simplicity which should ever characterize the Disciples of Christ.

God forbid, that [the patients] should ever be disappointed and grieved in finding the managers of the Institute working only from a worldly standpoint instead of

adding to the hygienic practice the blessings and virtues of nursing fathers and mothers in Israel. (pp. 560-561)

This statement speaks clearly to the risk of deinstitutionalization which can readily occur when the managers and employees start to interpret their work through “a worldly standpoint” rather than as an extension of the healing ministry of Christ. Simply stated, the “greatest danger” to the Battle Creek Sanitarium was the deinstitutionalization of the core convictions of Seventh-day Adventist healthcare. To restate in the language of the theory base established in chapter 2, there is the grave possibility of deinstitutionalization when the leaders and employees enact a new reality through the interpretation of plausible environmental clues that are not in harmony with the institutional values.

In an attempt to outline the institutional factors necessary for ongoing success, Elder G. A. Irwin, President of the Board of Trustees for the College of Medical Evangelists, stated that a “steadfast adherence upon the part of the directors and medical faculty to the principles contained in the instruction upon which the institution was founded” (Robinson, 1965, p. 391) would be absolutely crucial.

The early founders of Seventh-day Adventist healthcare clearly understood the “greatest danger” to the Battle Creek Sanitarium would be the “departing from the spirit of present truth.” The leaders were called to protect the confessional identity through reflection and devotion to the ministry of Christ. The same challenge exists today that through a complete and devoted adherence to those items of sacred importance, the “spirit of present truth” will continue to find new applications for the core convictions within the context of the technological and sociological realities of the 21<sup>st</sup> century. It is clear that the health status of our world is different today from 1866, but in many ways

the challenge remains the same. Fortunately, the prescription has been written. Through the work of the Great Physician, the treatment can be rendered if a steadfast devotion to the core convictions is valued and implemented throughout each level of the organization.

Lest anyone propose that these institutional values are either unimportant or of vague consequence, one needs only to recall the experience of the Battle Creek Sanitarium. Although this first and most prominent Seventh-day Adventist health facility systematically changed the course of health habits in the United States, the separation of its leaders from the core convictions of the Seventh-day Adventist church in due course led to its demise. Unless the leaders, managers, and employees have an understanding and commitment to these values, the organization is likely setting on a path to deinstitutionalization.

The core convictions of Seventh-day Adventist healthcare as herein determined are wholeness, the healing ministry of Christ, the health principles, cherishing the beliefs of the Seventh-day Adventist Church, the belief that we are created in the image of God, and service to the community. These core convictions must not only be institutionalized, they must also be the paradigm by which its senior leaders, middle management, and employees function. In the next chapter, the results and analysis of a questionnaire survey are reported and explore the levels of engagement and alignment of the leaders, managers, and employees with these core convictions at Florida Hospital in Orlando, Florida.

## CHAPTER FIVE

### QUANTITATIVE RESULTS

#### **Introduction**

In this chapter, the findings from the quantitative research are presented. The research question with four corresponding null hypotheses are detailed, followed by a description of the population and demographics. The next section of the chapter describes the data analysis and results formatted around the four null hypotheses. The chapter concludes with a summary of the quantitative findings.

#### **Research Question**

The purpose of this quantitative research is to build on the core convictions identified in chapter 4 and contemplated in the second research question, which queries: “To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?” The results of the testing are presented in this chapter:

Null Hypothesis 1: There is no difference between senior leaders, middle management, and employees’ perceptions across the six core convictions.



Null Hypothesis 2: There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

Null Hypothesis 3: There is no difference between religious groups across the six core convictions.

Null Hypothesis 4: There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.

### **Population and Demographics**

Within this section, the survey population is profiled with a basic demographic sketch. On the questionnaire, two questions regarding demographic data were specifically included due to their relevance to this research and the underlying theory base. The first query regarded years of service and the second asked for religious affiliation. Hereafter in this section, the population is reviewed, followed by a description of religious affiliation, and concludes with years of service by segmented population group.

### **Population and Response Rate**

A summary of the survey population and response rates is shown in Table 7. The entire population of 43 senior leaders was surveyed with a response rate of 95% ( $n = 41$ ). The entire population of 292 middle management was also surveyed with a 74% response rate ( $n = 215$ ). A random sample of 1,000 employees with at least 5 years'

experience at Florida Hospital was also provided a survey. The entire population for this group is 6,265. The response rate for the employee group was 40% ( $n = 397$ ), which is sufficient representation for a 95% confidence level with a 5% margin of error as determined on [www.surveysystem.com/sscalc.htm](http://www.surveysystem.com/sscalc.htm).

Table 7

*Survey Population and Response Rates*

Segmented Group	Total Population	Survey Eligible	<i>N</i>	Response Rate	Margin of Error
Senior Leaders	43	43	41	95%	—
Middle Management	292	292	215	74%	—
Employees	6,265	1,000	397	40%	5%

## Religious Affiliation

The faith backgrounds included in the analysis are Protestant Christian ( $n = 272$ ), Seventh-day Adventist ( $n = 173$ ), Roman Catholic ( $n = 153$ ), No Religion ( $n = 35$ ), and Other Religion ( $n = 15$ ). Within the survey, those who chose Other Religion were given the opportunity to input their specific religious faith. Religions typed in, such as Baptist, Born Again Christian, Christian, Episcopal, Evangelical, Lutheran, Methodist, Non-Denominational Christian, and Southern Baptist, were reclassified to “Protestant

Christian.” Those who remained in the Other Religion include Judaism ( $n = 5$ ), The Church of Jesus Christ of Latter-day Saints ( $n = 4$ ), Buddhist ( $n = 2$ ), Hindu ( $n = 1$ ), Jehovah’s Witness ( $n = 1$ ), Quaker ( $n = 1$ ), and Rastafarian ( $n = 1$ ).

### Years of Service

To ensure that employees have sufficient exposure to the institutional values of Florida Hospital, a condition of participation required at least 5 years of employment. This requirement was not imposed on the senior leaders and middle management since mission orientation and education are a core function of the hiring and on-boarding process. The years of service by segmented population are shown in Table 8. It should be noted that the employees who indicated between 0 - 4 years of service ( $n = 3$ ) were not excluded because their years of service were confirmed in the Human Resources database as being 5 years or greater despite their response on the questionnaire.

In considering the years of service across the three segmented groups, the senior leaders and middle management participation appear to represent a normal distribution with the employees skewing towards the fewer years of service.

### Questionnaire Instrument and Analysis

As more fully described in chapter 3, the questionnaire is formatted around the six core convictions starting with a definition of that specific core conviction followed by a series of statements. The survey participants then rated their level of agreement with those statements based on a Likert scale from (1) Strongly Disagree, (2) Disagree, (3)

Undecided, (4) Agree, (5) Strongly Agree with the option to select (N/A) for Unknown.

The questionnaire was administered between January 30 and February 20, 2006, online

Table 8

*Years of Service at Florida Hospital by Segmented Groups*

Years of Service	Senior Leaders <i>N</i>	Middle Management <i>N</i>	Employees <i>N</i>	Total
0 – 4	3	25	3	31
5 – 9	7	52	138	197
10 – 14	4	40	98	142
15 – 19	8	35	77	120
20 – 24	11	24	31	66
25 – 29	4	28	35	67
30 +	4	11	15	30
Total	41	215	397	653

utilizing the Zoomerang ([www.Zoomerang.com](http://www.Zoomerang.com)) online platform. A copy of the questionnaire is provided in Appendix B. Due to the multiple analysis of the data across the four null hypotheses, the possibility of Type 1 errors may increase and are herein acknowledged. For the purposes of this analysis, the statistical probabilities are considered and reported at the  $p < .05$  and  $p < .01$  which allows the reader to draw

individual conclusions regarding statistical significance. For the purposes of this research, statistical significance is set at  $p < .05$ .

### **Null Hypothesis 1**

The purpose of this section is to fully explore the first null hypothesis which states: “There is no difference between senior leaders, middle management, and employees’ perceptions across the six core convictions.” As detailed in Table 9, the mean is higher at the senior leader level compared to the other two segmented groups (except in Wholeness compared to middle management) with a smaller standard deviation. Likewise, the mean at the middle management level is higher with a smaller standard deviation compared to the employees. Therefore, in general, the higher organizational levels have higher means and smaller standard deviations compared to the employees.

Despite the fact that the mean is higher and the standard deviation is smaller at the senior level compared to the other two groups and middle management is higher than the employee level, it is unclear at this juncture if these differences are statistically significant. In the following sections, these comparisons are further delineated to determine if statistically significant variances exist among each of the groups. To test the statistically significant alignments and deviations of the segmented groups across the core convictions, a one-way ANOVA by core conviction was performed with a subsequent post hoc analysis where significant differences are determined. A test of

homogeneity of variance by each core conviction was first conducted to test for the equality of population variances, which is a necessary assumption for ANOVA purposes.

Table 9

*Mean and Standard Deviation by Segmented Groups*

Core Conviction	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Wholeness	41	4.07	0.93	215	4.09	0.90	397	3.93	1.01
Healing Ministry	41	4.61	0.61	215	4.46	0.76	397	4.21	0.95
Health Principles	41	4.47	0.82	215	4.42	0.83	397	4.41	0.81
Honor SDA Beliefs	41	4.41	0.81	215	4.31	0.83	397	4.07	0.96
Image of God	41	4.37	0.79	215	4.24	0.90	397	4.15	1.03
Community	41	4.32	0.73	215	4.30	0.83	396	4.05	1.00

## Test of Homogeneity

The first test conducted is a test of homogeneity of variances across the six core convictions. Given the large differences in sample sizes between the three segmented populations, it is imperative to test the equality of population variance. As noted in Table 10, there are statistically significant differences among population variances with all six

core convictions ( $p = 0.000$ ). Given that the assumption of homogeneity of variance has been rejected, the selection of the post hoc method was the Tamhane's T2.

Table 10

*Test of Homogeneity of Variances by Core Conviction*

Core Conviction	Levene Statistic	<i>df</i> 1	<i>df</i> 2	<i>p</i>
Wholeness	8.33	2	650	0.000
Healing Ministry	13.17	2	650	0.000
Health Principles	8.53	2	650	0.000
Honor SDA Beliefs	10.98	2	650	0.000
Image of God	14.18	2	650	0.000
Community	9.90	2	650	0.000

## Analysis of Variance by Core Conviction

In Table 11, the results from a one-way ANOVA are presented by each of the six core convictions comparing the three segmented groups of senior leaders, middle management, and employees. The ANOVA demonstrates that statistically significant differences exist in five of the six core convictions. In particular, a significant *F* value was determined in Wholeness ( $p = 0.003$ ), Healing Ministry of Christ ( $p = 0.000$ ), Honoring the Seventh-day Adventist beliefs ( $p = 0.000$ ), Image of God ( $p = 0.047$ ), and Community ( $p = 0.000$ ). The sole core conviction where alignment exists between the groups is the Health Principles.

Table 11

*Analysis of Variance by Core Conviction*

Core Conviction		Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	$\eta_p^2$
Wholeness	Between	4.10	2	2.05	5.92**	0.003	0.018
	Within	224.90	650	0.35			
	Total	228.99	652				
Healing Ministry	Between	12.47	2	6.23	18.18**	0.000	0.053
	Within	222.90	650	0.34			
	Total	235.36	652				
Health Principles	Between	0.15	2	0.07	0.43	0.651	0.001
	Within	111.91	650	0.17			
	Total	112.06	652				
Honor SDA Beliefs	Between	10.06	2	5.03	12.07**	0.000	0.036
	Within	270.84	650	0.42			
	Total	280.90	652				
Image of God	Between	2.60	2	1.30	3.08*	0.047	0.009
	Within	274.99	650	0.43			
	Total	277.59	652				
Community	Between	9.90	2	4.95	15.57**	0.000	0.046
	Within	206.32	650	0.32			
	Total	216.22	652				

\*  $p < .05$ . \*\*  $p < .01$ .



For each ANOVA hereafter, the effect size for each variable is reported as the partial eta squared ( $\eta_p^2$ ). For interpretive purposes, the guidelines established by Green and Salkind (2004) are used wherein 0.01 is considered a small effect, 0.06 is a medium effect, and 0.14 is a large effect. As shown in Table 11, small effects can be attributed to Wholeness ( $\eta_p^2 = 0.018$ ), Honoring the Seventh-day Adventist Beliefs ( $\eta_p^2 = 0.036$ ), and Community ( $\eta_p^2 = 0.046$ ) while the Healing Ministry of Christ ( $\eta_p^2 = 0.053$ ) is approaching a medium effect.

Given the significance of the  $F$  value in five of the six core convictions, post hoc multiple comparisons were conducted to determine specific group differences. Tamhane's T2 was utilized since the homogeneity of variance assumption was violated. The results are shown in Table 12.

From this post hoc analysis, it is first determined that full alignment exists between senior leaders and middle management. Senior leaders are aligned with employees on Wholeness, and middle management is aligned with employees on the Image of God. However, statistically significant differences are present between the senior leaders and middle management compared to the employees. Specifically, senior leaders vary from employees in the Healing Ministry ( $p = 0.000$ ), Honoring the Seventh-day Adventist beliefs ( $p = 0.000$ ), Image of God ( $p = 0.016$ ), and Community ( $p = 0.001$ ). The differences between middle management and employees are evident in Wholeness ( $p = 0.002$ ), Healing Ministry of Christ ( $p = 0.000$ ), Honoring the Seventh-day Adventist Beliefs ( $p = 0.000$ ), and Community ( $p = 0.000$ ).

Table 12

*Post Hoc Analysis by Core Conviction*

Core Conviction	Group	Mean	Middle Management <i>p</i>	Employee <i>p</i>
Wholeness	Senior	4.07	0.986	0.179
	Middle	4.09	—	0.002**
	Employees	3.93		
Healing Ministry	Senior	4.61	0.068	0.000**
	Middle	4.46	—	0.000**
	Employees	4.21		
Honor SDA Beliefs	Senior	4.41	0.407	0.000**
	Middle	4.31	—	0.000**
	Employees	4.07		
Image of God	Senior	4.37	0.266	0.016*
	Middle	4.24	—	0.203
	Employees	4.15		
Community	Senior	4.32	0.986	0.001**
	Middle	4.30	—	0.000**
	Employees	4.05		

\*  $p < .05$ . \*\*  $p < .01$ .

Before drilling the data to the question level, it is appropriate to pull the various analyses together into a coherent preliminary explanation of understanding. It has been established that statistically significant differences exist between a majority of the core convictions when comparing the senior leaders and middle management to the employees. In reviewing the means from Table 12, the overall means range from 3.93 to 4.61 on a 5-point Likert scale, which are relatively high indicating respectable levels of

institutionalization of the core convictions. The highest mean ratings across all three groups is the Healing Ministry of Christ (senior leaders [4.61], middle management [4.46], and employees [4.21]). The lowest ratings across all three groups is for Wholeness (senior leaders [4.07], middle management [4.09], and employees [3.93]). Interestingly, the means tend to move in sync across the core convictions such that all three groups are proportionately higher and lower in similar proportion to the other core convictions. Furthermore, the low effect sizes ( $\eta_p^2$  of 0.001 to 0.053) suggest a small magnitude of group differences. However, the statistically significant gaps between the senior leaders and middle management compared to the employees suggest a dissonance in the sensemaking paradigm based on positional level within the organization.

Having established that statistically significant differences exist in five of the six core convictions and then further detecting differences in five core convictions between senior leaders and middle management compared to the employees, it is of interest to further isolate the specific area(s) of disconnect. To do so, item-level analysis of variance was conducted for each of the five core convictions.

#### **Analysis of Variance for Wholeness**

The six questions that comprise the core conviction of Wholeness are presented in Table 13 with the sample size, mean, and standard deviation for each. It is interesting to note that on the first two questions that probe the cognitive dimension of Wholeness, the means are higher and the standard deviations are smaller for the higher levels in the organization compared to employees. However, on Question 4 which queries if the caregivers practice wholistic care at Florida Hospital, the employees' mean is higher than

Table 13

*Mean and Standard Deviation of Segmented Groups for Wholeness by Question*

Question	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
1. I understand FH's concept of wholeness.	41	4.61	0.59	214	4.64	0.62	396	4.40	0.77
2. I believe in the importance of wholistic living and care.	41	4.85	0.36	215	4.78	0.46	396	4.56	0.62
3. I engage in wholistic practices to keep my mind, body, and spirit well.	41	4.20	0.60	215	4.15	0.72	392	4.15	0.79
4. The caregivers at FH practice wholistic care.	39	3.44	0.75	206	3.47	0.85	379	3.60	0.90
5. My entire health including mind, body, and spirit are nurtured at FH.	41	3.29	1.08	215	3.61	0.96	396	3.35	1.12
6. I feel a sense of wholeness at FH.	41	4.00	0.84	215	3.87	0.86	394	3.51	1.07

the senior leaders and the middle management. It is disconcerting that the collective means on Questions 4 and 5, which test the behaviors and affective connection with Wholeness, are among the lowest of any of the 44 questions in this survey.

A one-way ANOVA was conducted for the six questions which comprise the core conviction entitled Wholeness. See Table 14. Through this analysis, it was determined that a significant  $F$  value exists for Question 1: I understand Florida Hospital's concept of wholeness ( $p = 0.000$ ), Question 2: I believe in the importance of wholistic living and care ( $p = 0.000$ ), Question 5: My entire health including mind, body, and spirit are nurtured at Florida Hospital ( $p = 0.011$ ), and Question 6: I feel a sense of wholeness at Florida Hospital ( $p = 0.000$ ). It is worth noting that Questions 1 and 2 examine the cognitive understandings, whereas Questions 5 and 6 connect with the affective. It is in the behavioral aspects tested in Questions 3 and 4 that an alignment appears to be present. These dimensional differences will be further discussed in the next section on Null Hypothesis 2.

In considering the effect of each question between the three segmented groups displayed in Table 14, a small effect is determined for Question 1: I understand Florida Hospital's concept of wholeness ( $\eta_p^2 = 0.026$ ), Question 2: I believe in the importance of wholistic living and care ( $\eta_p^2 = 0.040$ ), Question 5: My entire health including mind, body, and spirit are nurtured at Florida Hospital ( $\eta_p^2 = 0.014$ ), and for Question 6: I feel a sense of wholeness while working at Florida Hospital ( $\eta_p^2 = 0.036$ ).

To further isolate the differences in the four questions identified with significant  $F$  values, a post hoc analysis was conducted using Tamhane's T2 given the violation of

Table 14

*Analysis of Variance for Wholeness by Question*

Question		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
1. I understand Florida Hospital's concept of wholeness.	Between	8.88	2	4.44	8.78**	0.000	0.026
	Within	327.81	648	0.51			
	Total	336.69	650				
2. I believe in the importance of wholistic living and care.	Between	8.39	2	4.20	13.40**	0.000	0.040
	Within	203.27	649	0.31			
	Total	211.66	651				
3. I engage in wholistic practices to keep my mind, body and spirit well.	Between	0.09	2	0.05	0.08	0.923	0.000
	Within	368.39	645	0.57			
	Total	368.48	647				
4. The caregivers at Florida Hospital practice wholistic care.	Between	2.85	2	1.43	1.86	0.156	0.006
	Within	475.89	621	0.77			
	Total	478.74	623				
5. My entire health of mind, body and spirit are nurtured at FH.	Between	10.32	2	5.16	4.54*	0.011	0.014
	Within	737.58	649	1.14			
	Total	747.89	651				
6. I feel a sense of wholeness at Florida Hospital.	Between	23.77	2	11.89	12.13**	0.000	0.036
	Within	634.09	647	0.98			
	Total	657.86	649				

\*  $p < .05$ . \*\*  $p < .01$ .

the homogeneity variance assumption. In Table 15, it is notable that senior leaders and middle management have full alignment with all four questions. The senior leaders are aligned with employees on Questions 1 and 5 but have a statistically significant difference with Question 2 ( $p = 0.000$ ) and 6 ( $p = 0.003$ ). Middle management is statistically different compared to employees on Questions 1 and 2 which probe the cognitive understanding and also Questions 5 and 6 which test the affective connection. The mean scores for Question 5 ( $m = 3.35$ ) and Question 6 ( $m = 3.51$ ) are among the lowest of all 44 questions on the survey which incates a fundamental lack of personal connection to wholeness among the employees.

#### **Analysis of Variance for the Healing Ministry of Christ**

The number of responses, means, and standard deviations for the six questions that comprise the core conviction of the Healing Ministry of Christ are detailed in Table 16. In reviewing the overall means by question, there is a significant difference between the first two questions with a mean range of 4.59 - 4.95, which probe the cognitive dimension compared to the more affective aspect of sensing love and grace as queried in Question 5 with a mean range of 3.68 - 4.14.

A one-way ANOVA was conducted for the six questions which comprise the core conviction entitled the Healing Ministry of Christ. See Table 17. Through this analysis, it was determined that a significant  $F$  value exists for all six questions. Specifically, the differences are for Question 1: I understand what it means to extend the healing ministry of Christ ( $p = 0.000$ ), Question 2: I believe that Christ provides an excellent model of

Table 15

*Post Hoc Analysis of Wholeness by Question*

Question	Group	Mean	SD	Middle Management <i>p</i>	Employee <i>p</i>
1. I understand FH's concept of wholeness.	Senior	4.61	0.59	0.987	0.105
	Management	4.64	0.62	—	0.000**
	Employee	4.40	0.77		
2. I believe in the importance of wholistic living and care.	Senior	4.85	0.36	0.599	0.000**
	Management	4.78	0.46	—	0.000**
	Employee	4.56	0.62		
5. My entire health including mind, body and spirit are nurtured at FH.	Senior	3.29	1.08	0.235	0.985
	Management	3.61	0.96	—	0.008**
	Employee	3.35	1.12		
6. I feel a sense of wholeness at Florida Hospital.	Senior	4.00	0.84	0.766	0.003**
	Management	3.87	0.86	—	0.000**
	Employee	3.51	1.07		

\*  $p < .05$ . \*\*  $p < .01$ .

compassionate care ( $p = 0.004$ ), Question 3: I extend the healing ministry of Christ ( $p = 0.036$ ), Question 4: I utilize prayer at Florida Hospital to extend the healing ministry of Christ ( $p = 0.000$ ), Question 5: I sense a spirit of love and grace at Florida Hospital ( $p = 0.000$ ), and Question 6: I experience meaning from the mission of Florida Hospital ( $p = 0.000$ ).

In considering the effect of each question between the three segmented groups displayed in Table 17, small effects are determined for Question 1: I understand what it



Table 16

*Mean and Standard Deviation of Segmented Groups for Healing Ministry by Question*

Question	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
1. I understand what it means to extend the healing ministry of Christ.	41	4.89	0.33	215	4.75	0.43	395	4.59	0.59
2. I believe that Christ provides an excellent model of compassionate care.	41	4.95	0.22	213	4.89	0.36	393	4.78	0.53
3. I extend the healing ministry of Christ.	41	4.46	0.55	212	4.53	0.55	386	4.39	0.74
4. I utilize prayer at FH to extend the healing ministry of Christ.	41	4.51	0.75	212	4.25	0.92	383	3.94	1.05
5. I sense a spirit of love and grace at FH.	41	4.14	0.69	214	3.95	0.90	395	3.68	1.08
6. I experience meaning from the mission of FH.	41	4.68	0.57	212	4.37	0.76	392	3.88	1.06

means to extend the healing ministry of Christ ( $\eta_p^2 = 0.030$ ), Question 2: I believe that Christ provides an excellent model of compassionate care ( $\eta_p^2 = 0.017$ ), Question 3: I extend the healing ministry of Christ ( $\eta_p^2 = 0.010$ ), Question 4: I utilize prayer at Florida Hospital to extend the healing ministry of Christ ( $\eta_p^2 = 0.033$ ) and Question 5: I sense a spirit of love and grace at Florida Hospital ( $\eta_p^2 = 0.023$ ). A medium effect is determined for Question 6: I experience meaning from the mission of Florida Hospital ( $\eta_p^2 = 0.078$ ).

As will be further considered in Null Hypothesis 2, it should be noted that a statistically significant variance exists in all three dimensions of cognitive (Questions 1 and 2), behavioral (Questions 3 and 4), and affective (Questions 5 and 6).

To further isolate the differences in the six questions identified with significant  $F$  values, a post hoc analysis was conducted using Tamhane's T2 given the violation of the homogeneity variance assumption, except on Question 4 where Tukey's HSD was used because the assumption of homogeneity was confirmed. In Table 18 it is notable that senior leaders and middle management are fully aligned in the first five questions but have a statistically significant difference in Question 6: I experience meaning from the mission of Florida Hospital ( $p = 0.009$ ).

In comparison to employees, the senior leaders and middle management are statistically different on all six questions except in Question 3 wherein senior leaders and employees are aligned. The details of these differences are fully displayed in Table 18.

Although there are statistically significant differences on almost every question when comparing the senior leaders and middle management to employees, an analysis of the means is even more telling. The gap between senior leaders and employees on

Table 17

*Analysis of Variance for Healing Ministry of Christ by Question*

		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
1. I understand what it means to extend the healing ministry of Christ.	Between	5.63	2	2.81	10.30**	0.000	0.030
	Within	181.70	648	0.28			
	Total	187.33	650				
2. I believe that Christ provides an excellent model of compassionate care.	Between	2.42	2	1.21	5.67**	0.004	0.017
	Within	137.49	644	0.21			
	Total	139.91	646				
3. I extend the healing ministry of Christ.	Between	2.98	2	1.49	3.33*	0.036	0.010
	Within	284.45	636	0.45			
	Total	287.43	638				
4. I utilize prayer at Florida Hospital to extend the healing ministry of Christ.	Between	21.02	2	10.51	10.65**	0.000	0.033
	Within	624.73	633	0.99			
	Total	645.75	635				
5. I sense a spirit of love and grace at Florida Hospital.	Between	15.54	2	7.77	7.73**	0.000	0.023
	Within	650.46	647	1.00			
	Total	666.00	649				
6. I experience meaning from the mission of Florida Hospital.	Between	48.48	2	24.24	27.19**	0.000	0.078
	Within	572.30	642	0.89			
	Total	620.78	644				

\*  $p < .05$ . \*\*  $p < .01$ .

Table 18

*Post Hoc Analysis of Healing Ministry of Christ by Question*

Question	Group	Mean	Middle Management <i>p</i>	Employee <i>p</i>
1. I understand what it means to extend the healing ministry of Christ.	Senior	4.88	0.116	0.000**
	Middle	4.75	—	0.000**
	Employee	4.59		
2. I believe that Christ provides an excellent model of compassionate care.	Senior	4.95	0.346	0.000**
	Middle	4.89	—	0.007**
	Employee	4.78		
3. I extend the healing ministry of Christ.	Senior	4.46	0.844	0.799
	Middle	4.53	—	0.017*
	Employee	4.39		
4. I utilize prayer at FH to extend the healing ministry of Christ.	Senior	4.51	0.270	0.001**
	Middle	4.25	—	0.001**
	Employee	3.94		
5. I sense a spirit of love and grace at Florida Hospital.	Senior	4.15	0.329	0.001**
	Middle	3.95	—	0.003**
	Employee	3.68		
6. I experience meaning from the Mission of FH.	Senior	4.68	0.009**	0.000**
	Middle	4.37	—	0.000**
	Employee	3.88		

\*  $p < .05$ . \*\*  $p < .01$ .

questions 4, 5, and 6 are very noteworthy. Specifically, on question 6 which probes the meaning extracted from the mission of Florida Hospital wherein a full 0.80 difference exists between senior leaders ( $m = 4.68$ ) and employees ( $m = 3.88$ ), which is consistent with the medium effect demonstrated for this question ( $\eta_p^2 = 0.078$ ). Despite the high mean on the cognitive dimension explored in Question 1 ( $m = 4.59$ ) and Question 2 ( $m = 4.78$ ), there is a clear diminishment for the employee group when examining the behavioral component tested in Question 4 ( $m = 3.94$ ) as well as the affective connections queried in Question 5 ( $m = 3.68$ ) and Question 6 ( $m = 3.88$ ).

#### **Analysis of Variance for Honoring the Seventh-day Adventist Beliefs**

The number of responses, means, and standard deviations for the five questions that comprise the core conviction of Honoring the Seventh-day Adventist Beliefs are detailed in Table 19. In reviewing the overall means by question, there is a significant difference between the last two questions with a mean range of 4.95 - 4.32, which probe the affective dimensions compared to Question 2, which focuses on the Sabbath aspect at Florida Hospital. Given the substantial importance expressed regarding the Sabbath from the qualitative research reported in chapter 4, it is disconcerting to see the low mean scores for this question. It should be noted that Question 2 is intended to reflect the practice and behavior rather than the cognitive belief.

As shown in Table 20, a one-way ANOVA was conducted for the five questions that comprise the core conviction entitled the Healing Ministry of Christ. Through this analysis, it was determined that a significant  $F$  value exists in four of the five questions.

Table 19

*Mean and Standard Deviation of Segmented Groups for Honoring the Seventh-day Adventist Beliefs by Question*

Question	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
1. Biblical teachings are cherished at FH.	41	4.29	0.60	214	4.10	0.86	385	3.95	0.93
2. Saturday (Sabbath) is a special day at FH.	40	3.55	1.04	213	3.87	0.99	387	3.81	1.15
3. Christian principles are practiced at FH.	41	4.29	0.68	215	4.11	0.76	395	3.89	0.95
4. I appreciate working for a faith-based hospital.	41	4.95	0.22	215	4.72	0.54	393	4.32	0.86
5. I respect the FH Seventh-day Adventist heritage.	41	4.92	0.26	213	4.71	0.53	393	4.40	0.71

Table 20

*Analysis of Variance for Honoring the Seventh-day Adventist Beliefs by Question*

Question		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
1. Biblical teachings are cherished at Florida Hospital.	Between	6.22	2	3.11	3.92*	0.020	0.012
	Within	505.38	637	0.79			
	Total	511.60	639				
2. Saturday (Sabbath) is a special day at Florida Hospital.	Between	3.55	2	1.77	1.49	0.227	0.005
	Within	759.33	637	1.19			
	Total	762.87	639				
3. Christian principles are practiced at Florida Hospital.	Between	11.25	2	5.62	7.35**	0.001	0.022
	Within	495.68	648	0.77			
	Total	506.93	650				
4. I appreciate working for a faith-based hospital.	Between	31.46	2	15.73	28.80**	0.000	0.082
	Within	352.76	646	0.55			
	Total	384.22	648				
5. I respect the Florida Hospital Seventh-day Adventist heritage.	Between	19.49	2	9.75	24.41**	0.000	0.070
	Within	257.17	644	0.40			
	Total	276.66	646				

\*  $p < .05$ . \*\*  $p < .01$ .

Specifically, the differences exist in Question 1: Biblical teachings are cherished at Florida Hospital ( $p = 0.020$ ), Question 3: Christian principles are practiced at Florida Hospital ( $p = 0.001$ ), Question 4: I appreciate working for a faith-based hospital ( $p = 0.000$ ), and Question 5: I respect the Florida Hospital Seventh-day Adventist heritage ( $p = 0.000$ ).

The effect of each question between the three segmented groups is displayed in Table 20. Medium effects are determined for the two questions testing the affective component. Specifically, Question 4: I appreciate working for a faith-based hospital ( $\eta_p^2 = 0.082$ ), and Question 5: I respect the Florida Hospital Seventh-day Adventist heritage ( $\eta_p^2 = 0.070$ ). Small effects are determined for Question 1: Biblical teachings are cherished at Florida Hospital ( $\eta_p^2 = 0.012$ ), and Question 3: Christian principles are practiced at Florida Hospital ( $\eta_p^2 = 0.022$ ).

As will be further considered in Null Hypothesis 2, it should be noted that a variance exists in all three dimension of cognitive (Question 1), behavioral (Questions 3), and affective Questions 4 and 5).

To further isolate the differences in the four questions identified with significant *F* values, a post hoc analysis was conducted using Tamhane's T2 given the violation of the homogeneity variance assumption. In Table 21, it is noted that senior leaders are aligned on Questions 1 and 3 but differ on the two questions probing the affective dimensions of Question 4: I appreciate working for a faith-based hospital ( $p = 0.000$ ), and Question 5: I respect the Florida Hospital Seventh-day Adventist heritage ( $p = 0.001$ ). The senior leaders are statistically different from employees on all four questions. Middle management is aligned on Question 1 with employees but have a statistically significant difference on Questions 3, 4, and 5.

By simple analysis of the means and as verified statistically, there is a measurable difference between the senior leaders compared to middle management and to employees in looking at the beliefs of the Seventh-day Adventist Church. Furthermore, the medium



effects determined for Question 5 ( $\eta_p^2 = 0.082$ ) and Question 6 ( $\eta_p^2 = 0.070$ ) suggest that the affective connection with the faith-based mission and heritage are the most significant determinants of the variance.

### Analysis of Variance for Image of God

The number of responses, means, and standard deviations for the five questions that comprise the core conviction of the Image of God are detailed in Table 22. In reviewing the overall means by question, although there are differences between the three

Table 21

#### *Post Hoc Analysis of Honoring the Seventh-day Adventist Beliefs by Question*

Question	Group	Mean	Middle Management <i>p</i>	Employee <i>p</i>
1. Biblical teachings are cherished at FH.	Senior	4.29	0.249	0.006**
	Middle	4.10	—	0.138
	Employee	3.95		
3. Christian principles are practiced at FH.	Senior	4.29	0.366	0.003**
	Middle	4.12	—	0.004**
	Employee	3.89		
4. I appreciate working for a faith-based hospital.	Senior	4.95	0.000**	0.000**
	Middle	4.72	—	0.000**
	Employee	4.32		
5. I respect the FH Seventh-day Adventist heritage.	Senior	4.93	0.001**	0.000**
	Middle	4.71	—	0.000**
	Employee	4.41		

\*  $p < .05$ . \*\*  $p < .01$ .

Table 22

*Mean and Standard Deviation of Segmented Groups for Image of God by Question*

Question	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
1. I believe that every person is created in the image of God.	41	4.95	0.22	215	4.79	0.58	392	4.71	0.68
2. Every person at FH is valued regardless of their race, gender, or ability to pay.	41	4.12	0.84	215	4.18	0.95	396	4.05	1.12
3. I treat others with respect because they are created in the image of God.	41	4.71	0.51	211	4.67	0.54	390	4.56	0.72
4. The staff at FH treat every individual as a child of God.	40	3.85	0.89	215	3.50	0.93	392	3.61	1.06
5. I feel respected at FH as a child of God.	41	4.22	0.72	212	4.09	0.76	391	3.82	1.04

segmented groups, the answers across all five questions seem to move in proportional rhythm. Perhaps the most disconcerting item within this core conviction is the notable difference between the overall means in Question 1 (4.95, 4.79, 4.71), which deals with the cognitive belief that every person is created in the image of God compared to Question 4, which queries if staff at Florida Hospital treat everyone like a child of God

where the mean scores are appreciably lower (3.85, 3.50, 3.61). This difference between the cognitive and the behavioral is disconcerting in consideration of institutional values versus sensemaking behaviors.

As shown in Table 23, a one-way ANOVA was conducted for the five questions that comprise the core conviction entitled the Image of God. Through this analysis, it was determined that a significant  $F$  value exists in two of the five core convictions. Specifically, differences are demonstrated in Question 1: I believe that every person is created in the image of God ( $p = 0.039$ ), and Question 5: I feel respected at Florida Hospital as a child of God ( $p = 0.001$ ). It should be noted that Question 3: I treat others with respect because they are created in the image of God ( $p = 0.092$ ), and Question 4: The staff at Florida Hospital treats every individual as a child of God ( $p = 0.100$ ), are approaching statistical significance.

In considering the effect of each question between the three segmented groups displayed in Table 23, only Question 1: I believe that every person is created in the image of God ( $\eta_p^2 = 0.010$ ), and Question 6: I feel respected at Florida Hospital as a child of God ( $\eta_p^2 = 0.023$ ), are determined to contribute a small effect to the variance.

As will be further considered in Null Hypothesis 2, it should be noted that a variance exists in the cognitive (Question 1) and affective (Question 5) dimensions while the behavioral aspect is fully aligned.

To further isolate the differences in the four questions identified with significant  $F$  values, a post hoc analysis was conducted using Tamhane's T2 given the violation of the homogeneity variance assumption. In Table 24, it is shown that senior leaders are

aligned with middle management on Question 5, which tests the affective dimension of feeling respected as a child of God. Middle management is aligned with employees on the cognitive dimension of belief that every person is created in the image of God. The

Table 23

*Analysis of Variance for Image of God by Question*

Question		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
1. I believe that every person is created in the image of God.	Between	2.59	2	1.30	3.25*	0.039	0.010
	Within	256.91	645	0.40			
	Total	259.50	647				
2. Every person at FH is valued regardless of their race, gender, or ability to pay.	Between	2.41	2	1.21	1.09	0.338	0.003
	Within	721.31	649	1.11			
	Total	723.72	651				
3. I treat others with respect because they are created in the image of God.	Between	2.05	2	1.02	2.40	0.092	0.007
	Within	272.82	639	0.43			
	Total	274.87	641				
4. The staff at Florida Hospital treat every individual as a child of God.	Between	4.73	2	2.37	2.32	0.100	0.007
	Within	657.91	644	1.02			
	Total	662.64	646				
5. I feel respected at Florida Hospital as a child of God.	Between	13.47	2	6.74	7.60**	0.001	0.023
	Within	567.79	641	0.89			
	Total	581.26	643				

\*  $p < .05$ . \*\*  $p < .01$ .

areas of statistical difference are between senior leaders and employees on both Question 1 ( $p = 0.000$ ) and Question 5 ( $p = 0.007$ ) along with middle management compared to employees on Question 5 ( $p = 0.001$ ).

### **Analysis of Variance for Community**

The number of responses, means and standard deviations for the five questions that comprise the core conviction of Community Service are detailed in Table 25. In reviewing the overall means by question, there appears to be a proportional change from question to question with similar relationships between the three groups. The lowest mean is for Question 2 (4.00, 3.82, 3.56) which explores actual individual community involvement whereas many of the other questions touch on beliefs on a more corporate basis.

As shown in Table 26, a one-way ANOVA was conducted for the six questions that comprise the core conviction entitled Community. Through this analysis, it was determined that a significant  $F$  value exists in four of the six questions. Specifically, statistically significant differences exist in Question 3: I am personally engaged in community activities on behalf of Florida Hospital ( $p = 0.000$ ), Question 4: I am involved with activities that improve the health status of the community ( $p = 0.002$ ), Question 5: I feel a sense of belonging at Florida Hospital ( $p = 0.000$ ), and Question 6: I feel that it is important for Florida Hospital to be actively involved in the community ( $p = 0.000$ ).

Table 24

*Post Hoc Analysis of Image of God by Question*

Question	Group	Mean	Middle	Employee
			Management <i>p</i>	<i>p</i>
1. I believe that every person is created in the image of God.	Senior	4.95	0.006**	0.000**
	Middle	4.79	—	0.373
	Employee	4.71		
5. I feel respected at Florida Hospital as a child of God.	Senior	4.22	0.659	0.007**
	Middle	4.09	—	0.001**
	Employee	3.82		

\*  $p < .05$ . \*\*  $p < .01$ .

In considering the effect of each question between the three segmented groups displayed in Table 26, a medium effect is determined for Question 3: I am personally engaged in community activities on behalf of Florida Hospital ( $\eta_p^2 = 0.073$ ) with Question 5: I feel a sense of belonging at Florida Hospital ( $\eta_p^2 = 0.059$ ), approaching a medium effect. Small effects can be attributed to Question 4: I am involved with activities that improve the health status of the community, and Question 6: I feel that it is important for Florida Hospital to be actively involved in the community ( $\eta_p^2 = 0.038$ ).

As will be further considered in Null Hypothesis 2, it should be noted that a variance exists in the behavioral (Questions 3 and 4) and affective (Questions 5 and 6) dimensions while the cognitive aspect is in full alignment among the three segmented groups.

Table 25

*Mean and Standard Deviation of Segmented Groups for Community by Question*

Question	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
1. I believe that FH has a positive relationship with the community.	41	4.37	0.70	215	4.47	0.54	395	4.39	0.67
2. FH is very interested in the health status of the community.	41	4.12	0.68	214	4.38	0.71	392	4.34	0.69
3. I am personally engaged in community activities on behalf of FH.	40	4.20	0.79	213	3.95	1.00	371	3.37	1.19
4. I am involved with activities that improve the health status of the community.	40	4.00	0.75	213	3.82	1.02	371	3.56	1.11
5. I feel a sense of belonging at FH.	41	4.41	0.71	215	4.33	0.72	393	3.90	0.98
6. I feel that it is important for FH to be actively involved in the community.	40	4.88	0.33	214	4.83	0.37	395	4.64	0.55

Table 26

*Analysis of Variance for Community by Question*

Question		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
1. I believe that FH has a positive relationship with the community.	Between	0.90	2	0.45	1.13	0.324	0.003
	Within	257.46	648	0.40			
	Total	258.36	650				
2. Florida Hospital is very interested in the health status of the community.	Between	2.35	2	1.18	2.40	0.092	0.007
	Within	315.48	644	0.49			
	Total	317.83	646				
3. I am personally engaged in community activities on behalf of Florida Hospital.	Between	59.90	2	29.95	24.45**	0.000	0.073
	Within	760.60	621	1.23			
	Total	820.50	623				
4. I am involved in activities that improve the health status of the community.	Between	14.12	2	7.06	6.26**	0.002	0.020
	Within	700.84	621	1.13			
	Total	714.96	623				
5. I feel a sense of belonging at Florida Hospital.	Between	31.53	2	15.77	20.14**	0.000	0.059
	Within	505.77	646	0.78			
	Total	537.30	648				
6. I feel that it is important for FH to be actively involved in the community.	Between	6.13	2	3.06	12.75**	0.000	0.038
	Within	155.27	646	0.24			
	Total	161.40	648				

\*  $p < .05$ . \*\*  $p < .01$ .



To further isolate the differences in the four questions identified with significant  $F$  values, a post hoc analysis was conducted using Tamhane's T2 given the violation of the homogeneity variance assumption. As demonstrated in Table 27, senior leaders and middle management are fully aligned across all four questions. Interestingly, statistically significant differences exist between senior leaders and middle management compared to employees on all four questions.

Table 27

*Post Hoc Analysis of Community by Question*

Question	Group	Mean	Middle Management $p$	Employee $p$
3. I am personally engaged in community activities on behalf of FH.	Senior	4.20	0.241	0.000**
	Middle	3.95	—	0.000**
	Employee	3.37		
4. I am involved in activities that improve the health status of the community.	Senior	4.00	0.488	0.004**
	Middle	3.82	—	0.010*
	Employee	3.56		
5. I feel a sense of belonging at Florida Hospital.	Senior	4.88	0.884	0.000**
	Middle	4.83	—	0.000**
	Employee	4.65		
6. I feel that it is important for FH to be actively involved in the community.	Senior	4.88	0.847	0.001**
	Middle	4.83	—	0.000**
	Employee	4.64		

\*  $p < .05$ . \*\*  $p < .01$ .

### Summary of Null Hypothesis 1 Comparisons

An analysis of variance reveals alignment on only one of the six core convictions, Health Principles, and statistically significant differences among the other five core convictions: Wholeness, Healing Ministry of Christ, Honoring the Seventh-day Adventist Beliefs, Image of God, and Community, thereby rejecting the null hypothesis. In considering these variances, post hoc analysis reveals full alignment across these five core convictions between senior leaders and middle management.

Statistically significant variances are evident between senior leaders and employees in the Healing Ministry of Christ, Honoring the Seventh-day Adventist Beliefs, Image of God, and Community. Between middle management and employees, statistically significant differences exist in Wholeness, Healing Ministry of Christ, Honoring the Seventh-day Adventist Beliefs, and Community.

Further analysis of variance reveals statistically significant differences in three of the six questions for Wholeness, six of six questions for the Healing Ministry of Christ, four of five questions for Honor the Seventh-day Adventist Beliefs, two of six questions for the Image of God, and four of six questions for Community.

Taking the analysis one step further, post hoc analysis reveals alignment between senior leaders and middle management on the vast majority of questions with significant differences between senior leaders and middle management compared to the employees.

### **Null Hypothesis 2**

The purpose of this section is to fully explore the second null hypothesis which reads: "There is no difference between senior leaders, middle management, and

employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.” As demonstrated in Table 28, the mean is higher at the senior level compared to the two other segmented groups with a smaller standard deviation. In addition, the middle management mean is also higher than the employee group with a smaller standard deviation.

Table 28

*Mean and Standard Deviation by Cognitive, Behavioral, and Affective Constructs*

Construct	Senior Leaders			Middle Management			Employees		
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>
Cognitive	41	4.71	0.55	215	4.67	0.60	397	4.55	0.69
Behavioral	41	4.10	0.88	215	4.04	0.94	397	3.99	1.00
Affective	41	4.39	0.83	215	4.28	0.84	397	3.94	1.04

However, it is unclear at this juncture if these differences are statistically significant. In the following sections, these comparisons are further delineated to show whether statistically significant variances exist among each of the groups. To test the statistically significant alignments and deviations of the segmented groups across the core convictions, a one-way ANOVA by core conviction was performed with a subsequent post hoc analysis where significant differences are determined. A test of homogeneity of variance by each core conviction was first conducted to test for the

equality of population variances, which is a necessary assumption to understand for ANOVA purposes.

To test the statistically significant alignments and deviations of the segmented groups across the cognitive, behavioral, and affective dimensions, a test of homogeneity of variance by each construct will be determined, followed by a one-way ANOVA for each construct with a subsequent post hoc analysis where significant differences are determined.

#### Test of Homogeneity

The first test conducted was a test of homogeneity of variances across the three constructs of cognitive, behavioral, and affective. Given the large differences in sample sizes between the three segmented populations, it was imperative to test the equality of population variance. As demonstrated in Table 29, there were statistically significant differences among population variances with all three constructs ( $p = 0.000$  and  $p = 0.001$ ). Given that the assumption of homogeneity of variance was violated, Tamhane's T2 was necessary when performing subsequent post hoc analysis.

#### Analysis of Variance by Cognitive, Behavioral, and Affective Constructs

In Table 30, the results from a one-way ANOVA are presented by each of the three dimensions of cognitive, behavioral, and affective, comparing the three segmented groups of senior leaders, middle management, and employees. The analysis of variance demonstrates that statistically significant differences exist in two out of the three

dimensions. In particular, a significant  $F$  value was determined for the cognitive ( $p = 0.000$ ) and affective ( $p = 0.000$ ) constructs.

Table 29

*Test of Homogeneity of Variances by Cognitive, Behavioral, and Affective Constructs*

	Levene Statistic	<i>df1</i>	<i>df2</i>	<i>p</i>
Cognitive	16.86	2	650	0.000**
Behavioral	7.12	2	650	0.001**
Affective	21.87	2	650	0.000**

\*  $p < .05$ . \*\*  $p < .01$ .

In considering the effect of each question between the three segmented groups displayed in Table 30, a medium effect is determined for the affective dimension ( $\eta_p^2 = 0.069$ ) and a small effect for the cognitive construct ( $\eta_p^2 = 0.029$ ).

Given the significance of the  $F$  value in the cognitive and affective construct, a post hoc analysis was run to further isolate the variance. Given that the assumption of homogeneity was violated for both of these constructs, Tamhane's T2 post hoc analysis was utilized.

As shown in Table 31, senior leaders and middle management are aligned across both cognitive and affective constructs. However, the senior leaders have statistically significant differences compared to employees on cognitive ( $p = 0.019$ ) and affective ( $p$

= 0.000). Likewise, middle management is also statistically different from employees on the cognitive ( $p = 0.000$ ) and affective ( $p = 0.000$ ) dimensions.

Table 30

*Analysis of Variance by Cognitive, Behavioral, and Affective Constructs*

Construct		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
Cognitive	Between	2.43	2	1.22	9.55**	0.000	0.029
	Within	82.69	650	0.13			
	Total	85.12	652				
Behavioral	Between	0.60	2	0.30	1.29	0.276	0.004
	Within	151.49	650	0.23			
	Total	152.09	652				
Affective	Between	19.75	2	9.87	23.94**	0.000	0.069
	Within	268.10	650	0.41			
	Total	287.85	652				

\*  $p < .05$ . \*\*  $p < .01$ .

## Summary of Null Hypothesis 2 Comparisons

A one-way ANOVA reveals alignment on the behavioral dimension of the core convictions and statistically significant differences in the cognitive and affective constructs across the segmented groups. In a post hoc analysis of the cognitive and affective constructs, it was determined that there is full alignment between the senior leaders and middle management on all three constructs. It was further determined that statistically significant gaps exist between senior leaders and middle management

compared to employees on both the cognitive and affective dimensions thereby rejecting the null hypothesis for these component comparisons. Furthermore, a medium proportion of the affect can be attributed to the affective dimension thereby delineating the greater cause of the overall variance.

Table 31

*Post Hoc Analysis of Cognitive and Affective Constructs*

Construct	Group	Mean	Middle Management <i>p</i>	Employee <i>p</i>
Cognitive	Senior	4.71	0.695	0.019*
	Middle	4.67	—	0.000**
	Employee	4.55	—	—
Affective	Senior	4.39	0.313	0.000**
	Middle	4.28	—	0.000**
	Employee	3.94	—	—

\*  $p < .05$ . \*\*  $p < .01$ .

### Null Hypothesis 3

The purpose of this section is to fully explore the third null hypothesis which states: “There is no difference between religious groups across the six core convictions.” In a cursory review of the descriptive statistics in Table 32, there appears to be higher scores for the Seventh-day Adventists, Roman Catholics, and Protestant Christians compared to lower scores for the “Other” and “None” categories. There also appears to

Table 32

*Mean and Standard Deviation of Core Convictions by Religious Groups*

Core Conviction	Religion	<i>N</i>	Mean	<i>SD</i>
Wholeness	Seventh-day Adventist	173	4.01	0.56
	Roman Catholic	153	4.00	0.62
	Protestant Christian	272	4.02	0.59
	None	35	3.67	0.62
	Other	15	3.97	0.50
Healing Ministry	Seventh-day Adventist	173	4.40	0.58
	Roman Catholic	153	4.29	0.51
	Protestant Christian	272	4.39	0.55
	None	35	3.59	0.68
	Other	15	3.81	1.22
Health Principles	Seventh-day Adventist	173	4.47	0.46
	Roman Catholic	153	4.40	0.36
	Protestant Christian	272	4.41	0.39
	None	35	4.34	0.56
	Other	15	4.29	0.61
Honor SDA Beliefs	Seventh-day Adventist	173	4.13	0.68
	Roman Catholic	153	4.18	0.65
	Protestant Christian	272	4.24	0.62
	None	35	3.87	0.66
	Other	15	4.10	1.23
Image of God	Seventh-day Adventist	173	4.18	0.68
	Roman Catholic	153	4.20	0.59
	Protestant Christian	272	4.28	0.59
	None	35	3.64	0.93
	Other	15	4.01	1.05
Community	Seventh-day Adventist	173	4.13	0.56
	Roman Catholic	153	4.14	0.58
	Protestant Christian	272	4.20	0.56
	None	35	3.90	0.64
	Other	15	4.12	1.03



be higher mean scores across all religions in the Healing Ministry of Christ and for the Health Principles compared to the other four core convictions.

It was unclear at this juncture if these differences were statistically significant. Thus, these comparisons were further delineated to determine if statistically significant variances exist among each of the groups. To test the statistically significant alignments and deviations of the religious groups across the core convictions, a one-way ANOVA by core conviction was performed with a subsequent post hoc analysis where significant differences were determined. A test of homogeneity of variance by each core conviction was first conducted to test for the equality of population variances, which is a necessary assumption to understand for ANOVA purposes.

#### Test of Homogeneity

The first test conducted is a test of homogeneity of variances across the six core convictions by each of the five religious categories. Given the large differences in sample sizes between the five religious groups, it was imperative to test the equality of population variance. As demonstrated in Table 33, the assumption for homogeneity of variance is verified for Wholeness and Community but violated for the Healing Ministry ( $p = 0.001$ ), Health Principles ( $p = 0.000$ ), Honoring the Seventh-day Adventist Beliefs ( $p = 0.029$ ), and Image of God ( $p = 0.000$ ).

#### Analysis of Variance of Core Convictions by Religion

In Table 34, the results from a one-way ANOVA are presented by each of the six core convictions comparing the five segmented religious groups. The ANOVA

Table 33

## Test of Homogeneity of Variances by Religion

Core Conviction	Levene Statistic	<i>df1</i>	<i>df2</i>	<i>p</i>
Wholeness	0.64	4	643	0.636
Healing Ministry	4.95	4	643	0.001**
Health Principles	7.05	4	643	0.000**
Honor SDA Beliefs	2.73	4	643	0.029*
Image of God	6.26	4	643	0.000**
Community	1.18	4	643	0.320

\*  $p < .05$ . \*\*  $p < .01$ .

demonstrates that statistically significant differences exist in four of the six core convictions. In particular, a significant  $F$  value was determined in Wholeness ( $p = 0.025$ ), Healing Ministry of Christ ( $p = 0.000$ ), Honoring the Seventh-day Adventist beliefs ( $p = 0.019$ ), and Image of God ( $p = 0.000$ ). It is noteworthy that Community is approaching statistical significance ( $p = 0.058$ ) whereas the Health Principles are aligned between the five religious groups.

Given the significance of the  $F$  value in the four core convictions, a post hoc analysis was run to further isolate the variance. Given that the assumption of homogeneity among the variances was confirmed for Wholeness, Tukey's HSD post hoc has been utilized. Whereas it was determined that the assumption of the homogeneity of

Table 34

*Analysis of Variance of Core Convictions by Religion*

Core Conviction		Sum of Squares	df	Mean Square	F	p	$\eta_p^2$
Wholeness	Between	3.09	4	0.98	2.81*	0.025	0.017
	Within	224.43	643	0.35			
	Total	228.36	647				
Healing Ministry	Between	25.53	4	6.38	19.66**	0.000	0.109
	Within	208.75	643	0.33			
	Total	234.28	647				
Health Principles	Between	0.91	4	0.23	1.32	0.260	0.018
	Within	110.40	643	0.17			
	Total	111.31	647				
Honor SDA Beliefs	Between	5.05	4	1.26	2.96*	0.019	0.048
	Within	274.16	643	0.43			
	Total	279.21	647				
Image of God	Between	13.43	4	3.36	8.19**	0.000	0.048
	Within	263.72	643	0.41			
	Total	277.15	647				
Community	Between	3.04	4	0.76	2.30	0.058	0.014
	Within	212.73	643	0.33			
	Total	215.77	647				

\*  $p < .05$ . \*\*  $p < .01$ .

variances was violated for the Healing Ministry, Honor Seventh-day Adventist Beliefs, and Image of God, Tamhane's T2 post hoc was utilized for these three core convictions.

In Table 35, a matrix of relationships between the five religious groups is presented. For Wholeness, there is full alignment between the religious groups other than in comparison to "None," where statistically significant differences are evident with Seventh-day Adventists ( $p = 0.016$ ), Roman Catholics ( $p = 0.022$ ), and Protestant Christians ( $p = 0.009$ ). For the Healing Ministry, there is full alignment between the religious groups other than in comparison to "None" where statistically significant differences are evident with Seventh-day Adventists ( $p = 0.000$ ), Roman Catholics ( $p = 0.000$ ), and Protestant Christians ( $p = 0.000$ ). For Honoring of the Seventh-day Adventist Beliefs, there is full alignment between the religious groups other than in comparison to "None" where a statistically significant difference is evident with the Protestant Christian group ( $p = 0.028$ ). For the Image of God, there is full alignment between the religious groups other than in comparison to "None" where statistically significant differences are evident with Seventh-day Adventists ( $p = 0.022$ ), Roman Catholics ( $p = 0.017$ ), and Protestant Christians ( $p = 0.003$ ).

In looking across the full analysis of the core convictions, the existing gaps are between "None" to all other religious groups. Among Christ-based religions (Protestant Christians, Roman Catholics, Seventh-day Adventists, and Other Religions), there is full alignment across all six core convictions. Therefore, the null hypothesis is substantiated except for the group claiming "None."

Table 35

## Post Hoc Analysis of Core Convictions by Religion

Core Conviction		Mean	SDA <i>p</i>	Catholic <i>p</i>	Protestant <i>p</i>	None <i>p</i>	Other <i>p</i>
Wholeness	SDA	4.01	—	—	—	—	—
	Catholic	4.00	1.000	—	—	—	—
	Protestant	4.02	1.000	0.999	—	—	—
	None	3.67	0.016*	0.022*	0.009*	—	—
	Other	3.97	0.999	1.000	0.998	0.461	—
Healing Ministry	SDA	4.40	—	—	—	—	—
	Catholic	4.29	0.420	—	—	—	—
	Protestant	4.39	1.000	0.451	—	—	—
	None	3.59	0.000**	0.000**	0.000**	—	—
	Other	3.81	0.357	0.374	0.374	0.997	—
SDA Beliefs	SDA	4.13	—	—	—	—	—
	Catholic	4.18	0.999	—	—	—	—
	Protestant	4.24	0.475	0.981	—	—	—
	None	3.87	0.329	0.152	0.028*	—	—
	Other	4.10	1.000	1.000	1.000	0.993	—
Image of God	SDA	4.18	—	—	—	—	—
	Catholic	4.20	1.000	—	—	—	—
	Protestant	4.28	0.458	0.885	—	—	—
	None	3.64	0.022*	0.017*	0.003**	—	—
	Other	4.01	0.998	0.995	0.925	0.859	—

\*  $p < .05$ . \*\*  $p < .01$ .

**Null Hypothesis 4**

The purpose of this section is to fully explore the fourth null hypothesis which states: “There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.”

In a cursory review of the descriptive statistics in Table 36, there appears to be higher scores for the Seventh-day Adventists, Roman Catholics, and Protestant Christians compared to lower scores for the “Other” and “None” categories. There also appears to be higher mean scores across all religions in the cognitive dimension compared to the behavioral and affective dimension.

It was unclear at this juncture if these differences were statistically significant. Thus, these comparisons were further delineated to determine if statistically significant variances exist among each of the constructs. To test the statistical significant alignments and deviations of the religious groups across the cognitive, behavioral, and affective constructs, a one-way ANOVA by core conviction was performed with a subsequent post hoc analysis where significant differences are determined. A test of homogeneity of variance by each core conviction was first conducted to test for the equality of population variances which is a necessary assumption to understand for ANOVA purposes.

**Test of Homogeneity**

The first test conducted is a test of homogeneity of variances across the six core convictions by each of the five religious categories. Given the large differences in sample sizes between the five religious groups, it was imperative to test the equality of

Table 36

*Mean and Standard Deviation for Cognitive, Behavioral, and Affective Constructs by Religious Groups*

Construct	Religion	<i>N</i>	Mean	<i>SD</i>
Cognitive	Seventh-day Adventist	173	4.67	0.38
	Roman Catholic	153	4.55	0.28
	Protestant Christian	272	4.62	0.37
	None	35	4.39	0.35
	Other	15	4.52	0.63
Behavioral	Seventh-day Adventist	173	3.97	0.49
	Roman Catholic	153	4.06	0.46
	Protestant Christian	272	4.07	0.46
	None	35	3.68	0.54
	Other	15	3.81	0.75
Affective	Seventh-day Adventist	173	4.15	0.70
	Roman Catholic	153	4.04	0.65
	Protestant Christian	272	4.13	0.63
	None	35	3.69	0.64
	Other	15	3.90	1.22

population variance. As demonstrated in Table 37, the assumption for homogeneity of variance was verified for the behavioral and affective dimensions but violated for the cognitive.

#### Analysis of Variance in Cognitive, Behavioral, and Affective Constructs by Religion

In Table 38, the results from a one-way ANOVA are presented by each of the three constructs for the five religious groups. The analysis of variance demonstrates that

Table 37

*Test of Homogeneity of Variances in Cognitive, Behavioral, and Affective Constructs by Religion*

Construct	Levene Statistic	<i>df</i> 1	<i>df</i> 2	<i>p</i>
Cognitive	6.73	4	643	0.000**
Behavioral	1.78	4	643	0.132
Affective	1.32	4	643	0.262

\*  $p < .05$ . \*\*  $p < .01$ .

statistically significant differences exist in all three constructs. In particular, a significant  $F$  value was determined in cognitive ( $p = 0.000$ ), behavioral ( $p = 0.000$ ), and affective ( $p = 0.002$ ) dimensions.

In considering the effect of each question between the three segmented groups displayed in Table 38, small effects are determined for cognitive ( $\eta_p^2 = 0.034$ ), behavioral ( $\eta_p^2 = 0.038$ ), and affective ( $\eta_p^2 = 0.025$ ) dimensions.

Given the significance of the  $F$  value for all three constructs, a post hoc analysis was run to further isolate the variance. Given that the assumption of homogeneity among the variances was confirmed for behavioral and affective, Tukey's HSD post hoc was utilized. Because it was determined that the assumption of the homogeneity of variances was violated for the cognitive dimension, Tamhane's T2 post hoc was utilized.

In Table 39, a matrix of relationships between the five religious groups is presented. For the cognitive dimension, there is full alignment between the religious



Table 38

*Analysis of Variance in Cognitive, Behavioral, and Affective Constructs by Religion*

Construct		Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	$\eta_p^2$
Cognitive	Between	2.90	4	0.72	5.69**	0.000	0.034
	Within	81.82	643	0.13			
	Total	84.72	647				
Behavioral	Between	5.81	4	1.45	6.40**	0.000	0.038
	Within	145.82	643	0.23			
	Total	151.63	647				
Affective	Between	7.28	4	1.82	4.18**	0.002	0.025
	Within	279.85	643	0.44			
	Total	287.13	647				

\*  $p < .05$ . \*\*  $p < .01$ .

groups other than in comparison to “None” where statistically significant differences are evident with Seventh-day Adventists ( $p = 0.001$ ) and Protestant Christians ( $p = 0.008$ ). There is also a statistically significant difference between Seventh-day Adventists and Roman Catholics for the cognitive dimension ( $p = 0.021$ ). This is the only occasion where a statistically significant difference exists between two Christ-based religions.

For the behavioral dimension, there is full alignment between the religious groups other than in comparison to “None,” where statistically significant differences are evident with Seventh-day Adventists ( $p = 0.009$ ), Roman Catholics ( $p = 0.000$ ), and Protestant Christians ( $p = 0.000$ ). For the affective dimension, there is full alignment between the religious groups other than in comparison to “None” where statistically

Table 39

*Post Hoc Analysis in Cognitive, Behavioral, and Affective Constructs by Religion*

Construct		Mean	SDA <i>p</i>	Catholic <i>p</i>	Protestant <i>p</i>	None <i>p</i>	Other <i>p</i>
Cognitive	SDA	4.67	—	—	—	—	—
	Catholic	4.55	0.021*	—	—	—	—
	Protestant	4.62	0.701	0.564	—	—	—
	None	4.39	0.001**	0.181	0.008**	—	—
	Other	4.52	0.947	1.000	0.997	0.992	—
Behavioral	SDA	3.97	—	—	—	—	—
	Catholic	4.06	0.496	—	—	—	—
	Protestant	4.07	0.250	1.000	—	—	—
	None	3.68	0.009**	0.000**	0.000**	—	—
	Other	3.81	0.722	0.317	0.260	0.902	—
Affective	SDA	4.15	—	—	—	—	—
	Catholic	4.04	0.594	—	—	—	—
	Protestant	4.13	0.997	0.715	—	—	—
	None	3.69	0.002**	0.041*	0.003**	—	—
	Other	3.90	0.619	0.927	0.687	0.859	—

\*  $p < .05$ . \*\*  $p < .01$ .

significant differences are evident with the Seventh-day Adventists ( $p = 0.002$ ), Roman Catholics ( $p = 0.041$ ), and Protestant Christians ( $p = 0.003$ ).

In considering the entire spectrum of cognitive, behavioral, and affective components, there are several trends and findings worth noting. In terms of alignment, there continues to be a strong correlation among the Christian-based religious subsets. The sole exception throughout this entire analysis was in the cognitive component between the Seventh-day Adventists ( $m = 4.67$ ) compared to the Roman Catholics ( $m =$

4.55) with a  $p = 0.021$  value. Within these constructs, there was also perfect alignment between the Christian-based religions and “Other” religions. The most notable statistically significant gaps were with the “None” religion category. On almost every construct, a statistically significant gap exists compared to the Christian-based religions.

### **Summary of Quantitative Findings**

The purpose of this chapter is to present the findings of the quantitative research designed to answer the second research question which queries: “To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?” A questionnaire (Appendix B) was developed from the core conviction attributes derived from the qualitative research reported in chapter 4.

A total of 653 employees of Florida Hospital in Orlando, Florida, completed the survey. The survey population was comprised of three distinct organizational levels: senior leaders ( $n = 41$ ), middle management ( $n = 215$ ), and employees ( $n = 397$ ). In assessing the responses among these three segmented populations, a test of homogeneity of variances was first completed, then an ANOVA followed by a post hoc analysis where a significant  $F$  value was determined. For post hoc calculations, either Tukey HSD (where equal variances were determined) or Tamhane’s (where unequal variances exist) post hoc analysis was conducted to further isolate where alignments exist and where statistically significant gaps were present.

The first analysis tested the first null hypothesis which states: “There is no difference between senior leaders, middle management, and employees’ perceptions

across the six core convictions.” In comparing the three segmented populations across the six core convictions, no statistically significant difference was determined between the senior leaders and middle management. Statistically significant differences were demonstrated in four out of the six core convictions (Healing Ministry, Honor Seventh-day Adventist Beliefs, Image of God, and Community) in comparing the senior leaders to employees. In four of six core convictions (Wholeness, Healing Ministry of Christ, Honor Seventh-day Adventist Beliefs, and Community), statistically significant differences were determined between middle management and employees. It was noted that there was full alignment among the three segmented groups for the Health Principles. Further analysis of variance and corresponding post hoc analysis were conducted by question to isolate the variances at the micro level.

Within each of the core convictions, specific questions were designed to assess the cognitive understandings, behavioral adherence, and affective connection among the three segmented populations. The next analysis was designed to test the second null hypothesis which states: “There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.” Through a one-way ANOVA and post hoc analysis, it was determined that a full alignment was evident between the senior leaders and middle managers across all three constructs of cognitive, behavioral, and affective. Furthermore, it was determined that a full alignment exists in the behavioral component across all three segmented groups. The analysis also determined that

statistically significant differences exist between the senior leaders and middle management compared to employees in both the cognitive and affective dimensions.

The next analysis was to determine the areas of alignment and gaps between the specified religious backgrounds of Protestant Christian, Roman Catholic, Seventh-day Adventist, No Religion, and Other Religion and to test the third null hypothesis which states: "There is no difference between religious groups across the six core convictions." In general, it was determined through a one-way ANOVA and corresponding post hoc analysis that there is no statistically significant difference in comparing the Christian-based religions (Protestant Christian, Roman Catholic, and Seventh-day Adventist) across the six core convictions. It was also determined that no statistically significant difference exists between the Christian-based religions and the Other Religions. On the vast majority of comparisons with "None" religion, statistically significant differences were demonstrated compared to every other religion.

The final analysis compared the various religious groups to test the fourth null hypothesis which states: "There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions." It was determined through a one-way ANOVA that there is no statistically significant difference in comparing the Christian-based religions (Protestant Christian, Roman Catholic, and Seventh-day Adventist) across the cognitive, behavioral, and affective constructs. There was one exception to this statement wherein Roman Catholics demonstrated a statistically significant difference with Seventh-day Adventists on the cognitive dimension. It was also determined that no statistically significant

difference exists between the Christian-based religions and the Other Religions on all three constructs. On all but one comparison with “None” religion, statistically significant differences were demonstrated compared to every other religion.

## CHAPTER SIX

### SUMMARY AND CONCLUSIONS

#### **Introduction**

This chapter summarizes the principal findings of this study but also reflects upon the implications related to the areas of alignments and disparities with the Seventh-day Adventist health core convictions at Florida Hospital. The findings directly inform the original research questions and hypotheses but these findings also raise lingering questions that lead to alternative interpretations which require further consideration. Throughout the chapter, I also discuss implications this study makes to those in organizational research, specifically, implications related to institutional theory and sensemaking in faith-based settings. Using these findings and lingering issues, the chapter concludes with specific recommendations for the leaders of Florida Hospital, the Adventist Health System, the faith-based healthcare industry, and for further research.

#### **Study Summary**

The prevailing literature suggests that organizations can sustain their vitality and longevity by preserving a set of core convictions and promoting adaptive innovations (Collins & Porras, 1994; Finke, 2004). The purpose of this mixed-methods sequential

exploratory study is to determine and articulate the core convictions of Seventh-day Adventist healthcare and then investigate how the senior leaders, middle management, and employees' cognitive understandings, behaviors, and affective components align across the spectrum of Florida Hospital.

To determine the core convictions, qualitative techniques comprising four complementary activities included a historical analysis of Seventh-day Adventist healthcare through published literature, a survey of the official published guidelines from the General Conference of Seventh-day Adventists, the commission of the original "white paper" manuscripts based on current research by some of the foremost contemporary academic scholars, and one-on-one interviews with 11 seasoned Adventist healthcare administrators. To determine and describe the areas of alignment and perceptual gaps with the core convictions, a questionnaire was developed and administered to the senior leaders, middle management, and employees at Florida Hospital.

### **Findings and Implications**

The findings are summarized in sections to reflect the two research questions utilized in this study. The first phase reports the qualitative findings and the second phase outlines the quantitative findings from the questionnaire. Within the quantitative section, the findings from the four null hypotheses are reported along with the implications of these results.



### Research Question 1: Qualitative Findings

The initial finding is in relation to the first research question which queries, “What are the theological and philosophical core convictions that comprise the Seventh-day Adventist health message?” Through qualitative research, the core convictions of Seventh-day Adventist healthcare were identified as Wholeness, the Healing Ministry of Christ, the Health Principles, Honoring the Beliefs of the Seventh-day Adventist Church, recognizing every person as a creation formed in the Image of God, and service to the Community. A description for each of these core convictions is as follows:

*Wholeness* – Wholeness is the integration of the mind and body with the spirit to enjoy the fullness of life. According to this view, the physical aspects of medicine are only one component of true health. All aspects of a person, including their emotional status, social, and spiritual health, need to be considered and addressed. In other words, all aspects of a person are interconnected and cannot be separated.

*The Healing Ministry of Christ* – During His life on earth, Jesus Christ spent the majority of time healing the physical and spiritual needs of those that He came in contact with in an effort to bring restoration to our heavenly Father. Therefore, Christian influences should be prevalent in word, symbol, and practice within a Seventh-day Adventist healthcare institution. Practical applications would include prayer, spiritual nurturing, care, and compassion which are all motivated from the loving example of Jesus Christ.

*Health Principles* – From the earliest days of the first Seventh-day Adventist health facility, the Battle Creek Sanitarium, a focus has been devoted to preventive health

practices and education. The eight principles of health are a nutritious diet, ample water consumption, regular exercise, plenty of fresh air, sufficient rest, appropriate use of sunlight, abstinence from harmful substances such as tobacco, and trusting relationships.

*Seventh-day Adventist Beliefs* – As a ministry of the Seventh-day Adventist Church, health clinics and hospitals such as Florida Hospital are extensions of the belief system as determined by the church. In addition to extending loving and compassionate care as demonstrated by Jesus Christ, being faithful to all biblical teachings including honoring Saturday as Sabbath are core to the Seventh-day Adventist belief system.

*Image of God* – As reflected in the biblical book of Genesis, man and woman were created in the image of God. This means that all individuals are of great value regardless of their race, gender, and social status. Therefore, all individuals are treated as worthy and afforded the highest levels of dignity.

*Community* – Seventh-day Adventist healthcare institutions were established as a reformation message in the 1860s in community service to promote health, wholeness, and ultimate restoration. Therefore, it is imperative that the betterment of the community health status be of significant ongoing concern. In addition to services provided within hospitals and health institutions, extended activities such as community clinics and events such as blood drives, heart walks, health screenings, and other similar initiatives are of core significance.

## **Reflections and Implications**

As I have reviewed and studied the six core convictions identified, there are several insights and implications that have become apparent. Although each of the core convictions is of great significance individually, all need to be considered in their totality in order to fully appreciate the integrated nature that creates a cohesive health message. To bridge together the core convictions into a singular statement, it would be as follows: It is because we are created in the image of God that Seventh-day Adventist healthcare serves the community as demonstrated through the life of Christ to restore man to wholeness consistent with the health principles and beliefs of our founding church entity.

If pressed to identify the core conviction of greatest significance, it would be wholeness. The integration of the mind, body, and spirit is a special understanding of the nature of man that has the potential to change healthcare as currently practiced. As demonstrated philosophically by Fritz Guy (2004) and theologically by Alden Thompson (2004), the “first word” of the Seventh-day Adventist health message is wholeness. Wholeness of the mind, body, and spirit means that the head, hands, and heart must all be integrated into a single unit. By a simple analysis of the means between the behavioral, cognitive, and affective components in the questionnaire, a clear dissonance exists between these components.

This perspective was explored by Richard Rice (2004) who wrote that a prerequisite of the delivery of wholistic care is wholistic caregivers. Given this premise, it is concerning that the lowest employee mean rating among all 44 questions was the statement which queries “My entire health including mind, body, and spirit are nurtured at

Florida Hospital.” If a core conviction is not personally evident by the senior leaders, middle management, and employees of an organization, it is beyond hopeful expectation that the patients and families will experience anything differently.

Despite the fact that wholeness is the “first word” of Seventh-day Adventist healthcare and was the basis for the original health message, there continues to be opportunity to truly understand and implement the care model associated with this core conviction. The intersection of where the mind, body, and spirit come together in the being that is human truly is a unique view to Seventh-day Adventist healthcare.

As demonstrated across the industry, many health systems are building individual components to address the mind, body, and spirit. In effect, they are starting with a physical being and are then adding pieces and parts to address the emotive and spiritual needs. When understood from a Seventh-day Adventist perspective, by caring for the physical, the spiritual and emotive needs are being addressed. By caring for the emotive needs, the physical and spiritual issues are being cared for. By addressing the spiritual, the physical and emotive matters will be affected.

There is a fundamental and significant difference of simply being a hospital with a spiritual wrapper versus one that practices wholistic care. Wholistic care is more inclusive philosophically and theologically which should be discernable at a very core level. Among preachers and professional speakers, it is understood that any given metaphor will eventually break down as it becomes more granular. I believe that the same is true for the practice of wholistic care. While many will aspire to wholistic health practices, unless integrated philosophically and theologically, the model will fail when

taken to the patient and care giver level. There will simply be a gap of authenticity within the ideology at the granular level that will render the model inoperable and the clinical results will be undistinguishable.

Despite the fact that Seventh-day Adventist healthcare stands on firm philosophical and theological footing, the sustenance of these core convictions will be determined by the level of understanding, aligned behaviors, and emotional commitment by its leaders and employees which is more fully explored in the following section.

#### Research Question 2: Quantitative Results

The following findings are framed by the second research question which asked: “To what degree, and in what ways, are the current leaders and employee perceptions at Florida Hospital aligned with the identified core convictions?” A questionnaire (Appendix B) was developed from the core conviction attributes derived from the qualitative research reported in chapter 4.

A total of 653 employees of Florida Hospital in Orlando, Florida, completed a 44-question survey scored on a 5-point Likert scale that was formatted around the six core convictions. The survey population was comprised of three distinct organizational levels: senior leaders ( $n = 41$ ), middle management ( $n = 215$ ), and employees ( $n = 397$ ). In assessing the responses among these three segmented populations, a one-way ANOVA along with either Tukey HSD (where equal variances were determined) or Tamhane’s T2 (where unequal variances exist) post hoc analysis was conducted to determine where alignments exist and where statistically significant gaps were present.

The specific results of the questionnaire were formatted around the four hypotheses tested.

### **Null Hypothesis 1**

The first null hypothesis stated: “There is no difference between senior leaders, middle management, and employees’ perceptions across the six core convictions.” In comparing the three segmented populations across the six core convictions, no statistically significant differences were determined between the senior leaders and middle management (although the Healing Ministry of Christ was approaching statistical significance). Statistically significant differences were demonstrated in four out of the six core convictions (Healing Ministry, Honor Seventh-day Adventist Beliefs, Image of God, and Community) in comparing the senior leaders to employees.

In comparing middle management to employees, statistically significant differences were determined in the following four of six core convictions: Wholeness, Healing Ministry of Christ, Honor Seventh-day Adventist Beliefs, and Community. Across all three segmented groups, full alignment was determined for the Health Principles.

Therefore, the first null hypothesis is rejected in that significant differences exist in the majority of core convictions when comparing across the segmented groups.

### **Implications**

As determined by the survey data, the difference between the leadership team (senior leaders and middle management) and the employees is of great significance and

concern. Stated theoretically, the continued sustenance of the Seventh-day Adventist confessional identity tradition will require the rapprochement of the macro mechanistic value system of institutional theory with the micro level enactment of sensemaking in order to ensure that the ongoing challenges and dissonance will be resolved consistent with core values. From a practical and organizational view, the senior leaders are ultimately responsible for the macro responsibility of institutional values and then work with middle management to embed these values at the micro level of daily implementation with the employees. While the alignment between the senior leaders and middle management is evident, the dissonance with employees is the source of great concern. The ability of middle management to embed the core convictions is an area that requires additional consideration by the entire leadership team.

Institutionalized practices are often inefficient and ineffective from a pure performance standpoint. Institutionalism tends to best flourish in conditions of ambiguity and technical uncertainty (Galaskiewicz & Wasserman, 1989; Selznick, 1957). However, the healthcare industry is experiencing increasing regulatory oversight and is forced to function under the mandates of such agencies and professional associations. This technical and professional advancement is clearly an antecedent of deinstitutionalization (Oliver, 1992). All of this raises the question, are the technical and professional advancements eclipsing the importance of the Seventh-day Adventist health core convictions?

From my perspective, this is certainly a possibility within our current healthcare environment and is supported by the data from Florida Hospital. With the significant

financial and operational constraints in the healthcare industry, the willingness to promote perceived inefficiencies is difficult. Since regulatory oversight by professional societies and associations dictate the daily policies and procedures within a healthcare establishment, institutional values could certainly become secondary to the mandates of an external agency.

In other words, a surgery will never commence without completing the national patient safety guideline checklist but ensuring a wholistic approach to patient care is absolutely optional. While a surgery will certainly be stopped if the “site and side” policy has not been completed, is there an equal willingness to delay that same surgery if prayer had not also been offered? While this prayer may be viewed as an inefficiency by many, institutional core convictions must prevail if the confessional identity is to be sustained. To preserve the core convictions, the opportunity to practice wholistic care and offer prayer has to be elevated to the same level of expectation as the external regulatory mandates.

### **Null Hypothesis 2**

The second null hypothesis states: “There is no difference between senior leaders, middle management, and employees in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.” Within each of the core convictions, specific questions were designed to assess the cognitive understandings, behavioral adherence, and affective connection among the three segmented populations. Through a one-way ANOVA and post hoc analysis, full alignment was evident between



the senior leaders and middle management across all three constructs of cognitive, behavioral, and affective. However, statistically significant differences exist in the cognitive understandings and affective connection between senior leaders and the employees.

In comparing middle management to employees, statistically significant differences exist in the cognitive understanding and affective connection. In fact, statistically significant differences exist between the senior leaders and middle management compared to employees in both the cognitive and affective dimensions. For the behavioral component, a full alignment was determined across all three segmented groups.

Therefore, the second null hypothesis is also rejected based on the statistical differences in the cognitive and affective dimension when comparing senior leaders and middle management to the employees.

### Implications

One of the propositions of this research suggests that for an organization to preserve its confessional identity, current actions must align with the stated core convictions. If misalignments or gaps exist between the stated core convictions and current practice, a dissonance exists. To bring consonance, either current practice will be brought into alignment or the core convictions will be compromised which may jeopardize the confessional identity. The data suggest that there are two different levels of cognitive understanding – behavioral adherence, and affective connection – between the

leadership team and the employees. The data also reveal a gap from the cognitive understanding compared to the behavioral adherence across all levels within Florida Hospital.

With the behavioral mean scores significantly lower than the cognitive across all three segmented populations, it would appear that there is a disconnect between what the mind comprehends versus what the hand is doing and to what the heart holds dear. In her work on the antecedents to deinstitutionalization, Oliver (1992) outlines that under certain specific conditions, institutional values and traditions are “vulnerable to challenge, reassessment or rejection” (p. 564). In particular, if an institutional value is “no longer reproduced or reenacted over time” (p. 567), it is vulnerable to be set aside as irrelevant. With the low behavior mean, many of the core convictions are vulnerable to be set aside since they are not being reproduced or reenacted.

The behaviors do not measure at the same level as the cognitive understanding. In processing these results with one of the psychiatrists at Florida Hospital, he diagnosed a hypocrisy wherein the head is disconnected from the hand. This “hypocrisy” can also be viewed as dissonance, which is a strong motivating force to either bring constancy or will drive toward a redefinition of the institutional core convictions.

The rapprochement of institutional theory and sensemaking must come together at this juncture. Whereas institutional theory can be described as a construct, sensemaking is the process. To achieve the construct, the process must be designed and function according to the specifications of the construct. As such, the cognitive construct must be

supported and evidenced through the behavioral processes. Given the gap described in the survey, the institutional values are not supported by the sensemaking paradigm.

These results raise a number of daunting questions: Why is there a gap between the cognitive and behavioral scores across all levels in the organization? What factors are leading to the chasm between the leadership team and the employees? Is there a gap in communication between the leadership team and the employees? Are the employees simply reflecting the behaviors that they perceive to be of greatest significance to the leadership team? These questions need to be further considered by the leadership team at Florida Hospital.

Upon reflection on these questions, I am convicted that for the successful ongoing sustenance of the Seventh-day Adventist health core convictions, the focus must be fixated on the behaviors and emotional commitment across all levels within the organization. In order to be reproduced and ultimately sustained from one generation to the next, the core convictions of Seventh-day Adventist healthcare must be individually internalized and organizationally embedded in order to be reproduced and ultimately sustained from one generation to the next. Since institutional values are meaningless unless practiced, the focus should start with the difference in the cognitive compared to behavioral dimensions at the leadership level. The core convictions of Seventh-day Adventist healthcare must be individually internalized and embedded in order to be reproduced and ultimately sustained from one generation to the next. The chasm between the leadership team and the employees can then be addressed by assessing the

management and transference of the behaviors and emotional attachment to the core convictions.

### **Null Hypothesis 3**

The third null hypothesis states: “There is no difference between religious groups across the six core convictions.” Through a one-way ANOVA, it was determined that there was full alignment on the Healing Ministry and Community. In the corresponding post hoc analysis for the other four core convictions, full alignment was demonstrated across the Christian-based religions (Protestant Christian, Roman Catholic, and Seventh-day Adventist) for all of the core convictions. It was also determined that no statistically significant difference exists between the Christian-based religions and the Other Religions. On the vast majority of comparisons with No Religion, statistically significant differences were demonstrated.

Therefore, the null hypothesis was confirmed for the Christian-based religious groups and rejected for the subsection who indicated “None” for religious affiliation.

Given the close connection between null hypotheses 3 and 4, I will defer the implications and combine the two together after the following section.

### **Null Hypothesis 4**

The fourth null hypothesis states: “There is no difference between religious groups in cognitive understanding, adherence of behaviors, and affective connection across the core convictions.” Through a one-way ANOVA, differences were determined across cognitive, behavioral, and affective dimensions. In the corresponding post hoc

analysis, a statistically significant difference was determined between the Seventh-day Adventists and Roman Catholics on the cognitive dimension. Across all three dimensions, statistically significant differences were demonstrated in comparing the Christian-based religions (Protestant Christian, Roman Catholic, and Seventh-day Adventist) to those who indicated “None” for religious affiliation.

Therefore, the null hypothesis is supported across most of the Christian-based religious groups and rejected for those who indicated “None” for religious affiliation.

### Implications

Of all the results, the alignment of the religious groups across all six core convictions was personally the most unexpected. I can certainly conceive that the Health Principles, the Healing Ministry of Christ, the Image of God, and Community Service are fundamental to many religious faith groups. However, given the underlying unique doctrinal concepts undergirding Wholeness (the nature of man) and the unique belief in a seventh-day Sabbath, my expectation was that the Seventh-day Adventist participants would have rated higher on at least Wholeness and Honoring the Beliefs of the Seventh-day Adventist Church compared to all others including the Protestant Christians and Roman Catholics. The data do not support my expectation in this regard.

In reflecting upon these results, I have created two opposing alternate explanations. In the first scenario, one could surmise that Wholeness, the Healing Ministry of Christ, the Health Principles, Honoring the Beliefs of the Seventh-day

Adventist Church, the Image of God, and Community are universal Christian tenets that are not exclusive to Seventh-day Adventist healthcare.

Given this premise, one could reason that the senior leadership who are Seventh-day Adventists merely belong to a Christian-based faith group to promulgate the Seventh-day Adventist health ministry. This supposition makes me uncomfortable. As detailed in the section entitled “A Corollary on Higher Education” in chapter 2, one of the factors leading to the secularization of many institutions of higher learning was the relaxation of requirements that mandated senior leaders and key faculty be members of the sponsoring sectarian faith. While I am not of the delusion that church membership is a guarantee of the necessary belief, it would seem to be a first stage requirement. The intent should be to populate the leadership with those individuals who maintain a significant level of understanding, behaviors, and emotional connection to the core convictions of Seventh-day Adventist healthcare that they will preserve and make consistent decisions at critical junctures. For Seventh-day Adventist healthcare, that would seem to necessitate leaders that practice a Sabbath rest, ascribe to the Seventh-day Adventist belief in the nature of man, and other doctrinally relevant issues.

The alternate scenario would propose that the core convictions, especially Wholeness and Honoring the Beliefs of the Seventh-day Adventist Church, have been diluted from their original intent to be socially comfortable in a religiously diverse environment. Furthermore, this premise would suggest that most Seventh-day Adventists do not fully appreciate or understand the theological and philosophical basis which undergirds the Seventh-day Adventist health message.

Despite being a fourth-generation Seventh-day Adventist with 16 years' experience in the healthcare field, I did not fully appreciate the theological and philosophical basis of the Seventh-day Adventist health message until the immersion of understanding afforded through this research effort. Through this study, my understandings have broadened to include the following: (a) The true understanding of wholistic medicine is often referenced casually as "mind, body, and spirit" as if they are three separate entities. Correctly understood, these three dimensions are descriptors of a single reality; (b) the Seventh-day Adventist understanding of the nature of man is the only consistent interpretation to support a wholistic care model; and (c) the health benefits of a Sabbath rest are not fully developed and tend to be lost in the rules of obedience. These three personal examples support the second scenario that the level of understanding of the Seventh-day Adventist health message is not fully appreciated or amply understood.

To protect and perpetuate the core convictions of Seventh-day Adventist healthcare, an effort must be exerted to provide ongoing education for all senior leaders and middle management that delves into the true meaning and purpose around each of the core convictions. The surface understanding evident in the current environment must be advanced into an organically embedded ontological basis of the organization. Furthermore, the understanding must progress into behavior that connects emotionally. This same effort must be extended to all employees to ensure the ongoing sensemaking paradigm is reflective of a correct understanding of the core convictions.

### Reflections on the Theory Base

In addition to the implications referenced in conjunction with the null hypotheses discussed previously. The following section explores the organizational implications when considering institutional theory and how the sensemaking paradigm factors into the preservation of the confessional identity of Seventh-day Adventist healthcare.

#### Institutional Theory

The core convictions as herein described would undoubtedly qualify as institutional values under Selznick's (1957) definition of institutionalism as organizational practices that "*infuse with value* beyond the technical requirements of the task at hand" (p. 17, italics in original). These core convictions were clearly articulated through the historical literature, the official publications of the General Conference, the writings of our current foremost scholars, and from the voice of the seasoned healthcare administrative leaders. These values are not only significant in an organizational sense, they are sacred in an institutional sense.

Within the survey, there was clear cognitive alignment with the core convictions at all levels of the organization. Without regard to the differences in degrees of alignment, the overall mean scores by senior leaders, middle management, and employees demonstrate a high level of cognitive understanding of these institutional values. The alignment between the various Christian-based faith groups is demonstrative of the institutionalization of a core value centered on the Healing Ministry of Christ. The



presence of a faith base is a unifying factor in leveling the perspectives around all the core convictions.

The Seventh-day Adventist Church entered the health field as a reformation against the current lifestyle practices of the day. To large measure, there were many unique doctrinal and cultural aspects of the Church that created a separatist mentality with corresponding organizational mannerisms. Through this research, I have come to understand that the unique aspects of Seventh-day Adventist healthcare are secondary to those items of *critical importance* that must be sustained. While we should certainly celebrate and cherish those unique attributes, the focus of institutional energy must be devoted to those items of most importance regardless of their unique or distinctive nature.

We must question the benefit of intellectual debates on the core convictions where the actions and emotions are not aligned with the cognitive ideals. Significant time has been devoted to the institutionalization of the core convictions among senior leaders and middle management at Florida Hospital, which will only further the existing gap with employees. Although a devotion to the education of employees is appropriate, it is most critical that the time be spent in practicum to instill the desired behaviors and emotions at a very primal level.

While the preservation of core convictions is of great significance to Seventh-day Adventist healthcare, institutional theory cannot, in and of itself, guarantee ongoing compliance to the confessional identity. For me, institutionalism is helpful in defining and defending an institutional value system, but is lacking in the robust tools and methods necessary to preserve the value set over time. Despite institutional qualities, individuals

will enact their plausible interpretations by means of the sensemaking paradigm. For this reason, to simply rely on institutionalism to preserve the confessional identity of Seventh-day Adventist healthcare without a more organic approach would be disastrous and foolhardy.

### Sensemaking

This research has identified the institutional values of Seventh-day Adventist healthcare and to what degree these values have been institutionalized throughout the fabric of the organization. The questionnaire has demonstrated that the sensemaking paradigm is not in total harmony with the institutional values. The senior leaders and middle management have a higher level of appreciation for the institutional values than do the employees. Furthermore, there is a clear gap between the cognitive understandings compared to the behavioral applications. To bring consonance, either current practice will be brought into alignment or the core convictions will be compromised, which will ultimately jeopardize the confessional identity.

One of the underlying aspects of sensemaking is that the cognitive dimension of organizational behavior is a weak anchor to secure institutional values. As written by Starbuck and Milliken (1988), sensemaking entails making sense of various stimuli extracted from the environment and determining an appropriate cognitive framework or mental map to derive meaning. It would be useful at this juncture to refer back to the seven distinguishing characteristics of sensemaking crafted by Weick (1995): (a) grounded in identity construction, (b) retrospective, (c) enactive of sensible environments,

(d) social, (e) ongoing, (f) focused on and by extracted cues, and (g) driven by plausibility rather than accuracy. Therefore, all individuals retrospectively make sense of their organization through the ongoing social cues regardless of whether they are connected to the institutional values.

Within the sensemaking paradigm, meaning is extracted from the behaviors and social emotions occurring within the organization, which creates individual cognitive understandings. Whereas institutional theory tends toward the mechanistic and statutory, which appeals to the cognitive, sensemaking develops from the extracted behaviors of the organization.

The implications of this theory base are significant to Florida Hospital. Given the fact that the behaviors across all segmented groups are lower than the cognitive ideals of the organization, this dissonance between institutional ideals and behavior will likely be resolved by the social reconciliation of the organizational values. The survey clearly demonstrates the top-down propensity within institutional theory. Given the gap of understanding and emotional connection between senior leaders and middle management compared to the employees, I would propose that the institutional values are at risk of compromise until such time as alignment throughout every level of the organization is achieved. From a structural standpoint, the institutional values are cognitively safe but are organically at risk.

What has been demonstrated through the questionnaire is that Seventh-day Adventist healthcare demonstrates high levels of cognitive understanding. The sensemaking paradigm functions largely on the behavioral and affective dimensions. As

such, additional focus must be given to ensure that a wholistic treatment of the core convictions is instituted so that the cognitive, behavioral, and affective components are all integrated and seamlessly aligned.

While I value the perspective of the sensemaking knowledge base, it would be far too relativistic for Seventh-day Adventist healthcare unless coupled with institutional theory. Sensemaking provides the organic bottom-up perspective that is clearly lacking at Florida Hospital based on the survey data. Whether the leadership team wants to acknowledge it or not, a sensemaking paradigm is functioning on a daily basis but not necessarily in support of the institutional values. The greatest organizational success will occur when that sensemaking framework is fully informing the daily decisions in alignment with the core convictions.

### **Recommendations**

Within this section, recommendations are made for Florida Hospital, the Adventist Health System, and to faith-based healthcare as well as for future research.

#### **Florida Hospital**

1. Create the necessary education and corresponding practicums to bring alignment between the leadership team and the employees on the core convictions of Wholeness, the Healing Ministry of Christ, Honoring the Seventh-day Adventist Belief System, Image of God, and Community.
2. Pursue opportunities to embed the core convictions into the daily behaviors and connect emotionally across all levels of the organization.

3. Initiate the necessary practicums to embrace the true Seventh-day Adventist philosophy of Wholeness into the daily care model at Florida Hospital.

4. Create a culture that supports a personal wholistic environment for the caregivers at Florida Hospital.

#### Adventist Health System

1. Devote the next Mission Conference to the topic of the Seventh-day Adventist healthcare core convictions and how they can be sustained throughout all Adventist Health System entities.

2. As an integral part of the bi-annual mission peer review, assess the current adherence to the core convictions by conducting the questionnaire developed herein across all Adventist Health System facilities.

3. In concert with the General Conference, create an association of Seventh-day Adventist health institutions devoted to the research and promulgation of the confessional identity of Seventh-day Adventist healthcare.

4. Assess the cognitive, behavioral, and affective connection with the core convictions for all officers, board members, and senior leaders across the Adventist Health System through administration of the questionnaire.

5. Create a board policy stipulating the parameters of employment for senior leadership and middle management level positions across all Adventist Health System institutions consistent with the core convictions.

6. Incorporate the latest scientific research on wholistic care into the evidence based practice algorithms being developed for the PowerPlans initiative.

#### Faith-based Healthcare

1. Create a professional association of faith-based healthcare facilities to collaborate on research demonstrating the clinical benefits of spirituality and healthcare.

2. Despite the fact that the “hospital” was created as a Christian institution, only limited research is available on the process of “de-Christianization” (Engelhardt, 2001) that has occurred across the hospital industry. Through the proposed collaborative association, determine the “best practice” models to re-engage the Christian confessional identity into those hospitals with historical faith-based roots.

3. Although the hospital is currently viewed as the epicenter of the health message, the parish church community needs to be incorporated into the wholistic healthcare model thereby recognizing the full spectrum of physical, spiritual, and emotional health.

#### Future Research

1. Additional research should be devoted to the rapprochement of institutional theory with sensemaking to provide an organizational model that combines the macro mechanistic attributes of institutional theory with the micro organic nature of sensemaking.

2. Given the clinical connection with patients, physicians should be included as one of the segmented populations in future research to determine their cognitive,

behavioral, and affective connection with the core convictions of Seventh-day Adventist healthcare.

3. Conduct research on the most successful approaches to the protection of confessional identity. A variety of questions could be pursued including: How significant does the dissonance need to be before an organization should be concerned? Is the gap between the leadership and employees a natural phenomenon that is problematic only when the dissonance is determined to be significant?

4. Conduct a longitudinal study at Florida Hospital to determine how the cognitive, behavioral, and affective scores change over time given various initiatives such as the “Florida Hospital Way.”

5. The conversion of sanitariums to acute care hospitals occurred during the time period of 1910 with the Flexnor report to 1945 with the mass production of penicillin. For Seventh-day Adventist healthcare and the protection of its confessional identity, this transition time frame is of great significance but has not been fully explored to date.

### **Summary of Findings**

The core convictions of Seventh-day Adventist healthcare are Wholeness, the example of the Healing Ministry of Jesus Christ, the Health Principles (nutritious diet, ample water consumption, regular exercise, plenty of fresh air, sufficient rest, appropriate use of sunlight, abstinence from harmful substances such as tobacco, and trusting relationships), Honoring the Beliefs of the Seventh-day Adventist Church, the recognition that man is created in the Image of God, and that the health ministry is a Community

service. In testing the cognitive, behavioral, and affective alignment of these six core convictions, it was determined that the senior leaders and middle managers were fully aligned across most every aspect. However, statistically significant gaps exist between senior leaders and employees in four of the six core convictions as well as cognitively and affectively. Statistically significant gaps were also determined between the middle management and employees in four of the six core convictions as well as cognitively and affectively as well.



APPENDIX A  
INTERVIEW PROTOCOL

# Andrews University

Leadership Program – School of Education  
Research Protocol

Researcher - Randall L. Haffner

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<b>Title:</b>	An Inquiry of the Core Convictions of Seventh-day Adventist Healthcare
<b>Purpose:</b>	The purpose of this qualitative inquiry is to determine the beliefs and experiences of Seventh-day Adventist healthcare executives regarding the core philosophical convictions of Seventh-day Adventist healthcare.
<b>Methods:</b>	The methodology to be employed is one-on-one interviews of three Seventh-day Adventist healthcare executives with at least 20 years of experience within the field.
<b>Time Frames:</b>	The interviews will be conducted between October 1, 2003 and May 1, 2005.
<b>Description of Subjects:</b>	The subjects will be retired and active Seventh-day Adventist healthcare executives with at least 20 years of experience.
<b>Criteria:</b>	Criteria for the subjects to be included in the study will be individuals who have served in a leadership role within a Seventh-day Adventist healthcare institution for at least 20 years.
<b>Benefits of the Research:</b>	The benefits of this research to the subjects will be measured only in the professional pride of relating ones stories and accomplishments. The benefits to the Seventh-day Adventist healthcare system will be contributory information leading to a formalized establishment of the core philosophical convictions that under gird the healthcare message within the church.
<b>Protection of Subject Rights:</b>	No deleterious effects are anticipated to the subjects.
<b>Risks and Discomforts:</b>	No deleterious effects are anticipated to the subjects.
<b>Privacy and Protections:</b>	The subjects will be given the right to specify any materials or comments that they wish to be protected or held in confidence. A summary transcript will be offered to each of the subjects upon request.
<b>Consent Form:</b>	Attached.
<b>Off-Campus Permission:</b>	Whereas the interviews will occur in a variety of locations including the potential of the subjects' private residence, site permission would not seem to be necessary.
<b>Ethical Responsibilities:</b>	The subjects will be given opportunity to specify any ethical concerns they have regarding this research endeavor.

# Andrews University

## Leadership Program – School of Education Informed Consent Form

Researcher: Randall L. Haffner

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- Title of Study:** An Inquiry of the Core Convictions of Seventh-day Adventist Healthcare
- Purpose:** The purpose of this qualitative inquiry is to determine the beliefs and experiences of Seventh-day Adventist healthcare executives regarding the core philosophical convictions of Seventh-day Adventist healthcare.
- Inclusion Criteria:** I understand that in order to participate in this study, I must have served in a leadership role within a Seventh-day Adventist healthcare institution for at least 20 years.
- Procedure:** I understand that I will be asked questions and given the opportunity to respond based on my own personal beliefs and experiences. I understand that I will be given the right to specify any materials or comments that I wish to be protected or held in confidence. I understand that a summary transcript will be offered to me upon request.
- Risks and Discomforts:** I understand that there are no known risks for participating in this study. I retain the right to cease or postpone the interview at any juncture of this process to maintain comfort.
- Benefits/Results:** I understand that I will not receive any direct benefits from participating in this study. I understand that the benefits of my participation will lead to a formalized establishment of the core philosophical convictions that undergird the healthcare message within the church. I understand that the information collected during this study may be included in a doctoral dissertation, and may be presented or published in professional meetings or journals.
- Voluntary Participation:** I understand that my participation in this study is voluntary. I understand that I may discontinue my participation in this study at any time without penalty or prejudice. I also understand that there is no compensation in return for my participation.

Participant's Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Dated: \_\_\_\_\_ Witness: \_\_\_\_\_

At: \_\_\_\_\_

# Andrews University

Leadership Program – School of Education  
Interview Questions

Researcher: Randall L. Haffner

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1. From your experience, what are the essential elements of a Seventh-day Adventist hospital?
2. Are there enduring values within our heritage that can sustain Seventh-day Adventist healthcare? How can we keep the heritage of Adventist doctrine and belief vibrant in the context of technological and sociological changes of the 21<sup>st</sup> Century?
3. From your experience, what are the unique contributions that Adventist theology contributes to health care institutions that you have been affiliated with?
4. How should the whole-person healing ministry of Christ inform and challenge Florida Hospital's operations today?

APPENDIX B

QUESTIONNAIRE AND LETTERS



601 East Rollins Street  
Orlando, Florida 32803  
407/303-6611

January 23, 2006

Dear Fellow Employee,

In a few days, you will receive an electronic questionnaire being conducted in cooperation with Andrews University. You have been randomly selected among the Florida Hospital employees to participate in this research so it is critical that you complete the survey. I am writing in advance because many people like to know ahead of time that they will be contacted.

The research focuses on how Florida Hospital has protected its institutional values. This research will explore your individual beliefs, behaviors and feelings with Florida Hospital's core beliefs.

Your answers are completely confidential and will be released only as summaries in which no individual's answers can be identified. Within the next week, please watch for an e-mail from [FH-Andrews\\_Research@hotmail.com](mailto:FH-Andrews_Research@hotmail.com). All the necessary information will be contained in that message including a link to the actual questionnaire.

Thank you for your time and consideration. Since only a limited number of employees will have the opportunity to respond, your participation is critical to the success of this research.

Yours in Health,



Randy Haffner  
Chief Operating Officer\Orlando

Operated by the  
Seventh-day Adventist Church



601 East Rollins Street  
Orlando, Florida 32803  
407/303-6611

January 23, 2006

Dear Fellow Leader,

In a few days, you will receive an electronic questionnaire being conducted for my dissertation research at Andrews University. I am writing in advance because many people like to know ahead of time that they will be contacted.

As discussed during leadership weekend, my research focuses on the necessity for Florida Hospital to protect its institutional values. This research will explore your individual beliefs, behaviors and feelings in relation to Florida Hospital's core beliefs.

Your answers are completely confidential and will be released only as summaries in which no individual's answers can be identified. Within the next week, please watch for an e-mail from [FH-Andrews\\_Research@hotmail.com](mailto:FH-Andrews_Research@hotmail.com). All the necessary information will be contained in that message including a link to the actual questionnaire.

Thank you for your time and consideration. Since the data will be segmented in multiple ways, it is critical that every person participate by completing the questionnaire when it arrives in a few days.

Yours in Health,

A handwritten signature in black ink, appearing to read "Randy Haffner".

Randy Haffner  
Chief Operating Officer/Orlando

Operated by the  
Seventh-day Adventist Church



601 East Rollins Street  
Orlando, Florida 32803  
407/303-6611

January 30, 2006

Dear Fellow Employee,

I would like to personally ask for your assistance in determining Florida Hospital employees' level of understanding of the institutional values at Florida Hospital. This survey is being conducted in cooperation between Florida Hospital and Andrews University. You have been selected at random to answer these questions along with the entire management and administrative team.

Results from this survey will assist Florida Hospital accurately assess the current beliefs, behaviors and feelings of employees in relation to the six institutional values defined in the attached questionnaire. Your responses will be combined with those of your fellow employees and presented to the senior management of Florida Hospital. By determining this information, Florida Hospital can take the necessary steps to ensure that we stay true to our original calling.

Your answers are completely confidential and will be released only as summaries in which no individual's answers can be identified. Upon completing the attached survey, your name will be deleted from the mailing list and never connected to your answers in any way. This survey is completely voluntary. However, because only a limited number of employees have been selected to provide this feedback, your participation is very critical to the research.

Once you are prepared to take the survey, simply click on the link below. On average, this survey only takes ten minutes to complete. This questionnaire is scheduled to close on **February 20, 2006**, but I would request that you respond as soon as you can.

If you have any questions or comments regarding this research, please feel free to email me or call at (407) 303-7920. Thank you for your assistance in this important research endeavor.

Yours in Health,

A handwritten signature in black ink, appearing to read "Randy Haffner".

Randy Haffner  
Chief Operating Officer\Orlando



# Andrews University

Department of Leadership  
School of Education



## Survey on Institutional Values

**Purpose:** The purpose of this questionnaire is to determine the gaps and alignments between the institutional values of Seventh-day Adventist healthcare and the understanding, behaviors, and emotions of employees at Florida Hospital in Orlando, Florida.

To accurately assess the current beliefs, behaviors and feelings by the employees of Florida Hospital, it is critical that you respond to this survey. Please answer the questions exactly as you perceive them and not according to how you believe the organization or any individual may wish for you to reply. Your honest assessment will help Florida Hospital determine the levels of understanding and engagement on the six institutional values as defined below.

**Participation Agreement:** As this is an online survey, completing and returning the survey will constitute your consent to participate in this research study. Your participation is voluntary and individual confidentiality will be assured in the analysis and reporting of all data. There are no known risks for participation in this study. To review the complete research protocol and informed consent form, please click here: [www.flhosp.org/database/protocol](http://www.flhosp.org/database/protocol)

**Directions:** The following rating scale should be used to evaluate the six institutional values of Florida Hospital. After reviewing the definitions for each of the institutional values, circle the rating that best applies based on your assessment and understanding of Florida Hospital. This survey should take approximately 10 minutes to complete.

1. Strongly Disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly Agree
- N/A Unknown

Thank you for your participation.

**I. Wholeness** - The integration of the mind and body with the spirit to enjoy the fullness of life. According to this view, the physical aspects of medicine are only one component of true health. For a full life, all aspects of a person including their emotional status, social, and spiritual health need to be considered and addressed. In other words, all aspects of a person are interconnected and cannot be separated.

1.	I understand Florida Hospital's concept of wholeness.	1	2	3	4	5	N/A
2.	I believe in the importance of wholistic living and care.	1	2	3	4	5	N/A
3.	I engage in wholistic practices to keep my mind, body and spirit well.	1	2	3	4	5	N/A
4.	The caregivers at Florida Hospital practice wholistic care.	1	2	3	4	5	N/A
5.	My entire health including mind, body and spirit are nurtured at Florida Hospital.	1	2	3	4	5	N/A
6.	I feel a sense of wholeness while working at Florida Hospital.	1	2	3	4	5	N/A

**II. The Healing Ministry of Christ** - The mission of Florida Hospital is to extend the healing ministry of Christ. Therefore, Christian influences should be prevalent both in word, symbol, and practice. Practical applications would include prayer, spiritual nurturing, care, and compassion all motivated from the loving example of Jesus Christ.

1.	I understand what it means to extend the healing ministry of Christ.	1	2	3	4	5	N/A
2.	I believe that Christ provides an excellent model of compassionate care.	1	2	3	4	5	N/A
3.	I extend the healing ministry of Christ at Florida Hospital.	1	2	3	4	5	N/A
4.	I utilize prayer at Florida Hospital to extend the healing ministry of Christ.	1	2	3	4	5	N/A
5.	I sense a spirit of love and grace at Florida Hospital.	1	2	3	4	5	N/A
6.	I experience meaning from the mission of Florida Hospital.	1	2	3	4	5	N/A

**III. Health Principles** – From the earliest days of the Florida Sanitarium, a focus has been given to preventative health practices and education. The eight principles of health at the Florida Sanitarium were a nutritious diet, ample water consumption, regular exercise, plenty of fresh air, sufficient rest, appropriate use of sunlight, abstinence from harmful substances such as tobacco, and trusting relationships.

1.	I understand the health benefits of:						
	A. A nutritious diet	1	2	3	4	5	N/A
	B. Ample water consumption	1	2	3	4	5	N/A
	C. Regular exercise	1	2	3	4	5	N/A
	D. Fresh air	1	2	3	4	5	N/A
	E. Sufficient rest	1	2	3	4	5	N/A
	F. Appropriate use of sunlight	1	2	3	4	5	N/A
	G. Abstinence from harmful substances such as tobacco	1	2	3	4	5	N/A
	H. Trusting relationships	1	2	3	4	5	N/A
2.	I personally practice the following health principles:						
	A. A nutritious diet	1	2	3	4	5	N/A
	B. Ample water consumption	1	2	3	4	5	N/A
	C. Regular exercise	1	2	3	4	5	N/A
	D. Fresh air	1	2	3	4	5	N/A
	E. Sufficient rest	1	2	3	4	5	N/A
	F. Appropriate use of sunlight	1	2	3	4	5	N/A
	G. Abstinence from harmful substances such as tobacco	1	2	3	4	5	N/A
	H. Trusting relationships	1	2	3	4	5	N/A

**IV. Seventh-day Adventist Beliefs** - Florida Hospital is owned and operated by the Seventh-day Adventist Church and therefore the beliefs of the Church are to be honored. In addition to extending the loving and compassionate care as demonstrated by Christ, following all Biblical teachings including honoring Saturday as Sabbath are core to the Seventh-day Adventist belief system.

1.	Biblical teachings are cherished at Florida Hospital.	1	2	3	4	5	N/A
2.	Saturday (Sabbath) is a special day at Florida Hospital.	1	2	3	4	5	N/A
3.	Christian principles are practiced at Florida Hospital.	1	2	3	4	5	N/A
4.	I appreciate working for a faith based hospital.	1	2	3	4	5	N/A
5.	I respect the Florida Hospital Seventh-day Adventist heritage.	1	2	3	4	5	N/A

**V. Image of God** - As reflected in Genesis, man and woman were created in the image of God. This means that all individuals are of great value regardless of their race, gender, and social status. Therefore, all individuals are treated as worthy and afforded the highest levels of dignity.

1.	I believe that every person is created in the image of God.	1	2	3	4	5	N/A
2.	Every person at Florida Hospital is valued regardless of their race, gender or ability to pay.	1	2	3	4	5	N/A
3.	I treat others with respect because they are created in the image of God.	1	2	3	4	5	N/A
4.	The staff at Florida Hospital treats every individual as a child of God.	1	2	3	4	5	N/A
5.	I feel respected at Florida Hospital as a child of God.	1	2	3	4	5	N/A

**VI. Community** - Florida Hospital was established as a community service to promote health and wholeness. Therefore, Florida Hospital should be actively engaged in the betterment of the health status of the community. In addition to the services provided in the hospital, these activities would include extended services such as community clinics and community events like blood drives, heart walks, backpacks for kids, and other community related initiatives.

1.	I believe that Florida Hospital has a positive relationship with the community.	1	2	3	4	5	N/A
2.	Florida Hospital is very interested in the health status of the community.	1	2	3	4	5	N/A
3.	I am personally engaged in community activities on behalf of Florida Hospital.	1	2	3	4	5	N/A
4.	I am involved with activities that improve the health status of the community.	1	2	3	4	5	N/A
5.	I feel a sense of belonging at Florida Hospital.	1	2	3	4	5	N/A
6.	I feel that it is important for Florida Hospital to be actively involved in the community.	1	2	3	4	5	N/A

### **Demographic Data**

1. Years of service at a Seventh-day Adventist healthcare institution including Florida Hospital:
  1. 0 – 9 Years
  1. 10 – 19 Years
  1. 20 – 29 Years
  1. 30 Years and greater
  
2. Religious Affiliation:
  2. Protestant Christian
  2. Seventh-day Adventist
  2. Roman Catholic
  2. Judaism
  2. Muslim
  2. Hindu
  2. None
  2. Other: \_\_\_\_\_

Thank you for completing this survey and participating in this research. If you have any further questions, please contact either myself or the Chair of the Dissertation Committee as follows:

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Maitland, FL 32751  
[Randy.Haffner@flhosp.org](mailto:Randy.Haffner@flhosp.org)

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APPENDIX C

HUMAN BEING: PHILOSOPHICAL CONTEXT  
FOR ADVENTIST HEALTH CARE  
BY FRITZ GUY, PH.D.

**Human Being: Philosophical Context for Adventist Health Care  
Presented by Fritz Guy  
Centennial Vision Retreat  
March 5-6, 2004**

In the modern and postmodern context of the twenty-first century, Adventist thinking about health care needs more than ever to be informed by careful consideration of what it means to be human. The reflections I offer here elaborate the thesis that human being is constituted by the multilayered interactivity of four very different kinds of reality—body, mind, world, and God. This understanding of humanness is certainly not unique, but neither is it entirely unproblematic; hence the need for serious reflection.

To begin, I would like to give preliminary definitions of the key terms in the title and thesis of this paper. Fuller meanings will become clearer as we proceed.

*Human being* means the distinctively human way of being, of existing. In this discussion the word *being* needs to be understood (and pronounced) as *be-ing*—a verbal form (specifically, a gerund) indicating the continuing activity of being.<sup>1</sup> Because *being* is also a noun—we frequently refer to an individual person as “a human being,” and to ourselves collectively as “human beings”—I need to emphasize that in this paper the term *human being* refers not to a person but to the human way of being—human existence, humanness. This human quality of being is shared by all the recipients and all the providers of health care.

3. *Philosophical context* means thinking that is broad and careful, critical and constructive, and based on current knowledge about human nature. This kind of thinking does not presuppose any particular theological commitment other than recognition of a reality corresponding to generally accepted meaning of the word “God.” Occasional references to Scripture and Christian thought are intended to be illustrative rather than evidential.
4. *Adventist health care* means health care that is characterized by deliberate, thoughtful reflection of the sort that is taking place at this retreat, and that should become a permanent part of Florida Hospital’s institutional culture. Unfortunately (but not surprisingly) not all of the health care provided in Adventist medical settings and/or by Adventist personnel is characterized by this kind of rigorous thinking.

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This use of *being* corresponds to the Latin infinitive *esse*, which can be translated *act of being*. The term *human being* points to the distinctively human way of *being*, a meaning related to Martin Heidegger’s use of the German *Da-sein* in his influential book *Being and Time* (1996, xiii-xiv). This meaning could perhaps be indicated more obviously by using the hyphenated form *be-ing*; but that seems (to me) to be too clumsy typographically.



5. *Body* means the sheer physicality of human being, its material basis. Here the most important single element is obviously the brain, especially its neocortex and the frontal lobes. But we will be concerned with the human significance of the rest of the body as well.

*Mind* means consciousness, cognition, centeredness, agency—the entire complex of human selfhood—the understandings, deliberations, values, purposes, and decisions that define and express the particular “self” one is. This is what the ancient Hebrews usually meant by the word *nephesh*, and what the New Testament writers meant by *psuche* (the etymological root of the English word *psyche* and its cognates).<sup>2</sup>

6. *World* means the totality of relationships, knowledge, and values that constitute the context of meaning within which a person exists, of which a person is a part, and which inevitably and profoundly shapes what a person is and can be. Like the body and the mind, this world brings both possibilities and constraints.
7. Finally, the word *God* means the Ultimate Reality, the source and empowerment of human (and all other) existence, meaning, and value. Intentionally or not, consciously or not, every person exists in relationship to this Reality, which is transcendent and immanent, beyond and present.

The order of these reflections will be both logical and historical. We will begin by considering human being as *body*, always and irreducibly physical, because that is the most obvious, tangible aspect of human being, and also because Adventist health care began in conjunction with a rejection of the substance dualism entailed by the traditional idea of an immortal, separable soul. Then we will consider human being as *more than body*. This “more” has become problematic because of two philosophical factors: first, a widespread tendency to define human being materialistically (that is, neurophysiologically); and, second, the extraordinary difficulty of adequately explaining the relationship of the “more” to the body. (So the present intellectual challenge to Adventist thinking about human being is the opposite of its original challenge: now, instead of insisting that human being is *inescapably* physical, the task is emphasizing that it is *not merely* physical.) Next we will consider human being in its *social and cultural world*. This is an aspect of humanness that both defeats a materialistic anthropology and also deserves more serious Adventist attention than it usually receives (because we have usually been so caught up in opposing the idea of an immortal soul). Finally we will consider human being in its *unique relation to Ultimate Reality*, reflecting briefly on the relationship of human being to God, and much more extensively on the nature of divine agency in relation to human being.

#### The Localization of Mental Functions: Human Being as Body

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2

Unhappily, our English word *soul* carries so much traditional metaphysical baggage that it is not useful for our present reflections.

"Whatever it means to be a person is rooted in the brain and its body" (Hefner 2000, 74). This brings us to the story of Phineas P. Gage, which is told in fascinating detail at the beginning of the book *Descartes' Error: Emotion, Reason, and the Human Brain* (Damasio 1994, 3-10). Gage was severely injured when an accidental explosion sent an iron rod through the front part of his head, and the continuing significance of his story is its dramatic illustration of the fact that particular mental functions are located in specific areas of the brain.<sup>3</sup>

Now widely recognized, Descartes' error was his assertion of two separate and opposite kinds of created reality—matter (*res extensa*, extended stuff) and mind (*res cogitans*, thinking stuff). In this assertion Descartes (1596-1650), often called "the father of modern philosophy," was following the ancient tradition of Plato (c.427-348 B.C.E.) and Augustine (354-430 C.E.), affirming a radical substance dualism (Murphy 1998a, 2-9). Descartes' ensuing philosophical challenge, which he never successfully met, was to explain the obvious fact that in human being his two opposite kinds of reality act on each other: on the one hand, the mind's decision to write a letter causes the matter of one's fingers to pick up a pen; and on the other hand, the liquid matter of wine causes the mind to behave in strange ways. Furthermore, extreme physical pain "does not simply resist language but actively destroys it" (Scarry 1985, 4). Descartes' suggested that the two kinds of substance interact in the brain's pineal gland (about which very little was then known).

Descartes was, of course, wrong, not only about the pineal gland, but also about the metaphysical opposition between mind and matter—just as the dominant Western theological tradition had been wrong about the separability of the human soul from the human body. The traditional dualistic view was derided at the middle of the twentieth century as "the dogma of the Ghost in the Machine" (Ryle 1949, 15-16). It is now widely

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In the summer of 1848 Phineas Gage was a 25-year-old construction foreman for the Rutland and Burlington Railroad, in charge of a gang of workmen who were laying down new tracks across Vermont. Part of their task was blasting away rock in order to facilitate the construction of as straight and level a route as possible. The process involved the repeated procedure of drilling a hole in the rock, filling it halfway up with blasting powder, inserting a fuse, covering the powder with sand, tamping the sand with an iron rod, and lighting the fuse. About 4:30 on a hot September afternoon Gage put in the powder and the fuse, and told the man helping him to pour in the sand. Just then, Gage was momentarily distracted by someone shouting at him. Turning back to his work, he absent-mindedly began tamping before his man had put in the sand on top of the powder. His iron rod struck the rock and created a spark that ignited the powder and caused a huge explosion. The iron rod, about three and a half feet long and an inch and a quarter in diameter, shot upward, entered Gage's left cheek, pierced the base of his skull, went through the front of his brain and out through the top of his head, and landed a hundred feet away covered with blood and tissue. Gage lay on the ground, stunned but awake. In a few minutes he was able to speak, and was carried to an ox cart in which he rode, sitting up, three-fourths of a mile to a hotel. About an hour after the explosion, a doctor arrived and proceeded to examine and dress the horrendous wound in Gage's head, while Gage talked perfectly rationally and described what had happened.

Gage survived not only the initial trauma to his head but also the ensuing infections, and two months later he was pronounced cured. He walked normally, spoke without difficulty, and used his hands with dexterity. Although the vision in his left eye was gone, in his right eye it was perfect. But—and this is the point of the story—as his friends put it, "Gage was no longer Gage." He was radically different in personality and character. Previously smart and capable, energetic and persistent, efficient and successful, he had suddenly turned coarse and profane, erratic and undisciplined. Unable to hold a job, he became a circus attraction, showing off his wound and his tamping iron. He spent some time in South America, then returned to the United States and ended up in California. His health eventually deteriorated, he developed epileptic seizures, and in May 1861, twelve and a half years after the accident, he died in a convulsion.

accepted that a person does not simply *have* a body; in a profound sense a person *is* a body.<sup>4</sup>

Physicality discloses several important characteristics of human being. In establishing personal boundaries and identity, it expresses human finitude. In its susceptibility to suffering and nonbeing, it expresses human vulnerability. Human being is, after all, “dust” (Gen. 3:19), so “every body is a fragile temple of God’s Spirit.” In its dependence on reality outside itself, it expresses human relationality to other humanity (and to all physical reality); thus “bread that is blessed, broken, and shared becomes the food of angels” (Paulsell 2002, 12, 109).

Plato and Augustine to the contrary notwithstanding, human physicality is neither an ontological deficiency to be transcended nor a moral defect to be rectified. Instead, it is a positive good both a sacred gift (Paulsell 2002, xiv) and the ontological foundation—that is, the necessary condition—of human personhood. For humans not less than for elementary particles, “matter matters” (Oberg 2004). So it is scientifically and philosophically appropriate that Christian and Adventist belief honors the radical physicality of human being.<sup>5</sup> It is through our physicality—its birthing and nourishing, its growing and aging, its embracing and suffering—that “we love and serve God and one another,” and thus “participate in God’s activity in the world” (Paulsell 2002, 9).<sup>6</sup> Since the

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<sup>4</sup> The question has been raised whether dualism is “the cause of patriarchy, slavery, [and] the debasement of sex and body.” A sober claim is “not for a clearly causal relationship between substance dualism and these regrettable realities, for surely history is more complex in the etiology of wrongfulness,” but rather for “a certain affinity between ideas and social practices. Whether or not substance dualism has been a seedbed of oppression, Christian inclusivity has certainly been undermined in some instances by use of the analogy of dualism and the dualistic account of human nature to distinguish between superior (soul, male, free) and inferior human beings (body, women, slave). Substance dualism has served as an ideological support for the exclusionary inclination . . . to place categories of human beings outside of ordinary restraints on wanton infliction of harm and on coercion” (Post 1998, 203). But even this moderate view overlooks the correlative facts that almost any philosophical view can be (and has been) employed in the service of injustice, and that at present there is not even a noticeable “affinity” between mind-body dualism and oppression. A similar response can be made to the suggestion that “a dualist anthropology in the early centuries of the church was largely responsible for changing Christians’ conception of what Christianity is basically all about”—namely, from “continuing the work of Jesus” to “having one’s sins forgiven and receiving eternal life” (Murphy 2002, 26).

<sup>5</sup> The doctrine of the divine incarnation as Jesus of Nazareth presents human physicality as a sacrament, a bearer of the holy, a means of grace. Our major symbols—baptism, foot washing, the Lord’s Supper, even the Sabbath—are, like all the rest of human being, intrinsically physical. (The radical contrast sometimes made between the Sabbath as temporal and other symbols as spatial is not entirely valid; while the Sabbath does not require material objects (such as water or bread) for its experienced reality, as a day it is defined by the revolution of the earth on its axis.) The doctrine of the eschaton presents physicality as humanity’s destiny, its everlasting future. And in the Christian understanding of humanity’s vocation, physicality makes possible human fulfillment in and as the image of God, for which physicality is the context, the occasion, and the means.

<sup>6</sup> A recent hymn on the physicality of the body, “Good Is the Flesh,” written by Brian Wren (1989, no. 16), is based on Gen. 1:31; John 1:14; 14:23:

Good is the flesh that the Word has become,  
 good is the birthing, the milk in the breast,  
 good is the feeding, caressing and rest,  
 good is the body for knowing the world,  
 Good is the flesh that the Word has become.

Good is the body for knowing the world,

middle of the twentieth century, Christian theology has increasingly acknowledged that the idea of an immortal, separable human soul comes more from Platonic than from Biblical thought (Stendahl 1965), and that the proper Christian view of human being sees it as a multidimensional unity (Tillich 1963). The physicality and unity of human existence mean, among other things, that “when the body is honored, the whole person is honored. And when the body is dishonored, the whole person is harmed.” It is ironic that Christianity “has long struggled with an uneasiness about the body, even as it affirms the goodness of the body in its bedrock beliefs.” (Paulsell 2002, 2, 5).

Some respected and influential scholars persist in affirming the traditional Platonic-Christian dualism—“mainline” thinkers on philosophical and theological grounds (Ward 1992, 1998; Popper 1994; Swinburne 1997), and “evangelical” thinkers on Biblical grounds (Gundry 1976; Cooper 2000). Nevertheless, the evidence against substance dualism is pervasive and (in my judgment) persuasive. The principal philosophical argument remains the inexplicability of mind-body interaction—that is, how a nonphysical entity that occupies no space can exert an efficient causal effect on a material object (Griffin 1998, 49-50). The most powerful scientific evidence comes from cognitive localization studies that show “how specific mental processes or even component parts of those processes appear to be tightly linked to particular regions or systems in the brain. Within those regions, moreover, there often emerged a further specificity indicating that certain columns of cells were involved when a particular aspect of the task was being performed” (Jeeves 1998, 79).

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sensing the sunlight, the tug of the ground,  
feeling, perceiving, within and around,  
good is the body, from cradle to grave,  
Good is the flesh that the Word has become.

Good is the body, from cradle to grave,  
growing and ageing, arousing, impaired,  
happy in clothing, or lovingly bared,  
good is the pleasure of God in our flesh,  
Good is the flesh that the Word has become.

Good is the pleasure of God in our flesh,  
longing in all, as in Jesus, to dwell,  
glad of embracing, and tasting, and smell,  
good is the body, for good and for God,  
Good is the flesh that the Word has become.

### Emergent Supervenience: Human Being as More Than Body

If the “ghost in the machine” model of human being won’t do, neither will the “steam whistle” model proposed by T. H. Huxley in 1902, more formally known as “epiphenomenalism” and still widely propounded. According to this latter model, consciousness in humans as well as animals is “related to the mechanism of their bodies simply as a collateral product of its working, and to be as completely without any power of modifying that working as the steam-whistle which accompanies the working of a locomotive is without influence on its machinery” (Midgley 2000, 25).

Many scientists and some philosophers claim that nature consists entirely of “particles and their relations with each other,” so that “everything can be accounted for in terms of those particles and their relations” (Searle 1984, 86). In other words, “The human brain is a machine which alone accounts for all our actions, our most private thoughts, our beliefs. It creates the state of consciousness and the sense of self. It makes the mind.” Thus, “to choose a spouse, a job, a religious creed—or even to choose to rob a bank—is the peak of a causal chain that runs back to the origin of life and down to the nature of atoms and molecules. . . . All our actions are the products of the activity of our brain. . . . We feel ourselves usually to be in control of our actions, but that feeling is itself a product of our brain, whose machinery has been designed, on the basis of its functional utility, by means of natural selection” (Midgley 25-26).

According to this view, the phenomenon to be explained is the fact that that “we think of ourselves as conscious, free, mindful, rational agents in a world that science tells us consists entirely of mindless, meaningless, physical particles” (Searle 1984, 13). But the “astonishing hypothesis” is inescapable: “‘You,’ your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behavior of a vast assembly of nerve cells and their associated molecules. As Lewis Carroll’s Alice might have phrased it: ‘You’re nothing but a pack of neurons.’ . . . The scientific belief is that our minds—the behavior of our brains—can be explained by the interactions of nerve cells (and other cells) and the molecules associated with them” (Crick 1994, 3, 7). So you may think you are making a decision, but you are really just finding out what your neurons are making you do.

This view is generally known as monism or materialism, but is also called (usually by its opponents) “eliminative materialism.” The opponents regard materialism as “crass reductionism” (Polkinghorne 1996, 26) and insist that “terms such as ‘consciousness’, ‘person’, ‘social fact’ and, in general, the languages of the humanities, ethics, the arts and theology . . . are not prematurely to be dismissed from the vocabulary used to describe the human condition, since in all these instances a strong case can be made for the distinctiveness and non-reducibility of the concepts they deploy” (Peacocke 1993, 41).

Ranged against materialism’s “steam whistle” model are four lines of argument:

1. First, materialism is contrary to what we may call “incorrigible common sense” (also called “hard-core common sense”). This incorrigible common sense differs significantly from “received wisdom” (or “soft-core common sense”). Received wisdom

“involves beliefs that are widespread at a particular time and place but that, given new knowledge, can be given up,” such as “beliefs in a flat Earth, a geocentric universe, and solid matter” that have been superceded. By contrast, incorrigible common sense involves beliefs that are “common to all humanity [in all times and places]. This does not mean, to be sure, that they are consciously and verbally affirmed by all human beings, but only that they are inevitably presupposed in practice, even if denied in theory. The fact that they are inevitably presupposed means that, if we do try to deny them verbally, we will inevitably contradict ourselves, in the sense that our behavior (our ‘practice’) will contradict the content of our verbal statement” (Griffin 2000, 99). It is not simply the case that “this hypothesis is so alien to the ideas of most people alive today that it can truly be called astonishing” (Crick 1994, 3); actually, this hypothesis is literally incredible, impossible intelligently and consistently to believe.

Second, materialism entails total determinism, which is, in philosophical jargon, self-referentially incoherent. “Any argument . . . that it is rational to believe the total determinist thesis must be logically suicidal, or self-refuting.” For “the concept of rational belief presupposes intellectual freedom; so that a mind whose history is determined cannot be said rationally to believe anything. . . . Thus any attempt rationally to establish total determinism involves the contradiction that in arguing for it the mind must presume itself not to be completely determined, but to be freely judging, recognizing logical relations, assessing relevance and considering reasons; whereas if the determinist conclusion is true the mind is, and always has been, completely determined and has never been freely judging, etc.” (Hick 1976, 117).<sup>7</sup>

2. Third, materialism ignores the universal phenomenon of social-contextual influence. As a matter of fact, much human behavior is motivated by social rather than genetic or neurophysiological factors. “Higher-order consciousness inescapably depends on extrinsic cultural and social features that are not mirrored in the physical structure of an individual brain. . . . The contents of our beliefs, the ideals guiding our choices, the aims of our desires, etc., are never determined [simply] by the character of individuals (and their brains), but depend [also] on sociocultural facts of the linguistic communities to which we belong” (Gregerson 2000, 174).
3. Finally, materialism is inferior to the idea of mental causation in explanatory power. “Mental causation makes the best sense of the phenomena of human experience” (Clayton 1997, 256). “As long as the explanatory power of idea-idea causation continues to be much greater than the neurophysiological account, we should straightforwardly assert its superiority and indispensability. Indeed, we have good reason to think that even an advanced neurological science . . . would not provide the simpler causal account—any more than advanced physics would lead us to tell the

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To say it differently: “The recommendation . . . that we eliminate [the] threefold belief [in conscious experience, in an element of freedom, and in behavioral efficacy] presupposes (1) that we consciously understand the recommendation, (2) that we can freely choose to accept the recommendation, and (3) that our bodily actions, such as our ‘speech acts,’ will henceforth be guided by this free choice. The denial of this threefold belief is, therefore, irrational, because it involves a performative self-contradiction.” Note that a “performative self-contradiction” occurs when “when whatever is being claimed is at odds with the presuppositions or implications of claiming it” (Griffin 2000, 139, 99 n. 6).

story of cell reproduction in terms of physics alone. In both cases the mathematics would be incredibly complex and the predictive value close to nil" (Clayton 1997, 255). Although it may well be true "that a brain causes mind, and that the development of brains is a *sufficient* explanation of the emergence of mind," the fact remains that "the physical functioning of [the] brain is not the *complete* explanation of *what* mind is, *how* it works, *what* it *effects*" (Gregersen 2000, 172).

These kinds of argument help to explain the survival of mind-body dualism: materialism suffers from an apparently decisive combination of objections. For much of the period of modern philosophy, both dualists and materialists argued their cases primarily in negative terms: dualists argued that the objections to materialism were insuperable; and materialists argued that the objections to dualism were insoluble (Griffin 1998, 2-3). In important ways they are both right. But the arguments against materialism do not require the conclusion that the "more" besides the brain in human being is some kind of substance, entity, or container—a sort of "mental milk bucket" (Clayton 1997, 254). Rather, it can be understood as what philosophers sometimes call an "emergent" and "supervenient"<sup>8</sup> property—that is, a quality or capacity that arises out of an existing reality (in our case, a brain), and that can then exert a "downward" (or "top-down") causality on its underlying, "subvenient" reality. The idea of emergence "has strong scientific credentials to back up its claim to be a conceptually coherent and empirically viable middle road" between dualism and materialism (248), and it accurately expresses the relation of a human mind to a human body: Having arisen from the structural and functional complexity of the brain, and ontologically dependent on it, the mind (or, better, the "person" or "self") can and does causally affect the brain—and, through it, the body and the surrounding reality. The "more" of human being thus includes several related mental functions: consciousness, cognition or rationality, interpretation, practical and moral evaluation, intention, decision, agency, and a sense of Ultimate Reality.

Current versions of this view are called "nonreductive physicalism" (Murphy 1998b), "dual-aspect monism" (Polkinghorne 1994, 21) and "emergent [or "emergentist"] monism" (Clayton 1997; Peacocke 2003). Whatever the terminology, this view recognizes both the physical reality of human existence and the emergent, supervenient, functional "more" of human selfhood. It also recognizes the inevitable dialectical tension between *being* a body and *having* a body and the complementary fact that "the impossible attempt to divide body and spirit does violence to both" (Paulsell 2002, 16-21, 157).<sup>9</sup> Even so, there

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The lexical history of *supervenience* and its cognates runs from the first documented occurrence of the adjective *supervenient* in 1594 and the noun *supervenience* in 1664 through the first philosophical usage (Latin *supervenire*) by G. W. Leibniz (1646-1716) and to its introduction into philosophical ethics by R. M. Hare in 1952 and into the philosophy of mind by Donald Davidson in 1970. Currently "the most important contributor to the supervenience literature" is Jaegwon Kim (Bieffeldt 2000, 121-24). Kim's work has been examined from a panexperientialist perspective by Griffin 1998, 218-42. For further discussions of the idea of supervenience and its philosophical significance, see Horgan, 1995; Murphy 1996, 141-44; 1997, 193-97; 1999, 148-57; Clayton 1997, 247-57.

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Although the ideas of "nonreductive physicalism," "dual-aspect monism," and "emergent monism" have developed primarily in the context of evolutionary thought, assuming a gradual development of life forms through an extensive earth

is some reason for caution: "Though non-reductive physicalism is an attractive position, . . . the jury is still out on whether it is tenable. Until the matter is resolved, it would be unwise to assume that [it] represents the salvation of Christian theology of the person" (Watts 2000, 48). So the scientific and philosophical conversation needs to continue.

### Personal Identity: Human Being as Social Construction

Besides the two human "worlds" of physical facts and mental states, there is also a third "world" of cultural constructs (Popper 1994, 7-8).<sup>10</sup> It seems self-evident that "microphysical brain states cannot make a pledge" and that "a mouth cannot promise anything," because "only persons can do so." Furthermore, persons can function "only inside given social settings" (Gregersen 2000, 175). So human being involves something more than the supervenient mind (or "self") emerging from the subvenient brain and effecting the downward causality of conscious agency on the brain and body; it also involves acting upon the cultural materials received from the environment, shaping them into "an understanding of the self, an understanding of the self's relation to the world in which it lives and to the people in that world, and into a life that holds itself accountable to those understandings of self, other people, and world" (Hefner 2000, 73). *Human* being is thus unique among the various forms of terrestrial reality, but it is essentially related to all of them as well.

How does social construction happen? One answer is that mental life "emerges through a long period of individual development, requiring lengthy dependency on other human beings, and extensive social support. This [combination of] dependency and support not only meets, but shapes our biological and emotional needs, and brings out cognitive capacities and our personhood into being, building within each of us an identity and an interior life." The immaturity and plasticity of a newborn human's nervous systems entail a need for "experiential shaping" throughout a person's life. Similarly, the comparatively large size of the prefrontal cortex is believed to entail "a need for extensive social scaffolding for normal human functioning" in order to make possible "the emergence of a socially constructed virtual reality," which is in fact "a supervenient symbolic world transcending immediate experience. Our engagement with such a world is rooted in familial and communal attachments which generate the emotional and spiritual patterns of adulthood." Thus the wholeness of personhood is evidently contingent on the relational contexts of which individual persons are parts. So it seems likely that "even 'internal states' [such as emotions and thoughts] are constituted within a semantic [as well as] a physical space"; and the semantic space is itself "a social and intellectual product" (Teske 2000, 189, 191-992).

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history, they are conceptually independent of such a context, because they are required just as much for an understanding of individual human development. The same can be said regarding the need to account for mind-body intercausality.

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Popper's mind-body dualism does not negate the value of his three-worlds model, because the two ideas are conceptually independent. Although it serves Popper's dualist purposes, it can also serve our own nondualist purposes.



Significantly, “elements of determinism originated at the biochemical, genetic, and neurobiological levels are significantly modulated at the cultural level.” For example: “After I have heard the presentation on genetic determinism and biochemical reductionism, I leave the lecture hall, and face a whole range of decisions as to how I shall spend my evening, spend my money and fill out my [appointment] book. Even if I am as much a creature of determinism as the lecturers say, I must endure the struggle and discomfort of wrestling with any number of decisions for my life, just as if I possessed a modicum of freedom. This is because I am a creature of culture as much as a creature of biochemistry” (Hefner 2000, 79).

For another obvious example of the supervenient influence of social relationships as well as mental agency, think of sexual behavior, which, like all morally significant activity, “requires us to imagine what another person feels, to seek what will give pleasure and avoid what will not.” A quite different example (particularly relevant to the present discussion) is physical healing, which “is not possible if you have no safe place to go to regain your strength” (Paulsell 2002, 156, 167). Sadly, however, not all the examples of the social construction of human being are positive. We all know that “bodies are used to sell products, and our anxieties about the appearance of our bodies are manipulated to sell even more” (Paulsell 2002, 4). Thus our culture perpetuates “the alienation of the body from the self” (Nelson 1978, 37).

#### Transcendence and Providence: Human Being as Divine Interest

Human being is *being* in a unique relation to Ultimate Reality. According to one of the most famous sentences in the history of Western thought, human being is created both by and for God, and the human heart is restless until it rests in God (Augustine 1991, 3). Without supposing that every person experiences an immediate awareness of the presence and power of God, we can recognize that human being includes some sense of Transcendence, some glimpse of Ultimacy (Berger 1969; Gilkey 1969). Indeed, we can say that in human being this sense is the final supervenience—a irreducible emergent property that arises out of the physical, mental, and social realities of humanness, and is thus dependent on them, but is neither determined nor explainable by them.<sup>11</sup>

While the idea of the presence of God can provide reassurance and energy to both the recipients and the providers of health care, the very notion of divine action raises some of the most profound and difficult questions in the philosophy of religion.<sup>12</sup> The belief that

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It is the *sense* of Ultimate Reality, not Ultimate Reality *itself* that is regarded as an emergent, supervenient reality. This fundamental difference seems effectively to invalidate analogies that are sometimes drawn. For example: “If mental events can ‘downwardly cause’ behavior, and if culture itself can ‘downwardly cause’ particular mental events, why not posit a God who can ‘downwardly influence’ the values, meanings, and purposes of culture?” (Bielfeldt 2000, 143).

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The breadth, depth, and complexity of the scientific and philosophical questions surrounding the idea of divine action are evident in the series of five volumes, *Scientific Perspectives on Divine Action*, edited by Robert J. Russell et al. and published by the Vatican Observatory and the Center for Theology and the Natural Sciences: *Quantum Cosmology and the Laws of Nature* (1993), *Chaos and Complexity* (1995), *Evolutionary and Molecular Biology* (1999), *Neuroscience and*

divine providence undergirds, surrounds, permeates, and interacts with created reality is widely held, but there is little clarity about what this belief actually means in concrete terms (Gilkey 1961).<sup>13</sup> That God acts in, or interacts with, the world (and human lives) is, on theistic grounds, entirely plausible and easy enough to affirm; but *how* God acts in, or interacts with, the world is very difficult to explain in a context of a scientific worldview. When God acts (or interacts), just what does God *do*? Theories about the nature of divine action are “attempts to achieve a degree of consonance between science’s talk of physical process, humanity’s experience of agency, and theology’s talk of divine providential action, by suggesting, however tentatively, what the causal joint involved might be” (Polkinghorne 1996, 38).

In the High Middle Ages, Thomas Aquinas (c.1225-1274) proposed that God’s activity is the “primary causality” that is always present but hidden within the “secondary causalities” of the natural order. A modern neo-Thomist has explained that the divine agency works “omnipotently on, in and through creaturely agencies, without either forcing them or competing with them” (Farrer 1968, 76). This, however, has been described as “so mysterious a notion that it effectively removes the question of God’s action from discussion in ordinary human conversation.” Indeed, the whole idea of primary causality “seems no more than the imposition of a mysterious theological gloss on natural process” (Polkinghorne 1996, 31).

Yet alternative explanations have been at least as problematic as “primary causality.” One is the deist proposal that divine action is the initial design and establishment of the natural order, which has functioned with cause-and-effect regularity ever since. God designed the whole, incredibly complicated system, planned the Big Bang and lit the fuse; and has not intervened. Another explanation is that divine action includes both the initial creation and the subsequent maintenance of the natural order. A third explanation is the panentheistic view that the world exists “in” God but does not constitute the whole divine reality. A fourth explanation is the “process” view that, drawing on the thinking of Alfred North Whitehead (1861-1947), presents “a God of persuasion rather than compulsion,” who “influences the world without determining it” and who “acts by being experienced” and thus draws the world toward its fulfillment (Barbour 1990, 29, 224). None of these alternatives, however, seems entirely adequate to actual religious experience

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*the Person* (2000), *Quantum Mechanics* (2002).

13

Consider the following example: “A child riding his toy motor-car strays onto an unguarded railway crossing near his house, whereupon a wheel of his car gets stuck down the side of one of the rails. At that exact moment an express train is approaching with the signals in its favor. Also a curve in the track will make it impossible for the driver to stop his train in time to avoid any obstruction he might encounter on the crossing. Moreover, the child is so engrossed in freeing his wheel that he hears neither the train whistle nor his mother, who has just come out of the house and is trying to get his attention. The child appears to be doomed. But just before the train rounds the curve, the brakes are applied and it comes to rest a few feet from the child. The mother thanks God for the miracle, although she learns in due course that there was not necessarily anything supernatural about the manner in which the brakes came to be applied. The driver had fainted, for a reason that had nothing to do with the presence of the child on the line, and the brakes were applied automatically as his hand ceased to exert pressure on the control lever” (Peterson et al. 2003, 174-75).

In what sense (if any) is divine action involved in this sort of incident? If an event in itself is explainable by natural factors, is extraordinary coincidence evidence of divine involvement?

A more attractive proposal draws on three scientific ideas: first, “the probabilistic character of quantum events, which does not permit the determination of a specific outcome on most occasions”; second, “chaotic systems, whose exquisite sensitivity to the fineness of detail of their circumstances imposes severe restrictions on predictability, even in the regime of classical Newtonian physics”; and third, “holistic causal principles of a pattern-forming kind, leading to . . . the idea of ‘active information’: ‘active’, because the holistic principle brings about actual future behaviour; ‘information’, because its action relates to structure rather than to energetic properties.” This proposal assumes that “epistemology models ontology,” so that “what we know or cannot know is to be treated as an indication of what is actually the case. This is clearly the conviction that underlies the almost universal indeterministic interpretation of quantum theory,” and “this attitude should encourage us to take a similar stance in relation to the unpredictabilities of chaos theory.” The proposal thus assigns divine action to “a hiddenness within the inescapably cloudy unpredictabilities of physical process, interpreted realistically as the sites of ontological openness” (Polkinghorne, 1996, 34, 36, 35, 40).

In this way, it is claimed, “quantum indeterminacy meets the conditions for an understanding of divine agency that does not clash with any (actual or possible) scientific causal account and thus is not ‘interventionist’ in the pejorative sense of the word. It is possible that chaos theory will provide a viable mechanism for amplifying quantum effects into large-scale macrophysical results, and hence that chaos effects could be used by an omniscient being in combination with quantum indeterminacy to bring about its purposes.” However, “the ‘could’ here should be emphasized here: there is as of yet no established physical theory that brings together quantum mechanics and chaos theory in the fashion envisioned here” (Clayton 1997, 247). This is perhaps as close as we can come at this time to a philosophical understanding of divine action in nature and in human being.<sup>14</sup>

But what about the possibility of miracle? Ironically, “the stronger one’s account of divine action, the more perplexing must become the problems of evil and suffering in the world” (Polkinghorne 1996, 31-32). Specifically, if God can and does act in ways that result in miracles, why do horrendously painful, degrading things happen to wonderfully honest, compassionate, generous people? Here the best response is to begin by clarifying what one means by “miracle.” If a miracle is defined as “an event that is (a) extraordinary, (b) unexplainable by ordinary natural or human factors,<sup>15</sup> and (c) religiously significant” (Bull and Guy, 2004, n. 1) we can make the following affirmations: God is always present and active in regular ways for human good. Prayer for healing is always appropriate. A miracle is always a logically possible result of extraordinary divine action. A miracle cannot be evoked by human activity (such as individual or collective prayer, or the ritual

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A somewhat different account of both divine action and the mind-body relationship is available in process thought (Griffin 1998, 2000, 2001). The persuasiveness of this account depends, however, on the overall persuasiveness of process philosophy, to which there are philosophical and scientific objections (Polkinghorne 1994, 22-23).

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In the case of the express train and the boy in the toy car (n. 13 above), while the stopping of the train has a natural explanation, the coincidental timing does not.

of anointing). The occurrence of a miracle can not be proved or disproved scientifically. Belief that a miracle has occurred is neither necessary nor sufficient for religious belief.

Careful thinking about the actual experience of human being affirms God's interest in and activity for the benefit of human being, but it does not claim to know how, when, or why God may act in extraordinary ways.

#### Some Implications: Human Being as Agent and Object

What does all this philosophizing mean for Adventist health care in general and for Florida Hospital in particular? What does it have to say to and about the patients, the providers, and the institutions? Detailed consideration of the implications of the nature of human being for health care is a task for other papers, but some elements begin immediately to appear.

4. The physicality of human being means simply, directly, and obviously that caring for the human body is caring for (and thus honoring) a person created in and as the image of God—whether the person is oneself or someone else. When the body suffers from injury or illness, a person experiences an ambivalence of selfhood. “Whatever its cause, suffering involves a person’s perception of the threat of disintegration,” so that “when I am sick I have an ambiguous relation to my body. It is intimately me, and yet it is foreign” (Nelson 1992, 125, 133). With the increasing technologization of health care (which brings invaluable human benefits), the challenge of responding to this particular human need also increases. “Through the vulnerability of our bodies, God has given us into the care of one another” (Paulsell 2002, 180). This is a challenge Adventist health care is called to meet.
5. The ideas of “emergence,” “supervenience,” and “nonreductive physicality” have quite different (but equally important) implications. First, they show that the historic Adventist understanding of human being as both body and more-than-body is not only scientifically and philosophically defensible but is also increasingly accepted. Adventist health care (which no one claims to be perfect) is intellectually sound. Second, because the relevant meaning of “supervenience” is that the body and the mind are mutually influential, the health of each is important to the health of the other; thus adequate health care is by definition care of the whole person. Even in the midst of financial pressures that result in overworked personnel, whole-person care is not an optional extra; it is moral necessity. Third, because the body and the mind are not identical, it is possible for the latter to be effectively healed even when the former is not. This fact further emphasizes the necessity of spiritual care.

The social construction of human being—individual and collective—reminds us that because our cultural context is changing, we too are changing—whether we know it or not, and whether we like it or not. But we are not simply at the mercy of cultural influences any more than we are the mercy of biological drives; just as individual persons can consciously and conscientiously choose how they will integrate their physicality, mentality, and sociality, so health care personnel and institutions can consciously and conscientiously choose which cultural influences they will integrate into their own identity,

and which they will reject. It is notoriously more difficult for an institution than for an individual to be constructively countercultural, but it is possible. An institution can, for example, consciously choose to become a true community of healing rather than a mere purveyor of expert medical services, and thus to enhance the effectiveness of its healing environment.<sup>16</sup> Moreover, an institution of the size of Florida Hospital can significantly influence public policy regarding health care; just as it is inevitably shaped by its socially constructed environment, it is called to be an increasingly influential factor in improving the cultural and sociopolitical environment of all medical institutions in regard to both the quality and accessibility of health care in the United States.

6. The idea that human being is an object of divine interest is a reminder that God's permanent intention and continuing activity on behalf of all human being is healing—making whole all persons and communities; remedying defects and reducing suffering everywhere; giving hope, illuminating the future, and opening up possibilities of grace for all human being. Assurance of the presence and power of God in and with the health care they give is not a substitute but a motivation for the highest scientific and professional quality on the part of the providers and their institutions. It is a motivation also for the broadest possible human concern and public influence. What challenge! What joy! What hard work! Thanks be to God! (Pausell 2002, 181).

– Fritz Guy  
La Sierra University

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For such a fundamental choice to be possible, and for its actualization to be a realistic goal, a non-for-profit financial structure is probably imperative.

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APPENDIX D

HEALING-MINISTRY: AN ADVENTIST PERSPECTIVE  
ON HEALTHCARE AND RELIGION  
BY RICHARD RICE, PH.D.

**MINISTRY-HEALING**  
**AN ADVENTIST PERSPECTIVE ON HEALTHCARE AND**  
**RELIGION**

by **Richard Rice**

**Centennial Vision Retreat**

**March 5-6, 2004**

Does healthcare have a place in religion? Does religion have a place in healthcare? According to a recent *Newsweek* cover story, these are not academic questions, but pressing practical concerns.<sup>1</sup> According to some medical professionals, religion is a private matter and caregivers have no business getting involved in the spiritual life of patients.<sup>2</sup> For others, faith and health are closely connected, and good medical care must address spiritual as well as physical needs. However people answer these questions, the fact that they are being asked today with increasing urgency calls for renewed attention to religion and health.

There are several reasons why Adventists should participate in this discussion. First, Adventists have always seen a connection between religion and health, and their commitment to healthcare has led to the development of healthcare systems, medical institutions, and health science education. Second, Adventists bring a particular perspective to religion and healthcare. Their extensive involvement in healthcare expresses a distinctive theological vision.

Third, the connection between this underlying vision and the welter of activities involved in delivering modern healthcare is not always clear. The pressing needs of the public for medical care and the demands of operating large medical facilities can obscure the fundamental goals these endeavors are meant to serve. The purpose of this discussion is to clarify these goals, and to strengthen this connection. In our attempt to do this, we will outline a theological basis for the Adventist interest in healthcare. Then we will suggest the kind of healthcare that this theology calls for. We will begin by briefly noting the Adventist legacy of healthcare and religion.

### **1. Healthcare and religion: the Adventist legacy**

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<sup>1</sup> Claudia Kalb, "Faith and Healing," *Newsweek*, November 10, 2003, 44-56.

<sup>2</sup> Richard Sloan of Columbia-Presbyterian Medical Center (*ibid.*, 50).

*We have nothing to fear for the future, except as we shall forget the way the Lord has led us, and His teaching in our past history.*<sup>3</sup>

Every religious community has a unique and complex story to tell. The Seventh-day Adventist Church had its beginnings in a mid-nineteenth century religious revival in the northeastern United States. It is now a worldwide community of over 14 million members, well over ninety percent of whom live outside North America. Along with vigorous evangelistic programs, Adventists are actively engaged in a variety of other enterprises. Early in their history they embarked on publishing, educational and medical work. In North America alone, there are more than a dozen Adventist colleges and universities—it has been said the Adventist church operates the largest unified private educational system in the world—and Adventist medical institutions are known throughout the world. Florida Hospital was founded in 1908. As an expression of the church's commitment to both health care and education, an institution like this one embodies several important elements in the Adventist spirit—a desire to serve, a commitment to excellence in all human endeavors, and a belief that physical and spiritual health go together. It also reflects some important convictions about human nature and the mission of the church in the world. Behind Florida Hospital, therefore, stands a powerful religious vision.

An interest in health is not unique to Adventists, however. In fact, it is not unique to Christianity. Religion has always shared common ground with medicine. Etymologically, the words “holiness” and “healing” stem from a single root, conveying the idea of wholeness.<sup>4</sup> To cite the example of just one ancient culture, Asklepios was the Greek god of healing, and the sick in ancient Greece visited his shrines in hopes of being cured. It is touching to contemplate their offerings in a museum like the one in Corinth: plaster replicas of body parts—ears, hands, feet, legs, breasts, genitals, even a brain—poignant reminders that humans all through history have suffered in similar ways and similarly hoped for divine assistance.

From their early days, Christians were extensively involved in healthcare. By AD 250 the church in Rome developed an elaborate charitable outreach, with wealthy Christians providing food and shelter for the poor. Their care for the sick was one of the features that set Christians apart from their contemporaries, and it contributed to the rapid rise of Christianity in the Mediterranean world. Fabiola, for example, a wealthy Christian convert devoted her life to charity. According to St. Jerome, she brought sick people from the streets and highways, often washing their sores and wounds with her own hands. Such actions were unknown to classical paganism. People had responsibilities to family and friends, pagans believed, but hardly to the downtrodden of society.<sup>5</sup> According to historians, the hospital is a Christian institution.<sup>6</sup> After Constantine officially recognized

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<sup>3</sup> Ellen G. White, *Life Sketches*, 196.

<sup>4</sup> Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (Norton, 1997), 84.

<sup>5</sup> Porter, 86.

<sup>6</sup> Says Roy Porter, “Christianity planted the hospital” (Porter, 86).

Christianity, Christians began to erect buildings to meet the needs of the sick and suffering. In time they not only constructed hospitals in Jerusalem, Constantinople, Edessa, and Antioch, they also established a number of medical schools.

Adventists were involved in healthcare from the beginning. Like the evangelical Christians that surrounded them, early Adventists, and the Millerites before them, embraced a broad spectrum of nineteenth-century reform movements.<sup>7</sup> The most dramatic was abolition; the most widespread was the temperance movement. Among the others were dress reform and health reform. With the notable exception of sabbatarianism—there was widespread sympathy for Sunday laws—Adventists supported them all. So, a general concern for health and a commitment to healthcare did not set Adventists apart from the larger Christian world. They located them firmly within it. Similarly, Adventists today share an interest in healthcare with many other faith communities. Though some are better known for it than others, Christian groups across the board are engaged in the relief of human suffering, and many denominations operate hospitals and clinics. Mother Teresa, arguably the best-known religious figure of the 20<sup>th</sup> century, is famous for her work among the sick of Calcutta.

Although their interest in healthcare places Adventists within a broad stream of Christian concern, healthcare occupies a unique place in Adventism. Its role in the Adventist vision of Christian life and service is so important that, to use one of Ellen G. White's best known metaphors, it represents "the right arm of the message." The connection is more than a strategy, however. There are elements within Adventist thought that give healthcare a strong theological foundation.

## 2. Healthcare in religion

It is one thing to assert a connection between Adventism and healthcare; it is another to describe it correctly. When it comes to a complex reality like a religious community, the question of identity is a tricky one. First of all, there is the obvious danger of getting it wrong. A couple of impressive attempts to specify the essence of Adventism are noteworthy for their failure to do so. In *The Shaking of Adventism*, Geoffrey Paxton describes the heart of Adventism as its claim to be the modern heirs of the Protestant Reformation. And since the touchstone of that great religious movement was the doctrine of righteousness by faith, Paxton claims, Adventism is true to itself only if it achieves full agreement with the Reformers on that one doctrinal point.<sup>8</sup> Adventists are happy to see themselves in the great stream of reform that began in the 16<sup>th</sup> century, and they have long struggled to grasp the full meaning of righteousness by faith. But few Adventists feel

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<sup>7</sup> See Ruth Alden Doan, "Millerism and Evangelical Culture," and Ronald D. Graybill, "The Abolitionist-Millerite Connection" in *The Disappointed: Millerism and Millenarianism in the Nineteenth Century*, ed. Ronald L. Numbers and Jonathan M. Butler (University of Tennessee, 1993); and Timothy L. Smith, "Social Reform," and John B. Blake, "Health Reform," in *The Rise of Adventism: Religion and Society in Mid-nineteenth-century America*, ed. Edwin S. Gaustad (Harper & Row, 1974).

<sup>8</sup> Geoffrey J. Paxton, *The Shaking of Adventism* (Zenith Publishers, Inc., 1977).

that Paxton correctly views the center of Adventism as its link to the Protestant Reformers.

Another attempt to divine the essence of Adventism focuses on the sanctuary, but it, too, has failed to connect with an Adventist audience. The concept of a pre-Advent investigative judgment conducted in the sanctuary in heaven is often described as the one unique doctrine that Adventists hold. But for early Adventists the essential function of the sanctuary doctrine was to bolster their confidence in the prophetic interpretations that gave rise to the Advent movement.<sup>9</sup> Belief in the heavenly sanctuary did not replace the blessed hope in Christ's soon return; it provided a way to keep that hope alive. When early Adventists chose an official name, they referred to themselves as Adventists, not believers in the sanctuary.<sup>10</sup> They revised their prophetic interpretations, but the return of Christ remained at the center of Adventist life and it always has.<sup>11</sup>

As we seek a doctrinal center for Adventism, we also need not resist the temptation to glorify the past. This can be hard to do since a religious community, by definition, holds the past in high regard, and no religion holds it in higher regard than Christianity. For Christians, the Bible is the record of God's acts in history, and the life of Jesus, a first century Palestinian Jew, represents the supreme manifestation of God in the world. Nevertheless, there are helpful and unhelpful attitudes toward the past. Jaroslav Pelikan sums them up nicely when he says, "Tradition is the living faith of the dead; traditionalism is the dead faith of the living."<sup>12</sup>

Tradition is immensely valuable. In spite of the current popularity of new age and do it yourself religious movements, it is arrogant to assume that all truth starts with us and foolish to think we can get along without the past. Those who belong to a vibrant religious community will value what Christians in previous generations have thought and done, and they will build on their accomplishments today. In other words, they will be traditional.

But they will not be traditionalistic. Some people idolize the past.<sup>13</sup> Instead of building on the past, their goal is to guarantee that nothing ever changes. This sort of traditionalism

<sup>9</sup> The Millerites who became Seventh-day Adventists believed that the prophetic interpretations that pointed to Christ's return on October 22, 1844 were correct as far as the time was concerned, but wrong when it came to the event. In contrast, the Millerite majority maintained that these prophecies, Daniel 8:14 in particular, pointed to Christ's return, but for some reason their time calculations had been mistaken.

<sup>10</sup> Malcolm Bull and Keith Lockhart, *Seeking a Sanctuary: Seventh-day Adventism and the American Dream* (Harper & Row, 1989).

<sup>11</sup> Several months before he died at the age of 102, I asked a lifelong Adventist what aspect of the church's belief or life had meant the most to him over the years. Without a moment's hesitation, he replied, "Why, the second coming of Christ, of course. That is the most important thing of all." "But Adventists have been looking for Jesus' soon return for a long time," I continued, "and you have been looking longer than anyone else I know. How can you maintain your confidence year after year?" I'll never forget his answer. "I have always believed that Jesus could come very soon. I still do. But if I don't live until that happens, I know that Jesus' face is the first thing I'll see when I wake up."

<sup>12</sup> *The Emergence of the Catholic Tradition (100-600)*, "The Christian Tradition: A History of the Development of Doctrine," vol. 1 (University of Chicago Press, 1971), p. 9. See also, *The Vindication of Tradition: The 1983 Jefferson Lecture in the Humanities* (Yale, 1984), 65.

<sup>13</sup> Those who idolize the past also tend to idealize it. The past that most traditionalists seek to perpetuate never actually existed. As one old salt complained, "The Navy ain't what it used to be and never was."

gives tradition a bad name. Respect for the past is a sign of a religious health, but a determination never to change is not.<sup>14</sup> A vibrant Christian community will learn from the past, but will not attempt to repeat it.

Adventists have always committed themselves to be that sort of community. The expression “present truth” occupies an honored place in Adventist history. It was the title of the earliest Adventist periodical, and it nicely summarizes the perspective of early Adventists. They acknowledged their debt to the past, but they did not believe that the past contains everything we should believe, or that everything important has already been said. Consequently, they believed that God had new things for us to learn, and they were determined to hear what God has to say to us here and now. Adventists have always been both innovators and traditionalists. Those who are open to present truth believe that we must be faithful to the present as well as the past.<sup>15</sup>

There are important biblical precedents for this position. Jesus concluded the Sermon by the Sea with this portrayal of the ideal scribe: “Therefore every scribe who has been trained for the kingdom of heaven is like the master of a household who brings out of his treasure what is new and what is old” (Mt 13:52). No one embodied this ideal more fully than Jesus himself, of course. We see the way he connected the old and the new in the Sermon on the Mount. Jesus emphatically asserted that he came, not to abolish the law and the prophets, but to fulfill. Then he proceeded to contradict and correct the ways in which the law was misunderstood at the time. “You have heard that it was said,” he observes six times, and each time he adds, “But I say to you.” Mt 5: 17, 21, 22. Jesus was clearly committed to the past, but he showed that fidelity to the past requires us to transcend its limitations. The past that Jesus envisioned called for a future that was quite different from the one that was popular at the time.

Another danger to avoid as we seek our theological center is oversimplification. It is often remarked that a central characteristic of the ancient Greeks was their tendency to see things in relation to the whole.<sup>16</sup> Something similar is true of Adventists. There is an expansive, integrating tendency in Adventism. Adventists have a way of reaching out to embrace diverse themes and ideas, and they often hold contrasting ideas in creative tension.<sup>17</sup> This is particularly true of distinctive Adventist concerns like these.

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<sup>14</sup> Traditionalists in the best sense are those who give those who have gone before a voice in our current discussions. They recognize that we are not the only ones who have important things to say. “By including the dead in the circle of discourse, we enrich the quality of the conversation” (Pelikan, *The Vindication of Tradition*, 81).

<sup>15</sup> For this reason, the prologue to the 1980 Statement of Fundamental Beliefs is just as important as any of the 27 items that follow. It expresses the essential Adventist commitment to the further discovery of truth.

<sup>16</sup> To quote a standard authority on classical Greece, “A sense of the wholeness of things is perhaps the most typical feature of the Greek mind.... The modern mind divides, specializes, thinks in categories: the Greek instinct was the opposite, to take the widest view, to see things as an organic whole” (H. D. F. Kitto, *The Greeks* [Penguin Books Ltd., 1951], 169).

<sup>17</sup> This is true, of course, of many aspects of Christian faith, including its central claim, “the word became flesh” (Jn 1:14).

Creation and consummation. To many minds, the most striking paradox in Adventism is the fact that people who believe that the end of all things is at hand and that Jesus will soon return have worked so hard to improve life on the earth while it lasts. There are different ways to account for this. After the Great Disappointment, early Adventists had to expand their understanding of what it meant to prepare for Christ's return. The one who said, Behold, I come quickly, also said, Occupy till I come. Accordingly, being ready for the Lord's return involves more than an eagerness to see him in the clouds. It means doing something in the meantime, being about our Father's business, and finishing the work he gave us to do.<sup>18</sup>

From the beginning, the driving force of Adventism has been eschatological. The sense that time is running out, that we are living in the last days, provides Adventists with their most vivid religious sentiments. At the same time, however, Adventists not only sing, "This world is not my home," they also sing, "This is my Father's world." Far from evacuating history of meaning, a lively sense that history is coming to a climax fills the present with great significance. The Christ who comes is the one who loves the world and returns to reclaim it as his own.

Another reason for the Adventist commitment to outreach, uplift and service appears in the second most prominent theme in Adventism, namely, the sabbath. If the "Adventist" in our denominational name direct us to the end, the "seventh-day" reminds us of the beginning. Adventists are just as interested in the creation as the consummation. In fact, if the second coming was the most cherished aspect of Adventism in its early decades, the sabbath is probably the most appreciated aspect today. As the most distinctive feature of Adventism, sabbath observance not only sets Adventists apart from other Christians—Adventists are the largest community of sabbath-keeping Christians—it is also the most important facet of Adventist life-style. The sabbath experience creates vivid memories and generates strong sentiments. Its weekly arrival brings the assurance that God's presence is still with us, that he will never abandon the creation that he loves. It also reminds us that this world, and everything in it, is worth preserving and caring for. Human beings, in particular, are creatures of God, made in his image. Both the end and the beginning, then, direct us to the importance of the present, and call us to the service of healthcare and healing.

**Conversion and holiness.** Another pair of contrasting themes appears in the Adventist interest in conversion and holiness, or justification and sanctification. Their commitment to holy living goes back to the roots of 19<sup>th</sup> century revivalism. Along with Methodists, their theological cousins, Adventists have a long-standing concern for sanctification, the pursuit of personal holiness. And the blessed hope intensifies this interest in a holy life. Convinced that Christ will soon return, his people naturally desire to be worthy of his

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<sup>18</sup> As Jesus explained in one of the parables that pepper his apocalyptic discourse, "Who then is the faithful and wise slave, whom his master has put in charge of his household?" He is the one "whom his master will find at work when he arrives" (Mt 24:45-46).

fellowship. In later years, Adventists wrestled with the meaning of justification by faith. For people who emphasize commandment keeping and godly living, it is challenging to grasp the notion that salvation is entirely a gift, dependent solely on God's grace, and that human achievements contribute exactly nothing. And it is probably accurate to say that Adventists have never fully resolved this tension.<sup>19</sup> But the commitment to living a life in harmony with God's expectations accounts in no small measure for the Adventist interest in physical as well as spiritual health.

Body and soul. Important as these pairings are, none of them provides a more vivid backdrop for the Adventist interest in human health than the union of the spiritual and the physical. In contrast to dualism, Adventists insist that body and soul are not separate entities, but different aspects of one complex reality. A person is a physical organism with unique capabilities, not an immaterial, immortal essence that is temporarily joined to a physical form.<sup>20</sup> A human being is not merely a biological organism, of course, it is a highly intricate organism, a physical being of enormous complexity and astonishing potential. And although the most distinctive, and arguably interesting, feature of human existence is not its organic basis, the physical dimension of human existence is fundamental to everything else. We may be more than physical bodies, but we are certainly never less. This concept of human wholeness, which embraces and affirms the importance of the physical, therefore, provides the most obvious, and most important, basis for the Adventist interest in healthcare.

### The Adventist view of the human

However we define terms like "health," "healing" and "wholeness," these expressions involve two central themes—complexity and brokenness.<sup>21</sup> *Wholeness* emphasizes the complex, multifaceted nature of our make-up. According to a wholistic view of human life, there are many factors that make us what we are, and they are interrelated in complex and intricate ways. *Health* and its opposite, *disease* or *illness*, refer to contrasting states or conditions that characterize the entire person.<sup>22</sup> *Health* is the ideal state of human existence. Health is life at its best. A perfectly healthy person is everything a human being was meant to be. Everything essential to human nature is present, and all the

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<sup>19</sup> Adventists aren't the only ones who have trouble integrating these aspects of Christian experience, of course. As one of my graduate school professors once said, "The hardest thing in Christian thought is to separate faith from works; the second hardest thing is to put them back together again."

<sup>20</sup> The ancient Greeks had a play on words that expressed this idea: *soma*, *sema*, "body, tomb."

<sup>21</sup> I have in mind here something like Thomas Aquinas' concepts of original sin and original righteousness. Both presuppose that human existence involves a variety of elements. The ideal arrangement of these elements is "original righteousness" (or "justice"). In the state of "original sin" these elements, though still present, are in disarray, or out of balance.

<sup>22</sup> Perhaps this idea is reflected in expressions like "in sickness and in health," "in good health," "in poor health," etc.



elements are perfectly arranged. Health is therefore the “original” condition of human existence and the ultimate goal of the healing process.

As we actually exist, however, none of us is perfectly healthy. And *illness, sickness, disease*—various expressions come into play here—refer to the loss of health that we all experience in varying degrees.<sup>23</sup> Depending on the way we define health, its loss has fragmenting, corrosive, diminishing, distorting, alienating effects. Illness makes us less than we are meant to be. It weakens the various aspects of our existence; it compromises our integrity. It interferes with the relationships that are essential for human life, isolating the aspects of our existence that belong together.

*Healing* is the activity or process that aims at health. It involves counteracting illness, mitigating its effects, and restoring or recovering our essential wholeness, including its physical dimension. In their respective ways, the various healing sciences promote the recovery of the complete, high-level wholeness that health involves. With this basic vocabulary in hand, we can begin to spell out the religious vision involved in the Adventist commitment to the pursuit of health and the practices of healing.

As we just noted, the basic idea of wholeness points to two essential features of human existence. One is the enormous intricacy or complexity of human life. Each of us is a vastly complex reality—so complex, in fact, that it is difficult to find satisfying terminology for it. But an adequate account of human existence must seek to do justice to the full range of *qualities, attributes, dimensions, facets, aspects, elements, stages, states, and/or features* it comprises—whatever we call the various factors which constitute our humanity. It must take into account everything that contributes to what we are.

The other side of wholeness is the interrelation and interdependence of everything that makes us human. All the dimensions of our existence are connected to each other; each facet affects every other. No aspect of human life can survive in isolation, and a human being will cease to exist if any essential aspect of humanity is missing. Another attribute of wholeness is balance. It means that each factor in our existence has its ideal place, and exerts just the right influence on the others.

Wholeness therefore involves the emphatic rejection of dualism in all its forms. From a wholistic perspective, humans are not “composite” beings. They are not the combination, or conjunction, of two sorts of entities—one physical, the other mental or spiritual; one mortal, the other immortal; one material, the other immaterial. In other words, a human being is not the union of a body and a soul, as traditionally understood. There is nothing non-physical, such as a “soul,” “mind,” or “spirit,” that inhabits the body and continues to exist after the body dies. To the contrary, human life is inherently physical, or corporeal, in nature. Human beings exist in bodily form, or

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<sup>23</sup> Each expression can be defined in a variety of ways. For many people, *disease* represents a physical malady, and *illness* refers to the larger personal problem

they don't exist at all. Consequently, when physical life ends, the person in its entirety ceases to exist. Nothing human is inherently immortal.

Any account of human "qualities" will seem arbitrary.<sup>24</sup> But our discussion will follow three essential steps. We will examine our essential wholeness by exploring both the "basics" of human existence, the qualities we seem to share with other aspects of God's creation, and the human "distinctives," the qualities that apparently differentiate us from other forms of life. Next we will examine our fundamental brokenness, or loss of wholeness, and its effect on these essential human qualities. Finally, we will examine the way salvation counteracts the effects of sin and ultimately restores us to our original condition.

### **The human as creature**

*True education has to do with the whole being, and with the whole period of existence possible to man.*

*It is the harmonious development of the physical, the mental and the spiritual powers.*

*It prepares the student for the joy of service in this world and for the higher joy of wider service in the world to come.<sup>25</sup>*

We find strong support for a wholistic concept of the human in the biblical account of creation. According to Genesis 1 and 2, human beings belong to an ordered reality that originates in the power and purpose of God. We exist because he wants us to, because he brought us into the world and gave us the qualities that make us what we are.

The Bible's most basic descriptions of human beings are the expressions "creature" and "image of God." "Then God said, 'Let us make humankind in our image, according to our likeness'" (Gen 1:26 [NRSV]). These descriptions point, respectively, to what we have in common with other forms of life and to what distinguishes us within the natural world—to the basics and the distinctives of human existence, to repeat the expressions we just employed.

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<sup>24</sup> John Macquarrie identifies no fewer than twenty different aspects of our humanity (*In Search of Humanity: A Theological and Philosophical Approach* [Crossroad, 1985]).

<sup>25</sup> *Education*, 13.

When the Bible describes human origins, it places us squarely within a larger created order. We belong to the natural world, and we share the conditions and limitations that characterize all creaturely life. In other words, we are finite. While our existence depends ultimately on God, we depend moment by moment on the world around us to provide for our physical needs. The biblical writers remind us of this when they emphasize the contingency or frailty of human existence. The Psalms, especially, view the transitory nature of human existence in striking contrast to the power and eternity of God. "[Human beings] are like a dream, like grass which is renewed in the morning: in the morning it flourishes and is renewed; in the evening it fades and withers" (90:5-6).

**Time, space and humanity.** Our essential qualities—our finiteness, or finitude—are clearly visible in the way space and time define our existence. We are always somewhere, and we can never be in more than one place at the same time. I can't work in my office and swim in the ocean simultaneously. Similarly, time affects our existence in various ways. The passage of time has inevitable consequences for us. We grow older whether we want to or not. We are also situated in a particular time. We can't live yesterday over again, nor can we skip today and jump into tomorrow. Our place in history is something beyond our control as well. We can't decide to live in the nineteenth century, or in the twenty-second. Our historical location is one of the "givens" that defines us.

Although we often refer to our temporal and spatial qualities as "limits," this is not the best way to think of them. In reality, these features of our lives are positive rather than negative. After all, a human life is a very specific reality. We exist only as concrete individuals. Each of us has specific characteristics, and each of us faces a certain set of possibilities. No one is "merely human"; there is no human being "as such."

In addition to the fact that our individuality depends on the specific "limits" that characterize us, many of the satisfactions and pleasures of life depend on the sort "limits" that define our existence. Exploring the limits of our physical capacities and extending the range of our physical abilities accounts for a great deal of life's enjoyment. Activities like sports and dance would not be possible if we didn't exist in space. Adventures that involve courage and skill, like mountain climbing or deep sea diving, require an environment that limits the range of human viability. We exist in space, and we exist in this particular space, this particular environment.

Time contributes to our lives in rich and wonderful ways as well, whether we think of temporal passage in seconds and minutes or in years and decades. Timing is everything, we often say. Tempo or rhythm is as fundamental to music as melody and harmony, maybe more. Human life is essentially dynamic. Each phase of life brings its unique experiences. Childhood, youth, adulthood and age—each involves distinctive qualities and insights. Our lives would be poorer without the passages we make. We are always in

the process of becoming; we are always moving toward the future.<sup>26</sup> Some people also believe that having a finite life-span also enriches our existence. Because we do not have unlimited opportunities, each one is that much more important.<sup>27</sup> Knowing that life does not last forever sweetens the flavor of each moment and each experience.

The progressive quality of human life is widely appreciated today. Courses on human development are now a standard part of high school and college curricula. Many students of moral and religious behavior hold to a "stage theory" of human development, the general idea that human experience follows predictable patterns as we move through life.<sup>28</sup>

We also see the importance of time to our existence in what many people take to be the most central human experience of all, namely, remembering. Memory is basic to personal identity, of course.<sup>29</sup> And it is also basic to the unique pleasures of recounting past experiences.<sup>30</sup>

**Having bodies, being bodies.** The concrete, specific nature of human existence is anchored in the fact that we exist in bodily form. According to the Bible, God made physical organisms when he created human beings. The Bible knows nothing of human existence that does not involve physical, bodily form. For biblical thought, humanity and corporeality go together. It is not the case that we have bodies, we are bodies. A physical organism is constitutive of human existence.

An emphasis on the body also appears in biblical descriptions of human destiny. For New Testament writers, life after death begins with the resurrection of the body. "So it is with the resurrection of the dead. What is sown is perishable, what is raised is imperishable.... It is sown a physical body, it is raised a spiritual body" (1 Cor 15:42, 44). For the apostle Paul, the transition from this life to the future life involves a dramatic transformation, but it does not involve leaving bodily existence behind. To the contrary, everything he says about the life to come indicates that human beings will continue to exist in concrete, physical forms.

Because human existence is essentially physical, our bodies deserve to be cared for. In themselves, the things that sustain life and make it enjoyable are good. There is certainly

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<sup>26</sup> This temporal dimension of human existence is so important that some thinkers hold that our essential humanity is not a given, a possession to hang onto, but a possibility we must constantly strive for, an ideal we must consciously seek to realize. This approach is typical of existentialist thinkers like Martin Heidegger and Rudolf Bultmann, who employs Heidegger's thought in interpreting the New Testament.

<sup>27</sup> This is not to deny the reality of life beyond death.

<sup>28</sup> Lawrence Kohlberg is well-known for his account of moral development, James Fowler for his theories of religious development, Elizabeth Kubler-Ross for her five-stage description of the process of dying.

<sup>29</sup> Along with such things as bodily continuity and personality traits.

<sup>30</sup> No one mines the intricacies of memory more extensively than Marcel Proust. His great novel, *In Search of Lost Time*, expresses the conviction that remembering the past is more enjoyable than experiencing the present.

nothing wrong with eating and drinking as far as the Bible is concerned. God himself provided food for Adam and Eve (Gen 2:9, 16). Jesus promised to eat and drink with his disciples in the kingdom of God (Lk 22:16-18), and John says the redeemed will never hunger or thirst (Rev 7:16). So there is no place in the Christian view of humanity for the idea that natural physical needs and desires should be denied. The Bible never encourages us to submit to unnecessary physical hardship in the hope of improving our spiritual condition. To the contrary, it encourages people to get well and stay well. The New Testament letters urge their readers to attend to their health (see 1Cor 6:19; 3Jn 2), and the Gospels describe healing as a prominent part of Jesus' ministry.

The emphasis that the Bible places on the physical, and on physical well-being, provides a powerful mandate for healthcare, and for healthcare institutions. It encourages us to do everything necessary to maintain good health, and it supports our attempts to restore health. Healing is a divine activity. God not only "forgives all your iniquity," states the Psalm, he "heals all your diseases."<sup>31</sup> Accordingly, we are justified in bringing all the resources available to us in our efforts to help the sick get well.

Soul and spirit. The biblical concept that the body is essential to human life—that we *are* bodies—conflicts with some popular views of human nature. In particular, it is incompatible with the familiar idea that each human being has a non-physical soul or spirit that lives on after the body dies. "Soul" and "spirit" are biblical expressions, of course, but their original meanings support a view of humanity that is "wholistic" rather than "dualistic."

Both expressions appear in one of the Bible's most important statements about humanity, Genesis 2:7. "Then the LORD God formed man from the dust of the ground, and breathed into his nostrils the breath of life; and the man became a living being." The Hebrew word for "breath" here is often translated "spirit." It refers to the animating power within a physical organism, which comes from God. This spirit, or breath of life, makes the body alive, but it isn't something that can exist apart from the body. It doesn't have independent consciousness.<sup>32</sup>

Unlike the spirit or breath, the "soul" referred to in Genesis 2:7 is not something placed in the body or connected to the body. It *is* the body: it refers to the body as a living reality. The soul was what the body became when it was animated by the breath, or spirit, of

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<sup>31</sup> Ps 103:3.

<sup>32</sup> In fact, the spirit that animates humans isn't even distinctively human; it animates other forms of life as well. According to Ecclesiastes 3:19, human beings and animals have the same breath.

God.<sup>33</sup> In its basic biblical sense, then, the word "soul" refers to the organism as a whole, not to some part of it.<sup>34 35</sup>

The insights of modern science strongly supports the "wholistic" view of humanity we find in the Bible. Not only do human beings always exist in bodily form, but the interaction between mind and body is so intimate and extensive that it is impossible to imagine what disembodied human existence would mean.<sup>36</sup>

Since human life has both physical and spiritual dimensions, and each has an effect on the other, we can see that effective medical treatment must address the entire range of human needs. Anything that diminishes the physical threatens emotional and spiritual health, too. At the same time, a person is never merely a body. The body signifies the person as a whole. Perhaps the body is best described as "the symbol of the person," in the sense made famous by Paul Tillich, namely, that a symbol *participates* in that to which it points.

**Community and sexuality.** Another essential characteristic of human beings is community. We exist as groups, not merely as individuals, and what we are together is just as important as what we are by ourselves.<sup>37</sup> The social dimension of our humanity is easy to overlook in a society that values nothing more highly than individual accomplishments, but several things underscore this dimension of our lives. One is the obvious fact that we owe both our existence and our identity to others. We not only derive our existence from two other people; we also depend on others for our intellectual and cultural origins. We learn to speak

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<sup>33</sup> The biblical writers employ a variety of expressions in describing humanity. Paul, for example, uses terms that are frequently translated as "body," "soul," "spirit," "life," and "mind." But he does not conceive of these as independent facets or parts of a human being. Instead, each refers to the whole person with respect to the relationships in which he or she is involved. Rudolf Bultmann's analysis of Paul's anthropology is particularly helpful on this point (*Theology of the New Testament*, vol. 1, trans. Kendrick Grobel [Scribner's, 1951]). This synecdochic character of biblical anthropologic speech further illustrates how pervasive metaphors are in our conceptual make-up.

<sup>34</sup> The same Hebrew formula appears in Genesis 1:21 and 24, where it refers to the animals God brought forth from the waters and the earth. So, human beings were not the only souls God created. All animate beings are souls, in the biblical sense of the word—mammals, fish, birds, reptiles, insects, and so on.

<sup>35</sup> Since both are souls, human beings and animals are similar in their relation to both life and death. The Bible states that a soul can die (Ezek 18:20). And according to Genesis 7:23, the destruction of the flood had the same effect on "every living substance," including humans, cattle, "the creeping things, and the fowl of heaven." So, the Bible views a soul as a living organism animated by the breath of life that comes from God. It owes its existence to God, and when the breath of life departs, it dies.

<sup>36</sup> Knowing just what *soul* means in the basic biblical sense can prevent us from making serious theological mistakes. But it would be unfortunate to restrict its meaning entirely to this rudimentary definition. The Bible itself expands the meaning of the word, and over the centuries it has acquired a depth and richness too important to give up. As Christians generally use the term *soul* today, there is no other expression that conveys the same far-reaching ideas.

On one level, soul-language indicates that we are finite, limited creatures, dependent on God for life and capable of dying. On another level, it points to all the things that make us unique—the majestic height, the profound depth, the vast scope of our existence. To speak of souls is to speak of human beings as children of God, citizens of his kingdom and candidates for eternity.

<sup>37</sup> According to Paul Tillich, "individualization and participation" are "ontological elements." They form one of the essential polarities of finite existence (*Systematic Theology* [3 vols.; University of Chicago Press, 1951-63], 1:174).

because we are spoken to. And according to psychologists, we derive our basic self-concept from the way people treat us during the early months of life.

People in biblical times, and in more traditional societies today, attached far more importance to the group than we do in the Western world today. From the biblical perspective, we are fully human only in relationships, and the primary unit of human existence is the group, not the individual. The Bible affirms our basic sociality in its descriptions of both our origin and our destiny. When God made humanity, he created two persons, not just one.<sup>38</sup> And the biblical accounts of resurrection underscore the corporate nature of the life to come. The dead rise together to receive immortality. It isn't bestowed upon them one by one. According to the apostle Paul, when Christ returns "the dead in Christ will rise first. Then we who are alive, who are left, will be caught up in the clouds together with them to meet the Lord in the air; and so we will be with the Lord forever" (1 Th 4:16-17).

The physical and social aspects of human existence are apparent in human sexuality. Sexuality is obviously physical. The bodies of males and females have different features and perform different functions. Sex is social, too. It is the means by which two people express the most intimate human emotions. And sexual activity is the means of human procreation. The Bible is positive and realistic in its approach to sexuality. It presents sexual relations as something good in both their sensual and procreative dimensions (Gen 1:28; 2:21-25; Song of Solomon).<sup>39</sup>

Biblical descriptions of human sexuality underscore the close connection between the physical and spiritual dimensions of human life. Sexual behavior is obviously physical, but it is more than physical, too. On the biological level, human beings have sexual organs, as do many animals, and sexual activity enables them to reproduce. But for humans sex is never merely biological. Sex involves the center of the self. It touches a level of our existence that can only be described as spiritual.<sup>40</sup>

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<sup>38</sup> "So God created humankind in his image, in the image of God he created them; male and female he created them" (Gen 1:27).

<sup>39</sup> We find complementary descriptions of human sexuality in the first two chapters of the Bible. According to Genesis 1, the purpose of sexuality is to extend human dominion over creation. "Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth" (Gen 1:27). According to Genesis 2, human sexuality fulfills a fundamental human need for intimacy. It provides companionship on the deepest level of personal existence. God saw that it was not good for the man to be alone, so he created a woman, using a rib from Adam's side. She turned out to be the perfect companion, and the two became "one flesh" (Gen 2:24).

<sup>40</sup> In one of the "My Turn" columns that appear in *Newsweek*, "Another Kind of Sex Ed," Sharon A. Sheehan reports that young people want their teachers to talk about relationships, not just biology. "Sex education," she says, "is about nothing less than how and when we hand over this astonishing gift of the self. The goal is that we can love and trust and believe enough to commit our whole self and our whole future" (*Newsweek*, July 13, 1992, 10-11).

## The human as image of God

*Every human being, created in the image of God is endowed with a power akin to that of the creator—individuality, power to think and to do.*

*Higher than the highest human thought can reach is God's ideal for His children.*

*Godliness—godlikeness—is the goal to be reached.<sup>41</sup>*

Although human beings share many characteristics with other forms of life, we are remarkably different as well. In the Christian view of humanity, these distinctive qualities are embodied in the enigmatic and provocative designation, "image of God." Directly after God said, "Let us make humankind in our image, after our likeness," he said "And let them have dominion..." (Gen 1:26-27). The image of God thus involves a relationship of dominion, or sovereignty, over other forms of reality.<sup>13</sup>

This function is fulfilled as human beings modify their environment. We see it in the pursuits of art, science, and technology. Art inspires imaginative ways of looking at the world; science seeks explanations for the various phenomena we encounter; and technology employs the discoveries of science to alter certain features of our world. By these means we shape and fashion our surroundings to suit our purposes. We utilize the physical and biological resources of the earth to provide ourselves with food, shelter, and clothing, along with transportation and communication. Besides an environment that provides for our physical needs, human beings also need a *world*, a structure of meaning. Accordingly, the image of God manifests itself in the diverse cultural forms we find on the earth.

The "image of God" also indicates a distinctive relationship between human beings and God. It reminds us that human beings are God's representatives in the world and responsible to God for what he has entrusted to us. The earth is still the Lord's, and humans, too, are subject to God's sovereignty. Accordingly, we should think of our relation to the world's resources in terms of stewardship rather than domination.

**Thought and imagination.** Although the image of God is a function rather than an attribute, human beings could not fulfill the role God gives them unless they have unique abilities. People have tried to specify what it is that distinguishes human beings in many different ways. One popular choice is "reason." We often speak of humans, in contrast to animals, as "rational" beings, as capable of general concepts and abstract thought. For some thinkers, however, the most remarkable thing about us is not reason, but imagination. Compared to other life forms, they observe, human beings have very few

<sup>41</sup> Ellen G. White, *Education*, 17-18.

<sup>13</sup> One theologian describes the image of God as humanity's "creative mastery of existence," (Wolfhart Pannenberg, *What Is Man? Contemporary Anthropology in Theological Perspective*, trans. Duane A. Priebe [Fortress, 1970], 15.



instincts, and we respond to stimuli in a myriad of different ways.<sup>2</sup> So, while animals occupy an environment—the physical surroundings that provide them with life's essentials—the range of human experience transcends our environment. With imagination, we can always envision new possibilities. The world we inhabit is as large as the universe.

**Freedom and personness.** Other thinkers would say that the central, most essential human quality, is freedom. On the simplest account, freedom consists of making choices. If you are really free, *you* decide what you are going to do. Your action is not determined by factors over which you have no control. Freedom is important when it comes to personal identity, because it means that we are self-determined or self-creative to some extent. We play a major part in deciding our own destiny. Over time, our choices form a pattern. They eventually flow into the ongoing stream that we designate with words like “personality” and “character.” Thus, our choices both contribute to and reflect the sort of persons we are.

As the quotation above indicates, freedom is one of the most important characteristics human beings share with God. In particular, it is the quality that makes us persons. A person is a self-conscious unity capable of relationships with other persons. An essential characteristic of persons is therefore reciprocity. Instead of merely acting upon other persons, we interact with them. They have the same sort of effect on us that we have on them. In fact, a person exists as such only in relation to others.

Personal beings enjoy special dignity. We value persons more highly than anything else, and we rightly refuse to place the value of one person above that of another. Being free also means that human beings have responsibility. We hold persons accountable for their behavior. Our legal system rests on the assumption that people choose to behave as they do. Another aspect of personal being is mystery. Because they are free, the actions of a person are never entirely predictable. A person can always choose to do things differently.

In creating persons—conscious, self-creative and responsible beings—God took an enormous risk, for he brought into existence beings whose actions could not be entirely predicted. He had high hopes for his human children. He wanted their loyalty and love, but he knew that they were capable of choices that would disappoint him. But God took the risk and created persons anyway, because only personal beings would be capable of appreciating and returning his love for them.<sup>3</sup>

<sup>2</sup> Wolfhart Pannenberg is one who sees imagination as the key to our distinctive humanity. Pannenberg's best known anthropological works are *What is Man? Contemporary Anthropology in Theological Perspective*, trans. Duane A. Priebe (Philadelphia: Fortress, 1970), and *Anthropology in Theological Perspective*, trans. Matthew J. O'Connell (Philadelphia: Westminster, 1985).

<sup>3</sup> Did God know when he created them that human beings would fall into sin? This question has generated an enormous amount of discussion, and feelings run strong on both sides of the issue. Many people feel that given enough time and enough people, sin was inevitable. Sooner or later someone was bound to rebel against God. Others are convinced that sin was not inevitable. When something *does* happen, it sometimes looks as if it was bound to happen, but

Spirituality. Another term for the distinctive quality of human life is "spirituality."<sup>4</sup> Spirituality is not easy to define, but its most basic form is the capacity we have to appreciate and experience ultimate reality. It is our awareness of and openness to the mystery and meaning of the universe as a whole and a sense of our own place within it. Although we are physical organisms in a physical environment, we do not feel that our existence reduces to a succession of physical experiences that comes to an end, at best, after seven or eight decades. Instead, we have an abiding conviction that our lives contribute to a larger purpose, that in some measure they are the bearers of profound meaning.<sup>5</sup>

The topic of spirituality has attracted remarkable attention in recent years, and with this growing interest, the way of meeting spiritual needs has changed dramatically. People pursue spiritual health today in ways that resemble their pursuit of physical health. They may rely on traditional resources like mainline churches, but more and more frequently they turn to alternative sources of spiritual assistance—to other religious traditions, to new religions, to quasi-religious movements, like recovery groups. For increasing numbers spirituality has become a do-it-yourself project.<sup>6</sup> They make use of ideas wherever they find them. From one perspective, these developments are disturbing departures from traditional approaches to religion. They seem to subject spirituality to the individualizing, commercializing influences that pervade the Western world.<sup>7</sup> From another perspective, however, they are powerful indicators that spirituality is intrinsic to human existence, and that no life is complete without spiritual wholeness.

**Emotion.** Reason generally receives more attention than any other facet of human existence. Yet we are most likely to equate the quality of our lives with the affective domain, with the area of emotion or feelings. No matter how talented, intelligent, beautiful, rich and famous you are, if you still feel lousy about yourself, life will seem

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that's not necessarily so. So, what was the likelihood that sin would enter the world when God created beings who were morally free? We obviously don't know for sure, but it is possible that the likelihood was very small. Surely, God did everything he could to minimize it, without eliminating the capacity to choose.

<sup>4</sup> For Paul Tillich, "spirit" as a distinctive dimension of life "comes to its full actualization only in man, in whom as the bearer of the spirit the conditions for it are present" (*Systematic Theology* [3 vols.; University of Chicago Press, 1951-63], 3:25).

<sup>5</sup> While this inherent spirituality lies behind the world's many religions, it need not take the form of adherence to a particular religious tradition. Many people are spiritual in a non-religious way: they are not adherents of any specific religious tradition. The fact that human spirituality takes many different forms does not mean, however, that the world's various religions all boil down to the same thing. In recent years, scholars have become particularly resistant to the idea that the world's religions are simply different ways to express an experience that is essentially the same for every person. This notion obscures the unique insights and experiences that make each religion what it is.

<sup>6</sup> In one innovative proposal, Peter Tufts Richardson recommends a "psychology of spiritual choice," where people ascertain their basic personality type, using the Myers-Briggs Type Indicator, and then select from four basic types of spirituality the one that correlates with it. In this way, Richardson tells his readers, you can discover "your own spiritual aspirations," "your own inspiration," "your own truth" and "your own spiritual reality" (*Four Spiritualities: Expressions of Self, Expressions of Spirit: A Psychology of Contemporary Spiritual Choice* [Davies-Black, 1996], p. xii).

<sup>7</sup> One fitness expert in southern California offers a course designed to churn out yoga instructors in a single weekend. In her words, she wanted to develop "a user-friendly, fitness-oriented style of yoga." There are even yoga competitions in various countries, where contestants match their skills in maneuvering their bodies into traditional yoga positions. Needless to say, such activities have next to nothing in common with the 5000-year-old Hindu spiritual practices that classic yoga consists of (see *Los Angeles Times Magazine*, September 21, 2003, 10-15).

empty. Conversely, positive feelings seem to compensate for any other deficiency. People can learn to be happy in a great variety of circumstances.

Feelings are important because they are comprehensive and complex. Our feelings relate us to the totality of our existence, and they display enormous subtlety. In both respects, feelings differ from concepts or ideas. Conceptual activity sometimes seems immune to concrete circumstances, and thought never matches the subtlety of feeling. We can never put our feelings precisely into thought.<sup>8</sup>

The complexity of emotional experience brings us to our second theme—the interaction between the different aspects or facets of human existence, the way they join together to form a life.

### **The intricacy and integrity of human existence.**

Our list could go on and on, but it is clear that human beings are enormously complex. We comprise a vast range of qualities and attributes. To do justice to human complexity, however, we must also note the important ways in which the different dimensions of human existence affect each other. We are physical beings, obviously, but nothing about us is merely physical. There are layers of meaning involved in every aspect of our physical nature. The human body, for example, is not just a thing, an object in the physical world. It is a symbol of the person whose body it is. Moreover, we manifest ourselves in bodily ways. Our actions have meaning because they give expression to thoughts and attitudes. Like all organisms we need food to live, for example, but when humans eat they do more than ingest enough nutrients to survive. A meal is often an occasion for personal fellowship, and in certain settings it is an act of worship. Similarly, sex is a physical activity, but it involves the entire person, psychologically and spiritually, too. In fact, there is nothing about human behavior that is merely or purely physical. The “more” than characterizes human existence imparts a spiritual or symbolic dimension to every aspect of our physical existence.

People sometimes think of the mental and the physical as a hierarchy, with the superior mind resting on a physical substratum. But the physical dimensions of life are just as important as the others. Steve Callahan spent two and a half months drifting across the Atlantic Ocean in a small rubber raft until a fishing boat finally picked him up in the West Indies. One of his journal entries contains these remarks: “I have often thought that my instincts were the tools that allowed me to survive so that my ‘higher functions’ could continue. Now I am finding that it is more the other way around. It is my ability to reason

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<sup>8</sup> Pannenberg, *Anthropology in Theological Perspective*, 248, 252. When a pianist finished performing a Beethoven Sonata, someone asked him to explain what it meant. He paused for a moment and then, without a word, turned to piano and played the piece again.

that keeps command and allows me to survive, and the things I am surviving for are those that I want by instinct: life, companionship, comfort, play.”<sup>9</sup>

**Mind and body.** Nothing demonstrates the intricacy of human existence more dramatically than the interactions between the mind and the body. Eating disorders provide a sad example of the way the mind affects the body. Victims of anorexia often see themselves as overweight and deny themselves the nutrition they need to keep healthy. In 20% of untreated cases, the disorder is fatal.<sup>10</sup> Studies also show that the body has a profound effect on the mind. Brain research has demonstrated that mental functions are related to specific regions of the brain—the phenomenon of “localization.” And if these regions are damaged, our ability to do things like remember faces, or use proper nouns, may be impaired.<sup>11</sup>

Explorations of our “cognitive architecture” indicate that the basic structure of human thought arises from our corporeal experience in the world. In *The Body in the Mind*, Mark Johnson notes that we instinctively, spontaneously, employ metaphorical terms to communicate. And he demonstrates that many of the “basic metaphors” we use—such as “good is up, bad is down”—reflect the fact that we exist as physical forms within a physical world.<sup>12</sup> So, the body not only influences the mind, it provides the mind its fundamental conceptual structure.

The intimate contact between mind and body—the interaction of mental and physical—underscores the fact that nothing about us is isolated from the rest of us. Touch any part of a person, or any aspect of human life, and you touch the person as a whole. The dimensions of human life are not separate, independent items glued together in some sort of collage. Instead, they are extensively connected, like strands in a vast and intricate web of being.

The Adventist commitment to physical health arises from the conviction that mind and body are tightly connected, and that each has great influence on the other. Consequently, we cannot address a person’s physical needs without considering her spiritual needs as well.

<sup>9</sup> Stephen Callahan, *Adrift: Seventy-six Days Lost at Sea*.

<sup>10</sup> In 1993, the daughter of Pepperdine University basketball coach Tom Asbury died from anorexia at the age of 22. “She was afraid to die,” her father said. “But she was more afraid of gaining weight, losing control and the perception of being fat.” *The Press-Enterprise*, December 19, 1993, D-1.

<sup>11</sup> Among the many books on this topic are Daniel L. Schacter, *Searching for Memory: The Brain, the Mind, and the Past* (BasicBooks, 1996), Antonio Damasio, *Descartes’ Error*, and various books by Oliver Sacks, including *an Anthropologist on Mars: Seven Paradoxical Tales* (Knopf, 1995). Howard Gardner discusses the “biological foundations of intelligence” in *Frames of Mind: The Theory of Multiple Intelligences* (Basic Books, 1983). The contributors to *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature* argue for “non-reductive physicalism,” the view that “soul” refers to “a functional capacity of a complex physical organism, rather than a separate spiritual essence that somehow inhabits a body” (ed. Warren S. Brown, Nancey Murphy and H. Newton Maloney [Fortress, 1998], xiii).

<sup>12</sup> “Our ordinary conceptual system, in terms of which we think and act, is fundamentally metaphorical in nature” (*The Mind in the Body: The Bodily Basis of Meaning, Imagination, and Reason* [University of Chicago Press, 1987], 1).

In summary, the Adventist view of humanity attributes great complexity to human beings. As creatures, we share many characteristics with other forms of life on this planet. We, too, are finite and corporeal, physical, social, sexual, and emotional. But we are "more than nature" in certain ways as well. Our intelligence is superior to that of other creatures. More important, we have the quality of freedom, which gives us the capacity for self-determination, elevates us to the realm of the personal, helps us to master our environment, and enables us to touch the divine. We are creatures, then, and we never lose our creatureliness, but we are unique creatures. We are created in the image of God. We bear the imprint of the divine.

### **Sin—the whole human problem**

*Not only intellectual but spiritual power, a perception of right, a desire for goodness exists in every heart.*

*But against these principles there is struggling an antagonistic power.<sup>13</sup>*

A wholistic account of humanity must tell the "whole" truth about human existence, and the whole truth includes the sad admission that we are not, in fact, whole. So, to account for human existence, we must acknowledge the diminished condition in which we find ourselves. We are not only creatures in the image of God. We are also sinners.

The complexity of human nature has profound implications for human sin. If our humanity comprises a number of different dimensions, and all of them are intimately connected, then a problem anywhere in our lives is a problem everywhere. Sin affects everything about human beings, and its consequences take many different forms.

Some classic descriptions of sin underscore its wholistic character, including "total depravity"<sup>14</sup> and "original sin."<sup>15</sup> Sin touches us all, and it touches all there is of us—physically,

<sup>13</sup> *Education*, 29.

<sup>14</sup> Contrary to the impression they sometimes give, this does not mean that human beings are as corrupt as they could possibly be; it means that sin affects the entire human being. As John Calvin put it, "The whole man is overwhelmed—as by a deluge—from head to foot, so that no part is immune from sin and all that proceeds from him is to be imputed to sin" (*Institutes of The Christian Religion*, II.i.9, trans. Ford Lewis Battles, Vols. 20-21 in "The Library of Christian Classics" [Westminster, 1960, 253]).

<sup>15</sup> It refers to the disarray of human life, when the various elements of our being conflict with each other, or take on a life of their own and run out of control. For Thomas Aquinas, original sin is the loss of original righteousness, the harmonious arrangement of all the soul's faculties under the sovereign control of reason. Accordingly, original sin is disorder, or disruption. Says Thomas, "There was a time when original justice enabled reason to have complete control over the powers of the soul and when reason itself was subject to God and made perfect by him. But original justice was lost through the sin of our first parent.... In consequence, all powers of the soul have been left to some extent destitute of their proper order" (*Summa Theologica*, 12ae, Q. 85, Art. 3 [*Nature and Grace: Selections from the Summa Theologica of Thomas Aquinas*, trans. and ed. A. M. Fairweather, Vol. 11 in "The Library of Christian Classics" (Westminster, 1954), 130]). If Aquinas is right, sin is not a foreign object that invades us, nor the amputation of something that belongs to us. It is neither the addition nor subtraction of anything.

mentally, socially and spiritually. Everything essential to our humanity is still there—we are still creatures of God—but everything about us is different. Like broken down automobiles, we still have all our parts, but they no longer work as they were designed. As sinners, we are no longer together; we are no longer “whole.”

Creatures in sin are creatures in conflict,<sup>16</sup> and this conflict appears in all the essential dimensions of our existence, beginning with our relationship to God. According to Emil Brunner’s *Man in Revolt*, fallen human beings are still related to God, but this relationship is one of opposition and hostility. Like rebellious teenagers, we still belong to our heavenly Father, but we are constantly fighting against him.<sup>17</sup>

The most obvious conflicts that beset us involve our relations with each other. We are essentially social beings. We need companionship. But if life alone is not worth living, life together is extremely difficult. The clearest example of our social dis-ease is the perpetual unrest that engulfs peoples and nations. In the twentieth century human beings arguably made more technological progress than in all previous history, yet we killed one another at a rate that defies comprehension—by the tens of millions, in two global wars and dozens of other ones. In fact, mass destruction is the most conspicuous legacy of our time.<sup>18</sup>

The conflicts and rivalries that take such tragic and vivid form in war are universally at work in human relationships. Sin prevents us from seeing the true worth of human beings, our own or anyone else’s. We typically exaggerate our own importance at the expense of others, and, as feminist thinkers emphasize, we sometimes exaggerate the importance of others to our own detriment. Either way, sin isolates and alienates us. And because sin distorts our perspective, we view other people as threats, and we instinctively act to protect our own interests. What is true of individuals is even more true of communities. Groups, like individuals, typically pursue their own interests at all costs, but the selfishness of groups is less obvious and more difficult to counteract.<sup>19</sup>

The most pathetic manifestation of our brokenness is the fact that we are in conflict with ourselves. In *Man Against Himself*, Karl Menninger asserts that there is a self-destructive

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<sup>16</sup> It is natural to think of sin as conflict, but the symbolism of evil includes a host of metaphors, among them symbols of isolation and defilement. Sin interrupts all the essential relationships that constitute human existence, and it leaves us feeling guilty and stained. An influential portrayal of sin as defilement is Paul Ricoeur, *The Symbolism of Evil*, trans. Emerson Buchanan (Beacon Press, 1967).

<sup>17</sup> As Brunner puts it, “even the unbeliever is still related to God, and therefore [is] responsible” (*Man in Revolt: A Christian Anthropology*, trans. Olive Wyon [Westminster, 1939], 11).

<sup>18</sup> An interviewer once asked Leonard Bernstein, famous director of the New York Philharmonic, why he held the music of Austrian composer Gustav Mahler in such high regard. Bernstein answered, “Because he realized before any else did that this would be the century of death.”

<sup>19</sup> As Reinhold Niebuhr argues, large institutions can make extravagant claims seem plausible in ways that mere individuals never could. In addition, human institutions lack the moral resources that individuals have. Human collectives—whether families, races, classes, nations, or even churches—are notoriously incapable of self-criticism. When a group feels threatened, it inevitably acts to protect itself, and the individuals who belong to it typically subordinate their personal values to those of the larger community (*Moral Man and Immoral Society* [Scribner’s, 1932]).

tendency in all of us, and it takes many different forms.<sup>20</sup> "Each man has his own way of destroying himself," says Menninger; "some are more expedient than others, some more consciously deliberate than others."<sup>21</sup> This tendency can lead to voluntary death, but it can also lead to things like self-mutilation, purposive accidents, and organic illnesses.

Sin thus affects us physically and mentally, and it can work in either direction. Physical illnesses often have and spiritual and emotional causes, and they almost always have spiritual and emotional effects. The man whose four friends brought him to Jesus suffered in a variety of ways, and Jesus recognized that he needed both physical and spiritual restoration.<sup>22</sup> But whether physical illness has mental, emotional, spiritual or social *causes* or mental, emotional, spiritual or social *symptoms*, the fundamental truth is the same. A problem anywhere is a problem everywhere. Nothing about us is merely physical, or merely anything else.

This wholistic view of sin gives illness a spiritual identity. Sin is the ultimate cause of all our problems, and an adequate solution to any of them must include a spiritual dimension. The relation between sin and suffering is not one to one, of course. Few people suffer in direct proportion to their misdeeds—reality is more complicated than that.<sup>23</sup> But every illness, accident, and injury is a manifestation of human brokenness, and each one can leave a person feeling anxious, vulnerable and diminished. And because illness affects the whole person, effective healing must do the same.

### **Healing and the whole person**

As we have seen, a wholistic view of essential humanity affirms all the dimensions that make us human—physical, mental, emotional, social and spiritual—and a wholistic view of our actual existence acknowledges that every aspect of our humanity is unfulfilled and damaged by sin. Similarly, a wholistic view of salvation will envision the eventual restoration of all these aspects. Salvation involves physical, mental, emotional, social, spiritual and social renewal. Because healing is a dimension of salvation, our concept of healthcare must be similarly comprehensive. It must include attempts to meet all the dimensions that comprise our humanity.

**Healing and human significance.** However damaged by sin we may be, there is one thing that remains utterly unaffected by it, and that is our fundamental significance as children of God. Jesus' embraced people whom the society of his day excluded, whether

<sup>20</sup> Karl Menninger, *Man Against Himself* (Harcourt, Brace, Javonivich, 1938), 311.

<sup>21</sup> *Ibid.*, 343. (check p of previous footnote)

<sup>22</sup> Mark 2:1-12 (and parallels).

<sup>23</sup> When his disciples asked Jesus whose sin caused a man's blindness, his own or his parents, Jesus said that neither one did (Jn 9).

for spiritual reasons, like the “sinners” mentioned in Luke 15, or for physical reasons, like the lepers he healed and the woman with the issue of blood (Mk 5). He saw their problems in full relief, but he also saw the person beneath the problems. He never reduced people to their physical or spiritual maladies.

There is a widespread tendency—against which the “handicapped,” or “physically challenged,” in our society must constantly struggle—to regard people with serious physical limitations as less than fully human.<sup>24</sup> Injury and illness may damage what we are, but it does not remove what we were meant to be. Although we are inherently physical, we are never merely physical. There is always something about us that transcends our physical condition. Consequently, people who are diminished in one sense can be whole persons in another.<sup>25</sup>

**Healing and human community.** Illness not only affects the whole person—physical, mental, emotional, social and spiritual; it also cuts across all the boundaries that separate human beings. It is one of the great commonalities of human life. Just as we all share the essential dimensions of human nature, and bear infinite value as God’s children, we all share in the same basic affliction. The whole person is present to some degree in every human life, and to some degree every human life suffers from the destructive, fragmenting effects of sin. Consequently, every human being needs healing.

Along with a universal need for healing, our wholistic perspective also underscores the progressive nature of healing. Since we are temporal beings, our significant experiences typically involve a process. We acquire physical maturity gradually, for example, and our intellectual growth takes place over time. The same is true of healing. Healing is seldom instantaneous. It typically takes time to acquire health; we pass through stages on our way to wholeness. As the Gospel of John describes the man born blind, for example, Jesus healed his physical blindness and only later healed his spiritual blindness as well.<sup>26</sup>

### **Healing and our whole existence.**

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<sup>24</sup> Nancy Mairs, a victim of multiple sclerosis, provides a moving account of the challenges she faces in *Waist-high in the World: A Life Among the Nondisabled* (Beacon Press, 1996).

<sup>25</sup> When Aron Ralston, a 27-year-old engineer and outdoorsman, realized that the boulder pinning his hand to the side of a remote canyon in Utah could not be moved, he faced an agonizing decision. After three days without food he knew he would die alone unless he did something drastic. In a remarkable display of self-possession, he broke the bones in his lower arm, wrapped it in a tourniquet, and used a dull knife to sever it from his body. Then he walked six miles until he happened on a couple of Dutch backpackers who signaled a helicopter that was searching for him. Ralston gave an memorable news conference several days later. His resourcefulness and composure revealed a person who was very much together. Though physically handicapped by most standards, he nevertheless seemed spiritually and mentally a whole person.

<sup>26</sup> John 9:1-7, 35-38.



When Jesus healed the man born blind—first helping him to see and then helping him to believe—he also showed that people do not always receive physical, emotional, and spiritual healing simultaneously. They may be healed in one dimension and still need healing in another. Spiritual healing does not always involve physical healing. Consequently, people can be “healed” and still die. Moreover, since health at its fullest involves the restoration of every facet of humanity, we never achieve complete wholeness in this life. A man I know has suffered from multiple sclerosis for years. The elders of the church anointed and prayed over him,<sup>27</sup> and although his disease did not leave him, he was confident of his healing. He believes that his physical health will be restored, if not in this life, then in the life to come.

Healing thus has an eschatological dimension. In the Christian view of things, human beings will achieve complete wholeness, or perfect health, when God’s kingdom comes, in a future, transcendent realm of being. The final chapters of the Bible describe God’s coming kingdom in terms of complete human fulfillment. God’s people will receive spiritual healing in restored union with God, physical healing with bodies that are incorruptible, ecological healing in a new heavens and a new earth, and social healing in the city of God, the New Jerusalem.

This view of future wholeness has profound significance for the present. As scholars tell us, biblical visions of the final human future have their primary application to life here and now. In holding out the promise of ultimate wholeness in the life to come, they call us to live in the power of that promise and to strive for human wholeness in this life, too.<sup>28</sup> As we shall see in Part III, these conclusions have important implications for a theology of healing.

### 3. Religion in healthcare

*In the ministry of healing the physician is to be a coworker with Christ.*

*The Saviour ministered to both the soul and the body.*

*The gospel which He taught was a message of spiritual life and of physical restoration.*

*Deliverance from sin and the healing of disease were linked together.*

*The same ministry is committed to the Christian physician.<sup>29</sup>*

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<sup>27</sup> James 5:14-15.

<sup>28</sup> Is wholeness in any sense possible in this life? The answer depends largely on how we define it, of course. But in significant ways the answer is Yes. We may not achieve physical or mental fulfillment, but we can enter into the same relation to God that will characterize God’s people through eternity.

<sup>29</sup> *Ministry of Healing*, 111.

We have seen that healthcare has an important role to play in religion. The Bible presents a complex portrait of the human, which results in a complex understanding of sin, the fundamental human predicament. This, in turn, calls for a complex, or wholistic, view of salvation. An attempt to counteract the effects of sin in any area—physical, spiritual, emotional, or social—must consider its effects in others. To care for people spiritually, therefore, we must attend to their physical needs, and to care for people physically, we must also attend to their spiritual needs. In other words, healthcare not only has a place in religion, religion has an important place in healthcare.

Our task now is to develop a model of healing and healthcare that reflects this complex view of humanity. The model proposed here draws from the very center of Christianity, the story of Jesus. If we linked words together the way German speakers do, a helpful expression for our purposes would be something like “ministry-healing.” Awkward though it is, we will use it to express the conviction that healing and ministry belong together, not as two separate activities, but as two facets of one comprehensive enterprise.

Ministry-healing is more than the treatment of physical disorders. It is also more than attending to the “spiritual” or religious needs of people. It is not even the attempt to offer the two as parallel forms of service. Ministry-healing is the attempt to integrate all the endeavors that address human needs within a comprehensive, coordinated program of human care. Because a human being is a complex reality of many dimensions, we cannot deal with any aspect of the human without taking into account the others. Accordingly, we must consider the whole person, or the person-as-a-whole, whenever we address any particular problem. Ministry-healing seeks to be at the same time a ministry that heals and a healing that ministers.<sup>30</sup>

To develop a Christian theology of healing we will turn to the most appropriate source for a Christian theology of anything, viz., the life and ministry of Jesus. Jesus provided the ideal of ministry-healing. For Jesus, healing was a form of ministry and ministry was a dimension of healing. When Jesus ministered to people, he not only cared *for* the whole person, he also cared *with* his whole person. Ministry was the central concern of his life, and he poured his entire life into it. As the key text of the earliest gospel puts it, “The Son of Man came not to be served but to serve, and to give his life a ransom for many” (Mk 10:45).

### Ministry-healing in the life of Jesus

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<sup>30</sup> It is important to note that our approach to ministry-healing in this proposal presupposes the characteristic activities of a health sciences university. There are forms of wholistic treatment whose primary interest is non-traditional or alternative forms of medicine. Whatever their value, they are not our present concern. We are interested in the ways in which the various aspects of scientific medical care can be incorporated within an approach to healing that attends to the needs of the entire person as understood by Christian faith.

*The Saviour in his miracles revealed the power that is continually at work in man's behalf, to sustain and to heal him. Through the agencies of nature, God is working, day by day, hour by hour, moment by moment, to keep us alive, to build up and restore us.*<sup>31</sup>

**Jesus cared for the whole person.** The ministry of Jesus addressed concrete needs across the entire scope of human existence. His concern for spiritual welfare is evident in the overarching theme of his ministry, the "kingdom of God." And his concern for physical well-being appears in his miracles. He stilled a life-threatening storm on the Sea of Galilee, and on at least two occasions he fed the hungry crowds that followed him.

Jesus' miracles of healing demonstrate his concern for both physical and spiritual restoration, and at times that connection was explicit. When four men lowered a paralyzed friend into the house where Jesus was speaking, Jesus' first said, "Your sins are forgiven" (Mk 2:5), and afterwards, "Rise, take up your pallet and go home" (2:11). The contact between the spiritual and the physical also appears in the various instances—half a dozen or so—where Jesus cast out demons.<sup>32</sup> His exorcisms show that spiritual powers have physical manifestations, and spiritual healing has physical consequences.

As a whole, then, Jesus' ministry brought freedom from everything that dominates and depersonalizes us, and the restoration of every area of life where sin causes damage. On one occasion he compared his work to that of a physician, suggesting that he envisioned his mission as a ministry of healing, or as "ministry-healing," to use our neologism.<sup>33</sup> And because the Greek word for "heal," *sozo*, also means "save," it nicely expresses the comprehensive nature of his work.

Jesus was also highly sensitive to people's feelings.<sup>34</sup> When he met people in great need, and healed their diseases, he took account their feelings and attitudes, too. A good example is his response to the woman who touched his garment in a desperate

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<sup>31</sup> *Ministry of Healing*, 112-13.

<sup>32</sup> The phenomenon of demon possession is complex and controversial. Some people are inclined to view the Gospel accounts of "demon possession" as archaic descriptions of what we diagnose as psychiatric disorders today. Others see them as indications that human beings are locked in "spiritual warfare" with evil agents from another order of reality, who invade human minds and bodies and cause great suffering.

<sup>33</sup> "Those who are well have no need of a physician, but those who are sick." Mt 9:12.

<sup>34</sup> It is debatable whether ancient peoples envisioned emotions as a discrete sphere of human existence. So, we need to be cautious about talking about the emotions of biblical figures. Krister Stendahl raises serious questions, for example, about "psychological" interpretations of Paul's writings in "The Apostle Paul and the Introspective Conscience of the West," *Harvard Theological Review*, 56 (1963):199-215.

attempt to find relief from a hemorrhage. Jesus cured her disease, but he also did more. He listened while she poured out “the whole truth,” as the Gospel puts it, and he affirmed her by calling her “daughter.”<sup>35</sup>

There are other instances, too, where Jesus showed great sensitivity to people’s feelings, especially when they were the objects of neglect or scorn. He noticed a poor widow who put a mere pittance in the temple treasury.<sup>36</sup> He upheld Mary for choosing “the better part” when Martha complained that she was listening to him instead of helping her with household tasks.<sup>37</sup> He praised the woman who washed his feet for doing a beautiful thing, and promised that the story would be told “in memory of her” wherever the gospel was preached.<sup>38</sup> He comforted a woman accused of adultery by saying, “Neither do I condemn you.”<sup>39</sup> He was indignant when his disciples rebuked people for bringing their children to him.<sup>40</sup> He embraced the “tax collectors and sinners” who came to him, over the grumbling of Pharisees and scribes, and portrayed them in his greatest parables as valuable members of God’s family.<sup>41</sup>

There is a pattern here. Jesus was always sensitive to the way people felt, and he took conspicuous, sometimes aggressive, measures to reassure them, particularly when they were vulnerable. He was strong in defending the weak, encouraging the faint-hearted and lifting up the fallen. Conversely, he refused to sanction animosity and revenge. In the Sermon on the Mount, he urged his followers to love their enemies and pray for their persecutors.<sup>42</sup> On one occasion, he rebuked his furious disciples for wanting to call down fire from heaven to destroy some inhospitable Samaritans.<sup>43</sup>

In the thinking of some scholars, Jesus was unique in offering the invitation to salvation to individual human beings, especially to individuals who lay outside the circle of religious respectability.<sup>44</sup> His open acceptance of sinners, women, and foreigners mystified his followers and scandalized his critics. He offered them places in the kingdom of God alongside Israelites of good and regular standing. In fact, he asserted they would enter the kingdom *before* these respectable people.<sup>45</sup>

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<sup>35</sup> Mk 5:24-34.

<sup>36</sup> Mk 12:41-44; Lk 21:1-4.

<sup>37</sup> Lk 10:41-42.

<sup>38</sup> Mt 26:13; Mk 14:9.

<sup>39</sup> Jn 8:11.

<sup>40</sup> Mt 19:13-15; Mk 10:13-16; Lk 18:15-17.

<sup>41</sup> See the parables of the lost sheep, the lost coin, the prodigal son (Lk 15).

<sup>42</sup> Mt 5:44.

<sup>43</sup> Lk 10:53-54.

<sup>44</sup> In fact, there are even those who suggest that it was Jesus’ openness to the outcast and the downtrodden that ultimately led his enemies to arrange his execution.

<sup>45</sup> Mt 21:31.

Jesus' ministry-healing also involves the social aspect of human life. Just as Jesus healed more than physical ailments, his concern extended beyond individual human beings. His mission was to create a new community, to incorporate people within a fellowship whose members would exhibit the same love and support for each other that he displayed in his own life, and who would reach out to embrace people from every nation and every station in life. In other words, Jesus envisioned the most inclusive community possible—a community open to everyone, to the entire world.

Given the fact that the kingdom of God—a social symbol—was the theme of Jesus' preaching, the social dimension of healing is arguably the most important aspect of his ministry. We see the healing of communities in a number of Jesus' miracles. Each of the individuals he raised from the dead was restored to a bereaved family—Jairus' daughter, the son of the widow of Nain, and Lazarus of Bethany. Physical restoration was the means, social restoration the end. We see this in cases where Jesus healed people of diseases that carried a strong social stigma, and forced their victims to live apart from family and friends, such as lepers, the woman who suffered from a hemorrhage, and the Gerasene demoniac who was banished to the tombs.

When we look at Jesus' ministry-healing, then, we see that it involved caring for the whole person—physically, spiritually, emotionally, and socially. There is no essential aspect of human life that his ministry did not touch.

**Jesus cared *with* the whole person.** The way Jesus cared for others is just as noteworthy as the others he cared for. For he not only cared *for* the whole person, he also cared *with* his whole person. His concern for people was his consuming passion. It defined his existence.<sup>46</sup> And it affected every dimension of his life, just as it did the ones he helped. To appreciate all that ministry-healing involves, we need to examine the way Jesus poured out his life in service.

We don't often think of Jesus giving of himself physically, but according to the Gospels, he often did so. When Jesus reached out to the sick, he did so literally. He customarily put his hands on those he healed, and no one was too sick or too ugly to receive his touch.. He touched lepers, even though they were ritually "unclean."<sup>47</sup> He lifted Peter's mother-in-law up by her hand, and her fever left her.<sup>48</sup> He spat on the ground, made clay and put it on the eyes of the man born blind.<sup>49</sup> He healed a deaf mute by putting his

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<sup>46</sup> "Our Lord Jesus Christ came to this world as the unwearied servant of man's necessity" (Ellen G. White, *Ministry of Healing*, p. 17).

<sup>47</sup> Mk 10:41 (and parallels).

<sup>48</sup> Mt 8:15; Mk 1:31.

<sup>49</sup> Jn 9:6.

fingers in the man's ears, then spitting and touching his tongue.<sup>50</sup> He took children in his arms and blessed them, laying his hands on them.<sup>51</sup> And of course, he washed his disciples' feet and wiped them with a towel.<sup>52</sup> Jesus' willingness to touch people gave his care for them a concrete, palpable quality. Jesus did not love people in the abstract. He loved them as specific, individual, flesh and blood human beings. He cared for them as persons.

Jesus also allowed people to touch him. The crowds jostled him as he walked through Capernaum's narrow streets,<sup>53</sup> and he sensed the hand of a desperate woman who reached out to touch his cloak.<sup>54</sup> He praised the woman who bathed his feet with costly ointment and wiped them with her hair. He accepted her devotion, commended her faith, and assured her that her sins were forgiven.<sup>55</sup> Following his crucifixion, Jesus' friends and followers prepared his body for burial and placed it in a tomb.

So willing was Jesus to give physically that he sometimes ministered to the point of exhaustion. Bone-weary, he slept through a storm in the back of a fishing boat while his disciples battled the elements for their lives.<sup>56</sup> On other occasions he grew hungry and thirsty.

Jesus' care for others was the central burden of his relationship to God. Jesus spent a good deal of time in prayer.<sup>57</sup> He prayed for himself, of course—Gethsemane is the best example—but he also prayed for others. In the great intercessory prayer of John 17, Jesus poured out his concern for his inner circle of followers. He prayed for their spiritual security and the success of their future mission in the world. He prayed for people individually as well. When Simon Peter boasted of his loyalty, Jesus replied, "I have prayed for you that your own faith may not fail."<sup>58</sup>

Jesus placed the welfare and security of his disciples before his own interests. When he was arrested, he asked his captors to let his companions go.<sup>59</sup> And while on the cross, he made provision for his mother's care.<sup>60</sup> In his "farewell discourses," Jesus offered his

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<sup>50</sup> Mk 7:31-35.

<sup>51</sup> Mk 10:13-16.

<sup>52</sup> Jn 13:5.

<sup>53</sup> Mk 5:24, 31.

<sup>54</sup> Mk 5:28-30.

<sup>55</sup> Lk 7:36-50; Jn 11:2.

<sup>56</sup> Mk 4:35-41 (and parallels).

<sup>57</sup> Mk 1:35; Lk 11:1.

<sup>58</sup> Lk 22:32.

<sup>59</sup> Jn 18:8.

<sup>60</sup> Jn 19:26-27.

disciples his own fellowship with the Father. He wanted to join the intimate circle of love that defined his own relationship with God and enjoy the same privileges that he did as God's own Son.<sup>61</sup>

To use the language of our day, Jesus was willing to be emotionally vulnerable. He opened himself to the feelings of other people, and he was equally open in expressing his own. Jesus was deeply affected by those around him. When a rich young man ran up to him, knelt down, and asked Jesus to help him find eternal life, Jesus looked on him and "loved him."<sup>62</sup>

On several occasions, Jesus was "moved with compassion" or "pity" when faced with human need—when he met a leper,<sup>63</sup> when he witnessed the sorrow of a mother whose only son had died,<sup>64</sup> and when he saw the crowds following him, "like sheep without a shepherd."<sup>65</sup> The Greek behind this expression is a blunt and forceful term, referring to the inner organs of the body. It conveys deep-felt, spontaneous emotions that affect us viscerally, so to speak.<sup>66</sup> In other words, these scenes of human suffering hit Jesus in the pit of the stomach. In a similar way, Jesus was deeply moved by the mourners as he neared the grave of his friend Lazarus, and burst into tears himself.<sup>67</sup>

At times, Jesus was surprised and astonished by people's behavior. He marveled when people showed great faith, like the centurion,<sup>68</sup> and when they showed little faith, as at Nazareth, his childhood home.<sup>69</sup> We also sense that Jesus was sensitive to the way people responded to him, and stung when they rejected him. There is a touching scene in Capernaum when the multitudes, disillusioned with his dramatic claims for himself, left him in as readily as they had come not long before. He turned to his disciples and asked, "Do you also wish to go away?"<sup>70</sup>

The emotion we most readily apply to Jesus, of course, is love. And his love for people is nowhere more evident than in his care for his disciples, his closest followers and dearest friends. As the first verse of the passion story in John puts it, "when Jesus knew that the hour had come to depart out of this world to the Father, having loved his own who were in

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<sup>61</sup> Jn 14-17.

<sup>62</sup> Mk 10:21.

<sup>63</sup> Mk 1:41.

<sup>64</sup> Luke 7:13.

<sup>65</sup> Mk 6:34.

<sup>66</sup> Helmut Koester, *splanchnon*, etc., in *Theological Dictionary of the New Testament*, ed. Gerhard Friedrich, trans. Geoffrey W. Bromiley (10 vols.; Eerdmans, 1964-76), 7:549. The same word appears in Jesus' parables, where it describes the feelings of the father for his wayward son and the response of the Good Samaritan to the wounded traveler on the Jericho road (Lk 15:10, 10:33).

<sup>67</sup> Jn 11:35.

<sup>68</sup> Mt 8:10;

<sup>69</sup> Mk 6:6.

<sup>70</sup> Jn 6:67.

the world, he loved them to the end.”<sup>71</sup> Jesus loved his disciples to the very end of his life, and he loved them to the fullest extent possible: he laid down his life for his friends.<sup>72</sup>

Jesus was generous with his company. He spent a great deal of time in public, he mingled with people freely, he shared his provisions with others, and he accepted their hospitality in return. In fact, Jesus was so inclusive in the company he kept that his critics accused him of being “a glutton and a drunkard, a friend of tax collectors and sinners.”<sup>73</sup> He could engage people from completely different strata of society. He ate with the in-crowd, with Pharisees, and he also ate with social outcasts.<sup>74</sup> John 3 records his conversation with Nicodemus, a Pharisee and a member of the Sanhedrin, the highest Jewish council. John 4 records his conversation with a promiscuous Samaritan woman. We cannot imagine two more diverse individuals, yet Jesus was perfectly at ease with each of them.

Jesus lived his life in close association with other people. He gathered an inner circle of disciples around him and gave them a great deal of his time.<sup>75</sup> But Jesus reached beyond them as well. In fact, one of the central burdens of his ministry was to establish a community that had no boundaries, that was open and welcoming to every human being. To illustrate the nature of this community, the kingdom of God, he developed conspicuous associations with those least likely to be candidates for God’s kingdom in the conventional thinking of the day.<sup>76</sup> He placed himself among the suffering. In the great parable of the sheep and the goats, the king identifies himself with the hungry, the thirsty, the stranger, the naked, the sick and the imprisoned.<sup>77</sup>

Jesus was so committed to offering others his companionship that he had no place to call his own. Foxes have holes,” he once exclaimed, “and the birds of the air have nests; but the Son of man has nowhere to lay his head.”<sup>78</sup> He sacrificed comfort and security so others could benefit from his ministry. It is also significant that Jesus affirmed human happiness. He attended feasts and celebrations, and he performed his first miracle at a wedding.

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<sup>71</sup> Jn 13:1.

<sup>72</sup> Jn 15:13.

<sup>73</sup> Mt 11:19; Lk 7:34.

<sup>74</sup> Lk 7:36; Lk 15:1-2.

<sup>75</sup> See Mt 5:1.

<sup>76</sup> The citizens of the kingdom Jesus describes in the beatitudes includes a surprising group of people—the poor, the meek, those who mourn, the merciful, the persecuted, the hungry and thirsty, etc.—not the sort most people would expect to build up a kingdom of any significance. Mt 5:3-13.

<sup>77</sup> Mt 25:37-40.

<sup>78</sup> Mt 8:20; Lk 9:58.



Jesus' commitment to ministry-healing encompassed his entire life. He poured himself into service and ministry. Every aspect of his person was devoted to others. Physically, spiritually, emotionally, and socially—Jesus drew on every facet of his life to bless and benefit others. It is no wonder that Christians view his ministry as a costly sacrifice and find a precedent for his life and work in the servant songs of Isaiah.<sup>79</sup> He identified with the objects of his care so completely that he became one with them. Their sufferings became his, and his suffering became the means of their salvation.

The ministry-healing exemplified in Jesus is unsurpassed in scope and intensity. There was no aspect of human existence that did not concern him, there was no one who lay outside the circle of his compassion, and there was no resource available to him that he did not use. To meet the needs of others, he drew on the full range of his personal powers, but and he emptied himself of these resources. When his ministry came to an end, there was nothing further he could have done to achieve the goals of his mission. There was no avenue of service he had not explored, no physical, mental, emotional, or spiritual resource yet available to him. His sacrifice was complete. When Jesus reached the end of his life, he had revealed "the full extent of his love."<sup>80</sup>

### **Ministry-healing in our lives**

The ideal of ministry-healing that Jesus provides is exactly that—an ideal. Jesus embodied the life of service to which all his followers are called, and he is the only one who ever fulfilled it perfectly. Nevertheless, it is an ideal for us, and to the extent that we take it as our guide and inspiration, it will expand and sharpen our vision of service. The ministry-healing of Jesus contains a theology of healing, and it provides a model for Adventist healthcare. It also has implications for both care-receivers and care-givers. It calls us to care *for* the whole person, just as Jesus did, and it calls us to care *with* the whole person as well.

According to the biblical view of human existence, human beings are creatures belonging to this planet's complex biosphere whose distinctive qualities endow them with unique dignity and power. Their misuse of these qualities has plunged them into unique tragedy. The only creatures whose destiny lay within their own hands consistently thwart the purpose of their existence. But the creator is also the redeemer, and God is at work to overcome the consequences of sin and achieve his original purpose for humanity. God incorporates a wide range of resources in this process, and ministry-healing is our way of participating in God's own work of salvation. From a theological standpoint, the various dimensions of healthcare are an extension of God's redemptive work in the world, a

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<sup>79</sup> "He was despised and rejected by others; a man of suffering and acquainted with infirmity... Surely he has borne our infirmities and carried our diseases; yet we accounted him stricken, struck down by God and afflicted. But he was wounded for our transgressions, crushed for our iniquities; upon him was the punishment that made us whole, and by his bruises we are healed" (Isa 53:3-5).

<sup>80</sup> Jn 13:1 (NIV).

manifestation of his abiding commitment to human welfare, and an example of his providential use of human abilities and energies to achieve his purposes.

**Caring for the whole person.** Ministry-healing involves a comprehensive vision of health care. It is comprehensive, first, in the sense that it extends to all human beings. No one should be without the medical resources they need to meet life's physical challenges. Those who participate in the ministry-healing of Jesus will recognize that no one is undeserving of healthcare. They will seek ways to provide the benefits of modern medicine to all who need them.

The healthcare ministry-healing envisions is also comprehensive in the sense that it extends to the entire life experience. What assistance is needed at the beginning of life? What is needed at the end? We have seen that ministry-healing means attending to everything that makes a person a person; it also means caring for a person during the whole of life—that is, to life's very end—and it means treating the person as a whole person the whole time.

To do this, it is important distinguish death from dying. Though they are often linked together—as in the most famous title on the topic<sup>81</sup>—the two are not the same. If life is God's greatest blessing, there can be nothing positive in death. Death is the loss of life; it is purely negative. When it comes to dying, however, things are different. Dying is the last stage of life, and as such it can hold positive experiences. People sometimes find that the closing experiences of life are among the richest.<sup>82</sup>

The end of life is not to be postponed at all costs, however. Those engaged in ministry-healing will view disease and death as enemies, yet they will recognize that we live in a world where salvation is not fully realized, and complete restoration will not take place until the God's kingdom comes. At the same time, ministry-healing will affirm the value of a human being whose physical problems have exhausted the resources of human nature and human knowledge. No one involved in ministry-healing will "check out" when a person's physical problems reach the point where there is no known solution.

The healthcare that ministry-healing envisions is comprehensive, third, in the sense that it affirms the full humanity of each human being. No person is complete, in the sense that he or she is everything that God intends him or her to be, and in some cases this incompleteness is more obvious and more drastic than others. But Jesus treated everyone he met as an object of infinite value, as a child of God and a potential citizen of the kingdom of heaven. No one was worthless or dispensable, contrary to popular

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<sup>81</sup> Elizabeth Kubler-Ross, *On Death and Dying* (1969).

<sup>82</sup> For this reason, it is not possible to speak of a good death, but it is appropriate to speak of dying well. A woman I know whose husband died after a long struggle with cancer told me that they were never as close to each other as during this most painful time. "The love we shared during his last illness," she said, "was more intense than any other part of our marriage."

opinion. Jesus took an interest in people when those around him tried to send them away.<sup>83</sup> Jesus cared so deeply for the poor and suffering that in one of his greatest parables he actually identified himself with the victims of human misery. He asserted that those who helped them were, in fact, helping him. In the spirit of Christ's own ministry, ministry-healing will address the needs of the most desperate members of the human family.

Finally, the healthcare that ministry-healing envisions is comprehensive in the sense that it addresses all the dimensions of human existence, all the things that make us human—physical, spiritual, emotional, and social. It recognizes that human wholeness requires fulfillment in all these areas.

Physical needs are the most obvious and often the most pressing, but they are seldom isolated from other needs. People with physical problems almost always have spiritual, emotional and social needs as well. Ministry-healing makes spiritual health a priority. It looks on each human being as a child of God and seeks ways to make people aware of God's love for them.

A sick person often experiences emotional as well as physical distress, and ministry-healing will always be sensitive to this aspect of illness. If we cannot assure them that all is well physically, we can demonstrate that we are aware of their struggles, and we can reassure them of their infinite value to us and to God. Unless they affirm these aspects of a patient's experience deliberately and repeatedly, caregivers can easily lose sight of them. While no one disputes the importance of learning how better to diagnose and cure disease, true ministry-healing will never subordinate a patient's personal priorities to the advance of medical science.<sup>84</sup>

Human beings are social; we live in relationships. And ministry-healing will take note of the "significant others" in the life of each sufferer. A serious illness can strain relationships within the best of families. Sometimes it brings to the surface long-standing tensions among siblings and between parents and children. But it also provides opportunities for reconciliation and forgiveness.<sup>85</sup> And occasionally it deepens and strengthens affection that is already strong. For all these reasons, it is helpful to include

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<sup>83</sup> When a blind man near Jericho cried out for Jesus, people in the crowd tried to silence him. But Jesus met the man and healed him (Lk 18:35-43). When his disciples tried to prevent mothers and children from taking his time, Jesus rebuked them, and took the children in his arms (Mt 19:13-15).

<sup>84</sup> According to Sherwin B. Nuland, doctors in training inevitably become preoccupied with the intellectual challenges of medicine. Most people decide to become physicians out of a desire to relieve human suffering. But over the course of their education, young doctors become preoccupied with "The Riddle"—Nuland's term for the challenge of diagnosing disease and prescribing effective treatment. And it is this concern, rather than humanitarian motives, that advances a physician's career and stimulates the development of new forms of treatment. Consequently, Nuland observes, physicians who make *The Riddle* their primary concern can easily overlook their patients' personal interests (*How We Die: Reflections on Life's Final Chapter* [Vintage Books, 1995], 248-49).

<sup>85</sup> According to Gerald Winslow, there are four things that everyone needs to say, and hear, as the end of life approaches: "I love you," "I forgive you," "Will you forgive me?" "Goodbye."

in ministry-healing caregivers who have special skills in restoring and developing relationships.

It is evident that ministry-healing is a multifaceted endeavor. It calls for caregivers who have a variety of skills and who are sensitive to the full spectrum of human needs. In few cases will one person be able to meet the wide-ranging needs that illness involves. Consequently, effective ministry-healing brings together people who have a diversity of complementary skills and a desire to coordinate and integrate their efforts on behalf of the people they serve.

**Caring with the whole person.** Construed as ministry-healing, healthcare is not primarily a business, a career, or a profession. It is fundamentally a calling. And it is primarily a calling to serve. To participate in Jesus' healing ministry to this world, caregivers will draw on all their human resources—physical, emotional, spiritual and social.

At its heart, ministry-healing is a spiritual endeavor. It consists in participating in God's own redemptive work in the world. For this reason, those who engage in such ministry will draw strength from a sense of God's presence in their lives. They will consciously remind themselves that they are God's agents in the world, that they share with Jesus the work of relieving human suffering. Should they communicate their religious concerns for those who are sick in an explicit way? As we have seen, such questions sometimes provoke heated replies. Some people feel that it is manipulative or coercive for caregivers to broach religious issues with their patients. On the other hand, people have spiritual needs, they often become aware of them when they suffer, and caregivers can provide a valuable resource at the time. The crucial question is how to respect a person's religious integrity and emotional vulnerability as we address their spiritual needs. It calls for great wisdom and skill, and most importantly, for the guidance of the Holy Spirit.

It obviously takes physical strength and stamina to meet pressing human needs over time, especially when many of them are critical. So, ministry-healing can be a costly activity. A more specific physical resource that appears in the ministry of Jesus is the power of touch. A touch has a personalizing effect. It reassures the care-receiver that he or she is not just a disease, a condition, a case, or a chart, but someone whose humanity and individuality deserve to be recognized and affirmed. Other physical gestures that "connect" with care-receivers can contribute to the healing process as well, such as taking a position close to the people, speaking and looking to them directly.

To what extent should caregivers commit themselves emotionally to the objects of their concern? This is a perennial question, and there is no simple answer. But there is a growing recognition that emotion has an important role to play in the practice of

medicine—to mention one facet of ministry-healing<sup>86</sup>—and that we cannot respond to emotional needs effectively without drawing on emotional resources. A caregiver who remains emotionally detached would be a contradiction in terms. For how could such a person provide “care” in any significant way? On the other hand, we have to wonder how a person who spends herself unstintingly in caring for others could avoid running out of emotional energy long before her responsibilities are fulfilled. The solution is not to keep from spending oneself emotionally, but to find ways of replenishing one’s emotional resources.<sup>87</sup>

As for the social aspect of caring, ministry-healing brings people together in important ways. For one, it unites caregivers in their common endeavors. The “healing team” includes not only those who are primarily concerned with a patient’s physical condition, but also those whose primary concerns lie with people’s spiritual, emotional and social needs. Physicians, nurses, medical technologists, physical therapists, ministers, psychologists, and social workers—all have roles to play in the healing process. The needs that preoccupy one group may be more urgent, or more apparent than others, but all the needs of a suffering person are important. As George Khushf puts it, “A Christian ‘ethic of care’ will not be primarily a form of medicine, but rather a broader ministry, which accounts for an appropriate medicine within its concern with spiritual well-being.”<sup>88</sup>

More significant, ministry-healing brings caregivers and care-receivers together, combining their efforts to restore health. Science doesn’t heal people, not in the full sense of the word. More accurately, it is the Lord who heals people, and the human role is to learn how to cooperate with him. Caregiver and care-receiver do not stand in a hierarchical relationship, where one directs or orders the other. To achieve healing and wholeness, they must work together. On a deeper level, care-givers and receivers are united by a common “illness.” They share the same fundamental predicament. We are all afflicted by sin.<sup>89</sup> We all suffer, we are all broken, and we all need healing, “patients” and “care-givers” alike—the distinction is merely provisional.<sup>90</sup> The ultimate goal of ministry-healing is spiritual community, and it sees the healing community as an avenue to this end.

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<sup>86</sup> See the discussion in *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel*, ed. Howard Spiro et al. (Yale, 1993). Jerome Groopman, M.D., describes a number of patients in whose lives he became deeply involved in *The Measure of Our Days: A Spiritual Exploration of Illness* (Penguin, 1997).

<sup>87</sup> Philosopher William Ernest Hocking spoke of the great principle of alternation. A balanced life alternates between rest and activity, society and solitude, work and recreation. Jesus recognized this need when he sent his disciples out to minister and invited them to rest when they returned to him. After the twelve returned from a mission he had sent them on, Jesus “took them with him and withdrew privately to a city called Bethsaida” (Luke 9:10).

<sup>88</sup> “Illness, the Problem of Evil, and the Analogical Structure of Healing: On the Difference Christianity makes in Bioethics,” in *Christian Bioethics*, 1(1995): 112-113.

<sup>89</sup> George Khushf makes this point forcefully by describing illness as “general revelation,” as “revelatory of the human condition in general,” and as “a manifestation of the structure of sin” (“Illness, the Problem of Evil, and the Analogical Structure of Healing: On the Difference Christianity Makes in Bioethics,” *Christian Bioethics*, 1[1995]: 108-109).

<sup>90</sup> To quote Khushf again, illness is “revelatory of the human condition in general” (Khushf, 109).

**Conclusion.** Let us summarize our answers to the questions with which we began. From an Adventist, illness is a manifestation of sin, the disorder that affects all of human existence, and the attempt to overcome illness and restore health is an aspect of God's saving work in the world. Consequently, healthcare has an important place in religion.

Essentially, we are creatures in God's own image—made from the dust of the earth, yet capable of responding to our creator and representing him in the world. We are both physical beings in a physical world and creatures in the image of God, with mental, emotional, social and spiritual dimensions—all interconnected. As we actually exist, however, we are alienated from God, from others, from our environment, and ultimately from ourselves. And we bear the damaging effects of sin in every aspect of our existence—physically, mentally, spiritually, emotionally, and socially. To fulfill our destiny we need a solution to the wide-ranging problems that afflict us. In a word, we need salvation. And for this reason, religion has an important role to play in healthcare.

God's saving response to our predicament provides the ideal for Adventist healthcare. It addresses the entire range of human needs and it seeks the restoration of all that sin diminished. It came to clearest expression in the ministry-healing of Jesus, and it continues in the ministry-healing of Jesus' followers. Like him, they care *for* the whole person and *with* the whole person, and like him they eagerly await the restoration of all things.

APPENDIX E

ENDURING VALUES WITHIN  
OUR ADVENTIST HERITAGE  
BY ALDEN THOMPSON, PH.D.

**Enduring Values within Our Adventist Heritage**  
**by Alden Thompson**  
**Centennial Vision Retreat**  
**March 5-6, 2004**

The purpose of this paper is to place the visioning process of the Florida Hospital within the context of its Seventh-day Adventist heritage. The formal letter inviting my contribution to this process states: "The mission of Florida Hospital is to 'extend the healing ministry of Christ.' This we view as our *raison d'être* and our commitment is to be faithful to that. Our centennial vision is to become 'a global pacesetter by delivering preeminent faith-based healthcare.'"

The paper consists of four parts:

1. **Jesus' Holistic Vision.** Here I summarize the essential elements of Jesus' vision as recorded by those closest to him. Primary attention is paid to the four Gospels.
  
2. **The Adventist Understanding of Law.** I trace the development of the Adventist understanding of law through four stages:
  - A. Obedience to law as duty.
  
  - B. Law as gift and guide.
  
  - C. Grateful obedience as the *result of* salvation.
  
  - D. The law of love as the foundation for all of life, including human relationships.
  
3. **Adventism in Tension.** The Adventist understanding of law is the backdrop for my analysis of four key tension points within which Adventism must find its place:



A. Sociologically: Do we separate from culture and condemn it, or integrate and cooperate?

B. Biologically: Do we deny our appetites and passions (asceticism) or nurture them (hedonism)?

C. Theologically: Do we affirm human freedom and responsibility or divine sovereignty, power, and grace?

D. Anthropologically: Do we stress the value of the individual or the community?

**4. Implications and Applications.** Finally, I apply my understanding of our Adventist heritage to current issues and trends, some largely internal to the church and the Health Systems, some more directly linked with outside forces.

### 1. Jesus' Holistic Vision

In the process of preparing this paper, the discoveries I have made have led me into irresistible temptation, namely, to inject more of a personal element (first-person singular) than would normally be the case in a formal paper. The result could perhaps be called "theology casual" or "academic casual," the equivalent version of the dress code for this week end, "business casual," a term which had to be interpreted for at least some of the theology participants.

After sketching out the broad outline of what I wanted to present, I went to the Gospels, intending to explore more carefully how Jesus and his followers related the physical and the spiritual, especially with reference to healing. In our increasingly secular world, the tension between the physical and the spiritual persistently haunts the lives of devout Christians who seek to be faithful witnesses for their Lord. It is a question which I would imagine looms large for those responsible for the institutions currently a part of Adventist Health.

In our present situation in America, our lives are complicated even further by the increasingly diverse nature of our American religious culture. When Adventists finally got serious about missions in the more formal sense, we began sending missionaries to work

in Muslem, Hindu, and Buddhist lands. Now these good people live among us in increasing numbers as neighbors, colleagues, and employees. Do we have more in common with these deeply religious people than with our erstwhile Protestant compatriots, now increasingly secularized?

So my question has been: How can the story of Jesus help us address this tension between the merely physical, where we find common ground with the secularists professing no religion at all, and the more strictly religious or spiritual, where we find common ground with those who are deeply religious, but not Christian.

To my amazement, I have had to conclude, that the New Testament gives us very little basis for separating the physical and the spiritual. Yes, it would appear that Jesus often simply healed people's bodies, no strings attached. He did not always explicitly link the eternal with the temporal, the spiritual with the physical. Similarly, he sometimes seems to have spoken about the spiritual without explicitly relating it to the physical.

In fact, such observations may help explain a curious phenomenon in American Protestantism, namely, the seeming separation of the physical and the spiritual along what might be called party lines. "Liberal" or "mainstream" Christians focus on ministry to physical needs in the here and now, defining their mission in terms of transforming human culture, while "conservative" or "evangelical" Christians focus on ministry to ultimate spiritual needs, defining their mission in terms of saving souls for eternity.

I believe the distinction between the physical and the spiritual is still helpful, indeed essential, in our modern culture. Atheism and secularization manifest themselves today in ways which were totally foreign to the world of the New Testament. And we must take that difference into account. Yet I also firmly believe that the way we articulate the distinction between the physical and the spiritual today should still be shaped by our understanding of Jesus' holistic ministry.

But the word "holistic" provides yet another occasion for noting a surprise for me, uncovered in the process of preparing this paper, namely, that neither the term "holism" nor any of the related forms merit entries in the latest edition of the *Seventh-day Adventist Encyclopedia* (1996). Nor is the term present in our *Fundamental Beliefs* (1980), though the description of humankind in statement #7 reflects the concept, stating that each person "is an indivisible unity of body, mind, and soul."

In my view, the essence of Adventism, indeed its uniqueness, is found in the way we integrate all our beliefs and practices within a holistic understanding of humanity, the capstone of God's good creation. Our reason for existence does not depend upon a unique belief or a unique cluster of beliefs, unless it would be the belief that the whole of

our belief system is far more than the sum of its parts. Yet if such a conviction is to be accepted as a valid Christian conviction, it must be rooted in the New Testament witness to Jesus. And so I turn to the New Testament.

For purposes of this paper, I have chosen two ways of looking at the New Testament evidence: First, through an overview of passages which highlight the relationship between the physical and the spiritual. Second, by means of a list of defining moments, turning points, and summarizing statements in Jesus' ministry. As I see it, both ways of looking at the evidence reveal a holistic blending of the physical and the spiritual.

#### 1. The Relationship between the Physical and the Spiritual: An Overview

**Synopsis:** The separation of the physical (healing the body) from the spiritual (healing of the mind and/or soul) in Jesus' ministry is only possible at a superficial level. Jesus modeled a holistic ministry by affirming the link between sin and sickness (paralytic, man at the pool of Bethesda), but also by denying it (man born blind), while affirming that physical healing was all for the glory of God. Conversely, when Jesus pointed the way to eternal life, the link with the physical was often emphatic: the rich young ruler had to sell all and give to the poor; and in the stories of the Good Samaritan and Zacchaeus, Jesus defined the way to eternal life in terms of charitable acts.

To summarize in advance, I believe a case can be made for the conclusion that Jesus' redemptive ministry linked the physical with the spiritual in ways which justify the use of the term "holistic." Superficially, one can divide Jesus' ministry into that which restores the body (physical) and that which heals the soul (spiritual). But where would casting out demons fit into that simple scheme? Furthermore, depending on circumstances, Jesus sometimes confirmed and sometimes denied a direct relationship between sin and sickness.

The most memorable examples of Jesus' affirming a causal link between sin and sickness involve the healing of the paralytic (Matt. 9:1-8//Mark 2:1-12//Luke 5:17-26) and the restoration of the man at the pool of Bethesda (John 5:1-18). When dealing with the paralytic, Jesus first forgave the man's sins and then healed him. But in this instance, at least, Jesus declared that the forgiveness of the man's sins and the healing of his body were interchangeable (Matt. 9:5-6). Similarly, at the pool of Bethesda, Jesus linked sickness and suffering, healing the cripple first and later establishing the link with sin: "Do not sin any more," Jesus told him, "so that nothing worse happens to you" (John 5:14, NRSV).

But in at least one significant case, namely, the healing of the man born blind (John 9:1-12), Jesus specifically *denied* any causal link between sin and sickness. Yet in a very marked way he still affirmed the link between the physical and the spiritual, claiming that the man “was born blind so that God’s works might be revealed in him” (John 9:3, NRSV).

If, however, we turn our attention to those instances where Jesus spoke first and foremost about eternal matters – the spiritual, in other words – the link with the physical can still be direct and unmistakable. In a narrative found in all three of the synoptic Gospels, the story of the “rich, young, ruler” – a rich male in all three accounts, but young only in Matthew, and a ruler only in Luke – Jesus lays down the highest possible demands as prerequisites for eternal life, spelling them out in three steps, the second of which vividly highlights the physical: first, keep the commandments; second, *sell all that you have and give to the poor*; third, come and follow me (Matt. 19:16-22//Mark 10:17-22//Luke 18:18-23).

But while all three Gospels tell the hard story of the rich young man, Luke’s Gospel drives the point home with even greater emphasis by means of two additional stories. The first is a loose parallel with an incident recorded in both Matthew and Mark, the story of a lawyer asking Jesus about the greatest commandment (Matthew 22:34-40//Mark 12:28-34). The closest parallel in Luke is found in 10:25-28, where a lawyer asks, not about the greatest commandment as in Matthew and Mark, but, like the rich young ruler, about eternal life – the Greek text is identical in both narratives – “Teacher, what must I do to inherit eternal life?”

In Luke, Jesus does not provide the answer as he does in Matthew and Mark. Rather, he turns the question back to the lawyer: “What is written in the law? What do you read there?” The lawyer responds with a variant of the two great commands: “You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself.” To which Jesus answers: “You have given the right answer; do this, and you will live.”

But this is where Luke raises the bar. In Matthew’s version, the lawyer simply disappears without comment after Jesus’ response, his reputation tarnished by the fact that his question falls within a cluster of trick questions (22:15-40: questions about taxes, marriage in the resurrection, and the law), all intended to trap Jesus.

In Mark’s version (12:13-34), though the cluster of trick questions remains the same, the lawyer’s wise response rescues him from the taint of his scheming colleagues. Affirming the two great commands, he ends his answer with these words: “‘To love one’s neighbor as oneself,’ – this is much more important than all whole burnt offerings and sacrifices.” To which Jesus responds, “You are not far from the kingdom of God.”

But Luke goes his own way, and in so doing, strengthens the link between the physical and the spiritual. The context in Luke is quite different – no trick questions as in Matthew and Mark. And Luke doesn't join Mark in almost nudging the lawyer into the kingdom; rather, he joins Matthew in passing judgment, slipping the lawyer back into the shadows with words which also set the stage for the story of the Good Samaritan: "But wanting to justify himself" – that is Luke's judgment – he reports the lawyer as asking, "And who is my neighbor?" (Luke 18:29). Jesus answers by telling the story of the Good Samaritan, a narrative which appears only in Luke, not in any of the other Gospels.

And what truth is Jesus wanting to teach with this story, a story which answers the question: "What must I do to inherit eternal life?" When the lawyer said: "Love your neighbor as yourself," Jesus affirmed him: "You have given the right answer; do this and you will live." But when the lawyer returned with the question, "Who is my neighbor?" Jesus told the story of a Samaritan who came to the aid of a battered robbery victim, a man who had already been ignored by a priest and a Levite.

Jesus concluded his story with a question for the lawyer: "Which of these three, do you think, was a neighbor to the man who fell into the hands of the robbers?"

"The one who showed him mercy," answered the lawyer.

"Go and do likewise," was Jesus' response.

So, to put the matter very bluntly, a despised non-Jew – not an ordinary pagan, but a hated Samaritan – was *in the kingdom* because he had shown mercy to one in need. Meanwhile, those with all the right theology and the rich heritage had walked right by and on out into the night.

One of my favorite comments on this story is from Kari Sandhaas, a comment which should encourage Florida Hospital in its universalizing efforts to do good and to be part of all that is good wherever it may be found:

**One of the remarkable experiences for we who measure goodness by the person of Jesus Christ is that we see it displayed in people who do not follow him. Our Lord once met a Samaritan, whose belief was condemned by Judaism. Jesus so admired the man's tenderhearted action that he held him up as a model of compassion. Jesus didn't become a Samaritan, and he didn't give up his passion**

**for the Jewish vision of God's reign. But when he met goodness, he simply rejoiced in it.<sup>91</sup>**

The other story in Luke which directly links the physical and spiritual is the story of Zacchaeus (Luke 19:1-9). This tax collector, touched by Jesus' accepting love, had declared that he would give half of his goods to the poor and restore four-fold to anyone whom he had defrauded. In response, Jesus simply exclaimed: "Today salvation has come to this house."

Now if some are tempted to think that salvation can or must be earned by works or money, they should remember Jesus' promise to the repentant thief on the cross: "You will be with me in Paradise" (Luke 23:43), and Paul's response to the Philippian jailer: "Believe on the Lord Jesus, and you will be saved, you and your household" (Acts 16:31). In both of these instances, salvation was granted simply on the basis of verbal commitment alone, no strings attached.

**Summary:** In short, one cannot predict how easy or how difficult Jesus and his followers would make the path to eternal life. That's a major reason why I have concluded that the physical and the spiritual in Jesus' ministry cannot be separated from each other. Some acts of ministry may appear to be strictly physical, and some teachings and affirmations may appear to be strictly spiritual. Yet there are enough counter examples to show that the categories are inextricably woven together. Jesus' ministry was incurably holistic, a ministry to the whole person, the physical and the spiritual. What he did and taught made a difference in the here and now and it made a difference for eternity. In the light of Jesus' ministry, then, the two extremes – neglecting the spiritual in favor of the physical (liberal or mainstream Protestantism) or emphasizing the spiritual to the neglect of the physical (conservative or evangelical Protestantism) – do not properly model Jesus' holistic ministry.

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. Kari Sandhaas, *Signs of the Times*, July 1993, p. 6, citing Context

## B. Jesus' Ministry: Defining Moments, Turning Points, and Summarizing Statements

From the broad survey of Jesus' ministry, we turn to those defining moments and turning points which illumine the nature of his ministry, and to key summarizing statements in the Gospels. From the list which follows, one can see how a selective reading of the New Testament could lead to a one-sided emphasis on one's personal preference: a ministry focused on *physical* human need in the here and now or one pointed toward *spiritual* issues involving salvation and eternity. But, as in the survey above, this list of defining moments, turning points, and summarizing statements affirm a holistic blending of the physical and the spiritual.

**1. Isaiah 61:1-4//Luke 4:18-19. Announcing his ministry in Nazareth.** As recorded in Luke 4:18-19, Jesus defined his mission early in his ministry with words from Isaiah 61: He had been anointed to bring "good news to the poor," "release to the captives," "sight to the blind," and freedom to the "oppressed."

**2. Isaiah 53//Matt. 8:17. Fulfilling the servant's mission.** Three Gospel passages apply Isaiah 53, the famous "suffering servant song," to Jesus' ministry. But only one, Matthew 8:17, actually interprets the content of the chapter.<sup>92</sup> After reporting that Jesus had healed Peter's mother-in-law of her fever, cast out spirits and "cured all who were sick," Matthew quotes Isaiah 53:4 as follows: "This was to fulfill what had been spoken through the Prophet Isaiah, 'He took our infirmities and bore our diseases'" (NRSV). Thus, at least in this context, this famous "salvation" passage is surprisingly applied to Jesus' healing ministry, not to his atoning death on the cross.

**3. Matthew 11:2-6//Luke 7:18-23. Jesus' report to John the Baptist.** Struggling with doubt as he languished in prison, John the Baptist sent his own disciples to inquire about the nature of Jesus' ministry. Jesus' answer focused on the physical: "the blind receive their sight, the lame walk, the lepers are cleansed, the deaf hear, the dead are raised, and the poor have good news brought to them" (Matt. 11:5, NRSV).

**4. Jesus' Sabbath miracles of healing.** John Brunt's little book, *A Day for Healing*, offers an important corrective to the modern Adventist tendency to see the Sabbath primarily from the perspective of last days events. Brunt opens his book with these words: "By far the majority of New Testament references to the Sabbath occur with regard to

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John 12:38 links Isaiah 53:1 to the Jewish rejection of Jesus ("Lord, who has believed our message...?" [NRSV]) and Luke 22:37 quotes Jesus' own words linking Isaiah 53:12 to his condition on the cross ("And he was counted among the lawless" [NRSV]).

Jesus' Sabbath miracles of healing."<sup>93</sup> Brunt focuses on the five times in the Gospels when Jesus "specifically performs acts of healing on the Sabbath."<sup>94</sup> Jesus' message? The Sabbath, a *spiritual* high day, is a very good day for miracles of *physical* healing.

5. Matt. 24:14; 28:19-20. The Gospel to all the world: What is the "good news" which the disciples are called to take to the world? It can be defined either with a physical slant or with a spiritual one. Certainly modern American Evangelicals have been inclined to interpret the Gospel as the message of eternal salvation. In my view, that more narrow spiritual view, neglects the weighty evidence in the Gospels that Jesus was concerned about the quality of life in the here and now. In short, a "gospel" which neglects the physical is not the one reflected in Jesus' more holistic earthly ministry, even though it can be claimed as the plain reading of the key passages in Matthew 24 and 28.

6. Matthew 25:31-46. The issue in the judgment: If Jesus' mandate to preach the gospel can be seen as representing a more strictly spiritual message, then the judgment parable of the sheep and goats certainly moves to the other end of the spectrum, perhaps even suggesting a ministry exclusively physical. The deeds for which one may be commended or condemned in the judgment, all represent some form of outreach to those in need: "I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me" (Matt. 25:35-36, NRSV).

For those who may fear that the parable teaches righteousness by works, it can be noted that neither those who were commended nor those who were condemned were aware of what they were doing or neglecting to do. Both were "surprised" by their respective verdicts. Nothing in the story suggests that the righteous were attempting to win favor with God by their good deeds. They did what they did naturally, with no apparent hope of reward.

Ellen White's interpretation of the parable is simple and pointed. In "the great judgment day," she notes, the decision is represented as "turning upon one point. When the nations are gathered before Him, there will be but two classes, and their eternal destiny will be determined by what they have done or neglected to do for Him in the person of the poor

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<sup>93</sup>

. John C. Brunt, *A Day for Healing* (Washington, D. C: Review and Herald, 1981), 9.

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. Brunt, 25. The five Sabbath miracles are: 1) The healing of the man with the withered hand (Matt. 12:9-14; Mark 3:1-6; Luke 6:6-11); 2) The healing of the stooped woman (Luke 13:10-17); 3) The healing of the man with dropsy (Luke 14:1-6); 4) The healing of the man at the pool (John 5); and 5) The healing of the man born blind (John 9).



and suffering.”<sup>95</sup> She goes on to include in the kingdom the heathen who “worship God ignorantly,” those who have “cherished the spirit of kindness.”<sup>96</sup>

To sum up, the only one of the six points noted above which does not explicitly include a strong physical aspect as a defining element of Jesus’ mission, is the command to take the “good news” (gospel) to the whole world. But since all the others include the physical, it would seem quite justifiable to conclude that the “good news” is a message which makes people whole both in body and in soul, enhancing the quality of their life in the here and now as well as pointing them to the coming kingdom of God.

## 2. The Adventist Understanding of Law

**Synopsis:** Initially, Adventists simply viewed law as a requirement for salvation (1840s), then came to see it as a gracious guide to life (1860s). But even the gracious gift was often a heavy burden, until Adventists learned that true obedience cannot earn salvation but is the result of salvation (1880s). Finally, God’s law of love came to be seen as the foundation for every aspect of life, including our relationships with others (1900s).

Those who believe that a personal God actively intervenes in human affairs, at least at some level, can justifiably be called “conservatives” and can be distinguished from “liberals” who see God as more distant and/or impersonal, a God who does not actively intervene in human affairs. By that measure, Adventism as a community is clearly conservative, quite apart from whatever nightmares any of us as individuals may experience after dark.

And that presents Adventism with enormous challenges, for as we become more actively involved in the social and economic mainstream – Florida Hospital could be called Exhibit A – we have to grapple increasingly with both change and diversity, probably the two most volatile and troubling words for “conservatives” as I have defined them. Old Testament? “I am the Lord, I change not” (Mal. 3:6, KJV). New Testament? “Jesus Christ the same yesterday, and to day, and for ever” (Heb. 13:8, KJV).

As a devout conservative, I firmly believe those biblical passages to be true. But I believe they speak of God’s character. They do not refer to all that happens in God’s chaotic

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<sup>95</sup>

. Ellen White, *Desire of Ages*, 637 (1898).

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. DA, 638.

creation. The God I have experienced and see reflected in Scripture is one who grants remarkable freedom to human beings. I could not describe God as good if he did not grant us such freedom.

But what is so hard, even for many freedom-loving conservatives, is to admit to the diversity and change which result from such freedom. Hopefully, now that Adventist scholars are actually publishing books which document the changes in Adventism,<sup>97</sup> we will be in a better position to respond to change in ways that reflect a serious Christian commitment. Certainly, the willingness of Florida Hospital to convene this kind of conference is a very encouraging sign.

In this section of my paper I want to describe the development of key elements in Adventism through the early decades of our movement, then succinctly plot the course of change within Adventism by means of a four-fold matrix of key tension points, one largely sociological, one rooted in the biological, one thoroughly theological, and one mostly anthropological.

A central element in my description and analysis is the Adventist understanding of law. I will sketch the path by which Adventism developed its understanding of God's law and how human beings are to relate to that law. It is my conviction that it is our understanding of God's law which has shaped, and should continue to shape, our understanding of Christ's holistic ministry. And, I will argue, that it should be in a proper understanding of God's law that Florida Hospital will find its guiding star in their plans to "extend the healing ministry of Christ."

#### **A. Obedience to Law as Duty and Requirement for Salvation (1840s)**

In the 1844 movement, that apocalyptic movement which gave birth to the people who would later call themselves Seventh-day Adventist, concerns for health, wholeness, and healing played a very minor role, if any at all. You didn't have to worry about your health because Jesus was coming soon. The focus was almost entirely on the next world: Get ready for the soon coming of the Lord. Captain Joseph Bates, for example, was actively involved in the Millerite movement, but not as a health reformer, even though by 1843 he personally had adopted virtually every element of what Adventists would later call the "health message": abstinence from alcohol and tobacco (by about 1823), tea and coffee (in 1838), and flesh foods (in 1843). After the disappointment, his energies were directed

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. See, for example, George Knight, *A Search for Identity: The Development of Seventh-day Adventist Beliefs* (Hagerstown, MD: Review and Herald, 2000), and Rolf Poehler, *Continuity and Change in Adventist Teaching* (Frankfurt: Peter Lang, 2000). See my review of both books: "Gored by Every Sharp Tongue?" *Spectrum* 29:3 (Summer 2001), 68-71.

toward support of such doctrinal issues as the Sabbath and Adventist prophetic understanding. He didn't come on stage as an active participant in life-style issues until Ellen White had her health reform vision in 1863.<sup>98</sup>

In a subtle way, however, the Great Disappointment of 1844 prepared the way for the understanding of God's law which would become prominent in Adventism, especially in the writings of Ellen White. The Great Disappointment demonstrated rather brutally that the earth could not be the sanctuary referred to in Daniel 8:14. Yet as these devout believers read their Bibles, Daniel 8:17 still said that the vision was for "the time of the end." They finally concluded that the only sanctuary left was the one in heaven. While contemplating that heavenly sanctuary, Revelation 11:19 struck home: "And the temple of God was opened in heaven, and there was seen in his temple the ark of his testament."

What was in the ark? The decalogue. At the heart of the decalogue? The Sabbath. The final line of the third angel's message was the great clincher, speaking of those who "keep the commandments of God, and the faith of Jesus" (Rev. 14:12).

At that point in the Adventist experience, however, the law was not yet a gracious guide to good living. It was simply the path to heaven. In 1853, for example, James White published a brief summary of Adventist beliefs in response to an inquiry from a Seventh Day Baptist: "We are united in these great subjects: Christ's immediate, personal second Advent, and the observance of all of the commandments of God, and the faith of his Son Jesus Christ, as necessary to a readiness for his Advent."<sup>99</sup>

#### B. Law as Gift and Gracious Guide to Life (1860s)

Soon, however, early Adventists began to realize that God wanted them to take care of their bodies now, and that to obey the laws of health was simply being faithful to God's law. Indeed, Ellen White's health reform visions (1863, 1865) came to be seen as God's great gift to rescue his diseased and dying people. Ellen White herself could be downright spunky on that point as she attempted to bring the saints on board. In one of her hardest-hitting health reform sermons, given at the Battle Creek Church, March 6, 1869, this is how she put it:

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. "Bates, James," in *Seventh-day Adventist Encyclopedia* (1996), 170-172/

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. *Review and Herald* 4:52, August 11, 1853, cited in "Doctrinal Statements, Seventh-day Adventist," *SDAE* (1996), 464.

I do not regard it as a great privation to discontinue the use of those things which leave a bad smell in the breath and a bad taste in the mouth. Is it self-denial to leave these things and get into a condition where everything is as sweet as honey; where no bad taste is left in the mouth and no feeling of goneness in the stomach? These I used to have much of the time. I have fainted away with my child in my arms again and again. I have none of this now, and shall I call this a privation when I can stand before you as I do this day? There is not one woman in a hundred that could endure the amount of labor that I do. I moved out from principle, not from impulse. I moved because I believe Heaven would approve of this course I was taking to bring myself into the very best condition of health, that I might glorify God in my body and spirit, which are His.<sup>100</sup>

One senses in that quotation the element of duty to God, but combined with it is the idea that duty to God has great benefits in this life: food tastes better and stamina increases 100-fold, to cite Ellen White's exuberant illustration.

But all this "good news" about law could still have a hard edge to it. In 1878, for example, the three-person General Conference Executive Committee held a special session to address the life-style of the 26-year-old Dr. John Harvey Kellogg, physician at Battle Creek Sanitarium. This was their official action: "Resolved, that in our opinion [Dr. J. H. Kellogg] is sinning against God and himself and committing a wrong against the supporters and patrons of the sanitarium, in depriving himself of...eight hours in bed in every twenty-four, whether able to sleep or not."<sup>101</sup>

The move towards understanding God's law as "natural" rather than mandated law, can illumine some otherwise difficult statements from the pen of Ellen White. When I was a student at Walla Walla College, for example, I vividly remember one dormitory morning worship when our devout dean of men quoted this line from Ellen White: "It is a sin to be sick, for all sickness is the result of transgression."<sup>102</sup> It was the height of the winter cold season with coughing and sneezing echoing throughout the worship room. Of course, after hearing the good words from Ellen White, we all got well....

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. *Testimonies for the Church* 2:372 (1870).

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. Cited by Bert Haloviak in *Adventist Review* 173:14 (April 1996).

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. *Counsels on Health*, 37 (1923), citing, "A Knowledge of First Principles," *Health Reformer* 1:1 (August, 1866). The preceding line in this 1866 article (also found in CH, 137) clearly states the idea that God's law is not simply a mandated law, but is a guide to life: "Many have inquired of me, 'What course shall I take to best preserve my health?' My answer is, Cease to transgress the laws of your being; cease to gratify a depraved appetite; eat simple food; dress healthfully, which will require modest simplicity; work healthfully; and you will not be sick."

But when I checked the context of that very sobering quote, I discovered something very interesting. Here it is with the larger context included:

It is a sin to be sick, for all sickness is the result of transgression. Many are suffering in consequence of the transgression of their parents. They cannot be censured for their parents' sin; but it is nevertheless their duty to ascertain wherein their parents violated the laws of their being, which has entailed upon their offspring so miserable an inheritance; and wherein their parents' habits were wrong, they should change their course, and place themselves by correct habits in a better relation to health.<sup>103</sup>

Note that it is possible to “sin” without incurring “guilt.” That is clearly implied by the line, “they cannot be censured for their parents' sin.” Thus “sin” may be broadly defined as anything that detracts from health, anything which violates the laws of our being, regardless of the motive or intention involved. Thus it is quite possible for a person to “sin” without incurring guilt. To use Ellen White’s words, the person “cannot be censured.”

That highly rationalized view of law lies at the very foundation of the Adventist health reform vision. And in some ways, it is analogous to the modern scientific approach to truth: search for cause-and-effect relationships, describe the world as it actually is. But then the matter of motivation becomes crucial: a Christian will use scientific description as a means of plotting a course for helping and healing, for making the world a better place. That’s why this conference is a Christian conference.

Alternatively, one could take that same scientific description and use it for quite different purposes: to manipulate individuals and groups for financial or political gain, to advantage myself or my group at the cost of others. Science is neutral and strictly descriptive. Jesus’ way is not. Those who follow him will do careful science, then bend every effort to improve themselves so that they can play an active role in a movement that wants to make this world a better place and keep alive the hope of a better world where no one will hurt or destroy in all God’s holy mountain.

But there are at least three significant dangers lurking in that rationalized view of law: arrogance, discouragement, and secularization:

**1. Arrogance.** Those who stand solidly in the free-will tradition, tend to be optimists who can easily become over-confident in their own ability. In the moral and spiritual realm, the resulting arrogance can lead to a suffocating advocacy of perfection. In the

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<sup>103</sup>. CH, 37.

intellectual realm, the more likely result will be an attitude of condescension toward more ordinary mortals.

2. Discouragement. If the energetic optimist is at risk from arrogance and a condescending attitude, discouragement is the great enemy for the more reflective and spiritually sensitive person, the person who knows that the emphasis on action, on transforming the world, does not really touch the wounded and diseased heart. For them, the call to action and the cheerful admonitions to be perfect can result in deadly discouragement.

To oversimplify the differences between the arrogant and the discouraged, we could say that the free-will optimists love a challenge. For them, the parable of the talents in Matthew 25:14-30 is *the* parable to motivate them. Rewards are based on human effort. But for those more spiritually sensitive souls who are easily discouraged by the suggestion that salvation depends on their efforts, the parable of the vineyard workers in Matthew 20:1-16 is *the* parable to motivate them. All the workers got paid the same regardless of how long they had worked or how much they had accomplished.

3. Secularization. A thorough-going rationalization can lead down the garden path, so to speak, to pure secularization. When the "sanctified" disappears from "sanctified reason," a phrase popularized by Ellen White, nothing Christian remains.

#### C. Grateful Obedience as the *Result* of Salvation (1880s)

Adventism began to address the first two dangers, arrogance and discouragement, in 1888. The third one, secularization, is perhaps our greatest danger today, at least in my view. And though in many ways it is a distinct danger from the ones faced in 1888, the 19<sup>th</sup> century tussles over law can still be instructive for us who face the threat of secularization. Without going into the details of the 1888 debate, I will simply cite a key Ellen White quotation as a striking summary of what had happened to Adventism up to that point: "Let the law take care of itself," she exclaimed "We have been at work on the law until we get as dry as the hills of Gilboa, without dew or rain. Let us trust in the merits of Jesus Christ of Nazareth."<sup>104</sup>

As a result of the 1888 emphasis on righteousness by faith, an emphasis highlighted by A. T. Jones and E. J. Waggoner and encouraged by the voice and pen of Ellen White, God's sovereignty and grace began to play a stronger role in Adventism; a deeply

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. MS 10, 1890, *The Ellen G. White 1888 Materials* (Washington, D.C.: The Ellen G. White Estate, 1987), 2:557.

religious theocentric element began to temper the hard-driving anthropocentric impulse which our Wesleyan free-will heritage had bequeathed to us. In short, Adventists were now in a better position to recognize that all human efforts to do good will fall far short of the ideal unless transformed and renewed by God's grace. Most importantly, they were now in a better position to recognize that those who follow Jesus will not seek to obey God's law *in order to* be saved, but *because of* being saved by God's grace, a dramatic difference in perspective. Note also that this development brings back a distinct *religious* element as a corrective to the secularizing rational impulse. But this religious impulse is rooted in gratitude, not mere duty, and thus is encouraging, rather than potentially discouraging.

#### D. Law of Love as the Foundation for Human Relationships (1900s)

After 1888, one more crucial element needed to be addressed in connection with the Adventist understanding of law, though it has rarely been seen in connection with law, and that is the doctrine of the church, ecclesiology: how human beings work together with each other under God to do his work. The example and teachings of Jesus point toward a community typified by loving service to others, a community without privilege which seeks to live out Jesus' two great commands. Loving your neighbor as yourself looms large in the Gospels. Indeed the survey of New Testament evidence above suggests that the best way to love God is to love your neighbor. And in Matthew's version of the two great commands, Jesus says that "on these two commandments hang all the law and the prophets" (Matt. 22:40, NRSV).

In other words, a holistic understanding of God's law must involve interpersonal relations. Those who follow Jesus cannot be satisfied simply with a clinical concern for the "laws of our being" to keep the human machine in good working order. If God's law is a natural law like the law of gravity or the laws of mathematics – Ellen White often used the phrase "law of love" – then it must take into account every aspect of our nature, including that side of us which longs to be treated with care and respect. Paul gives us the right list: "Love is patient; love is kind; love is not envious or boastful or arrogant or rude. It does not insist on its own way; it is not irritable or resentful" (1 Cor. 13:4-5, NRSV).

But in spite of Jesus' best efforts to model that kind of love, his closest followers did not easily tumble to its full implications. James and John, for example, came to Jesus with their mother to ask for the top two positions in the kingdom. The other ten disciples were incensed. But Jesus' response is one that should sober us all: "You know that the rulers of the Gentiles lord it over them, and their high officials exercise authority over them. Not so with you. Instead, whoever wants to become great among you must be your servant, and whoever wants to be first must be your slave – just as the Son of Man did not come to be served, but to serve, and to give his life as a ransom for many." (Matt. 20:25-28).

In Adventism, that issue of how the law of love relates to the exercise of authority and position came to a head at the General Conference of 1901. Early in the 1890s, the brothers in Battle Creek had, in effect, shipped Ellen White to Australia to get her out of their hair. She did not attend a General Conference for ten years. When she returned to the United States, she finally agreed to attend the 1901 General Conference at Battle Creek. In my view, her words to the delegates at the opening of the conference are some of her most powerful and moving. I include here three paragraphs excerpted from that address. The first one constitutes her opening words at the very beginning of the conference:

I feel a special interest in the movements and decisions that shall be made at this Conference regarding things that should have been done years ago, and especially ten years ago, when we were assembled in Conference, and the Spirit and power of God came into our meeting, testifying that God was ready to work for this people if they would come into working order. The brethren assented to the light God had given, but there were those connected with our institutions, especially with the Review and Herald Office and the Conference, who brought in elements of unbelief, so that the light that was given was not acted upon. It was assented to, but no special change was made to bring about such a condition of things that the power of God could be revealed among his people.

As Ellen White unburdened her heart, she expressed sentiments that had never before been uttered before a General Conference, nor have they been repeated since:

All who are educated in the office of publication should see there exemplified the principles of heaven. I would rather lay a child of mine in his grave than have him go there to see these principles mangled and perverted. . . . You have no right to manage, unless you manage in God's order. . . .

O, my very soul is drawn out in these things! Men who have not learned to submit themselves to the control and discipline of God, are not competent to train the youth, to deal with human minds. It is just as much an impossibility for them to do this work as it would be for them to make a world. That these men should stand in a sacred place, to be as the voice of God to the people, as we once believed the General Conference to be, -- that is past. What we want now is a reorganization. We want to begin at the foundation, and to build upon a different principle.<sup>105</sup>

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. Ellen White as cited in *General Conference Bulletin*, Vol. IV, Extra #1, 3 April 1901, 23, 25.



If that foundation is God's law of love, if that different principle is God's law of love, then everything we do should reflect our commitment to that law. This is one of the clearest teachings of Jesus, yet continues to be the most difficult to implement. It was not easy for our Adventist forebears. It is not easy for us today. When Florida Hospital seeks to "extend the healing ministry of Christ," you have set for yourselves a lofty standard indeed, but one that I hope and pray you will seek with all your heart, with all your soul, and with all your mind.

### 3. Adventism in Tension

We turn now to the challenge of implementing this Adventist understanding of law. How have we done in the past? How are we doing now? In what follows, I simply plot the development of Adventism within a four-fold matrix, each of which reflects a significant tension, and in most cases a significant change in perspective over time. In each case, I pose the question about the role of our understanding of the "law of love," and I frequently illustrate the transition and change with key Ellen White quotations.

#### A. The Sociological Tension (Isolation or Integration?): From Sectarian Confrontation to Mainstream Cooperation.

Typically, sectarian movements separate from mainstream churches or denominations because devout believers seek a deeper experience of holiness than is possible in a community largely at peace with the prevailing culture. Early Christianity was clearly a counter-cultural sectarian movement; as was early Adventism. Increasingly, however, primarily as a result of education and wealth, American Adventists are part of the prevailing culture. Viewed from a positive perspective, the key transition is from confrontation to cooperation.

In my view, a fuller understanding of God's law of love, informed by the conviction that God himself took human flesh, enables us to shift the emphasis from confrontation to cooperation. Admittedly, that shift poses dangers of compromise, lethargy, and loss of vision. Confrontation may be necessary in the early days of a movement, but can embitter the spirit of the believers if it remains the dominant mode of interaction. The two quotations which follow (1864, 1887) illustrate the dramatic change in Ellen White's perspective:

Sectarian Confrontation (1861, 1864)

No name which we can take will be appropriate but that which accords with our profession and expresses our faith and marks us a peculiar people. **The name Seventh-day Adventist is a standing rebuke to the Protestant world.** Here is the line of distinction between the worshipers of God and those who worship the beast and receive his mark. The great conflict is between the commandments of God and the requirements of the beast. It is because the saints are keeping all ten of the commandments that the dragon makes war upon them. If they will lower the standard and yield the peculiarities of their faith, the dragon will be at peace; but they excite his ire because they have dared to raise the standard and unfurl their banner in opposition to the Protestant world, who are worshipping the institution of papacy.

The name Seventh-day Adventist carries the true features of our faith in front, and will convict the inquiring mind. Like an arrow from the Lord's quiver, it will wound the transgressor of God's law, and will lead to repentance toward God and faith in our Lord Jesus Christ.<sup>106</sup>

#### Mainstream Cooperation (1887)

In laboring in a new field, do not think it your duty to say at once to the people, We are Seventh-day Adventists; we believe that the seventh day is the Sabbath; we believe in the non-immortality of the soul. This would often erect a formidable barrier between you and those you wish to reach. Speak to them, as you have opportunity, upon points of doctrine on which you can agree. Dwell on the necessity of practical godliness. Give them evidence that you are a Christian, desiring peace, and that you love their souls. Let them see that you are conscientious. Thus you will gain their confidence; and there will be time enough for doctrines. Let the heart be won, the soil prepared, and then sow the seed presenting in love the truth as it is in Jesus.<sup>107</sup>

#### B. The Biological Tension (Appetites and Passions: Negative or Positive?): From Burdensome Asceticism to Joyous Simplicity.

In the experience of many devout conservatives, the celebration of the beautiful, the delicious, or the sensuous is fraught with great danger. God is everything, humans are nothing. Now the self-denial impulse is not limited to a believer's experience. Mark Twain

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. *Testimonies* 1:223-24 (1861), reissued virtually unchanged in 1864 in *Spiritual Gifts* 4a:54-55 (1864), apparently the only uses of the phrase "standing rebuke" in Ellen White's published writings.

<sup>107</sup>

. *Gospel Workers*, 117-120; cf. "Letter to a Minister and His Wife Bound for Africa" (June 25, 1887 = Letter 12, to Elder Boyd; almost verbatim "original" of the *Gospel Worker* quote) in *Testimonies to Southern Africa*, pp. 14-20.

has been quoted as saying, "The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not." When the suspicion that self-denial (asceticism) is the way to life turns into a religiously driven conviction, the result can be either a joyous simplicity, modeled perhaps best of all by Francis of Assisi, or a painful and burdensome austerity.

Early Adventism stood solidly for self-denial, but hardly a joyous self-denial. Indeed, there is ample evidence to suggest that the life of self-denial as envisioned by our early forebears was a burden, not a joy. In Ellen White's experience, however, two key factors contributed to a remarkable transition in her perspective: First, the understanding that God's law was a gracious gift, and that obedience was, therefore, a life-giving privilege. This insight seems to be closely linked with her health reform visions in the 1860s. Second, the understanding that the Lawgiver was God incarnate, God in human flesh, a development which seems to have happened in the late 1880s and is expressed most strikingly in her book on the life of Christ, *The Desire of Ages* (1898): "In Christ is life, original, unborrowed, underived."<sup>108</sup>

Several Adventist pioneers, including Ellen White's husband James, were stridently anti-trinitarian. In 1852, for example, James White went into print against "that old Trinitarian absurdity,"<sup>109</sup> a line which the kinder, gentler *Seventh-day Adventist Encyclopedia* renders as "the 'old Trinitarian' idea."<sup>110</sup> Because Ellen White never used such strong language, Adventist authors typically have taken the position that she was a kind of closet Trinitarian, biding her time until the right moment came to speak the truth. Recent publications, however, are more candid. As Rolf Poehler notes with reference to the Trinity, early Adventists were "fully agreed – in rejecting it."<sup>111</sup>

George Knight cites the reaction of M. L. Andreasen as confirming the fact that a transition had taken place. Andreasen remembered having been "astonished" when the book *Desire of Ages* was published, "for it contained some things that we considered

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. *Desire of Ages*, 530 (1898).

109

. *Review and Herald*, Aug. 5, 1852, 52, cited by George Knight, *Search*, 17.

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."Christology," in Don Neufeld, ed., *Seventh-day Adventist Encyclopedia*, second revised edition (Hagerstown: Review and Herald, 1996) 1:353.

111

. Rolf Poehler, *Continuity and Change in Adventist Teaching* (Frankfurt: Peter Lang, 2000), 37 (note 1).

unbelievable, among others the doctrine of the Trinity which was not then generally accepted by the Adventists."<sup>112</sup>

The Ellen White quotations cited below illustrate the progression in her experience from a burdensome asceticism to a joyous simplicity. Three of the four quotations are drawn from the successive editions of her devotional commentary on Scripture (1858, 1877, 1898). The other is from an 1897 article in the *The Youth's Instructor*:

### **From Burdensome Austerity to Joyous Simplicity (1858, 1877, 1897, 1898)**

#### No Joy

1858 (SG) "John's life was without pleasure. It was sorrowful and self-denying" (*Spiritual Gifts* 1:29). The somber contemporary application follows a few paragraphs later:

"I was pointed down to the last days, and saw that John was to represent those who should go forth in the spirit and power of Elijah, to herald the day of wrath, and the second advent of Jesus" (*Spiritual Gifts* 1:30-31).

#### A Touch of Joy – at Least at Work

1877 (SP) "John's life, with the exception of the joy he experienced in witnessing the success of his mission, was without pleasure" (*Spirit of Prophecy* 2:69).

#### Joy Takes Over

1897 (YI) "John enjoyed his life of simplicity and retirement" (*Youth's Instructor*, January 7, 1897). Note how the omission of the phrase "without pleasure" transforms the parallel in *Desire of Ages*:

1898 (DA) "Aside from the joy that John found in his mission, his life had been one of sorrow" (*Desire of Ages*, 220).

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. M. L. Andreasen, MS, Nov. 30, 1948, cited by George R. Knight, *A Search for Identity: The Development of Seventh-day Adventist Beliefs* (Hagerstown, MD: Review and Herald, 2000), 116-17.

When I first shared this progression in class, a student quipped: "You mean the more Ellen White enjoyed her experience, the more John the Baptist enjoyed his." Indeed. The goal, simplicity, had not changed. But now it was driven by joy, rather than by fear or mere duty.

Note that the earliest version of John's life (1858), written before her health reform visions (1863, 1865), not a trace of joy appears. But in the account written after those visions (1877) and when she had come to see law as a gracious gift, John begins to glimpse moments of joy, at least at work ("with the exception of the joy he experienced in witnessing the success of his mission"). But in light of the conviction that God himself had taken human flesh and come to save humanity, joy simply takes over.

Ellen White never endorsed a life of unrestrained hedonism, the pursuit of pleasure and beauty for the sake of pleasure and beauty. But because her motivation had been transformed from mere duty and/or fear, to that of joyous gratitude, a life of simplicity was no longer burdensome; it could actually be enjoyed.

### C. The Theological Tension: Human Freedom and Divine Sovereignty.

The tension between those who emphasize the importance of human freedom and responsibility and those who emphasize God's sovereignty and grace can be clearly documented at several points in Christian history. I consider this tension point to be one of the greatest challenges for a community that seeks to be an all-encompassing body of Christ in our day. The pairs listed below simply represent some of the more famous examples:

<b>Anthropocentric Human freedom</b>		<b>Theocentric Divine sovereignty</b>	
James	100s		Paul
Pelagius	400s		Augustine
Jacob Arminius	1500s		John Calvin
John Wesley	1700s		George Whitefield

While my colleague Richard Rice and others working with the idea of the "openness of God" have made some fine contributions in their attempts to resolve this tension. I am less optimistic about the possibility of a rational solution. Augustine expressed his conviction on the tension as follows: "In trying to solve this question I made strenuous

efforts on behalf of the preservation of the free choice of the human will, but the grace of God defeated me."<sup>113</sup>

My own observations have led me to conclude that more often than we care to admit, free-will parents give birth to predestinarian children and predestinarian parents give birth to free-will children. My proposed "solution" to the tension is to develop a model which affirms a diversity of theological perspectives within the body of Christ. The result would be a community which would actually recognize and admit publically the differences between James and Paul, insisting that both perspectives be nurtured in the church as necessary for the health of the whole body. The following quotation from Ellen White, sounding very post-modern, is one that I find very helpful in just that respect:

Every association of life calls for the exercise of self-control, forbearance, and sympathy. We differ so widely in disposition, habits, education, that our ways of looking at things vary. We judge differently. Our understanding of truth, our ideas in regard to the conduct of life, are not in all respects the same. There are no two whose experience is alike in every particular. The trials of one are not the trials of another. The duties that one finds light are to another most difficult and perplexing.

So frail, so ignorant, so liable to misconception is human nature, that each should be careful in the estimate he places upon another. We little know the bearing of our acts upon the experience of others. What we do or say may seem to us of little moment, when, could our eyes be opened, we should see that upon it depended the most important results for good or for evil.<sup>114</sup>

For at least two reasons, the tension between divine sovereignty and human freedom is crucial for the visioning of Adventist health ministries. First, the rationalized approach to law which the Adventist position implies – at least as I have described it – can be viewed with alarm by those who have an intense appreciation for divine sovereignty. The more intense supporters of divine sovereignty tend to restrict human research and exploration in the name of "divine revelation." In our day, the strongest proponents of an "inerrant" Word of God come from the Calvinist/Reformed tradition, probably the best known modern advocates of divine sovereignty.

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. *Retractationes* ii.1 (to Simplicianus of Milan), cited in Henry Chadwick, *Augustine* (Oxford, 1986), 117.

114

. *Ministry of Healing*, 483 (1905).

Secondly, within Adventism, those born with a predisposition to accept a strong emphasis on divine sovereignty are also inclined to accept an absolutist standard for the writings of Ellen White. From a scientific perspective, that absolutist position can be dangerous, for it does not make room for growth, change, and contextualization with reference to Ellen White's writings. But from an experiential perspective, an absolutist view of Ellen White's writings is at least as dangerous. The conscientious attempt to do everything Ellen White said we should do is bound to fail, not only because she said quite different things to different people – the specter of contradiction looms large – but also because the sheer volume of her work makes a conscientious rule-oriented obedience virtually impossible. Those who are burdened with such a perspective either reject religion completely, or use critical methodologies to dismantle Ellen White's authority while seeking to shield the Bible from the same kind of scrutiny. "Don't you tear down my Bible to save Ellen White!" is a classic line from those who have left Adventism for various forms of conservative evangelicalism.

More heroic souls who for deeply religious reasons revel in the conviction of divine sovereignty, can sometimes come close to a thorough-going life of self-denial, and with buoyancy, simply because they know themselves to be secure within the folds of God's predetermining and discriminating love. Their salvation depends on God, not at all on their own efforts. The kind of introspection typical of Augustine, for example, would drive a free-will person to distraction. But knowing himself to be secure in God's grace, Augustine could openly confess the following:

I struggle every day against uncontrolled desire in eating and drinking. It is not something I could give up once and for all and decide never to touch it again as I was able to do with sexual intercourse. And so a rein has to be held upon my throat, moderated between laxity and austerity. Who is the person, Lord, who is never carried a little beyond the limits of necessity? Whoever this may be is great and will magnify your name (cf. Ps. 68:31). I am not like that, for I am a sinful man. Yet I too magnify your name. And he who has overcome the world (John 16:33) intercedes with you for my sins (Rom. 8:34). He counts me among the weak members of his body, for "your eyes have seen its imperfection and in your book everyone is inscribed" (Ps. 138:16).<sup>115</sup>

If, however, one is naturally inclined toward the rationalizing impulse typically inherent in the emphasis on human freedom, the danger of slipping toward a non-religious secularization is very real, especially in our modern western culture. In my view, one of the best antidotes against these multiple dangers is for believers of both perspectives to worship together, pray together, and explore together every aspect of God's creation. In that very connection Scripture speaks powerfully to our situation:

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. Augustine, *Confessions*, Bk 10, xxxi (47), translated with notes and introduction by Henry Chadwick (Oxford, 1991), 207.

Let us hold fast to the confession of our hope without wavering, for he who has promised is faithful. And let us consider how to provoke one another to love and good deeds, not neglecting to meet together, as is the habit of some, but encouraging one another, and all the more as you see the Day approaching (Hebrews 10:23-25, NRSV).

#### D. The Anthropological Tension: The Individual and the Corporate.

For a variety of reasons, America has made a name for itself as being one of the most individualistic cultures in human history. Rich natural resources, a frontier heritage, a love of freedom have all served to strengthen this individualistic impulse. From a religious perspective the result has been a powerful impulse for communities to splinter rather than stay together. As one of my European colleagues quipped, "In America, every person is a sect unto himself."

Since the tribal impulse has faded almost completely from the American scene, the only possibility for community is a community based on choice. In our culture, people will not be coerced into community, they must be enticed. The story of God's law of love must be presented in an attractive, winning form.

Not unexpectedly, that vision, rooted in goodness and freedom, is deeply embedded in Adventist theology. In our understanding of the great controversy between good and evil, God brings the controversy to an end when all the evidence is in, i.e. when the universe is convinced of the goodness of God and his law. The alternative vision would simply emphasize God's power: a sovereign majesty arises in holiness and wrath to obliterate every trace of sin and sinners.

The Adventist, good news, free-will version of the conflict finds expression on the last page of Ellen White's *The Great Controversy*:

And the years of eternity, as they roll, will bring richer and still more glorious revelations of God and of Christ. As knowledge is progressive, so will love, reverence, and happiness increase. The more men learn of God, the greater will be their admiration of His character. As Jesus opens before them the riches of redemption, and the amazing achievements in the great controversy with Satan, the hearts of the ransomed thrill with more fervent devotion, and with more rapturous joy they sweep the harps of gold; and ten thousand times ten thousand and thousands of thousands of voices unite to swell the mighty chorus of praise....

The great controversy is ended. Sin and sinners are no more. The entire universe



is clean. One pulse of harmony and gladness beats through the vast creation. From Him who created all, flow life and light and gladness, throughout the realms of illimitable space. From the minutest atom to the greatest world, all things, animate and inanimate, in their unshadowed beauty and perfect joy, declare that God is love.<sup>116</sup>

#### The Four Tension Points: A Summary.

In summary form, these are the primary implications which I see as a result of my analysis of the four tension points within which Adventism must find its place:

A. Sociologically: Confront or Cooperate? If I could dream dreams for my church, I would like to see Adventism be a self-confident “mainstream sectarian” body. Sociologically, of course, that is impossible, even though that is what the New Testament tells us that is what we should be. I believe Adventism is right in moving away from confrontation toward the ideal of cooperation, though the dangers are very real: inappropriate compromise, loss of identity, apathy. The following Ellen White counsel to A. T. Jones I find intriguing, challenging, exciting.

The Lord wants His people to follow other methods than that of condemning wrong, even though the condemnation be just. He wants us to do something more than to hurl at our adversaries charges that only drive them further from the truth. The work which Christ came to do in our world was not to erect barriers and constantly thrust upon the people the fact that they were wrong.

He who expects to enlighten a deceived people must come near to them and labor for them in love. He must become a center of holy influence.

In the advocacy of the truth the bitterest opponents should be treated with respect and deference. Some will not respond to our efforts, but will make light of the gospel invitation. Others – even those whom we suppose to have passed the boundary of God's mercy – will be won to Christ. The very last work in the controversy may be the enlightenment of those who have not rejected light and evidence, but who have been in midnight darkness and have in ignorance worked against the truth. **Therefore treat every man as honest. Speak no word, do no deed, that will confirm any in unbelief.**<sup>117</sup>

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*The Great Controversy*, 678 (1911).

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B. Biologically: Ascetic Denial or Hedonistic Pleasure? I would be deeply troubled if Adventism simply capitulated to the hedonistic pleasure drives of our modern culture. But I am also troubled by the specter of a burdensome asceticism which I see haunting our Adventist forebears and many today in so-called "historic Adventist" circles. If, however, we can really absorb the meaning of God's gracious gifts to humankind, I believe a joyous simplicity is an attractive possibility. There are many good things in God's creation which we can fully enjoy. But our joy should be tempered by the knowledge that many, indeed most, in our world are caught in a world of pain, sorrow, and difficulty. If we follow Jesus, we will want to share with them some of our bounty.

C. Theologically: Human Freedom or Divine Sovereignty? My natural home is solidly on the side of free will. But in my old age, I am finding deeper meaning and real solace in what Scripture has to say about our sovereign God. If Adventism can preserve a proper balance within the community, then our scientists can move confidently ahead in their research, but in the full knowledge that we are merely human. God's grace has made us what we are. I find the CEV rendering of 1 Cor. 4:7 to be a helpful corrective to my natural impulses: "What is so special about you? What do you have that you were not given, and if it was given to you, how can you brag?"

D. Anthropologically: Individual or Community? The sectarian nature of Adventism has preserved an echo of tribal feeling among us. Sabbath and dietary habits have probably had much to do with this bonding as anything. Still, we are and will continue to be a community of choice, composed of individuals. It troubles me deeply when people leave Adventism for any reason. Surely there should be room in the family for them.

Emphasizing the positive and making room for diversity will help us as much as anything. If we really could treat people as we would want to be treated if we were in their place, that is, take Jesus' second great command very seriously, then Adventism would be one of the most unique communities on planet earth. I would like that kind of inclusive uniqueness. I believe that is what God's law is all about.

#### 4. Implications and Applications

Any attempt to speak about the future of Adventist health care, should be prefaced with the recognition of the profound gulf fixed between what Florida Hospital is doing today and any thing in the biblical world. An innkeeper caring for the Good Samaritan's robbery victim is perhaps the closest thing to hospital care in the New Testament. Even since the birth of Adventism the changes in health care have been dramatic. So implications should be drawn and applications made with a great deal of care.

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*Testimonies* 6:121-122 (1900).

Right up front we should admit that if Florida Hospital is to fulfill any mission at all, it must remain economically viable. Whether it is smaller or larger than it now is, is not a question I will address. But in the light of Jesus' holistic ministry and in the light of our Adventist heritage, the five points noted below are ones I would hope Florida Hospital will consider in its visioning process.

A. Treating People Right in a Mixed Secular and Religious Culture. An observation often overlooked by devout Christian believers is the scholarly suggestion that the secularization process is rooted in Scripture, especially in the Old Testament.<sup>118</sup> In a thorough-going traditional religious culture, the gods are untouchable. One does not question the divine. But in the Old Testament Abraham challenges God over his plans for Sodom and Moses challenges God over his intentions to destroy Israel at Sinai. And in the Old Testament, God repents more often than anyone else.

Ironically, secular cultures have often been more tolerant than religious ones. That is at least part of the reason why Adventists have been so eager to maintain the separation of church and state. While Adventists have not put very many people to death for religious reasons, we have been quite intolerant, even putting up billboards to attack those with whom we disagree.

In the trajectory within which I have placed Ellen White's experience, however, I have been intrigued with the link between her comment to A. T. Jones, cited above – "Treat every man as honest" – and a comment by Owen Chadwick in his *The Secularization of the European Mind in the 19<sup>th</sup> Century*. One of the signs that culture was indeed become more secularized, Chadwick says, was "the willingness of devout men to meet undevout men in society and to honour them for their sincerity instead of condemning them for their lack of faith."<sup>119</sup>

In short, thanks to the ministry of Ellen White, we have mediated to us in religious form, the secular ideal of treating people as honest. That fully accords with Jesus' second command, of course, but that is a command that devout conservatives have some difficulty remembering.

I have fewer worries on this point with Florida Hospital than I do with some other Adventists. Still, it is an ideal that we should always keep before us.

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. Cf. Peter Berger, *The Sacred Canopy* (Doubleday Anchor, 1969), 113: "We would maintain that the 'disenchantment of the world' begins in the Old Testament."

119

. Owen Chadwick, *The Secularization of the European Mind in the 19<sup>th</sup> Century* (Cambridge, 1975), 37.

B. The Needs of the Poor. The true extent of poverty in the world is mind-boggling. Should Florida Hospital be concerned about that? I believe so. Can it do something about it? Maybe. Perhaps through specially-funded projects and through political action. Our younger daughter and her husband live and work in Italy where a cycling colleague of theirs lost control of his bicycle, shattering his pelvis. The Italian health services provided him with an ambulance ride, a week in the hospital, and two operations for a total tab of \$1000. His employer, Nike, had insurance to cover the \$60,000 tab for returning him to the States by air ambulance. By contrast, when I went to our local Adventist hospital to get three stitches in a finger I had sliced with my garden clippers, the tab was \$750. Health care costs as much in Italy; it's simply funded differently.

C. Management Style. I suspect that the church itself may often do a worse job here than Florida Hospital. But wherever there are sinful humans, the challenge remains. Can we really treat others as we would want them to treat us if we were in their place? Imagine what would happen if in all Adventist institutions the management style was such the following ideal could be realized without fear of retribution. I think Jesus would be pleased:

The younger worker must not become so wrapped up in the ideas and opinions of the one in whose charge he is placed, that he will forfeit his individuality. He must not lose his identity in the one who is instructing him, so that he dare not exercise his own judgment, but does what he is told irrespective of his own understanding of what is right and wrong. It is his privilege to learn for himself of the great Teacher. If the one with whom he is working pursues a course which is not in harmony with a "Thus saith the Lord," let him not go to some outside party, but let him go to his superior in office, and lay the matter before him, freely expressing his mind. Thus the learner may be a blessing to the teacher. He must faithfully discharge his duty. God will not hold him guiltless if he connives at a wrong course of action, however great may be the influence or responsibility of the one taking the wrong course.<sup>120</sup>

D. Remuneration. I suspect that the egalitarian wage scale is gone forever. But if we are following Jesus, we should be aware of our responsibility to touch the lives of those in need. As I was writing this paper, a "Quotation of the Day" in the New York Times daily email caught my attention. A business consultant, commenting on large executive benefits, had noted that those who receive them typically have "no idea how much C.E.O.

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. *Gospel Workers*, 102-103.

perks anger other employees."<sup>121</sup>

From a Christian perspective, I have been intrigued by some of the advertisements from the highly regarded Calvin College in Grand Rapids, Michigan. In 1996 I saved one from *Christianity Today* which featured a 1977 graduate of theirs named Dirk Holkeboer. They entitled their ad, "The Joy of Downward Mobility," and in the text, they noted that he had accepted a job with Habitat for Humanity in 1988 for an annual salary of \$8,500. Remarkable.

Within Adventism, I am relieved that the Health Systems have pulled back from their fun-and-games advertisements attempting to lure graduates from Adventist Colleges to the good life. I am thankful that I don't have to be angry about that anymore. But it might be well for all of us to explore creative alternatives. Tony Campolo is full of suggestions. But whatever happens it must be voluntary. Management-mandated sharing is quite out of keeping with the spirit of Jesus.

E. Service to the Church. I am grateful that Florida Hospital is concerned about vision and passing on the heritage. Under this heading, I want to suggest that you reach out beyond your own specific interests to those involving the larger Adventist world. And you have already been doing that, so this is not intended as a criticism. All of us, including church leaders, can be powerfully tempted to follow self-serving worldly models in our work. It may be that the Health Systems can help call to account the church at large when it appears to be going astray.

Related to that concern is the need for thoughtful people to encourage the church to be more open and progressive. The very nature of religious institutions, especially those of a conservative bias, tempts their leaders to cut off initiative, eliminate diversity, and ignore change. All three of the Adventist scholars who have been invited to this conference have felt the heat from our church for attempting to explore our heritage in ways that are both creative and supportive. We are grateful to you for your support. And I pray that our contribution to this conference will enable you to continue to support those in the church who want to do more than simply support the status quo in their desire to follow Jesus.

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.New York Times "Quotation of the Day" for February 22, 2004, in "Daily Headlines" (email), quoting Sarah Teslik, executive director for the Council of Institutional Investors.

APPENDIX F

FREQUENCY DISTRIBUTION BY SURVEY QUESTION

Summary Frequencies of "Wholeness" by Segmented Groups

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown or Blank	M	SD
I understand Florida Hospital's concept of wholeness.	Employee	.8%	2.8%	4.5%	39.8%	51.9%	.2%	4.40	0.77
	Middle Mgmt	0	1.4%	3.3%	25.1%	69.8%	.4%	4.64	0.62
	Senior Level	0	0	4.9%	29.2%	65.9%	0	4.61	0.59
I believe in the importance of wholistic living and care.	Employee	.3%	.3%	4.7%	32.2%	62.2%	.3%	4.56	0.62
	Middle Mgmt	0	0	1.9%	18.1%	80.0%	0	4.78	0.46
	Senior Level	0	0	0	14.6%	85.4%	0	4.85	0.36
I engage in wholistic practices to keep my mind, body and spirit well.	Employee	.7%	2.3%	13.1%	48.4%	34.3%	1.2%	4.15	0.79
	Middle Mgmt	0	3.7%	8.4%	57.2%	30.7%	0	4.15	0.72
	Senior Level	0	0	9.8%	61.0%	29.2%	0	4.20	0.60
The caregivers at Florida Hospital practice wholistic care.	Employee	1.8%	10.3%	23.9%	47.9%	11.6%	4.5%	3.60	0.90
	Middle Mgmt	1.0%	12.1%	31.6%	43.7%	7.4%	4.2%	3.47	0.85
	Senior Level	0	12.2%	31.7%	48.8%	2.4%	4.9%	3.44	0.75
My entire health including my mind, body and spirit are nurtured at Florida Hospital.	Employee	5.3%	21.2%	20.9%	38.3%	14.1%	.2%	3.35	1.12
	Middle Mgmt	1.0%	15.8%	19.5%	48.8%	14.9%	0	3.61	0.96
	Senior Level	4.9%	21.9%	21.9%	41.5%	9.8%	0	3.29	1.08
I feel a sense of wholeness while working at Florida Hospital.	Employee	4.5%	15.6%	18.9%	45.3%	14.9%	.8%	3.51	1.07
	Middle Mgmt	0	9.3%	15.8%	53.0%	21.9%	0	3.87	0.86
	Senior Level	2.4%	4.9%	4.9%	65.9%	21.9%	0	4.00	0.84

*Summary Frequencies of "The Healing Ministry of Christ" by Segmented Groups*

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
I understand what it means to extend the healing ministry of Christ.	Employee	0	.8%	3.0%	32.2%	63.5%	.6%	4.59	0.59
	Middle Mgmt	0	0	0	24.7%	75.3%	0	4.75	0.43
	Senior Level	0	0	0	12.2%	87.8%	0	4.88	0.33
I believe that Christ provides an excellent model of compassionate care.	Employee	.3%	.5%	2.0%	15.6%	80.6%	1.0%	4.78	0.53
	Middle Mgmt	0	0	1.4%	8.4%	89.3%	.9%	4.89	0.36
	Senior Level	0	0	0	4.9%	95.1%	0	4.95	0.22
I extend the healing ministry of Christ.	Employee	.5%	1.5%	7.3%	38.5%	49.4%	2.8%	4.39	0.74
	Middle Mgmt	0	0	2.3%	41.4%	54.9%	1.4%	4.53	0.55
	Senior Level	0	0	2.4%	48.8%	48.8%	0	4.46	0.55
I utilize prayer at Florida Hospital to extend the healing ministry of Christ.	Employee	2.8%	8.8%	13.4%	37.8%	33.8%	3.6%	3.94	1.05
	Middle Mgmt	1.4%	5.1%	8.4%	36.3%	47.4%	1.4%	4.25	0.92
	Senior Level	0	2.4%	7.3%	26.8%	63.4%	0	4.51	0.75
I sense a spirit of love and grace at Florida Hospital.	Employee	4.3%	10.8%	20.7%	40.3%	23.4%	.6%	3.68	1.08
	Middle Mgmt	.5%	7.9%	15.8%	47.0%	28.4%	.5%	3.95	0.90
	Senior Level	0	2.4%	9.8%	58.5%	29.3%	0	4.15	0.69
I experience meaning from the mission of Florida Hospital.	Employee	3.8%	7.3%	17.1%	39.5%	31.0%	1.3%	3.88	1.06
	Middle Mgmt	.5%	2.3%	7.4%	38.6%	49.8%	1.4%	4.37	0.76
	Senior Level	0	0	4.9%	22.0%	73.2%	0	4.68	0.57



Summary Frequencies of "Health Principle - Benefits" by Segmented Groups

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
I understand the health benefits of a nutritious diet.	Employee	0	.5%	.8%	26.7%	72.0%	0	4.70	0.51
	Middle Mgmt	0	0	.5%	18.1%	81.4%	0	4.81	0.41
	Senior Level	0	0	0	9.8%	90.2%	0	4.90	0.30
I understand the health benefits of ample water consumption.	Employee	.3%	.3%	0	26.2%	73.3%	0	4.72	0.50
	Middle Mgmt	0	0	.9%	18.6%	80.5%	0	4.80	0.43
	Senior Level	0	0	2.4%	9.8%	87.8%	0	4.85	0.42
I understand the health benefits of regular exercise.	Employee	0	.3%	.3%	27.0%	72.3%	.3%	4.72	0.47
	Middle Mgmt	0	0	.5%	17.2%	82.3%	0	4.82	0.398
	Senior Level	0	0	0	7.3%	92.7%	0	4.93	0.26
I understand the health benefits of fresh air.	Employee	.3%	0	1.0%	26.4%	72.0%	.3%	4.71	0.51
	Middle Mgmt	0	0	.5%	19.1%	80.5%	0	4.80	0.41
	Senior Level	0	0	2.4%	7.3%	90.2%	0	4.88	0.40
I understand the health benefits of sufficient rest.	Employee	.3%	0	.3%	25.7%	73.6%	.3%	4.73	0.48
	Middle Mgmt	0	0	0	17.7%	80.9%	1.4%	4.82	0.38
	Senior Level	0	0	0	9.8%	90.2%	0	4.90	0.30
I understand the health benefits of appropriate use of sunlight.	Employee	.3%	.3%	2.0%	32.5%	63.2%	1.8%	4.61	0.57
	Middle Mgmt	0	.5%	1.9%	21.4%	75.8%	.5%	4.73	0.51
	Senior Level	0	0	7.3%	9.8%	78.0%	4.9%	4.74	0.60
I understand the health benefits of abstinence from harmful substances such as tobacco.	Employee	.3%	.5%	1.3%	19.4%	77.8%	.8%	4.75	0.52
	Middle Mgmt	0	0	1.4%	12.1%	86.0%	.5%	4.85	0.40
	Senior Level	0	0	0	4.9%	92.7%	2.4%	4.95	0.22
I understand the health benefits of trusting relationships.	Employee	0	0	1.76%	24.69%	71.54%	2.01%	4.71	0.49
	Middle Mgmt	0	0	1.4%	16.3%	80.0%	2.3%	4.81	0.43
	Senior Level	0	0	2.4%	12.2%	78.0%	7.3%	4.81	0.46

Summary Frequencies of "Health Principles - Practice" by Segmented Groups

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
I practice the health principle of a nutritious diet.	Employee	.3%	5.5%	9.1%	59.4%	25.2%	.5%	4.04	0.77
	Middle Mgmt	0	6.0%	10.2%	60.9%	22.3%	.5%	4.00	0.76
	Senior Level	0	2.4%	9.8%	61.0%	26.8%	0	4.12	0.68
I practice the health principle of ample water consumption.	Employee	.8%	8.8%	7.3%	43.8%	38.8%	.5%	4.12	0.94
	Middle Mgmt	0	11.6%	9.8%	48.8%	29.8%	0	3.97	0.93
	Senior Level	0	12.2%	9.8%	41.5%	34.1%	2.4%	4.00	0.99
I practice the health principle of regular exercise.	Employee	1.5%	17.9%	13.9%	45.6%	20.7%	.6%	3.66	1.05
	Middle Mgmt	2.3%	22.8%	17.7%	36.3%	20.9%	0	3.51	1.13
	Senior Level	0	19.5%	9.8%	41.5%	29.3%	0	3.81	1.08
I practice the health principle of fresh air.	Employee	0	4.3%	8.1%	48.4%	38.5%	.8%	4.22	0.77
	Middle Mgmt	0	6.0%	12.1%	49.8%	31.6%	.5%	4.08	0.83
	Senior Level	0	2.4%	9.8%	61.0%	26.8%	0	4.12	0.68
I practice the health principle of sufficient rest.	Employee	2.0%	15.1%	11.3%	46.6%	24.4%	.5%	3.77	1.05
	Middle Mgmt	.9%	20.5%	18.6%	42.3%	17.7%	0	3.55	1.04
	Senior Level	2.4%	31.7%	12.2%	43.9%	9.8%	0	3.27	1.10
I practice the health principle of appropriate use of sunlight.	Employee	1.0%	7.3%	9.1%	50.9%	31.2%	.5%	4.05	0.89
	Middle Mgmt	0	9.3%	14.4%	53.0%	23.3%	0	3.90	0.86
	Senior Level	2.4%	4.9%	9.8%	68.3%	14.6%	0	3.88	0.81
I practice the health principle of abstinence from harmful substances such as tobacco.	Employee	2.0%	3.5%	3.0%	15.6%	73.8%	2.0%	4.59	0.89
	Middle Mgmt	0	2.3%	1.4%	15.8%	79.5%	.9%	4.74	0.60
	Senior Level	0	2.4%	0	12.2%	85.4%	0	4.81	0.56
I practice the health principle of trusting relationships.	Employee	.5%	1.51%	5.79%	31.74%	59.70%	.75%	4.50	0.72
	Middle Mgmt	0	.5%	4.2%	33.5%	61.4%	.5%	4.57	0.60
	Senior Level	0	0	2.4%	34.1%	63.4%	0	4.61	0.54

Summary Frequencies of "Honor Seventh-day Adventist Beliefs" by Segmented Groups

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
Biblical teachings are cherished at Florida Hospital.	Employee	1.5%	6.3%	16.4%	43.8%	29.0%	3.0%	3.95	0.93
	Middle Mgmt	0	5.6%	15.3%	41.9%	36.7%	.5%	4.10	0.86
	Senior Level	0	0	7.3%	56.1%	36.6%	0	4.29	0.60
Saturday (Sabbath) is a special day at Florida Hospital.	Employee	4.3%	10.8%	17.1%	32.2%	33.0%	2.6%	3.81	1.15
	Middle Mgmt	1.9%	7.4%	21.9%	38.1%	29.8%	1.0%	3.87	0.99
	Senior Level	2.4%	9.8%	39.0%	24.4%	22.0%	2.4%	3.55	1.04
Christian principles are practiced at Florida Hospital.	Employee	2.8%	5.0%	18.9%	46.6%	26.2%	.6%	3.89	0.95
	Middle Mgmt	0	3.3%	14.0%	50.7%	32.1%	0	4.12	0.76
	Senior Level	0	2.4%	4.9%	53.7%	39.0%	0	4.29	0.68
I appreciate working for a faith based hospital.	Employee	1.5%	2.0%	10.3%	34.5%	50.6%	1.0%	4.32	0.86
	Middle Mgmt	0	.5%	3.3%	20.0%	76.3%	0	4.72	0.54
	Senior Level	0	0	0	4.9%	95.1%	0	4.95	0.22
I respect the Florida Hospital Seventh-day Adventist heritage.	Employee	.8%	.5%	6.5%	41.1%	50.1%	1.1%	4.41	0.71
	Middle Mgmt	0	.5%	2.3%	22.3%	74.0%	1.0%	4.71	0.53
	Senior Level	0	0	0	7.3%	92.7%	0	4.93	0.26

*Summary Frequencies of "Image of God" by Segmented Groups*

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
I believe that every person is created in the image of God.	Employee	1.0%	.8%	4.5%	13.4%	79.1%	1.3%	4.71	0.68
	Middle Mgmt	0	1.9%	2.8%	10.2%	85.1%	0	4.79	0.58
	Senior Level	0	0	0	4.9%	95.1%	0	4.95	0.22
Every person at Florida Hospital is valued regardless of their race, gender, or ability to pay.	Employee	3.0%	9.3%	14.4%	25.9%	47.1%	.3%	4.05	1.12
	Middle Mgmt	0	7.9%	14.0%	30.2%	47.9%	0	4.18	0.95
	Senior Level	0	4.9%	14.6%	43.9%	36.6%	0	4.12	0.84
I treat others with respect because they are created in the image of God.	Employee	.5%	2.5%	2.5%	28.2%	64.5%	1.8%	4.56	0.72
	Middle Mgmt	0	.5%	2.3%	26.0%	69.3%	1.9%	4.67	0.55
	Senior Level	0	0	2.4%	24.4%	73.2%	0	4.71	0.51
The staff at Florida Hospital treats every individual as a child of God.	Employee	3.3%	11.8%	27.0%	34.5%	22.2%	1.3%	3.61	1.062
	Middle Mgmt	.5%	15.3%	32.1%	38.1%	14.0%	0	3.50	0.932
	Senior Level	0	9.8%	17.1%	48.8%	22.0%	2.4%	3.85	0.893
I feel respected at Florida Hospital as a child of God.	Employee	3.8%	7.6%	18.6%	41.1%	27.5%	1.6%	3.82	1.04
	Middle Mgmt	0	3.7%	13.0%	52.6%	29.3%	1.4%	4.09	0.76
	Senior Level	0	4.9%	2.4%	58.5%	34.1%	0	4.22	0.73

Summary Frequencies of "Community" by Segmented Groups

Question	Population	(1.) Strongly Disagree	(2.) Disagree	(3.) Undecided	(4.) Agree	(5.) Strongly Agree	(N/A) Unknown	M	SD
I believe that Florida Hospital has a positive relationship with the community.	Employee	.3%	1.0%	5.5%	45.1%	47.6%	.5%	4.40	0.67
	Middle Mgmt	0	0	2.3%	48.4%	49.3%	0	4.47	0.55
	Senior Level	0	2.4%	4.9%	46.3%	46.3%	0	4.37	0.70
Florida Hospital is very interested in the health status of the community.	Employee	.5%	.8%	7.3%	45.8%	44.3%	1.3%	4.34	0.69
	Middle Mgmt	0	1.4%	9.3%	38.6%	50.2%	.5%	4.38	0.71
	Senior Level	0	2.4%	9.8%	61.0%	26.8%	0	4.12	0.68
I am personally engaged in community activities on behalf of Florida Hospital.	Employee	5.3%	22.2%	15.6%	33.2%	17.1%	6.6%	3.37	1.19
	Middle Mgmt	.5%	13.0%	9.8%	43.3%	32.6%	1.0%	3.95	1.00
	Senior Level	0	2.4%	14.6%	41.5%	39.0%	2.4%	4.20	0.79
I am involved with activities that improve the health status of the community.	Employee	3.3%	18.4%	12.8%	41.1%	17.9%	6.6%	3.56	1.11
	Middle Mgmt	.9%	14.4%	13.0%	43.7%	27.0%	.9%	3.82	1.02
	Senior Level	0	4.9%	12.2%	58.5%	22.0%	2.4%	4.00	0.75
I feel a sense of belonging at Florida Hospital.	Employee	2.5%	6.3%	18.6%	42.8%	28.7%	1.1%	3.90	0.98
	Middle Mgmt	0	2.3%	7.9%	43.7%	46.0%	0	4.34	0.72
	Senior Level	0	2.4%	4.9%	41.5%	51.2%	0	4.42	0.71
I feel that it is important for Florida Hospital to be actively involved in the community.	Employee	0	.3%	3.0%	29.0%	67.3%	.6%	4.64	0.55
	Middle Mgmt	0	0	0	16.7%	82.8%	.5%	4.83	0.38
	Senior Level	0	0	0	12.2%	85.4%	2.4%	4.88	0.34

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