

“It’s a fraught subject”: Listening to Evangelical Doctors Talk about Abortion

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ABSTRACT

News coverage, social media and protests alike tend to polarise people’s stances on abortion. Moreover, these also often reveal category slippage between ‘pro-life’ and ‘Christian’ or ‘religious,’ perpetuating the impression that to be religious is to reject abortion. Contrary to both tendencies, this article engages with abortion from a lived religion perspective. It listens to evangelical healthcare practitioners as they talk about their attitudes towards abortion. This reveals a complex picture, their ethical engagement variously taking the form of resistance, neutrality, uncertainty, compartmentalisation, change and situational negotiation, while drawing upon multiple sources of ethical authority, including their own ‘experiential knowledge.’ Having presented these complexities, the article concludes by exploring their implications. First, it considers the value of foregrounding emotion when engaging in lived religion research around ethics and controversial topics. Secondly, it suggests that combining social bioethics with emotional narratives might represent a means of communicating this complexity.

KEYWORDS

Evangelicalism; Abortion; Ethics; Lived Religion; Healthcare; Emotion

Introduction

Abortion remains a controversial topic in medical ethics, for individuals and nation-states alike. This article examines abortion in light of a recent qualitative study with evangelical Christian healthcare practitioners working in the NHS in England, using a lived religion approach (Ammerman, 2007; McGuire, 2008). In particular, it uses interview and autobiographical materials to present the lived reality of evangelical ethical engagement on the topic. The medics' narratives reveal complexity, subtlety and nuance which starkly contrast with the presentations of abortion perpetuated in media coverage (Astley, 2002, 21-34). In place of elision between 'Christianity' and 'pro-life attitudes' it suggests a much messier picture, presenting the variety of modes of ethical engagement evident among participants. This article, and the complex narratives it contains, also challenges academic conceptualisations of ethical engagement with abortion. In closing, this article suggests that foregrounding emotion in narrative explorations of individuals' ethical standpoints might represent a means of communicating the complexity of controversial topics such as abortion.

Background

An article exploring medical ethics - and particularly abortion - through the lens of lived experience is timely for two reasons. In the first place, abortion continues to spark controversy; it continues to make headlines; it continues to encourage protest and debate. Whether in traditional media, online via social media, or on the streets, it has significant public exposure, locally, nationally and internationally, particularly in the Anglophone world. For example, on 22nd October 2019, in the absence of a Northern Ireland Executive, Westminster extended the decriminalisation of abortion to Northern Ireland, to a mixture of praise and dismay (Connolly, 2019; BBC News, 2019a). Early 2019 witnessed a flurry of new anti-abortion measures entering law in several states in the USA, and backlash against these (BBC News, 2019b). In Australia, September 2019 saw New South Wales decriminalise abortion, following weeks of heated and divisive debate and protest (BBC News, 2019c). In January 2019, Durham University - my own local context - witnessed a microcosmic pro-life versus pro-choice feud (Leggatt and Taylor, 2019). A pro-life group, formed within the university, though not ratified by the students' union, organised a meeting in a local Anglican church. Pro-choice groups were established in response and organised a counter-protest outside the church on the evening of the meeting, with a parallel counter-protest occurring on Facebook and Twitter.

In these physical protests and their digital parallels, much of the debate and media coverage quickly becomes not only polarised but polarised around religion. In addition to the binary categories 'pro-life' and 'pro-choice,' it is common to see category slippage between 'pro-life' and 'religious.' 'Religious' - and particularly 'Christian' - is elided into pro-life, and everything its detractors associate with that label. 'Christian' thus becomes allied with anti-choice, anti-women, and anti-freedom. For example, in Alabama in May 2019, protestors' banners included the phrases 'Keep your theology of my biology' (My República, 2019) and 'No Christian Sharia Law' (Parham, 2019). The

latter example allies pro-life attitudes to Islamic Sharia Law, here perceived and presented as a very strict form of religious legalism. Across Anglophone contexts, from Ireland to Australia, protestors often rally behind the rhyme 'Not the Church. Not the State. Women must decide our fate.'

In Durham in 2019, I completed some informal online ethnography in order to understand how the student body responded to these events. In both the physical protest and its digital equivalent, there was clear evidence of elision between religion and a dogmatic and harmful pro-life attitude. Thus, protesters' banners, pictures of which were posted on Facebook, included the phrases 'Keep your beliefs off my body' and 'Keep your rosaries off my ovaries.' Though the pro-life group expressly avoided describing itself as religious, the fact that their meeting was held in a church and co-convened by a Catholic priest made an impression. Facebook comments left on the pro-life group's page included: 'Groups like this, whose beliefs are based on outdated morals and religion have no place in modern society' and: 'You proliferators [...] [you] value life from the confines of a bubble of ignorant idealism [...] banning abortion won't take us back to Eden.' This category slippage between religion and pro-life attitudes does not characterise nor indeed summarise all protestors' beliefs, or opinions. However, it did occur consistently and frequently, and was often among those banners and images singled out for media coverage, traditional and new.

This article suggests that such category slippage, and the polarised tone with which abortion is so closely associated in the media, represents an oversimplified presentation and understanding of the relationship between religion and abortion. While it would not be fair to accuse abortion protestors of ignorance, this article nevertheless problematises the category slippage and elision evident above. In seeking out complexities masked by dominant discourses, this article is clearly allied with a lived or everyday approach to religion (Ammerman, 2014, 7; McGuire, 2008).

In the second place, this article is timely because there has been very limited qualitative exploration of doctors' views on abortion (Lee et al., 2018, 27). While an extensive range of quantitative studies have explored a myriad of variables, including numerous measures of religiosity, these are of more limited use for exploring breadth and diversity, and the complexity of individual perspectives (Kelley et al., 1993; Neuman and Olive, 2003; Hoffman and Johnson, 2005).

Cowley (2008, ix) suggests that this lacuna is indicative of a broader trend. In his 2008 work *Medical Ethics, Ordinary Concepts and Ordinary Lives*, he argues that mainstream academic philosophy has ignored ordinary people's lives, language, concepts and understandings of ethics, resulting in a 'confused, oversimplified and misplaced understanding of the problem' (ibid, p.xi). Cowley is perhaps excessively dismissive of the value of academic philosophy, given the utility of its critical, detached perspective, and ability to consider diverse perspectives and examples in parallel. That said, his stark approach signals the value of an 'ordinary' approach to ethics, even it is helpful to soften Cowley's approach and view it as complementary to 'academic' philosophical approaches, the two together forming a fuller picture of ethical engagement. Indeed, Nie suggests precisely such an approach. Nie (Nie and Fitzgerald, 2016, 232-235; Nie et al., 2018; Nie, 2019) clearly notes the importance of the *social* empirical turn in medical bioethics research for

effecting change, and encouraging transcultural communication on difficult subjects. Along with Fitzgerald, he calls for a 'social bioethics,' namely 'research that employs methods and conceptual frameworks drawn from a range of academic disciplines including the social sciences and bioethics [...] integrating systematic and in-depth empirical investigation with normative bioethical inquiries' (Nie and Fitzgerald, 2016, 221, 227-228). This must, he suggests, involve attending to the internal plurality of ethical traditions.

Nie and Cowley both suggest that ethical research must be informed by exploring people's narratives and experiences. Cowley's work on Ordinary Ethics deliberately does not focus upon healthcare practitioners. However, his distinction between propositional and experiential forms of knowledge within ethical engagement is useful in exploring how medical experience can shape ethical engagement (2008, xii-xiii). He writes:

A classic case of propositional knowledge is that 'all human beings are mortal,' whereas many people lack the experiential knowledge gained from living through the dying of a loved one. I contend that many discussions in medical ethics take place at the level of propositional knowledge between participants who lack sufficient experiential knowledge, and that this impoverishes and distorts ensuing discussions (ibid, xiii).

Cowley (ibid, 177) uses euthanasia as an example, saying, 'It is very hard to know what one's position [...] is until one has been in the situation where one has to make up one's mind for real.' For each of the healthcare practitioners in this study, abortion was, to some extent, a 'personal problem' – that is, the 'problem of what an individual person is to do' in relation to an ethical issue (ibid, xiii). They had 'made up their minds for real.' Evans, similarly, suggests that abortion, for patients, is, following William James, a '*living, forced and momentous* decision' (2008, 382, emphasizes original). Evangelical healthcare practitioners do not face abortion decisions in the same way as patients. Nevertheless, though, there is a strong sense in which their decision-making on the subject is also living, forced and momentous: the 'stake is significant' and decisions are 'irreversible' (ibid., 383).

Additionally, Cowley (2008, 95) argues that the most powerful forms of ethical change occur when people are 'brought to see' another perspective. Philosophers, he suggests, have 'less authority to speak on matters of medical ethics because they were less proximate to the medical world than healthcare professionals; that is, they lacked the relevant experience' (ibid, 102). Healthcare professionals, by contrast, are uniquely poised to 'bring [others] to see' precisely because of their proximity to and prolonged, immediate experience of such issues. In a similar vein, John Habgood (1980) described a 'working faith' as 'a faith which can actually be put to work shedding some light on the practical problems of our age.'

Evangelical healthcare practitioners' proximity to abortion means their faith can be a working faith. While the stories presented below are not representative or generalisable, they are rich and complex to an extent which renders the pro-life versus pro-choice binary unhelpful and unenlightening as a means by which to analyse them. This is by no means to say that those who choose or rally behind these labels lack experiential knowledge or

justifications for doing so. Rather, it is to say that this study suggests that this binary risks papering-over important nuances and complexities. Conversations around abortion can be enriched by engaging with religious people's narratives and values in a way which does not distort or oversimplify.

In the discussion which follows, the evangelical medics' modes of engaging with abortion are gathered under five headings. The idea that people engage in ethical reasoning in different ways – or, in different modes – is a familiar one. Kelley et al. (1993, 591-593) suggest that of the four dominant modes used in modern Western moral reasoning (deductive; authoritative; consequential; expressive) three are 'commonly' used in relation to abortion: deductive, authoritative and consequential. In addition to challenging category slippage between 'pro-life' and 'religious,' this article also questions Kelley et al.'s model. It will show that for these evangelical Christians, differentiating between deductive and authoritative moral reasoning is artificial, since many engaged in deductive reasoning *based on* biblical principles treated as authoritative. It also observes other modes of reasoning beyond the deductive, authoritative and consequential. Finally, this article pushes for the inclusion of the expressive mode as centrally important to understanding evangelical doctors' ethical engagements with abortion. While 'judging actions as right or wrong according to one's immediate emotive reaction' (ibid, 591) was not observed in isolation in this study, the significance of emotion throughout the examples below is consistent and clear. On that note, this article closes by suggesting how the participants' narratives, in their complexity and emotionality, might be put to 'work shedding some light' on abortion more widely.

Methodology

The data used to probe this polarised presentation was gathered as part of my PhD research on the consequences of healthcare work for evangelicals' worldviews and senses of identity. The complex narratives it generated, explored below, suggest that the present methodology is well-suited to helping meet Nie and Fitzgerald's (2016) call for a 'social bioethics' which draws attention to the internal plurality of ethical traditions.

I conducted 23 semi-structured interviews with doctors and nurses working or training in the NHS in England who had self-identified as evangelical Christians. The broader project aimed to provide an initial map of potential interactions between healthcare work and evangelical faith, and made no false claims at generalisability or representativeness. As such, a combination of opportunity, snowball and purposive sampling was used to create a small sample which did not unduly exclude particular demographics, voices or perspectives (including ethical perspectives). As Figure 1 shows, the sample thus intentionally captured a variety of medical specialities (since different areas of healthcare generate different kinds of experiences, and interact differently with evangelicalism). Within the sample were those who had already specialised in psychiatry or child psychiatry (5); neurology (1); surgery (1); Accident and Emergency (A&E) (1); General Practice (GP) (8); geriatrics (1); and palliative medicine (2). Since different career stages present different challenges and responsibilities, it was important to include trainee

medics, those newly qualified and yet to specialise in a particular medical field (juniors), those who had already specialised (specialists), and those who had retired. The spread of career stages also controlled for age, as well as historical changes within medical culture, law and training since the late 1960s. I also ensured a balance of genders, and incorporated some who had not trained in Britain. I included black, Asian and minority ethnic (BAME) voices. The names used in this article are all pseudonyms.

It is important to explicate that particular ethical perspectives on topics such as abortion were not part of the purposive recruitment rationale, per se. However, I did consider the likelihood that particular avenues for access would lend a conservative bias to the sample. In particular, regional Christian Medical Fellowship (henceforth CMF) groups often provided useful points of access. The CMF is an evangelical organisation with a conservative ethical ethos and public discourse. Local group representatives acted as gatekeepers. However, it was important to use a second recruitment strand in order to broaden the sample, so as not to exclude medics who self-identified as evangelical, but found that the CMF's conservative ethos dissuaded them from membership. I therefore additionally recruited through several large evangelical churches, several of which had many doctors and nurses in their congregations, often by virtue of their proximity to significant teaching hospitals. Snowball sampling increased the sample size, as those I had interviewed offered to connect me with others. As May (2011, 145) explains, 'this form of non-probability sampling is very useful in gaining access to certain groups,' especially those where the researcher is, in some manner, an 'outsider.' One is awarded a degree of social capital by virtue of knowing members of a network, which helps facilitate access. Equally, though, to avoid undue homogeneity within the sample, I pursued access created by snowball sampling with caution, monitoring the demographic characteristics in Figure 1 continuously (see below).

Interviews averaged 54 minutes in length. 22 of the interviews were preceded by a period in which the interviewee produced a series of 'reflections' around suggested themes. The guidance was provided as follows:

You can tell me anything about your faith or work that you think is important. If you need some ideas to get you started, I would particularly love to know about the following:

- Have there been any particular times or contexts in your work where you have been especially conscious of your faith? Why was that?
- Does your faith shape how you go about or approach your work? How so?
- Has working in medicine affected your faith, beliefs or religious activities? If so, have these changes been good, bad, or perhaps a mixture of both?
- What is joyful about being a Christian in medicine? What is challenging?
- Are there people you feel you can speak to about these and similar issues? Where can you talk freely about them?
- If you had to give a piece of advice to a Christian starting out on a medical career today, what would it be?

GENDER		CAREER STAGE				REGION (ENGLAND)			
MALE	FEMALE	TRAINEE	JUNIOR	SPECIALIST	RETIRED	North East	North West	Midlands	South East
13	10	3	5	10	5	8	1	7	7
WORK PATTERN ¹		ETHNICITY		SPECIALTIES ²					
Full Time	Part Time	White British	Non-White British	Psychiatry or child psychiatry	4				
18	5	19	4	General Surgery	1				
				General Practice (GP)	8				
				Accident and Emergency (A&E)	1				
				Neurology	1				
				Palliative Medicine	2				
				Geriatric Medicine	1				

Figure 1. Demographic characteristics of the sample at time of interview

This two-stage methodology had several clear advantages over semi-structured interviewing alone. First, it meant that each person's interview was based around themes and topics they had deemed important. This took seriously the participants as agentic religious practitioners (Schielke and Debevec, 2012, 3). Secondly, since both researcher and interviewee had had a chance to consider each other's interests before the interview itself, the time these busy participants could allot to a face-to-face interview was utilised maximally, avoiding irrelevant and hypothetical topics (Hollway and Jefferson, 1997, 55; Davies, 2008, 105-106). Thirdly, the lengthier process facilitated the development of rapport between researcher and interviewee, in turn generating honesty and openness conducive to discussing ethics. Additionally, the fact that I also self-identify as an evangelical Christian facilitated a shared discourse.

¹ That is, the work pattern that characterised the majority of their training or career up to the time of the interview.

² As noted, many participants were yet to specialise in a particular medical field; others had specialised in different fields at different times. All had experience working in a variety of fields as part of their medical training. As such, this section does not total 23.

Mode 1: Resistance

While we will seek to move beyond such associations, it is important to acknowledge that some participants were indeed firmly pro-life, often for reasons directly linked to their evangelical faith. Elizabeth, a GP and palliative care doctor, told me the following stories from her time at medical school:

I conscientiously objected to attending a Termination of Pregnancy surgical list [...] The surgeon doing the list said something like 'no one likes doing abortions but you have to' I think I replied 'no you don't - I won't witness it'

'I felt so confident and assured in my faith that actually, no, no I would speak to the Dean of the Medical School and tell him why I wasn't gonna do that – If I had to.'

Believing that life is 'not hers to take,' but God's, Elizabeth resisted what she perceived to be a dominant assumption in medical culture: that abortion was unpleasant, but that doctors would perform them anyway. This deductive reasoning was reinforced by experiential knowledge: in her reflections she described her horror at being shown, first hand, the violence of abortion procedures. Deductive reasoning, in Elizabeth's case, was also based upon the authority of the Bible, from which she elicited her ethical principles, and also clearly had important expressive, emotional dimensions.

Elizabeth was willing to defy the significantly hierarchical culture of medicine to stand up for her beliefs and ethical values. Indeed, across Elizabeth's narratives, her stance on abortion was of clear significance for her sense of identity. In most scenarios she felt she was, and aspired to be, a 'Christian doctor' with a sense of mutuality and affinity between these two significant facets of her identity. Regarding abortion, however, it was clear that Elizabeth was Christian first, and doctor second, as she refused to compromise her Christian ethical principles. She thus moved from the specific issue of abortion to discussing her Christian faith and identity. Her stance did not only have to do with the value of life or the wrongness of murder. Rather, her entire religious worldview – indeed, her religious identity - was implicated. Her ethical stance, and attendant beliefs about the value of life and wrongness of murder, implicated her entire religious identity. In this sense, abortion functioned as a significant identity marker for Elizabeth. The significance of identity markers, theological and moral, has often been observed of evangelicalism, both in institutional and individual forms (Hunter, 1987, 63-64; Penning and Smidt, 2002, 70-71).

Developing this further, we could also call abortion a 'paradigmatic issue' for Elizabeth. Davies (2011, 27, 43) speaks of 'paradigmatic scenes,' which he defines as images, narratives or scenes 'which say it all' and which 'enshrine core beliefs and commitments' within the world religions. They 'compress complex ideas' and 'focus prime values in a single event' (ibid, 42-43). For Elizabeth, abortion was perhaps a paradigmatic identity issue: a cluster of ideas and values which seem to 'say it all' and distil her religious worldview and identity into a single, contentious presenting issue.

Knight and Kim (2011, 104-107) observe that religious doctors can feel the need to 'speak up,' either to resist changes in medical ethical culture, or to

call for change. Elizabeth was grateful that conscience clauses protected her from prosecution on account of her unwillingness to facilitate abortions by signing the requisite paperwork. While she did not have to 'speak out,' therefore, she did explain that if there were ever a risk such conscience clauses might be removed, she would fight hard to protect them. On other ethical topics, however, participants had spoken out. In particular, several doctors firmly rejected movements towards pre-natal screening for, and eradication of, genetic disorders such as Down's Syndrome. Several had written to their MPs and given presentations on the topic for other Christians. Lewis, a former GP, commented:

It is chilling to learn that in now in Iceland, and shortly in Denmark, no one with Down's Syndrome will be allowed life beyond termination in the womb. Such is the power of modern medicine, with its arbitrary decision making of what is truly human and what is not. This is a serious misunderstanding of what it means to be made in the image of God; who has the right to say that 46 chromosomes are better than 47, as is the case of those with Down's Syndrome?

Lewis's beliefs about the sanctity and start of life, and what it 'means to be made in the image of God,' led him to feel 'chilled' and angry, firmly at odds with those advocating the eradication of Down's Syndrome. The same was true of suggestions that there should be greater legal lenience towards euthanasia and assisted suicide. For example, Peter, a trainee doctor, explained that 'as a Christian, I have great respect for life, and death, and the sanctity of life.' These faith-based commitments led him to reject abortion and euthanasia:

As someone who believes in the sanctity of life, that we're made in the image of God, I – I can never support an attempt to end anyone's life [...] that is why I have this stance on abortion and in other areas, so be it euthanasia, or be it assisted dying, or whatever you want to call it, it's – it's not something I can support.

Peter and Lewis saw such ethical developments as fundamentally contravening their belief that humanity was made in God's image. In these examples, deductive reasoning, based upon the authority of the Bible, with significant emotional dimensions, combined to encourage ethical opposition.

Mode 2: Neutrality

Such resistance towards particular medical and ethical trends was a consistently important among many of the participants. In Elizabeth's case, as in others, ethical engagement with abortion manifested in a resolute, oppositional stance, deduced from and sustained by particular biblical or traditional Christian ideas. It is important not to overlook this. However, it is also essential to recognise that biblically- and doctrinally-grounded resistance were by no means the only modes of ethical engagement evident. These

participants did not merely retreat to dogma and tradition, or to authoritative modes of ethical reasoning, but grappled, emotionally and cognitively, with medical ethics, abortion included.

Richard, a retired GP, on first glance had a typically conservative stance on abortion: he rejected it except where the mother's life was in danger. Yet his resolve had wavered on one occasion, on which he had prepared a woman for an abortion procedure following pressure from his colleagues:

In my obstetric [rotation] I was able to explain my position and the plan was that colleagues would carry out the drips/ injections etc involved with preparing someone for early termination. There was an occasion when the other staff on duty were not in the hospital and I was made to feel very uncomfortable as the [duty doctor] until I did accept being involved rather than the unhappy colleague several miles away having to come in. Having taken that step however I found it very hard when challenged in the future that what I had done once must mean there was no real problem. Lesson learnt.

His intense regret at this episode was clear. This temporary divorcing of action and attitude on account of normative, interpersonal pressures ultimately served to strengthen Richard's resolve against facilitating abortion, allying action and attitude once again: 'lesson learnt' was his final word on the matter. However, Richard's attitudes were more nuanced still. Despite his personal stance against abortion, he nevertheless felt an ethical drive, as a medical professional, to present all of the options available to those seeking abortions, in as neutral a way as possible:

There were several patients over the years who decided to continue with a pregnancy after discussions of their feelings and the options. This was done gently with information and helping them to consider also what they wanted, not with coercion. There is no question in my mind that some women came primed by family or unsupportive boyfriends to ask for what they were told was the only way, but when they were asked what they personally wanted, their own wish would have been to continue the pregnancy.

Thus Richard's ethical reasoning incorporated values deriving from both his faith and his medical role, and its attendant sense of duty. Both were important authorities in his deductive reasoning, and in forming his ethical position.

In this particular sense, Richard and Hannah were very similar. Hannah, a junior doctor, was also clear that it was her job as a medical professional not to impose her opinions:

I don't feel it's my role as a practitioner to be – even be making opinions in the place of work at all, about what [...] I am willing to refer a patient for. [...] I don't feel that it's right to tell a vulnerable young woman my opinions [...] but only to, um, make her aware of her choices, um, in a completely balanced way.

Cowley (2008, 98) amongst others, argues that 'it is disingenuous to suggest that the GP can merely spell out the options. The problem is that most GPs have neither the time nor the training.' However difficult it might be to actualise it is significant that both Hannah and Richard made such neutral presentations of the 'options' or 'choices' available to their female patients their goal.

In contrast to Richard, however, Hannah's personal opinions were in favour of abortion. In stark contrast to assumptions that to be 'evangelical' is to be 'pro-life,' Hannah embraced the term 'pro-choice' – albeit with caution. As the below shows, her stance, like Richard's, was also informed by multiple ethical authorities, despite her different resulting conclusion: she notes the significance of her Christian faith, her sense of medical duty, and her feminist commitments within her moral reasoning:

It's about – it's about, like, going to like [an] event, and having an American lecturer say, tell you that, like, the focus becoming these women, who are just getting pregnant. [Forgetting] there was a man involved! And so I think [laughs] – then, then my just, like, feminist side feeds the kind of – like, that is outrageous, why are we even getting involved. Because we should be protecting these vulnerable women as a priority [...] actually, as Christians.

Scully et al. (2017, 25) show that a similar blending of ethical frameworks and authorities occurs when laypeople (that is, church members with no formal theological training) make decisions on topics in medical ethics, explaining that 'the faith group position did not determine their decision; rather, it was something they needed to understand and take into account in their deliberations.' Again, it seems ethical engagement with abortion is not so simple a matter as either authoritative or deductive moral reasoning informing evangelical healthcare practitioners' stances.

Hannah's perspectives also valuably highlight the fact that evangelical healthcare practitioners can and do support women's rights to choose to have an abortion. Hannah took this stance on abortion with a clear conscience, having weighed up multiple ethical authorities, frameworks and values. She was not the only doctor in this study who felt this way. However, again, there are further subtleties it is important to note. As we discussed abortion in her interview, it was clear that Hannah's affirmation of abortion was something she continued to question, her assurance mingling with emotional uncertainty:

[T]he most acute scenarios where you would need an abortion. So where the mother's life is at risk, like, always, always is her life more valuable. Irrespective of whether she's already got children. Than – well – is it? It's confusing!
But then I'm like, do you REALLY think that life begins at conception? [Laughs] But then it's like, it might be, because it might be one of the – the – I've, aaaagh! Minefield!

Mode 3: Uncertainty

Martha and Liam – both also junior doctors - were profoundly uncertain about where they stood on abortion, more so than Hannah. Martha felt she had her 'head in the sand' on the issue. Both felt unable to form a clear opinion on the topic, aware of its complexity. They struggled with what they referred to as ethical 'shades of grey' between the 'black and white' options of pro-life or pro-choice. Indeed, ethical 'shades of grey' was a phrase which many of the participants used. Whether they felt able to take a particular stance amid these shades or not, the majority of those I interviewed were profoundly aware of 'shades of grey' surrounding decision making on abortion and other topics. Put differently, most participants had come to recognise that it was not straightforward to employ deductive or authoritative moral reasoning in a lot of cases.

In part, Martha and Liam's uncertainty had to do with a lack of exposure. Neither had ambitions to specialise in obstetrics and gynaecology, nor much experience of abortion in their training. Thus, to an extent, their uncertainty was assuaged and achieved by avoidance. This avoidance was linked to their awareness that they, in a sense, lacked the experiential knowledge from which to make a fully informed decision or opinion.

I have some Christian medic friends who are against abortion fully [...] I think it is probably more grey than this, especially in difficult cases such as rape. – Liam

I am uncertain about [abortion], but I think, in a way, you do – you do need to, sometimes, choose a stance on it. Especially in a professional context. I think at my level it's not so important, because I'm not going to be making decisions on this [...] But I think at the moment – yeah, I don't really have a firm stance. – Liam

The way that I've thought about them is – to be honest – avoidance! [...] I hav- I basically don't want to articulate an opinion because I – I haven't fully formed my opinions. [...] But I find it very, very difficult that there is no safe forum to discuss these things. – Martha

Martha's handling of abortion could also be framed as a form of partial compartmentalisation. The quasi-popularised notion of compartmentalisation is often presented as a potential consequence of healthcare work among religious and spiritual healthcare practitioners. Franzen (2016, 442), following Balboni et al. (2015), describes compartmentalisation as 'erecting a sort of cognitive and emotional partition' between one's work 'self' and 'the rest of [...] life.' Martha did not divide her 'work self' from her 'life' or indeed her 'faith.' However, she did erect 'a sort of cognitive and emotional partition' around the issue of abortion by keeping her 'head in the sand' because of the cognitive and emotional difficulties she encountered in trying to address it.

Mode 4: Change

Where Martha and Liam's uncertainty regarding abortion was related to having not yet made up their minds, the opposite was true for Mel. Growing up in what she described as a conservative evangelical home, Mel began work as an A&E nurse with clear attitudes towards abortion. Her exposure to abortion in the clinic, however, had profound consequences:

I hadn't really given [abortion] a lot of thought, but had been brought up [...] to think it was wrong, and that was the end of it. [I did have] the task of being on the clearing up team after the procedure – emptying suction bottle contents etc in many respects having my nose rubbed in it a bit. The result of this was quite marked for me. [...] although I was now in no doubt about the violence of an abortion procedure upon what is most certainly not just a blob of unrecognisable cells [...] this didn't push me further into the thinking of my upbringing. [...] I had the opportunity to chat and talk with the women before the procedure who were not the awful and promiscuous people I had been brought up to think they were [...] It made a big difference.

As she became more conscious of 'grey shades,' and old certainties were removed, Mel shifted from an inherited rejection of abortion to ethical uncertainty. Previous deductive and authoritative modes of engagement with abortion were disrupted. This shift did not come easily. She described her faith going 'AWOL' for some time, not least because of these destabilising effects of her work upon previously unquestioned beliefs and values. Ultimately, she developed a more nuanced and situational attitude: even as she retained her belief that foetuses are much more precious than just a 'bunch of cells,' she nevertheless recognised that in some contexts, abortion was the correct course of action. Her story highlights the importance of differentiating between long- and short-terms when exploring ethical reasoning, and when considering the broader worldview consequences of healthcare work (Haynes and Kelly, 2006, 96, 104; Wright, 2005, 44). While Mel came to see her early career as formative and valuable, leading her eventually to a more situational, nuanced view of abortion, at the time she felt that 'God was playing games' with her.

For Mel, upon beginning work, abortion went from an abstract problem to being a 'personal problem,' requiring decision and action. What had previously been a matter of largely propositional knowledge also became a matter of 'experiential knowledge.' This, in turn, precipitated cognitive dissonance (Festinger, 1957, 3). Knowledge derived from experience conflicted with the propositional knowledge and ideas she had adopted as a result of her conservative upbringing. This conflict ultimately necessitated a change of perspective (ibid, 18).

The same was true for Gwen, with whom I discussed abortion at some length. She repeated the phrase 'it's a fraught subject' five or six times, not sparing any indication that she had always found it – and continued to find it – an emotionally difficult issue. She explained that her attitude towards abortion was dramatically changed early in her medical career. Gwen, now a retired

GP, first qualified as a doctor shortly after the legalisation of abortion in England and Wales in 1967. Initially, she resisted abortion, believing it was out-of-step with Christian beliefs about the sanctity of life and prohibitions against murder, much like Elizabeth. However, early in her career, she had to operate on a teenager whose uterus was punctured during a botched backstreet abortion. While Gwen spared me most of the details, she noted that it was a sufficiently gory procedure to necessitate a swap of her usual surgical clogs for Wellington boots. The young woman died on the operating table.

At this point in the interview, Gwen looked straight at me, and slowly and carefully told me, 'You never forget something like that.' And it was clear that she had not forgotten. This episode was a significant experience, creating significant experiential knowledge. Following this, she made several resolutions. First, she affirmed her belief that abortion should always be taken very seriously. During her interview, she decried what she now saw to be a state of affairs wherein some saw abortions as no more serious than 'having a tooth removed.' Secondly and relatedly, she refused to sign any abortion paperwork without a full consultation with the patient: she 'drew the line' when, later in her career, she felt she was expected to countersign abortion paperwork without having met the woman in question. This was because, thirdly, she was convicted of the importance of treating each abortion request on its own terms. While she retained a belief in the sanctity of unborn babies' lives, she held this in tension with her experiences of the horrors of backstreet abortions. She was thus willing to facilitate safe, legal abortions in some cases. As a female GP, abortion was an intensely 'personal problem' on which Gwen regularly needed to make, and act upon, decisions. Her moral decisions and actions were profoundly shaped by her experiential and emotional, expressive knowledge.

Both Mel and Gwen shifted from their previously-held perspectives, and thus from perspectives which many around them continued to hold. Mel noted that her changed perspective on abortion caused tension with her conservative evangelical parents. Gwen felt acutely aware that her perspective was 'out of sync' and 'slightly different' from what she perceived to be the mainstream Christian tendency to reject and resist abortion:

I know this is a little – [pause] out of sync with what people mainly say now, you know, I think Christians say, [...] But I am slightly different. And I just feel – [sighs] – well it's wrong to say they're taking the easy way out... [Sighs.] You're not struggling with it. So I struggled with it.

Experience taught and formed both Gwen and Mel, necessitating a change of perspective, putting both out of step with dominant or traditional religious norms. This epitomises suggestions, made by several lived religion scholars, that individual religion is often very different to formalised or 'official' religion, which can leave individual believers very conscious of their distinct perspective (Ammerman, 2007, 213-219; McGuire, 2008, 4-11). This limits any extent to which one can expect to find straightforward authoritative reasoning at work.

Stringer (2008, 113-114) notes that there is some debate regarding the extent to which a religious individual might experience 'conflict' as a result of deviating from a normative mainstream. Gwen and Mel certainly did feel uncomfortable as their experiences stimulated a change of perspective, feeling 'out of sync' not only with where their religious peers stood on abortion, but with where they themselves had previously stood. Sarah, a retired psychiatrist, described feeling silenced by the 'groupthink' in her local congregation which assumed abortion should always be resisted. Her personal stance, like Gwen's, was more nuanced and complex, informed by her experiential knowledge. This meant she questioned this congregational manifestation of authoritative moral reasoning. Martha, in grappling with abortion and other complex ethical issues, experienced similar ethical silencing. She felt she had 'no safe space' to discuss ethical issues openly, because in Christian circles 'you're already told what you should think.' There is, it seems, potential for conflict in standing apart from the mainstream on ethical issues, whether through a change of personal perspective, a distinct perspective, or recognition of the complexity of forming a perspective at all. Equally, though, others found it very easy to discuss ethical issues openly, particularly those who attended large city-centre churches home to many other evangelical doctors.

Mode 5: Situational negotiation

Both Mel and Gwen's changes of perspective on abortion represented a shift not only from a perceived dominant and normative ethical perspective, but also from a more absolute perspective, to a more consequential or situational mode. They came to approach abortion not as a singular issue, but as a series of individual circumstances. This resembles the 'consequential' mode of ethical reasoning, in which the rights and wrongs of actions are determined by anticipating their likely outcomes (Kelley et al., 1993, 591).

Several other participants similarly found that their medical socialisation and experiences in clinical contexts persuaded them to take a situational approach: they treated particular patients and cases on their own terms, deciding how best to be both a Christian and a doctor in each instance. Ginny, a GP and hospice doctor, characterised her whole ethical outlook in these terms. Explaining what advice she would give to a new Christian doctor, she wrote:

Be aware that you will come across ethical issues – [and] that there is sometimes conflict between faith/theology and how the NHS works. May need to explore a pragmatic approach and there may be different answers, not necessarily one right one, e.g., abortion

John Habgood (1980, 112) cites Joseph Fletcher (1997) one of the first to articulate a Christian form of situation ethics, noting that '[Fletcher] described this as a person-centred rather than a principled ethic [...] in its developed form it admits of only one obligation – to love – whose implications must be worked out in an endless variety of unique situations.' This is precisely what Ginny and Gwen sought to do.

Interestingly, though, in this study, those not willing to treat abortion requests in situational terms to the same extent as Gwen and Ginny nevertheless felt they were showing love to their patients. Several GPs, including Elizabeth and Richard, 'loved' their patients by caring for them before and after the procedure to the best of their ability, even where they refused to sign abortion paperwork. Indeed, David, a GP who also refused to facilitate abortions, explained:

Obviously the most important aspect is to show the woman involved the care and support they need when going through such a traumatic time in their life. [...] I still feel, that as a Christian doctor it's the care and support you show that woman that is the mark of a Christian doctor, and that you are very keen to help them and support them afterwards, if they want it.

Mixed Modes

It is important, finally, to recognise that participants' modes of ethical engagement varied not only situationally, but by topic. I interviewed Ben, a retired GP, who articulated the dilemma he had experienced when asked to complete an adoption medical for a male couple. Believing homosexuality 'was sinful,' but knowing that he might lose his job for refusing to sign the paperwork, he felt caught, saying 'Lord, what am I going to say? What am I going to do?' When we then moved on to discuss abortion, I was expecting Ben to articulate a similarly conservative view, based upon biblical propositions. However, like Gwen, Ben favoured a situational ethic over an absolutist, or more straightforwardly deductive or authoritative mode. He explained that medicine can make one:

look at a thing in a different light. The Lord – what did he say to the woman taken in adultery? He didn't condemn her – in fact, he specifically said, I *don't* condemn you. [...] [W]hen it comes to referring people for ToP, did I do so? Yes, I did. Umm. And I would have backed them to the hilt on that.

This also highlights the Bible's complexity as a source of ethical authority in deductive reasoning. For Ben, Jesus' compassionate treatment of the vulnerable was a biblically-derived rationale which dictated his stance on abortion, even as he weighed it up, situationally, alongside a commitment to the sanctity of life. By contrast, Elizabeth prized the biblical portrayal of the sanctity of all life, including babies in the womb, most highly as an ethical imperative. Different individuals gave different biblical ideas and ideals different weight in forming their ethical attitudes.

Conclusions

Cowley (2008, 20) suggests that 'the persistence of disagreement and dilemma [around ethical topics] indicates that our relationships are irreducibly complex, and that our first task is to do justice to this complexity while striving for a greater lucidity of detail.' This article has tried to do justice to complexity.

Within a sample of 23 evangelical medics, apparently united by their self-identification as evangelical, some five different modes of ethical engagement with abortion were evident. The participants' approaches were diverse, and their resulting personal stances and decisions often nuanced and complex, formed through grappling processes in which manifold 'shades of grey' became very clear. Jylhänkangas et al. (2014, 364) suggest that medical experience and training are more powerful socialising forces than personal religious ideological convictions. I suggest this is a false binary: both experience and ideology were clearly at work in shaping many of the participants' perspectives. These processes were informed by multiple ethical authorities. Christian beliefs and biblical ideas were significant among these, alongside medical socialisation and expectations, and emotion-laden 'experiential knowledge.'

This brief survey suffices to show that there can be no easy elision between evangelical Christianity and pro-life attitudes. The first mode of ethical engagement above certainly shows that some evangelical medics do resist abortion, holding firmly pro-life stances: but the remaining four highlight that even where pro-life instincts and principles significantly or partially shaped the participants' evaluations, a great deal of complexity was also evident. As such, these five modes of ethical engagement highlight the inadequacy of both the pro-life versus pro-choice binary, and of the temptation to elide 'evangelical' with 'pro-life'.

Neither do these modes of ethical engagement neatly match the deductive, authoritative and consequential modes which Kelley et al. suggest are most 'deeply implicated' in people's engagement with abortion (1993, 591). This article thus echoes Nie and Fitzgerald's call (2016, 232-235) for a 'social bioethics' which draws attention to complexity, and to the internal plurality of ethical traditions. The complexity of evangelical healthcare practitioners' attitudes should encourage us to explore the subtleties masked by neat ethical categories and binaries, using in-depth qualitative methods to explore 'ordinary ethics.'

Expressly focusing upon emotion might further bolster such 'ordinary' or 'social bioethics' research. It is essential, in all of the accounts above, to note the emotionality at work. From Elizabeth's horror, to Hannah's subtle uncertainty, to the experiences which changed Mel and Gwen's attitudes, few of the narratives can be fully appreciated without an understanding of the often complex ways in which the participants *felt* about them. This suggests that Kelley et al. were wise to call for 'attention' to the role of 'expressive' moral reasoning (1993, 591). Focusing upon emotion, as manifest in words, tone, pauses and sighs, as well as facial expressions and body language - difficult to capture in audio, let alone in text - enables us to recognise, on multiple levels, the intensity with which the participants engaged with this difficult ethical topic.

In analysing the reflections and interviews collected for this study, it was revealing to dedicate several iterations of qualitative coding to focusing exclusively upon emotions. These brought felt dimensions to the fore and highlighted their significance for understanding how participants engaged with their work in general, and with ethics in particular. To my knowledge, lived religion research, while clearly concerned with emotion and feeling as key components of everyday lives, has yet to utilise any such emotion-led

analysis. By giving emotion dedicated attention its consistent significance is revealed. For this reason, it is essential that ethical research, especially within a lived religion framework, continues investing in deep qualitative studies which attend to emotional dynamics and complexities.

Emotionality is more impactful when one is afforded the opportunity to listen to narratives, rather than only to read them. Certainly this was my experience. Oral historians have begun embedding archival soundbites within digitalised articles, so that online readers can also *hear* the quotes (McHugh, 2012). While it would be important to address confidentiality issues, including participants' voices – and with them, nuance, complexity and emotion – within digital research outputs on forming ethical opinions might serve to communicate how complex religious people's ethical viewpoints are, disrupting binaries such as pro-life versus pro-choice. Thus twinning social bioethics and audio-outputs would represent using religious medics' narratives as 'working faiths,' shedding light on the complexity of abortion where, currently, discourses and category slippage serve to mask it. Additionally, it might encourage further deep, qualitative research into individual engagement with controversial topics such as abortion, stimulating a broadening of perspective beyond the somewhat narrow typology of four 'modes' used by Kelley et al. Finally, it might also disrupt the ethical silencing which some participants in this study encountered among Christian peers and fellowships.

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