ABSTRACT

Title of Dissertation: "THE VOICE OF DUTY IS THE VOICE OF GOD": THE SPATIAL MANIFESTATION OF THE RELIGIOUS DUTY OF HEALTH IN SEVENTH-DAY ADVENTISM

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The Seventh-day Adventists are a millennial Christian denomination that traces its lineage to the Millerites of the mid-nineteenth century. Among the various theological differences espoused by Adventism is a predilection towards healthful living and providing healthcare services to those in need; a religious duty of health. This research studies the intersection of religious behavior, health, and space within Adventism. A content analysis of the writings of Ellen G. White, a particularly important voice in the creation of Adventism, demonstrates that healthful practice is a religious duty. This religious duty towards health can be categorized as both an individual and an institutional duty; adherents themselves have duties towards health, as well Adventist institutions have duties of healthcare provision.

To understand how religious duty interacts with space, a model of spatialization of duty is constructed. Extending upon Lefebvre's spatial triad, religious duty is theorized to meet with an individual's agency of belief within a filter of space. Religious duty therefore manifests spatially through the construction of a dutyscape, or a landscape spatially constructed around duty. The terms *religious space* and *sacred space* are defined to clarify difference. Religious space is social space that establishes a connection between the physical and metaphysical realms, while sacred space is personal space in which the connection between the physical and metaphysical is experienced. Both types of space can manifest through a filter of space as dutyscapes.

Adventist spaces of healing are assessed in the context of existing therapeutic landscapes literature and the model of the construction of dutyscapes. This research shows that the Adventist institutional duties of health manifest as a worldwide dutyscape of hospitals. Additionally, a content analysis of YouTube videos published by Adventist healthcare institutions, in conjunction with a narrative interview with an employee of Adventist HealthCare, demonstrates that these religious duties are still current to Adventist spaces of health. The spatial manifestation of these religious duties make Adventist hospitals religious spaces, and give the potential to create sacred spaces when individuals experience a connection with the metaphysical within the constructed spaces of care.

“THE VOICE OF DUTY IS THE VOICE OF GOD”: THE SPATIAL MANIFESTATION OF THE RELIGIOUS DUTY OF HEALTH IN SEVENTH-DAY ADVENTISM

By

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Dissertation submitted to the Faculty of the Graduate School of the
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Dedication

For Kathryn,

With respect and admiration

With compassion and empathy

With faith and love

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Chapter 1: Introduction

Nux vomica, strychnine: No antidote

The Sabbath was beginning, and prayer was needed. Group prayer would help the believers usher in the Sabbath, and give good fortune for the tent revivals planned in the upcoming days. On carriages pulled by horses, the group of believers traveled roughly thirty miles from the village of Battle Creek to the village of Otsego, Michigan. It was 1863; it would be in the decades following in which the kindred of these believers would be involved in making Battle Creek become "Cereal City" with the invention of flakes of cereal grains. Travel can be hard on all, but especially the Whites; both James and Ellen suffered at this time of many maladies. Perhaps it was the stress of carrying this religious movement that weighed on Ellen, as her fainting spells, common among her myriad lifelong ailments, came at a daily pace. Perhaps the same stresses fell upon the shoulders of James, wearying his body and his faculties to the edge of their breaking. But their support of their brethren at the tent revival was needed. At least the Hilliard's were hospitable hosts.

The group prayed, but Ellen would not be long for praying this Friday evening. Ellen left the reality of this world, temporarily. While her fainting spells were more common, these ephemeral gifts of prophetic visions were less so. Ellen's body remained in Otsego, but her mind was receiving a message from heaven. She had been receiving visions for her entire adult life by this point. But this was different. She was receiving a vision about the religious duty of health.

In her vision, she was presented a branch from a tree. Written onto the branch were the words *Nux vomica*, *strychnine* and *No antidote*. She was shown what happens

to people that use this substance. Even at small doses, even with the intention of curing some ailment, it is a poison and as poisons do, it destroys the body. In her vision, she saw that it was not strychnine alone that was destructive. Be they stimulants or depressants, opium, mercury, calomel, quinine, tobacco, alcohol, coffee and tea among others were shown to be against what was heavenly. All may give the user a jolt, a quick start, or a temporary alleviation of suffering, but all leave the body in a worse place that it was. These were not cures; rather, these substances brought about more suffering by not allowing the body to overcome illness naturally. They were against the Laws of God.

Ellen was reminded in her vision that each human's body is a temple of God, wholly owned by him. Each person must keep the body temple clean in order to honor God. We keep the body temple pure by following God's laws of nature. Her vision showed the many gifts that God has given that can cleanse the temple, and the many things to avoid sullying the body temple with. Drugs, stimulants, flesh meats, and dingy living conditions poison the blood and weaken the constitution. There is a path towards health; a path of temperance in all things, a path in union with nature, a path towards pure religion. God has given the bright disinfecting power of sunlight. God has given pure, pleasant air. God has given fresh, soft, clean water. God has given healthful, nutritious foods. Ellen saw that these were the gifts.

Ellen left the metaphysical world and rejoined her body. Previous visions had been much easier to disseminate to her friends, family, and brethren. She had read the Bible and was familiar with the word. But this vision was different. So much of this vision seemed to be against the common sense of the times. Prescribing such levels of temperance might fly in the face of the many Christians that felt that religion did not lie

within the tobacco they smoked, the alcohol they drank, or the flesh they ate. She was no doctor; how could she make sense of the medical issues at play in order to make a sensible, Biblically-correct account of the teachings of her visionary gift? Ellen was reticent to speak much of this vision at first. But once coaxed out of her, this vision helped form core tenets of a religion practiced around the world, directly affecting tens of millions more non-adherents through the creation of spaces of healing and health.

Who is Ellen White and who are her brethren?

Overview of research

Over the next six chapters, this dissertation will show how religious duty, health, and space intersect using the Christian denomination of Seventh-day Adventism as the ecumenical and theological center of research. While this nexus of connection (Figure 1) is grounded in Adventism, it is possible to use similar methods to understand other religious duties of other sects. It may also prove fruitful to apply the model of spatialization created in Chapter 4, the construction of a *dutyscape*, to other religions and their specific duties. While no other religions besides Adventism were used within this research, the author believes that the model provided will have uses beyond health and Adventism. The spatialization of the Adventist

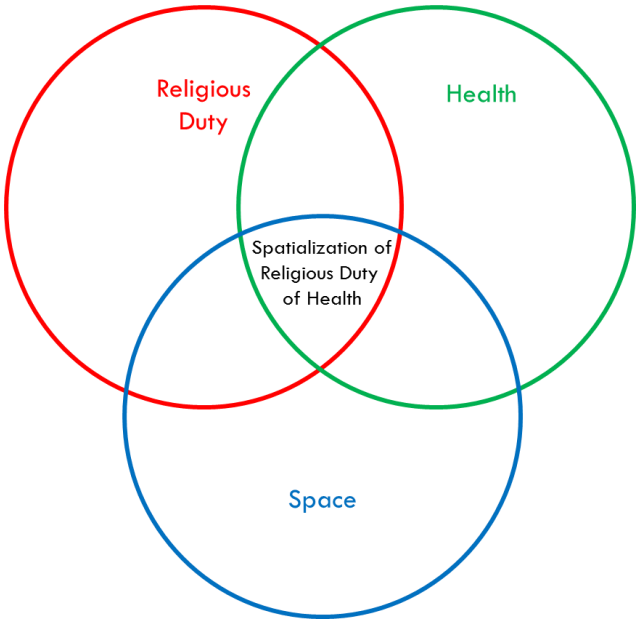

Figure 1 - Conceptual model of the spatialization of religious duty of health

religious duty of health, however, is the milieu of the following six chapters.

Chapter 2 provides an overview of the Seventh-day Adventist denomination. Historically, Adventism is born of the Second Great Awakening that stoked the fires of religious revivalism in the mid-nineteenth century in the northern portion of the United States. Adventism coalesced after the Great Disappointment, when Jesus did not return to Earth at a predicted time, by giving religious meaning to His nonappearance. One of the prominent people that grew early Adventism was Ellen White, a woman that suffered various maladies through much of her life but devoted herself to Biblical study and to writing volumes on the tenets of Adventism, often through the aid of divinely-inspired visions. Adventism developed many theological tenets that separate this movement from others in Christendom; among these tenets was an emphasis in healthful living. Many of the health movements within Adventism are Biblically inspired; others were fads, fashions, and trends of the time that were glommed to this Adventist predilection towards the care of one's body as if it was a temple of God. Adventism is evangelical and proselytizing in nature, and the methods of healthful living were heavily used in recruiting new adherents, often through the provision of medically-sound healthcare in official spaces such as dispensaries, clinics, and hospitals.

Chapter 3 outlines the research questions and methodologies used in the subsequent analysis chapters. Adventism is rife with books, biographies, and histories regarding their denomination – Ellen White herself wrote hundreds of thousands of pages in her lifetime in the forms such as books, periodicals, manuscripts, and pamphlets. While it is not feasible for this research to assess everything written by every Adventist historian, what has been reviewed has shown that spatiality of Adventism has been given

short shrift. Chapter 3 provides the methodologies used to understand the religious duty of health in Adventism and to spatialize the duty. Three research questions, each with individual data and methods, are outlined in Chapter 3. These research questions are intended to build upon the effort at developing a nexus of religious duty, health, and space in Seventh-day Adventism.

Chapter 4 represents the first analysis chapter of the dissertation. This chapter reviews literature on how sociocultural practices spatialize. This review brings together social theorists from many disciplines and perspectives. As the cultural practice being spatialized in this dissertation is religious duty, the review of literature particularly investigates what scholars of religion have to say about space, and what scholars of space (geographers) have to say about religiosity. While this research project does not come from a sacred spaces paradigm directly, literature on that special case of spatial manifestation is interrogated and used in the formulation of a model. The literature points towards a model of spatialization that fits well, but not perfectly, into the parameters necessary to see religious duty spatialize; that is Lefebvre's spatial triad. The triad is built to avoid directionalities of influence which are paramount to the understanding of the power structures inherent to religious duty and belief. Therefore, the spatial triad is extended and reconfigured as a filter of space in the construction of a *dutyscape*. The dutyscape model is then assessed with various spaces commonly found in Adventist hospitals.

Chapter 5 returns more specifically to Adventism, albeit from a historical perspective. This second analysis chapter demonstrates that there is an emphasized religious duty of health found within Adventism. Through a content analysis of the

writings of Ellen White, Chapter 5 establishes that she often spoke of a 'duty' for Adventists to live within the parameters of certain healthful living standards. This duty is religious in nature; many of her mentionings of 'duty' are modified by words like 'sacred' and 'religious.' Ellen White's writings are central to the Adventist faith system. While they are not placed on the level of the Bible, what Ellen White wrote and said has carried much weight for more than a century within Adventist theology. With the content analysis, it is shown in Chapter 5 that Ellen White discussed nine different categories of health-related duties, which can then be narrowed into two major types of duties; individual and institutional. The institutional duty – a duty of religion that is put upon the organizations within a religion rather than individual adherents – is a concept that is investigated more fully in Chapter 6.

Chapter 6 engages institutional duty from a therapeutic landscapes perspective, answering that this religious duty creates a *dutyscape* within thereapeutic and/or health spaces in Adventism. Chapter 6 melds the previous two analysis chapters by relating the model of the spatialization of duty with the specific Adventist duty of health. This analysis is done using current views within Adventism, rather than the largely historical vantage of Chapter 5. This current prevalence of health-as-duty within Adventist spaces of healing is assessed using both an interview subject and a content analysis of YouTube videos posted by various Adventist health organizations. These data points show that a duty towards health is still present and create religious spaces within Adventist hospitals. Institutional duties are further found, accenting those that Ellen White wrote about. Beyond these duties, codes about the religious spaces created and the religious nature of the work of the institution are found and described. In addition the duty, tied to a

missionary zeal, has manifested in a worldwide dutyscape of Adventist hospitals, each tasked with institutional duties.

Chapter 7 concludes the research by outlining six findings from the previous three analysis chapters. These six findings represent the major output of this dissertation research, aimed at understanding the connection between religious duty, health, and space within the Adventist context.

Chapter 2: The history and health message of Seventh-day Adventism

Seventh-day Adventism is a branch of Protestantism developed in the United States in the mid-nineteenth century. Rising from the evangelical fire of the Second Great Awakening, Seventh-day Adventism integrated a more literal reading of the Bible with a millennial zeal. One peculiar tenet of Seventh-day Adventism that separates it from many other religious organizations is the emphasis of healthful living and using curative means to espouse their religious truths. While there are a great many religious organizations that create spaces of health, the history and meaning of the Adventist health message implies a deep connection in the ordinary lives of Adventists between faith and the adherence to God's laws of healthful living. This chapter provides a brief outline of the history of the Adventist church, and how the health message came to have such a prominent place in Adventist theology.

The Millerite movement

The Second Great Awakening

The Second Great Awakening was a Protestant movement in America in which traveling preachers, meetings, pamphlets and tent revivals were used to enthuse crowds and sweep a wave of revivalism over parts of New England and the Mid Atlantic (Gaustad and Schmidt 2002). The camp meetings of the Second Great Awakening were rife with "simple, lively, and persuasive preaching", "common folk turning to evangelical faith often with untamed emotion" and "cooperation between a variety of denominations" (Hatch 1983). The fires of revivalism burnt so intensely in Upstate New York that Charles G. Finney referred to the region as a "burnt district", which developed into the

cognomen of the Burned-over District (Johnson 1983). During this time, many new sects and denominations of Protestantism were born. While most of these sects did not last long, there are a few denominations born of these years in the early to mid-1800s that still exist today. A branch of Protestantism, called Millennialism, is the source of Seventh-day Adventism, preaching that Christ would return to earth soon to usher in the Kingdom of God (Gaustad and Schmidt 2002).

Seventh-day Adventism traces its lineage to the Millerite movement, named after preacher William Miller (Plantak 1998). Miller, pictured in Figure 2 (Loma Linda University Photo Archive n.d.), a native of Low Hampton, New York (Theobald 1985) preached during the Second Great Awakening. In reading the Bible, Miller recognized the Bible passage Daniel 8:13-17 to seemingly state when Jesus would return to earth (London 2009). The passage mentioned a time frame of "two thousand and three hundred days; then shall the sanctuary be cleansed," which Miller interpreted as the time remaining before the Second Coming of Christ, also known as Christ's Second Advent. Miller assumed that each 'day' mentioned in prophecy was actually one year, and that the 2300 year countdown began in 457 BCE with Artaxerxes of Persia proclaimed that Jerusalem would be rebuilt (Numbers 1992). With this as a basis, and using other Biblical timelines and histories, he calculated that the Second Coming of Christ would occur in 1843. Miller kept his revelation to himself until he began preaching in 1831, giving him only 12 years to spread his message, which generally occurred in upstate New York and New England (Bull 1989; Numbers 1992; London 2009).

By 1842, there were nearly 50,000 Christians following Miller's prophecies, coming from established denominations such as the Methodists, Congregationalists, Presbyterians, and Baptists (Gaustad and Schmidt 2002; London 2009). Millerites were encouraged to stay within their natural congregations, as Miller himself was not trying to birth a new denomination; however the power of his message led mainline Protestant denominations to feel he was a threat (Vance 1999). Miller was, however, fighting against the hegemony of the clergy in biblical interpretation of prophecy, wanting people to do their own Bible study (Hatch 1983). The unifying power of his message among Millerites from disparate congregations led to the inevitability of a new, separate sect. *The Midnight Cry,* preceded by *The Sign of the Times,* publicized by Joshua V. Himes had been established as the official newspaper that promoted the teachings and revivals of the Millerite movement. So important was Himes' hype that some credit him as being more important than Miller towards the establishment of Adventism in the decades following (Hatch 1983). The movement survived despite Christ not returning to earth in 1843, and multiple new dates for Christ's return were set, passed, and

Figure 2 - Picture of William Miller. Image from the Loma Linda University Photo Archive, n.d.

reassessed through the spring of 1844 (Vance 1999; Morgan 2001; London 2009). With the help of Samuel Snow's new mathematical calculation that Christ's Second Advent would occur during the seventh month of the Jewish liturgical calendar, instead of the first as it had been assumed, a specific date for the return of Christ was set. Christ would return on the tenth day of the seventh month of the Jewish liturgical calendar, which coincided with October 22, 1844 (Vance 1999; Morgan 2001; London 2009).

Preparing for the end times

In preparing for Christ's Second Advent, adherents either left their mainstream churches or were asked to leave (London 2009). As the Second Coming was occurring in the fall, many adherents ignored the fall harvest and shed themselves of possessions (Vance 1999; London 2009). Millerite business owners shuttered their stores. Accounts of Millerites wailing prostrate, sitting on rooftops staring at the sky, and wearing all-white ascension robes were made, but were probably at best overstated or at worst apocryphal (Vance 1999). The movement had grown much in the years preceding the expectant return of Christ, numbering some 100,000 fervent believers, and many more that were somewhat spiritually curious out the prophecy (Cross 1950).

October 22, 1844 came and passed without the Second Coming of Jesus, and they day became known as the "Great Disappointment". Followers of Miller were distraught with the non-occurrence of the Second Coming, which led adherents, and especially Millerite leaders like Miller himself, to be embarrassed and ridiculed publically. The Great Disappointment caused the Millerite followers to take stock in what occurred, and those that were unable or unwilling to return to their original churches separated into

many smaller groups (Morgan 2001). After the Great Disappointment, Hiram Edson (1806-1882) of Port Gibson, New York, spoke of the experience:

> Our fondest hopes and expectations were blasted, and such a spirit of weeping came over us as I never experience before. It seemed that the loss of all earthly friends could have been no comparison. We wept and wept until the day dawned (Gaustad and Schmidt 2002).

Edson, after leaving the gathering of adherents awaiting Christ's Second Advent, had a vision of a sanctuary in the heavens as he passed through a cornfield. This led to Adventists Franklin B. Hahn and O. R. L. Crozier to research the Bible to try to give Edson's vision context and meaning. Their research led to the conclusion that on or about October 22, 1844, Jesus entered the Holy of Holies; the heavenly sanctuary. From this point until the time that Jesus leaves the Holy of Holies, God is reviewing the records of all those living and dead for Judgment (Bull 1989; Vance 1999; London 2009). Judgment is closed when Jesus leaves the sanctuary and returns to Earth to gather His followers, reinforcing the Seventh-day Adventist belief in the literal Second Coming of Christ.

The foundation of Seventh-day Adventism

Coalescing a movement

Adventist groups were nebulous at best in the years following the Great Disappointment. Meetings of Millerites occurred after the Great Disappointment to determine what direction the movement would take. The Great Disappointment caused the Millerite followers to take stock in what occurred, and those that were unable or unwilling to return to their original churches separated into many smaller groups (Morgan 2001). Some adherents, however, worked to unify the incongruent Adventist groups

through the development of doctrinal pillars of belief. Among the largest were the Evangelical Adventist and the Advent Christian denominations, neither of which had staying power of unifying post-Millerites long-term (Numbers and Larson 1986). A small group, the Seventh-day Adventists, began to grow momentum as Joseph Bates (1792-1872), James Springer White (1821-1881) and Ellen Gould Harmon White (1827-1915) were the driving forces behind the unification of the movement, occurring in meetings in 1948 (Theobald 1985; Morgan 2001; London 2009). Bates and the Whites followed a more radical path outlined by Hahn and Crozier's research that gave meaning to October 22, 1844 by noting that something important had happened, only the movement had misunderstood what it was (Theobald 1985; Bull 1989; Vance 1999; Morgan 2001). The post-Millerites were already united in the belief in the literal Second Coming of Christ. Hohn and Crozier's research developed the Adventist belief in the sanctuary message, while Bates developed firm conviction in the need to fully observe the seventh-day Sabbath, which must occur from sunset on Friday until sunset on Saturday every week. The belief in observing the seventh-day Sabbath of Saturday is where the Seventh-day Adventists received their name; the group was first known as the Sabbatarian Adventists until the current name came about in 1860 (Theobald 1985). These two messages met at an Adventist conference with a meeting between Hiram Edson and Joseph Bates that led each to convince the other of their own message. James White, who experienced the Great Disappointment but kept faith in Adventism, married Ellen Gould Harmon in 1846. The Whites, pictured in Figure 3 (Loma Linda University Photo Archive n.d.), became convinced of Bates' Sabbath doctrine and joined him to work at uniting Sabbath-keeping Adventists. The unification of these various, and often

radical Millerite beliefs made the Seventh-day Adventists the strongest of the post-Millerite groups despite only drawing some one hundred adherents from the Millerite movement (Bull 1989).

Each of the three had a different role in promoting the newly-developed belief system of the Seventh-day Adventists. Bates, using his background as a preacher, became a traveling evangelist to spread the word of the Advent. James White, among other occupations, was a publisher and became the main publicist of many Adventists writings and publications. Ellen White, with her divinely inspired visions and writings, became the voice of the Adventists and worked to hone the finer points of Adventist theology. Ellen White's visions themselves were not revelation; instead of creating central tenants of belief, the "testimonies" were used to create consensus among those that did thorough Bible study in the aims of codifying the emerging beliefs (Morgan 2001). The visions and writings of Ellen White were to be considered the "lesser light" as compared to the "greater light" of the Bible, and exerted a great influence in doctrinal direction (Numbers and Larson 1986). Adventists saw her visions as inspired prophecies, and Ellen White denounced pseudo religions like mesmerism and spiritualism as Satanic (Numbers and Schoepflin 2014).

Figure 3 - Picture of James and Ellen White. Image from the Loma Linda University Photo Archive, n.d.

Ellen White's health before visions

Ellen Gould Harmon White's importance to the Seventh-day Adventists cannot be understated. Ellen Gould Harmon, and her twin sister Elizabeth, were born in Gorham, Maine on November 26, 1827. She was only nine or ten years old when a schoolmate of hers threw a rock that hit her in the face, putting her into a comatose state for three weeks and disfiguring her face, particularly her nose (Numbers 1983, 1992). Recovery from this incident was slow but it led her to make healthful living a goal of her life. As with many other health reformers of her time, including those that she would later work close with, an early life filled with sickness and other physical or mental maladies plagued her. Even after reaching maturity and marriage, it was remarked that she often had feinting spells, breathing difficulties, and other accidents, even into adulthood (Numbers and Larson 1986; Numbers 1992; Numbers and Schoepflin 2014).

Despite her lack of good health, Ellen, pictured in Figure 4 (Loma Linda University Photo Archive n.d.), would not seek the help of physicians for ailments afflicting her and her family as she seldom found relief through physicians the same way she did through prayer. As she wrote in 1849, "If any among us are sick, let us not dishonor God by applying to earthly physicians, but apply to the God of Israel" (Numbers and Larson 1986; Numbers 1992; Numbers and Schoepflin 2014). The pre-Adventist Millerites published rather little on the subject of health besides the occasional reports faith healings (Numbers and Larson 1986). By the 1850's, choosing prayer over the help of doctors was common among Adventists. In the early 1850's, however, Ellen began to reverse her judgment against the use of physicians. A republication of her work included

a deletion of the line quoted above (Numbers 1992; Numbers and Schoepflin 2014). In reshaping her views, Ellen stated that "[i]t is not a denial of faith to use such remedies as God has provided to alleviate pain and to aid nature in her work of restoration. It is no denial of faith to co-operate with God, and to place themselves in the condition most favorable to recovery." (White 1905). Prayer was to be an additional treatment but not the sole or primary treatment (Numbers and Larson 1986).

Ellen White's divine visions of health

Ellen White's gift of prophecy – the ability to receive divinely-inspired visions – guided her numerous writings. These visions and writings helped Ellen White become the most influential person in the beginning of the Adventist movement (Numbers 1992; Taylor and Carr 2009). The divinely-inspired visions started at age 17 (Numbers 1983); near the time she first met her future husband James White. Her visions guided many of the

Figure 4 - Picture of Ellen White. Image from the Loma Linda University Photo Archive, n.d.

theological tenets associated with early Adventism, but perhaps her most influential visions dealt with health, diet and temperance. Ellen White received two visions in the 1860s that helped shape the Seventh-day Adventist health program; the first was in Otsego, Michigan in the summer of 1863, and the other was two years later in Rochester, New York on Christmas Day. The visions spoke to Ellen to promote the salubrious use of water, fresh air, sunlight, physical activity, a sensible vegetarian diet and faith in God over drugs and medications (Nichol 1964).

The Otsego vision, in particular, galvanized Ellen White towards promoting health reform. On June 5th, 1863, the Whites were at Aaron Hilliard's home with another dozen Adventists. During a kneeling prayer, Ellen White fell into a vision (Numbers 1992). In describing her vision, she spoke of God wanting His followers to reject intemperance of all kinds, not only what one ingests but also in one's work. Overwork had deleterious effect upon health as did overindulgence of food, drink, and drugs. Ellen White wrote of the vision:

> I saw that when we tax our strength, overlabor, and weary ourselves much, then we take colds and at such times are in danger of diseases taking a dangerous form. We must not leave the care of ourselves for God to see to and to take care of that which He has left for us to watch and care for. It is not safe or pleasing to God to violate the laws of health and then ask Him to take care of our health and keep us from disease when we are living directly contrary to our prayers. I saw that it was a sacred duty to attend to our health, and arouse others to their duty, and yet not take the burden of their case upon us. Yet we have a duty to speak, to come out against intemperance of every kind--intemperance in working, in eating, in drinking, and in drugging--and then point them to God's great medicine, water, pure soft water, for diseases, for health, for cleanliness, and for a luxury.
>
> Ellen White – Manuscript release 283: Writings on health (1990)

The overarching thrust of the vision was that ill health came from violating God's laws of nature (Numbers 1992; Bull and Lockhart 2007). Natural cures were the only acceptable

way to gain health; in the vision, the Lord "specifically and graphically forbade the use of opium, mercury, calomel, quinine, and strychnine" (Numbers 1992).

Whereas the 1863 vision implored Adventists of the duty to both healthfully care for themselves and convince others to do so, the 1865 vision grounded the duty into action. During the 1865 vision, James White was staying at Dr. Jackson's Our Home in Dansville, New York. Dr. Jackson used "the water cure," known as hydropathy, as a restorative and curative method. James White at the time was suffering from severe illness, partially brought on by overwork in resettling the Adventist base to Battle Creek. The vision first relieved Ellen White of her worry over her husband, as she was shown that he would recover. The second part of the message was more important for the health movement of the Adventists going forward; Adventists must build and operate their own homes to care for the sick and weary. This would allow the membership "who wish to have health and strength that they may glorify God in their bodies and spirits which are his" (Numbers 1974). In other words, it allowed Adventists to use the water cure in a setting based strictly on Adventist theology (Numbers and Larson 1986). This vision showed that it was their duty as God's people to direct people "to God's great medicine, water, pure soft water, for diseases, for health, for cleanliness, and for luxury" (Numbers 1992).

Health reform movements

Influencers?

Ellen White's visions led to her writing a great deal about health. Though she claims that her writings on the subject of health are divinely-inspired, analysis has shown

a good deal of similarity between her writings and those of other health reformers of the time (Numbers 1983; Numbers and Larson 1986). In one case her husband and publisher James added a note in one addition of Appeal to Mothers to clarify that she had not read the works of authors such as Sylvester Graham, James C. Jackson, and Mary Gove Nichols among others, and instead that the content which was quite similar was developed through her visions (Numbers and Schoepflin 2014).

Hydropathy

In her search for God-given natural cures for ill health, Ellen White had become a disciple of Dr. James C. Jackson's hydropathic treatments for diphtheria and other ailments (Numbers 1992). Water-cures like hydropathy spread through the northeast United States in the 1840's; a time when many physicians used strong drugs and bloodletting as a means for cures (Monteith 1951). Medicines themselves were purported in Ellen White's teachings to be unable to cure ailments, and that only natural remedies such as pure water, sunshine, fresh air and simple food were able to fix the maladies that harmed people. The Whites spent time at Dr. Jackson's Our Home in Dansville, New York, inspiring Ellen to want to open her own healing center in Battle Creek (Numbers 1974, 1983). Ellen White shared the interest in hydropathy with Joshua V. Himes and other Adventists (Numbers and Larson 1986). This inspiration did not wane even after the Whites returned to Our Home in ill health and did not find the water-cure able to cure despite treatment over the course of many months (Numbers 1974).

Temperance in food and drink

Just as the use of physicians and worldly remedies was slow to take hold in the Adventist movement, temperance and a healthful diet was accepted slowly through the next years. Like many other religious movements of the time, a number of Millerites were proponents of the temperance movement as well (Numbers and Larson 1986; Numbers 1992). Temperance is one of the most prominent movements of health reform advocated by Ellen White and early Adventists. Ellen White implored her Adventist supporters to also support the efforts of the Woman's Christian Temperance Union (WCTU), which started in 1874 (Morgan 2014; Vance 2014). The WCTU promoted temperance legislation, which Ellen White agreed with and promoted in public speeches and writing (Morgan 2014). These reform movements at times predated the Adventist movement, and were not mainstreamed into the Adventist movement until the 1860s (Numbers and Larson 1986). For example Sylvester Graham, a Presbyterian evangelist and health reformer, preached about the derelictions effects of meats, stimulants, alcohol, and recurrent sexual intercourse (Numbers 1983). Graham, nicknamed "Bran-Bread Graham", pushed for Americans to find sustenance only in vegetables and pure water. Graham inspired Joseph Bates to beg off the consumption of tea, coffee, meat and rich foods. Slowly over time, Bates dropped the use of spirits, wine, cider, beer and tobacco from his diet. It was Bates that pushed much of the dietary reforms that would become commonplace among Seventh-day Adventists. In 1848, Ellen White received her first vision regarding dietary and healthful reform, which included abstinence from alcohol, coffee, tea, tobacco and other stimulants including pepper (Numbers 1992; Taylor and Carr 2009; Numbers and Schoepflin 2014). As was common among diet reformers of the

time, spices, dairy and meat products were seen to increase sexual desires and could cause consumers of those items to masturbate; a most unhealthful practice through the eyes of health reformers (Numbers and Larson 1986; Vance 1999; Numbers and Schoepflin 2014). The Whites pushed for the church to accept Old Testament dietary restrictions, such as a ban on eating pork. Ellen, despite a great love of eating meat and a few relapses, eventually was able to adhere to the Grahamite eating recommendations (Numbers 1983, 1992; Numbers and Schoepflin 2014).

Dress

Ellen White's influential 1863 Otsego vision did not only cover water, food, and temperance. The vision also spoke to the need for Adventist women to stop wearing the fashionable full-length dresses and instead wear skirts with pantaloons (Numbers 1983; Vance 2014). Other encourage changes to women's dress were the avoidance of suffocating corsets and long, heavy skirts that picked up filth from the ground (Nichol 1964). Some of Ellen White's divinely-inspired visions contradicted and her specifics for reform changed over time. She first claimed that God wanted dress hems to hit the ground, but later writings called for boot-length and finally "nine inches from the floor" (Numbers 1983). The reform dress put forward by Ellen White was notorious; Lauretta Kress, who with her future husband would become important doctors and medical missionaries in Adventism, promised herself as a child to never become an Adventist partially because of the reform dress (Kress and Kress 1932). Ellen White wrote that the reform dress should be worn because of a "sense of duty" as her visions showed that God wanted this style of dress for women (Vance 2014). This reform was perhaps the most

frustrating put forward by White (Numbers and Larson 1986). Stories of women being egged and ridiculed by boys when wearing the reform dress circulated (Vance 2014). Few followers fully adopted White's prescribed style, with perhaps even more holding it in outright "contempt", leading to a new, well-timed message from God to move away from that form of dress reform (Numbers 1983).

Regardless of this rejection, the issue of dress remains a part of the health message of Adventism. In following the true law of God, Adventists are advised to not fall into the influence of changing fashions. Adventists "have been called out from the world" and therefore should not blend with the fashions of the times (General Conference of Seventh-day Adventists 2005). Setting themselves aside from the world is a sacrifice necessary to avoid the extreme materialism of the current day (General Conference Ministerial Association 1988). It is emphasized that true Christians must avoid the gaudiness adornment of jewelry and cosmetics as a part of dress. Rather, clothes should demonstrate high moral virtue by being conservative in nature, modest, and healthful (General Conference Ministerial Association 1988; General Conference of Seventh-day Adventists 2005).

Sanitariums and medical education

The Western Health Reform Institute

Having ties to Western New York, the Whites set Rochester, New York as their home site in 1852. James set up a printing press and was soon printing numerous documents regarding Adventist beliefs. The Whites stayed in Rochester for three years before deciding to move, with printing press in tow, to Battle Creek, Michigan in 1855

(Numbers 1992; London 2009). By 1863, the Seventh-day Adventist church headquarters had followed the spiritual leadership of the Whites to Battle Creek (Morgan 2001).

The year 1866 brought the beginning of two important Adventist institutions; a monthly publication called *The Health Reformer* was started, and the Western Health Reform Institute, pictured in Figure 5 (Loma Linda University Photo Archive n.d.), was opened in Battle Creek, fulfilling Ellen White's vision for a place for Seventh-day Adventists (and others) to find their way back to good health (Numbers 1992; Morgan 2001). Ellen White described to the 1866 General Conference a vision that impressed upon her the need for the Adventist movement to provide a place of healing and health reform education. After successfully lobbying the delegates of the fourth General Conference in May (Monteith 1951), the Western Health Reform Institute was opened on September 5th, 1866 (Quevedo 2003). While the provision of health care and health reform was deemed vital to the Adventist mission, Ellen White also deftly pointed out that such services may help non-Adventists discover the 'truth' of their message through the curing of their ailments (Theobald 1985). The Institute was a rousing and immediate success in terms of hosting enough patients, but this led to an overcrowding of rooms and a desperate lack of qualified medical personnel, with only Horatio S. Lay serving as someone with a modicum of medical experience.

Figure 5 - Picture of the Western Health Reform Institute. Image from the Loma Linda University Photo Archive, n.d.

Lay both had an education in medicine and experience with hydropathic therapy favored by Ellen White (Loughborough 1905). Ellen was prodded by other people involved with the Institute to give testimony to the needs for rapid expansion, which she gave hesitantly for Ellen worried about the Institute growing too large too quickly. Despite the large new building being partially built, James White and directors of the Institute forced the building to be razed (Numbers 1992). Ellen was dismayed with the predilection of some at the Institute to take in amusements (such as board games like checkers) and to call people "Mister" or "Miss" instead of "Brother" and "Sister". Reform came as James took over as director, and while the Institute may have become purified to the White's liking, it was insolvent by the end of the 1860's (Numbers 1992).

The Institute, and the Seventh-day Adventist health reform movement was given a boost when America's foremost hydropathic practitioner, Dr. Russell Trall, began to write for the Adventist publication *The Health Reformer*. It would be Dr. Trall's teaching and influence that would allow a young Adventist to rise to become a renowned doctor; a doctor skilled and influential enough to save the insolvent Institute. That doctor was John Harvey Kellogg.

John Harvey Kellogg

A dearth of qualified doctors led the new Western Health Reform Institute to institute funding for medical school at the University of Michigan in Ann Arbor for three young men. Included was John Harvey Kellogg, a second-generation Adventist (Nichol 1964). Kellogg, pictured in Figure 6 (Loma Linda University Photo Archive n.d.), learned from Dr. Trall by working at his Hygeio-Therapeutic College in New Jersey.

After training at the Bellevue Hospital Medical College, Kellogg became the superintendent of the Western Health Reform Institute at age 24 (Quevedo 2003). He would serve in that capacity for 67 years (Numbers and Larson 1986). Kellogg, having the rare trait of Adventist medical professionals by being both versed in both Dr. Trall's hydropathy and orthodox medicine, was able to convince the Whites to turn the Institute into a respected scientific facility through the building of a large sanatorium in 1878 (Loughborough 1905; Numbers 1992; Taylor and Carr 2009).

Dr. Kellogg had to battle for this scientific update to the Adventist health message. At the time, the health message of Adventists included the complete condemnation of the use of drugs in medicine. While this may seem backwards in the modern view, this rejection of drugs had a basis in healthful truth. During this age, some of the more common drugs given in medicine were opium and strychnine. These dangerous compounds, rejected by Adventist health advocates, led to the avoidance of safer, more effective drugs. With Dr. Kellogg's guidance, Adventists began administering drugs when their effect was proven scientifically to conform to natural

Figure 6 - Picture of John Harvey Kellogg. Image from the Loma Linda University Photo Archive, n.d.

laws, such as in the case of penicillin (Nichol 1964). Dr. Kellogg's leadership created much improvement and growth in the facility over the last years of the 19th century. Renamed the Medical and Surgical Sanitarium, success continued until February 18, 1902, when a great fire destroyed the main sanitarium and hospital buildings. By good fortune, the "four hundred invalids and guests" were removed from the buildings by doctors and nurses without reports of serious injuries (Loughborough 1905).

Medical education and Kellogg's fall

Kellogg's reign over the institute had a share of successes and failures for the Adventist health movement. Kellogg needed properly trained doctors to work at the Institute. Promising Adventist medical students were sent study in a non-Adventist environment. This led to a level of unorthodoxy towards Adventist health beliefs among the new class of Adventist medical practitioners. To battle this trend, Adventist medical students shared a house together while attending the University of Michigan in order to maintain continuity of Adventist belief. Finding this arrangement still lacking, Kellogg founded the American Medical Missionary College in Battle Creek in 1895 to help educate doctors for Adventist health institutions (Quevedo 2003). Prior to the opening of the American Medical Missionary College, Dr. Kate Lindsay, one of the first female medical students at the University of Michigan and a staff member of the Sanitarium, pushed for the opening of a nursing school. The nursing school began with a three-month course in 1883, and became a full-fledged two-year program in 1884 (Monteith 1951). A picture of students of the College at the Battle Creek Sanitarium can be seen in Figure 7 (Loma Linda University Photo Archive n.d.).

Kellogg and the Adventist Church disagreed over both theology and how to run both the Institute and the medical school. Some of these battles boiled over after the 1902 fire. The board of the Sanitarium called for the reconstruction to consist of a single, smaller building. Kellogg instead had a large building, pictured as Figure 8 (Loma Linda University Photo Archive n.d.), inlaid with marble floors built (Quevedo 2003). Kellogg, by being a well-respected doctor, grew in influence and deviated from accepted Adventist doctrine (Numbers and Larson 1986). Kellogg had previously written articles in support of evolution and special creation, in opposition to accepted Adventist theology. Kellogg believed that religious truths and scientific truths should be confined to their respective spheres (Numbers 1998). The board of the Sanitarium and Adventist leadership would have battles with Kellogg as he insisted in running the Sanitarium as a place of science and not a place of theology. As the two most influential voices in Adventism, Kellogg and Ellen White disagreed over the true purpose of Adventist health-care facilities; Kellogg saw the mitigation of suffering as the primary goal, while Ellen White saw the facilities as a missionary component to increase the number of adherents (Numbers and Larson 1986; Numbers and Schoepflin 2014). Kellogg eventually got his wish of disentangling the Institute from the Church and was

Figure 7 – Picture of the American Medical Missionary College class of 1902. The class is posing at the Battle Creek Sanitarium laboratory. Image from the Loma Linda University Photo Archive, n.d.

disfellowshipped in 1907. Enrollment dwindled at the American Medical Missionary School, as Dr. Kellogg maintained control of the school rather than the denomination. The school closed 1910. Dr. Kellogg would run the Battle Creek Sanitarium until his death in 1943. In 1957, the Seventh-day Adventist church reacquired the sanitarium (Quevedo 2003).

Ellen White used the break from the Battle Creek Sanitarium as an opportunity to push for the removal of the General Conference from Battle Creek to "the Atlantic Coast or elsewhere" (Loughborough 1905). The decision was made to locate near Washington, and a tract of fifty acres in nearby Takoma Park was purchased in 1901 (Loughborough 1905; Numbers and Larson 1986; Vance 1999). Ellen White also insisted the church found another medical school and she pushed for it to be located in Southern California, where there was both a sizable Adventist population and ample inexpensive parcels of land. John Burden, who was the business manager for the Glendale Sanitarium near Los Angeles, California, found a deserted tourist hotel on a hill called Loma Linda near San Bernardino, listed for $40,000. Ellen White felt that the site was perfect for a new sanitarium, but the leadership of the local conference was diffident to spend. Eventually, Burden purchased the land himself, later being repaid by Adventist donations from across the country. The Loma Linda Sanitarium opened in 1905 and in 1906 the College of

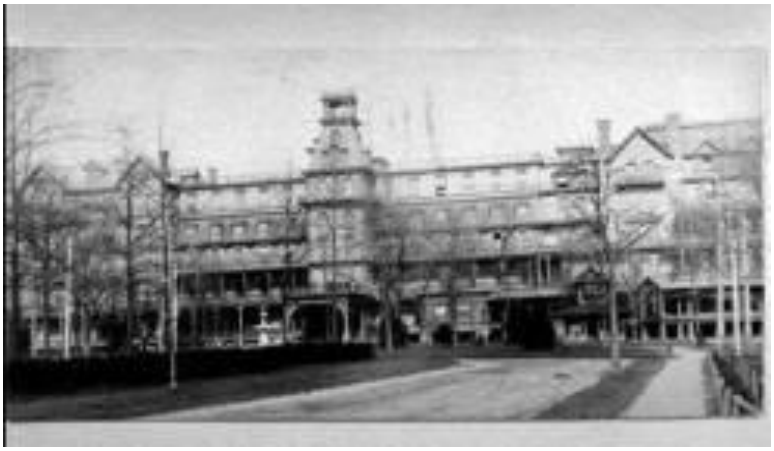

Figure 8 - Picture of the rebuilt Battle Creek Sanitarium. The Sanitarium was rebuilt after damage from a large fire in 1902. Image from the Loma Linda University Photo Archive, n.d.

Medical Evangelists followed, serving as the newest training center for Adventist medicine (Quevedo 2003). This allowed for "an orthodox educational center" for creating medical missionaries (Numbers and Larson 1986). Later named Loma Linda University, this medical school would be the primary training grounds for Adventist health care providers, both physicians and nurses.

Ellen White insisted that the training had to be to the standard needed to pass state competency boards (Nichol 1964). This served problematic at first, as the American Medical Association, looking to discredit some of the medical degree diploma mills across the country, gave the College of Medical Evangelists its lowest "C" rating in 1914. Faced with the possibility of losing students and faculty to the draft during World War I, the leadership of the College was able to procure a "B" rating, which not only made the students and faculty ineligible for the draft, but also gave graduates a better chance of placement in medical institutions. The College received the "A" rating in 1922 (Quevedo 2003). In the years after World War I, Adventists pushed to have as many of their colleges accredited as possible. In doing so, Adventist faculty were exposed to secular training from other accredited schools, which led to an increase in medical educational quality in Adventist schools and help build the "upward mobility of their graduates" (Lawson 1998b).

Health fundamental doctrines and modern predilections

The 28 Fundamental Beliefs

Over the years, the Seventh-day Adventist Church has formally outlined fundamental beliefs of the denomination. In 1872, Adventist faith was summarized in 25

separate parts. This was then updated to 28 beliefs and published in the *Seventh-day Adventist Yearbook* of 1889. Requests for better outlines for missionary efforts led to a more official committee within the General Conference to develop 22 fundamental beliefs, which were published in the *Yearbook of the Seventh-day Adventist Denomination* of 1931. These doctrines were updated as a summary of 27 paragraphs of belief in 1980 (General Conference Ministerial Association 1988). Subsequently, a 28th paragraph was added in 2005 (Seventh-day Adventist yearbook 2012). Of these, six address issues of health[1].

Belief 7 is "The Nature of Man." The accompanying paragraph describes humans as "indivisible unity of body, mind, and spirit." This is a common refrain through Adventism and emphasizes that the ability to receive the full word of God requires proper upkeep of the body and of mental faculties. A further explanation surrounds Paul speaking of "spirit, soul, and body be preserved blameless at the coming of our Lord Jesus Christ" (1 Thess. 5:23), in which the spirit is interpreted as the mind and the soul the emotions and feelings internal to a person. This order is seen as important for sanctification; sanctify the mind, which sanctifies the emotions and desires, which sanctifies the body in a healthful position necessary to receive Jesus' advent. Belief 11 is "Growing in Christ." Within the doctrinal paragraph ends by describing the transformation of "every moment and every task into a spiritual experience." As will be clarified in Chapter 5, Ellen White would describe even small tasks or duties as sacred to

[1] The paragraphs, included on the denominational website and in published yearbooks, are officially sanctioned by the General Conference. The organization has published 'unofficial' books that writes "in an expanded, readable, and practical manner, these doctrinal convictions and their significance for Adventist Christians in today's society." The book used as a reference in this research is based on the 27 fundamental beliefs. The newest addition, slotted as the 11th belief is "Growing in Christ", does have relevance in health but of course is not more fully expanded upon in the older book. The numbering of the beliefs in this paper reflects the newer 28-belief version.

both honoring God and to keep one's mind, body, and soul in conformity of God's laws of nature. Belief 17 is "Spiritual Gifts and Ministries." In this belief, it is shown that God gives everyone spiritual gifts and it is incumbent upon the believer to use these gifts as tools in ministry. "Healing" is listed as one of the spiritual gifts. Those given such gifts are to use the gift to "foster unity of the faith and knowledge of God" in spreading the Gospel through the ministry of their work. The work of ministry is not only for members of the clergy, but for the entirety of the church. This will apply to the important medical ministry work completed by Adventists. Belief 21 is "Stewardship." While Christian stewardship is often pointed towards the responsible use of earthly natural resources, in Adventism the body is also a possession of God that must be cared for. Adventists draw from the Bible passage "Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own? For you were bought at a price; therefore glorify God in your body and in your spirit, which are God's" (1 Cor. 6:19, 20) to connect Christian stewardship as necessitating caring for the body temple. The body, like earthly resources, are God's possession and the Christian is responsible over its proper care. Belief 23 is "Marriage and the Family." Further explanation elucidates on sex; a topic that Ellen White and other Adventists wrote about in works on health, but one that merits but passing message in this research. The family unit and the raising of children also is important, especially in educating the family on the laws of God as it comes to living healthily (General Conference Ministerial Association 1988).

The aforementioned fundamental beliefs give glancing blows at issues of health; in each of the beliefs, more focus is put upon other parts of spiritual life besides the

Adventist duty towards health. However, belief 22 on "Christian Behavior" is devoted in its near entirety to issues of health. The official paragraph is as follows:

> We are called to be a godly people who think, feel, and act in harmony with biblical principles in all aspects of personal and social life. For the Spirit to recreate in us the character of our Lord we involve ourselves only in those things that will produce Christlike purity, health, and joy in our lives. This means that our amusement and entertainment should meet the highest standards of Christian taste and beauty. While recognizing cultural differences, our dress is to be simple, modest, and neat, befitting those whose true beauty does not consist of outward adornment but in the imperishable ornament of a gentle and quiet spirit. It also means that because our bodies are the temples of the Holy Spirit, we are to care for them intelligently. Along with adequate exercise and rest, we are to adopt the most healthful diet possible and abstain from the unclean foods identified in the Scriptures. Since alcoholic beverages, tobacco, and the irresponsible use of drugs and narcotics are harmful to our bodies, we are to abstain from them as well. Instead, we are to engage in whatever brings our thoughts and bodies into the discipline of Christ, who desires our wholesomeness, joy, and goodness (General Conference Ministerial Association 1988)[2].

This belief pulls and unifies parts of the prior illustrated beliefs. Humans are composite of a trio of mind, soul, and body (belief 7), and the body is a temple to God (belief 21). God has created natural laws which have been designed to best allow humans to live a good Christian life. The lifestyle of the Christian is declared to be different from what is commonly done in order to better serve God. Behaviors alone do not lead to salvation; behaviors, actions, and works are "a natural fruit of salvation" (General Conference Ministerial Association 1988).

Adventists believe that God has bestowed many blessings to give humans the health of body, mind, and soul necessary to best accept His word. In *Seventh-day Adventists Believe…* (General Conference Ministerial Association 1988), eight blessings are elucidated to varying degrees of detail:

1. Exercise
2. Sunlight

[2] All 28 fundamental beliefs can be found in the Appendix of this document. This particular belief is so central to the theme of this research that it was included in its entirety in the body of the text.

3. Water
4. Fresh air
5. Temperate, drug-free, stimulant-free living
6. Rest
7. Nutritious food
8. Christian dress

The first four blessings are explained shortly and straightforwardly, and need little extra detail needed here[3]. The final four blessings delve more deeply into subsections. Tobacco, alcohol, and other drugs destroy the body; whether slowly like tobacco or in some cases quickly, this is a destruction of God's purchased possession. The blessing of rest delves mostly into recreation, and how many forms of media consumption can bring wickedness into the mind, body, and soul of a person. This not only applies to film and television, but even to music, reading, and other amusements that aid in breaking the moral fiber of the body of the church; included are gambling and dancing. In terms of food, it is outlined the God's original diet for people did not include any meat-based products; even animals declared as 'clean.' After the Flood, God gave permission to Noah to eat meat since all vegetation had been devastated under the great waters. In this section, Biblical explanations are put side-by-side with modern scientific studies showing the improved health effects of the vegetarian lifestyle. In Ellen White's time, the style of dress, particularly for women's fashion demanding items like corsets, had an impact on one's health and was a topic of relevance in White's writings on health. While the fundamental beliefs in this section do not address Ellen White directly, the influence is clear with calls for wearing simple, practical, and virtuous clothing. Heavy and

[3] The *Seventh-day Adventists Believe…* (General Conference Ministerial Association 1988) book is naturally peppered with references to Biblical verses as a means to show how these fundamental principles of belief are Biblically supported. Interestingly enough, the blessings of water and fresh air contain no Biblical references in their scant coverage, which lends credence to scholarship pointing towards health reform movements of the age as being in some aspects as influential as the Bible itself.

audacious adornment is not a pathway to His grace in Adventism (General Conference Ministerial Association 1988). The emphasis on living healthily is shown as a fundamental part of a religious Adventist life. That these ideas of healthful living are put side-by-side with other theological underpinnings of this Protestant Christian denomination clearly demarcates the importance of how one lives and how that symbolically demonstrates one's love of God and God's love.

Adventism and health in modern times

The health message remains current. To support the Adventist predilection towards healthy and vegetarian diets[4], many foodstuffs and food companies have been developed within the landscape of Adventist health. The most famous is Kellogg's, developed by William K. Kellogg in consultation with his brother John Harvey Kellogg, chief physician and leader of the Western Health Reform Institute of Battle Creek, Michigan (Numbers 1992; Parkview Adventist Medical Center 2004). The brother's Kellogg's first major product would become better known as Corn Flakes. Ellen White turned down an offer by the Kellogg's to allow the Adventists to own and distribute Corn Flakes, leading William Kellogg to make a fortune producing the product himself (Numbers and Larson 1986; Numbers 1992; Numbers and Schoepflin 2014). A trip down the grocery aisle serves as an introduction to a variety of Adventist-based health food companies, such as Morningstar Farms' line of meat replacements. While not denominationally controlled, Morningstar Farms, and its former parent company

[4] Numbers and Larson (1986) make an important note that the Adventist predilection for vegetarianism probably varies by culture and socioeconomic situation. There are a great many Adventists that live in regions of the world in which a diet with absolutely no meat may be difficult to maintain.

Worthington's, served the Adventist community and was largely operated by Adventists as it came to national prominence (Parkview Adventist Medical Center 2004; Byrd 2009). Foods coming out of the Adventist movement that became popular nationally and internationally included graham crackers, peanut butter, whole wheat cereal and bran (Nichol 1964).

Adventist hospitals have long served food in line with Adventist dietary teachings. As vegetarianism and healthful eating spread beyond niche communities, non-Adventist hospitals and organizations have asked foodservice directors of Adventist hospitals to share healthy, good-tasting vegetarian fare (Schuster 1989). This emphasis has even spread to the governance of the handful of places in which Adventists are a plurality population. Loma Linda, California – the home of the Adventist-operated Loma Linda University and Medical Center – in 2012 made news headlines as the heavily Adventist population of the city argued against the city council allowing McDonald's to open a restaurant inside the city (Karlinsky and Patria 2012; Willon 2012).

The spread of Adventism

Early missionary efforts

The Seventh-day Adventist church in its beginnings was composed of rural whites (Lawson 1998a). In the 1850s, early Adventist evangelists survived upon both charity from believers and through agricultural work, completed in the same rural New England and Midwest regions in which they were preaching (Theobald 1985). The Adventist community has spread widely, keeping Adventists in most places an under-the-radar minority, avoiding the notoriousness of groups such as the Mormons that came to become

dominant majorities in some places (Bull 1989). Freed blacks in the south of the United States were seen by many denominations as a ripe population for conversion. While mainline Protestant denominations like Baptists and Methodists had much success in recruiting blacks (Tinder 1983), Adventists also evangelized the American South in the 1890's, allowing many blacks to begin joining the ranks of adherents. The mixing of whites and blacks in congregations was problematic at times, leading Ellen White to endorse segregation based upon race to "temporarily" alleviate the issue (Lawson 1998a). To answer the calls from black congregations to be given the opportunity for administrative advancement, separate Local Conferences composed primarily of black congregations were created (Lawson 1998a, 1999). This should not be seen as a condemnation of Adventism. While in antebellum times slaves worshipped in white churches (in a segregated area), postbellum times led to separate churches, with black churches in the south being important social centers of community (Marsden 1983).

American sects of Christianity began foreign missionary work in the early 1800's through the "Benevolent Empire," a sobriquet for various agencies promoting Christian reforms such as temperance and abolitionism (Hatch 1983). Coming from the same milieu, Adventists promoted foreign missionary work within a few decades of their establishment. Adventist missionary work worldwide allowed foreign membership to grow in tandem with increased domestic adherence rates. After the death of James White in 1881, Ellen White began to live abroad where Seventh-day Adventist missionaries were located, primarily in white, Christian countries such as Switzerland, Australia, and New Zealand (Numbers and Larson 1986; Vance 1999). There, Ellen White saw

firsthand how prejudice against Seventh-day Adventists became rarer when their proselytizing was coupled with medical missionary work (Numbers 1992).

In the late 1800's and early 1900's, many American-based mainline Christian denominations were competing in overseas missionary work. Non-mainline denominations, such as Jehovah's Witnesses, Mormons, and Seventh-day Adventists also found much success overseas. Those three, in particular, were so successful in their expansive missionary works that a large proportion of each denomination's adherents can be found outside of the United States (Tinder 1983; Lawson and Cragun 2012). Research on the missionary efforts of these three denominations overseas found that higher rates of growth occurred in countries that were in the process of modernizing, while lower rates occurred in countries that were either highly modernized or pre-modernizing (Cragun and Lawson 2010). The denominations, for a variety of reasons, have differing geographic patterns; Adventists are more often in developing-world countries and rural landscapes, while Mormons and Witnesses are more commonly found in developed-world countries and in urbanized regions (Lawson and Cragun 2012).

Global expansion and migration to the United States

As early as 1909, the General Conference noted that while there was a 4% annual growth of members of the Church, the growth in America was only 1% (Theobald 1985). Many mainline denominations found the 1930s a difficult time for recruitment due to economic uncertainty and a more liberalized ministry. Adventism, with a fundamentalist slant, was able to increase the number of adherents by more than 60% between 1929 and 1941 (Wells and Woodbridge 1983). Figure 9 (Loma Linda University Photo Archive

n.d.) displays an example of evangelical flyers used by Adventist preachers and churches during this time, using Adventist fundamentalism as an advantage. Through the 1970s, denominations such as Presbyterian, Lutheran, Episcopal, and Methodist continued to drop in membership. More conservative denominations gained; Adventism saw growth of 3.2% per year (Wells and Woodbridge 1983). Figure 10 displays a small multiples map[5] showing the growth and spread of Adventism the contiguous United States from the late 1800's through 2010[6].

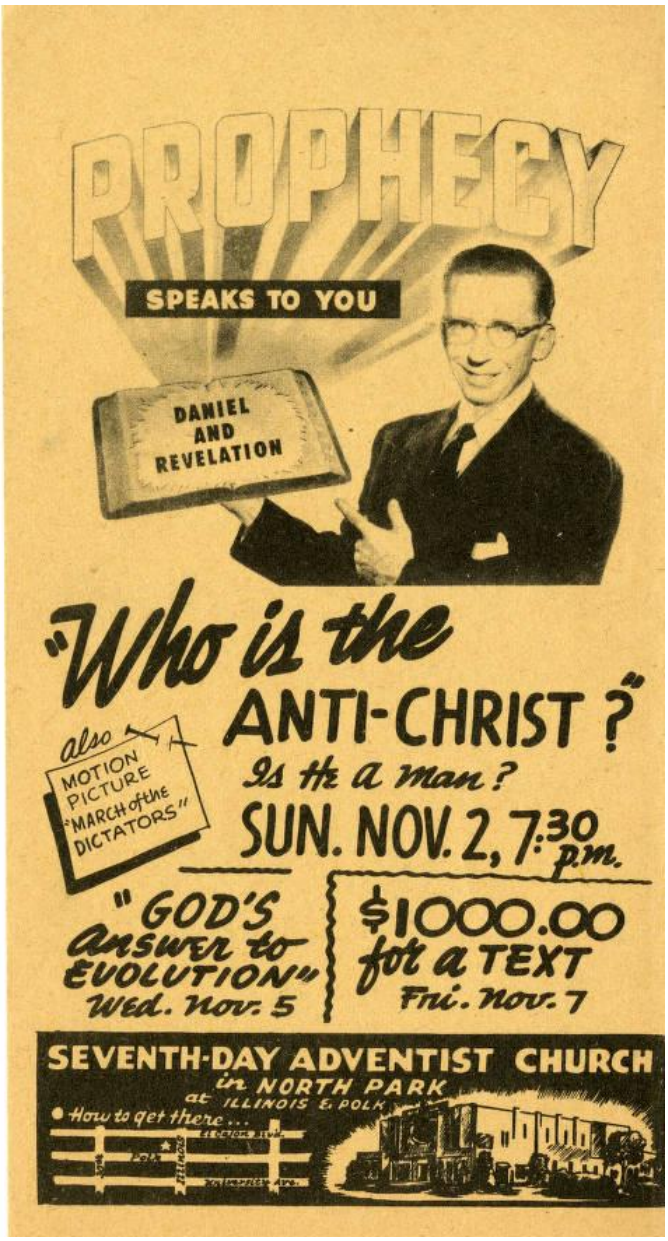

Figure 9 - An evangelical Adventist flyer. Flyers of this style represent the evangelical nature of Adventism. Image from the Loma Linda University Photo Archive, n.d.

The county-level data displays the number of adherents to Adventism per 1000 people. While there are most probably data

[5] Maps throughout this book were created using ArcGIS® software by Esri. ArcGIS® and ArcMap™ are the intellectual property of Esri and are used herein under license. Copyright © Esri. All rights reserved. For more information about Esri® software, please visit www.esri.com.

[6] Data on church membership comes from the US Bureau of the Census (1891, 1910, 1920, 1930, 1940); The National Council of Churches (1956); Johnson, Picard, and Quinn (1974); Quinn et al. (1982); Bradley et al. (1992); Jones et al. (2002); Grammich et al. (2012). Historical county shapefiles come from the Minnesota Population Center (2011).

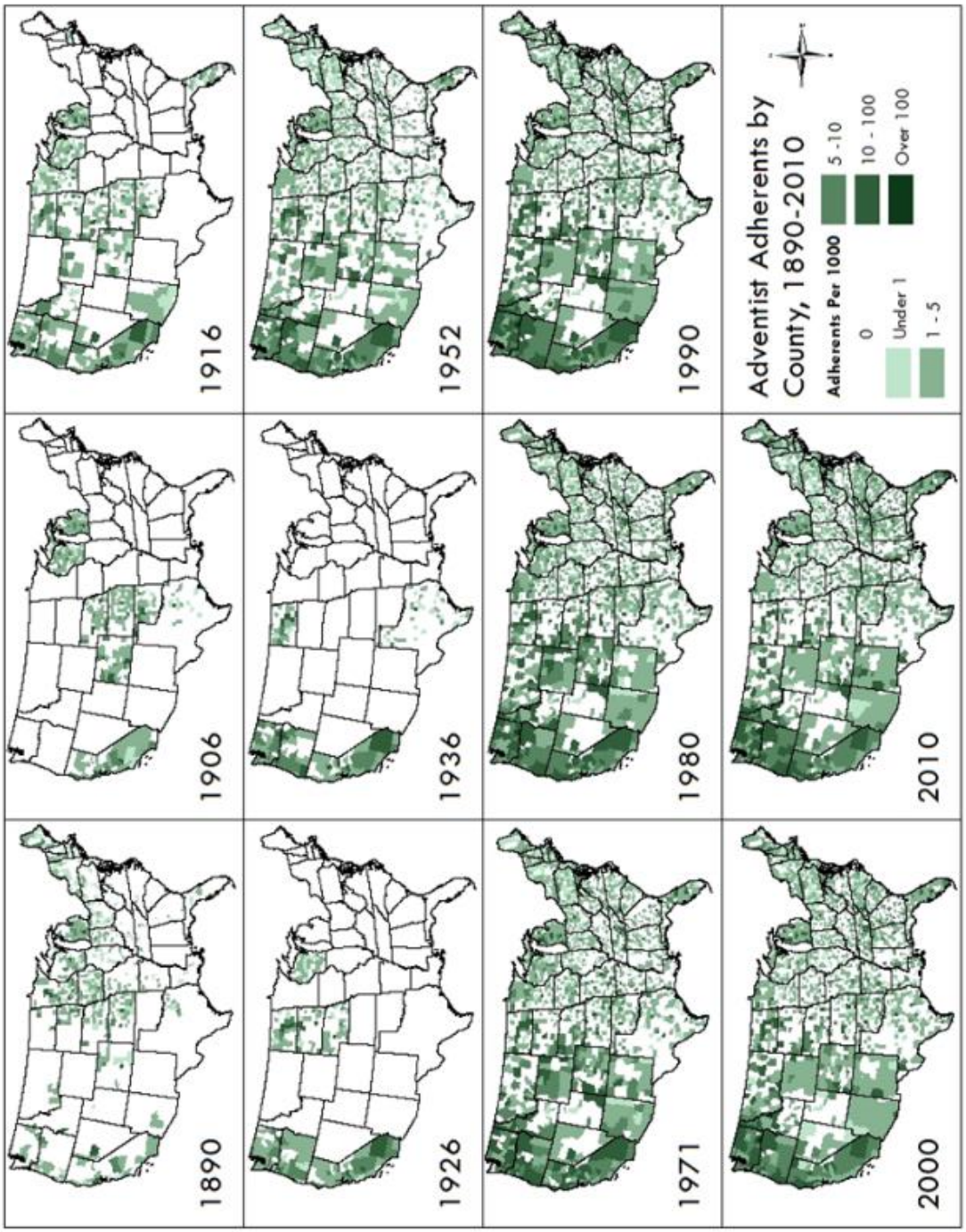

Figure 10 - Map of Adventist adherents by county, 1890 – 2010. This map uses small multiples to show the spread of Adventism by county across the United States through time. Each small multiple map uses a reference scale of 1:60,000,000. Map created by Nathan Burtch. Data for the number of adherents from the US Bureau of the Census (1891, 1910, 1920, 1930, 1940); The National Council of Churches (1956); Johnson, Picard, and Quinn (1974); Quinn et al. (1982); Bradley et al. (1992); Jones et al. (2002); Grammich et al. (2012). Historical county shapefiles come from the Minnesota Population Center (2011). State boundary shapefile source: ESRI, derived from Tele Atlas, and U.S. Census.

collection issues for the maps pre-WWII – with adherents completely disappearing from states only to reappear shortly thereafter – general migration trends can be seen. The movement was largely based in the Midwest and West Coast regions early on. Some missionary work occurred in the Southeast, particularly in Tennessee and North Carolina. In this century, the West Coast and parts of the Rocky Mountain West, along with Michigan and Florida, appear to have the most adherents.

While growth was negligible among long-term Americans, the missionary work overseas allowed Adventism to survive and grow in a post-Vietnam War era of religious loss in America. Adventists from Latin America and Asia began to migrate to the United States in large numbers. By the 1990's, 75% of new membership in the North American Division of the Seventh-day Adventist Church came from people migrating from developing countries (Lawson 1998a, 1999). Growth among American-born white and black populations slowed in the United States, and in some places turned negative (Lawson 1998a). The influx of migrants was especially prevalent in urban areas, where the character of Adventism has been turning from white and black to a mixture including individuals from Latin America and Asia. This trend is seen in the Washington, DC metropolitan region; Figure 11 displays a map of all Seventh-day Adventist churches in the region, symbolized by the language spoken in the church. While English-speaking churches are the plurality, they are not the majority within the region. A large percentage of churches in the region are Spanish-speaking, with larger numbers naturally located in suburban locales with higher levels of Latino/a immigration.

Hispanic Adventist populations in particular tend to be more sectarian than most American Adventists (Lawson 1999). Hispanic Adventists are more likely to be labeled

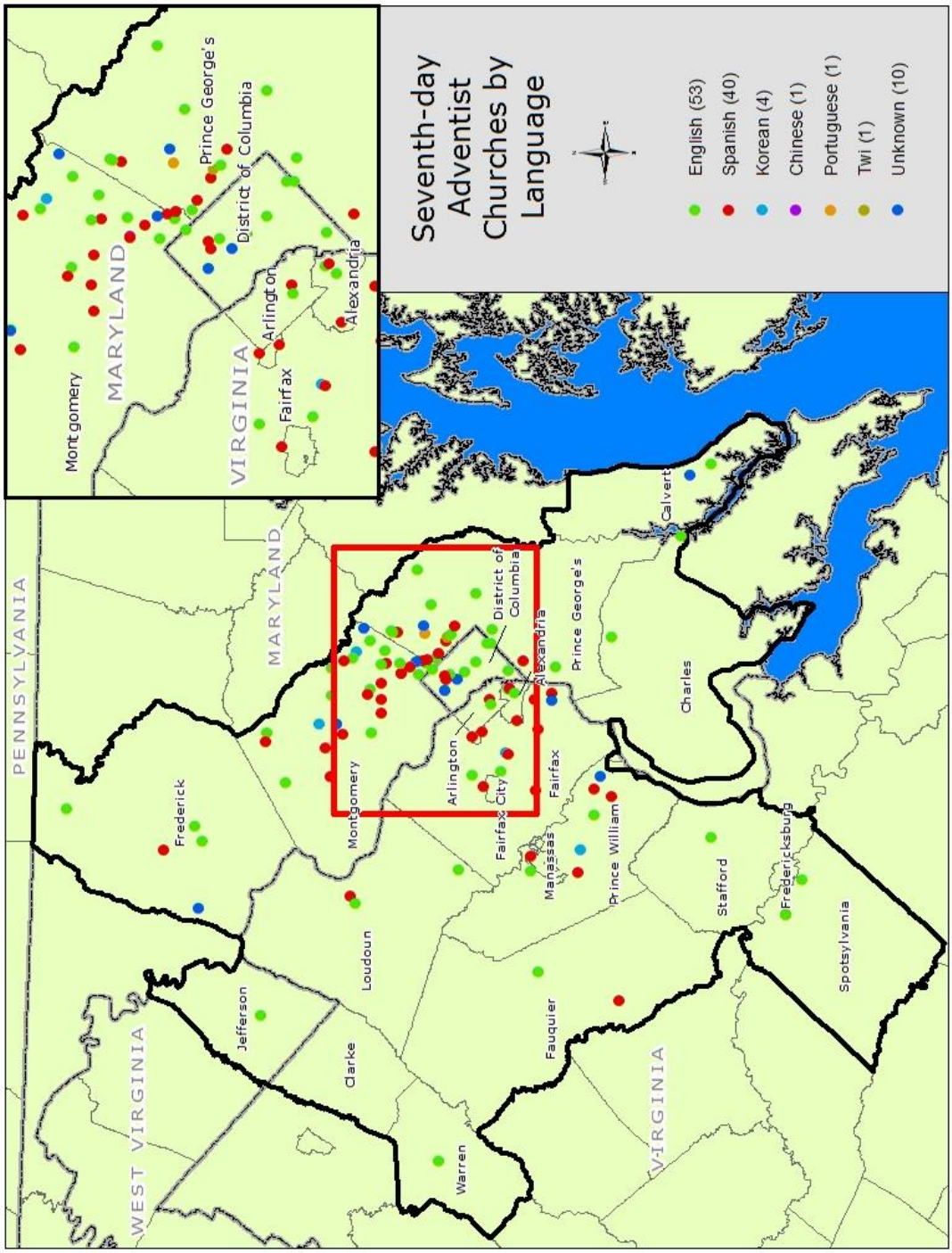

Figure 11 - Map of Adventist churches in the Washington, DC metropolitan region by language. This map gives a potential view into the immigrant nature of Adventism by showing the variety of languages spoken in metro DC churches. The map uses a reference scale of 1:1,000,000 for the main map and 1:535,000 for the inset. Map created by Nathan Burtch. Shapefile sources: ESRI, derived from Tele Atlas, and U.S. Census. Point locations of Adventist churches from Adventist Directory (www.adventistdirectory.org).

as separate from the American Adventist congregations based upon their extreme orthodoxy to some older Adventist tenets that American Adventists deem extreme. In Latin America there are tensions between the dominant Catholic tradition and Adventism, leading to some increased fervor among adherents to their own particular belief system. The congregations often become the central part of community life among Hispanics, especially upon migration to the United States, and the congregations have stricter rules about protecting the nature of their community by removing those that do not maintain the communal ideals from the congregation. This solidarity within culture and religion has led Hispanic Adventist congregations in America to grow faster through proselytization of their family and neighbors (Lawson 1999). Religious commitment links to community attachment not only for Adventists, but across many denominations. Urbanization does not affect this localization of community attachment (Welch 1983).

Adventism has pushed the idea that adherence brings the benefit of upward mobility in society, often based upon the Adventist emphasis of education but also upon a notion that Adventism encourages middle class ambition and represents the Protestant ethic of the modern day (Theobald 1985). Language and culture each play an important part in the ability of recent immigrants to show upward mobility in society. Adventist migrants from the West Indies tend to possess both higher education (provided by their home missionary-based Adventist schools) and English language skills. Hispanic Adventist migrants, much like their non-Adventist brethren, tend to have low education levels relative to American society and lack the necessary language skills to allow for work beyond jobs requiring unskilled labor (Lawson 1999). Despite this, Seventh-day Adventist pastors have noted that these incoming immigrants are generally successful in

finding a stable, poverty-free living, which allows subsequent generations to further advance with increased education (Lawson 1999). The education promoted and provided by Adventist schools allows the second and third generation Hispanic Adventists to become more ingrained within broader society, thereby creating a less sectarian denomination. However, the higher education of individuals ultimately leads to a problem of retention within the congregation; as generations become "Americanized" they become more inculcated within the broader American culture and desire to be less involved in their 'home' congregation. The traditional congregation of their forebears remains focused upon evangelizing new migrants through maintaining services in their mother tongue of choice, whereas the educated and Americanized second and third generation prefer English (Lawson 1999). While some research shows that the socioeconomic status of parents impact strongly the outcomes of their children – as in, poverty begets poverty (Snell 2011) – it appears that research on Hispanic Seventh-day Adventist above bucks this trend. Instead, Hispanic Adventists follow the religious role of segmented assimilation theory through the large number of second generation members predominately joining American society (Warner 2007).

The connectivity of church social networks can impact health outcomes; not only for Adventist churches that emphasize healthful living, but for all churches through social leveraging (Davis et al. 1994). This is especially prominent within the Seventh-day Adventist tradition, as an adherent can stay completely within the subculture of Adventism through attending Adventist-run primary, secondary, and post-secondary schools, receive medical service at Adventist hospitals, and work in Adventist companies (Bull 1989). Despite being able to remain securely in the Adventist subculture, the

growth of many Adventist institutions, such as higher education, healthcare facilities, food factories, and publishing companies, have led to Adventists becoming more integrated in society, and has brought government regulation further into these realms (Lawson 1998b).

Chapter 3: Questions and methods

Research questions

As established in Chapter 2, the Seventh-day Adventists are a Protestant denomination birthed from the religious fires of the Second Great Awakening. Adventist theology begins with the Bible. In many ways, Adventists are Biblical literalists. The development of a specifically Adventist theology coincides with the varied reform movements that became at least marginally popular during the mid to late nineteenth century. Among these reforms were those related with health; diet, temperance, and movements to connect humans with the natural elements of air and water. The Seventh-day Adventists used Biblical evidence as a rationale to adopt these reform movements as their own through deep interpretation of the text. Generations of Adventists have now been raised within the paradigm of health emphasis. The cultural results are stark; Adventists as a group tend to have such high levels of health that they are often used as a control group when studying disease in populations (Euler et al. 1988; Hunt, Murphy, and Henderson 1988; Gimsing 2014).

Little attention has been given to questions of space and Adventism. As an evangelical Christian denomination, discussion of the spread of Adventism through missionary work is within the literature. What has been largely ignored is the social construction of space, especially as it pertains to both spaces of health care and religious or sacred spaces. In their seminal work *Seeking a Sanctuary*, Bull and Lockhart (2007) provide an interesting paragraph regarding sacred space in Adventism. Within the chapter "Adventism and America," Bull and Lockhart describe how Adventism fits into the ideals of America. A large division between Adventism and the greater American

society lays at an interpretation of space. Bull and Lockhart describe that "Americans viewed their country as a sanctuary from the Old World, but… Adventists sought their sanctuary in heaven." That is, mainstream American culture sees salvation physically manifest in their country, while Adventists do not. Bull and Lockhart put a finer point on this by comparing Adventism to another Christian denomination born of America in the Burned-Over District around the time of the Second Great Awakening; the Mormons.

> In Mormonism, the sacred is located in space, not time. Its boundaries are geographical, not temporal. It can be reached by a physical journey across land and sea, not through an experiential journey through time. In this respect, Mormonism represents the mirror image of Adventism. Adventists separated themselves from other Americans by choosing as sacred their own portion of time – the Sabbath. The Mormons distanced themselves from America by moving outside the then territorial boundaries of the United States and choosing for themselves a sacred place. Adventists were content to share American space, to remain dispersed throughout the continent, but were determined not to participate in American time as manifested in the observance of Sunday and the expectation of an earthly millennium. In contrast, the Mormons fought, often literally, to preserve their own space, but acknowledged the validity of Sunday and anticipated a millennium on American soil…
>
> In Mormonism, spatial extension – achieved through migration, farming, building, and fecundity – is the primary dimension of experience. In Adventism, time is the primary dimension. Self-restraint engenders a heightened awareness of duration; Sabbath keeping promotes chronometry; prophetic interpretation focuses on chronology, health reform on longevity, and the Second Advent on the hope of eternity. For a Mormon, morality is the proper use of space; for an Adventist, it is the correct use of time. In their peculiar concentration on either space or time, Mormons and Adventists were both dissenting from an ideological consensus in which God's time was combined with American space to form the spatio-temporal unit of the American millennium.
>
> Adventism was thus not unique in responding to the dominant ideology of civil religion; Mormonism, which developed in similar circumstances, reacted to the same stimulus. But the Adventist response diverged from that of the Mormons in almost every respect. While the Mormons embarked on noisy migration across space, Adventist[s] were setting out on a quiet pilgrimage through time.

Bull and Lockhart admit that this comparison may ignore some of the more complex parts of the histories of both of these socio-religious movements. Still, this remains an apt analysis in terms of not only early emphasis, but subsequent

manifestation. Despite this emphasis on the temporal, there is no reason to theorize that space has no material importance in Adventism. The sacredness of space may not be at the forefront of Adventist theology, but as a social movement spaces of faith and practice are constructed. The research presented in this dissertation aims to uncover the Adventist relationship with space, through the context of the denomination's predilection towards providing healing to the public.

In a project with National Geographic, journalist Dan Buettner investigated Loma Linda, California – the home of a major Adventist university and hospital that has an accompanying large Adventist population – as one of five Blue Zones in the world where people much more frequently live to age 100 (Buettner 2005, 2016). The proclivity towards healthful living by Adventists drives Loma Linda as being a place of health. This touches upon the central theme of this dissertation; the intersection of religious behavior, health, and space. While the effects of Adventist health behavior have been researched in depth, the spatial manifestation of healthful living has seen little to no discussion within the literature. This research attempts to view religious behavior from a perspective of cultural geography. Three questions are at the core of determining the nexus of religious behavior, health, and space in the Adventist tradition, which will be outlined in the next sections.

Research question 1: How does religious duty affect the creation of religious or sacred space?

The production of space within society has been a topic theorized by a wide variety of scholars. This research question focuses on the creation of a category of space;

one related to religious or sacred practices. It also relates the concept of religious duty. Little research specifically discusses how religious duties manifest spatially. The thrust of this question therefore is to attempt to model the production of space as it pertains to religious duty. A mechanism of how religious duty manifests spatially is necessary to understand the nexus of religious behavior, health, and space within Seventh-day Adventism. This question will be explored in Chapter 4.

Research question 2: What is the nature of the religious duty of health in Adventism and how is it emphasized in the practices of Adventists?

Healthful living in Adventism seems to be a religious behavior of devotees. But, could it be something more central to personal religion? I am choosing to use the word *duty* as a signifier of a religious behavior that is not merely condoned or culturally accepted, but rather an obligation that adherents are expected to follow. Before understanding how healthful behavior manifests spatially within a religious denomination, it is important to see if a predilection of health rises to the level of religious duty. In this way, it is possible to see that spatial manifestation is a result of religious adherence. The research question guides research to first identify that health within Adventism is central to theology by being a religious duty. The second part of the research question is to give a rough understanding of how important this duty was seen by one of the founders of Adventism, Ellen White. Ellen White's writing have been highly influential to Adventist theology, and she wrote about a multitude of topics. The research question aims to find if Ellen White emphasized the *duty* of health in her

writings. In other words, was healthful living something Adventists should do, or *must* do? This question will be explored in Chapter 5.

Research question 3: Does a religious duty for health create a religious 'dutyscape' of therapeutic/health spaces?

This research question combines the findings of the first two research questions. The first research question's intent is to establish that Adventists have a religious duty of healthful living. The second research question is to theorize how a religious duty manifests spatially as religious or sacred space. This third question melds those into understanding how the specific duty of health in Adventism manifests spatially. This question uses the term 'dutyscape' as a portmanteau of 'duty' and 'landscape'; it is the concept of whether a religious duty can become indelibly embedded within a cultural landscape of a religious denomination. This research question seeks to establish that within Adventism, there are intersections of religious duty, health, and space. This question will be explored in Chapter 6.

Influences and viewpoints

Humanism

Research into the nature of religious duty and personal health actions is inherently humanist. Humanism posits that humans are intentional agents; that is, humans are autonomous entities that use multiple sources, such as morality, religion, and personal experience to make their own decisions (Entrikin and Tepple 2006). Humanist research focuses on the subjective relationship that humans have with human-constructed

meaning. Part and parcel with subjectivity is understanding oneself; human problems cannot be solved without it (Tuan 1974). Studying how religious duty creates religious or sacred spaces is thoroughly humanistic; through understanding how place becomes sacred, we are able to study the meaning of this sacred place, and through that, know the subjective meaning of people (Sherrill 1995). Methodologically, humanistic geography draws from two sources. First, hermeneutics brought a focus upon reading texts to understand how humans give meaning to place. Second, elements of ethnography were used to ground phenomenological perspectives on human agency and place (Limb and Dwyer 2001). As will be shown later in this chapter, hermeneutics is a major methodological focus. While a classic approach to ethnography – grounded in field study and observation – is not used, the Adventist healthcare culture is explored through social media, representing a source of experience of human agency. In researching health care, Gesler and Kearns (2001) identify three questions the humanist perspective leads to: "(1) the beliefs of different actors in medical encounters; (2) feelings of identity with places where health care is administered; and (3) the role of concrete and abstract symbols." While researchers may prefer humanistic stances over structuralist (or vice versa), it is important to keep both in tension and blend each together in the form of structuration or critical realism when studying health care (Gesler and Kearns 2001) and cultural materialism in the study of landscapes (Gesler 1992).

Constant comparison

This research uses a deductive *a priori* approach, unlike some qualitative methodologies in which an inductive *a posteriori* approach is warranted. A deductive

approach was necessitated because the in-depth background research into the writings of Ellen White and other Adventists lead to the idea of researching the duty of health as a religious duty. In other words, the research question begins with the idea of measuring the impact of this particular religious duty, rather than entering research from a theory-less position. While the use of an *a posteriori* stance is rejected for this research, the methods proposed by some scholars entrenched in the inductive paradigm are influential. In particular is the use of constant comparison, in which data and coded categories of data made by the researcher is compared at all times during the data collection and analysis steps (Glaser and Strauss 1967; Strauss and Corbin 1990; Charmaz 2006; Creswell 2007).

Creswell (2007) defines two major approaches to conducting research based on constant comparison; the systematic approach developed by Strauss and Corbin (1990) and the constructivist approach developed by Charmaz (2006). In the systematic approach, 20-30 interviews are typically compiled, with as many as 60 being necessary to fully saturate the model, with participants chosen via theoretical sampling to best provide for theory development. Data are constantly compared as data gathering and analysis happen in a "zigzag" fashion. Data analysis consists of open coding (finding the major categories), axial coding (coding around a single open code) and selective coding (development of propositions to interweave the categories of data) (Creswell 2007). The coding process is recursive; categories and relationships are constantly analyzed as new data are collected. The data collection process of constant comparison is shown in Figure 12 modified from Creswell (2007). Research examples of this coding process include the study of women's health decisions based upon culture (Stern and Pyles 1985), spirituality

of patients recovering from heart attacks (Walton 1999), commuters' rational for driving (Gardner and Abraham 2007), and how satisfied therapists are with their work (Hunter 2012). Categories are eventually replaced when subsequent data shows them to not be fruitful theoretically (O'Connor, Netting, and Thomas 2008). The constructivist approach depends more upon the heuristic values and feelings of individuals, including the point-of-view of the researcher, rather than on the rigidity of the systematic approach (Creswell 2007; O'Connor, Netting, and Thomas 2008). Charmaz (2006) points that the constructivist approach is moving away from positivistic and structured methodological rigor found in the proposed methodologies of Glaser and Strauss (1967).

Interviews are not used significantly within this research. While some functional reasons for this choice are outlined later in this chapter, a major reason for the lack of interviews is the strongly historical nature of this research. Geores (1996) describes research using historic geography methodologies as immersive. The researcher is required to look at all available resources that are tangentially related to the research topic. Context is reconstructed through the interaction with the people that wrote the cultural history.

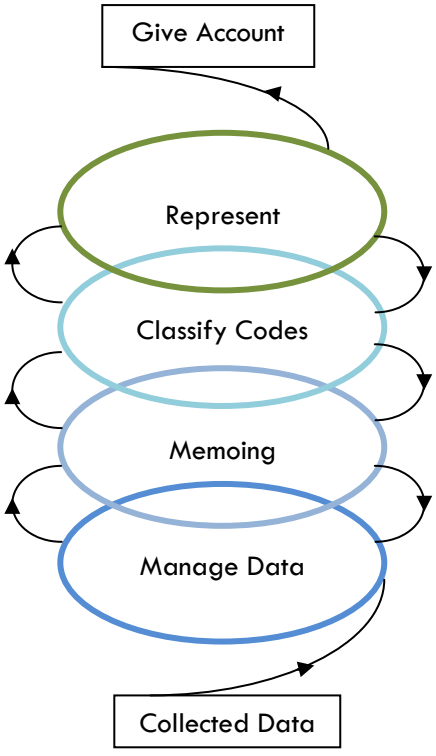

Figure 12 - Data analysis spiral. Adapted from Creswell (2007).

Assessing authenticity

Verification of research of a humanistic variety, based upon empathy, respect and personal experience, with knowledge considered "continuous

and incomplete", cannot be completed in the positivistic paradigm of comparison with other completed studies. The validity of research instead comes from evaluating how the methodology is designed to develop findings and how honest the researcher was with his or her own experiences, feelings, and relationships with that being studied, be it humans or places (Rodaway 2006). In humanism, the term "authenticity" is used. Authenticity is "not the verification of an abstract fact or causal relationship, but a kind of confirmation or assertion, and ultimately a sharing of an insight into the wholeness, the character or essence of a place, its people, its lifeworlds" (Rodaway 2006). The constant comparison method used in this research leads to a verificational model of assessing authenticity; authentic findings are produced through recursive development and refinement of codes. The verificational model was favored by Strauss but not Glaser (1967), who preferred an emergent form he called validation (Crang 2001). This process can be used in humanistic research because validity does not come from studies outside of each particular study. The use of triangulation can improve the rigor of research by using multiple sources and methods to crosscheck developing codes and further construction of theory (Bradshaw and Stratford 2010; Winchester and Rofe 2010).

Methods for analysis chapters

Methods for Chapter 4

The literature lacks a theoretical model to ascribe how a religious duty manifests spatially. The first research question is proposed to fill this gap by creating a model of the spatialization of religious duty. Methodologically, Chapter 4 uses a review of literature to understand the mechanism that connects religious behavior, health, and space

in the general sense. The review of literature investigates the views of both geographers and religious scholars understanding the intersection of religion and space. The special case of scholars discussing sacred space is reviewed, especially with a connection of health and sacredness. Through this application of the literature, Chapter 4 will describe the scholarly difference between religious and sacred space; a difference that is not used in the writings of Ellen White but nonetheless help to explain how duty manifests spatially. The social constructions of space, as described by geographers and sociologists, and the effects of power systems on the creation of social spaces as described by Marxist and structuralist scholars is also included.

In completing the literature review, one particular theory for the social production of space comes to the forefront; Henri Lefebvre's spatial triad. Literature of applying the spatial triad to various social constructions of space are reviewed, especially religious or health-related spaces. The spatial triad of conceived-perceived-lived spaces is used as a basis of theorizing how duty manifests. The theoretical model that is created is an extension of the spatial triad and applied to Seventh-day Adventist health spaces in a general sense. After establishing the presence of a religious duty, the model developed to answer the second research question uses a review of academic literature to theorize how duty spatializes. Further saturation of the model is completed in Chapter 6, when Adventist hospitals are investigated directly along with understanding if the historical duty of health remains currently practiced.

Methods for Chapter 5

The second research question is regarding the level at which health was seen as a religious or sacred duty within Adventism. The usage of past tense in the previous sentence is purposeful; Chapter 5 of this dissertation is aimed at understanding health and Adventism through a historical lens. This allows for an assessment of the historical importance health has been in the denomination of Adventism. As such, the methods for Chapter 5 are focused on using a content analysis of writings by Ellen White. Ellen White, an inspired writer and leading voice of early Adventism, still receives deference and respect for her role in shaping the beliefs of Seventh-day Adventists to this day. An assessment of her writings provides an insight towards not only what she found important, but by extension, what are important tenets of early Adventism; tenets that helped recruit adherents and build the fledgling denomination into a worldwide movement of over 18 million believers (2015 Annual Statistical Report 2015).

Content analysis is a qualitative methodology that has often been used on studies on many fields but also on topics relating to health, such as nursing (Graneheim and Lundman 2004; Elo and Kyngäs 2008). Content analysis uses "explicit rules of coding" (Stemler 2001) in order to reduce the massive number of individual words in textual document into a relatively small number of categories (Stemler 2001; Elo and Kyngäs 2008). The underlying supposition of content analysis is that the analysis of texts shines light upon 'social reality,' represented by cultural expression via writing (Bos and Tarnai 1999). Depending upon its application, content analysis can be both a qualitative and quantitative method (Bos and Tarnai 1999; Hsieh and Shannon 2005; Elo and Kyngäs 2008), and additionally can be employed in mixed methods approaches to boost validity

(Kolbe and Burnett 1991). While counting how often words are mentioned is part of the method, content analysis is not merely displaying a word count. Instead, language must be interpreted so that the meaning of the word is contextualized properly into accurate codes that can include various synonyms, homonyms, and variations of word conjugation (Stemler 2001; Hsieh and Shannon 2005). It is the process of coding into categories that allows content analysis to be a valid method. Stemler (2001) describes the approaches to coding as being either emergent (allowing categories to develop through examining data) or *a priori* (categories are created before analysis), which is similar to what Elo and Kyngäs (2008) describe as inductive or deductive approaches. Hsieh and Shannon (2005) outline three approaches to content analysis. Conventional content analysis aims to describe a phenomenon without preconceived categories, directed content analysis uses a deductive approach to build upon existing theoretical frameworks, and summative content analysis quantifies counts of specific words and then uses latent content analysis to understand the meanings of the words within context. The categorization of codes, which allows themes of content to be created, should be both exhaustive and mutually exclusive (Stemler 2001), however an analysis of human experiences cannot always create mutual exclusivity due to the "intertwined nature of human experiences" (Graneheim and Lundman 2004).

The sheer volume of writing by Ellen White is astounding. Her prolific amount of writing is difficult to fully quantify. Arthur Patrick (2014) describes Whites authorship as containing "26 books, 200 tracts and pamphlets, and 5,000 periodical articles" along with over 70,000 pages of incomplete manuscripts, diaries, and letters. The Ellen G. White Estate (2015) agrees that some 5,000 periodical articles were penned

by White in her lifetime, but cites 40 books, with "more than 100 titles" now being available due to compilations pulling from her 50,000 manuscript pages. While the final tally of pages will probably never be known – especially with her writings having exact repetition between articles, pamphlets, books, and compilations – it is safe to declare the volume of pages in the hundreds of thousands of pages. Sampling portions of her life's work for the content analysis is essential. The literature on content analysis methodology is littered with varied interpretations of *sampling units*, *units of analysis*, *meaning units*, *context units*, and other delineations of units of analysis. As such, this analysis uses the following descriptions. The *target population*, or the complete set of items from which to sample, are the writings of Ellen G. White. The *sampling frame*, or the operational structure in which the sample is actually drawn, are books and compilations of Ellen White as listed on the EGW Writings website (Ellen G. White Estate 2016). The *context unit*, or the section of writing that is used to code for content, are paragraphs that make a mention of 'duty'. The sampling of books is purposive; that is, books have been selected purposely for reasons beyond randomness. In this case, there are two purposive samples. First, books relating to health-related topics is analyzed regarding the propensity of mentionings of 'duty.' Second, the same analysis is conducted on non-health related books. The books chosen for this sample are picked for their relative importance within the publishing history of Ellen White.

The content analysis for Chapter 5 is summative. The selected books written by Ellen White are searched for mentionings of the words 'duty' and 'obligation', using the shortened search terms 'dut' and 'oblig' to find word variations such as 'duties' and 'obliged'. The paragraph in which the word was found was analyzed for context to

ensure that Ellen White was speaking of a duty was religious in nature or in some way either glorified or reflected on God. This eliminated a few mentions of 'duty' in the context of taxes on internationally shipped foods among others. As this research is regarding the religious or sacred duty of health, categories are only created for the health-related books. Additionally, a word cloud is used to visually analyze the context units of the health-related books. A word cloud allows for visual analysis of frequently-mentioned words through the creation of a visualization in which the font of words is proportional to their frequency within a text (DePaolo and Wilkinson 2014; Chi et al. 2015). While there are valid criticisms that font size alone can lead to improper analyses – font size is one-dimension (height) while words are two-dimensional, meaning longer words will appear larger and thus more prominent on the screen – it can be used in conjunction with other analyses to bring a perspective unseen in simple tables and counts.

Methods for Chapter 6

The third research question seeks to bring the theoretical findings of the first two questions together under the rubric of therapeutic landscapes research. In order to complete this, Chapter 6 will endeavor to create two theoretical connections. The first connection is to demonstrate that there is a worldwide landscape of health spaces in Seventh-day Adventism. This will demonstrate that the duty outlined in Chapter 5 has caused a spatial manifestation. The second connection is to establish that the duty is still a current message, leading to a creation of religious *dutyscapes* within individual hospitals. Each of these connections will be established with different methodologies.

By demonstrating that Adventists have spread health care facilities worldwide at the same time as overall denominational growth, it can be theorized that the duty to spread the message of health care is an important tenet of Adventism. In order to understand this spread, the growth of hospitals over time will be recorded. The Seventh-day Adventists have been fastidious at gathering statistics that measure the size and scope of their religious movement. Among the multitudes of documents posted and freely available on a denominationally-operated online archive, adventistarchives.org, is the official publication of the Seventh-day Adventist Yearbook. These yearbooks have been published most years since 1883[7]. While the content has changed over the years, in general the yearbook serves as world directory of the bureaucratic organization of the Church and includes institutions such as schools, food industries, media, and most importantly to this work, healthcare institutions. Approximate geo-locations of the hospitals will be mapped. Using both GIS and statistical charts, the spatial spread of Adventist hospitals will be visualized, demonstrating how a religious duty has manifested as a worldwide dutyscape of health spaces.

Gesler and Kearns (2001) suggest that in-depth interviews are preferable in researching health geographies, as it can create new experiences within the mode of qualitative research through the relationships between the researcher and subject. Differences between the researcher and subject, whether religious, cultural, racial, affiliation-based or health-based, must be considered within the context of research. Gesler and Kearns (2001) identify three questions the humanist research perspective on

[7] All yearbooks were accessed through the Seventh-day Adventist Church Office of Archives, Statistics, and Research website (www.adventistarchives.org). No yearbooks exist for the years 1895-1903. The years 1965-66 and 1973-74 were combined; in the reference section, these are listed as the years 1966 and 1974, respectively.

health care leads to: "(1) the beliefs of different actors in medical encounters; (2) feelings of identity with places where health care is administered; and (3) the role of concrete and abstract symbols." While researchers may prefer humanistic stances over structuralist (or vice versa), it is important to keep both in tension and blend each together in the form of structuration or critical realism when studying health care (Gesler and Kearns 2001) and cultural materialism in the study of landscapes (Gesler 1992).

The creation of *dutyscapes* within current hospitals will be assessed using a content analysis. There will be two primary research sources for this content analysis; a narrative interview of an employee within an Adventist health care organization and YouTube videos uploaded under the accounts of various Adventist health care organizations. The narrative interview used a semi-structured style, with audio recording to ensure completeness of transcript and attentiveness of conversation, was used in order to have some predetermined interrogative direction, but with flexibility to allow the participant to open new avenues of understanding. (Valentine 1997; Kitchin and Tate 2000; Bennett 2002; Dunn 2010). As mentioned above Gesler and Kearns (2001), two of the most prominent names in the field of therapeutic landscapes research, recommend in depth interviews as a data gathering method. The use of multiple interviews will not be used in this research. The reason for this decision is mainly because of the difficulty experienced in finding and retaining a key informant from which a snowball sample can be obtained. Whether through expressing lack of knowledge or interest, leaving a position in the organization before an interview could be scheduled, or not responding to efforts of contact, multiple potential key informants were contacted and could not be successfully interviewed. Snowball sampling is often used in researching topics of a

personal nature (Biernacki and Waldorf 1981) and there is potential that discussing core religious beliefs or views on health care with an outsider[8] was unattractive enough to some to wish to not participate. One of the people that was contacted agreed to an interview, which was conducted with enthusiasm enough that the participant offered to be a key informant for the beginning of a snowball sample and to personally provide tours of various Adventist health spaces in the metropolitan Washington, DC area (should schedules allow this time). All subsequent correspondence with this contact was unreturned. While this represents but one viewpoint, it is an important viewpoint to include in this research. This employee is in an executive position and is tasked with connecting spiritual beliefs and rationales to the provision of health care in an Adventist healthcare organization. Chapter 6 investigates institutional duties of health, meaning that this one interview subject represents an influential voice in current trends connecting Adventist religious duty to health.

As it became more likely that a critical mass of interviews was unlikely to be obtained, the research methodology turned towards using YouTube videos as a replacement for in-depth interviews. Social media is a primary means of reaching an audience with an organizational message. These are official forms of communication to the community; both the community of believers and the general community surrounding hospitals. Both Washington, DC metropolitan Adventist hospitals and others were used to build this data. YouTube videos can represent space lived within the experiences of a

[8] I had an experience in my early research that demonstrated my standing as an outsider. I went to the Sligo Seventh-day Adventist Church in Takoma Park, MD to observe a church service. Sitting in the back row before service began, I was tapped on the shoulder by an older woman. She asked me, "What are you doing here?" This instantly flummoxed me; I managed to say I was there to watch the service and we had a short conversation. She asked if I was an Adventist, to which I replied that I was not. She stated that she had something for me and exited the room. She returned soon after and gave me a book of Bible quotes with Adventist interpretations, intended for home Bible study. I thanked her and the service began.

community, making these new expressions a prime source to be used within the context of humanist geography.

Social media is a burgeoning source of primary research content within many academic fields. YouTube, one of the most popular Web 2.0 sites (Tian 2010), has been featured as a source of data in content analyses in studies of social sciences. YouTube, being a part of Web 2.0, allows for a massive amount of user generated or curated content within a platform that encourages interaction between content providers and users (Tian 2010; Guo and Harlow 2014). While the "Broadcast yourself" motto of YouTube implies a level of citizen-generated new media, many polished videos made by professionals now populate the site (Guo and Harlow 2014). The ability for organizations to shape and spread their brand and bypass traditional media outlets has "become an essential communication tool for the third sector organizations," such as non-profits (Almaraz, González, and Van-Wyck 2013). An analysis of user-generated content on YouTube can give insight into the phenomenological experiences of people dealing with quite personal situations, such as bullying against the LGBT (Green, Bobrowicz, and Ang 2015) and racial stereotypes (Guo and Harlow 2014). Other research has used YouTube to measure the quality of communication of information (or misinformation) or exposure to certain topics, such as the portrayal of driver sleepiness (Hawkins and Filtness 2015), the exposure of tobacco and alcohol in popular music videos (Cranwell et al. 2015), organ donation (Tian 2010), and bowel preparation before colonoscopy (Ajumobi et al. 2016).

Content analysis of YouTube videos can be both quantitative and qualitative. As this particular research question is attempting to ascertain the currency of Adventist religious duty of health as it manifests spatially, it should be answered similarly to the

second research question covered in Chapter 5. In that chapter, a content analysis is conducted that is both quantitative and qualitative. Quantitatively, mentionings of 'duty' are counted with summary stats provided. Qualitatively, categories of 'duty' were developed from the process of coding. A similar approach is used for Chapter 6. In this case however, searching for specific mentionings of 'duty' will not be possible. Of the videos that were selected for analysis (the process of selection is outlined below), the word "duty" was not used a single time. Instead, this content analysis selects and codes whenever there are implied mentionings of the intersections of duty, health, and place. First, videos will be assessed quantitatively through counting the number of times that pertinent mentionings were duty was stated, described, or most commonly, implied. The quantification will be completed similarly to the methods used in Cranwell et al. (2015) in which videos are segmented into 10-second intervals. Both audio and visuals are assessed, with each 10-second interval marked for either presence or absence of a pertinent mentioning. These 10-second intervals will act similarly to pages in the writings of Ellen White assessed in Chapter 5. Second, the 'mentionings' marked from above will be coded and categorized qualitatively in order to understand the intersections of duty, health, or space. As these pertinent mentionings intersect, coupled with the production of video that allows for multiple visuals and topics within 10-second intervals, up to two different codes are marked in any particular interval.

The process of selecting videos to analyze begins with a search for "Adventist health" on YouTube. The first ten pages of results, with each page showing 20 videos or playlists, are observed. The preponderance of research that searches YouTube videos have used in upwards of 10 pages of search results (Ajumobi et al. 2016). As this

research is intending to look at organizational conceptions of duty, the user that uploaded each video is noted. If the user is an Adventist health-based organization, the user's webpage is opened in a new browser tab. Those that are posted by individual users, non-health organizations (such as churches), or undetermined users are ignored. The "Videos" tab for each of the selected organizations is opened. Each video is then assessed for its pertinence in relation to institutional duty by observing both the title and thumbnail of each video. Videos that simply describe services provided by the hospitals involved, advertisements, and stories from hospital patrons are generally ignored as these do not focus upon organizational duties of health. All other videos at watched for their pertinence, with those providing pertinent content being added to the above analysis. In some instances, a longer video was posted along with shorter videos for different sections of the longer video. In these cases, only the long, full video was assessed.

Chapter 4: Religious duty and the production of the dutyscape

This analysis chapter focuses on the development a model of the spatialization of duty. Chapter 2 discussed some of the duties in Adventism pertaining to health. Having this as a background, this chapter will demonstrate a pathway of how this religious duty manifests upon the landscape. These spaces that are created will serve both the individual and the institutional duties towards health, as will be discussed in Chapter 5. How does this religious duty manifest spatially? This chapter will introduce an extension of Henri Lefebvre's (1991) spatial triad as a new theoretical model that connects religious duty and personal agency. The creation of what this paper terms a *dutyscape*, a cultural landscape embedded with religious duty, occurs through *the filter of space*. Before discussing this new theoretical model, this paper will outline different theories of how space is socially constructed. In addition, this paper will discuss religious space from two perspectives; how scholars of space (geographers) view religious space, and how scholars of religion view religious space. A discussion of religious spaces within hospitals and places of health is also included.

Social constructions of space

Space and place

Within the field of geography, space has been considered empty, universal, scientific and devoid of embodiment, while place has been considered as humanistic and bounded (Cresswell 2002). Place should not be considered simply as a location, but rather as "where people do things" (Rodman 1992). Place has agency; rather than being an "inert container", places are socially constructed and have power. Places have

multilocality, meaning that place construction can be understood from many viewpoints, imbued with different meanings for different people within the place (Rodman 1992). Within the humanities, a 'spatial turn' has developed in the past few decades (Thrift 2006), inspiring multitudes of new spatial investigations beyond academics in geography. Historically in anthropology, culture has been treated discretely, occupying discrete space, much like a political map neatly cuts space into wholly separated polygons called nations (Gupta and Ferguson 1992). Instead of being rooted in locality and physical spaces, cultures inhabit imaginary spaces (Gupta and Ferguson 1992). Researchers concerned with space must question any assertion that the human world is divided between insiders and outsiders, ourselves and others (Gupta and Ferguson 1992; Rodman 1992). Thrift (2006) outlined four principles in approaching space. First, everything is distributed in space. Second, there are no boundaries. Third, spaces are not static. And fourth, space comes in many different types.

Michel de Certeau (1984) uses the practice of walking through a city to differentiate between producers, the ones that create power structures, and consumers, who act within the city. The city has its own space, rationally structured and organized by producers into flattened "strategies". Individuals, the consumers of space, practice "tactics" as a way to move about and use space. When walking through a city, the producers have created certain strategies in which a consumer should move about; gridded street systems, fences and walls to prevent movement, and so forth. Consumers, walking about the city, actualize the different possibilities of movement. The walker actualizes some of the spatial order through their use, but also creates more possibilities via shortcuts or detours and creates more prohibitions by eliminating certain paths from

his or her use (Certeau 1984). Certeau sees the consumers in a state of constant subversion of the spatial strategies laid out for them (Knott 2005).

Certeau, interestingly, takes a different approach to defining "space" and "place" than many theorists. To Certeau, "*space is a practiced place*" (1984). Certeau uses an analogy of a word; when a word is actualized (spoken), it is the same as when a place becomes practiced (space). Places are a stable "configuration of positions" while spaces are composed of mobilities of consumers in situating a place. A map is symbolic of place; an organized plane that shows geometric locations of objects. Objects, according to Certeau's definition, cannot occupy the same place at the same time, which seemingly ignores the multitudes of scales that can operate simultaneously. An itinerary is symbolic of space; it is place being actionable through the process of using tactics to travel through it. Map is authority, a power structure of strategies for the city, whereas the itinerary is a tour of individualized tactics.

Space is experiential; Bachelard (1997) uses topoanalysis, the "systematic psychological study of the sites of our intimate lives," as a means to describe the spaces of memories in human lives. Memory is not recorded in terms of its duration but instead its spatiality; strong memories are housed through space. Memories imbued in place are fragmented and are imparted in a place through the experience of visitors (Aden et al. 2009). Cultural geographer J.B. Jackson (1994) uses an experiential definition for the term "sense of place". Derived from the Latin *genius loci*, a sense of place was meant to describe places that "derived much of its unique quality from the presence or guardianship of a supernatural spirit". Jackson further expands:

> So one way of defining such localities would be to say that they are cherished because they are embedded in the everyday world around us and easily accessible, but at the same time are distinct from that world.

> A visit to one of them is a small but significant event. We are refreshed and elated each time we are there. I cannot really define such localities any more precisely. The experience varies in intensity; it can be private and solitary, or convivial and social. The place can be a natural setting or a crowded street or even a public occasion. What moves us is our change of mood, the brief but vivid event. And what automatically ensues, it seems to me, is a sense of fellowship with those who share the experience, and the instinctive desire to return, to establish a custom of repeated ritual (1994).

It is space revered and ritualized, often through cyclic occurrences through time, similar to the Eliadian (1959) descriptions of sacred time. Jackson writes of the sense of place developing through "shared experience", generally consisting of nonpolitical places and events; in the words of Certeau, these would be spaces created through the practice of tactics rather than through the structure of strategies.

Marxist ideals

Marxists have critiqued that capitalism has led to undermining the uniqueness of space and quality of place. Debord (1994) remarks upon the unifying nature of capitalist production upon space, creating "banalization" of space. Massey (1991) has described how movement has changed our perception of sense of place. Movement has been increasing, as jet travel brings people to disparate places and email allow us to communicate instantly across the world. This is referred in the article as time-space-compression, meaning that social relationships are geographically wider because of our ability to move and communicate over long distances (Massey 1991). By lessening the travel time between places, the economic organization of tourism equalizes places and eliminates "any real space" (Debord 1994). Time-space-compression is not happening equally for all people and places, however. Massey (1991) refers to this as the power-geometry of these new flows of movement. There are people that control the time-space-

compression and use it to their advantage. Others may move physically but have no control over the system, such as refugees. Others still receive inputs from time-space-compression only, such as those that from a single location can view foreign films and eat foreign food but do not travel themselves.

The compression of space and time has led to an overhaul of how place is viewed. The local has become fragmented by the addition of the non-local. Massey (1991) argues that other writers incorrectly tie the increase of time-space-compression to a decrease in security, but Massey wants to develop a more progressive ideal of place. In doing so, Massey argues against places having a true identity and that "sense of place" being based solely on a historical inward-looking view. Massey uses her neighborhood of Kilburn as an example of a fragmented place that has a high level of outside connections that allow someone to feel it has character but not have that character be based upon reactionary views. The use of the word "community" is a misnomer as it implies one single identity, which few places have. A progressive sense of place, recognizes that places are not static, do not have firm borders, do not possess singular identities, and that the specificity of place is not based upon history, but instead it is constantly reproduced. In this way, Massey argues that globalization is another source of place reproduction that furthers place uniqueness.

Foucault and power

Power organizes within space. Foucault (1995) uses the metaphor of the Panopticon as the means in which individuals are disciplined and under surveillance. Certain buildings, such as hospitals, prisons and schools have been constructed with this

element of control, making these disciplined spaces. These power dynamics can switch as people transform spaces of discipline or structure into spaces of protest. The Plaza de Mayo is the preeminent public square in Argentina and is also the location of the May Pyramid, a monument to the fight for Argentinean independence. The military junta forbade gatherings of more than two people in the plaza in an effort to transform the plaza into something different than a public gathering space. The Mothers of Plaza de Mayo, in silent protest over the "disappearing" of their husbands or children by the military junta, counteracted this by only walking around in switching pairs. Thus, the space was transformed the plaza into a place of thought and protest (Torre 2000). Colonial powers have asserted spatial control over landscape, creating "nervous landscapes" of racialized space (Byrne 2003). Similar to how Certeau described, the minority groups within nervous landscapes use tactics of movement that subvert the overlaid strategies of spatial control by colonizers such as fence-jumping and trespassing (Byrne 2003). Power, in the form of racism, has a profound impact upon the creation of space; as Toni Morrison (1997) writes, "I have never lived, nor has any of us, in a world in which race did not matter."

Foucault (1997) describes *other* spaces; spaces that either do not physically exist or that exist ubiquitously yet can be spatially localized. Foucault refers to the former as utopias, and the latter as heterotopias. These arrangements, in his view, replaced location; it is the spatial relationships and not the pure location that give us information. Foucault defines utopias as arrangements that lack real space, but have real relationships in the form of an inverse analogy with real space. That is to say, utopia is the imaginary space of societal perfection. One could argue that this is a spatial extension of the

Platonic Ideal; the view that societies create abstract and perfect and abstract form of Space-ness. Heterotopias, on the other hand, actual locations but are not real in terms of their arrangements. Rodman (1992) uses the idea of heterotopias as rational for multilocality of sites. Foucault outlines six principles of heterotopias. In particular for this study, three of Foucault's heterotopias are of particular importance as it comes to the creation of religious spaces. One, heterotopias exist in every culture. They are not universal in the sense that there is not one standard form of heterotopia in all cultures, but there are two categories identified by the author. There are heterotopias of crisis, which are places which are reserved for individuals going through crisis or changes from the norm of the social group. There are also heterotopias of deviance, which are places for individuals that are different from the societal standard. Two, societies can change the way in which heterotopias function. This can mean the same place as multiple heterotopian functions, or different sacred/profane functions. And third, heterotopias are both open and closed. Often, people must perform rites to enter, such as for a sacred building/room, or are forced into a heterotopias, like a prison. Some heterotopias may seem open, but are truly exclusionary (Foucault 1997).

General takeaways

The theories presented in this section provide multiple aspects of formulating a model of spatialization. First, spaces are theorized as experiential. Bachelard (1997) and Aden et al. (2009) both discuss the importance of memory in the creation of spaces. Memories become implanted within space, which gives opportunities for people to experience these memories within their interactions of space. Likewise, Jackson (1994)

defines a ‘sense of place’ when there is an embeddedness of something distinct from this world within an everyday space. The inserting of the ephemeral, of the untouchable, into space gives space both individual and community meaning. From the Marxist perspectives, along with Foucault, and understanding of the importance of power in creating socially-constructed spaces is found. Massey (1991) argues at odds regarding the historical aspects of sense of place, but still sees that larger structural systems, through globalization, create differentiation between places, and these power systems are constantly reproducing and changes spaces. Foucault’s (1995) Panopticon demonstrates how these power systems create spaces to control and discipline the population in institutional buildings. Foucault argues that hospitals are constructed with discipline and surveillance in mind. From these theorists, a model of spatialization requires the implantation of memory that can be experienced, while also allowing for power systems to construct space for their own purposes. A religious denomination like Adventism represents a power system that creates spaces such as hospitals for socio-cultural purposes, such as instilling and spreading the duties of health to individuals.

Religious and sacred space

On the spatiality of religion

Seeing the disjointed nature of scholarly literature on the geographic nature of religion, Sopher (1967) compiled a comprehensive treatment on the subject. Basing his work as a means to ascertain the investigations sought by the subfield of the geography of religion (Levine 1986), Sopher begins by classifying religions as either ethnic, universalizing or neither (which he calls segmental), and describing geographic patterns

of each. Of the five major world religions, Judaism and Hinduism are ethnic in nature while Buddhism, Christianity and Islam are universalizing. From this point, Sopher describes how land and religion interplay. Religions have both positive and negative expressions upon landscape. An example of a positive expression is a sacred structure, which Sopher categorizes by function; as a house for a congregation, or a house for a god. Negative expressions come in the form of taboos upon food and activities. Sopher and other geographers of religion of the time came to understand the dialectical nature between religion and the environment (Kong 1990; Cooper 1992).

Cultural geography, by dealing with cultural interaction with other cultures or the environment, has focused upon how organized systems behave rather than individuals (Levine 1986). This can be problematic for studies of sacred space based upon individualized perception. Sopher uses an experiential approach to defining sacred places in saying that, "[s]ince perception of the sacred varies from group to group, one can hardly generalize about the principles of sacred location." While firmly entrenched in cultural geography – *Geography of Religions* is part of the Foundations in Cultural Geography Series – Sopher is able to bring in an aspect of the experiential and phenomenological view of Otto and Eliade. Sopher uses an evolution-based argument in relating the change of sacred places to religious centers with the process when "simple ethnic religious systems evolve into more complex ones", which also harkens back to Otto and Eliade, albeit to ideas of theirs that have fallen out of style.

Religious systems range from being locally autonomous to being rigid hierarchies. In American Protestantism some denominations organize in a manner called congregationalism, in which there are rising levels of hierarchy but local congregations

retain the ability to define for themselves how to ritualize and how clergy are trained. Other Protestant denominations follow in a similar vein to Roman Catholicism with defined religious territories, albeit with less rigidity compared to Catholicism by granting more leeway for congregations to individualize. Sopher uses multiple examples for different hierarchical systems in religions (1967).

After Sopher's seminal work, it took two more decades for a similar assessment of the past and current streams of the geography of religion subfield to be made. Park (1994) remarks though that his book is not about the geography of religion, but instead geography and religion. The difference is that geography of religion focuses upon spatial patterns, while geography and religion can allow for other religious foci of geographers to be included. Park begins with an overview of where the subfield has developed from, and includes a discussion of the subfield's major writers reviewing the field's lack of cohesion; a section that comes off as navel-gazing to some extent. Park continues with reviews on the distribution, diffusion and dynamics of religion – traditional directions of research in the sub-discipline (Kong 2001) – before discussing landscapes and sacred places. At different times, terms such as sacred space, sacred place and sacred sites are used without any note to their definitions or differentiations. Prorok (2007) has claimed that Park's work contains misrepresentations.

Zelinsky (2001) describes some of the features of the American religious landscape that make it unique as compared to other parts of the world, particularly the Old World. Zelinsky uses the common but loaded term "American exceptionalism" as a way that describes the oddness of America's religious landscape. The focus of American religion and American sacred space is on metropolitan areas, for they hold the majority of

people and the plurality of individuality among religious structure. Sacred natural areas in America have been wiped out or forgotten, replaced with religious buildings that are haphazardly placed and designed. The pervasiveness of the automobile in America has created a need for churches to have huge, seldom-filled parking lots, fleets of cars to bring the flock to service, and a proliferation of roadway signs, used to find a niche in the religious marketplace. While Old World areas are dominated by a single, centrally located church that dominates the view, the American religious landscape has many denominations, sited in many places, with many different names, and using many different building styles (Zelinsky 2001). The plurality of religion and religious experiences in America has led to polarization in terms of trust in religion, but as an aggregate America puts more trust into religion and the state as do Europeans (Proctor 2006). Gaustad (1962) provides a historical review of the times and places that certain churches dominated in the United States from Colonial times through to the 1960's. Gaustad argues that while America is a pluralist society, single denominations will dominate the religious makeup of certain counties, regions, and states. Gaustad cites three reasons for the change in American religion since the Colonial times; freedom of religion, westward expansion of the population, and immigration.

Tuan (2009) opens the book *Religion: From place to placelessness* by stating "Geography and religion are antithetical." Religion is a process of appeasing nature, while attempts to control nature are geography. Humans have responded to the fear of numinous nature through appeasement, which became religion. Different cultures have reacted differently to the sanctification of nature. Where Native Americans found sacred places based upon historic happenings and numinous events in natural areas, while

Europeans focused upon buildings such as churches. Churches can spring up anywhere in which they are consecrated, whereas natural sacred places are location dependent. In America, much of the sacred natural landscape of the Native Americans has been replaced by the nature-controlling, building specific sacred space of the European religious geography (Sherrill 1995).

Tuan outlines a mixing of sacred and secular spaces in the concepts of apartness, order, and wholeness (2009). Tuan discusses how the city, while secular, was used to set apart, give order to, and complete sacred spaces. These spaces can manifest as a sacred state, which "divinely" defines the three above categories. The power inherent in this sacred space construction can lead to violence in various forms of sacrifice. Tuan notes that modern people tend to focus on the positive, peaceful notions of religions and sacred space, in which "they repress, or simply demonstrate, their ignorance" about the violent histories of religions and sanctified sites.

On the religiosity of space

Space can become imbued with many aspects of cultural importance. One of those aspects is sacredness. Emile Durkheim (1965) found that all religious beliefs shared a classification of all things into a dichotomous pair of the sacred and the profane. Sacred does not only connect with connotations of a god or spirit; mundane physical objects like rocks, groves, streams and homes can be sacred. Words and motions too can be set aside as sacred. Durkheim points out that sacredness has varying degrees, meaning that some things have placement in different hierarchies of sacredness than others. For Durkheim sacredness may be individual in nature, but this is only possible through a

cultural group giving the idea of sacredness a context through integrative performances (Robbins and Anthony 1979).

In Otto's *The idea of the holy* (1950), an argument is made that religion cannot be wholly understood from a rationalist perspective; rather, there is an inherent non-rationalist reality to religion. Otto calls this the *numinous*, which is his term describing the extra implications of the word 'holy' beyond 'moral goodness'. The numinous, Otto states, cannot be defined, but instead can only be experienced; as Otto writes, "… our X cannot, strictly speaking, be taught, it can only be evoked, awakened in the mind…" So experiential is the numinous that Otto implores readers who lack true religious experiences "to read no further".

Otto explains multiple facets to the numinous to give it more depth. The numinous is felt outside the self; it is not internal to us. When the numen is present, we experience what Otto describes as 'creature-feeling', which analogously describes man as "abased and overwhelmed by its own nothingness in contrast to that which is supreme above all creatures". The numinous is described as being *mysterium tremendum*. The numinous manifests as a stupefying wonder in the presence of a 'wholly other' (mystery) and a feeling of daunting awfulness and dread (tremors). Contrasting with dread is an element of fascination, which describes the wonderfulness of the holy vis-à-vis the awfulness.

Unabashedly, Otto mentions that Christianity is the superior form of religion. This is similar to the theories of Tylor and Frazer, both of whom applied an evolutionary track to religions, putting monotheism in general, and Christianity in particular, upon a higher evolutionary plane. Other criticisms of Otto's work include problems with his

concept of schematism. Schematism is Otto's attempt to relate the non-rational and the rational by an *a priori* connection. He fails to logically show why this is the nature of the connection, that the non-rational numinous forces the rational mind into action (Ware 2007). Critics of *The idea of the holy* need to also keep in mind that this work represents Otto's starting foray into studying the numinous, and is not intended to be seen as ending point (Streetman 1980).

Like Otto, Mircea Eliade felt that religion had to be studied from a religious standpoint, and not in the reductive ways of other religious theorists such as Marx, Freud and Durkheim. While breaking from the reductionist ways of Durkheim, Eliade used Durkheim's terms of the sacred and the profane. Eliade's sacred, however, was not the social order sacred of Durkheim, but instead very similar to the phenomenological, experiential sacred of Otto (Pals 1996). Eliade developed a foundation regarding how profane space is converted into sacred space (Park 1994). Eliade describes sacred space as being a type of *hierophany*, or manifestation of the sacred (Eliade 1959). Sacred space is space oriented at a fixed point, whereas profane space is homogenous. Profane space can be thought of as unoccupied chaos, and sacred space is a constructed *cosmos* representing the center of the world. In many cultures, these sacred spaces are consecrated by an *axis mundi*, or a vertical pillar that connects the earth to both heaven and the underworld. In Eliade's conception, archaic people founded cities by locating at sacred high points that would represent the heavens. While cities are founded at sacred points, Eliade sets sacred space completely apart from that of profane space.

Pals (1996) outlines three common critiques of Eliade's work. First, some interpret Eliade to come from a theological rather than scientific standpoint. While there

is no direct appraisal of which faith system Eliade may himself have believed in, some critique that a belief system has influenced his work. Because of the dearth of evidence about Eliade's own belief system, others will maintain that his approach is based in phenomenology rather than theology (Studstill 2000). Second, his historical methods of finding similarities between different faith systems can be seen as superficial. Much of the context of distinct rites and symbols are stripped of their temporal, spatial and cultural contexts. This is a similar critique that was levied against earlier proponents of religious generalization, such as Frazer. Third, Eliade's work contains some confusion within concepts; for example, he mentions in some places that the symbol of a linkage between the earth and heaven is the important aspect (and not what the object itself is), but other times lifts certain types of *axis mundi* above others, such as the great tree.

In his famous essay *Map is not territory* (Smith 1993), Jonathan Z. Smith describes three different maps of the cosmos. The locative map is used to interconnect everything within the cosmos and to put everything under control through symbols and rituals. The utopian map shows the chaos and fear that is the interconnectedness of things. The third map, which Smith does not name, maps the incongruities of the two above maps. The locative map denies disjunctions through ritual and repetition, whereas the utopian map shows that man must flee from disjunctions. The third map lets the incongruities of both to exist at the same time, leading to introspection. Chidester and Linenthal (1995) write of the first two of Smith's maps but do not detail the third. Chidester and Linenthal refer to locative maps as "fixed" and "bounded" while utopian maps are the opposite.

Another of Smith's works, *To take place: Toward theory in ritual* (1987) was written during the 'spatial turn' seen in many humanities. Smith hits on multiple ideas and examples through the book, with the key theme of the relationship of ritual and place. Over the course of the book, Smith criticizes Eliade's take on the Tjilpa myth described in *The Sacred and the Profane* and investigates Christian sites in Jerusalem. On Eliade, Smith claims Eliade used as source material a piece contaminated with Near East and Indic conception, not pure to the actual myth, and falsely tries to put all religious experience under the umbrella of establishing a 'universal' pattern of the sacred Center. Smith points out examples of how we describe place linguistically, through connections to memory (commonplace, "I can't place it"), its "value-laden" use (using the chorus to Country Road as an example), and of course, the name of his book.

One of the more interesting portions of the book is his appraisal of humanistic geography. Smith outlines the theories of humanistic geography regarding space and place as 'intimate' and 'meaningful experience', in which space is abstract, and place is embodied with meaning. Geographers use the ideal of 'home' to describe place, and can be stretched to include all places inhabited by people. Smith makes three points about humanistic geography: first, the ideas of home and place may be 'parochial' based upon the richness applied to those words in English that are not laden in other languages; second, humanistic geographers flipped the historic relationship of place and culture ("environmental determinism") to man and culture creating place; third, how much does the idea of perceptive home-place differ from the geographical idea of the 'uniqueness' of spatial phenomenon.

In making these three points, Smith is critiquing geographic theory. He supposes that space is not in fact unique, using theories by sociologists such as Durkheim (Knott 2005). Instead place is a "social position within a hierarchical system." It is ritual that sacralizes places or things; a way to indicate difference between places. This book by Smith does not appear to be cited often in the geographic literature, perhaps because he is making these critiques. Humanistic geographers have been loath to associate with the past geographic concept of environmental determinism. And indeed, the thought of the uniqueness of place and location is the crux of geographic inquiry. While Smith is right that the environment can impact culture, it is difficult for a geographer to reconcile his claim against the uniqueness of place.

Lane (1988) outlines four axioms to guide those wishing to study sacred places, listed below in his words:

- Sacred place is not chosen, it chooses;
- Sacred place is ordinary place, ritually made extraordinary;
- Sacred place can be tred upon without being entered;
- The impulse of sacred place is both centripetal and centrifugal, local and universal.

These axioms come from an Eliadian basis (Knott 2005). Lane puts an emphasis upon the ordinary as sacred, recounting from his own experience, Lane recalls visiting a clearing in the woods that he had been to multiple times, but during one certain visit he had a special and serene experience. Lane describes the human propensity for hyperbole when it comes to sacred spaces; that these must be "extraordinary" or "monumental".

General takeaways

This section has looked at the combination of religiosity and space from two perspectives. Both perspectives add to the necessary elements of a model of

spatialization. From geographers like Sopher (1967), it becomes clear that religious organizations through institutional power often create spatial hierarchies. Through these spatial hierarchies, institutional religious practices can be ascribed. From Sherrill (1995) and Zelinsky (2001) it is shown that American spaces of religion and sacredness are most often tied to buildings, an influence from European colonialists. It is a usurping of Native American tradition, coming from those with power to control nature rather than live within nature. From religious scholars more perspectives are provided. Durkheim (1965) posited that within societies there is both the sacred and the profane, and the sacred found order through social interaction. Eliade (1959) built upon the sacred and profane dichotomy but proposed the sacred as more experiential. Eliade calls sacred space a *hierophany*, which is a fixed manifestation of the sacred with space. Smith (1987) focuses upon how ritual is the important cultural practice that differentiates space. These theorists are adding ingredients to a model of spatialization. The model must allow for spatial hierarchy and the sanctification of human-constructed buildings, while also allowing for a mixing of the sacred and profane within these spaces. Religious practice, such as rituals, can be used to create religious spaces. In the case of Adventist duties of health, these theories allow for the spatialization within institutional spaces of power such as hospitals, which mix the sacredness of duty with the profane of scientific medicine. Rituals practiced by those in the hospital, including prayer, can distinguish difference within these spaces.

The special case of sacred space

The Eliadian construction of setting the sacred and profane apart can be somewhat reductive to the idea of sacred space as temples and shrines, but often, sacred space is much more complex than this and is often mixed with the profane (Chidester and Linenthal 1995). Sacred spaces can be and are created anywhere. In some cases nature is a place in which the connection to sacredness is especially strong (Hume 1998; Ashley 2007). Humans have long had deep connections to the sacredness they sense in places untouched by humans (Durkheim 1965). While there are numerous examples of religious ecology - or a sanctification of nature - sacred space need not be natural. Park (1994) states that there is not an universal agreement upon what accounts for the sacredness of place. There are hierarchies of sacred space, both defined by researchers and perceived among the faithful. Park describes sacred space as ranging from zero dimensional points to three dimensional space; one could add a fourth dimension involving sacred time, as outlined by Eliade (1959). Elsewhere, the built environment is imbued with sacredness. Early rabbinical interpretations declared that not only was the temple sacred, but the entirety of the temple city was sacred ground, leading to barring the both unclean persons and unclean actions, such as the discharge of bodily fluids, from anywhere within the temple city walls (Bokser 1985). In America, the environmental conceptions of sacred space used by Native Americans were largely reformed by the ideals of European colonialists that tended to regard the built form as sacred (Sherrill 1995). Puritanical tradition brought to America an idea that there was no distinguishing between sacred and profane spaces. Using the New Testament as rationale that all places are holy, Puritans in New England built plain meetinghouses designed to homogenize sacredness. Despite this

democratization of sacred space, Puritans in America in practice spatialized sacredness specially through centrally locating meetinghouses in towns and seeing “a sacred place of refuge” in their new home of New England (Walsh 1983). The built form does not necessarily need to be connected to a particular religion. Roadside shrines, for example, can be either permanent and connected directly to a religion (Park 1994), or temporary and connected solely to a real and specific person that recently died with no overt religious connection (Larson-Miller 2005).

Chidester and Linenthal's introduction to American Sacred Space (1995) describes the nature of sacred space as ritual, contested and significant space; a space in which human bodies can both consecrate and desecrate sacred space. Constructed and built structures often operate as "nodal points" of an entire network of sacred places. Sacred space is not absolutely set apart from the mundane world as Eliade proclaims, but instead is mixed with profane systems. Power systems guarantee that sacred space is contested through appropriation of space and exclusion from places. Sacred space within America often is not created with an overt and direct theological theme, but instead connected to nationalism and the identity of what is “America” (Chidester and Linenthal 1995).

The overarching response from the literature is the idea of sacred space as experience. Durkheim (1965) writes of the deep connections individuals have with space, especially those spaces untouched by humans. For Durkheim sacredness may be individual in nature, but this is only possible through a cultural group giving the idea of sacredness a context through integrative performances (Robbins and Anthony 1979). Otto (1950) finds religious experience so important to the idea of the numinous that one

has to have experienced it to understand his work. Eliade (1959) built from Durkheim and Otto in defining the hierophany. Sopher (1967), in one of the first major works on the geography of religion, directly calls to the phenomenological when writing about sacred spaces. These early works – all are from before the 1970's – are further expanded and elucidated by subsequent scholars, but few critique the experiential nature of sacred spaces.

In Chapter 5 of this paper, both the terms 'sacred' and 'religious' will be used to better understand the qualifiers Ellen White used to describe 'duty'. Especially in the aspect of colloquial speaking and writing, 'sacred' and 'religious' tend to be used somewhat interchangeably. In the academic literature, authors tend to use one term or the other within their writings, but when compared across authors, the terms again can be used to describe the same phenomenon when talking about space. Park (1994) warns that one must not confuse religious sites as sacred sites; there are times when sites do not belong to both categories, as he exemplifies with Quaker meeting houses. Within this paper, the terms 'religious space' and 'sacred space' are used. The difference is two-fold. First, there is experience. 'Religious space' will be defined as space used within the context of a religious tradition that forms a link between the physical and the metaphysical. This definition is disembodied, with no regard to phenomenological and personal experience. These are spaces in which we can see members of a religious tradition connect with the metaphysicality of the religious tradition. This definition is similar to that of Livingstone, Keane and Boal (1998), as these authors define religious space as "multi-dimensional, incorporating both the material and the metaphysical." However later in the article it is stated that religious spaces "come in a variety of forms,

both material and metaphysical." The implication is that religious spaces can be either material or metaphysical in nature. The definition given in this paper emphasizes that religious spaces are those in which the physical and metaphysical are *linked*; not simply occupying similar or adjacent spaces, but integrated and merging as one. The definition of 'sacred space' used depends upon personal experience. Sacred space is defined as space in which an individual has manifested and experienced the link between the physical and the metaphysical. This space need not be associated with any religious order. Devout atheists, for example, can still experience a connection with an entity that is generally beyond cognition except in the context of certain spaces. For example, those without religion can still experience this metaphysical plane through the emotions associated with place; the awe of the Grand Canyon, the longing of a childhood home, or the sorrow of Ground Zero in New York City. Sacredness as it manifests in space is dependent upon an individual's personal experience with the space. If any person feels this connection between physical and metaphysical in a space, it must be sacred. This is clearly vague and circular definition, but it is purposefully vague and circular. As David Chidester states, "[a] descriptive approach to the study of religion *requires* a circular definition of the sacred: Whatever someone holds to be sacred is sacred" (1987). The circularity is necessary because the sacredness of space is dependent upon an individual's sense of place, as elaborated by Jackson (1994) and other cultural geographers. Both terms will be used in the context of this project, depending upon whether the spaces being discussed pertain to spaces used by a religious order, or spaces in which individuals feel a connection with the extraordinary.

The second difference is implied in the preceding paragraph and deals with social construction versus personal construction. Religious space is social space; it is space that is constructed by a society for interaction among members of the group. In the case of religious space, the social space is designed for adherents to socially practice their religion. Religious space is often, but not always, constructed through the power structures of religious hierarchies, at least in religions that have these hierarchical power structures. The hierarchical structure is to control the religious experience of the group. Sacred space is not social; it is personal. Sacred spaces are created through personal experience rather than social practice. Sacred space is space lived by those that experience the phenomenon of the sacred. Being personal, sacred space falls outside the hierarchical power structures of religion and can be completely opposed to the overarching religious power structures. Disembodiment versus experience and social versus personal; both of these dichotomies create differences between religious and sacred space.

Sacred spaces of health care

Hospitals

With a sense of transcendence, ordinary hospital spaces can become sacred spaces (Reimer-Kirkham et al. 2012). Hospitals will often contain formal sacred space in the form of a chapel or non-denominational meditation room (Leguit 2004; Reimer-Kirkham et al. 2012). These formal spaces in secular hospitals tend to be designed for generic spirituality, with multiple symbols mixed from various religious traditions (Reimer-Kirkham et al. 2012). In Catholic hospitals, religious sacred spaces such as chapels were

placed closer to patients' rooms and further from operating rooms to both give easier spiritual access to patients and to keep the sacred and profane separated (Wall 2003). Informal religious spaces are created in hallways, multipurpose rooms, areas outside the hospital and perhaps most importantly, inside patients' rooms (Wall 2003; Reimer-Kirkham et al. 2012). Wall (2003) found that Catholic patients who believe in religious objects being able to provide miraculous cures welcomed shrines, relics and symbolic representations in their rooms. People from other religious or spiritual backgrounds equally found comfort in their own sacred symbols (Reimer-Kirkham et al. 2012).

Catholic hospitals have gone through a similar metamorphosis as their Adventist brethren in adapting to modern times with advanced medical and surgical scientific procedures. Both made efforts to provide comfort and healing both bodily and spiritually; the primary goal of Catholic hospitals was to spread the word of Christ's salvation. Despite the insatiable push for science in the hospital, Catholic hospitals also expanded hospital chapels, added symbolic embellishments and named patron saints of the hospitals (Wall 2003).

Leguit (2004) argues that a hospital can and should be treated as a temple. Using personal experiences of trying to heal the patients' spirits along with the body, Leguit found that hospitals needed to "readmit the soul" to render full health care. Ignoring the spirit and the soul of health care creates contested sacred spaces through impersonal and cold interactions between health care providers and patients (Reimer-Kirkham et al. 2012). Complementary and alternative medicine (CAM) brings elements of body, mind and soul into a holistic way of providing health care, but CAM must battle for space

within the scientific evidence-based medical paradigm (Leguit 2004; Knott and Franks 2007).

Metaphysical spaces

Not only are physical rooms important for studying sacredness in hospitals, but so are the physical and mental spaces of bodies and the interactions of bodies in space (Knott and Franks 2007). Buehler (1992) used grounded theory to understand traditional health care beliefs and practices of Crow Indians. Crow Indians, similarly to the Seventh-day Adventists, believe that compromise in the interconnection between mind, body and spirit caused illness. In addition, many Crow Indians believe that illness can come from malevolent spirits that are especially found within hospitals. As such, some Crow Indians use rituals and sacred objects in their health care practices. Rituals such as sweat baths and sun dances, along with sacred objects such as herbs and amulets were used not only for healing but also as a practice of preventative health care.

Sacred space can be mental space; a space in which health providers access to help patients. Hunter (2012) uses the expression "walking in the sacred spaces" used by one interviewed therapist to describe the enrichment felt when joining a trauma client on a path towards mental healthfulness. Hospitalized patients often think spiritually about the meaning of life and their relationships with others and higher powers. Feeling a presence of the divine in the hospital during their recovery from an acute myocardial infarction, be it from loved ones, health care providers, or natural sources, helped to promote peace and comfort while lowering fear and stress (Walton 1999). By still using the older societal agreements of oaths and covenants, the sense of sacredness is given to

the practice of medicine; a sense that is felt both by patients and doctors. Transactions between patients and doctors were set apart from the profane self-interest of markets and instead placed in a sacred selfless advocacy, partially because of the implied god-like life-and-death power possessed by doctors (Fine 2003). Through using compassion while sharing spaces with patients, health care providers help create spiritual and sacred spaces for the patient and health care provider (Reimer-Kirkham et al. 2012). The power dynamic of the doctor-patient relationship is inherent historically and creates contested spaces (Knott and Franks 2007).

Lefebvre and the spatial triad

The spatial triad

One major theorist on the social conception of space has been purposely left out of the discussion until this point. The work of Henri Lefebvre (1991) and the spatial triad forms the starting point for understanding how religious spaces are created in this paper. Lefebvre states that every society produces space. The space is singular to that society; independently constructed, within that particular society's time or time. Lefebvre created a conceptual spatial triad to describe the various intersections of social space within society (Figure 13). First is *spatial practice*, which is space in which members of society use and perform within. It is the space for the everyday, constituting daily commutes and patterns of life each member of a society practices from day-to-day. Certain spatial practices may be religious in nature, such as a pilgrimage, but there is nothing about spatial practice that is intrinsically religious (Knott 2005). The second of the triad is *representation of space*, which is the conceptual space designed by "scientists, planners,

urbanists, technocratic subdividers and social engineers" to order and control spatial relationships of production (Lefebvre 1991). Lefebvre calls this "the dominant space in any society (or mode of production)." The third is representational spaces, which is space "directly *lived* through its associated images and symbols", space that overlays physical space to create symbols out of the physical items we see (Lefebvre 1991). This is the same space Ed Soja described as 'Thirdspace', a space of "social and cultural resistance" (Knott 2005). Lefebvre described the triad as having advantages over the commonplace usage of dual relationships. Dualism led to "oppositions, contrasts or antagonisms" within philosophy that are not always useful or relevant in description (Lefebvre 1991). The spatial triad, instead of being composed of contrasts, is an interconnected system in which an individual can shift from one space to another logically and easily. Space is simultaneously a product and a means of production; it is both the goods we use and the way those goods are traded.

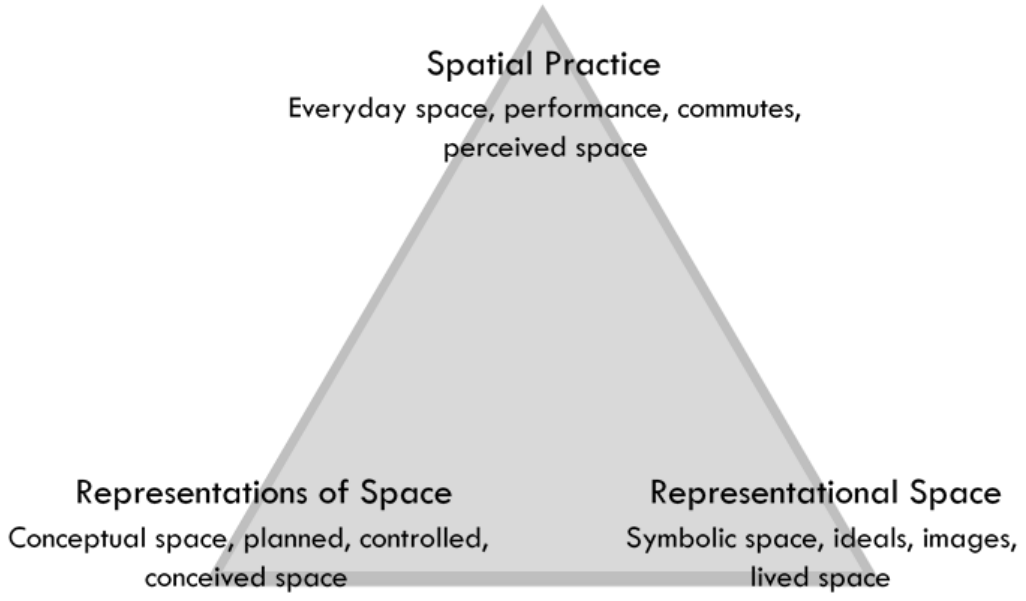

Figure 13 - Demonstration of Lefebvre's spatial triad

Applications to religious spaces

In her book *The Location of Religion,* Kim Knott (2005) developed a spatial methodology to study location within a field of religious/secular relationships within Western culture. The utilization of geography and spatial analysis by scholars of fields outside religion has been welcomed within the sub-discipline of the geography of religion (Yorgason and della Dora 2009; Kong 2010). In opening up the concept of space for the study of religion, Knott leans heavily upon the spatial triad of spatial practice–representations of space–representational space outlined in Henri Lefebvre's *The Production of Space*. Knott clarifies these labels by using perceived space, conceived space, and lived space. Spatial practice, or perceived space, is the space of everyday performance. Representations of space, or conceived spaces, are conceptual spaces built to impose power structures. Spaces of representation, or lived spaces, are spaces that overlay symbolic meaning to physical objects. Each of these aspects of space has value in studying religion from a spatial standpoint. Instead of focusing purely on the sphere of the religions, a view in which decreasingly few people perceive as wholly separate from the secular, Knott chooses to work within a field of religious/secular relationships. The research conducted in this dissertation uses a similar world view insomuch that the relationship between duty and health is well placed in the religious/secular paradigm.

Knott (2005), in discussing Smith's maps, writes that although it is tempting to force Smith's three maps into Lefebvre's spatial triad, the third map is problematic in finding a correct match. While the locative map is similar to 'representations of space' (order and control space), and the utopian map is similar to 'spaces of representation' (disruptive of order), the third map is also representational and doesn't fit strongly with

'spatial practice'. This critique is well-situated; while it is important to acknowledge Smith's important work in spatializing religion, it should not be directly applied in research utilizing Lefebvre's spatial triad directly.

Beyond Knott's pivotal efforts of placing and practicing Lefebvre, other scholars have extended Lefebvre. Watkins (2005) uses the spatial triad as an approach to use for organizational analysis; in this case, a community theater. Organizations traditionally deal with one form of space, Cartesian abstract space, and Watkins argues that the spatial triad allows for a "richer, more insightful" analysis. Carp (2008) uses the spatial triad framework as a means to integrate the professional expertise found in the discipline of planning with local, participatory perspectives. Using this helps to reinforce the reciprocal nature of planning decisions, as decisions affect and are affected by multiple scales of relationships. In this, Carp uses planning's participatory nature to combat Lefebvre's view of social space being designed and imposed by a power structure onto the public. Simonsen (2005) cites Lefebvre's use of embodiment as an entry to understand his potential contribution to body geography. Lefebvre does not use the metaphorical idea of space, as contemporary body theorists did. While Lefebvre did not outright create a theory of the body, Simonsen finds that his theories create a duality of the body, contributing to debates on body politics and performativity.

Both Gregory et al. (2014) and Barina (2015) have applied the spatial triad to health care spaces; the former on an acute care ward and the latter on non-acute spaces outside of the hospital. Gregory et al. use qualitative methods to assess the perceived, conceived, and lived spaces within an acute care ward of a teaching hospital. The authors find learning is both enabled and constrained by space; a strong connection to the

Lefebvreian view of the dialectical process of social production of space. Barina expands upon Lefebvre's social construction of space with the ideal of ethics. As Barina states, "[e]thically neutral spaces do not exist." As such, morals are imbued within spaces created from each of the points of the spatial triad. This forms a segue to scholars beyond Knott applying Lefebvre to religious spaces. MacDonald (2002) draws upon the spatial triad and applies it to Presbyterian worship services in the Scottish Hebrides. MacDonald uses a new application in describing only the religious geographical processes connected to mobile capital. Bugg (2012) applies Lefebvre to place identity of religious facilities for minority populations (Islamic and Hindu) as generated within and against spaces designed through land-use planning policies and other local residents.

From the spatial triad to the construction of dutyscapes

Both Lefebvre's work in breaking space into a perceived-conceived-lived spaces and Knott's work of applying it to the spatial study of religion are exemplary works. However, it is argued here that religious spaces are more complex than the interplay of perceived-conceived-lived spaces. The issue is that the spatial triad implies an equity in the production of space; a notion completely fair to the general ideas of the arrangement of social spaces. The difference in religious space is the imposed hierarchy in which the individual is interpreting not only social space, but God's spatial intention. As such, this paper re-conceptualizes the spatial triad as the construction of the *dutyscape* through the filter of space (Figure 14).

The spatial triad itself, composed of spatial practice, representations of space, and representational space, is reconceived as the filter of space. It is the filter of space that

allows religious duty to connect with an individual's agency of belief. Religious duty is therefore manifested and interpreted as a *dutyscape*, or a cultural landscape embodied with religious duty. This can be either religious space, as disembodied and social in nature, or sacred space, as personally experienced. Religious duty is interpreted through its spatial manifestation. And this duty manifests in three ways; as the perceived, conceived, and lived spaces of the original spatial triad of Lefebvre.

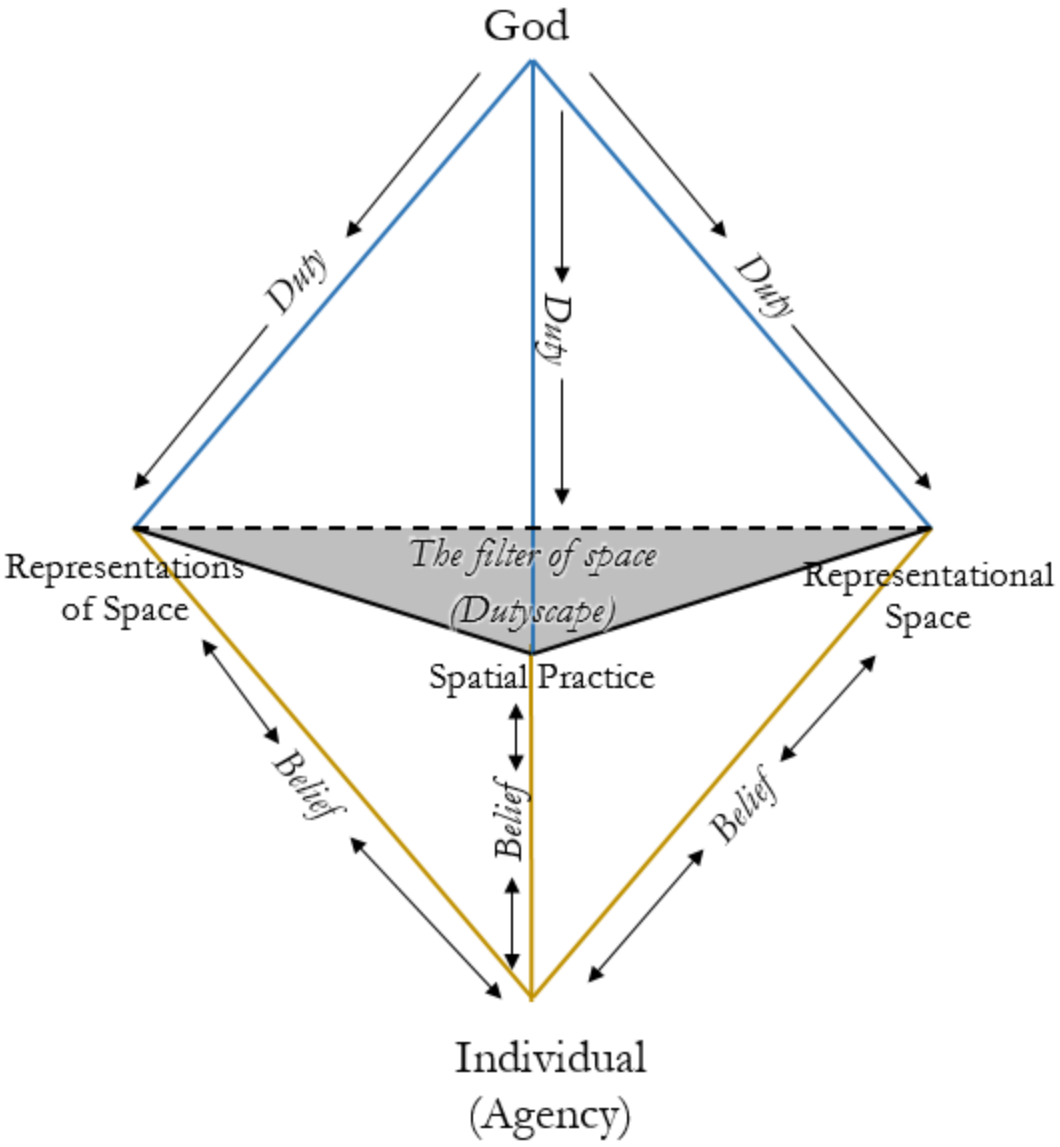

Figure 14 - Conceptual model of the spatial construction of dutyscape

Let us take the religious duty of health in Adventism, as described somewhat in Chapter 2 and more deeply investigated in Chapter 5, as an example. Spaces of health, based upon religious duty and religious belief, manifest within the three locations of the spatial triad. Spatial practice – space perceived in daily life – manifests for example within the spaces of religious practice; that is, the spaces in which the laws of God are obeyed and followed. For those working within the health care industry, these are the daily routines of their jobs; caring and curing for the ill and helping awaken the laws of God within patients. Those Adventists that do not work within health care likewise experience spatial practice in the spaces in which they themselves follow the laws of God as it comes to health. Eating healthily, taking in fresh air, and choose to exercise are among some of the daily activities that spatialize. Representations of space – space conceived by power – manifest for example in the formal health spaces of Seventh-day Adventists. The worldwide landscape of Adventist hospitals have been planned via the power hierarchy of Adventism. These are spaces that are designed to regulate the spatial relationships related to duties for the provision of health; particularly institutional duties as to be outlined in Chapter 5. Formal health spaces are the spaces that bring order to the dissemination of God's laws of health, as places that connect the doctor to the patient, the conduit of God's laws to the recipient. Adventism has many other formal spaces within the category of representation of space, including medical schools and other sites of Adventist learning, which are related to institutional duties of advancing health reform education and professionalism. Representational spaces – symbolic spaces – manifests most prominently within the ideal of treating one's body as a temple of God. The human body, for an Adventist, is God's possession and must be treated healthily to truly follow

God's laws. This symbolic view of the body gives religious meaning to the physical body. It is that constant reminder of the connection each person has to a higher power.

If the spatial triad so adequately fits the Adventist health model, then why propose an extension to Lefebvre? The reasons are duty and the agency of belief. While various parts of the duty to health care can be placed within the spatial triad, the placements fully ignore the affect duty has in the spatial manifestation. It is the *why* of spatialization; spatial manifestation in this case is occurring for a reason. These are the spaces of the human interpretation of God's laws; of the duty of health. The spatial triad represents the space of this interpretation as a *dutyscape*. When it comes to the construction of religious space, the *axis mundi* as described by Eliade should be considered. Religious (and sacred) spaces involve the connection of the physical and the metaphysical. This directionality is not inherent to the spatial triad. Within the context of this spatial model, the connection made between the physical and the metaphysical is religious duty. Religious duty does not manifest itself; rather, it must be constructed through the process of belief. The realization of duty happens spatially, creating the landscape of duty or *dutyscape*.

The spatial interpretation of religious duty has dimensionality both above and below the spatial triad. Religious duty, the duties required by God, are unidirectional. Duty 'comes from on high'; it is sent downwards towards humanity. The individual, however, has a bidirectional relationship with space. Humans have agency; the choice to believe. As religious duty manifests in space, the individual interprets this duty and using the choice of belief will either interact with space with duty in his or her heart, or choose not to. This is the rationale for renaming the spatial triad the filter of space through

which a *dutyscape* is created. It is through religious spaces that humans conceive, perceive, and symbolically live the duties of God. It is through sacred spaces that humans can connect physically with the metaphysical. These religious and sacred spaces only exist if there is the directionalities of duty and agency.

It is of note to signify that the construction of the '-scape' is not a new phenomenon. Besides the common uses of landscape, seascape, and cityscape, among others, academic research has produced other '-scapes' to describe various human-environment spatial interactions. One such iteration is the taskscape. The term 'taskscape' was coined by Tim Ingold (1993)to describe an collective of related activities, related in temporality to each other. Ingold further discusses taskscapes in *Perception of the environment* (2011). Ingold's perspective on the taskscape is that activity and temporality goes into the construction of landscapes. Thus, human activity is not something that simply plays on a background of the landscape, but instead is a composite component of landscape transformation. This paper's conception of the *dutyscape* is similar in construction but differs in emphasis. Duty is an activity that can be practices in real and metaphysical spaces and has a recursive relationship with landscape. But Ingold uses the term 'task' to signify acts that are "part of his or her normal business of life" (Ingold 1993). While some religious duties as described above in the model of the *dutyscape* are quite mundane, others are inherently abnormal and apart from the everyday life of people. *Dutyscape* encompasses a different manifestation upon the landscape.

Discussion

Space and place are the basic units of analysis in geography. The abstract 'space' and the agency-imbued 'place' have found usage in other social sciences and the humanities, as the 'spatial turn' has engaged scholars beyond geographers into the analysis of the spatiality of cultural expressions. Marxist theoreticians have identified how power systems and institutions create space for the rest of society to exist, which can be rebelled against as described by de Certeau, flatten the difference and uniqueness of place as theorized by Massey, and are used to monitor and control populations as illustrated by Foucault.

Religions themselves are power structures of society, creating spaces along with theologies. The intersection of religion and geography provides the literature with two perspectives upon the same phenomenon. Those in the discipline of geography try to understand religion in the context of its spatiality, while scholors of religion attempt to understand space in the context of its religiousity. While many of the religious scholars have work grounding in how rituals are performed in space, theoreticians of geography tend to look at the spatiality of the cultural expression of religion. In both cases, the concept of sacred spaces are exposed. While different theorists will use the terms 'religious' or 'sacred' to describe essentially the same concept, this research differentiates the two on the basis of experience. Spaces can be religious on the basis of a religious power structure declaring the spaces to be religious, regardless of practice or experience of those inhabiting the space. Sacred spaces however are experienced by the individual through his or her own agency. In that way, religious spaces are those in which a link between the physical and metaphysical is formed. Sacred spaces are those in which the

link is perceived and experienced by the individual. Literature shows that spaces of health care, both physical and metaphysical, can be perceived as sacred spaces.

Henri Lefebvre theorized a societial production of space based upon the interplay of what he called the spatial triad. This model rejects the dualism of other theories of space creation, instead depending upon the three legs working together to make space both a product and a means of production. This perceived – conceived – livid triad of space has been adapted towards the analysis of religious spaces. However, despite the overall high quality of analysis done by these theorists, the issue of religious duty is not described explicitly within these analysis. Religious duty has a directionality that, on its face, appears to be in conflict with the interplay of the spatial triad. But that is because the spatial triad lacks directionality due to its flatness. This chapter recommends an extension of the spatial triad in order to fit the directionality of duty, coming from God, and the human agency of belief. This three dimensional rendering creates a hexahedron, through which a *dutyscape* is created duty and belief pass through this *filter of space*.

The major application of this theoretical model is describing how religions manifest spatially. It is through the creation of a dutyscape that God is interpreted and manifests, via the connection of God's duty to human agency of adherence. The connection happens spatially. It is a religious space when the link between religious duty and human belief is created, but sacred space when the connection is experienced. Similarly, spaces created for social practice are religious while the personal manifestations of duty through human agency create personal sacred spaces. It is through space that God's duty manifests.

Chapter 5: The religious duty of health

> "But I think you will agree that because we believe as we do, God expects us to engage in the care of a sick man's body as a sacred task."
> Francis D. Nichol (1964)

The academic literature regarding Seventh-day Adventists often centers on health outcomes and difference on the basis of common health decisions by Adventists; medical studies investigate cardiovascular and cardiopulmonary health (Harris et al. 1981; Cooper et al. 1984; Kwok et al. 2014), sexual behavior (Hopkins et al. 1998; Ashley, Ramirez, and Cort 2013), mental health (Fayard et al. 2007; Thygesen et al. 2013), differences in diet (Hokin and Butler 1999; Kiani et al. 2006; Beezhold, Johnston, and Daigle 2010), and an overall trend of using Adventists as a control group (Euler et al. 1988; Hunt, Murphy, and Henderson 1988; Gimsing 2014), among others. What this literature fails to analyze is the question of why; why do Adventists put so much focus upon the health? This section will outline that it is so important because Adventists label it a religious duty.

Religious duty

Religious duties, standard and nonstandard

Near as can be ascertained in the context of this research, all religions present religious or sacred duties in which adherents are encouraged or obligated to follow. While not every one of these duties is directly and clearly written in holy books, religious duties have been taught through the religious systems to practitioners. Some of the actions most commonly associated with religion come from a sense of duty. In his book *The geography of religion*, Roger W. Stump (2008) outlines a variety of religious duties

and obligations found in many religions. Being a book based on geography, these are duties that generally manifest spatially.

Prayer is a common duty among practitioners of many religions. One of the five fundamental pillars of Islam is a requirement of five time daily prayer towards the direction of Mecca. Prayer itself can be both a personal and a communal duty, as many religions expect their adherents to gather in group religious activity. This implies another essential duty for a majority of religions; the consecration of communal spaces of worship. Perhaps the most dominant religious form on the landscape, the myriad churches, temples, mosques, and other spaces of religious community form a necessary bond between bodies, people, and deities. How one uses the body is another common category of religious duty. Public self-flagellation in medieval Christianity was seen as a way to atone and connect with Christ. Fasting is a religious duty associated with Christianity during Lent, Islam during the holy month of Ramadan, Judaism during Yom Kippur, and associated Native American religions during rites of passage such as the vision quest. How one dresses or appears in public can be a religious obligation. Distinctive dress of Orthodox Judaism, the veiling of Muslim women, and Khalsa Sikh men wearing the five kakars – articles of faith – display this type of duty. Muslims during the Hajj are required to dress in a particular way to emphasize purity and community. Of course, the religious pilgrimage is another common sacred religious duty among practitioners. While the Hajj is the most well-known obligatory religious pilgrimage, others such as the Shinto pilgrimage to the shrine of Ise exist. Stump (2008) describes pilgrimages of obligation "in part serve to reinforce in the believer's mind the

principal ideals of the religious system's ethos, but serve as well to strengthen the sense of community shared by the region's adherents."

In the case of proselytizing religions there is a duty to use missionary work to expand the faith. This is a common expression of territoriality and dominance of the group's religious ethos through the spreading of the faith. In Islam the concept of hijra has been interpreted as some as a religious duty to migrate as an effort to expand the Dar al-Islam, or the "realm of Islam". Christianity has a long history of missionary work as well. Recently, Protestant evangelists have created the "10/40 Window", a geographic space in Africa and Asia stretching between 10 degrees and 40 degrees north latitude. This area, where the largest numbers of non-Christians are located, has been designated as a major focus of missionary work. This effort is often led by American-born religious movements such as Seventh-day Adventism[9], Mormonism, Jehovah's Witnesses, and some Pentecostal churches. Maintaining religious pureness is another common duty given to leadership or the entire body of a religious movement. Kings of Theravada Buddhism, particularly in Thailand, saw as an obligation to protect and impose orthodoxy upon the sangha, or religious community.

The prior duties are in large part seen as universal duties to religions or at least sizeable sects of religions. There are a plethora of other potential religious duties that are argued by a smaller number of adherents. Dumsday (2011) even argues that adherence is not a requirement for a religious obligation to exist. Applying the 'duty of easy rescue', Dumsday argues that atheists and agnostics that do not completely discount the existence

[9] The *2015 Annual Statistical Report* (2015) published by the General Conference has a short section on the 10/40 Window, along with a map of countries that fall within, describing it as "the home to some of the largest people groups who do not have access to the Gospel message."

of God have a duty to pray to God in situations that offer even the smallest probability of success coupled with no harm to oneself. The duty to protect the weak by the powerful has religious and legalistic ties. Rulers in Islam have a duty to protect their subjects, and subjects to obey, which within the geopolitical landscape of the early 21st century leads to questions of how Muslim-ruled countries must respond to political movements like the Arab Spring in bringing changing views of human rights to their populace (Oh 2013). Maring (2012) argues that a 'duty of interference' is required of any authority structure when the authority can easily step in to prevent evil; be that authority human in nature or God himself. While not purely religious in nature, some arguments have been made that religious institutions have a duty to protect both their membership and community, at least from a legal standpoint. Schwartz and Lorber (2005) argue that courts can find valid claims that religious organizations have a duty to protect people from predatory conduct from clergy, but that courts need to ensure this duty does not extend to protection from the entirety of the adherent membership, which by its nature would be nearly impossible for a religious organization to entirely monitor or control.

Religious duties for health

In 1998, the Cambridge Quarterly of Healthcare Ethics published a special section discussing access to healthcare from religious points of views. The lead guest editorial on the section declares that while not intended to give a complete view on all religious perspectives, the papers give enough depth on varied religious duties of health care access that the "relative silence" of voices of religion in the public debate over universal access to health care in America is readily apparent (Moros and Rhodes 1998). From the

Jewish prospective it is seen that there exists a duty for individuals and the whole of the community to provide the basic needs for all in a community. However, this duty is not unconditional, as exorbitant costs that would negatively impact the provision of other forms of care to the community is a rationale to ration care (Zohar 1998). The Catholic perspective adopts healthcare access as a human right only after it was established as a personal duty first. The author, coming from the Catholic tradition, summarizes this personal duty as coming from the principle of subsidiarity for the individual to not take life, to preserve life, and to enhance life (McCormick 1998). The Protestant perspective is that while there is great diversity in Protestant thought, there is a general consensus that people must have access to healthcare. Protestant churches are to persuade the public discourse on the virtue of healthcare access, but at the same time, must acknowledge that there are limited funds a community can provide (Verhey 1998).

The creation of spaces of health within religious traditions can in some cases be made because of a sense of religious duty, and sometimes not. Beyond this section, this particular chapter will delve into how religious duty to be healthful and provide healthcare is paramount in Seventh-day Adventism. As will be seen, other traditions follow this path as well. While a duty-based reason in the context of a Protestant religion is not completely unique, the emphasis and importance of this duty within the tenets of Adventism is unique.

Baptist congregations of all stripes set up hospitals, especially in foreign missionary locations, as a means of evangelism. Northern Baptists, Southern Baptists, Seventh-day Baptists, and National Baptists all created and funded dozens of hospitals, clinics, dispensaries, and medical schools in foreign lands (Weber 1986). Despite the

voluminous differences between Baptists, which led to the creation of so many flavors of Baptists, all saw medical missionary work as a tool to save souls from damnation by vigorously encouraging an acceptance of the gospels[10]. But that is essentially as far as health and wellness go with Baptists; it is a means of conversion but not a particular duty. Weber (1986) describes the Baptist relationship with matters of as stating "[l]ike many other Christians, Baptists have concerned themselves with matters of health and medicine without making them central to their practice or theology." Catholicism is mixed in the sense of duty. While caring for the sick and miserable was considered one of the many "good works" that Catholics could do to help their own salvation, there was not a specific duty to heal in order to allow the sick to find God. Rather, healing was a means in which to administer the gospel (O'Connell 1986).

Healing in Judaism is seen as an obligation. Laity of all ages are religiously required to visit the sick as a means of ameliorating their illness, with Jewish legal guidelines for how to best make use of these visitations for their curative effects (Dorff 1986). While this duty to provide health was present, there was not a duty to create spaces of health like hospitals. Jewish hospitals prior to 1950, built in many countries in the West, were built to both provide spaces for Jewish patients and to give professional opportunities to Jewish doctors. In both cases, these were practical solutions to issues of discrimination and antisemitism established in societies, even secular hospitals (Dorff 1986). John Wesley, founder of the Methodist tradition, wrote extensively about health. Though he saw himself not as a physician but as a minister, he wrote *Primitive Physick*, a

[10] Northern Baptists in particular were swept up in the liberal/conservative divide that occurred through many Protestant denominations. The Liberal wing rejected the idea that those that did not accept Jesus Christ in their hearts were headed to eternal damnation (Weber 1986).

book outlining health principles and remedies for various maladies. Wesley emphasized the reciprocal connection between the imperfect, physical body and the pure, incorporeal, "image of God" soul. Medical care, therefore could be seen as a duty to enable the body to be healthful enough to enable soul salvation. Providing medical care also sanctified the practitioners (Vanderpool 1986), leading to the creation of a large system of hospitals. The Disciples of Christ began as a rationalist denomination that rejected superstition and instead accepted living by God's natural laws. Despite building hospitals as part of a missionary zeal, health and wellness were not emphasized much within the theology. As Harrell, Jr. (1986) wrote, "[t]he preservation of physical health, while rarely discussed at any length, was the assumed responsibility of Christians." Thus there was a duty to maintain health, especially through temperance, but it was not a large part of the Disciples of Christ theology. Anabaptists and Mennonites saw the congregation as "a visible, concrete certainty, in which members became sisters and brothers in the family of God" (Klaassen 1986). In addition, good deeds were needed in order to receive salvation from Christ. These combined into a spiritual duty to create institutions to bring health to their congregations. When available, caring was also extended to the surrounding community regardless of faith; an action the denominations saw as required by Christ (Klaassen 1986). In general, many Protestants believe that those that provide medical care are doing God's work. American Protestant Walter Rauschenbusch wrote prayers for doctors and nurses to remind them that their work is a "holy calling" from Jesus the Healer (Verhey 1998).

Healing in Christianity

Early Christianity

The Christian understanding of suffering is paramount to describing how early Christianity dealt with health (Amundsen and Ferngren 1982). Suffering in early Christendom was seen as being positive as God used suffering as a method in purifying one's spiritual wherewithal; and if you were suffering, it meant that you were truly one of God's children. The connection between sin and sickness is mixed in the New Testament. Jesus attests in John 9:3 that sin did not create the inborn blindness of a man but rather the blindness is a way of allowing God's work to be within the man. On the other hand, in John 5:14 Jesus tells a healed man to "Sin no more, that nothing worse befall you" (Amundsen and Ferngren 1982). This manifests throughout the history of Christianity as a tension between faith and medical technology. While many Christians will view physicians and medical treatments as instruments of God to be used to assuage illness, there have always been voices advocating that treatment shows one's inability to accept God (Amundsen and Ferngren 1982).

By the middle ages, medical treatment was administered by Christian clergy at major shrines, monastic orders, and sites of pilgrimage (Amundsen and Ferngren 1982; Gerlach-Spriggs, Kaufman, and Warner, Jr. 1998). Christian organizations, especially monastic orders, deemed health care and hospitality duties that must be completed as part of the good works required of all Christians before the End of Days (Gerlach-Spriggs, Kaufman, and Warner, Jr. 1998). Soon, monasteries became a shelter to the poor and a sanctuary to the sick (Amundsen and Ferngren 1982). Restorative gardens, while originating in non-Christian regions, became an integral part of the healing landscape in

Christian Europe. Restorative gardens, defined as "an ordered place where its occupants will experience a sense of well-being and wonder that will alter their mood," were often included in many medieval Christian charitable institutions (Gerlach-Spriggs, Kaufman, and Warner, Jr. 1998). These foundations were early instances of hospitals, coming from the Christian usage of the Latin *hospitium*, meaning a place where positive feelings transfer back and forth from hosts and guests. In some cases, monasteries or other sacred sites were placed at sites believed to have curative powers, such as springs, mountains, or rivers. The usage of sacramental substance as cure is found in Christianity not only as these sites that become places of pilgrimage but also in the use of holy water (Stump 2008).

After the Reformation

In more modern times, Christian motivations have been at the fore of many healthful movements. The movement to clean up tenement slums in large cities during the Victorian age was in part led by Christians, including a Quaker physician named John H. Griscom that insisted that ventilation is a "*religious* duty" (Numbers and Sawyer 1982). The hospital model developed through Christian places of healing and were strongly connected with the church through the 1500's (Numbers and Sawyer 1982; Gerlach-Spriggs, Kaufman, and Warner, Jr. 1998; Porterfield 2005). Into the 1800s and 1900s, Protestant denominations, seeking to emulate and connect with Jesus the Healer, built hospitals to care for the ill and misfortunate (Verhey 1998).

The ability to connect cure to Christ became all the more important when Christian medical ministries were constructed in lands previously untouched to

Christianity (Numbers and Sawyer 1982). Of course, some movements of healing in Christianity were based primarily upon faith alone and not in health reform movements. Christian Science for example focuses upon spiritual healing rather than modern medical treatment. Faith healing itself is practiced with some regularity among several conservative Protestant groups (Stump 2008). Jehovah's Witnesses still bans blood transfusions and formerly banned vaccinations as religious desecrations involving blood consumption (Stump 2008). While it is common convention today to see religion in general and Christianity in particular arguing vehemently against medical and technological advancement, these voices were in fact few, whereas the majority of Christian clerical opinion was supportive (Amundsen and Ferngren 1982; Numbers and Sawyer 1982). As discussed in Chapter 2, in early Seventh-day Adventism Ellen White emphasized faith as the primary vehicle to curative treatments and expressed distrust of doctors and their methods. This period was short-lived, as Adventists in general and Ellen White in particular found health reforming medical practitioners that used evidence-based medicine that was theologically consistent with their religious faith.

The Importance of the duty of health in Adventism

"The right arm of the message"

"The Lord gave, and the Lord hath taken away; blessed be the name of the Lord" (Job 1:21). This classic Christian scripture, argued the Adventists, can be insulting to God because many people will die not because of God's will, but because of their inability to live by His natural laws. By coupling natural laws with God's design, Adventists embrace science, especially in the medical field (Nichol 1964). Adventists

rejected the belief of some Christians of the duality of the body and the soul; the idea that the soul is immortal after the body dies. Instead, the dead are unconscious until eventual resurrection during the Second Advent (Numbers and Larson 1986; Numbers and Schoepflin 2014). Thus, body and soul are intertwined in the eyes of God. To properly respect and worship God means to have sound mind, body and spirit. Ellen White's theology saw that the brain, where the mind is located, controls the body. It is a "sacred place" (Numbers and Schoepflin 2014) that must be healthy to hear the words of God. The best way to keep this soundness was through the proper maintenance of the self through salubrious living. One should not shortcut the laws of nature solely through medicine or other treatment, but instead should live life in a blend of nature and science to promote good health. Good health, though, was not an individual goal; health reform needed to be, as Ellen said, the right arm of the body of the message (Nichol 1964; Quevedo 2003; Numbers and Schoepflin 2014). Indeed, it was seen as a necessary Christian duty to maintain body and mind health, as the human body should be seen as "the temple of God" (Bull and Lockhart 2007). It was necessary to establish health care institutions to properly pass this message (Nichol 1964). While health reform movements existed prior to those pushed by the Adventists, Ellen White's argument that connected ill-treatment of our bodies as sin readily "elevated health reform from a physiological to a theological obligation, essential to salvation" (Numbers 1983).

Ellen White described to the 1866 General Conference a vision (elaborated upon in Chapter 2) that impressed upon her the need for the Adventist movement to provide a place of healing and health reform education. While the provision of health care and health reform was deemed vital to the Adventist mission, Ellen White also deftly pointed

out that such services may help non-Adventists discover the 'truth' of their message through the curing of their ailments (Theobald 1985). By operating hospitals, Adventists "create good will, break down prejudice, and open doors" (Nichol 1964). The change from the sanitarium model to the community hospital model has led to a lessening of the amount of Adventist-based witnessing on health theory and theology can be spread to patients. Ellen White emphasized in her writings that the chief reason for sanitariums operated by Adventists was to teach Adventist beliefs on God. While early Christians put an emphasis upon caring for the soul, even to the detriment of the body, Adventists believe in caring for both the body and the soul equally. The body, mind and spirit of man were all created by God, and thus, man needs all three to be in good condition to follow God's plan properly. The body, mind and spirit are interconnected and dependent upon each other; thus, one cannot help the spirit without sound mind and sound body. Hence Adventists "believe we should be concerned about literal food, as well as spiritual, with physical discipline, as well as spiritual" (Nichol 1964). Health care for Adventists does not come from a wellspring of sympathy, but instead a higher motivation of returning the body of man to the God's design (Nichol 1964). Indeed, the church declares that the message of "[h]ealth reform and the teaching of health and temperance are inseparable parts of the Advent message" (General Conference of Seventh-day Adventists 2005).

Denominational manuals

The General Conference of Seventh-day Adventists Medical Department published a manual on the proper administration of denominationally-controlled hospitals

in 1968. Within this document, five objectives of Adventist hospitals and four services of ministry are provided (Table 1 - Hospital objectives and services. Information within this table adapted from the General Conference of Seventh-day Adventists Medical Department (1968).). The first objective is related to the Christian concern of alleviating the suffering of those with medical maladies. The next three objectives are related to the much more specifically Adventist health-based theology on awakening the human spirit to the laws of God regarding health and health reform. The last objective relates to creating medical ministry, in order to essentially feedback into the system of denominational growth and recruitment (Manual of operations for Seventh-day Adventist hospitals 1968). The order of these objectives has a specific, cascading order; heal the sick, which makes the healed wonder why Adventists are dedicated to this path, let the curious know about God's laws on health, inform the curious that we have a path of health reform that leads to following God's natural laws, and create an apparatus that the faithful can fulfill their place in the

medical ministry to cure and awaken the spirit. It is plain to see the influence of Ellen White nearly a century after she helped open the Western Health Reform Institute in Battle Creek. She spoke that the mission of the Institute was "to relieve the afflicted, to disseminate light, to awaken the spirit of inquiry, and to advance reform" (Numbers and Larson 1986). Though in a different order, those are the first four objectives listed in the manual. The fifth probably would have been mentioned by Ellen White if she had foreseen the missionary zeal of health care in Adventism.

The services provided by the hospitals also summarize many of the Adventist reasons for providing health care espoused by Ellen White generations beforehand and other Adventists since. Hospitals serve as incubators of health reform education for the church body. Hospitals also are used in recruitment of new adherents and as positive public relations in areas in which Adventists do not abound; while these are two separately-listed services, they follow together rationally as Ellen White explained during the

Adventist hospital objectives	Services provided
1. To relieve the sick and afflicted by scientific medical ministry; 2. To awaken a spirit of inquiry by demonstrating Christian compassion and deep dedication that prompts inquiry as to the motivation; 3. To disseminate light by making known the laws of God pertaining to health of body and soul; 4. To advance reform by precept and example, thus encouraging healthful habits of life; 5. To prepare others to serve by conducting educational and training programs.	1. Help the church membership learn the laws of health; not as a "measuring stick by which to evaluate the piety or holiness of others" but instead to follow God's will with clear minds and healthy bodies; 2. Increase membership through showing "human service and compassion" to those in need of healthcare; 3. Provide positive public relations for the Seventh-day Adventist Church; 4. Give members of the Church opportunity for advanced professional training (General Conference of Seventh-day Adventists Medical Department 1968).

Table 1 - Hospital objectives and services. Information within this table adapted from the General Conference of Seventh-day Adventists Medical Department (1968).

initial phases of international medical ministry. The last service is to provide opportunities for Adventists for professional careers in the medical field (Manual of operations for Seventh-day Adventist hospitals 1968). These fourfold services act as a means of showing Adventism as a benevolent denomination, intent on helping both those within the movement but also the public at large.

The 2005 version of the Seventh-day Adventist Church Manual (2005), while devoted mostly to the structure of churches, clergy, and adherents, also espouses denominational directives and descriptions of the function of institutions of health-care. In a supplement for the North American Division regarding church properties, health-care institutions are described as:

> The gospel ministry is advanced through health-care institutions which are influenced by Christ and His Spirit. Seventh-day Adventists see in the gospel commission, and the example of the Lord and His apostles, the responsibility of followers of Christ to serve the spiritual, mental, and physical needs of humankind through motivated Christian lives and service. Thus from the earliest years of the Adventist movement, health-care institutions have been established to help facilitate the total ministry of carrying the gospel to all the world.

The importance of using health care facilities to extend the evangelistic arm of the denomination is reinforced, as both a historical artifact of faith to a current day rationale of service. The manual puts health-

Duties of Health Ministries Leader	
a.	To outline, plan, and budget, in consultation with the pastor, the church Health Ministries Council, and the church board, programs for the year that will emphasize total health and temperance for the church and the community.
b.	To promote an ongoing witness in the community concerning the destructive effects of tobacco, alcohol, and other health-destroying drugs and substances.
c.	To foster good relationships with community health and temperance organizations.
d.	To encourage the study of the biblical principles and the Spirit of Prophecy counsels on health and temperance.
e.	To encourage the application of the principles of healthful living among church members.
f.	To arrange for and promote the holding of health and temperance education programs for the church and the community it serves, in close cooperation with the conference/ mission/field Health Ministries director.
g.	To serve as secretary of the Health Ministries Council, except when asked to serve as chairperson.

Table 2 - Duties prescribed to a health ministries leader. Information within this table adapted from the Adventist church manual (2005).

care institutions on equal footing with all other institutions, such as individual congregations and schools, as a means to spread the "divine commission" of the world church. Under the umbrella of the General Conference, these institutions are how "the world church reaches out in the name of Christ to meet the needs of a distraught world." It becomes the responsibility of the health ministry not only to alleviate the suffering of the ailing, but also to prevent illness through education and leadership in the fields of health reform. The church manual directs those churches interested in health ministry to appoint a Health Ministries Leader; specific duties listed are included in Table 2 - Duties prescribed to a health ministries leader. Information within this table adapted from the Adventist church manual (2005).. These duties appear to be more organizational and not specifically religious in nature, although the duties involved in spreading the word of health, health reform, and temperance fall quite close to the specific religious duties outlined by Ellen White. This paper will outline these religious duties in the next section.

Comparing duty in the writing of Ellen White

From that first vision, Ellen White has talked about the necessity of the sacred duty of health care. The sacred in religion is frequently manifested spatially, and this sacred duty is no different. Mircea Eliade (1959) describes sacred space as being a type of *hierophany*, or manifestation of the sacred. In many cultures, these sacred spaces are consecrated by an *axis mundi*, or a vertical pillar that connects the earth to both heaven and the underworld. This connection of the sacred act and space occurs for many aspects of religious life, even if religious texts do not specifically call the act or duty sacred. The act of worship manifests in churches and shrines. The duty of tithing manifests in houses

of charity. Likewise, the specified duty to inform and help people with their health for Adventists has manifested into a landscape of healing.

A content analysis of nine books written by Ellen White was conducted to elucidate the importance of sacred duty when it comes to personal health and health provision within the Seventh-day Adventist denomination. The nine books are *Christian Temperance and Bible Hygiene* (1890a), *Healthful Living* (1897), *The Ministry of Healing* (1905), *Counsels on Health* (1923), *Medical Ministry* (1932), *A Call to Medical Evangelism and Health Education* (1933), *Counsels on Diet and Foods* (1938), *Temperance* (1949), and *The Health Food Ministry* (1970). Many of these were published after Ellen White's death in 1915. *The Ministry of Healing* is the only of these nine volumes that was originally penned by Ellen White as a complete book. The other eight are compilations, pulling from among other sources letters, manuscripts, lectures, pamphlets, and Adventist publications, some previously unpublished. These volumes covered various topics of health; Percy T. Magan describes in his preface to *Counsels on Health* (1923) that "[i]n no realm were her teachings more far-reaching and thorough than in that relating to the care of the body – the temple of the Holy Spirit." Because these volumes are compilations, many share similar and even verbatim sections with each other. Despite that, through the use of content analysis, it has been found that Ellen White strongly and often declared that there was a duty of Adventists to care for their health and also to arouse in others their duty.

Each mention of the word 'duty' and its derivatives such as 'duties' was noted in every volume. Synonyms of 'duty', such as 'obligation' were also tracked. The context was expansive in what constitutes duties pertaining to health, as Ellen White often talked

about the duties of families in the household; these remain pertinent as these duties allow for a healthful family. While not every mentioning specifically related to a religious duty, Ellen White was clear that these 'little duties' were and important part of the duties of a devout Christian, and the performance of these mundane duties helped perfect the mind, body, and spirit to receive the word of God (thus being healthful):

> The perfection of God's work is as clearly seen in the tiniest insect as in the king of birds. The soul of the little child that believes in Christ is as precious in His sight as are the angels about His throne. "Be ye therefore perfect, even as your Father which is in heaven is perfect." Matthew 5:48. As God is perfect in His sphere, so man may be perfect in his sphere. Whatever the hand finds to do should be done with thoroughness and dispatch. Faithfulness and integrity in little things, the performance of little duties and little deeds of kindness, will cheer and gladden the pathway of life; and when our work on earth is ended, every one of the little duties performed with fidelity will be treasured as a precious gem before God (White 1923).

Mentions that also involved words such as 'sacred' or 'religious' as a descriptor of the duty or act were highlighted. If the word 'duty' or derivatives was mentioned multiple times in a paragraph, it was marked as only a single mention to avoid double-counting expressions like "duties and obligations". To compare the prevalence of 'duty' in the health context, the same analysis was applied to seven other books of Ellen White which are not about health, but are readily known in Adventism; *Early Writings* (1882), *Patriarchs and Prophets* (1890b), *Steps to Christ* (1892), *The Desire of Ages* (1898), *Acts of the Apostles* (1911a), *The Great Controversy* (1911b), and *Prophets and Kings* (1917). These volumes represent important works of Ellen White. *Early Writings* is a compilation of her early works, giving some comparability to the health-related books that are often compilations. *Steps to Christ* is her only book originally published by a non-Adventist publisher and became her most widely bought volume, with "over 100 million copies in more than 165 languages" (Patrick 2014). The other five are all parts of

Ellen White's *Conflict of the Ages* book series, which has been described as her *magnum opus* (Guy 2014). The final volume of the series, *Prophets and Kings*, was completed posthumously using some prior materials (McGraw and Valentine 2014). The most famous of the series is *The Great Controversy*. *The Great Controversy* has been revised multiple times by Ellen White and others and has been widely distributed as a resource in understanding the Biblical interpretations of Adventists. During Ellen White's lifetime, a version was sold "using door-to-door canvassers or colporteurs" (Patrick 2014), and as recently as 2012 the leadership of the General Conference sought to distribute some 170 million copies around the world (McGraw and Valentine 2014)[11]. The other four books were written to expound and interpret the narrative of the Bible, which Ellen White considered as the only valid source of Christian theology (Guy 2014).

[11] I myself may have been one of these 170 million. In 2013, a copy of *The Great Controversy* found its way into my mailbox. This occurred within weeks of beginning Saturday observations of church services to become more familiar with the denomination. This close occurrence was unsettling; that is, until a friend in an apartment building in the same neighborhood stated that a stack of the books were in her building lobby. It was relieving to not be targeted but instead a part of a neighborhood-wide carpet-bombing of liturgical literature.

The results of the content analysis for the nine health-based books are in Table 3 - Summary of 'duty' content analysis for health-related books, while the seven non-health books are in Table 4 - Summary of 'duty' content analysis for non-health related books. A total of 544 paragraphs within the health-based books have a pertinent mentioning of 'duty'. Of those, 55 specifically mention words like 'sacred' or 'religious' in describing these duties. In order to create a comparison with the non-health books, the proportion of pages with at least one mention of 'duty' was calculated. This is a rough measure of showing how often duty is mentioned within the context of the length of the book. Each of the books was downloaded from the Ellen G. White writings website egwwritings.org (Ellen G. White Estate 2016). With the exception of *The Health Food Ministry*, the health-based books

Book	Mentions	W/ Sacred	Pages in Book	Pages w/ 1+ 'duty' mentions	Proportion pages with 'duty'
A Call to Medical Evangelism	8	0	45	7	.1556
Christian Temperance and Bible Hygiene	60	15	156	54	.3462
Counsels on Diet and Foods	91	9	380	75	.1974
Counsels on Health	143	17	621	123	.1981
The Health Food Ministry	5	0	88	4	.0455
Healthful Living	42	2	234	33	.1410
Medical Ministry	76	5	336	70	.2083
The Ministry of Healing	64	3	366	58	.1585
Temperance	55	4	274	48	.1752
TOTAL	544	55	2500	472	.1888

Table 3 - Summary of 'duty' content analysis for health-related books

have more than 14% of their pages with at least one pertinent mentioning of 'duty'. This appears to be different from non-health books, as only one, *Steps to Christ*, has more than 14% of pages with at least one mentioning of 'duty'. It is worth mentioning that these two books have the appearance of being outliers in another aspect. Both of these books are among the three books, along with *A Call to Medical Evangelism*, analyzed that are less than 100 pages long.

Using the measure of the proportion of pages with at least one mentioning of 'duty' allows for a statistical inference of difference. Imagining each book as a separate sample, a plot of confidence intervals for the estimated proportion of pages with at least one mention has been created as Figure 15. With health-related books in blue and non-health books in red, visually we can see that there is some overlap with the individual

Book	Mentions	W/ Sacred	Pages in Book	Pages w/ 1+ 'duty' mentions	Proportion pages with 'duty'
The Acts of the Apostles	45	2	400	42	.1050
The Desire of Ages	57	3	707	51	.0721
Early Writings	29	1	264	28	.1061
The Great Controversy	72	4	662	66	.0997
Patriarchs and Prophets	98	10	732	88	.1202
Prophets and Kings	45	0	711	38	.0534
Steps to Christ	16	0	76	13	.1711
TOTAL	362	20	3552	326	.0918

Table 4 - Summary of 'duty' content analysis for non-health related books

book 'samples'. Of course, the relative 'small' sample sizes (number of pages) of some of the individual books leads to the larger error figures and the longer spread of confidence intervals. The overlap is not absolute; for example, there is no overlap

between the confidence intervals of the four health-related books with the highest proportion, and the six non-health books with the lowest proportions. This gives some visual evidence that there is a difference between the groups; namely, that duty is mentioned more often in health-related books. To further measure this effect, the two sample difference of proportions test is utilized. To do so, all of the values for the two types of books were summed, giving two larger, independent samples. These are also plotted on Figure 15 as thicker lines. The larger sample merits smaller confidence bounds, which demonstrate no overlap with each other. This evidence of significant difference between the types of books is tested using the prop.test tool in R. The resultant test gives a χ^2 test statistic of 119.8, with a p-value less than .0001. This result shows a statistically significant difference in the mentionings of 'duty' between health-

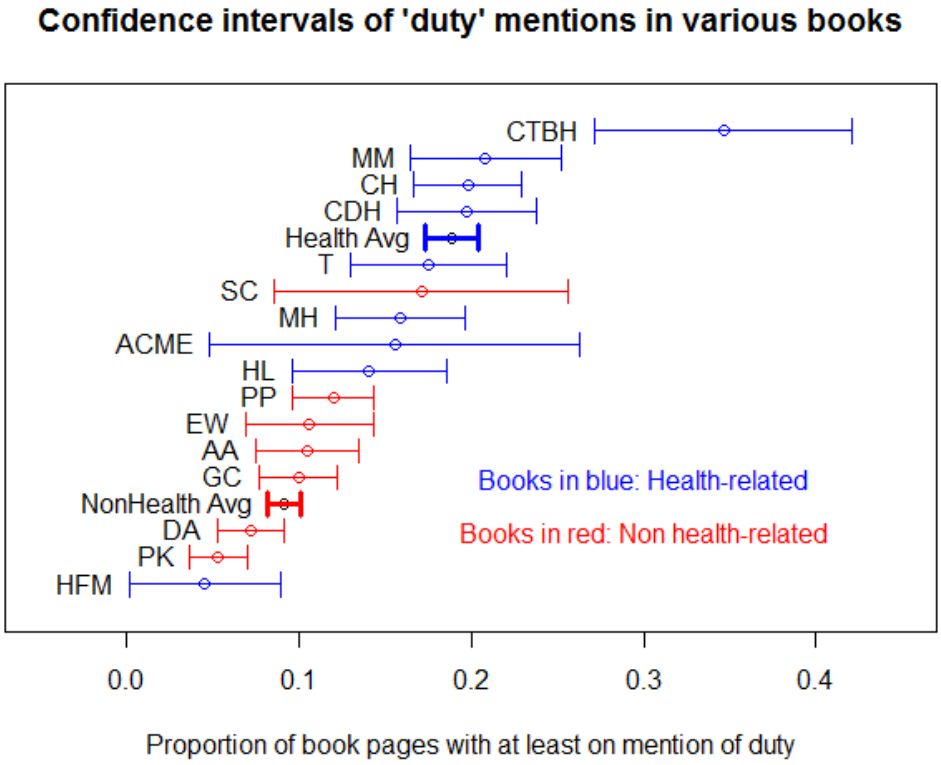

Figure 15 - Plot of confidence intervals for proportion of pages in books with at least one mention of 'duty'. Blue lines represent health-related books, and red lines represent non health-related. The proportions of pages that contain at least one mention of 'duty' for each book are shown as dots. The interval represents a 95% confidence interval of this measurement. Book titles are abbreviated (for example, The Ministry of Healing is abbreviated as MH).

related and non-health books written by Ellen White. This demonstrates that the duty of provided health to oneself and to others is a dominant trait of Ellen White's writings, and influential to the missionary directions of the Adventists.

Categories of Adventist duty of health

Analysis of Ellen White's books

Beyond the counting of mentions, the various quotes have also been categorized into nine different topics relating to health.

On the laws of God for health:

> Our first duty, one which we owe to God, to ourselves, and to our fellow men, is to obey the laws of God, which include the laws of health.
>
> *Healthful Living* (1897)

> It is the duty of every human being, for his own sake and for the sake of humanity, to inform himself or herself in regard to the laws of organic life, and conscientiously to obey them.
>
> *Healthful Living* (1897)

On the body being a temple:

> Our bodies are Christ's purchased possession, and we are not at liberty to do with them as we please. All who understand the laws of health should realize their obligation to obey these laws which God has established in their being. Obedience to the laws of health is to be made a matter of personal duty.
>
> *The Ministry of Healing* (1905)

> All who profess to be followers of Jesus should feel that a duty rests upon them to preserve their bodies in the best condition of health, that their minds may be clear to comprehend heavenly things.
>
> *Counsels on Health* (1923)

> Whether they acknowledge it or not, God lays upon all human beings the duty of taking care of the soul temple. The body is to be kept clean and pure. The soul is to be sanctified and ennobled. Then, God says, I will come unto him and take up My abode with him. We are responsible for our own salvation, and God holds us accountable for the influence we exert on those connected with us. We should stand in such a position, physically and spiritually, that we can recommend the religion of Christ. We are to dedicate our bodies to God.
>
> *Medical Ministry* (1932)

On the need for health reform:

> All are bound by the most sacred obligations to God to heed the sound philosophy and genuine experience which he is now giving them in reference to health reform. He designs that the great subject of health reform shall be agitated, and the public mind deeply stirred to investigate.
>
> *Healthful Living* (1897)

> All are bound by the most sacred obligations to God to heed the sound philosophy and genuine experience which he is now giving them in reference to health reform. He designs that the great subject of health reform shall be agitated, and the public mind deeply stirred to investigate; for it is impossible for men and women, with all their sinful, health-destroying, brain-enervating habits, to discern sacred truth, through which they are to be sanctified, refined, elevated, and made fit for the society of heavenly angels in the kingdom of glory.
>
> *A Call to Medical Evangelism and Health Education* (1933)

> When we adopt the health reform, we should adopt it from a sense of duty, not because somebody else has adopted it.
>
> *Healthful Living* (1897)

On the necessity of medical missionary work:

> Every physician ought to be a Christian, and if he is, he bears with him a cure for the soul as well as the body. He is doing the work of an apostle as well as of a physician.... How essential that the missionary should understand the diseases which afflict the human body, that he may combine the physician, trained to care for diseased bodies, with the faithful, conscientious shepherd of the flock, giving sacredness and double efficiency to the service!
>
> *Healthful Living* (1897)

> This is the high duty and precious privilege of the medical missionary. And personal ministry often prepares the way for this. God often reaches hearts through our efforts to relieve physical suffering. Medical missionary work is the pioneer work of the gospel. In the ministry of the word and in the medical missionary work the gospel is to be preached and practiced.
>
> *The Ministry of Healing* (1905)

> It is a positive duty to go into regions beyond. Rally workers who possess true missionary zeal and let them go forth to diffuse light and knowledge far and near.
>
> *Counsels on Health* (1923)

On the duty of doctors and other health practitioners:

> None but a Christian physician can discharge to God's acceptance the duties of his profession. In a work so sacred, no place should be given to selfish plans and interests.

Medical Ministry (1932)

It is the duty of physicians and nurses to shine as lights amid the corrupting influences of the world.

Medical Ministry (1932)

On the need of professional health education:

One night I was awakened and instructed to write a straight testimony regarding the work of our school at Loma Linda. By that school a solemn and sacred work was to be done.

Medical Ministry (1932)

Education is not complete unless the body, the mind, and the heart are equally educated. The character must receive proper discipline for its fullest and highest development. All the faculties of mind and body are to be developed and rightly trained. It is a duty to cultivate and to exercise every power that will render us more efficient workers for God.

The Ministry of Healing (1905)

On sanitariums and spaces of healing:

I am instructed that our sanitariums are to be cleansed and purified from those persons whose course of action is a discredit to the sacred work of the sanitarium. Our health institutions should preserve a sanctified dignity.

Medical Ministry (1932)

Those connected with our sanitariums should realize the duty resting upon them to give the patients an education in the principles of healthful living.

Medical Ministry (1932)

On the family and domestic duties leading to healthy outcomes:

Woman should fill the position which God originally designed for her, as her husband's equal. The world needs mothers who are mothers not merely in name, but in every sense of the word. We may safely say that the distinctive duties of woman are more sacred, more holy, than those of man. Let woman realize the sacredness of her work, and in the strength and fear of God take up her life mission. Let her educate her children for usefulness in this world, and for a home in the better world.

Christian Temperance and Bible Hygiene (1890a)

Will mothers of this generation feel the sacredness of their mission, and not try to vie with their wealthy neighbors in appearances, but seek to excel them in faithfully performing the work of instructing their children for the better life? If children and youth were trained and educated to habits of self-denial and self-control, if they were taught that they eat to live instead of living to eat, there would be less disease and less moral corruption. There would be little necessity for temperance crusades, which amount to so little, if in the youth who

> form and fashion society, right principles in regard to temperance could be implanted. They would then have moral worth and moral integrity to resist, in the strength of Jesus, the pollutions of these last days....
>
> *Counsels on Diet and Foods (1938)*

On the preparation of healthful food:

> It is a sacred duty for those who cook to learn how to prepare healthful food. Many souls are lost as the result of poor cookery. It takes thought and care to make good bread; but there is more religion in a loaf of good bread than many think. There are few really good cooks. Young women think that it is menial to cook and do other kinds of housework, and for this reason many girls who marry and have the care of families have little idea of the duties devolving upon a wife and mother.
>
> *The Ministry of Healing (1905)*

> There is a class who seem to think that whatever is eaten is lost, that anything tossed into the stomach to fill it, will do as well as food prepared with intelligence and care. But it is important that we relish the food we eat. If we cannot, and have to eat mechanically, we fail to receive the proper nourishment. Our bodies are constructed from what we eat; and in order to make tissues of good quality, we must have the right kind of food, and it must be prepared with such skill as will best adapt it to the wants of the system. It is a religious duty for those who cook, to learn how to prepare healthful food in a variety of ways, so that it may be both palatable and healthful. Poor cookery is wearing away the life energies of thousands. More souls are lost from this cause than many realize. It deranges the system and produces disease. In the condition thus induced, heavenly things cannot be readily discerned.
>
> *Christian Temperance and Bible Hygiene (1890a)*

These duties can be arranged into two major groups; individual duties and institutional duties. In the religious context, individual duty dwells internal to a person. These are the myriad religious duties prescribed that ought to be taken upon, at an individual level, in order to create a proper relationship with a higher power. It is through personal human agency that an individual decides whether or not to complete, to fulfill their faith. Institutional duties do not fall upon the individual; at least, not directly. These are the religious duties prescribed to the whole of a religious organization or sub-organization. Denominations at the highest level prescribe certain duties, often referred to as tenets of a religion. As one works down through the hierarchies of religious organization, these sub-organizations – churches, schools, and hospitals among others –

also have institutional duties. Some of these duties are inherited from the overarching organization; creating a supportive faith community for example will flow from larger scales to smaller. Other times, suborganizations will magnify or create duties that have only small import at the highest organizational scales. Adventist health organizations, in trying to emphasize ways to better health, will push for vegetarian diets, even though vegetarianism is not seen as a marker of faithfulness. When working within the institution, these institutional duties will naturally fall upon individuals to push forward, but that does not make the duty an individual duty when it is being completed outwardly. Inward duties, duties to improve oneself towards the image of God, are individual while outward duties, duties to improve and perfect the organization, are institutional.

Of the nine categories of 'duty' found in Ellen White's health writings, four pertain to individual duties, one to institutional duties, and four have a mixture of the two, but are mainly prescribed individual duties. The duties of regarding the body as a temple, of the actions of Adventist health practitioners, home and domestic duties, and food preparation are all directed as individual duties. Duties on the laws of God for health, the need for health reform, the necessity of medical missionary work, and the need for professional health education each possess some flavors of both individual and institutional duty. However, much of that mixture is mainly implied for the first three of this category; when investigating the separate quotes, the main thrust of the duties falls upon the individual to do these things. It is the duty of the individual to follow the laws of God and to be a part of health reform to enable him or herself to properly accept the blessings of God. It is a sacred task that Christian physicians spread the light of God

through their work. Implicit in these categories is an institutional duty to spread the Gospel through health care and health reform in the Adventist way.

The need for professional health education is mixed but different. Of the two quotes provided (and also found in the larger database not listed) are both explicit individual and institutional duties. One of the duties in a provided quote is explicitly "regarding the work of our school at Loma Linda," which directs to the idea of institutional duty. The other quote though focuses upon the individual student, who to be able to be properly educated must improve him or herself in order to receive the message.

The duty involved with sanitariums and spaces of healing is the one explicit and full duty that can be categorized as being institutional. Explicit in Ellen White's quotes is that there is an institutional duty of the organization outward to the public and patients. In one of the quoted passages, Ellen White writes "our sanitariums are to be cleansed and purified from those persons whose course of action is a discredit to **the sacred work of the sanitarium**" (emphasis added). The work, the task, the obligation, the duty is on the sanitarium. Implicit is that an individual working there has duties to forward the mission, but the explicit duty is institutional; Adventist spaces of healing have an outward, institutional duty. This institutional duty will be further studied in Chapter 6.

Visual analysis with word clouds

Graphical representations of data have long been effective means of creating information from data. Whether these take the form of charts for quantitative data, maps for spatial data, or another of the multitudes of visualization tools currently available, graphical representations allow meaningful patterns to emerge from large amounts of

data. While often associated with the realm of quantitative analysis, graphical representations are used with qualitative data as well. One such tool is the word cloud; also referred to as a tag cloud. Word clouds are described as "text-based visual representations that display word significance in terms of popularity and importance by using different font sizes and colors" (Chi et al. 2015). Frequencies of words, shown offset by text size and/or color combinations allow for visual analysis of key words or phrases in text (DePaolo and Wilkinson 2014). Word clouds, along with other tools and technologies developed within web 2.0, are being used widely within pedagogical research; for example, word clouds have been shown as useful in student self-assessment of writing and vocabulary skills (Stone 2011; Frunzeanu 2015). Likewise, instructors can use the visualization as both an informal and formal assessment of student understanding of concepts through the observation of patterns of prominently mentioned words in text (Kitchens 2014).

The writings of Ellen White pose an excellent opportunity to use word clouds as a visualization tool to assess what words she commonly used when discussing the sacred duty of health. Of the many freely-available online tools for creating word clouds, I have used the tool developed by Jason Davies (https://www.jasondavies.com/wordcloud/). Using the same eight Ellen White books assessed above, mentions of 'duty' were found. The entire paragraph in which the mentioning was located was copied into a document. All of these paragraphs combined were input into the word cloud generator. This methodology was chosen, rather than simply inputting the entirety of the book text, in order to look closer at the mentionings of 'duty'. Instead of duty being potentially obfuscated by the sheer number of words in a book, this methodology allows an

assessment of what words are used in the general context surrounding paragraphs that discuss the duties of health. The paragraphs were pasted into Microsoft Excel, and each individual word was then processed into an individual Excel cell. The list of words was then alphabetized and edited. Articles like 'the', pronouns like 'our' and 'I', and prepositions like 'by', 'in', and 'than' were removed as being words that are not pertinent for analysis. Words were then standardized into the singular and present tense. This enabled words that mean the same thing, but differ by conjugation to be properly counted together. For example, this allows 'duties', 'duty', and 'dutiful' to all count as the same word in the word cloud. Additionally, 'heal', 'heals', and 'healed' were joined together into the word 'heal'. This methodology kept separate words with similar roots that the author determined to be prominent enough to be kept separate, generally through allowing distinct noun forms to be apart from verb forms. On the root 'heal', the word 'health' was kept separate. 'Health' itself was joined by forms built off of its root, such as adverbs like 'healthfully'. Words that identified a type or trait of a person were also kept separate; thus 'healer' was not merged with 'heal' and 'preacher' was not combined with 'preach'. The author did this with the 59,552 separate words found in the 'duty' paragraphs as a means of using the visualization of word clouds to more accurately view the words being used. The word cloud was set to display the 200 most mentioned words. The resultant word cloud is shown as Figure 16.

The word 'duty' is prominent in the word cloud on the basis of the purposeful choosing of paragraphs that specifically have one or more mentionings of 'duty' and close synonyms like 'obligation'. More importantly, this word cloud shows three words of significance mentioned around 'duty'; 'God', 'work', and 'health'. These words occur

in the quotes from the above sections of this chapter and the word cloud aids in showing that these are prominently mentioned around 'duty'. 'God' gives more evidence that these duties are based in sacredness and a connection to God. 'Work' emphasizes that much of the sacred duty comes from daily tasks of life and being involved in health care fields of employment. Not as prominent, but still present near the word 'God' are the triumvirate of 'body', 'mind', and 'spirit'; the three attributes Adventist writings point out need to be healthy to truly be able to accept the laws and word of God. Words also related to this concept include 'physical' and 'soul'. Similar, but different words appear to emphasize that these duties involve learning; 'teach', 'study', and 'educate' all are found near each other on the right side of the image. Of course, the importance of diet to health is also prominent, as the words 'food', 'cook', 'eat', and 'appetite' are found. Words like 'labor' and 'habits' also occur within the word cloud, again with an

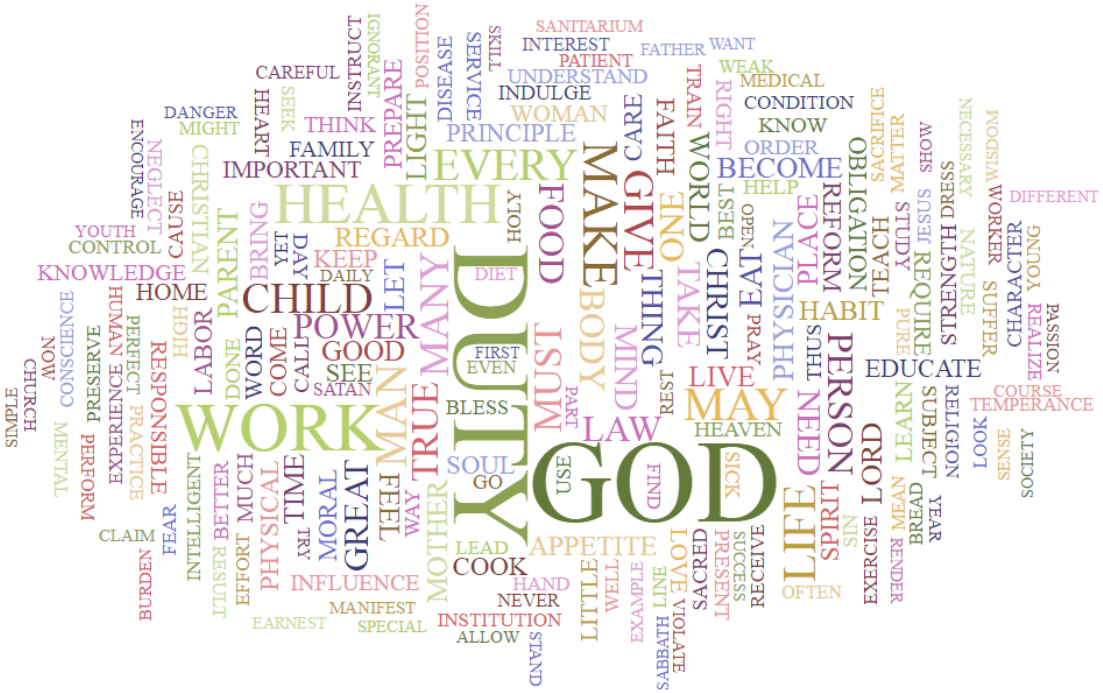

Figure 16 - Word cloud of common words found in the same paragraph as mentionings of 'duty'. The more often a word is used, the larger the font. Color and positionality do not represent quantitative differences and are only for aesthetic purposes. The world cloud was generated using the online tool developed by Jason Davies (https://www.jasondavies.com/wordcloud/).

implication that these religious duties involve work and creating a certain lifestyle. The importance of family is also present, as the words 'child', 'parent', 'father', and 'family'.

What also becomes clear is the positivity connected to these paragraphs. Many of the words that occur most frequently are connected with positive emotions, attributes or concepts. Within the word cloud, one can see the positive emotions of 'love', the attributes of 'knowledge', 'strength', and 'faith', and the positive concepts of 'moral' and 'light'. Few negative words reach the frequency of mentions to show in the word cloud. The words 'sick' and 'disease' occur; from reading the text, it is clear these most often come from the idea that by not following the laws of God, one can fall into illness. Words like 'never', 'ignorant', 'suffer', and 'neglect' are also present; again, often as warnings of what happens when one does not follow the laws of God.

Discussion

While not dissected often in the academic literature, duties are myriad in religions. Dress, action, ritual; religions often have duties that pertain to many aspects of culture and life. In some cases, there is an emphasis on duties pertaining to personal health or the provision of health services to others. In some cases, health care is seen simply as a means to an end; a way to save souls from damnation by using health provision as a means of religious recruitment. Other religions see health as more central to a sacred obligation of faith. This can manifest as an adherent practicing 'good deeds' to aid in their own salvation, or as a way to help the afflicted become healthful so that they can properly accept the word of God. These are particularly evident in the history of Christianity, which has a long history of mixing health and theology, from the view of

Jesus Christ as a healer to the creation of spaces of healing at monasteries – the beginning of what would become modern hospitals. The connection of healing and faith is paramount within some Christian denominations, particularly those that have strong evangelical movements. Conflict does exist as to whether religious health spaces must use scientific, proven methods, or if belief alone – faith healing – is the true connection of religion and bodily health.

Within Seventh-day Adventism, health has been a central tenet of belief. Ellen White referred to it as the "right arm of the message," meaning that the true message of salvation from God has prominently conjoined at its side an emphasis on healthful living. While some Christian denominations believe in a duality between body and soul, Adventists view the triumvirate of mind, body, and soul inexorably linked. The mind, body, and soul must also be in proper working condition to truly accept God's message, and a breakdown in one of these three legs of health prevents a person from truly acting in Christ's way. This is not just a message from a bygone era that was enthralled by the burgeoning growth of scientific medicine and various fads of health; it is a message that remains current through the General Conference of the Adventist church. Modern manuals still spell out the importance of the health message within denominational institutions of health.

Much of Adventism is still bound to the wellspring of writing by Ellen White. She wrote volumes about many topics dealing with tenets of Adventism. Issues of health were among these. In this chapter, an analysis was completed upon the writings of Ellen White to measure how prominent the duty of health was within her written record. Using the listing of authored books on the website "Ellen G. White Writings", nine books that

centered on issues of health were selected. A control group of seven non-health centered books were picked as a comparison. The control group consisted of some of Ellen White's most prominent or most distributed books. A content analysis was conducted, counting the number and page location of each mentioning of 'duty' and similar terms to see if Ellen White wrote about health duties more prominently than other religious duties. The results were that the proportion of pages that had pertinent mentionings of 'duty' was significantly higher in health-related books than in non-health-related books. There also tended to be more mentionings of 'duty' near the words 'sacred' or 'religious'. The paragraph for each mentioning of 'duty' was extracted from the health-related books and further analyzed. Nine categories of health-related duties were found; following the laws of God regarding health, treating the body as a temple to God, the need for health reform, the necessity of medical missionary work, the duties of health practitioners, the need for professional health education, duties for institutional spaces of healing, family and domestic duties, and preparing healthful food. These duties represent both individual and institutional duties. The paragraphs were also visualized with a word cloud, allowing other words that are prominently mentioned in proximity to 'duty' to be observed.

The analysis shows that Adventism, in regards to its health message, is a product of Christianity but also has forged a new path in terms of the emphasis given to health. Health figures prominently in the overall message of Adventism. Through an analysis of Ellen White's writing, it is shown that not only is the health message in the forefront of the religious movement, but healthful living and the provision of health is seen as a religious and sacred duty to Adventists. It is a theological tenet as much as it is a means for recruiting new adherents. It is a pillar of faith and a major part of what God has

revealed to man about life and religion.

Chapter 6: The therapeutic dutyscape of Seventh-day Adventist hospitals

Thus far, the research presented in this dissertation has established various religious duties to live healthily and to provide health care in Seventh-day Adventism. In Chapter 4, a theoretical model of the spatialization of duty was presented. This extension of Lefebvre's spatial triad has been called the creation of the *dutyscape*. The purpose of this chapter is to investigate the spatial manifestation of a specific duty (health) for a specific religious group (Adventists). Within the context of this spatialization, spaces of healing within Adventism will be viewed through the lens of therapeutic landscapes. In assessing historical documents along with a content analysis of Adventist organizational YouTube videos and a narrative interview, a view of the worldwide landscape of Adventist hospitals will be created along with elucidating how the connections between religious duty, health provision, and space intersect in current Adventism.

The therapeutic landscape model

Cultural landscapes

The history behind the term "cultural landscape" is long and detailed, with many theoretical discourses accounted for in numerous publications. The modern usage of the term *landscape* was coined by Alexander Pope as "something a person makes and does," thus freeing *landscape* from solely being constructed by romanticists to an idea that can be physically experiences by everyone (Gerlach-Spriggs, Kaufman, and Warner, Jr. 1998). A cultural landscape is not a natural area untouched by humans, but instead a place where man-made systems are placed upon the land (Jackson 1984). It is argued

that there are precious few purely natural areas, especially in America, because humans tend to attach cultural value of some kind to nearly all land (Lewis 1982). Cultural landscapes need not be only elite in scale; it is important for the cultural landscape researcher to investigate all things that make up cultural landscapes, be these things big or small (Lewis 1982). Big or small, all parts of material culture are equally important in the analysis of a cultural landscape. Researchers can find a more truthful result into a culture when both big and small are investigated with vigor. As Peirce Lewis states, cultural landscapes are comprised of "nearly everything we can see" (1982). A cultural landscape is not static, however; it is constantly evolving and being re-theorized dynamically as human culture affects and effects itself (Schein 1997). Richard Schein defines a cultural landscape as being "a tangible, visible entity, one that is both reflective and constitutive of society, culture, and identity" (1997). Cultures constantly change and at the same time are constantly attaching cultural narratives to landscape (Smith 2008). The perception of what a place means within a culture shifts and evolves with the changing culture.

Place should not be seen just as a setting where events happen. Instead, it is important to understand that a place is a social construction and is not fixed (Massey 1991; Rodman 1992). A cultural landscape is similarly not a fixed and static entity. The impact of a cultural landscape is known better when the history of the geographic location is understood (Lewis 1982). This requires listening to the multivocality that affects the multilocality of a landscape (Rodman 1992). Too often, researchers, particularly architectural historians, place too much importance in the design of a single building instead of focusing on the contextual relations the place has within its cultural

landscape (Upton 1991). Focus upon a single building or site does not allow the researcher to develop a fuller understanding of both the tangible and intangible aspects of culture that manifest, often unintentionally different than as designed, upon the entirety of the landscape. The researcher must reach outside of the building and draw on the cultural connections beyond the structure's walls. The implication of these foci is the emphasis on studying space instead of place. Places are bounded and known; places can be delineated and defined with coordinates, giving it a specific site. Space on the other hand is boundless in that space has multiple hierarchies and scales of meaning. Cultural landscapes allow a researcher to study social space at particular sites. Spaces in which societies operate are social products themselves (Lefebvre 1991). All societies, young and old, create culturally-constructed space, but they do not know the implications of this space. By looking holistically at the entire cultural landscape, the researcher will be able to better understand the impact that the space has upon culture, and vice-versa, through both intended and unintended human processes of space creation. A cultural landscape is a space in which cultural importance has been imbued. The use of the word "importance" does not denote the largeness of the impact that the space has upon culture, but instead implies a facet of the culture that is distinguishing.

Health geography

The subdiscipline of therapeutic landscapes comes from a combination of medical geography and cultural landscapes. Early research in medical geography was roughly split into two paths; disease ecology and the spatial distribution of health care services (Mayer 1984; Kearns and Gesler 1998; Andrews 2002; Gesler 2003), with spatial

analysis being the major methodology of medical geography from its inception in the 1950's to the 1980's (Mayer 1984; Gesler 2003). While this "strong normative component" (Mayer 1984) remains important as part of the discipline, some researchers began to investigate models of well-being and the social components of health and heath care, leading to a discipline name change to health geography (Gesler 2003). The discipline name change to geography of health better labels the discipline's research interest, places geographers closer to other social scientists that study population health, and better allows geographers to study "emerging models of health and dis-ease"(Kearns 1995; Kearns and Gesler 1998). Marxist and humanistic critique within human geography influenced this new stream of health geography (Williams 1999; Andrews 2002). The cultural turn towards health geography gave voice to research that was more theoretical and qualitative over the applied and quantitative research of medical geography (Moon 1995; Kearns and Gesler 1998).

The discipline of therapeutic landscapes

With a renewed interest in cultural landscapes from "new" cultural geography, Gesler (1992) began a geographic subdiscipline devoted to investigating therapeutic landscapes. Gesler simply defines therapeutic landscapes as "landscapes associated with treatment or healing." Throughout the development of the idea of therapeutic landscapes in his paper, an emphasis is put on the combination of many social science disciplines to better understand how health couples with space. Gesler (1992) closes by stating:

> Indeed, in so far as there is a social science of health, a coming together of geography, anthropology, sociology, political science, psychology, and economics in the common goal of better health for all, the concept of therapeutic landscapes provides a means for interacting with the other social sciences, borrowing ideas such as symbolic cultural forms

> and class struggle on the one hand and demonstrating the unique contribution of geography on the other… It revives a very strong human/environment tradition which some geographers fear the discipline is losing; it applies a renewed interest in humanistic cultural landscapes to health care; it demonstrates once again that the social and the spatial are intimately intertwined; and it shows how structure, agency and time-geography might all be brought together to study health care-seeking behavior in particular environments and places.

Three perspectives on cultural landscapes strongly influence the definition of therapeutic landscapes: first, humans shape and style the physical earth; second, meanings within landscapes are personal constructs; and third, landscapes are social constructions (Gesler 1992; Kearns and Gesler 1998).

Therapeutic landscapes need not be studied from a materialistic point of view to determine how place leads to health. The activities conducted can lead to place-based health outcomes, such as a taskscape for troubled youth (Dunkley 2009), Christian summer camp (Thurber and Malinowski 1999), alcohol treatment and recovery programs (Wilton and DeVerteuil 2006), yoga practice (Hoyez 2007), and communal gardening by older people (Milligan, Gatrell, and Bingley 2004). The cultural setting is important, as "[t]herapeutic landscapes or spaces of care may be perceived differently by different people" (Gesler 2005). Therapeutic landscapes can be 'special' places or everyday spaces in which healing occurs (Gesler 2005). Landscapes of healing can be viewed as human-environment interactions, societal constructions, and perceived constructions (Gesler and Kearns 2001). Gesler and Kearns (2001) identify five taxa of therapeutic landscapes: natural, built, symbolic, belief and social relation landscapes.

The built environment

Therapeutic landscapes can and often are built environments, and not necessarily the traditional view of a healing landscape as natural spaces (Williams 1999) and

"bucolic locales" (Gesler 1992). The design of the hospital, and what patients have access to, can affect patient outcomes. Hospital design has recently updated as hospitals shift from providing surgery and recovery services to including a more holistic approach to health care. Hospital design has shifted likewise in terms of the "social, symbolic and physical spaces of hospitals" (Gesler et al. 2004). Patients with a view of natural areas have been found to have shorter hospital stays and need fewer potent analgesics compared to patients that have monotonous brick wall views out their room window (Ulrich 1984). The design and naming of the "Starship" children's hospital in Auckland, New Zealand evoked a symbolic metaphor of otherworldliness and "high tech optimism" for positive health care outcomes (Kearns and Barnett 1999). The inclusion of environmental artwork in hospital waiting rooms can give calming feelings and shift focus away from the anxiousness of a hospital, not only for patients but also for health care providers (Evans, Crooks, and Kingsbury 2009). In some health care situations, informal spaces like homes have replaced formal spaces as sites of healing and health care provision. Studying these home spaces, with the myriad overlaid meanings of 'home', as therapeutic landscapes can be elucidating in understanding how homes affect the quality of health care received (Williams 2002; English, Wilson, and Keller-Olaman 2008). Therapeutic landscapes can also be conceived as non-physical spaces of the mind (Gastaldo, Andrews, and Khanlou 2004).

Places of health care can be viewed through the Foucauldian lenses of spatial discipline and govermentality. Using the lens of spatial discipline, researchers can attempt to understand how the design of place is meant to discipline and order bodies within it (Dunkley 2009; Evans, Crooks, and Kingsbury 2009). Including spatial

discipline within research allows for the consideration of resistance against order and discipline (Dunkley 2009). Governmentality for Foucault is defined as any attempt to mold how individual agents or collections of agents conduct themselves (Wilton and DeVerteuil 2006). Pressure from one's social network or from state powers for individuals to 'take care' of themselves health-wise are forms of Foucault's governmentality. Both spatial discipline and govermentality are related to the Foucauldian idea of the 'medical gaze.' The 'medical gaze' is an objective and dominating relationship between the physician and the body of the patient (Evans, Crooks, and Kingsbury 2009). The physician both disciplines and molds the patients' body through the power relationship of physician and patient (Gesler and Kearns 2001). Therapeutic spaces can be contested, as various parties wage power struggles over the care and space provided in places of health care, compromising the space and those that must live within or use the space (Geores and Gesler 1999). Spatial ordering or arrangement is another way in which therapeutic landscapes discipline those within the space, creating hierarchies of both people and spaces and entrenching established order (Dunkley 2009).

Spirituality and therapeutic landscapes

The relationship between spirituality and therapeutic landscapes is limited within the current research (Williams 2010). Early therapeutic landscape work by Gesler used case studies of spiritual sites, such as the Aselepian sanctuary near Epidauros, Greece (1993) and the Catholic pilgrimage site of Lourdes, France (1996). Dobbs (1997) focused on the Navajo sacred landscape of healing, providing the literature with a diffuse

(not site-specific) and non-Western cultural example of a spiritual therapeutic landscape. Geores (1998) explored how the conceptions of the sacredness of the healing Hot Springs in South Dakota in a Native American tradition was used by white Americans as a selling point to bring tourists into the region. Nestled in the Black Hills[12], the Sioux and Cheyenne Nations created a treaty of peace for all that entered the area of the Hot Springs, as the medicinal waters were held as a sacred space. The white Americans that settled into the area used this sacredness as a means commodification, creating a metaphor of 'Health = Hot Springs' to draw in tourists, focusing on Native American lore rather than current practice in order to alleviate the contestation of place between Native Americans and white Americans at the time. Williams (2010), choosing to further develop spirituality in therapeutic landscapes by studying a traditional site, completed a case study of the pilgrimage site of St. Anne de Beaupre Shrine in Quebec. Williams argues that with research pointing towards positive correlations between spirituality and well-being, researchers of therapeutic landscapes should expand and investigate more fully how spirituality interacts with landscapes of healing.

Spatial manifestation of the duty of health

The growth of Adventist hospitals

The Whites spent much of the 1870's traveling, especially to the western United States, helping to make inroads in building congregations, schools and hospitals in the region (Numbers 1992). By the 1890's there were hospitals and sanitariums in and around half a dozen large cities operated by Adventists. Adventists continued to found

[12] The Black Hills were themselves seen as the "abode of the Great Spirit" (Geores 1998), giving the space a dual sacredness of both being a place in which a god dwells and also a place of near miraculous healing.

health care facilities as part of their missionary work at home and abroad. By 1910, Adventists operated 22 sanitariums in the United States. While that number fell to 19 by 1950, the bed capacity had nearly doubled during that time. In the years after World War II, the services rendered by Adventist health care facilities were changing. The facilities were less focused on the sanitarium model, of prolonged stays, health education, recreation and lengthy hydrotherapy (Quevedo 2003), and rather used the community hospital model. As such, many Adventist sanitariums began renaming themselves as hospitals. Often, Adventist sanitariums were places in exurban or rural areas near cities. As cities sprawled, the sanitariums became community hospitals by default in these now developed suburban regions. With expanding bed capacity and focusing on shorter, acute care, more and more non-Adventist physicians began to work with Adventist hospitals, and in many cases became the majority of physicians at the institutions (Nichol 1964). The Seventh-day Adventist Church owned and operated the sixth-largest health-care system within the United States by the 1980's (Morgan 2001). In upwards of one third of all people employed by the world church at that time were in the worldwide health system (Numbers and Larson 1986). By the first decade of the 21st century, the Seventh-day Adventist Church owned and operated 168 hospitals and many more additional care facilities worldwide (Taylor and Carr 2009). Within the United States, there are about 60 Seventh-day Adventist hospital facilities. In addition, the Seventh-day Adventists own and operate schools that educate nurses, doctors, and other health care practitioners. The emphasis on healthful reform by the founders of the Church has now led to a health care system that uses modern medical techniques (Numbers 1992; Taylor and Carr 2009). These hospitals are generally the same as non-Adventist hospitals in terms of the

treatments offered, but differ in certain customs. Many Adventist hospitals try to schedule as few surgeries as possible for the Sabbath, strongly push the same health reform habits discussed previously, and stay outwardly religious with Adventist and Christian literature and employees that will pray with patients (Numbers and Larson 1986).

A worldwide dutyscape of Adventist hospitals

To visualize how the provision of healthcare has manifested into a world-stretching dutyscape of Adventist hospitals, the collection of Adventist yearbooks freely available on the denominationally-operated online archive adventistarchives.org, were used to identify the location of each hospital. The location and number of hospitals was recorded for each year from the first Adventist sanitarium in Battle Creek, Michigan in 1866 until 2012.[13] The results have been summarized by geographic area in a stacked bar chart (Figure 17) and a small multiples map showing the locations of hospitals in ten-year increments (Figure 18). Note that the collation of hospitals into geographic locations is based upon generally continental classifications, with the isolation of the United States, and not on Seventh-day Adventist defined Divisions. This is mainly due to the ever-changing borders of Adventist Divisions over the decades; a situation that can be assumed to be beneficial for administration but detrimental for geographic analysis. Both

[13] Each yearbook attempts to outline information on all denominationally-affiliated organizations and institutions generally from the previous year, meaning the 2000 yearbook will contain information up to the year 1999. Naturally, difficulty in distributing information during the early years of the denomination leads to some data lags. The previous footnote also outlines gaps in the yearbooks available online. Hospitals that existed in both the 1894 and 1904 yearbooks were considered for this dataset in operation during this gap. Some hospitals in the 1904 yearbook listed the year in which it was established, which was used to fill the yearbook gap years. Additional hospitals very well may have been in existence during those years but are not in this dataset.

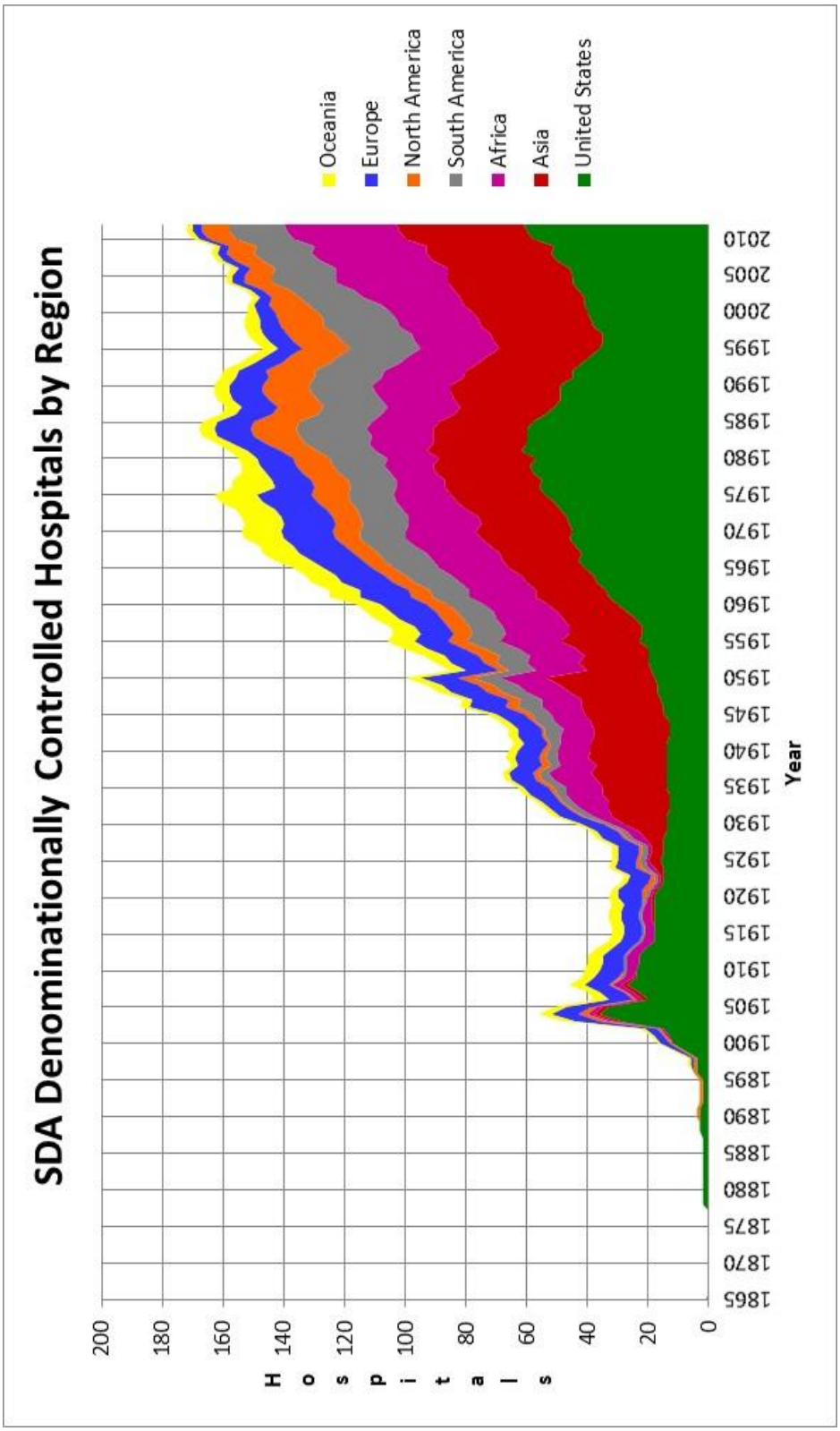

Figure 17 - Stacked bar chart showing the number of denominationally-controlled Adventist hospitals by world regions over time. Data for this chart comes from the series of Seventh-day Adventist yearbooks published in most years from 1883 to 2013.

Figure 18 - Small multiples map of Adventist hospitals in 10-year increments, 1900 – 2010. This map uses small multiples to show the spread of denominationally-controlled Adventist hospitals around the world through time. Each small multiple map uses a reference scale of 1:360,000,000. Map created by Nathan Burtch. Data for the location of hospitals derived from Seventh-day Adventist yearbooks, published in most years between 1883 and 2013. Shapefile source: ArcWorld Supplement.

figures demonstrate the overall pattern of hospital missionary work, which seems to match other missionary foci of Adventists to some degree. At the beginning, the focus was on the United States. The next movement of missionary zeal is in Western Europe. As the denomination grows, looking for new places in which to recruit, hospitals begin to develop in the Global South, particularly with regions that were still under colonial control at the time. The stacked bar chart demonstrates this; hospital investment by the denomination is stagnant or dropping between the two World Wars, while there is strong growth in Asian and African hospitals.

Geopolitics are at play with hospital locations. The stacked bar chart shows that there is a drastic decrease in Asian hospitals from 1950 to 1951. In this year, a full 14 Adventist hospitals located in China fell out of denominational control due to the China Communist Revolution of 1949. The Chinese government persecuted Adventist missionaries and took over control of all hospitals, clinics and schools. Some argued that the church spread the missionary work too thin, applying a Westernized health model to places that needed basic sanitation and health needs, and failed at truly converting the people and hospital employees to Christianity (Lin 1976; Oosterwal 1976). The lack of Adventist doctors and nurses intent on the missionary work of the hospital demonstrated that the "sanitariums in this field were financially independent but spiritually dead" (Lin 1976).

The figures also show the decrease in Adventist hospitals in the United States, beginning in the early 1980s through the mid-1990s. This ties into prevailing nationwide trends of hospital closures, particularly in rural areas which is well documented (Mullner and McNeil 1986; Mayer et al. 1987; Mullner et al. 1989). This pattern fits well with the

Adventist pattern of developing hospitals in many exurban or rural locations near cities, made to serve the community hospital model of care (Quevedo 2003; Parkview Adventist Medical Center 2004). As well, many corporate hospital structures were saw mergers and consolidations during this time in the United States (Numbers and Larson 1986). A similar, but smaller pattern occurred at the same time within Europe, possibly through a similar economic pattern or as part of a process of nationalizing health care.

It is important to acknowledge the complexity of the dutyscape of Adventist spaces of healing and thus the limitations of this study's attempt to locate health care spaces. Different types of institutions are listed in the yearbooks, including hospitals, sanitariums, treatment rooms, and orphanages. This study has focused only on the hospitals and sanitariums as the main spaces of healing within the denomination. There is also the issue of ownership and control of the health care institutions. Prior to 1906, the yearbooks listed all hospitals and sanitariums in one section, regardless of whether the Church itself managed the sites. Between 1906 and 1912, the yearbooks separately list privately owned or managed sanitariums. These are affiliated with Adventism, but are not officially operated under the auspices of the General Conference or one of the large Divisions. After 1912, these private hospitals are not listed. There are many examples of hospitals and sanitariums appearing in the list, then dropping out for years or decades before reappearing. It could be that these hospitals are shifted into private ownership for some period before being brought back into the fold, or these hospitals cease existence for some time; the documents are opaque on this issue. Numbers and Larson (1986) describe North American Adventist hospital development along two different lines. First, there are the hospitals controlled through the Church, operated in a corporate manner and

found in the yearbooks. Some of the hospitals in the system employ only a minority of Adventists[14]. Second, there are the self-supporting Adventist hospitals. While there are a variety of flavors of these hospitals, with some urban and some quite rural, most attempt to retreat towards Ellen White's inspired teachings with simplistic health reform rather than the vast Westernized corporate denominationally-controlled hospitals.

This also implies that there is another part of the dutyscape of Adventist spaces of healing that is missing from this study. The size of this unaccounted for, decentralized collection of hospitals cannot be estimated. In the 1913 yearbook (which accounts for institutions through 1912), there are 70 sanitariums listed overall, with 30 listed under private control. Many hospitals came and went in these early years of Adventism, but it still remains a potentially large and important unknown part of the dutyscape of healing. Within the Washington, DC metropolitan region, Leland Memorial Hospital[15] is illustrative of this point. Adventist doctors and brothers Wendell and Lawrence Malin opened the private hospital in Riverdale, Maryland in 1942 as a 58-bed facility. Though private, the local and union conferences of the Seventh-day Adventists made loans to help the project along (Lorenz 1968), making it the first modern hospital in Prince George's County (Lorenz 1968; Godbey 1998). Incorporating as the non-profit Medical Group Foundation and making a stated interests in "the encouragement and dissemination of religion and religious thought", two more hospitals were founded (Lorenz 1968). In 1981, the hospital came under the auspices of Adventist Health System (and the Church),

[14] In an interview conducted for Chapter 6, an employee for Adventist HealthCare, which operates the Adventist healthcare facilities in the Washington, DC metropolitan region, states that only about 2% of the employees are Adventist. Even graduates of local Adventist nursing programs have high numbers of non-Adventists among them.

[15] The hospital would make national headlines as the place in which University of Maryland basketball player and Boston Celtic draftee Len Bias would be pronounced dead of an apparent drug overdose at age 22 (Harriston and Jenkins 1986).

which runs a number of health care facilities in the Washington, DC area. Facing dwindling admissions and operating losses, the Adventist Health System attempted to close, sell, or change from being a general hospital in 1989 (Schneider 1990) before closing and leaving the Adventist yearbook in 1992. While the hospital had a full 50-year lifespan, it is only present for 12 years in this paper's database. The building still exists as a medical facility, but it is no longer Adventist controlled. Now the Crescent Cities Center, a bearing the name of Leland Memorial Hospital (Figure 19) still exists.

It is because of duty that these hospitals manifest. Without Adventist institutionalized duties relating to hospitals and sanitariums, medical missionary work, and spreading the gospel of health reform, there would not be Adventist hospitals. There are religious denominations that do not explicitly have a theological duty towards spreading health. In those denominations, spaces of health are rare. Adventism strongly emphasizes the duty of health, both individually and institutionally. The duty is interpreted spatially as a *dutyscape* of healing spaces.

Figure 19 - Photograph of the former Leland Memorial Hospital, with sign still intact. Photo taken by author.

Analysis

Interview and YouTube content analysis

As outlined in Chapter 3, the analysis designed for this chapter pulls from two sources. A

narrative interview, conducted through the use of open-ended questions, was conducted with an employee of Adventist HealthCare. Adventist HealthCare is a regional health care organization located in the greater Washington, DC metropolitan region, with most community health care resources located in Montgomery County. This first and largest nonprofit health care system in Montgomery County is based around the anchor institutions of Washington Adventist Hospital and Shady Grove Medical Center, with many other smaller locations for urgent care and rehabilitation services in Maryland (Adventist HealthCare 2016a). This interview, conducted in 2016, provided insight regarding how an individual connects to the overarching institutional duties in Adventist health care systems.

A content analysis of YouTube videos was used to understand the current nature of the religious duty of health in Adventism. The selection process for choosing videos is outlined in Chapter 3. Nine different Adventist health organizations with a presence on YouTube were assessed. These organizations are identified in this analysis by their YouTube username. Table 5 - Adventist health care organizations with YouTube videos assessed in the content analysis outlines the number of videos each of these organizations posted on YouTube and the number that were included in this content analysis. The nine

Organization	Total Videos	Pertinent to Study	Percent Pertinent	Average Length	Total Intervals
Adventist HealthCare (AHC)	179	6	3.4%	3:56	145
Adventist Health / Central Valley Network (AHCVN)	215	4	1.9%	2:42	67
AdventistHealthNW (AHNW)	149	2	1.3%	2:11	27
Adventist Health System (AHS)	40	3	7.5%	5:05	93
CenturaHealth (CH)	717	4	0.6%	3:26	84
Florida Hospital (FH)	796	8	1.0%	3:07	153
Florida Hospital West Florida Region (FHWFR)	182	4	2.2%	2:18	57
GAMCinTheCommunity (GAMC)	187	7	3.7%	2:07	93
SJCHBakersfield+SJCH (SJCHB)	96	5	5.2%	5:15	160
Total	2561	43	1.7%	3:20	879

Table 5 - Adventist health care organizations with YouTube videos assessed in the content analysis

organizations posted a total of 2561 videos as of November 11, 2016. Nearly all videos were marked as not pertinent for the context of this study; these videos include those centered on, among other subjects, specific medical treatments, short local news segments, and patient stories that do not pertain to the intersection of religious duty, health care provision, and space. Informally, this does not seem to be much different than other forms of self-promotion or advertising conducted by organizations; most content will be about the services rather than the mission.

A total of 43 videos were assessed, with an average length of 3:20 and encompassing a total of 879 separate 10-second intervals and remainders (the last segment of a video that usually is less than 10 full seconds). Full citations of these videos can be found in the reference section, under the organization name. Divided by organization, six videos were posted by Adventist HealthCare (2009, 2011, 2013, 2015b, 2015a, 2016b), four by Adventist Health / Central Valley Network (2011, 2014, 2015a, 2015b), two by AdventistHealthNW (2010, 2015), three by Adventist Health System (2011b, 2011a, 2014), four by CenturaHealth[16] (2011, 2014, 2015c, 2015b), eight by Florida Hospital (2012b, 2012a, 2013a, 2013b, 2013c, 2015, 2016a, 2016b), four by Florida Hospital West Florida Region (2015a, 2015b, 2015c, 2016), seven by GAMCinTheCommunity[17] (2012a, 2012b, 2012c, 2014, 2015a, 2015c, 2015b), and five by SJCHBakersfield[18] (2008; 2011, 2012, 2015b, 2015a). Of those 43 videos, each were

[16] Centura Health was formed in 1996 from parts of the Adventist Health System and Catholic Health Initiatives. The joint mission "is to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities" (Centura Health 2015a). The individual Catholic and Adventist hospitals retain their respective theological differences but share this joint corporate structure. When assessing YouTube videos, only those associated with specifically Adventist spaces of health were used; Catholic hospitals were ignored.

[17] GAMC stands for Glendale Adventist Medical Center, located in California.

[18] Technically, this entry represents two different YouTube usernames. Eight videos were posted by SanJoaquinCH, representing San Joaquin Community Hospital. These eight videos were all posted

found to have at least one mentioning, either through audial or visual communication, of an intersection of religious duty, health, or space. A total of 434 of the 879, or 49%, of the segments contained at least one mentioning. 133, or 15%, contained two different codes of intersectionality. These codes are expanded upon in the next section.

Codes and categories

As outlined in Chapter 3, the process of devising codes in a content analysis is recursive. Codes were developed over the process of analyzing the 43 individual videos. The content analysis identified 12 separate codes that delve into the intersections between religious duties, health care provision, and spatial manifestation. These codes were then sorted into one of three topical categories. A full graphic of all categories, codes, and frequencies of occurrence can be found in Table 6 - Categories and codes of YouTube video content analysis of Adventist health care organizations (Part I) and Table 7 - Categories and codes of YouTube video content analysis of Adventist health care organizations (Part II). The three categories are institutional duties, therapeutic dutyscapes, and the religious or sacred. Institutional duties are comprised of five separate codes; body, mind, and spirit (duties pertaining to caring for the whole person through physical, emotional, and spiritual care), mission/ministry (mentionings of work as a mission or a ministry of Christ), demonstrate God's care (duties to show the connection between God's love and health), compassion in healing (an obligation to use Christian compassion during care), and duty to community (mentionings of outreach and implications that the health spaces must serve

between April 8th and April 9th in 2008, including one pertinent video representing the first in the organization's series on Sacred Work. A new username for SJCHBakersfield began posting videos on September 23, 2009, including more videos on Sacred Work. For ease, these two have been combined into one entry as it appears to represent one hospital and one organization.

not just the community of believers but the entire community). Therapeutic dutyscapes are comprised of four separate codes; nature's healing (the connection of natural spaces and objects to health care), place of healing (mentionings that state or imply strongly that

CATEGORIES	Codes	Total Freq.	(%)	Total Interval	(%)	Adventist HealthCare (AHC) Video Freq.	(%)	No. of Interval	(%)	Adventist Health / Central Valley Network (AHCVN) Video Freq.	(%)	No. of Interval	(%)	AdventistHealthNW (AHNW) Video Freq.	(%)	No. of Interval	(%)	Adventist Health System (AHS) Video Freq.	(%)	No. of Interval	(%)
INSTITUTIONAL DUTIES		39	91%	203	23%	6	100%	47	32%	4	100%	23	34%	1	50%	3	11%	3	100%	26	28%
	Body, mind, and spirit	27	63%	57	6%	6	100%	20	14%	4	100%	10	15%	0	0%	0	0%	1	33%	2	2%
	Mission/ministry	25	58%	52	6%	1	17%	2	1%	3	75%	5	7%	1	50%	1	4%	3	100%	14	15%
	Demonstrate God's care	19	44%	39	4%	5	83%	10	7%	4	100%	11	16%	0	0%	0	0%	2	67%	5	5%
	Compassion in healing	16	37%	40	5%	5	83%	15	10%	2	50%	3	4%	0	0%	0	0%	1	33%	2	2%
	Duty to community	18	42%	52	6%	5	83%	14	10%	0	0%	0	0%	1	50%	2	7%	1	33%	6	6%
THERAPEUTIC DUTYSCAPES		34	79%	122	14%	5	83%	27	19%	4	100%	9	13%	2	100%	14	52%	3	100%	13	14%
	Nature's healing	9	21%	21	2%	3	50%	7	5%	0	0%	0	0%	1	50%	3	11%	1	33%	2	2%
	Place of healing	13	30%	33	4%	4	67%	11	8%	3	75%	4	6%	1	50%	2	7%	1	33%	2	2%
	Prayer as care of patients	14	33%	40	5%	3	50%	4	3%	1	25%	2	3%	1	50%	10	37%	2	67%	9	10%
	Professional/team healing	18	42%	36	4%	4	67%	8	6%	2	50%	3	4%	0	0%	0	0%	0	0%	0	0%
RELIGIOUS OR SACRED		30	70%	196	22%	5	83%	29	20%	1	25%	1	1%	2	100%	3	11%	3	100%	21	23%
	Sacred work	9	21%	82	9%	1	17%	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	History of care	17	40%	56	6%	4	67%	11	8%	0	0%	0	0%	0	0%	0	0%	1	33%	10	11%
	Christ, blessings, faith, and spiritual healing	24	56%	59	7%	4	67%	16	11%	1	25%	1	1%	2	100%	3	11%	3	100%	11	12%
TOTAL		43	100%	434	49%	6	100%	88	61%	4	100%	30	45%	2	100%	17	63%	3	100%	50	54%

Table 6 - Categories and codes of YouTube video content analysis of Adventist health care organizations (Part I)

		CenturaHealth (CH)				Florida Hospital (FH)				Florida Hospital West Florida Region (FHWFR)				GAMCinTheCommunity (GAMC)				SJCHBakersfield+SJCH (SJCHB)			
CATEGORIES	Codes	*Video Freq.*	*(%)*	*No. of Interval*	*(%)*	*Video Freq.*	*(%)*	*No. of Interval*	*(%)*	*Video Freq.*	*(%)*	*No. of Interval*	*(%)*	*Video Freq.*	*(%)*	*No. of Interval*	*(%)*	*Video Freq.*	*(%)*	*No. of Interval*	*(%)*
INSTITUTIONAL DUTIES		4	100%	10	12%	7	88%	17	11%	3	75%	13	23%	6	86%	18	19%	5	100%	46	29%
	Body, mind, and spirit	3	75%	3	4%	5	63%	7	5%	1	25%	1	2%	4	57%	8	9%	3	60%	6	4%
	Mission/ministry	3	75%	3	4%	4	50%	4	3%	2	50%	6	11%	5	71%	8	9%	3	60%	9	6%
	Demonstrate God's care	0	0%	0	0%	1	13%	3	2%	1	25%	2	4%	3	43%	3	3%	3	60%	5	3%
	Compassion in healing	1	25%	1	1%	1	13%	2	1%	2	50%	3	5%	1	14%	1	1%	3	60%	13	8%
	Duty to community	2	50%	3	4%	3	38%	6	4%	1	25%	3	5%	2	29%	4	4%	3	60%	14	9%
THERAPEUTIC DUTYSCAPES		2	50%	3	4%	6	75%	17	11%	3	75%	7	12%	5	71%	13	14%	4	80%	19	12%
	Nature's healing	0	0%	0	0%	2	25%	3	2%	1	25%	2	4%	1	14%	4	4%	0	0%	0	0%
	Place of healing	1	25%	2	2%	1	13%	2	1%	0	0%	0	0%	1	14%	7	8%	1	20%	3	2%
	Prayer as care of patients	1	25%	1	1%	2	25%	6	4%	1	25%	3	5%	2	29%	3	3%	1	20%	2	1%
	Professional/team healing	0	0%	0	0%	4	50%	6	4%	2	50%	2	4%	2	29%	3	3%	4	80%	14	9%
RELIGIOUS OR SACRED		3	75%	9	11%	6	75%	24	16%	2	50%	14	25%	3	43%	7	8%	5	100%	88	55%
	Sacred work	1	25%	1	1%	0	0%	0	0%	1	25%	1	2%	1	14%	1	1%	5	100%	78	49%
	History of care	1	25%	3	4%	6	75%	18	12%	2	50%	9	16%	3	43%	5	5%	0	0%	0	0%
	Christ, blessings, faith, and spiritual healing	2	50%	5	6%	5	63%	7	5%	2	50%	4	7%	1	14%	1	1%	4	80%	11	7%
TOTAL		4	100%	20	24%	8	100%	46	30%	4	100%	29	51%	7	100%	32	34%	5	100%	122	76%

Table 7 - Categories and codes of YouTube video content analysis of Adventist health care organizations (Part II)

the place itself is connected to healing), prayer as care of patients (acts by employees that emphasize the usage of prayer within the healing landscape), and professional/team healing (mentionings that speak of the importance of having scientific, professional care or emphasizes that the staff works especially well as a team of healers). The religious or sacred is comprised of three codes; sacred work (mentioning the sacred nature of the tasks or work in healing spaces), history of care (an emphasis on the longer history of health care within Adventism or these particular hospitals), and Christ, blessings, faith, and spiritual healing (a composite code of mentionings that emphasis Jesus, faith, and spirituality as a part of the sphere of healing).

None of the categories or codes are mentioned in every video. Institutional duties have the most mentions in videos at 91% and the most individual intervals, with 23% of all intervals containing a mention in the category. Therapeutic dutyscapes appear in 79% of videos and 14% of intervals. The religious or sacred appears in the fewest videos at only 70%, but is mentioned in only 7 fewer intervals than institutional duties, comprising 22% of all intervals. Much of this pattern is explained by the code of sacred work in general, which is mentioned in the fewest percentage of videos of any code at 21% but in the most intervals of any code at 9%. In particular, videos published by SJCHBakersfield (SJCHB) account for most of this code. SJCHB has a series of videos about their hospital emphasis on "Sacred Work". 100% of their five videos have mentionings of sacred work, comprising 78 total intervals, or 49% of all intervals in videos published by SJCHB. AdventistHealthNW (AHNW) has two videos published, with 52% of intervals categorized as therapeutic dutyscapes. Prominent in this organization is prayer as care of patients, with 37% of all AHNW segments containing a mention. The entirety of that

code is within one AHNW video, about a program called PrayerWorks. Further examples of the 12 separate codes will be provided over the next sections under category headings. 133 intervals, or 15%, contained 2 separate codes, providing a significant level of overlap. Intervals with overlap of codes are often demonstrating important or core concepts of the hospital spaces. To avoid repetition, examples shown below that are dual coded will only be placed in one of the representative codes. Additionally, most of the examples shown below will represent multiple intervals of videos.

Institutional duties of Adventist hospitals

Individual versus institutional duty

The analysis completed in Chapter 5 found that in reviewing Ellen White's major writings on health that nine themes of 'duty' were covered. These duties were differentiated as individual duty and institutional duty. Of the nine categories of 'duty' elucidated in Chapter 5, four explicitly pertain to individual duty, four are mixed individual and institutional duties, and one is explicitly institutional in thrust of duty. These categories of duties fit within the model of the filter of space; the extension of the Lefebvre spatial triad from Chapter 4. Individual duty fits as spatial practice. These are duties that are to be maintained in an everyday manner. Institutional duty manifests as representations of space. These are planned spaces created by the power structures of the culture. This section will focus upon the one explicit institutional duty that pertains to Adventist spaces of healing rather than the individual. Within the content analysis of the Adventist YouTube videos, subcategories of institutional duty were found. These are expectations fostered by the institution. While many are carried out by the individual, the

drive to complete these duties comes not from the individual fulfilling their own religious duty to their own God, but rather a collective duty or mission coming from the overall organization.

Institutional duty – assessing YouTube videos

Five codes of YouTube video mentionings comprise the category of institutional duty. Examples of each code, through both quoting audio and screenshots of video, are included along with a general discussion of the category.

Body, mind, and spirit

> I provide body, mind, and spirit through my job by communicating with patients, understanding patients, and trying to get on their level. To share God's love in my work is to be compassionate, kind, caring, and to listen to our patients.
>
> *"Adventist Health – mission"* (Adventist Health / Central Valley Network 2011)

> All hospitals treat the body but it's our mission to treat the mind, body, and spirit.
>
> *"Our campus"* (Florida Hospital 2013c)

Mission/ministry:

> At Porter Adventist Hospital we extend the healing ministry of Christ by caring for those that are ill and by nurturing the health of the people in our community. We are pleased that you have chosen Porter, where we embrace the Seventh-day Adventist philosophy of whole person care, blending the best of science and spirit.
>
> *"Porter Adventist Hospital tour"* (Centura Health 2011)

> … that it's a Christian organization and not only can I live out our mission statement but I can also live out my goal for my life which is to serve the Lord in what I do.
>
> *"Adventist Health – mission"* (Adventist Health / Central Valley Network 2011)

> Without the hospital's support there will be no team for Guatemala because the hospital supplies all the surgical supplies that we need and the clinic supplies that we need, as well as most all of the pharmacy, the IV pharmacy supplies that we need. So without the hospital there will be no Bakersfield Helps medical mission.
>
> *"Sacred work – Deanna Salyards"* (SJCHBakersfield 2015a)

Demonstrate God's care:

> To have people understand that when they are in a hospital setting that God hasn't forgotten them. Sometimes when a person is sick, they feel overwhelmed. Why is this happening to me? Where is God? As I have opportunities, I explain to folks that God is the one who invented the laws of physics and he's the one who's taking care of all those different things.
>
> *"Adventist Health – mission"* (Adventist Health / Central Valley Network 2011)

> Our commitment to the health of our community reaches far beyond our four walls. We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing.
>
> *"About Adventist HealthCare"* (Adventist HealthCare 2013)

Compassion in healing:

> But they wanted to know if I had any dietary needs based on my religion or my faith or my beliefs, and I think that is really important. I think that again that's trying to make the care that you receive in their facility like the care you would receive at home and they are trying to give you the same compassion you would get as though you were at home. And in my opinion, I think that aids in your healing.
>
> *"Sacred work at SJCH, 2012 version"* (SJCHBakersfield 2012)

> And quality and compassionate healthcare without nurses is unimaginable. Their competency, experience, and commitment are at the very heart of our work.
>
> *"Serving God and the D.C. region"* (Adventist HealthCare 2016b)

Duty to community:

> … the need to address health in our community, it can't all happen in our hospitals. A big part of it has to happen in collaboration with other organizations out there also building health in our communities. Glendale Adventist's mission is whole person care and community outreach. Why is there such a mission with the GHCC and Glendale Adventist to combine sources to get a stronger and healthier community? Well, you hit it out when you said "mission." This is really core to us as a hospital. Our mission is whole person care. That means we really are concerned about what happens to our patients before they come to the hospital and after the discharge. And the way we can do that is by making sure that we are collaborating with other organizations that have a similar mission.
>
> *"Glendale Healthier Community Coalition with Gregory and Bruce Nelson"* (GAMCinTheCommunity 2012b)

> I think as a major employer we have certain community obligations. If we truly build our community, we know that the hospital that serves that community will be equally strong.
>
> *"Winter Park Memorial Hospital's 60th"* (Florida Hospital 2015)

These codes have been grouped together as institutional duties as each pertains to the religious purpose of the organization. While in some cases there is an aspect of the personal, insomuch that the employee is doing the work as part of a personal ministry to become close with Christ, each of these tasks are intended as duties that build towards the purpose of the institution. While these videos come from different organizations, many share similar a similar mission. There is communication between the organizations at the Division level of Adventism (see Appendix A for organizational chart), but each is roughly independent. Glendale Adventist Medical Center describes a mission, shown in Figure 20, "[t]o share God's love with the community by promoting healing and wellness for the whole person" (GAMCinTheCommunity 2015c). Similarly, Adventist

Figure 20 - Body, mind, and spirit visual code from YouTube. Video titled "Glendale Adventist Medical Center I'm Here For You" by GAMCinTheCommunity. <https://www.youtube.com/watch?v=IZJHlnpULBE>.

HealthCare, as shown in Figure 21, describes its one mission as "[w]e demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing" (Adventist HealthCare 2015a). These organizations are on opposite sides of the United States but both share similar visions for what drives the operation of their health care institutions. Additional videos invoke directly the stated mission of Adventist HealthCare; "We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing." The mission is displayed as text on the screen to open the videos "Our Mission to Heal Mind, Body, Spirit" (Adventist HealthCare 2015b) and "Adventist HealthCare by the Numbers 2014" (Adventist HealthCare 2015a). The phrase is spoken in the videos "About Adventist HealthCare" (Adventist HealthCare 2013) and "100 Years of Care (Extended Play)" (Adventist HealthCare 2009) through the use of a cutting technique of having multiple narrators each speak a part of the statement.

Figure 21 - Demonstrate God's care visual code from YouTube. Video titled "Adventist HealthCare By the Numbers 2014" by Adventist HealthCare. <https://www.youtube.com/watch?v=02lGG3NvNqc>.

Both Adventist Health System and Florida Health West Florida Region posted videos that describe a purpose of "[e]xtending the healing ministry of Christ" as shown in Figure 22 (Adventist Health System 2014; Florida Hospital West Florida Region 2015a). The codes of "mission/ministry," "demonstrate God's care," and "body, mind, and spirit" are shared as common institutional duties among the spaces of health care. Adventist health spaces are mission-oriented. The mission is to extend a Christian ministry through showing that God cares for each person. The organization demonstrates this love through healing mind, body, and spirit. While it is not described in this set of videos, Chapter 5 of this dissertation showed that Adventists care about the mind, body, and spirit triumvirate is because one needs all three aspects working in proper order to accept Christ. It is also through compassionate care (Figure 23), as shown by both Adventist Health System and Florida Health West Florida Region that Adventist organizations

Figure 22 - Mission/ministry visual code from YouTube. Video titled "Adventist Health System Heritage Video AUGUST 2011" by Adventist Health System. <https://www.youtube.com/watch?v=-_cFKRiwm3o>. Florida Hospital West Florida Region had the same frame in the video "Adventist Health System Hertiage [sic]"

show the truth of this mission (Adventist Health System 2014; Florida Hospital West Florida Region 2015a).

There is an institutional duty, which persists to this day, to extend the healing ministry of Christ. But to whom? The mission is not only to care for the community of believers, but to extend the ministry to outsiders. In the current health paradigm of community-based hospitals, it means extending the healing ministry to the community as a whole. As San Joaquin Community Hospital shows in a video (Figure 24), there exists a 'sacred trust' with the community (San Joaquin Community Hospital 2008). Adventist HealthCare also emphasizes this point. In the video "100 years of care" (Adventist HealthCare 2009), a section about the Emergency Department starts with the text "Our Front Door to the Community is Always Open." The speakers on the video then describe that providing care for the community has been a mission from the start of the hospital.

Figure 23 - Compassion in healing visual code from YouTube. Video titled "Adventist Health System Heritage Video AUGUST 2011" by Adventist Health System. <https://www.youtube.com/watch?v=-_cFKRiwm3o>. Florida Hospital West Florida Region had the same frame in the video "Adventist Health System Hertiage [sic]"

"Mind, body, and spirit – it happens here 24/7" is stated moments later. It is described that "no one is turned away." This section is emphasizing that while this hospital is Adventist, the patients need not be. The subsequent section is about connecting health care with the community. "Everyone deserves access to healthcare, not just those that can afford it. For 100 years, that's what we've been all about." The mission to bring education and health programs to the community is discussed. The hospital is not inward looking; it is outward, looking to make the whole of the community feel the message of whole care.

Institutional duties – interview

In order to get more information on institutional duties, an interview was conducted with an employee of Adventist HealthCare, the organization that operates the Adventist health-care facilities in the Washington, DC metropolitan region. This

Figure 24 - Duty to community visual code from YouTube. Video titled ""Our Sacred Work" - San Joaquin Community Hospital" by San Juaquin Community Hospital. <https://www.youtube.com/watch?v=YsuHWPZpZak>.

participant also has a history in nursing and ministry, allowing for answers to questions from multiple perspectives. The work that the subject does currently fits into the definition of institutional duty as described previously:

> And so what I do in my job here is to take our mission and, which is demonstrate God's care - that's the shortness of our mission - and really provide for it, not only at theological foundation but a sacred expression. Or an expression that is grounded on something sacred. And so my job is to help individuals understand. Help the organization understand what does it mean to demonstrate God's care.

In this, the subject's work is ensuring that the organization is following with an organizational mission of demonstrating God's care; God's compassion and God's laws, which can be faithfully followed for good health. On the current role within the organization, the subject responded:

> Part of what I do is managing the network of communities of faith, both Adventist and non-Adventist communities of faith. And we've got some plans that will, it's related to population, health, and we want to target these communities of faith and help them get healthy and whole. Physical, spiritual, and mental.

This comment is discussing one of the roles of health-care institutions in Adventism. The administration of health, especially in these suburban hospitals, is to care for the community; not just the community of believers, but the entirety of the geographic community. As well, the subject describes what it means to be whole, going back to the mind-body-soul triumvirate seen so frequently described in Adventism and categorized within the YouTube analysis as a part of institutional duty. When asked why Adventists run hospitals, the subject differentiated between sick care and wellcare:

> I think it begins with this idea of whole health and then hospitals are sick care, alright? And our denomination began with the idea of wellcare. Wellness care. And you know, the sanitariums. Because we really didn't start out with hospitals. And so these sanitariums and hydrotherapy and these organizations - the focus was on wellness care. And I think the society and the environment almost forced us to have to go and do sick care.

The concept of 'wellcare' is essentially the idea of health reform that has been put forth by Adventists for their history. It is about preventative care; early sanitariums were places in which people came to be healthy, and not necessarily places in which they came to be cured. Proactive steps have always been encouraged in Adventist health theology; stop smoking, stop drinking, stop eating poor foods, begin exercising. And as was seen in the history of Adventist hospitals, many had to change over into acute care hospitals as suburban sprawl swallowed their locations. They became sick care, short stay, community hospitals. This is a change of institutional duty; changing from the primary duties of mission/ministry and whole care towards duties that the hospitals have to caring for the unwell in the community.

There can be a contestation on the holistic, mind-body-soul treatment as this answer to whether it is a personal duty to maintain one's own health shows:

> Absolutely. I think this is one of the tenets. This is one of the real strong tenets of Adventism. You know, believing as we're told for instance our body is the temple, and so Adventists try very hard to live a healthful life. Now, my biggest criticism here is - and what I've seen, I saw this in pastoral ministry - our focus sometimes too much on the physical and not on the mental. And spiritual actually. And so I don't see it just as a duty. I mean it's, for me, it's a call and an obligation. Having come from pastoral ministry, it's sad to say that we have many, many unhealthy pastors. Many. And so when you have unhealthy pastors who are leading congregations, you know, it's safe to say that then the congregation will not be healthy. Or as healthy as it should be. And our pastors focus on the spiritual. They focus on the physical. Rarely do they focus on the mental, so there's not a sense of wholeness there.

The contestation is two-fold. First, there is a battle in terms of following individual duty or not. We see that there is a duty to preserve one's health, but with human agency, this duty is not always fulfilled. The problem increases then when there are differences in institutional duties between the health care institutions and the church institutions. The health care institutions focus on the wholeness of health, in having

mind-body-spirit all healthy. The pastoral ministry, which may not be completely versed in the specificity of the health vision as the health ministry is, may focus wrongly on only portions. As was seen in the history section, this is a common contestation of power between the pastoral and health ministries.

Therapeutic dutyscapes of Adventist health spaces

Dutyscapes – assessing YouTube videos

Four codes of YouTube video mentionings comprise the category of therapeutic dutyscapes. Examples of each code, through both quoting audio and screenshots of video, are included along with a general discussion of the category.

Nature's healing

> The associations with nature help our patients with mental illness to reconnect. They reconnect with nature, with pleasurable experiences, with other people, and with themselves. If you have a family member, friend, or a loved one that is suffering from mental illness, they won't find a more beautiful place to heal than here at Adventist Medical Center in the Hope and Healing Garden.
>
> *"Health & healing garden"* (AdventistHealthNW 2010)

> Flowing water and a variety of plantings in combination with views of the surrounding landscape create a true therapeutic sensory experience to aid in the healing process. A recreational trail around the lake provides opportunities for the community to participate in their own health.
>
> *"Washington Adventist Hospital: Our vision for the future"* (Adventist HealthCare 2011)

Place of healing

> We strive to really make it a place of healing and a place where people don't have to feel vulnerable or scared to come here because we are doing everything we can to make it very comforting for them and not so scary of a place to come.
>
> *"Our mission to heal mind, body, spirit"* (Adventist HealthCare 2015b)

> Introducing Florida Hospital Wesley Chapel. A hospital born from the philosophy that the environment you heal in matters. And every aspect of a patient's care is important. More than a century of expertise is reflected in every detail.

"Learn more about the new Florida Hospital Wesley Chapel" (Florida Hospital 2012b)

Prayer as care of patients

> Even though I'm not expected to pray with patients or talk to the patients about the Lord, I still do it because I feel they need to know the Lord. Sometimes, some are Christian people. I love when I walk into a room and they know the Lord. It just makes me happy. But if they don't say anything about the Lord or anything then I talk to them about the Lord.
>
> *"Metroplex Hospital"* (Adventist Health System 2011b)

> I like the ability to be able to pray with my patients whenever I want to. I really wanted the opportunity to be able to pray with my patients and incorporate my spirituality into my care of my patients. Prayers with my patients, faith, it has a lot to do with healing.
>
> *"Our mission to heal mind, body, spirit"* (Adventist HealthCare 2015b)

> To also do that, I pray with them before I place lines. I pray during my lines and I always ask God to guide my hands, my eyes, my ears, and my heart so that the patient comes out. There's a positive outcome at the end.
>
> *"Inspired health at Florida Hospital: The significance of prayer"* (Florida Hospital West Florida Region 2015b)

Professional/team healing

> Interestingly in the last two months I've had several physicians stop me in the hall, unsolicited, to tell me how special the y think the sacred works program is to them because they see that level of care and commitment in the staff. It's not just one individual that has a responsibility for a large staff, but it's each of us not only being in tune with what is going on with us, but looking out for other individuals and when we go up and ask "how are you doing?" and they say "fine" we say, "but how are you really doing?" and give an invitation to talk and maybe two or three get together and they learn from one another. They are strengthened by one another and it's a community working together and not just one individual helping fifty people. It's everyone helping one another and being concerned and seeing our work as a team.
>
> *"Sacred work at San Joaquin Community Hospital"* (SJCHBakersfield 2011)

> We've carefully created collaborative teams that help to ensure that you receive consistently excellent care. From housekeeping to dietary, to your direct medical treatment.
>
> *"Florida Hospital Carrollwood"* (Florida Hospital 2013b)

These four codes have been categorized as mentionings in the content analysis that point towards the creation of therapeutic dutyscapes. What binds these codes together is that these are being used to create spaces in which healing can occur, but

through a distinctly Adventist worldview. Two are distinctly spatial; these are the codes for nature's healing and place of healing. Figure 25 displays a historical photograph of the use of nature's amenities for healing at an Adventist sanitarium of the past, used by Adventist Health System (2014) to describe the heritage of health services. More recently, Centura Health (2014) describes that Parker Adventist Hospital, shown in Figure 26, is designed with "soothing, serene spaces for body, mind and soul". The codes of nature's healing and places of healing at times have some overlap. These are the only codes that occur in the video "Washington Adventist Hospital: Our vision for the future" (Adventist HealthCare 2011). The visuals of the video are a fly-through of the proposed new Washington Adventist Hospital campus in White Oak, Maryland, in Montgomery County near the border with Prince George's County. The site is described as "48 picturesque acres," inspiring the built landscape to "invoke[s] the dapple rhythm of a woodland setting, the materials and colors representing nature's role in healing."

Figure 25 - Nature's healing visual code from YouTube. Video titled "Adventist Health System Heritage Video AUGUST 2011" by Adventist Health System. <https://www.youtube.com/watch?v=-_cFKRiwm3o>.

The emphasis on the Adventist beliefs of healing happening in concert with nature is further explained throughout the video, with references to a garden separating the main entrance and the emergency services entrance, a sunken garden providing a "natural setting for the oncology program", healing gardens outside of the hospital chapel, terraces and patios leading to a lake, which has a recreational trail surrounding it. To reinforce the religiosity at the midpoint of the health message, the hospital will have a Center for Spiritual Life and Healing, which includes a chapel that overlooks the healing gardens. In describing the healing gardens, the video discusses the usage of varied planting and flowing water to "create a true therapeutic sensory experience, to aid in the healing process." The walkway around the lake is meant as a community resource, and not just for hospital patrons. Exercise kiosks are placed around the recreational trail, helping to "encourage everyone's pursuit of health in mind, body, and spirit." Grounded into the design of the hospital is a conception of wellcare instead of sickcare; creating a place of healing through the use of mixing natural and religious spaces.

Figure 26 - Place of healing visual code from YouTube. Video titled "Parker Adventist Hospital - 10 Year Anniversary" by CenturaHealth. <https://www.youtube.com/watch?v=ntfRRneVnZ4>.

Along with providing the physical spaces of healing is a push for Adventist hospitals to demonstrate that their procedures and staff are highly professional. At times, there can be a connotation of lacking modern, scientific techniques in Christian hospitals, in some part due to some denomination's using faith healing among other practices. Adventist hospitals demonstrate that while their version of healing is connected to a Christian ministry, the techniques that are used are as advanced as any other hospital. Adventist HealthCare (2015b) emphasizes being "the largest provider of medical and health services to our community. We opened the first comprehensive cancer center. And for more than 35 years we've operated the highest level neonatal intensive care unit." Florida Hospital West Florida Region (2015a) describes having "the most advanced level of care". Glendale Adventist Medical Center's (2014) location allows the community "to find world class care without travelling far from home." Similarly, Florida Hospital (2012b) states that "residents no longer need to travel for state-of-the-art healthcare" due to the new location at Wesley Chapel. This code also includes references to the staff working as a unit or team. Adventist HealthCare (2016b), in a video that is used to recruit nurses, describes the teamwork of the staff during a portion of the video that pans past many pictures of nurses, highlighted in Figure 27, that are part of the staff. The unified staff is being used to create a consistent place of health within the hospitals.

Prayer is used by employees to create a therapeutic dutyscape. Prayer itself is not an institutional duty as it is not a requirement in terms of providing spiritual care or to spread the ministry of Christ, but prayer is considered a duty by some individuals that work in the institutions as a fulfillment of either their own faith or as their attempt to heal the spirit through ministry. It is thus a task some employees use to create therapeutic

spaces within the context of a religious space of healing. The usage of prayer can even be completed by people not involved in direct health care; in the "Metroplex Hospital" (Adventist Health System 2011b) video that is cited above, the quote comes from a member of the environmental services of the hospital rather than a nurse or doctor. Florida Hospital produced a video regarding some victims of the Pulse Nightclub shooting[19]. The phrase "#PrayForOrlando" is posted at both the beginning and end of the video. Additionally, a section of the video shows a large group of staff engaged in a prayer.

Perhaps the most evident case for the usage of prayer to create a therapeutic dutyscape at Adventist health spaces is the program developed by Adventist Health NW. The organization posted a video on YouTube to announce a new program called

Figure 27 - Professional/team healing visual code from YouTube. Video titled "Serving God and the D.C. Region" by Adventist HealthCare. <https://www.youtube.com/watch?v=uWhhTJGVicU>.

[19] Florida Hospital in Orlando treated 12 of the victims of the mass shooting at the Pulse Nightclub on June 12, 2016. The hospital announced that it would waive the fees for all 12 of the victims that came to Florida Hospital (Anderson 2016; Berman 2016; Domonoske 2016). The total cost of expenses being waived is around $535,000 (Anderson 2016; Domonoske 2016).

PrayerWorks (AdventistHealthNW 2015). Throughout the video are visuals of people with Bibles or in contemplation. The voice over asks the listener if they pray by themselves. PrayerWorks itself is introduced with this portion of the voiceover:

> The Bible says whether two or three are gathered together, God will be with them. So it's clear that we all need this kind of community prayer. This is why Adventist Health is launching a new website called Adventist Health PrayerWorks. It is a prayer community that you can connect to 24/7. All you need is internet access. You can post any request, concern, or struggle to the site and you'll instantly be surrounded by the largest prayer community in the city. And if you want affirmation that others are lifting you up in prayer, you can choose to be notified when they do. In fact if you see someone that has a particular need, you can even surrounding them with prayers of your own. On top of this, several Adventist Health chaplains and volunteers will take these requests and pray over them every week. It is part of Adventist Health's mission to demonstrate the healing ministry of Jesus Christ.
>
> Adventist Health PrayerWorks (AdventistHealthNW 2015)

During this voiceover, the camera zooms or pans towards an individual that is shown alone. When the camera zooms outward or pans away, the person is now surrounded by multiple people, heads bowed in prayer. At least one of the members of the prayer community is touching the arm or shoulder of the original person seeking prayer. Not only is this a community of people that can pray for you; for some, it is part of their duties at the hospital. "[S]everal Adventist Health chaplains and volunteers" will print out and make prayers for the person making the request. A circle of these chaplains and volunteers is seen in Figure 28. Prayer, even over electronic media, is being used to build both community and a dutyscape of therapy.

Dutyscapes - interview

The creation of therapeutic dutyscapes did not appear much in the narrative interview. The one instance emerged when discussing the purposeful design of the new Washington Adventist Hospital, discussed in the context of how suburbanization has

obliterated the previous sanitarium model of care. This process of suburbanization was discussed in the interview, and the subject began to discuss ways in which the new Washington Adventist Hospital is being designed to keep the hospital as a therapeutic landscape:

> And that's why we were talking spatially, now we take a look at what we're doing at Washington Adventist Hospital, creating spaces, refuge, you know. The rooftop gardens. The surrounding areas. I mean there's a lot, a lot, a lot of thought put into how we can create this place to be a refuge.

The suburban community, with sprawling houses and busy expressways, is not an ideal therapeutic landscape for many. The designers of the new hospital are cognizant of this and are attempting to build areas of reflection and relaxation; means of lessening the burden of illness. The emphasis is again on creating a space that does not just treat the illness, but treats people in a holistic way.

Figure 28 - Prayer as care of patients visual code from YouTube. Video titled "Adventist Health PrayerWorks" by AdventistHealthNW. <https://www.youtube.com/watch?v=lmJ9vVieAAQ>.

From therapeutic landscape to dutyscape

One major observation comes to light when reviewing the therapeutic landscape literature while developing a model in which religious duty manifests. It is a new paradigm of directionality in terms of duty, space, and therapy. Most often, the literature points towards a model in which a space is found or created in which therapy occurs, and a duty flows from that. Research on the religious duty of healthcare for Seventh-day Adventists posits a different relationship. In this relationship, it is the duty to provide therapy that comes first, and then space is created to satisfy that duty. The different pathways can be viewed in Figure 29.

Therapeutic landscape research on sacred or religious spaces follows the general path of the space being socially constructed before the duty. In Gesler's seminal work on Epidauros, Greece (1993), it is explained that environmental factors which influenced where Asclepian temples would be set. In that way, it was the space that came first, followed by therapy that, while not argued in the paper, could be argued to have brought about a duty to pilgrimage to the site. Gesler's follow-up investigation of Lourdes, France (1996) uses a similar pattern; a miraculous event occurs at a specific site, healing

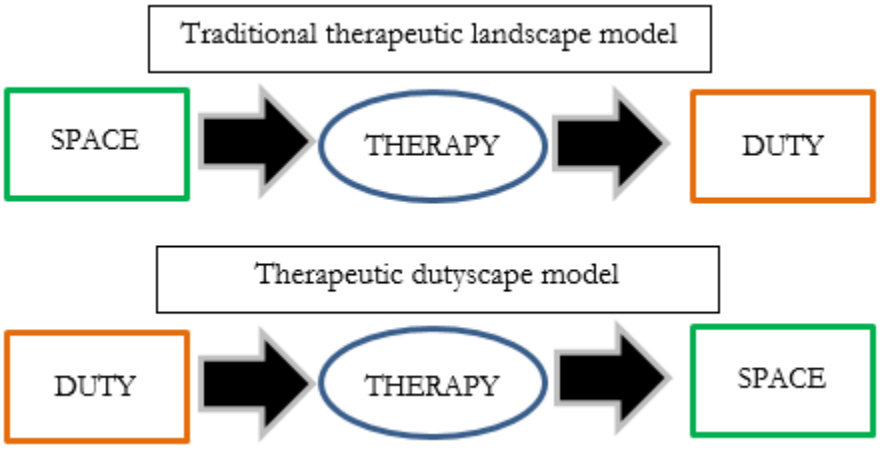

Figure 29 - Model of directional relationship of space and duty

and therapy come from that site, and the promise of healing brings a duty of pilgrimage. Williams' study of St. Anne de Beaupre in Quebec (2010) follows a similar pattern to that of Lourdes. If looking through the perspective of the *filter of space* from Chapter 4, Epidauros is representations of space by being built through the dominant socio-religious structures of society, while Lourdes and St. Anne de Beaupre are representational spaces by being symbolic spaces of sin being washed away.

Adventist hospitals follow a different pattern of being established based upon duty first. While it can be seen through the story of the siting of Washington Adventist hospital that the exact chose space is important, what came first was a specific religious duty. The duty was to educate new people on health reform and laws of God. The Washington, DC region was chosen for a hospital. Geographic considerations came into effect afterwards. In that way, duty was the primary function; a duty to create therapy. From that duty, landscapes of therapy were created and altered. This change in directionality shows intent of purpose. In many other sacred spaces in which healing occurs, any sort of duty comes secondarily and often, accidentally. There is not intentionality of duty in the construction of those landscapes. Adventist institutional spaces of healing are intentional based on a theology. Space is not as important to foundation. These spaces of healing can in many ways appear almost randomly on the landscape, whereas many other therapeutic landscapes of the sacred have specific geographic reasons for occurring.

Sacred work and sacred space

Sacred spaces – assessing YouTube videos

Three codes of YouTube video mentionings comprise the category of the religious or sacred. Examples of each code, through both quoting audio and screenshots of video, are included along with a general discussion of the category.

Sacred work

> We want to take a just a few moments to give you sense of our organizational culture at San Joaquin Community Hospital that we call sacred work. Sacred work is for us the expression of God's love in the work that we do every day and it's experienced whenever need is met with love. The kind of love that chooses to deliver the highest standards of quality and service all wrapped up in deep caring and compassion. Our staff put together a statement that says that sacred work is recognizing that no matter who you are and no matter what you're doing, whether you are waxing the floor or making an executive decision, or changing the bed or giving a medication, that your work is sacred because your life and the life of the one you are serving is sacred. And we like that. To us our work is not just a job, it is a calling and it's an opportunity to bring healing and hope every day to the people that we care for.
>
> *"Sacred work at San Joaquin Community Hospital"* (SJCHBakersfield 2011)

> There's just so much that drags you down in our culture that doesn't build you up and the whole philosophy of sacred work, seeing everyone as sacred, seeing what you do for them as sacred, even the janitor understands that all the good work of our surgeons, of our nurses, of our staff, our administrators, all of it can be undone by staph infection if the floors are dirty, the walls aren't clean. So the work of the janitor is just integral and crucial to this whole process of feeling and caring for each other. When you have a caring and compassionate staff of executives that want to make certain that they provide the very best care to this community, that ripple effect runs throughout the staff, all the way down to the first person you meet when you walk into the ER, or the valet person that helps park your car when you pull up out front. The whole hospital takes on that ethic if you will and it's representative in the care that they are providing to their patients.
>
> *"Sacred work at SJCH, 2012 version"* (SJCHBakersfield 2012)

History of care

> In the early 1900's the Seventh-day Adventist Church wanted to bring its unique holistic vision for health care to the Washington, DC region. What is now known as Adventist HealthCare Washington Adventist Hospital opened in 1907, combining pioneering thinking on how diet, exercise, and rest affect a person's health with traditional medical care.

"Serving God and the D.C. region" (Adventist HealthCare 2016b)

I think it's amazing 85 years after Henry Porter had the vision for what Porter could become that it still lives on today. Things have changed, but the philosophy is the same. People are important.
"Porter 85 years in the making V4 HD" (Centura Health 2015c)

… the work of Adventist Health System is defined by a unifying thread that winds through more than 150 years of a health and healing legacy. In the mid 1800's, health and long lives were rare. Good health care was practically nonexistent. And doctors often prescribed odd elixirs and treatments, some of which were as harmful as the diseases they promised to cure. People were afraid of night air, and bloodletting was still a common practice. But several founders of the newly organized Seventh-day Adventist Christian church had a better idea. They believed that God had already provided the best remedies in nature, and they turned their attention to prevention, suggesting that fresh air, sunshine, rest, exercise, nutritious food, and clean water could help people stay healthier. They also proposed that a simple diet rich in nutritious foods would help build stamina and strength. Health reformers, led by James and Ellen White and other early Seventh-day Adventists looked at the life of Jesus Christ and wanted to follow in His ways. Caring for those that were hurting, physically, emotionally, and spiritually.
"A legacy of Adventist health care: 150 years of health & healing" (Florida Hospital 2016a)

Christ, blessings, faith, and spiritual healing

No one understands the role faith plays in health care better than we do. We're Adventist Health, and we do our best to ensure you never question the faith you put in us.
"Health & healing garden" (AdventistHealthNW 2010)

The power of the spirit has been at the heart of what we do since day one. As a Seventh-day Adventist institution, we've never shied away from the power of faith. Whether for its power to heal, to give comfort, to aid in understanding, or to be in awe of undeniable miracles, as well as give blessing to our outcomes. Our faith has always been integral to our approach to care. In 2002, we started our grief recovery program, helping families and caregivers to cope with loss. Through support groups and bereavement services, the people of Washington Adventist Hospital have used faith to bring comfort to hundreds of people. And today faith joins science, using spirituality and prayer to aid in healing. In clinical studies, the power of prayer has been shown to contribute to improve outcomes, as we have known from the beginning. For one hundred years, we've been practicing what the National Institute of Health today calls "frontier medicine." Coupling science and medicine with the power of faith. Whole person care; it's not frontier medicine here, its frontline. Mind, body, and spirit.
"100 years of care (extended play)" (Adventist HealthCare 2009)

The codes within this category relate religiosity as validity of their health care work. The code of the history of care may seem as a questionable fit, but the way in which Adventist health history is argued in these videos is that this relatively long history of health care validates the religious rationale. Adventist HealthCare created a posted the video giving a history of the century of health care provided to the region by Washington Adventist Hospital (Adventist HealthCare 2009). The video description states that "[t]his is the story of Washington Adventist Hospital at one hundred years. It's a story of a century of compassion and a century of the best of care, at a hospital ahead of its time." An image from the video regarding the length of service history in the region is shown in Figure 30. In emphasizing the religious underpinning of the hospital, the first section of the video is entitled "It started with a blessing." It describes how Ellen White taught the precept of health reform. The profits of her book *The Ministry of Healing* were used to purchase the 14-acre site that would become the site of Washington Adventist Hospital.

Figure 30 - History of care visual code from YouTube. Video titled "100 Years of Care (Extended Play)" by Adventist HealthCare. <https://www.youtube.com/watch?v=MGPz6Dy1MgY>.

During this section, it is emphasized how the site itself would aid in the therapeutic work that was to be done, "with fresh air and pure water, and isolated from busy city life. It was here that whole person care became a reality, with 40 beds and a staff of 12. The Washington Post wrote, 'it would be difficult to find a better place for quiet and rest'." The organization is demonstrating that the original Adventist teachings on health, of finding bucolic retreats where nature could aid in healing, made this particular site perfect for health. The history is brought forward to demonstrate that Adventists have been right all along. In the past, other supposed health practitioners used poisons. Adventists did not, and Adventists recognized that clean air, water, and food would lead to health. These, along with exercise, are scientifically consistent and currently in vogue for those seeking health without drugging. The history lends credence to the religion.

The code of Christ, blessings, faith, and spiritual healing[20] is a composite of mentionings that circle around connections to Jesus or the use of faith as a part of health care. One of the longest and most prominent appeal to faith made in these videos comes from Adventist HealthCare and is quoted above. This section is narrated by three people. Visually, many of the shots are based around the hospital chapel. Other video cuts show a Bible being opened, a chaplain giving comfort to a bereaved family member in the chapel (Figure 31), and an employee next to the bed of a patient, speaking while holding open a book (presumably, a Bible). Both the short bereavement scene and the hospital bed scene include cuts that zoom into the people holding hands, emphasizing the compassion being given by the caretakers at the hospital. This section goes again to the institutional duties involved in the hospital. It is the mind, body, and spirit that must be

[20] Not at all to be confused with faith healing, which has been viewed with disdain in Adventism since the Fox sisters in Rochester, New York were cracking their toe joints to represent rappings by spirits.

healed. The through faith and adherence to the laws of God, the whole of a person can be well. By giving evidence that their brand of faith-based healing coupled with advanced scientific methods is an improved way to health, this opens to the door to one to wonder what else may be improved through the Adventist faith.

One of the clearest codes that comes forward is that of sacred work. Multiple organizations make reference to the work of their organizations being sacred. "Our mission to heal mind, body, spirit" (Adventist HealthCare 2015b) has a registered nurse speak that the mission is a "sacred trust" to give healing of the mind, body, and spirit. Parker Adventist Hospital in Parker, Colorado has a video in particular that fit in this context. The video "Parker Adventist Hospital – 10 Year Anniversary" (Centura Health 2014) has no spoken words, but among the story given by the words posted on the screen,

Figure 31 - Christ, blessings, faith, and spiritual healing visual code from YouTube. Video titled "100 Years of Care (Extended Play)" by Adventist HealthCare. <https://www.youtube.com/watch?v=MGPz6Dy1MgY>.

the line "It's a *sacred* work" appears (emphasis original)[21] (Figure 32). However, most prominent in the line of sacred work comes from San Joaquin Community Hospital. This Adventist Hospital in Bakersfield, California has a series of videos about the Sacred Work that occurs at the hospital. The first video in the series describes sacred work as "where need is met with love" (San Joaquin Community Hospital 2008). All employees, regardless of position, are taught that they have a "sacred trust" with all that they serve. As it is summarized, "it's about taking care of the people that take care of people." The sacred trust also extends to the community, in giving quality, compassionate, and honest care. The speaker brings up that patients are treated "as a whole person, as emotional, spiritual, and physical." In that video, God is not brought up, but perhaps using the term 'sacred work' is a way to emphasize the deeper connections to health without invoking God directly.

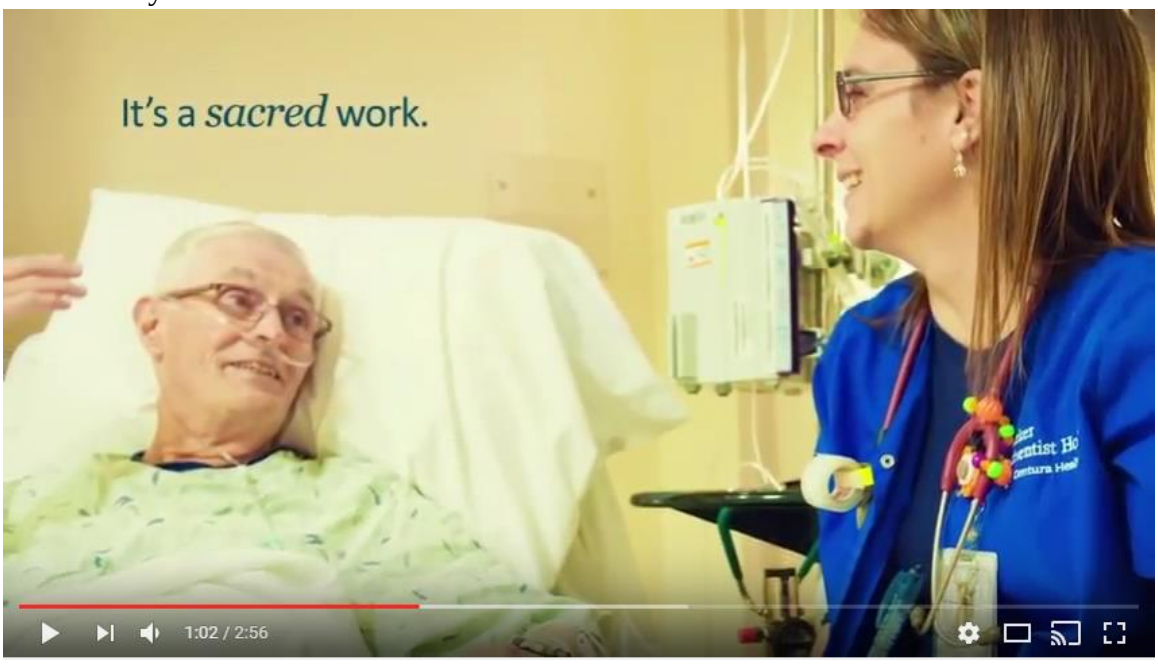

Figure 32 - Sacred work visual code from YouTube. Video titled "Parker Adventist Hospital - 10 Year Anniversary" by CenturaHealth. <https://www.youtube.com/watch?v=ntfRRneVnZ4>.

[21] As an interesting side note, there is another video called "Parker Adventist Hospital, Our Clear Mission" that states in words that the clear mission is "to nurture the health of people in our communities." However, the Parker Adventist Hospital website states the mission is "to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities."

God is invoked in the next video from San Joaquin Community Hospital, "Sacred Work at San Joaquin Community Hospital" (SJCHBakersfield 2011). This follow-up video is designed to better describe the "organizational culture" at the hospital. Sacred work is defined as "the expression of God's love in the work that we do every day and it is experienced whenever need is met with love." This is quoted at length above and shows that sacred work extends to all positions, regardless of where in the hierarchy one works; your work is sacred because you are serving someone whose life is sacred and your own life is sacred. The speaker states that "to us, our work is not just a job; it's a calling," emphasizing that God is with everyone throughout their little duties. The majority of the video are employees talking about what sacred work means to them, and how this specifically Adventist culture has aided the workplace and the work. The third video in the series, "Sacred Work at SJCH, 2012 Version" (SJCHBakersfield 2012) is the longest of the videos at over 10 minutes long (Figure 33). The video talks about how

Figure 33 - Sacred work visual code from YouTube. Video titled "Sacred Work at SJCH, 2012 Version" by SJCHBakersfield. <https://www.youtube.com/watch?v=3b_Q34HJqJc>.

"the mission drives what we do" and that mission is what makes the hospital unique enough to be called 'Adventist.' It is an expansion of the previous videos with new voices describing sacred work. One commentator mentions that "this hospital treats the person as sacred before God. And therefore, every act of service to each individual is considered sacred." This last quote is reminiscent of the Adventist thought of body as temple of God. The thrust of this series is understanding that God comprises everything, and that the entire staff needs to consider their work sacred to fulfill the sacred duties composite in the institution.

Sacred spaces – interview

In an attempt to ascertain that the idea of sacredness of place exists in the experience of those that work in Adventist health care spaces, the interview subject was asked questions regarding the role of work and what spirituality of an employee brought to these hospital spaces. The subject was asked about if the work is spiritually rewarding; while mostly answering in reference to nursing work, the current job's position in the health-care industry for Adventism is also a part of the answer. Unprompted, the word 'sacred' is brought up by the subject:

> For me personally, I have to say yes. Again, you know, when I... there is something very sacred about being part of the beginning of life and being part of the end of life. And in my nursing career, I have had the opportunity to work with a high-risk OB, and then I worked with, towards the end of my nursing career, I worked in trauma ICU. And you know, to be able to see and hold life as it enters into the world, I consider that a sacred moment. To be able to be with somebody, to hold their hand as they are taking their last breath, to me that is a sacred moment. And it's the whole idea of God gives life and even though there is life in the womb, alright, but when that baby comes out takes that first breath, you know, there is something very spiritual about that, because breath comes from God. And so, yes it is a profoundly spiritual moment for me because it's sacred. It is holy ground, it is a sacred moment. And in the same respect, as people are taking their last breath and again, the Bible says the breath returns to God, that again is

> a very sacred, holy moment. And that has really been the foundational driver for both my call and my philosophy for nursing and for health care.

The term ‘sacred moment’ is brought up multiple times. These are moments in which God is present, giving and taking the breath of life. This emphasis on a temporal sacredness harkens back to the work of Bull and Lockhart (2007) discussed in Chapter 3. But, the interview subject goes further by invoking a sacred manifestation in place. In understanding that God is present, the subject uses the term ‘holy ground’ as a descriptor. As the term ‘sacred’ was brought up, an unplanned follow-up question was posed; how would you define ‘sacred’?

> You know, for me, it's that, it's an almost inherent sense of what I define as the presence of God. It is an intimate moment with an individual or individuals, alright? And in my experience, to tangibly feel a difference, a difference in the air, a difference in what I hear, a difference in how the surface of my skin feels, that's what I consider sacred. But the sacredness also, you know, for me comes when there is a moment that, again, in our lives in which in between the beginning and in between the end is my pastoral ministry. And the sacred moments to me happen when I am having a conversation with someone. A spiritual conversation, or I am counselling somebody, and there is that moment in which they get it. OK? Whether it is a self-awareness, or an understanding of God, or it's that moment in which I again define it as God has been speaking to them, and they get it. That to me is the sacred moment too.

To clarify, the subject was then asked “Would you describe it as the idea that God is coming into the place that you are? And so it is a meeting point between the spiritual realm of God and our physical world?” The response given:

> Yes. Yes. And God is there. You know? God is there. And this is the foundation for my [unintelligible], God is there and I often times don't see that, don't recognize that, don't experience that. And I tend to blame me. I tend to look at myself first and say, "Wait a minute. No. God is here, but where am I?" And then when I am able to let go expectations, ideas, how I expect God to manifest, how I expect a conversation to go, when I am able to let go of that and just really allow God to be God, it's that moment. It's that click, it's that... hrmpf. I can't articulate it. I can only express it.

In this quotation, it is seen that the subject believes that the sacred is when not only God inhabits the physical world, but when we feel that metaphysical difference. In the Adventist view – and the view of many religions, Protestant Christian and others – God is imbued within everything as part of His creation. It is reductive to then declare that every single thing, every object, every step taken through space is an experience in the sacred. By strict definition, yes, but the important piece is experiential. Sacredness is feeling the ephemeral wave of otherness, of fully experiencing that at this time, in this place, a feeling which is generally beyond common perception is filling the mind-body-soul. The prior quote discusses how sacredness and otherworldness is perceived through all the senses. The experience is so otherworldly that it is difficult to put into concrete words, at least when asked to answer a question on-the-spot. The end of the quote contains what I as the interviewer wrote as 'hrmpf.' This body-clenching exhale exclaimed so many emotions – wonderment, fulfillment, glee – that truly was difficult to put into words. The subject can only express it through emotive body language.

These above quotes imply that hospitals much have sacred spaces within them, as these are locations in which God makes His presence felt. When asked if specifically the subject believes that hospitals are sacred space, the answer was:

> Yes, yes. If utilizing my definition, a little bit of my definition of what sacred, what sacred space is; when somebody is in the hospital, they're naked honestly. Everything has been stripped away. Their clothes you know, their makeup you know. They can't even wear nail polish. They're in a surrounding that is just very sterile. Everything has been stripped away and I just find that individuals are most vulnerable - and we're not even just talking about health issues, we're just talking about the psychological - they are most vulnerable. And sometimes I think that it's in this rawness, it's in this nakedness, is where we're really are in the position to experience God. Because we have nothing, nothing else to bring and nothing else to hide from, and so when you take a look at sacredness in that sense, sacredness in the sense of "I've got nothing else to give. I'm just completely raw and naked." Yes, hospitals can be those moments. And that vulnerability, and again, from a pastoral sense, from a chaplaincy sense, that's where people do a

> lot of self-reflection, self-awareness, reevaluating their lives, and you know they have a God moment in that space.

Again, the experiential is put at a forefront. The stark nakedness of the hospital space for the patient opens up the possibilities of perceiving the presence of God within the room. These naked moments can occur at many parts of life, as the subject states when speaking of self-reflection and reevaluations. But the hospital itself has that otherworldly sensation for patients not used to being there, allowing for an openness that could be beneficial to finding that feeling of sacredness.

In another response, regarding a question on quality of health care with a more spiritually-connected employee, the subject began to talk about developing a theology of care. The response included a piece that fits well into the proposed *filter of space* from Chapter 4:

> I say in the Bible, we see over and over again that God is a God that responds to the cries of people. When Israel was in Egypt, they cried out to him because they were burdened. They cried out to Him and He responded, but the way God responded was through human agency. And we are the human agents of God's response. So that's the framework. That's the vision that I'm casting for them right now. As kind of like a foundation. Well, how does God respond? Well let's take a look at His responses through scripture. And so that's how I am putting in what these providers do, I'm helping them understand it from a theological, Biblical, character of God foundation. And some individuals are able to make that connection to the sacred and some aren't. And that's OK too. That's OK too. But what I want our employees to really feel is the sense of something deeper in what they do. It's not just doing this for that individual to get a paycheck, but something a little bit more altruistic. Something deeper. Something a little bit more sacred.

The subject, again unprompted, brings up the concept of human agency. It is through human agency, through the individual decision of faith that God's duty is manifesting as sacred space. As the subject points out, some can feel this, and some cannot. And that is through human agency; the choice of belief. Through trying to explain the deeper theological underpinning of institutional mission, we can interpret that effort is being

made to spatialize sacredness within the hospital, with space being the interpreter between God's duty and human agency of belief.

The potential for the sacred

This discussion leads to a major question; does a duty create a sacred space in Adventism? And in particular, does a duty to health care create sacred spaces in health care institutions? Perhaps first it should be established that there is evidence of a denominationally-approved idea of sacred space in general. Evidence for this is found in the *Seventh-day Adventist Church Manual* (General Conference of Seventh-day Adventists 2005). The following quote outlines a section on the 'Reverence for the Place of Worship'; the quotations within this set aside text contains references to books by Ellen White or Biblical passages (emphasis added with bold words).

> Christians who appreciate God's omnipotence, His holiness, and His love will always and under all circumstances manifest a spirit of deep reverence for God, His Word, and His worship. "Humility and reverence should characterize the deportment of all who come into the presence of God."—*Patriarchs and Prophets*, p. 252. They will recognize that "**the hour and place of prayer are sacred, because God is there.**"—*Gospel Workers*, p. 178. They will come to the house of worship, not carelessly, but in the spirit of meditation and prayer, and will avoid unnecessary conversation.
>
> Parents should reverently instruct their children as to how they should behave in "the house of God" (1 Tim. 3:15). Faithful instruction and discipline in the home, Sabbath School, and church during the days of childhood and youth in regard to reverence for God and His worship will go far in holding their loyalty in afteryears.
>
> The minister who senses the sacredness of God's service will, by his example, instruction, and conduct in the pulpit, foster reverence, simplicity, good order, and decorum in the church. "But the Lord is in his holy temple: let all the earth keep silence before him" (Hab. 2:20).

The place of worship is a sacred space during the worship time because God is dwelling within that place; an Eliadian conception of sacred time and sacred place. It is the same connection mentioned by the interview subject. But what about places of health? As could best be determined in the course of this research, there are no

references specifically to the terms ‘sacred place’ or ‘sacred space’ when it comes to health care facilities. Is God dwelling within these healthcare spaces, and therefore making them sacred? One must be careful in declarations of what is sacred. Going back to the definition of ‘sacred space’ in Chapter 4, it is an inherently circular and personal concept. It is based upon experience; flippantly, a space is sacred if someone thinks it is sacred. But more precisely, Chapter 4 has differentiated the terms ‘religious space’ and ‘sacred space.’ Though the title of this subsection refers to the sacred spaces of Adventist hospitals, it is important to remember that the sacredness is personal. We can relate this to the ideas of individual versus institutional duties. In Adventist hospitals, religious spaces have been set up in regards to the institutional duties involved in operating a hospital. That means that links between the metaphysical and the physical realms have been created by the power structures of the religion. These *can* become sacred spaces if an individual with his or her agency experiences the link between the physical and the metaphysical. The emphasis is on *can*; it cannot be said that sacred spaces *are* created. While a hospital can be a lonely place for the patient, overall it is a socially-constructed place. In the Adventist context, it is a religious place. The sacred is personal. For some, perfunctory medical services are provided without the presence of God entering their mind, body, or spirit. For these people, they are experiencing what they may see as the generally profane task of medical care being conducted in a slightly religious place. Others will fully feel the breath of God, filling their spirit. Their health care becomes a sacred experience; sacred in time and sacred in space.

Discussion

The discipline of therapeutic landscapes comes from the intersection of the study of cultural landscapes and health geography. These "landscapes associated with healing" are locations in which humans imbue a location with meanings regarding health. Being cultural landscapes, there is an intersection of the human and the environment at the heart of study; although it is readily possible to use the same analysis methods on healing spaces that are either largely natural or largely built. Hospitals fall firmly in the latter category and have been investigated as places in which cultural meanings of therapy have become embedded. Interestingly, research on the interaction of spirituality and healing within place is lacking, with only a few studies integrating the cultural embodiment of religion and spirituality into place with the meanings of healing.

Adventists have been building sanitariums, hospitals, and other spaces of healing since 1866. Joining both a missionary zeal and a duty to promote health, Adventists have created a worldwide landscape of hospitals. These hospitals are a spatial manifestation on the landscape of the religious duty of health, and represent only a portion of the overall Adventist landscape of health. Adventist hospitals represent institutional duties as interpreted by the denomination of fulfilling God's will. Duties are not often mentioned in the therapeutic landscapes literature, but in some cases religious duties can be implicitly determined. In the cases of much of the therapeutic landscapes literature, it is a space or place that is first created in which a therapeutic outcome occurs, which then creates a religious duty manifest in that space. Adventist health spaces appear to use a different model, as it is a religious duty to provide health care that comes first, which then manifests spatially.

Institutional duties were investigated using two data sources. One source was an interview with an administrator in Adventist HealthCare. The other source was the repository of videos on YouTube made by various Adventist health care organizations. From both there is an emphasis upon the idea that what is being done at Adventist hospitals is a sacred work. It demonstrates that the hospitals are attempting to fulfill the institutional duty as outlined by Ellen White and other early Adventist theologians. In doing so, the fulfillment of sacred duties creates the possibility for the creation of sacred spaces within the hospitals themselves. These can be spaces that are sacred for both the caregiver and the patient, based upon the ability of each to use human agency to feel the religious connection fostered by the Adventist health systems.

Chapter 7: Conclusions

"The voice of duty is the voice of God"

> The light which God has given upon health reform cannot be trifled with without injury to those who attempt it; and no man can hope to succeed in the work of God while, by precept and example, he acts in opposition to the light which God has sent. The voice of duty is the voice of God,—an inborn, heaven-sent guide,—and the Lord will not be trifled with upon these subjects. He who disregards the light which God has given in regard to the preservation of health, revolts against his own good and refuses to obey the One who is working for his best good.
>
> Ellen White, *Counsels on Health* (1923)

The quote above, from *Counsels on Health* by Ellen White, contains a line which is the basis of the title of this dissertation. "The voice of duty is the voice of God," as a quote, has not been discussed in the context of this research until this point. In the categorization of duties in the books of Ellen White from Chapter 5, this quote was placed into the grouping of duties regarding the need for health reform. But this quotes goes further than that classification; this quote reaches the essence of how pertinent this duty of health is in Adventism. Duty is not simply a prescription of how one should live, or a proscription of antisocial behavior. Duty instead is inherent to God. It is inherent to the message God has given his people. It is inherently what a person that wishes to serve God must follow. In the case of Adventism, one of these broad, God-mandated duties is to live healthfully and help others live healthfully. A rejection of a sacred duty is a full rebuke of God Himself. God has prescribed duties to aid all in living well, in peace and prosperity. It is not meant to be a cudgel to force obedience, but instead the lighted path to righteousness.

The overarching thrust of this dissertation has been to answer a question; how does the religious duty of health provision for Seventh-day Adventists manifest spatially?

To answer this question, multiple additions have been made to the literature, by interpreting the historical record, theorizing new models of spatiality, and grounding with empirical analysis. Along the way, new findings have been made. These findings appear in the discussion section of each analysis chapter. The findings are included here to illustrate the connective tissue of religious duty, health, and space that unifies this research into one whole.

Findings

1. Religious space is different from sacred space

Depending on the predilection of the author, the adjectives 'religious' and 'sacred' are often used to describe the same phenomenon; usually space in which religious ritual occurs. Scholars of sacred space tend to be more descriptive in what it means to be 'sacred,' in some cases focusing upon individual experience of the phenomenon of the sacred. Both spaces are created based upon a connection between the physical world and metaphysical existence. Religious space are spaces in which the link between the physical and the metaphysical is created. These are essentially institutional spaces; spaces created within the context of the power structures of organized religion to modulate the connection with the otherworldly. Sacred spaces, on the other hand, are individual. These are created when the link is truly experienced by the individual. The individual feels the meeting of the knowable world and the realms that are usually imperceptible. The individual has agency in accepting that the metaphysical has become perceptible. It is this perception of the otherworldly, of the holy, of the uncommon that differentiates the spaces that are religious from those that are sacred. This implies that

spaces can be both religious and sacred, and perceived differently and individually among people interrogating the space.

2. Religious duty manifests through the construction of the dutyscape

Power structures of society shape religious spaces. Those structures though cannot modulate all constructions of space. Henri Lefebvre theorized the spatial triad of perceived-conceived-lived spaces as continually interacting in both producing space and being a product of space. While the perceived-conceived-lived triumvirate is illustrative of how individuals and societies construct and interact with space, this model lacks the directionality, the intention, of why spaces come to be. This is especially true when one looks at religious spaces; the findings from earlier in this dissertation show that religious duty is an important cultural concept. It would follow then that like other cultural embodiments that duty would become spatialized within a society. An extension to the spatial triad has been developed in this research. Here, the spatial triad acts as a *filter of space* through which a *dutyscape* is created; the medium in which God's duty, directed from above, connects with a human agency to create religious spaces. Within the context of this directionality of duty and agency, the three legs of the spatial triad still operated in modulating space. The importance of this model though is showing that all religious duty will manifest spatially. That is, it is through an interaction with space that people truly interact with God through believing and following the religious duties that He prescribes. The construction of the dutyscape is how God's duty and human faith are linked; religious belief and religious practice are inherently spatial as the connection between the otherworldliness of God's realm and the human practice of religion occurs within

religious space.

3. The religious duty of health is an emphasized tenet of Adventism

Much has been written about the predilections of health in Adventism, especially in the context of Adventists having positive health outcomes. In terms of the history and religiosity of the health message, Ronald Numbers has written extensively about Ellen White and health in Adventism in general. This is the first study that is focusing on health as a religious duty. Religious duties themselves seem to not have much pertinence in the literature, and a duty that is seemingly so secular and professional has even less written about it. Through the use of a content analysis on a sample of books, it was demonstrated that the term 'duty' is mentioned at a significantly higher rate than duties in other types of books written by Ellen White. It shows that Ellen White, the fount of much of the theological direction of Adventism, had a special emphasis on health. This emphasis was in duty; that is, binding healthful living and the dissemination of the laws of health reform with that of God rather than that of various scientists or pop culture fads. While one may not hear a preacher in the church devote many sermons to health directly – perhaps part of the battle between Adventist health practitioners and Adventist clergy dating back to the time of John Harvey Kellogg – the health message of duty remains current in both the institutions of Adventism along with the population of adherents.

4. The religious duty of health is both an individual and an institutional duty

It is not enough to analyze the counts of how often 'duty' is mentioned in different contexts. Rather, it needs to be contextualized through qualitative methods.

Each of the pertinent mentionings of 'duty' and synonyms – 544 in total through the nine health-related books by Ellen White – were categorized. The mentionings, in context within their paragraph setting, were sorted into nine categories of duty. These categories were further shown to either individual duties or institutional duties. Although religious duties, as stated above, are not prominent in the literature, those that are tend to be the duties of individuals. Ellen White, said to be an inspired writer, described some duties that fall to the institutions of the denomination rather than just upon the shoulders of individuals. The diversification of duty shows that the religious duty of health is both to be healthful but to also spread the word and help others become healthful. This mainly manifests as duties for health care institutions. In Adventism, these started as sanitariums; generally bucolic retreats meant as often for well care as for sick care; for revitalization and reinvigoration as for comforting the afflicted. The sanitarium model ceded to the hospital model, but this change in style did not stymie the creation of more spaces of health to continue the efforts of institutional duty. The conception of individual and institutional duties builds upon the previous finding that separately defined religious and sacred spaces, analogously separating the categories based upon, among other differences, whether it is the group or the person that has the duty expectation.

5. *Adventist institutional duty of health has manifested into a worldwide dutyscape of health spaces*

Health in Adventism has both an individual and institutional aspect of duty. In both cases, the duty will spatialize as a dutyscape as outlined above. Institutional duty, tied in with the missionary zeal of Adventism, will manifest spatially in hospitals and

other spaces of health care. This has become a worldwide dutyscape of health spaces, with institutional duty driving the need to create these centers of recovery and comfort. While the official denominational guides only list those controlled by the hierarchies of power in Adventism, there also exists another landscape of health of private Adventist hospitals. This is also an extension of institutional duty as believers are creating private institutions to fulfill the duties outlined by God. The creation of the hospitals, private or denominationally-owned, is driven by the need to follow the religious duties that have been given by God.

6. *Adventist hospitals are religious spaces that make the perception of sacred spaces possible*

The divine reason for the creation of health spaces in Adventism, fulfilling institutional duty, makes Adventist hospitals religious spaces. Those Adventists that work within these institutions speak of the institutional duty, in running hospitals, of providing God's care to the world. The language of Adventist duty is used throughout; though, often not with the word 'duty.' Treating the body as temple, opening up hearts to health reform and the laws of God; these duties are sacrosanct in the work done in these institutions of health. Their work is alternatively described as "a calling" or "sacred work." This is not work for work's sake; it is not a simple vocation. This is God's duty connecting with human agency to create a link between the physical and the metaphysical. This is religious space manifest in the outcome of institutional duty. Because this link is created, and because of the 'nakedness' of those in the hospital – to borrow a term from an Adventist interview subject – human agency of belief *can* allow

the link to be experienced in a way to create sacred spaces. Sacred spaces, as outlined above, are personal perceptions, so the institutional duty of health cannot create sacred spaces, but the spatial manifestation of the duty of health allows the possibility of the sacred to be felt by both caregivers and care receivers.

Appendix

A: Organizational structure of the Adventist church

The General Conference is the Seventh-day Adventist central organization from which all Adventist activities come from (Vance 1999). Every five years, a General Conference meeting is held, where among other activities, members of the General Conference Executive Committee are elected to five-year terms. Below the General Conference are 13 Divisions, which are groupings of countries. Each Division is made up of several smaller Union Conferences, which are comprised of smaller Local Conferences. Local Conferences are comprised of several individual congregations (Figure 34). In the 2005 update of the Church Manual, the Adventist church is described with four levels of organization (General Conference of Seventh-day Adventists 2005). From the bottom is the individual church, "a united body of individual believers." The other three levels upward, in order, are the local conference, union conference, and the General Conference. Divisions are explained as 'sections' of the General Conference, with delegated geographic areas of administration (General Conference of Seventh-day Adventists 2005).

Figure 34 - Chart of Adventist organizational hierarchy. Information in this figure derived from the Seventh-day Adventist church manual (2005)

Within the structure of the Seventh-day Adventist Church are a large number of other institutions. These institutions are used by the General Conference for commission of the gospel message. Included as these institutions are "health-care institutions, publishing houses,

health food industries, and educational institutions" (General Conference of Seventh-day Adventists 2005). That isn't to say that these are all appendages of the General Conference; Adventist institutions can be organized and operated at any of the levels of organization down to the individual congregations. Another organization, essentially on par with the individual congregation, is the organized company. A company is a group of believers that organize together in fellowship with the goal of eventually founding an individual church, with the permission of the local conference of that area (General Conference of Seventh-day Adventists 2005). An example of the myriad institutions and organizations that can be found in an area can be seen in a map of all Adventist locations within the Washington, DC metropolitan region (Figure 35). On the map key, the term 'hierarchies' is used to describe the location of the headquarters of the varying levels of authority outlined above.

In 1981, the General Conference trademarked the name of the church to control who could use the name 'Adventist,' denying a chance for some to link disagreeable sects back to Adventism (Lawson 1998b). Victor Houteff, after declaring himself as Ellen White's successor and writing about his message, was disfellowshipped and left the denomination in 1934 to form a new group in Waco, Texas, eventually naming the group the "Davidian Seventh-day Adventists." Over time and many theological disputes, the group became known as the Branch Davidians and was led by Vernon Howell, who changed his name to David Koresh (Bull and Lockhart 2007). Though the infamous siege by the Bureau of Alcohol, Tobacco and Firearms (ATF) and Federal Bureau of Investigation (FBI) occurred a decade after the trademarking of 'Adventist', it is no doubt

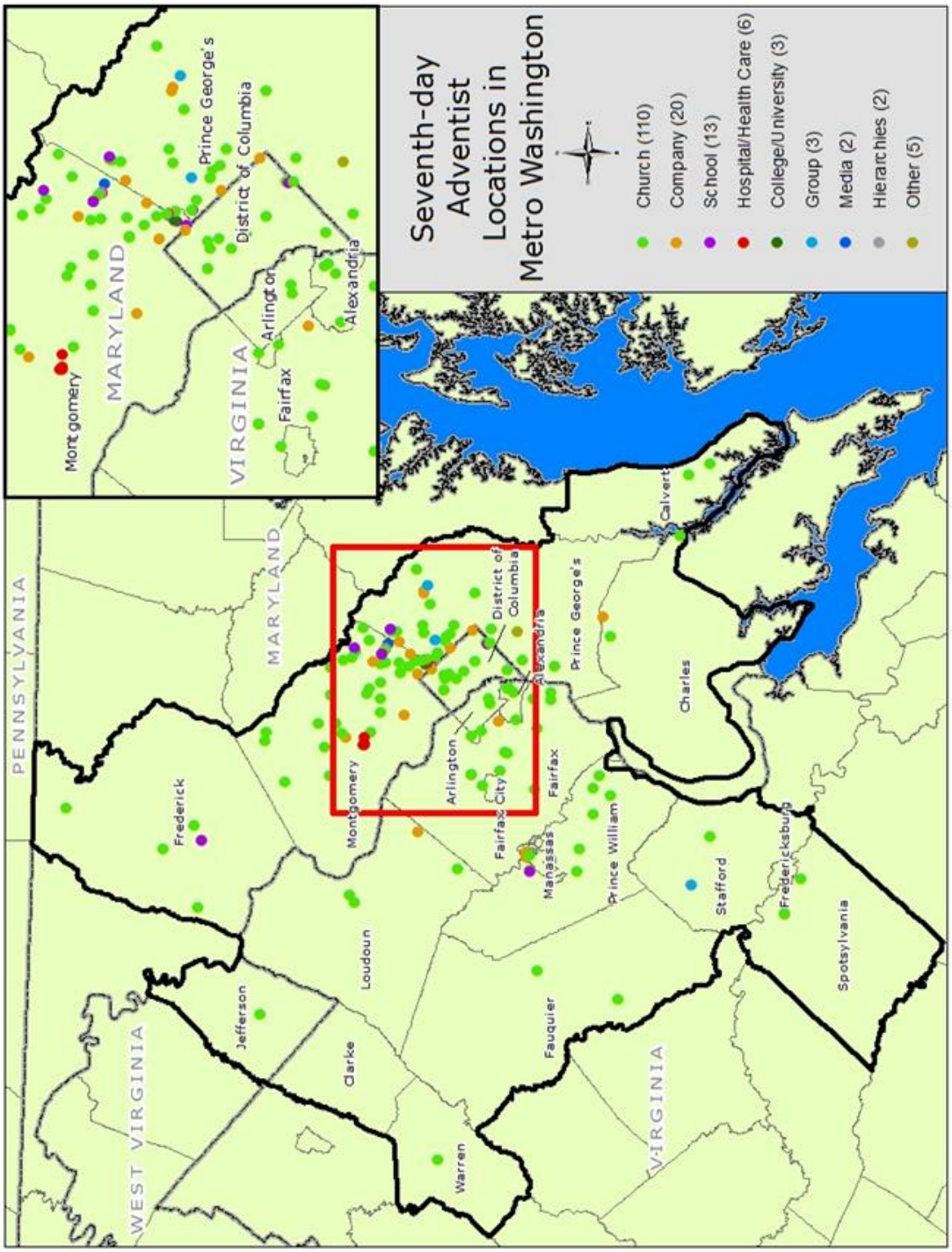

Figure 35 - Map of Adventist institutions in the Washington, DC metropolitan region. This map shows the wide variety of Adventist institutions and organizations in metro DC. The map uses a reference scale of 1:1,000,000 for the main map and 1:535,000 for the inset. Map created by Nathan Burtch. Shapefile sources: ESRI, derived from Tele Atlas, and U.S. Census. Point locations of Adventist organizations from Adventist Directory (www.adventistdirectory.org).

clear that the Seventh-day Adventist church wanted to completely separate itself from splinter groups[22].

The number of Adventist adherents worldwide is now over 18 million. A breakdown of the number of adherents by Adventist Division is displayed in Table 8. Divisions are created geographically and follow country borders, but not continental separations and in some cases are not contiguous[23], as can be seen in a map of world divisions in Figure 36. The largest division in terms of number of adherents is the Inter-American Division, with over 3.6 million adherents from Central America, northern South America, and the Caribbean. The North American

Division	2010 Adherents	2014 Adherents	Change (Pct)
East-Central Africa	2,648,520	3,046,313	397,793 (15.0%)
Inter-European	177,668	178,460	792 (0.4%)
Euro-Asia	139,111	114,879	-24,232 (-17.4%)
Inter-American	3,403,718	3,608,385	204,667 (6.0%)
North American	1,126,815	1,201,366	74,551 (6.6%)
Northern Asia-Pacific	642,916	688,106	45,190 (7.0%)
South American	2,064,743	2,329245	264,502 (12.8%)
South Pacific	427,589	429,136	1,547 (0.4%)
Southern Africa-Indian Ocean	2,683,212	3,346,372	663,160 (24.7%)
Southern Asia	1,533,815	1,527,238	-6,577 (-0.4%)
Southern Asia-Pacific	1,090,160	1,285,341	195,181 (17.9%)
Trans-European	115,379	85,081	-30,298 (-26.3%)
West-Central Africa	869,593	635,081	-234,512 (-27.0%)
Total	16,923,239	18,479,257	1,556,018 (9.2%)

Table 8 - Number of adherents by division, Adventist church. Information for this table is from the 2015 Annual Statistical Report.

[22] Lawson (1998b) notes that courts have found 'Adventist' to be a generic while 'Seventh-day Adventist' is not. However, it does not prevent groups previously created, like the Davidian Seventh-day Adventists, from using that portion of the name, but it will prevent "new splinter groups" from using it.

[23] Historically, divisions are constantly changing and being renamed. Attempting to look at long-term historical changes in adherent rates by division is very difficult due to the constantly shifting geography. This still occurs to this day; a sharp eye might see that there are 14 divisions on the map in Figure 36 but only 13 listed in Table 8. The Middle East & North Africa is not technically a division; it is an Attached Field to the General Conference, as is Israel. It was created in 2012, taking those countries out of the Euro-Africa (now Inter-European) and the Trans-European divisions. This difference in the statistics given in Table 8 are negligible; in 2014, the Middle East & North Africa attached field had only 3423 adherents, meaning that in real terms the slight growth in the Inter-European Division might be slightly higher and the large decrease in Trans-European might be slightly lower.

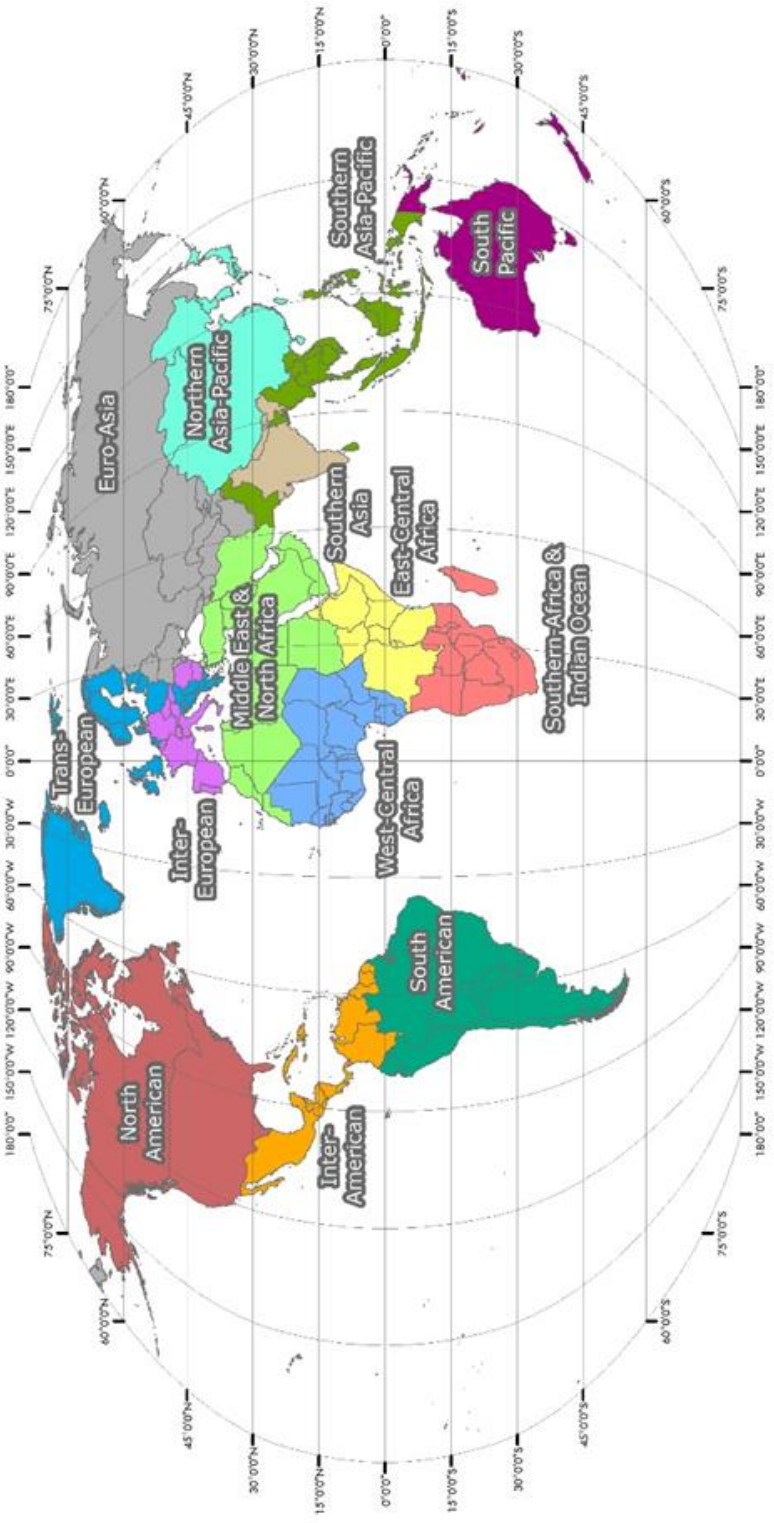

Figure 36 - Map of world divisions, Adventist church. Information on this map derived from the 2015 Annual Statistical Report. The map uses a reference scale of 1:140,000,000. Map created by Nathan Burtch. Shapefile source: ArcWorld Supplement.

Division, comprised of the United States and Canada, has 1.2 million adherents as of 2014. As can be seen, divisions associated with Europe have the lowest numbers of adherents and are generally decreasing (2015 Annual Statistical Report 2015). The North American division is growing at a robust 6.6% clip recently, although as stated in Chapter 2 much of that may be from immigration, with adherents mainly originating from the world divisions that are seeing the most growth currently. Missionary efforts in Africa appear mixed; East-Central Africa has some of the largest percentage growth of any of the divisions at 15.0%, while West-Central Africa has the largest percentage decrease of any division at -27.0%.

B: 28 Fundamental Beliefs

The following is quoted from the official website of the Seventh-day Adventist world church (General Conference of Seventh-day Adventists 2016).

1. The Holy Scriptures

The Holy Scriptures, Old and New Testaments, are the written Word of God, given by divine inspiration. The inspired authors spoke and wrote as they were moved by the Holy Spirit. In this Word, God has committed to humanity the knowledge necessary for salvation. The Holy Scriptures are the supreme, authoritative, and the infallible revelation of His will. They are the standard of character, the test of experience, the definitive revealer of doctrines, and the trustworthy record of God's acts in history. (Ps. 119:105; Prov. 30:5, 6; Isa. 8:20; John 17:17; 1 Thess. 2:13; 2 Tim. 3:16, 17; Heb. 4:12; 2 Peter 1:20, 21.)

2. The Trinity

There is one God: Father, Son, and Holy Spirit, a unity of three coeternal Persons. God is immortal, all-powerful, all-knowing, above all, and ever present. He is infinite and beyond human comprehension, yet known through His self-revelation. God, who is love, is forever worthy of worship, adoration, and service by the whole creation. (Gen. 1:26; Deut. 6:4; Isa. 6:8; Matt. 28:19; John 3:16 2 Cor. 1:21, 22; 13:14; Eph. 4:4-6; 1 Peter 1:2.)

3. The Father

God the eternal Father is the Creator, Source, Sustainer, and Sovereign of all creation. He is just and holy, merciful and gracious, slow to anger, and abounding in steadfast love and faithfulness. The qualities and powers exhibited in the Son and the Holy Spirit are

also those of the Father. (Gen. 1:1; Deut. 4:35; Ps. 110:1, 4; John 3:16; 14:9; 1 Cor. 15:28; 1 Tim. 1:17; 1 John 4:8; Rev. 4:11.)

4. The Son

God the eternal Son became incarnate in Jesus Christ. Through Him all things were created, the character of God is revealed, the salvation of humanity is accomplished, and the world is judged. Forever truly God, He became also truly human, Jesus the Christ. He was conceived of the Holy Spirit and born of the virgin Mary. He lived and experienced temptation as a human being, but perfectly exemplified the righteousness and love of God. By His miracles He manifested God's power and was attested as God's promised Messiah. He suffered and died voluntarily on the cross for our sins and in our place, was raised from the dead, and ascended to heaven to minister in the heavenly sanctuary in our behalf. He will come again in glory for the final deliverance of His people and the restoration of all things. (Isa. 53:4-6; Dan. 9:25-27; Luke 1:35; John 1:1-3, 14; 5:22; 10:30; 14:1-3, 9, 13; Rom. 6:23; 1 Cor. 15:3, 4; 2 Cor. 3:18; 5:17-19; Phil. 2:5-11; Col. 1:15-19; Heb. 2:9-18; 8:1, 2.)

5. The Holy Spirit

God the eternal Spirit was active with the Father and the Son in Creation, incarnation, and redemption. He is as much a person as are the Father and the Son. He inspired the writers of Scripture. He filled Christ's life with power. He draws and convicts human beings; and those who respond He renews and transforms into the image of God. Sent by the Father and the Son to be always with His children, He extends spiritual gifts to the church, empowers it to bear witness to Christ, and in harmony with the Scriptures leads it into all truth. (Gen. 1:1, 2; 2 Sam. 23:2; Ps. 51:11; Isa. 61:1; Luke 1:35; 4:18; John 14:16-

18, 26; 15:26; 16:7-13; Acts 1:8; 5:3; 10:38; Rom. 5:5; 1 Cor. 12:7-11; 2 Cor. 3:18; 2 Peter 1:21.)

6. Creation

God has revealed in Scripture the authentic and historical account of His creative activity. He created the universe, and in a recent six-day creation the Lord made "the heavens and the earth, the sea, and all that is in them" and rested on the seventh day. Thus He established the Sabbath as a perpetual memorial of the work He performed and completed during six literal days that together with the Sabbath constituted the same unit of time that we call a week today. The first man and woman were made in the image of God as the crowning work of Creation, given dominion over the world, and charged with responsibility to care for it. When the world was finished it was "very good," declaring the glory of God. (Gen. 1-2; 5; 11; Exod. 20:8-11; Ps. 19:1-6; 33:6, 9; 104; Isa. 45:12, 18; Acts 17:24; Col. 1:16; Heb. 1:2; 11:3; Rev. 10:6; 14:7.)

7. The Nature of Humanity

Man and woman were made in the image of God with individuality, the power and freedom to think and to do. Though created free beings, each is an indivisible unity of body, mind, and spirit, dependent upon God for life and breath and all else. When our first parents disobeyed God, they denied their dependence upon Him and fell from their high position. The image of God in them was marred and they became subject to death. Their descendants share this fallen nature and its consequences. They are born with weaknesses and tendencies to evil. But God in Christ reconciled the world to Himself and by His Spirit restores in penitent mortals the image of their Maker. Created for the glory of God, they are called to love Him and one another, and to care for their environment.

(Gen. 1:26-28; 2:7, 15; 3; Ps. 8:4-8; 51:5, 10; 58:3; Jer. 17:9; Acts 17:24-28; Rom. 5:12-17; 2 Cor. 5:19, 20; Eph. 2:3; 1 Thess. 5:23; 1 John 3:4; 4:7, 8, 11, 20.)

8. The Great Controversy

All humanity is now involved in a great controversy between Christ and Satan regarding the character of God, His law, and His sovereignty over the universe. This conflict originated in heaven when a created being, endowed with freedom of choice, in self-exaltation became Satan, God's adversary, and led into rebellion a portion of the angels. He introduced the spirit of rebellion into this world when he led Adam and Eve into sin. This human sin resulted in the distortion of the image of God in humanity, the disordering of the created world, and its eventual devastation at the time of the global flood, as presented in the historical account of Genesis 1-11. Observed by the whole creation, this world became the arena of the universal conflict, out of which the God of love will ultimately be vindicated. To assist His people in this controversy, Christ sends the Holy Spirit and the loyal angels to guide, protect, and sustain them in the way of salvation. (Gen. 3; 6-8; Job 1:6-12; Isa. 14:12-14; Ezek. 28:12-18; Rom. 1:19-32; 3:4; 5:12-21; 8:19-22; 1 Cor. 4:9; Heb. 1:14; 1 Peter 5:8; 2 Peter 3:6; Rev. 12:4-9.)

9. The Life, Death, and Resurrection of Christ

In Christ's life of perfect obedience to God's will, His suffering, death, and resurrection, God provided the only means of atonement for human sin, so that those who by faith accept this atonement may have eternal life, and the whole creation may better understand the infinite and holy love of the Creator. This perfect atonement vindicates the righteousness of God's law and the graciousness of His character; for it both condemns our sin and provides for our forgiveness. The death of Christ is substitutionary and

expiatory, reconciling and transforming. The bodily resurrection of Christ proclaims God's triumph over the forces of evil, and for those who accept the atonement assures their final victory over sin and death. It declares the Lordship of Jesus Christ, before whom every knee in heaven and on earth will bow. (Gen. 3:15; Ps. 22:1; Isa. 53; John 3:16; 14:30; Rom. 1:4; 3:25; 4:25; 8:3, 4; 1 Cor. 15:3, 4, 20-22; 2 Cor. 5:14, 15, 19-21; Phil. 2:6-11; Col. 2:15; 1 Peter 2:21, 22; 1 John 2:2; 4:10.)

10. The Experience of Salvation

In infinite love and mercy God made Christ, who knew no sin, to be sin for us, so that in Him we might be made the righteousness of God. Led by the Holy Spirit we sense our need, acknowledge our sinfulness, repent of our transgressions, and exercise faith in Jesus as Saviour and Lord, Substitute and Example. This saving faith comes through the divine power of the Word and is the gift of God's grace. Through Christ we are justified, adopted as God's sons and daughters, and delivered from the lordship of sin. Through the Spirit we are born again and sanctified; the Spirit renews our minds, writes God's law of love in our hearts, and we are given the power to live a holy life. Abiding in Him we become partakers of the divine nature and have the assurance of salvation now and in the judgment. (Gen. 3:15; Isa. 45:22; 53; Jer. 31:31-34; Ezek. 33:11; 36:25-27; Hab. 2:4; Mark 9:23, 24; John 3:3-8, 16; 16:8; Rom. 3:21-26; 8:1-4, 14-17; 5:6-10; 10:17; 12:2; 2 Cor. 5:17-21; Gal. 1:4; 3:13, 14, 26; 4:4-7; Eph. 2:4-10; Col. 1:13, 14; Titus 3:3-7; Heb. 8:7-12; 1 Peter 1:23; 2:21, 22; 2 Peter 1:3, 4; Rev. 13:8.)

11. Growing in Christ

By His death on the cross Jesus triumphed over the forces of evil. He who subjugated the demonic spirits during His earthly ministry has broken their power and made certain their

ultimate doom. Jesus' victory gives us victory over the evil forces that still seek to control us, as we walk with Him in peace, joy, and assurance of His love. Now the Holy Spirit dwells within us and empowers us. Continually committed to Jesus as our Saviour and Lord, we are set free from the burden of our past deeds. No longer do we live in the darkness, fear of evil powers, ignorance, and meaninglessness of our former way of life. In this new freedom in Jesus, we are called to grow into the likeness of His character, communing with Him daily in prayer, feeding on His Word, meditating on it and on His providence, singing His praises, gathering together for worship, and participating in the mission of the Church. We are also called to follow Christ's example by compassionately ministering to the physical, mental, social, emotional, and spiritual needs of humanity. As we give ourselves in loving service to those around us and in witnessing to His salvation, His constant presence with us through the Spirit transforms every moment and every task into a spiritual experience. (1 Chron. 29:11; Ps. 1:1, 2; 23:4; 77:11, 12; Matt. 20:25-28; 25:31-46; Luke 10:17-20; John 20:21; Rom. 8:38, 39; 2 Cor. 3:17, 18; Gal. 5:22-25; Eph. 5:19, 20; 6:12-18; Phil. 3:7-14; Col. 1:13, 14; 2:6, 14, 15; 1 Thess. 5:16-18, 23; Heb. 10:25; James 1:27; 2 Peter 2:9; 3:18; 1 John 4:4.)

12. The Church

The church is the community of believers who confess Jesus Christ as Lord and Saviour. In continuity with the people of God in Old Testament times, we are called out from the world; and we join together for worship, for fellowship, for instruction in the Word, for the celebration of the Lord's Supper, for service to humanity, and for the worldwide proclamation of the gospel. The church derives its authority from Christ, who is the incarnate Word revealed in the Scriptures. The church is God's family; adopted by Him

as children, its members live on the basis of the new covenant. The church is the body of Christ, a community of faith of which Christ Himself is the Head. The church is the bride for whom Christ died that He might sanctify and cleanse her. At His return in triumph, He will present her to Himself a glorious church, the faithful of all the ages, the purchase of His blood, not having spot or wrinkle, but holy and without blemish. (Gen. 12:1-3; Exod. 19:3-7; Matt. 16:13-20; 18:18; 28:19, 20; Acts 2:38-42; 7:38; 1 Cor. 1:2; Eph. 1:22, 23; 2:19-22; 3:8-11; 5:23-27; Col. 1:17, 18; 1 Peter 2:9.)

13. The Remnant and Its Mission

The universal church is composed of all who truly believe in Christ, but in the last days, a time of widespread apostasy, a remnant has been called out to keep the commandments of God and the faith of Jesus. This remnant announces the arrival of the judgment hour, proclaims salvation through Christ, and heralds the approach of His second advent. This proclamation is symbolized by the three angels of Revelation 14; it coincides with the work of judgment in heaven and results in a work of repentance and reform on earth. Every believer is called to have a personal part in this worldwide witness. (Dan. 7:9-14; Isa. 1:9; 11:11; Jer. 23:3; Mic. 2:12; 2 Cor. 5:10; 1 Peter 1:16-19; 4:17; 2 Peter 3:10-14; Jude 3, 14; Rev. 12:17; 14:6-12; 18:1-4.)

14. Unity in the Body of Christ

The church is one body with many members, called from every nation, kindred, tongue, and people. In Christ we are a new creation; distinctions of race, culture, learning, and nationality, and differences between high and low, rich and poor, male and female, must not be divisive among us. We are all equal in Christ, who by one Spirit has bonded us into one fellowship with Him and with one another; we are to serve and be served

without partiality or reservation. Through the revelation of Jesus Christ in the Scriptures we share the same faith and hope, and reach out in one witness to all. This unity has its source in the oneness of the triune God, who has adopted us as His children. (Ps. 133:1; Matt. 28:19, 20; John 17:20-23; Acts 17:26, 27; Rom. 12:4, 5; 1 Cor. 12:12-14; 2 Cor. 5:16, 17; Gal. 3:27-29; Eph. 2:13-16; 4:3-6, 11-16; Col. 3:10-15.)

15. Baptism

By baptism we confess our faith in the death and resurrection of Jesus Christ, and testify of our death to sin and of our purpose to walk in newness of life. Thus we acknowledge Christ as Lord and Saviour, become His people, and are received as members by His church. Baptism is a symbol of our union with Christ, the forgiveness of our sins, and our reception of the Holy Spirit. It is by immersion in water and is contingent on an affirmation of faith in Jesus and evidence of repentance of sin. It follows instruction in the Holy Scriptures and acceptance of their teachings. (Matt. 28:19, 20; Acts 2:38; 16:30-33; 22:16; Rom. 6:1-6; Gal. 3:27; Col. 2:12, 13.)

16. The Lord's Supper

The Lord's Supper is a participation in the emblems of the body and blood of Jesus as an expression of faith in Him, our Lord and Saviour. In this experience of communion Christ is present to meet and strengthen His people. As we partake, we joyfully proclaim the Lord's death until He comes again. Preparation for the Supper includes self-examination, repentance, and confession. The Master ordained the service of foot-washing to signify renewed cleansing, to express a willingness to serve one another in Christlike humility, and to unite our hearts in love. The communion service is open to all believing

Christians. (Matt. 26:17-30; John 6:48-63; 13:1-17; 1 Cor. 10:16, 17; 11:23-30; Rev. 3:20.)

17. Spiritual Gifts and Ministries

God bestows upon all members of His church in every age spiritual gifts that each member is to employ in loving ministry for the common good of the church and of humanity. Given by the agency of the Holy Spirit, who apportions to each member as He wills, the gifts provide all abilities and ministries needed by the church to fulfill its divinely ordained functions. According to the Scriptures, these gifts include such ministries as faith, healing, prophecy, proclamation, teaching, administration, reconciliation, compassion, and self-sacrificing service and charity for the help and encouragement of people. Some members are called of God and endowed by the Spirit for functions recognized by the church in pastoral, evangelistic, and teaching ministries particularly needed to equip the members for service, to build up the church to spiritual maturity, and to foster unity of the faith and knowledge of God. When members employ these spiritual gifts as faithful stewards of God's varied grace, the church is protected from the destructive influence of false doctrine, grows with a growth that is from God, and is built up in faith and love. (Acts 6:1-7; Rom. 12:4-8; 1 Cor. 12:7-11, 27, 28; Eph. 4:8, 11-16; 1 Tim. 3:1-13; 1 Peter 4:10, 11.)

18. The Gift of Prophecy

The Scriptures testify that one of the gifts of the Holy Spirit is prophecy. This gift is an identifying mark of the remnant church and we believe it was manifested in the ministry of Ellen G. White. Her writings speak with prophetic authority and provide comfort, guidance, instruction, and correction to the church. They also make clear that the Bible is

the standard by which all teaching and experience must be tested. (Num. 12:6; 2 Chron. 20:20; Amos 3:7; Joel 2:28, 29; Acts 2:14-21; 2 Tim. 3:16, 17; Heb. 1:1-3; Rev. 12:17; 19:10; 22:8, 9.)

19. The Law of God

The great principles of God's law are embodied in the Ten Commandments and exemplified in the life of Christ. They express God's love, will, and purposes concerning human conduct and relationships and are binding upon all people in every age. These precepts are the basis of God's covenant with His people and the standard in God's judgment. Through the agency of the Holy Spirit they point out sin and awaken a sense of need for a Saviour. Salvation is all of grace and not of works, and its fruit is obedience to the Commandments. This obedience develops Christian character and results in a sense of well-being. It is evidence of our love for the Lord and our concern for our fellow human beings. The obedience of faith demonstrates the power of Christ to transform lives, and therefore strengthens Christian witness. (Exod. 20:1-17; Deut. 28:1-14; Ps. 19:7-14; 40:7, 8; Matt. 5:17-20; 22:36-40; John 14:15; 15:7-10; Rom. 8:3, 4; Eph. 2:8-10; Heb. 8:8-10; 1 John 2:3; 5:3; Rev. 12:17; 14:12.)

20. The Sabbath

The gracious Creator, after the six days of Creation, rested on the seventh day and instituted the Sabbath for all people as a memorial of Creation. The fourth commandment of God's unchangeable law requires the observance of this seventh-day Sabbath as the day of rest, worship, and ministry in harmony with the teaching and practice of Jesus, the Lord of the Sabbath. The Sabbath is a day of delightful communion with God and one another. It is a symbol of our redemption in Christ, a sign of our sanctification, a token of

our allegiance, and a foretaste of our eternal future in God's kingdom. The Sabbath is God's perpetual sign of His eternal covenant between Him and His people. Joyful observance of this holy time from evening to evening, sunset to sunset, is a celebration of God's creative and redemptive acts. (Gen. 2:1-3; Exod. 20:8-11; 31:13-17; Lev. 23:32; Deut. 5:12-15; Isa. 56:5, 6; 58:13, 14; Ezek. 20:12, 20; Matt. 12:1-12; Mark 1:32; Luke 4:16; Heb. 4:1-11.)

21. Stewardship

We are God's stewards, entrusted by Him with time and opportunities, abilities and possessions, and the blessings of the earth and its resources. We are responsible to Him for their proper use. We acknowledge God's ownership by faithful service to Him and our fellow human beings, and by returning tithe and giving offerings for the proclamation of His gospel and the support and growth of His church. Stewardship is a privilege given to us by God for nurture in love and the victory over selfishness and covetousness. Stewards rejoice in the blessings that come to others as a result of their faithfulness. (Gen. 1:26-28; 2:15; 1 Chron. 29:14; Haggai 1:3-11; Mal. 3:8-12; Matt. 23:23; Rom. 15:26, 27; 1 Cor. 9:9-14; 2 Cor. 8:1-15; 9:7.)

22. Christian Behavior

We are called to be a godly people who think, feel, and act in harmony with biblical principles in all aspects of personal and social life. For the Spirit to recreate in us the character of our Lord we involve ourselves only in those things that will produce Christlike purity, health, and joy in our lives. This means that our amusement and entertainment should meet the highest standards of Christian taste and beauty. While recognizing cultural differences, our dress is to be simple, modest, and neat, befitting

those whose true beauty does not consist of outward adornment but in the imperishable ornament of a gentle and quiet spirit. It also means that because our bodies are the temples of the Holy Spirit, we are to care for them intelligently. Along with adequate exercise and rest, we are to adopt the most healthful diet possible and abstain from the unclean foods identified in the Scriptures. Since alcoholic beverages, tobacco, and the irresponsible use of drugs and narcotics are harmful to our bodies, we are to abstain from them as well. Instead, we are to engage in whatever brings our thoughts and bodies into the discipline of Christ, who desires our wholesomeness, joy, and goodness. (Gen. 7:2; Exod. 20:15; Lev. 11:1-47; Ps. 106:3; Rom. 12:1, 2; 1 Cor. 6:19, 20; 10:31; 2 Cor. 6:14-7:1; 10:5; Eph. 5:1-21; Phil. 2:4; 4:8; 1 Tim. 2:9, 10; Titus 2:11, 12; 1 Peter 3:1-4; 1 John 2:6; 3 John 2.)

23. Marriage and the Family

Marriage was divinely established in Eden and affirmed by Jesus to be a lifelong union between a man and a woman in loving companionship. For the Christian a marriage commitment is to God as well as to the spouse, and should be entered into only between a man and a woman who share a common faith. Mutual love, honor, respect, and responsibility are the fabric of this relationship, which is to reflect the love, sanctity, closeness, and permanence of the relationship between Christ and His church. Regarding divorce, Jesus taught that the person who divorces a spouse, except for fornication, and marries another, commits adultery. Although some family relationships may fall short of the ideal, a man and a woman who fully commit themselves to each other in Christ through marriage may achieve loving unity through the guidance of the Spirit and the nurture of the church. God blesses the family and intends that its members shall assist

each other toward complete maturity. Increasing family closeness is one of the earmarks of the final gospel message. Parents are to bring up their children to love and obey the Lord. By their example and their words they are to teach them that Christ is a loving, tender, and caring guide who wants them to become members of His body, the family of God which embraces both single and married persons. (Gen. 2:18-25; Exod. 20:12; Deut. 6:5-9; Prov. 22:6; Mal. 4:5, 6; Matt. 5:31, 32; 19:3-9, 12; Mark 10:11, 12; John 2:1-11; 1 Cor. 7:7, 10, 11; 2 Cor. 6:14; Eph. 5:21-33; 6:1-4.)

24. Christ's Ministry in the Heavenly Sanctuary

There is a sanctuary in heaven, the true tabernacle that the Lord set up and not humans. In it Christ ministers on our behalf, making available to believers the benefits of His atoning sacrifice offered once for all on the cross. At His ascension, He was inaugurated as our great High Priest and, began His intercessory ministry, which was typified by the work of the high priest in the holy place of the earthly sanctuary. In 1844, at the end of the prophetic period of 2300 days, He entered the second and last phase of His atoning ministry, which was typified by the work of the high priest in the most holy place of the earthly sanctuary. It is a work of investigative judgment which is part of the ultimate disposition of all sin, typified by the cleansing of the ancient Hebrew sanctuary on the Day of Atonement. In that typical service the sanctuary was cleansed with the blood of animal sacrifices, but the heavenly things are purified with the perfect sacrifice of the blood of Jesus. The investigative judgment reveals to heavenly intelligences who among the dead are asleep in Christ and therefore, in Him, are deemed worthy to have part in the first resurrection. It also makes manifest who among the living are abiding in Christ, keeping the commandments of God and the faith of Jesus, and in Him, therefore, are

ready for translation into His everlasting kingdom. This judgment vindicates the justice of God in saving those who believe in Jesus. It declares that those who have remained loyal to God shall receive the kingdom. The completion of this ministry of Christ will mark the close of human probation before the Second Advent. (Lev. 16; Num. 14:34; Ezek. 4:6; Dan. 7:9-27; 8:13, 14; 9:24-27; Heb. 1:3; 2:16, 17; 4:14-16; 8:1-5; 9:11-28; 10:19-22; Rev. 8:3-5; 11:19; 14:6, 7; 20:12; 14:12; 22:11, 12.)

25. The Second Coming of Christ

The second coming of Christ is the blessed hope of the church, the grand climax of the gospel. The Saviour's coming will be literal, personal, visible, and worldwide. When He returns, the righteous dead will be resurrected, and together with the righteous living will be glorified and taken to heaven, but the unrighteous will die. The almost complete fulfillment of most lines of prophecy, together with the present condition of the world, indicates that Christ's coming is near. The time of that event has not been revealed, and we are therefore exhorted to be ready at all times. (Matt. 24; Mark 13; Luke 21; John 14:1-3; Acts 1:9-11; 1 Cor. 15:51-54; 1 Thess. 4:13-18; 5:1-6; 2 Thess. 1:7-10; 2:8; 2 Tim. 3:1-5; Titus 2:13; Heb. 9:28; Rev. 1:7; 14:14-20; 19:11-21.)

26. Death and Resurrection

The wages of sin is death. But God, who alone is immortal, will grant eternal life to His redeemed. Until that day death is an unconscious state for all people. When Christ, who is our life, appears, the resurrected righteous and the living righteous will be glorified and caught up to meet their Lord. The second resurrection, the resurrection of the unrighteous, will take place a thousand years later. (Job 19:25-27; Ps. 146:3, 4; Eccl. 9:5,

6, 10; Dan. 12:2, 13; Isa. 25:8; John 5:28, 29; 11:11-14; Rom. 6:23; 16; 1 Cor. 15:51-54; Col. 3:4; 1 Thess. 4:13-17; 1 Tim. 6:15; Rev. 20:1-10.)

27. The Millennium and the End of Sin

The millennium is the thousand-year reign of Christ with His saints in heaven between the first and second resurrections. During this time the wicked dead will be judged; the earth will be utterly desolate, without living human inhabitants, but occupied by Satan and his angels. At its close Christ with His saints and the Holy City will descend from heaven to earth. The unrighteous dead will then be resurrected, and with Satan and his angels will surround the city; but fire from God will consume them and cleanse the earth. The universe will thus be freed of sin and sinners forever. (Jer. 4:23-26; Ezek. 28:18, 19; Mal. 4:1; 1 Cor. 6:2, 3; Rev. 20; 21:1-5.)

28. The New Earth

On the new earth, in which righteousness dwells, God will provide an eternal home for the redeemed and a perfect environment for everlasting life, love, joy, and learning in His presence. For here God Himself will dwell with His people, and suffering and death will have passed away. The great controversy will be ended, and sin will be no more. All things, animate and inanimate, will declare that God is love; and He shall reign forever. Amen. (Isa. 35; 65:17-25; Matt. 5:5; 2 Peter 3:13; Rev. 11:15; 21:1-7; 22:1-5.)

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