

From Separation to Integration: The Odyssey of the Seventh-day Adventist Hospital System in the US

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The Adventist prophet, Ellen White, had a comprehensive health vision in 1863, from which she concluded that there was an intimate relationship between physical and spiritual health. Her subsequent writing on this subject greatly influenced church leaders, who within three years opened the first Adventist health-related center, "for the care of the sick and to give instruction re the preventative and restorative properties of such neglected elements as exercise, nutrition, sanitation, fresh air, fresh water and sunshine" (Wisbey 1992:13). It rejected medicine as then practised, especially the use of drugs.

From this beginning grew Battle Creek Sanitarium, which, under the leadership of John Harvey Kellogg, the inventor of cornflakes and peanut butter, attracted the famous and wealthy to water treatments, massage, and vegetarian food. Ellen White dubbed the Adventist medical work "the right arm of the message" and "the entering wedge." Since patients typically stayed at the Sanitarium health resorts for several weeks during the latter nineteenth century, this allowed time for the devoted Adventist staff to minister spiritually as well as physically to patients.

Sanitariums multiplied across the US during these decades, all still typically serving the well-to-do rather than, for example, the indigent chronically ill, who were the focus of most Catholic hospitals. To staff the growing empire, Kellogg founded first a nursing school and then a medical school at Battle Creek. These also provided "medical missionaries" to staff the growing array of mission hospitals that were being founded on the other continents. By 1901 Adventists were operating 75 sanitariums and mission hospitals.

The "sans" provided employment for members, encouraging their education and upward mobility because of the positions there that needed to be filled. They fostered lively churches and quality schools, which were usually built on their grounds. These in turn attracted more Adventists to settle in what often became "Adventist ghettos" surrounding the hospitals. These institutional churches, with their many professional members, often provided a hefty portion of their local conference's budget.

Both the mission of the Adventist hospital system and its medical radicalism and separation from the medical establishment have changed dramatically over time. Although both the mission and the clientele of Adventist sanitariums were initially very different from those of other church-operated hospitals, both Catholic and Protestant, in the nineteenth century, the trajectory followed has become ever closer to theirs. This trajectory has become ever closer to theirs. This trajectory also strongly mirrors - and has helped shape - the changes in the relationship of the Adventist Church to society, as the tension between the two has declined and it has moved from sect towards denomination (Stark and Bainbridge 1985:23; Lawson 1995, 1996a, 1996b, 1996c, 1998).

Research Methods

The research reported here is part of a large study of Seventh-day Adventism, which has included well over 3,000 in-depth interviews with church administrators, teachers, hospital administrators and medical personnel, pastors, students, and leading laypersons in 59 countries in all 13 divisions of the world church.

The US has received special attention because Adventism originated here, the headquarters are located here, the leaders, most of the missionaries, and the bulk of the funds have come from here, and the membership here has become extraordinarily pluralistic both racially and ethnically and also in terms of social class and variations in belief and behavior.

For data from the past I have drawn extensively from an array of general and specialized histories of North American Adventism, many of which have been written by members of the history departments of Adventist colleges. However, historians typically stop short of the present. I took opportunities to complete oral history interviews in order to fill in relevant gaps. I also drew on church publications - official statistics, books, and articles in periodicals - as sources of data.

I have interviewed extensively in the US. One focus was administrators, including those at the headquarters of the General Conference and North American Division, each of the eight union conferences, and 27 of the 50 local conferences. Many of these interviews dealt in part with issues covered in this paper. The same was true of some of the interviews completed at the 13 Adventist universities and colleges and at some of the congregations and schools - especially those attached to hospitals. However, most of the data utilized in this paper were drawn from interviews at hospitals and healthcare corporate headquarters, which were concentrated in two periods, thus unintentionally providing data from before and after the recent dramatic changes. The first wave of interviews was in 1984-85, when I completed interviews at the former national healthcare corporate headquarters, the regional headquarters, and 16 hospitals. The second wave was completed in 1997-98, by which time the changes had been so great that I felt it was imperative to update data before writing this paper. At this time I conducted interviews at all the main regional headquarters and at 10 key hospitals. I had also followed the changes during the intervening period of turmoil through intermittent interviews.

For the initial wave of interviews in 1984-85, I prepared separate interview schedules for different categories of interviewees, including one for hospital administrators. The in-depth interview format allowed me to interpolate follow-up questions that emerged from my interaction with an interviewee and to take advantage of his/her specialized knowledge as appropriate. The later interviews were more specialized, as I sought out respondents who were familiar with the change decisions and their impact. I prepared special interview schedules for these, often tailoring them individually to fit the focus of the interview.

In order to keep the confidentiality of interviewees, as was promised them, the convention adopted in this study is to refrain from citing the names of interviewees when they are quoted except when they are major figures in the church whose identity cannot be hidden.

Early Changes

Early in the twentieth century, Kellogg, the Battle Creek "San", and Kellogg's medical school were separated from the Adventist Church as a result of a conflict between Kellogg, on the one hand, and Ellen White and the church leadership on the other, over whether the medical "right arm" would come to dominate the church body. Having affirmed the centrality of the church organization at great cost, the church leadership demonstrated its resilience by founding a new medical school at Loma Linda, in southern California.

However, the growing organization of medicine and education in society forced the new medical school to seek accreditation around the time of World War I. This, in turn, forced the Adventist colleges, the medical school's feeder schools, to seek accreditation also, for an accredited medical school could accept students from only accredited colleges.

As changes in the organization of medicine continued, reimbursement from medical insurance became increasingly important and tied to acute care. This reorganization, plus the impact of the Great Depression on the ability and willingness of people to personally finance long stays at sanitariums, caused the supply of patients for the latter to dry up. Consequently, the Adventist sanitariums were forced to switch to the provision of acute care in order to remain financially viable. This switch was reflected in the changing names of the institutions, which typically moved over time from "sanitarium" to "sanitarium and hospital" to "hospital" or "medical center."

Meanwhile, the curriculum of the Adventist medical school became more medically orthodox. Its graduates gradually became less likely to become overseas missionaries, and instead followed medical careers in the US. This too was reflected in a name change, as what had been the "College of Medical Evangelists" became "Loma Linda University" in 1961.

That is, the mission of the Adventist hospital system had already changed considerably and it had lost much of its uniqueness.

Consolidation, Expansion and Crisis In The 1980s

Initially, most Adventist medical institutions were managed by clergy, who were paid denominational "sacrificial" salaries. Each institution was typically linked to the church structure at the level of the local conference, which appointed its board of trustees.

However, as medical institutions in the US entered an era of profit and expansion, Adventists joined in. Hospital managers became professionals, with MBAs, who then sought professional salaries: it was argued that the hospitals must have professional leadership if they were to compete and survive, and that if they were to retain their skilled managers, who were necessary for them to face the competition, they must offer competitive salaries. The church leadership accepted this argument with jealousy and bitterness; however, by this time the hospitals were entirely self-supporting.

The need to compete also encouraged organizational consolidation and linking, so that the hospitals were now linked to the second level of the Adventist organizational structure, the union conferences, of which there are eight in the US. The unions where hospitals were more sparse gradually joined together in hospital management.

There was considerable empire building during the early 1980s. The new regional corporate headquarters expanded their holdings through buying additional hospitals and taking over the management of others; they also added retirement communities and nursing homes.

Finally, a new national administrative layer, Adventist Health Systems US [AHS-US], was added at the apex of the organizational structure. It was claimed that through coordinated buying this would lower costs and achieve other economies of scale, but it was never able to wrest control from the regional headquarters. Nevertheless, Adventists now boasted that theirs was the largest Not for Profit hospital system in the US. Even though this was only the case because the Catholic hospitals had not formed a

single system, it gave Adventist administrators considerable satisfaction to claim that their empire building had taken them to such a position of prominence.

It was just at this time that experimental surgery at the Loma Linda University Medical Center hit the headlines, when a heart surgeon implanted the heart of a baboon into an infant, "Baby Fae," who otherwise had no hope of survival. Even though controversy swirled, especially after the infant died, the university hospital's strength in infant heart surgery had been demonstrated, and it went on to establish an eminent position in that field.

However, the rapid expansion of the Adventist system had spread thinner the Adventist employees available, so that the proportion of the Adventist staff in the Adventist hospitals fell sharply. While this was true across the system, the Adventist presence was especially low in the newly acquired and managed hospitals. Not only would the expansion have been too rapid for Adventists to fill the positions at the best of times, but the problem was exacerbated because of the trends among the graduates of Adventist colleges, who were no longer restricting themselves to the traditional church-related careers or to church employment. Moreover, since the hospitals were increasingly attempting to cement ties to their local communities, which provided their patients, they increasingly hired from those pools also. They also added non-Adventist notables from their communities to their boards of trustees. It was only the top management positions that were restricted to Adventists, just as these positions were the last bastions of Catholic sisters in Catholic hospitals. But here too the rapid expansion had had the effect of spreading skilled managers thin.

In the mid-1980s the Adventist hospital system was suddenly threatened by a financial crisis that was rooted in overexpansion and mismanagement. Several of the regions had invested heavily in nursing homes and retirement communities, but now found that demand for these was growing much less than they had been led to expect, so that these were causing a huge financial hemorrhage and were in danger of bankruptcy; another region was threatened by a disastrous investment in imaging equipment.

Church leaders feared that the bankruptcy of any church institutions would sully the reputation of the Church. Since the boards of all the institutions in each union conference were appointed by the union, the hospitals in the effected regions (in the Midwest and North/Northeast) were therefore asked to take responsibility for the debts of the collapsing institutions in order to prevent bankruptcies while the latter were sold off at huge losses. However, the non-Adventist trustees on the board of the Kettering Medical Center in suburban Dayton, Ohio, took offense at this demand, and sued to prevent funds that had been raised in their community from being used elsewhere. Ultimately, in an out-of-court settlement, it was agreed that the Kettering Medical Center would not participate in the rescue of the losing institutions. That is, while church ownership of the hospital was affirmed as a result of the case, its degree of control was limited by it.

There was also, at this time, a great fear of ascending liability among church leaders - that because the hospital system was church-owned, if it faltered financially the church headquarters building and other church-owned real estate, including local church buildings, since they too were owned by their conferences, could be seized. It was therefore decided to distance the hospitals from the church organization. Consequently, AHS-US was dismantled, leaving a group of autonomous regional corporations; moreover, in most regions, the union conference committee no longer appointed the hospital boards. Although the union president was usually a member of the board, the boards became self-perpetuating, and the formal influence of the union committees on their decisions was removed.

Although the hospital boards have to this point been at pains to demonstrate that the Adventist connection continues, it can no longer be guaranteed that this will continue into the future.

Meanwhile, the medical insurance companies were showing increased interest in cutting costs, and were pressuring hospitals to reduce the time patients spend in hospitals. This meant not only that the latter spent much less time as inpatients, but also that the average patient was much sicker than in earlier years. Chaplains found it more difficult to have meaningful conversations with them and to impact them spiritually.

The emphasis on professional management and empire building, and the shortened stays in hospital and decreased chance that patients would encounter Adventist staff whilst there, had the effect of blurring the mission of the Adventist hospitals. Many of the administrators, although formally Adventists, seemed to be primarily secular businessmen, formal ties to the Adventist Church were weakening, and it seemed as if the Adventist hospitals were proceeding towards total secularization, following the path of many of the hospitals founded by other denominations. Church notables -increasingly questioned their mission and raised questions concerning whether it would be better for the Adventist Church to abandon running hospitals.

The Impact of Managed Care During the 1990s

With the stampede towards Health Maintenance Organizations [HMOs] and managed care in the US during the 1990s, hospitals were often forced to form partnerships with others, so that together they might offer a full range of services and compete successfully for the vital HMO contracts. Meanwhile, the competition for contracts forced further cuts in costs, less inpatient time (so that there was less time to show caring to patients and fewer opportunities for personal contacts with them, and much more outpatient and at-home treatment).

The threats by church leaders during the 1980s to pull out of running hospitals were repeated at the highest level by Robert Folkenberg after his election as president of the General Conference in 1990, when he wondered aloud to what extent the hospitals furthered the Adventist mission, asking whether it would not be better to sell the hospitals and put the money instead into education. The General Conference had no direct control over any of these institutions except for Loma Linda University, and the Church had consciously allowed the formal ties at the union level to atrophy; moreover, it was doubtful if government authorities would allow the Adventist Church to take the money, which had mostly accrued from the local communities and government programs, and run. Nevertheless, the bold criticism of the head of the Adventist church had such symbolic power that it was taken very seriously. The result was a series of six rather strained annual conferences in Naples, Florida, between top hospital and church leaders.

The growing formal independence of the hospitals and the earlier criticisms by church leaders had in fact already raised the question of in what ways Adventist hospitals differ from the for-profit hospitals which dominate the market today. This spurred the Sunbelt corporate headquarters, which runs the hospitals in the Southern and Southwestern Unions, to sponsor a series of conferences re-examining their mission. These decided that their mission was to offer quality healthcare in a context of special caring. This focus was thus generically Christian rather than peculiarly Adventist in thrust, and it underlined the extent to which Adventist hospitals had lost their uniqueness. In sharp contrast to the focus of the Adventist Church, the hospitals did not emphasize proselytizing. Such a goal would have been bad for business and, given that the proportion of Adventist staff in patient contact positions was now typically less than 20%, and

much lower in the newly added hospitals, it would also have been impracticable. Indeed, in order to offer "special caring," Adventist hospitals are relying on attracting to their staff non-Adventist Christians who enjoy showing care, even praying with patients, which the hospitals encourage, when given the opportunity. However, the pressure to cut costs is having the effect of making the nursing staff more busy, and so leaving them less time to show special care to the patients. It is thus increasing the threat to the key remaining aspect of mission.

Almost every managerial position continues to be held by an Adventist, and these seem to be more committed to the Adventist Church and the spiritual mission of the hospitals as they have defined it than were their predecessors in the mid-1980s. This new commitment has several roots: the threat of the church to pull out of hospitals and the questioning of the commitment of the hospitals to mission, especially in a context of waning formal control by the Church, have led to a burgeoning determination, at least among the current generation of corporate managers, to demonstrate their commitment; moreover, mission statements are fashionable today in the corporate world, where it is believed that having a sense of mission pays off. Consequently, the hospitals, which were previously plain and devoid of symbols, with little to indicate to a visitor that he/she was in a church-run hospital, are increasingly hanging religious paintings, photographs, and slogans in their corridors. They are also changing their names to include the word "Adventist," so that their connection to the Adventist Church is clearer.

Meanwhile, church leaders have also gained a new appreciation of the Adventist hospitals. Recent surveys show that Adventism is much better known and positively regarded in cities with Adventist hospitals than in matching cities without them. This was especially noticeable in the wake of the -negative media publicity Adventists received from the Branch Davidian crisis in Waco, Texas (Lawson 1995): those familiar with Adventist hospitals were much less prone to place a "cult" label on Adventists. Church leaders have also realized that the Adventist hospitals interact with more non-Adventists than any other Adventist program. They may regret the absence of a strong Adventist content to such contacts, but they do realize that the reputations of the hospitals for quality and compassionate care create a positive image.

Although it is reported that Catholic hospitals would rather close than perform abortions, there is little sign that Adventist hospitals have drawn a line in the sand over any peculiar belief. The diet offered patients was originally completely vegetarian, but once most of the doctors serving the hospitals were non-Adventists, and some of these demanded meat for patients, the hospitals compromised. However, they continued for many years to make a point of serving only meatless dishes in their cafeterias. Recently, however, some hospitals have begun to compromise on this issue also. Similarly, Saturday, the Adventist Sabbath, used to be a quiet day in these hospitals, with only emergency surgery performed, little physical therapy, the business office closed, and reduced staff. However, HMOs have no patience with extra days in hospital in order to accommodate religious practices, so that once again there have been compromises. Elective surgery on the Sabbath is now defended by management on the basis that Jesus seems to have made a point of healing on the Sabbath, and that he did not restrict such healings to medical emergencies. However, the Adventists in the pews are confused by news of such changes.

Managed care is switching the focus of the US medical system from caring for the sick to maintaining wellness. Ironically, this change has propelled Adventist hospitals to some of the themes embraced earlier by their sanitariums. They are often grasping this opportunity with enthusiasm, and are setting out to show that they have special interests and skills in this area. A striking example is at the community of Celebration, near Orlando, where Disney, the sponsor, has set out to create a model of what a successful

twenty-first century community can be. There was considerable competition from the major hospital chains to win the contract to plan and run the medical center there. However, the contract was won by Florida Hospital, the largest of all the Adventist hospitals, which is located in Orlando. The new facility places considerable emphasis on maintaining wellness: there is a full gymnasium, lectures and programs aimed at helping people maintain health, etc., all of which are open to all residents of Celebration, in the same complex as hospital wards. The sponsor insisted that the gymnasium be open seven days per week, thus including the Sabbath; it an effort to lessen disquiet among Adventist laypersons, the hospital management opted to to contract its operation out to a non-Adventist company.

The pressure from HMOs to form partnerships in order to compete for contracts and to help reduce costs was especially great where Adventist hospitals were isolated, for there they could not link with one another. A few have not been able to survive this competition, and have been sold or closed. An excellent example of the issues at stake was seen in the case of New England Memorial Hospital, in suburban Boston, which had been formed originally as the New England Sanitarium. The debts here were too great for it to find a Not for Profit partner, for it needed an infusion of cash as it teetered on the brink of bankruptcy. Fearful of losing not only the hospital, but also the church building and school that shared the site, as is so often the case with the long-term Adventist hospitals, the management agreed to an 80% buyout by a For Profit corporation. Its small continuing interest allowed it to insert protections of the church and school and of its right to continue to control the chaplaincy services into the contract. In contrast, Adventist hospitals have proved much more resilient where they are concentrated, as on the West coast and in the South and Southwest. Here the regional systems have taken advantage of the pressures felt by other hospitals to expand their holdings while remaining in managerial control.

In the battle to survive, some highly unexpected partnerships have been formed by more isolated hospitals. In 1995, PorterCare Adventist Health Services, an Adventist system in Colorado consisting of three hospitals, and the larger Catholic Sisters of Charity Health Services Colorado joined together to form a new corporation, Centura Health, in order that both could survive in an increasingly competitive market. This shocked many Adventist laypersons, for Adventist eschatology expects persecution in the US from a church-state alliance led by the Catholic Church. However, Adventist officials involved in this decision argued that Adventist hospitals had more in common with Catholic hospitals than any others because both had religiously shaped missions. All my interviews there indicated that the -partnership is proceeding smoothly, even though the Catholic majority holding gives them the right to choose the corporation's president and a majority on the board (interviews). Similarly, an Adventist hospital in Kansas City joined a corporation dominated by a group of Episcopal hospitals.

As the pendulum has swung from inpatients to outpatients and home-care, and from care of the sick to promotion of wellness, the Adventist hospitals have ended their isolation and are becoming increasingly involved in their communities. Administrators are now expected to immerse themselves in the communities served by their hospitals, and play prominent roles in such organizations as the United Way, the Coalition for the Homeless, substance abuse centers, etc. The hospitals are also entering into partnerships with community groups, often churches, where they have trained them and helped establish parish nursing programs. Some of them have also launched programs reaching out to the underserved, which was not a focus in earlier years. However, this is still not a major concern. When I asked one Colorado hospital administrator about the cultural differences between the Sisters of Charity hospitals and the Adventist hospitals, he commented that while the Catholics retained their traditional concern for

the poor, the Adventists had traditionally served the better off, and their hospitals had functioned as a vehicle for the upward mobility of those employed there.

Nevertheless, the Adventist hospitals are much more involved in their local communities than are the typical Adventist congregations, for they have the added incentive that such involvement has become necessary to their survival and success. In their turn, the congregations often express dismay about the failure of the hospitals to spread the distinctive Adventist message.

A major hospital document, "Our Mission into the Next Century," speaks of creating close ties to communities, of being active with the needy, of forming partnerships of those who are not against Adventists, of thinking differently about "the world," etc. It notes that such thrusts are different from what Adventists have often practised and suggests that in adopting such an approach Adventist healthcare can have a positive impact on the Adventist Church at large (). At this point these changes are so recent that they have yet to make such an impact on many congregations.

Conclusion

The early radicalism and isolation of the sanitariums, when the medical work was "the right arm of the Adventist message," has passed. The Adventist hospitals have become very similar to others, molded by financial reimbursement systems, fashion, and their wish to survive amid the competition, and thus to preserve the careers of the hospital administrators. In the mid-1980s, when I completed my first wave of interviews, I concluded that the Adventist hospitals had set out on a course that would result -ultimately in secularization and separation from the Adventist Church. However, even though the legal ties to the Church have loosened since then, and the peculiarly Adventist standards have been compromised further, there is today a greater sense of connection to the Church and commitment to mission as it has been newly defined. In part this is because mission has become fashionable since it is believed that it helps build consumer commitment. In part it is because the HMO-engineered switch from acute care to preserving wellness makes Adventist hospital managers feel that this is their day - even though market forces are responsible for having returned them to their roots. As Adventism moves from sect towards denomination, from isolation from society towards integration with it, its hospitals have again assumed the bellwether role, helping to lead the Church along this trajectory.

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