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Hubert Department of Global Health

Title *Good News for the Whole Community: Reflections on the History of the First Century of the Social Gospel Movement.*

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Background Dr. Gunderson presented this paper as the Earl Lectures at PSR. The theme of the 1999 series was *Building Healthy Communities: Partners in Faith and Wellness.* Dr. Gunderson was joined by Dr. Nancy Eisland (former Professor of the Sociology of Religion at Candler School of Theology and A. Cecil Williams, pastor emeritus (then pastor) of Glide Memorial United Methodist Church in San Francisco.

Dr. Gunderson's paper examined the development of the Social Gospel movement in the early decades of the twentieth century and argued that the contemporary movements in faith and public health are the contemporary expressions of the deepest commitments of this movement.

Let me begin with thanks for the opportunity to stand in such a distinguished line of speakers and in such a historic company of witnesses. I thank you for lending the prestige of Pacific School of Religion and the Earl lectures to the subject of Faith and Health. PSR is a key partner for The Carter Center as the anchor for the Faith and Health Consortium, so I know this is no quickly passing commitment. I also want to acknowledge my teachers, mainly my colleagues with the Interfaith Health Program, Dr. Fred Smith, Dr. Fran Wenger and Mimi Kiser as well as the colleagues in the Whole Community Collaborative site here in California such as Katy Pitkin at UCLA. I have debts to many others that will become obvious as I go along. Indeed, my main is to explore the ways in that we are a company of debtors to a stream of people working for at least 11 decades on the same basic questions that we link today as faith and health.

The stream of discovery

This stream of which I speak of is has been known in theological circles through most of the 20th century as "the social gospel." It is literally the "good news" we discover at the heart of creation that is social, we might say "public." The field of public health as it is known in the U.S. flows from the same source, the deep stream of social optimism that surfaced toward

the end of the last century. So do most of the social service structures and health institutions public and private that employ many us today. A century later the stream has acquired many tributaries. And the movement itself had precedents in medical care. Catholics and Lutherans will note that their large-scale participation in ministries of healing precede the social gospel movement by decades. However, I will argue that the confluence of public health strategies and social gospel theology created such synergy that the religious assets already in hand were changed forever. And those of us working in the field of health or community improvement have largely remained in its channel ever since.

Gary Dorrien in his landmark study, Soul In Society, identifies the social gospel tradition as the spirit of modern social Christianity. At its best, this American tradition, "has been rooted in the teaching and way of Jesus Christ and the proleptic reality of Christ's kingdom-bringing Spirit. It has proclaimed that Christianity has an inspiriting and regenerative social mission, and it has sought to bring the transforming power of Christian faith to social struggles for freedom, democracy, peace and social justice." He later notes that, "more than any comparable religious tradition, liberal Protestantism has struggled creatively for two centuries to face up to the challenges of modern science, historical criticism and commercial society."[1] Faith, health and democratic citizenship: this is hopeful context in which the public health movement originated and for the last hundred years, has served as the channel in which flowed the great energies that mingled together as the faith and health movement. Today that flow is far more than liberal Protestant in a complexity that is only hinted at here. But even these other streams have found themselves flowing in channels of expectation that were cut by the thought that dominated at the crucial period of institutional formation in the U.S.

This movement is durable and tested. It can stand critical engagement, so my remarks will not simply applaud what is currently emerging, but try to put it in tension with the past and, with apologies to my boundless pretension, the future.

Not a unique moment

This is an opportune moment, but not a unique one. Both public health and progressive religious structures were partners at the birth of a curiously optimistic social movement about a hundred years ago that saw the possibilities of community scale change, itself born of the crisis of urban industrialism. Both public health and faith believe that there are social determinants to optimum health and wholeness-it is about relationships. But both have also tended to give in to entrepreneurial pressures to develop services for paying citizens or members instead of focusing on our core commitments to the social determinants of wholeness. Indeed, both of us have often found ourselves working to ameliorate the affects damaging social relationships rather than challenge their causes. Today our rediscovery of faith and health again experiences the tension between addressing the social factors while finding great opportunities to focus on services, techniques and tools for individuals.

I am making an important distinction on which almost everything else hinges. While this is a strong tradition, it is at odds with much of the current interest in spirituality. Many people, even public health professionals, hear "faith and health," and think about how personal spirituality affects personal health. It does, of course. But that is hardly the main

point. This is the health corollary to imagining that the great Salvation drama is mainly about one's personal heaven. In fact, I do believe that my personal salvation is involved: But only as part of God's larger drama. Beware saying it is simply "both." The ordering is crucial for it is possible, indeed likely that beginning with the individual implications aborts the other. We never quite seem to get the systems. Be clear that my subject is the community scale implications of faith.

I want to locate the current linkage of faith and health in the context of both streams of thinking. I'll first look at the field of public health and then its theological partner, the social gospel movement. I want to note some weaknesses in both streams of thought and practice. Finally, I want to note some strengths that would be useful to retain or recover.

I apologize in advance for vastly overreaching both in scale and intellectual scope although this overreaching is also part of the social gospel tradition. My remarks are interdisciplinary, drawing on the wells of faith and health fields, which is bound to disappoint and frustrate specialists in both. Even more disappointed will be those in the adjacent fields of ethics and economics which receive less attention here than they are used to receiving around the social gospel. Something here will probably offend everyone else, especially pastors, nurses, pastoral counselors, hospital administrators and public health professionals who may be annoyed by how far I suggest their disciplines have yet to evolve. Finally, let me note that while my remarks are interdisciplinary, they are not really interfaith. The Interfaith Health Program is very oriented toward learning across theological boundaries. However, I simply do not command the scholarship to treat the historical perspective on this subject that broadly. I would hope that scholars at the Graduate Theological Union and other Faith and Health Consortia schools could go farther than I am capable.

Why risk such overreaching? If these were merely intellectual questions, I would leave them to the academy and seek a smaller issue on which to chew. But I am trying to be a disciple, not just an intellectual; an activist, not merely an analyst. I'm a modern person trying to follow Jesus with what sometimes feels like the same level of naiveté as I had in high school. The only difference is that now I am deeply aware of the multiple levels of ambiguity in that attempt, made far more complicated by these deeply flawed human institutions called churches. Nobody can tell me anything negative or depressing about them that I don't know. But most Sundays, that's where I am; and most weekdays, that's how I understand my life. I like to sit near the door, of course, which troubles those who sit in the pews down front. And my friends on the street wonder what I'm doing inside at all. I say this of myself, but any number of social gospel pastors and activists could have said it. "How do we keep faith with our faith and with the modern world?" If exploring the confluence of faith and health does not help with that question, it is probably not worth doing. But I think it turns out to be on the critical path. Part of why I think so is that it was so helpful to others in a similar quandary a hundred years ago.

Social change, not social service

About a century ago in cities all over the United States it dawned on people like us that God wanted us to change, not just serve, the world. This is a short story that could only appear

to be history at all to a group of Americans. In this shift toward change, relating to God became a question of how organizational strategy and social behavior contributed to improvement, not just stability.

This is a social question. It is a question posed to "us" with the answer formed in the language of social-common, coordinated, purposeful-action. There are and always have been other theoretical possibilities for linking faith and health that have nothing to do with social structures. They imagine the benefits of spirituality apart from human relationships, social ties and community entanglement. Our movement - both its scientists and theologians-- has tangled with and been tempted by them all along. But I argue that our movement as it actually exists is inseparable from its social/political/scientific womb in this nation, this century, these institutions that have given us our intellectual frameworks. In the experience of 20th century United States all of these assume:

- broad participation in congregational life,
- governments accountable for community quality of life and
- a positive view of rational tools of analysis, implementation and evaluation.

Public health professionals are usually surprised to find themselves recipients of or contributors to a theological tradition of any kind, much less one that aspires to change the very warp and woof of U.S. society. But they are. Many clergy are surprised to learn that the accepted norms of what their congregation is supposed to do was formed and informed by the opportunities of community service and social change that reflect the public health struggles with tuberculosis, sanitation, maternal and child health, nutrition. But they are. That common history illuminates the serious, deep engagement as we once again explore the linkage between faith and health in similar ways.

The greatest struggles of the social gospel movement were usually framed in the language of economics and later, race and violence. However, its actions frequently focused on health ministry as a direct expression of its social hope. At its heart public health asks a public question about the role of science in the creating the conditions in which community could be healthy. Its early literature is full of strategies for linking with many partners in the task. However, a quick literature search of more recent decades shows that economics, race and violence are decidedly minor themes amid the flood of biomedical techniques.

Public health perspective preceded by decades the tools that would allow it to fulfill even its research questions, much less its social change expectations. At its formation the public health discipline simply did not have the capacity to assemble or analyze the vast amount of data it has now. Its institutions developed around simpler tasks such as the removal of obvious community health risks and the provision of fundamental disease treatments, immunizations and screening services to individuals who were not likely to receive them elsewhere. It offered services that made it possible for many to survive unjust circumstances, much like religious hospitals. Both justified their existence in terms of mercy, which is admirable but inadequate in both theological and scientific terms. Mercy does not necessarily lead to justice; to changing the social conditions which make the need for mercy inevitable. And health language is more frequently used in the connection with mercy than justice, with services rather than change.

It is not easy to recover health language as a tool for talking about social responsibilities. But I am hard-pressed to see where other languages for talking about social responsibilities and social change are much better. The American social discussion is too much about money and too little about life. Religion especially needs a vocabulary for public engagement that includes more than economic indicators. Money is only and always an intermediate good. What do we buy? What do we actually aspire to, hope for? These questions need more than a language of exchange toward a language of actual life status, outcomes and results. Health language can open a more dialogue about different approaches to secure length and quality of life. Public health offers the promise of a way to talk about evaluation, which in turn suggests a process of short-range accountability through measured results in the context of community. That's more than most health people think they are talking about and somewhat more mundane than theologians dream of engaging. Perhaps a good rule of thumb for our interdisciplinary dialogue is just this: is it more than health people are comfortable with? Is it too mundane for the religious ones? If so, it is just about right.

Many today are content to justify the linkage of faith and health on the grounds of mere efficiency. If the discussion was just about how to do blood pressures and home care services, it would be a simple cost-benefit analysis. What's so complicated? Just get the highest skilled volunteers and the lowest-skilled employees to do everything possible. Then make it hard to get reimbursed for everything else to dampen demand. This is what today passes for managing care. Am I missing something? When you engage the underlying strengths of public health language in the context of powerful social gospel questions, you have a whole different matter, a far more evocative question.

Religion and Medicine

For most of recorded human history "professionals" in both religion and health were essentially helpless before an overwhelming and unpredictable array of disease and calamities. The ancient religious tradition was familiar with suffering, death, disease, brokenness of all kinds. It is no small task to re-imagine the world as it was at the time of the great prophets, the time of Jesus, the world of Paul in which life was for most brutal, painful and short. Life expectancy was around 40 years or so at birth because of extraordinary death rates among the very young. The most that religion could hope for regarding health was mercy, comfort amid capricious suffering. The paradigms of ministry were necessarily caring, comfort, grief support. It is important to note that the success in these areas for many of these centuries made religion a major obstacle to anything more. Frederick Cartwright observes with not much tact, "We should honor the church for her unremitting care of the sick, but acknowledge that her influence upon medical and scientific advance was almost wholly evil."[2]

It was not until John Wesley's Complete Physic in the 1700's that a major religious thinker/leader linked faith to health in a way we would regard as remotely modern. Even then the Church focused on care and comfort in the context of a view of disease and injury as the very warp and weave of human life. Rousseau, writing about the same time as Wesley stated what was only common sense, when he warned against misplaced optimism:

it is the will of god that half of children die before age eight, do not try to overturn that law. This from an optimist! It is no wonder that religion tended to focus on salvation from this suffering world. And no wonder that religious ethics barely noticed the Biblical vision of the earth as a place in which God's reign could be sought. Today, no nation on earth has a death rate half of what Rousseau saw as God's law. And we know that any nation can modify that law by human action. Indeed, we now think that God intends that law to be replaced by a new possibility. The line of thought that connects that sort of grim religious resignation to the hopeful orientation of those of us gathered in this space today owes a great deal to the discipline of public health that began to emerge in the later 1800's. The idea that communities could systematically become healthier by using the tools of scientific analysis of patterns of disease and injury was not a religious idea. As with other new notions such as democracy and grace, religious people must explain how we managed to overlook an idea that now appear perfectly aligned with the deepest messages of our scripture. We always understood that God wanted us to serve the sick and the poor. It just didn't dawn on us until about a hundred years ago that God had built into the system the possibility of preventing disease and injury; of changing the world.

Public Health as Discipline
The formal discipline of public health only extends 127 years or so, when the American Public Health Association was established. The core competency of public health, most will tell you, is epidemiology, the study of risk factors that can be isolated, controlled, prevented and in some cases even eradicated. Actually, history suggests that the core competency is trash collection. Most public health departments emerged to deal with disease epidemics rooted in poor sanitation; many of the early leaders chose to be identified as sanitation physicians. Sanitation was one of those simple concepts that changes everything, a much more important contribution to longevity and quality of life than all the antibiotics put together. Life expectancy is about two thirds longer than when the first lecture in this series was first given 98 years ago. The largest part of that astonishing rise in life span occurred long before the pharmaceutical revolution. The notion that people could systematically study disease patterns, identify specific causes and prevent the problems by community intervention is revolutionary. In fairness, the public health pioneers weren't trying for a revolution; they just wanted people to take out the trash. Indeed, since we stand on this side of the revolution, it is easy to forget how recent it was and how much it changed. For that matter, the whole field of health sciences is young, measured by any other standard of human thought such as philosophy, politics or theology. The same decade that public health was organizing its national association saw the first aseptic surgical techniques. Doctors noticed the importance of washing their hands, although it took several more decades for cleanliness to really catch on as standard practice (it was the women nurses, of course). National standards for hospitals were not widely accepted for another half century, in 1920. About this same time it began to dawn on governments that somebody should decide on a credentialing process for physicians and other health professionals as nurses-- a process that is still under construction today.

This is the history of public health, but it is religious history, too. If you read the history of the religious hospitals, you find all these intellectual and administrative challenges being engaged by clergy, laypeople and denominations. For instance, Deaconess Hospital was

founded in 1889 by 70 people meeting at St. Peter's Evangelical Church in St. Louis to start a deaconess society to care for the sick and poor. They were inspired by the example of the Catholics who were already organized to provide in home nursing care. The first board had four pastors, four laymen and four ladies (a remarkable innovation for the time). The deaconess women were dually credentialed ordained health workers. The deaconess school, home and hospital predated the secular credentialing of nurses. The first Missouri board exams in nursing were in 1913 (all of the deaconesses passed.) Seven years later the US Constitution was amended allowing women to vote.[3]

The tuberculosis crucible

The watershed in the development of public health strategies and institutions was the struggle with tuberculosis.[4] The disease had similar implications within religious circles, shaping our enduring community strategies and the institutions that channeled the further development of health activities. This is the crucible in which the faith and health movement as we know it today as formed, not, as some would argue, in the earlier history of mercy. The patterns of collaboration, government-religious engagement, interdisciplinary research, interfaith institution building are all found here in a way that was-and is-new and unsettling, even a little subversive.

What happened? Only a hundred years ago the primary causes of death were infectious diseases, which is no longer the case at all. Until the later part of the 1800's epidemic diseases such as cholera and Tuberculosis were felt to be associated with various moral failings of one kind or another, an idea reinforced by millennia of religious thought. As scientists began in the mid 1800's to prove that epidemics were instead linked to environmental factors (especially sanitation and water) the focus turned onto community efforts, to social choices and not just individual moral failings. Urban growth, much of it from immigrants crowded into abyssal housing, created a fertile stew for infectious disease. Thus the early years of the public health association were filled with papers about sanitation and recognized the common cause with "moralists and priests," as one paper put it. Earlier moralistic attitudes adjusted to the new science of environmental risks by overlaying science with moral injunctions that came very close to identifying godliness with good sanitation, the kingdom of God with sewers.

Through TB one can see nearly the whole cycle from despair, to social action, to institutionalization, to overreliance on pharmacology to today's renewed recognition as a disease embedded in poverty and marginalization. Although TB was a leading cause of death until the turn of the century, it attracted little attention because it was thought to be hereditary and medical interventions had little effect. It was even thought to be slightly stylish, associated with creativity and the artistic sensibility. The victims remained alert throughout the course, were often optimistic and even somewhat stimulated-presumably by the low fever-into unusual mental activity. In 1865 it was proved to be contagious. In 1882 the tubercle bacillus was discovered (one of the first pathogenic organisms found), which established the disease as a communicable and thus preventable disease. However, this discovery was resisted well into the 1890's, notably among physicians who regarded the disease as a nerve problem.

At the early stages of the public health response to TB the movement was filled with laypeople and community-organizing strategies built on the religious leaders and congregational structures. The social activists preceded the medical experts in ways repeated when the gay community, awash with dying friends, moved in advance of the credentialed technicians. However, by the turn of the century leadership began to be preempted by physicians with women and clergy receding into the background.

The TB movement in Atlanta was beautifully described in a Ph.D. these of the Dean of the School of Nursing, Margaret Parsons, which I commend to you as a wonderfully thick and nuanced study of the early phase of the movement we now think of as faith and health.[5] The TB association was non-governmental, voluntary and linked to religious groups in the city. It carried major responsibilities for the metro area's engagement with TB for nearly five decades. Led by a triad of women, supported by a complex web of relationships with government, private and religious structures, the TB society attacked not only the disease, but the underlying social pathology. This included racism, labor oppression, unregulated housing, nutrition, poor schooling and, of course, sanitation. All of these were attacked through coordinated social campaigns that challenged business, political and religious behavior.

TB provided the justification for what would today be considered intrusive and paternalistic investigations into the home life of anyone suspected of having or harboring the disease. Visits by friendly nurses uncovered and reported not only TB but the whole range of unhealthy conditions endemic to poverty. In Atlanta the TB society formed a unusual relationship with African American women's groups anchored in the neighborhoods of the cluster of Black schools including Morehouse, Clark and Morris Brown. Atlanta-wide TB campaigns were able to be coordinated across racial boundaries. In many cities the treatment of TB within the Black community was publicly justified as a way to deter the spread of infection from servants to their (white) employers. In Atlanta the links formed around TB were also used as a wedge to open interracial discussions about other basic community problems that were acerbated by racism. I don't want to overstate the success, but it is worth comparing it to the general failure of social gospel leaders in the North to even broach the subject of race. The TB society lasted into the 1940's when the TB treatment was discovered and implemented making the complex social efforts seem unnecessary. The society folded most of its responsibilities into the newly augmented public health department. In effect, pharmacology supplanted social action, a story that would be repeated in communities throughout the country and with other diseases.

The revolutionary move: systematic prevention
The root idea of public health is that patterns of disease are predictable and therefor to a very significant degree capable of being modified by systematic action at the community level. Risks can be identified, once you know to look for them: mosquitoes, dirty water, human and animal waste, dirty food preparation and meat processing, smoke, toxins, lack of ventilation, unbalanced diet, lack of trace minerals, rodents. Beginning with tuberculosis in 1882, the specific pathogenic organism would be identified, analyzed, responded to, attacked, isolated and treated. Only eight decades later, beginning with smallpox, and

perhaps a handful of other deadly enemies, the disease could actually be eradicated from human experience entirely.

All of these interventions are ethically and theologically significant at the individual level, but they were truly revolutionary when applied to whole communities. The actual difference made by democracy was nothing compared to community-wide trash collection, food inspection and sewers. Indeed, as the HMO's are learning, most prevention strategies are not very effective when they are restricted to only one part of the population, much less to individuals. Like democracy, prevention only makes sense when it includes the whole population. The comparison is not coincidental, for the idea of community scale systematic prevention arose in an optimistic democracy. The strategy is little more than systematically coordinated human efforts implemented by politically structures accountable to the humans participating in the changes. The strategy depends on theology, democracy and public health science.

This linkage between theology and science becomes only more obvious as the sophistication of the health sciences advances. Interventions for small pox or HIV require a very sophisticated technical infrastructure that is even more reliant on, more expressive of, a social, political, moral infrastructure. The more sophisticated the strategy, the more complex the social infrastructure and the greater moral energy needed to steer the implementation. Before his tragic death last year, Dr. Jonathan Mann argued persuasively that public health is deeply connected to, ultimately dependent on, the universal declaration of human rights. He noted that there has never been a famine in a democracy.

It is still radical news that democratic political systems systematically change the likelihood of disease and injury. In all the history of religious and political thought, this was new, finding precedent only in efforts of much smaller scale and duration. Standing on this side of the revolution, it is almost impossible to imagine how new this is; how unusual a way of relating to all that matters in life-to our bodies, our families, the future, to God, to all the structures of society. This radical insight has yet to penetrate very far into our social ethics, our theology, much less institutional practice. We should not be disappointed-it is very new. This is the strong heart of the movement that is good news for the whole community. I would like to say that it could never be unthought. But we do know that it can be forgotten. As the health sciences developed over the next decades until now, this intellectual breakthrough has tended to be obscured by later (and lesser) discoveries in the field of pharmacology, especially antibiotics and immunization. More recent psychotropic, bimolecular and gene level interventions suggest the continuing direction. Medicine has almost become a derivative field of biochemical mechanics. Meanwhile, imaging breakthroughs that began with x-rays are rapidly allowing us to literally see diseases and abnormalities at a molecular level almost at conception, giving us a sense of transparency. However, it is misleading to speak of self-knowledge in this context because we are more and more reliant on highly trained specialists who can barely speak to each other. The mastery of disease is held by people that we need to pay, not by ourselves. It is not surprising that many of us think of health as something we must purchase from experts. And it is not surprising that public health policy devolves into the political art of getting

everyone access to these expert services. Or even that faith and health groups focus so often on creating charitable or alternative services.

Choosing the obscure over the obvious

Medical science and its vast institutions have made available to millions acts of mercy that were inconceivable throughout the development of our species. I don't want to disparage these experts. The problem is that the health sciences have forgotten almost as much as they have discovered. And it is not the obscure, but most obvious insights that have been lost in favor of the obscure. Jonathan Lomas, writing in Social Science and Medicine explores how the discipline of public health has largely focused on individual-level behaviors and interventions instead of exploring social -public-factors and processes. "The social system in a community relevant to health consists of at least three elements: physical structure, social structure and social cohesion."[6] All three are terribly relevant to religious life, of course. Lomas is not aiming at religion, however. He looks at the historical development of the core competency of epidemiology and sees a conceptual breakdown which turned it into a scientific lapdog. Rather than exploring if and how social patterns contribute to health, it ignored community and asked questions only of individuals. These end up, inevitably, focusing on individual behavior modification schemes, usually called health education or health promotion. Imagine the death rates today if we focused on individual sanitation, burning our trash in the back yard and didn't follow the science to build the public sewers.

Lomas' point was also made by Thomas Pynchon, "if they can get you to ask the wrong questions, then they don't have to worry about the answers."[7] The effect of wrong questions is not neutral. Rather, it favors the existing patterns of power, privilege and domination. Power uncontested, is power served. When I began attending public health association meetings a few years ago I recognized that public health believes in the public the way more religious organizations believe in God. That is, for practical day-to-day purposes, not at all.

Lomas argues that it is no coincidence that the disciplines that currently dominate the health policy world, economics and biomedical science, have deep within them a core assumption that the individual is the unit of measurement, analysis and modification. The cause-effect models that flow from these public health assumptions don't believe in the existence of a thing called a "public." It doesn't exist as a unit of measurement, analysis or modification. All you have are aggregates of individuals. Even they are usually understood one organ system at a time.

It is important for those of us in the religious community who value the partnership with health professions not to make the same mistake. The current dominant trend in the renewal of the faith and health movement risks exactly doing just that. Social spirituality is first about right relationships and about righting relationships. This is not because technologies, knowledge, structures and therapies are unimportant. But they are all derivative, reflecting social constructs. Research science asks some things and does not pursue others. Northern diseases tend to be studied; tropical ones much less. It is clear that both knowledge and ignorance have a pattern that reflects social reality. This is self-

reinforcing pattern because a body of accepted answers gradually forms and then protects a favored question. Look at how our healing ministries form around approved questions of education and mercy while avoiding or postponing change. As we seek to align our assets with each other, we must constantly ask the revolutionary and inconvenient questions: does this action reflect our most mature faith; does it reflect our most relevant and deeply reflected science? The questions are not new, but they have the power to re-new our commitments.

The good news that is social

Almost anyone trying to implement the linkage of faith and health in an American community works in the theological tradition of the social gospel movement. They risk making many of its same costly blunders and repeat its dangerous naiveté. I claim this tradition as my own. I also confess its tendency toward inappropriate optimism, its failures to grasp the depth and breadth of American racism, its dismissal of the lessons of other faiths and its casual undervaluing of many traditional Christian myths and confusion about the nature of Jesus himself. Let me explain why this flawed movement is so resilient and so crucial to us at this time.

The social gospel movement had hundreds of leaders, including the most articulate and thoughtful of several generations of theologians. I want to briefly sketch four names that mark the movement (who I must note include three Baptists and a non-Ph.D.): Walter Rauschenbusch, Shailer Mathews, Henry Emerson Fosdick and Reinhold Niebuhr.

Walter Rauschenbusch

Walter Rauschenbusch was a Baptist pastor in the part of New York called hell's kitchen, probably similar to where Cecil Williams pastors today in the San Francisco Tenderloin. Raised to promote the traditional Baptist focus on individual salvation, Pastor Rauschenbusch found himself working in a hell created by fabulously dysfunctional social systems awash in unconstrained greed who made his immigrant parishioners easy victims. The movement's most radical and conservative leader, Rauschenbusch discovered the Kingdom of God at the center of Jesus' thought, purpose and goal. This was no intellectual abstraction, but an organizing paradigm to guide congregational life. Like most social gospel pastors, Rauschenbusch's congregation began deaconess societies, settlement houses, schools, food ministries and the whole range of things that we now think of as normal. In his understanding these ministries were not just about service, but part of literally bringing in the Kingdom of God now, here, really. These activities were the first fruits of that Kingdom. Rauschenbusch wrote theology, economics and books of prayers that still read very well. Although never a member of the socialist party (as was Niebuhr) he was unabashed in arguing that a kind of Christian socialism held the only credible answer for America's social pathology. He poured himself into labor organizing. Not surprisingly, he took direct clues from public health in his descriptions of what the kingdom would look like. Listen to how the themes twin together in a book typically titled *Christianizing the Social Order*:

> We are a wasteful nation. We have long wasted our forests and the fertility of our fields. We pour the precious sewage of our cities into our rivers and harbors to

> defile and poison the water. We waste child life, the dearest and costliest product of the nation, by needless mortality. We waste the sufferings and pangs of motherhood that brought the children into being. We waste the splendid strength of manhood by industrial accidents and tuberculosis. But the most terrible waste of all has been the waste of the power of religion on dress performances. If that incalculable power from the beginning of time had been directed intelligently toward the creation of a righteous human society, we should now be talking on a level with angels.[8]

Public health people enjoyed explicit support in Rauschenbusch's writings:

> The eradication of tuberculosis, for instance, is a public task for the next decade. But the creation of public sanitariums for the infected, and the enforcement of sanitary regulations for the prevention of the disease, will never become a party question. Strong pressure will be brought to bear on legislatures and public officials to protect the financial interests of tenement-house owners who propagate tuberculosis by their death traps, but no party will dare openly to champion their cause. If the pulpit creates the public sentiment, which will insist on the enactment and enforcement of such laws and ordinances, it will not be meddling with party.[9]

I was surprised to learn that Rauschenbusch died in 1918 feeling marginalized, partly because of his outspoken resistance to world war one. He was disappointed that the Kingdom had not more fully come. I think he would be heartened to know that we can get his books on Amazon.com today. His book of prayers has been a best seller for seventy years. He was cited by another great Baptist activist, Martin Luther King, as one of the key theological anchors of the civil rights movement. Rauschenbusch's disappointment indicates a key weakness of the movement: exactly how do we think the Kingdom will come? How do we live in tension between such hopeful vision and such partial success?

Shailer Mathews

From the outset the social gospel movement had to deal with the biblical challenge of its time, the search for the historical Jesus. Health professionals are usually surprised to learn how contentious the study of Jesus was and still is. (Of course, theologians are amazed to learn how contentious germ theory remains!) Exactly at the moment Rauschenbusch was discovering the Kingdom of God and making it the organizing principle for a major social movement, biblical scholars were reducing Jesus' Kingdom claims to apocalyptic foolishness unworthy of modern consideration. In Albert Sweitzer's devastatingly popular one-liner which ended his book, modern religious liberals looked into a well for the historical Jesus and saw their own image.

This is a theological hit well below the water line. If Jesus can't be pried loose from the first century, what value is he personally, socially, theologically, politically? Shailer Mathews took this challenge on and provided the theological map through the abyss for the social gospel movement. Interestingly, his map turns out 90 years later, to be pretty much the one being rediscovered by biblical scholars today.[10] Mathews argued that Jesus lived amid the crude apocalyptic expectations of his time, but also defied them and transformed them with a revolutionary mindset oriented around a God of love, not vengeance. "The primary frame of reference for the ethical teachings of Jesus is not the eschatological hope of a divinely

wrought revolution in human history but the character and will of God."[11] Mathews examined Jesus' attitude toward social structures and found them enduringly relevant, indeed, a trustworthy guide for modern thinkers. Mathews was far more incremental in his politics than Rauschenbusch. His gradualistic optimism made him an irresistible target for Niebuhr's later critique. His dialogue with secular modernism made him a target for conservative Christians. But his serious effort to link Jesus with social understanding remains a crucial task that is far from finished. Those of us activists who claim the Christian tradition are in grave danger, if we imagine we can leave it to others to sort out.

Henry Emerson Fosdick

Henry Emerson Fosdick came along somewhat after Rauschenbusch and in some ways exemplified the later stages of the social gospel movement from the pulpit of the First Presbyterian Church of New York. He could have speaking for a generation of pastors when he said, "We did not go into the ministry for money or fun. We went in because we believed in Jesus Christ and were assured that only he and his truth could medicine the sorry ills of this sick world. And now, ministers of Christ, with such a motive, we see continually some of the dearest things we work for, some of the fairest results that we achieve, going to pieces on the rocks of the business world.... Everywhere that the Christian minister turns, he finds his dearest ideals and hopes entangled in the economic life. Do you ask us then under these conditions to keep our hands off? In God's name, you ask too much."[12] He was never a Presbyterian however, but a Baptist. As the central target of the fundamentalist/modernist wars of the early part of the century, he avoided Presbyterian heresy trials only because he wasn't one. Baptists, by definition don't have heresy because they (we) don't have creeds. The Presbyterians did eventually run him out, or more accurately down the street where he was the founding pastor of Riverside Church, funded by John D. Rockefeller. (Such is the endless ambiguity of our movement.) Fosdick turned the dominant direction of progressive theological thinking from social change towards what I would call the therapeutic gospel exemplified today by pastoral counseling. However, we would do well to live up to his standard of intellectual integrity and clarity of word. "They call me a heretic. Well, I am a heretic if conventional orthodoxy is the standard. I should be ashamed to live in this century and not be a heretic."[13] The faith and health movement today rests on pastoral counseling, caregiving and public health perspectives. A key question for now: can we do better than Fosdick in integrating the social and therapeutic gospels?

Reinhold Niebuhr

It is impossible to see the social gospel movement without looking through the lens of Reinhold Niebuhr, its best-known son and most devastating critic. He launched the theological torpedo in 1932 with his book *Moral Man and Immoral Society*. After the gas warfare of World War One, the death camps of World War Two, the brutalities of the depression and more recent horrors of Cambodia, Rwanda, Kosovo and the killing fields in many US neighborhoods, dark Niebuhr reads much better than optimistic Rauschenbusch. Niebuhr brought back into the movement a vivid sense of brokenness, evil and sin, especially in social and political structures. However, he never left the movement he criticized, never quit exploring the social terrain, even as he mapped its traps. I fear he would recognize in the current faith and health movement the same themes of incremental

optimism he found so "stupid" (his favorite word) in the original social gospel movement. He would easily dispense with a public science that hoped to advance health without even examining the embedded evil of our corporate, government and intellectual systems. Because of Niebuhr most seminary trained professionals are far less optimistic about human progress than the most jaded health professional, who are able to consider themselves educated without receiving even one lecture on the fallacies of the field's optimistic assumptions.

Strengths worth reclaiming

I have noted some of the weaknesses of the social gospel and public health movement. The strengths may not be as clear, so let me underline them. First, it did what it said it would do, which was to engage the challenges and opportunities of modernism from within the Christian tradition. It did so within the limitations of its understandings of modernism at a time when Christian thought was itself highly conflicted, torn between European reductionists on one end and rigid fundamentalists on the other. Social Gospel pastors went into their pulpits as modern Christians and did their best. Thus they showed laypeople that it was not necessary to leave their minds outside the sanctuary.

The social gospel was capable of brutal self-criticism. It learned in the open, made its mistakes boldly, and usually tried to correct them. It knew it was using borrowed language, especially in the field of economic policy, and tried to think through to better language (never quite making it). Social gospel thinkers contested their secular partners with the same energy they did each other giving us powerful precedent for the deep interdisciplinary, interfaith engagement we need today. The social gospel provided great creative energy to a process of institution building that we still benefit from. This is where most of our religious hospitals came from. Those religious hospitals that preceded the social gospel movement still benefited enormously from the political policies it made possible. The assets accumulated in the process make our current movement far more substantial than it would otherwise be. At a congregational level, the common expectations of social service and advocacy typified by Cecil's church and hundreds of others in cities everywhere around the nation were raised and modeled here. There was no split between mercy and justice in most of the social gospel congregations. They served as best they could and invented whole new disciplines if they needed to. But they also tried to do justice. Even those members of the churches that today resist many of the justice implications still find it absolutely common sense that this is what normal churches try to do.

The public health movement and the social gospel movement were born together, influenced and protected each other’s early years and must share credit for their joint accomplishments. Long before the antibiotic revolution began to chip away at death rates, the social changes of these movements had added decades of life expectancy to the average American child-about a 60% increase in longevity. This alone should cause us to doubt our doubt about the future. This is partnership with an astonishingly productive record of tangible gain.

Always we ask: does this reflect our most mature faith and most deeply reflected science? No. We would surely find easier questions, if either our faith or science would permit. The

question relativize our successes and leads us beyond our failures. So we try again, finding strength perhaps in the fact that we have shared these questions with more than a century of friends.

It would be disingenuous to be speaking at an endowed lectureship and not note that our movement has accumulated significant assets. We have an intellectual infrastructure, a service infrastructure, large capital assets in form of endowments, foundations and strong institutions. We do well to remember the end-of-life disappointment of Walter Rauschenbusch as well as his challenging voice. How do we live when one of the few things we know for certain is that our best efforts will be partial, flawed maybe even mistaken? On my office wall I have a print of the Prisoner of War monument at Andersonville. The inscription alludes to the passage in Isaiah, "prisoners of hope." Sometimes we feel like we are captured by a hope that can only expose us; that we cannot fulfill. The only good news is that this is true for all of us of every persuasion in every field, not just us social optimists.

I suggest that it was the science, not the faith, of the early social gospel movement that proved inadequate. Many people in many fields are thinking deeply about change today in ways that are quite, well, changed from the time of our peers in the 1900's. They suspected that God had created the potential for modern humans, acting in line with God's intentions to systematically implement the Kingdom. Their hope was deeply shaped by the apparent power of the sciences and rationality to change and control. Today we have more absolute power to communicate, destroy, shape, control, heal and create than Dr. Rauschenbusch could have imagined. But we now know --profoundly and painfully-- that this power is inadequate. Indeed, we fear the very power and do not trust ourselves. It is with far less confidence we ask how to keep faith with the modern world and with our faith. But it not a different question.

It is common on seminaries and campuses to speak of ourselves as living in a postmodern time, meaning mostly that we are liberated from the rational optimism that the early social gospel movement and public health movement exemplified. While it may be possible to be postmodern on campus, it is not on the streets. The fact is that we find ourselves with assets and privileges relevant to the task of engaging the powers and principalities on behalf of life. We cannot escape the same challenges faced by Rauschenbusch, Matthews, Fosdick, Niebuhr and several generations of other colleagues.

One thing we do know about change is that it emerges from asking the right questions with the right people and not just in implementing some time-bound "answer." Their question is still a pretty good one: "What will we do to keep faith with our faith and with the modern world?" If exploring the confluence of faith and health does not help with that question, it is probably not worth doing.

But I think it is. I think it is.

[1] Gary Dorrien, *Soul in Society: The Making and Renewal of Social Christianity* (Minneapolis: Fortress, 1995), vii.
[2] Fredrick F. Cartwright, *Disease and History* (New York: Dorset Press, 1972), 50.
[3] Ruth W. Rasche, *The Deaconness Heritage* (St. Louis: The Deaconness Foundation, 1994).
[4] Much of this section is based on a paper by Katy Pitkin and myself offered to the Caucus on Faith Community and Public Health at the November 1998 meeting of the American Public Health Association.
[5] Margaret Ellen Kidd Parsons, "White Plague and Double-Barred Cross in Atlanta 1895-1945," diss dmin (Atlanta: Emory University, 1985), 256.
[6] Jonathan Lomas, "Social Capital and Health: Implications for Public Health and Epidemiology," *Social Science and Medicine* 47, no. 9 (1998): 182.
[7] Dean Ornish, *Love and Survival* (San Francisco: HarperCollins, 1997), quoted.
[8] Walter Rauschenbursch, *Christianizing the Social Order* (New York: Macmillan, 1912), 98.
[9] Walter Rauschenbusch, Christianity and the Social Crisis, *Library of Theological Ethics* (Louisville, Ky.: Westminster/John Knox Press, 1991), 363.
[10] Richard A. Horsley, *Sociology and the Jesus Movement* (New York: Continuum Publishing Company, 1989).
[11] Kenneth Cauthen, "The Life and Thought of Shailer Mathews," in *Lives of Jesus Series*, ed. Leander Keck (Minneapolis: Fortress Press, 1971), lix.
[12] Dorrien, Soul In Society, 64.
[13] Dorrien, Soul In Society, 67.