'Am I a Christian Doctor?' Exploring the faith consequences and identity implications of healthcare work among evangelical medics in England

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Jennifer Riley

Abstract

While academic interest in the relationship between religion, spirituality and healthcare work has flourished in recent decades, comparatively little attention has been given to healthcare practitioners than to patients. Where practitioners have been the focus of research, this has tended to emphasise the ways in which their religion, faith or spirituality shapes their work, rather than how their work might shape their faith.

This thesis presents a study of the relationship between faith and work in the lives of evangelical Christians working, training for, or retired from healthcare work in the NHS in England. Using an autobiographical elicitation methodology, this study gathered and analysed qualitative data to illuminate the impact healthcare work can have upon those with evangelical faith. Situating this within scholarship, it synthesises and builds upon existing insights as to the consequences of healthcare work for faith and religious identity through the lens of a specific case study. This thesis maps several potential ‘faith consequences,’ observing ways in which the participants’ faiths were both ‘deployed in’ and ‘shaped by’ healthcare work: Calling; Resourcing; Opposing; Changing; Questioning; Compartmentalising; Compromising; Negotiating; and Growing.

This thesis also considers how these faith consequences relate to the evangelical medics’ identities. On the one hand, it traces a persistent desire and drive for work-faith affinity and consonant identity as ‘Christian medics.’ In places this was perceived; in others, it was achieved, not least through the participants’ responses to tensions arising at the interface of their work and faith. On the other hand, the participants maintained a hierarchy of identity, prioritising their faith above their work and seeking to be ‘Christian first and medic second.’ As such, some tensions between work and faith were theologically important, and not resolved. This observation of affinity-with-dissonance echoes broader scholarship in observing that evangelicals thrive because of engagement-with-distinction.

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Thine be the glory,
Risen, conqu'ring Son;
Endless is the victory,
Thou o'er death hast won.

Introduction

A Coronavirus Coincidence

This thesis began with an observation: academic interest in the relationship between religion and medicine was thriving, but there was a curious dearth of research into the experiences of religious healthcare practitioners. It set out to understand these experiences better, gathering extensive qualitative data, and situating it in contemporary religious and medical contexts, in the UK and beyond. I could not have predicted that I would complete it during a pandemic. I edited my drafts to refrains of Prime Minister Boris Johnson's threefold counsel: stay home; protect the NHS; save lives.

The immense cultural significance of the UK's National Health Service (NHS) has been widely documented.[1] In light of the Covid-19 crisis, this significance has been reaffirmed and reinvigorated, shaping everything from public policy and corporate generosity to social media and soundbites. Indeed, this significance took on new, spontaneous ritual forms, the UK's residential streets lined on Thursday nights at 8pm so the public could 'clap for carers.' It embodied itself in 100-year-old Colonel Tom Moore, the veteran who walked sponsored lengths of his garden to raise millions in charitable donations for NHS causes, hailing praise from every echelon of society. Documentaries following doctors and nurses on the 'front line' emerged on major broadcasting channels mere weeks after the beginning of the crisis. The title of Channel 4's contribution: *NHS Heroes, Fighting to Save Our Lives.* Even before the pandemic, medical memoirs were very much in vogue, consistently found in bestseller lists and bookshop windows. For example, Adam Kay's 2017 comedy-memoir, *This is Going to Hurt,* quickly sold over 2 million copies, becoming the best-selling e-book of all time, and the best-selling non-fiction book of the decade.

With its interest in medics' inner lives, this thesis thus taps into a contemporary zeitgeist which extends well beyond academia. While I collected and analysed its data before the phrase 'social distancing' appeared on anyone's horizons, coincidence renders this study all the more apt. As Hutch notes, biographers and their audiences have long been interested in the relationship between people's experiences and their faith.[2] While Hutch's focus is upon significant religious figures, this thesis extends the same interest to 'ordinary' nurses and doctors, the 'heroes' of this extraordinary time.

[1] Stephen G. Wright, *Reflections on Spirituality and Health* (London ; Philadelphia: Whurr, 2005), p.6; Douglas James Davies, *Mors Britannica: Lifestyle and Death Style in Britain Today* (Oxford: Oxford University Press, 2015), pp.18, 100 and 141.

[2] Richard A. Hutch, *The Meaning of Lives: Biography, Autobiography, and the Spiritual Quest*, Cassell Religious Studies (London: Cassell, 1997), pp.9-11.

Rationale and Research Questions

This thesis presents an in-depth qualitative case study conducted with evangelical Christian healthcare practitioners, giving voice to their views and experiences.[3] It seeks to understand evangelical faith better by, as Pearce and Denton put it, 'seeing it as a feature of an individual's life that unfolds along with other aspects of life.'[4] Where Pearce and Denton are concerned with a variety of 'aspects,' this thesis focusses upon one in depth: work in healthcare.

By focussing upon the effects healthcare work can have upon individuals belonging to a particular religious faith, and synthesising existing observations regarding the spiritual and religious consequences of healthcare work, this thesis also contributes to filling a scholarly lacuna. Academic interest in the relationship between medicine and religion has increased in recent decades; yet research into religion and spirituality among healthcare practitioners, as opposed to patients, remains under-emphasised.[5] As Puchalski and Ferrell observe: 'In the midst of all that is being written and said these days about spirituality and health care, it is surprising that so little has been said about the spiritual lives of physicians and nurses.'[6] This is particularly true outside the USA.[7] Where empirical work exploring the relationship between healthcare work and religion has taken place in the UK, it has typically focussed upon psychology and psychiatry, leaving other medical specialties under-examined. Studies of healthcare work's consequences, offering detailed understanding of how these affect practitioners, have the potential to shape training, mentoring and policy. As such, they are of both practical and academic interest.

This thesis's research questions are:

1) How can working in healthcare affect evangelical faith?
2) What are the implications of these effects for evangelical identity?

The autobiographical elicitation methodology developed for this thesis does not facilitate broad generalisations or assertions, but rather deep and detailed qualitative insights. Thus this study maps a range of possible consequences, and poses its first research question conditionally, rather than falsely presenting certainties.

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[3] Harold Y. Vanderpool and Jeffrey S. Levin, 'Religion and Medicine: How Are They Related?', *Journal of Religion and Health*, 29.1 (1990), 9–20 (pp.10-11); N. S. Goldman, 'The Placebo and the Therapeutic Uses of Faith', *Journal of Religion and Health*, 24.2 (1985), 103–116 (p.104).

[4] Lisa D. Pearce and Melinda Lundquist Denton, *A Faith of Their Own: Stability and Change in the Religiosity of America's Adolescents* (New York: Oxford University Press, 2011), p.20.

[5] Wendy Cadge, *Paging God: Religion In The Halls Of Medicine*, (Chicago ; London: University of Chicago Press, 2013) p.4; Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.16.

[6] Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, Pa.: Templeton Press, 2010), p.165.

[7] Cadge, *Paging God*, p.4; Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.16.

This study's focus upon the NHS is important for several reasons. Most empirical exploration of the relationship between healthcare work and religion has been conducted in the USA, whose private healthcare systems differ considerably from the UK's public NHS. In addition to broader resonances between Western medicine and religious values, we will see in 'On Work and Worldviews' that the NHS holds especial additional spiritual significance. Studying the NHS had the potential to contribute to deeper understanding of its significance in the UK. The decision to limit focus to the NHS in England was taken for geographical feasibility.

Evangelicalism was initially proposed as one of several case studies designed, together, to explore how working in healthcare might affect religious and spiritual worldviews in general. However, after a pilot study, it became apparent that doing justice to several case studies' worth of rich data was far beyond the scope of a single thesis. Focussing upon one case study traded superficial depth and comparison for thorough investigation which might, in due course, facilitate rich comparative and hypothesis-testing work. I make some recommendations to this end in 'Summary and Recommendations.'

Evangelical Christianity emerged around, and continues to emphasise, commitments to the centrality of the Bible, individual faith-commitments and conversions, a personal relationship with God through Jesus, and mission.[8] Insofar as it is a broad means of identifying strands of Christianity which share these 'family resemblances,' Bebbington's quadrilateral remains useful:

> There are four qualities that have been the special marks of Evangelical religion: *conversionism,* the belief that lives need to be changed; *activism*, the expression of the gospel in effort; *biblicism,* a particular regard for the Bible; and what may be called *crucicentrism*, a stress on the sacrifice of Christ on the cross. Together they form a quadrilateral of priorities that is the basis of Evangelicalism.[9]

Evangelicalism represented and remains a valuable case study for three reasons. First, it promised to facilitate deep qualitative exploration of tensions between traditional Christian perspectives and trends in medical ethics, particularly surrounding end- and start-of-life issues, and gender and sexuality. Individuals' approaches to these complex topics might, in turn, be compared to evangelical discourses associated with larger organisations and vocal public advocacy. Secondly, this case study would explore evangelicalism within a secular, state establishment, whose goals nevertheless resonate significantly with Christian themes. This promised to elicit complexly-interrelated affinities

[8] Linda Woodhead, 'Introduction' in *Religion and Change in Modern Britain,* ed. by Linda Woodhead and Rebecca Catto (London: Routledge, 2012), 1-33 (p.28); Mathew Guest, Elizabeth Olson and John Wolffe, 'Christianity: Loss of Monopoly' in *Religion and Change in Modern Britain,* ed. by Linda Woodhead and Rebecca Catto (London: Routledge, 2012), 57-78 (p.61); Guest, *Evangelical Identity and Contemporary Culture*, p.1.

[9] D. W. Bebbington, *Evangelicalism in Modern Britain: A History from the 1730s to the 1980s* (London: Routledge, 1993), pp.2-3 (emphases original).

and tensions, particularly related to evangelical discourses of being 'aliens and strangers' in 'the world.'[10] Thirdly, their power as corporate narratives within Christian traditions marked this case study as a welcome opportunity to examine vocation and calling in depth – something a pilot study confirmed. Despite their central importance when considering relationships between religion, spirituality and work, in recent decades these themes have fallen out of academic consideration. Such themes would introduce further complexities into the relationship between evangelical 'alien' discourses and work in a 'worldly' calling.

Roadmap

Following three chapters which lay important groundwork, this thesis has nine substantive, analytical chapters. Each is titled with a particular 'faith consequence': an effect, or group of effects, of healthcare work upon the participants' faiths. Together, these chapters highlight multiple potential answers to the first research question. 'Resourcing' demonstrates that working in healthcare can lead evangelical medics to utilise their faith as a resource. Equally, as observed in 'Opposing,' it can see them deploy their faith in order to resist particular trends in medical ethics. Healthcare work can change evangelical medics' worldviews: 'Changing' explores different forms this can take. It can also stimulate 'Questioning,' generating doubts and uncertainties in relation to faith. It can lead to 'Compartmentalising,' in several different forms. 'Compromising' shows that healthcare work can force medics to make what they perceive to be compromises in relation to their faith and values. It can encourage 'Negotiating' between the expectations stemming from their faith and from their work where these conflict. Finally, as explored in 'Growing,' healthcare work can encourage faith's development, and underpin its stability. The first substantive chapter, 'Calling,' explores vocation and suggests that healthcare work can both sustain faith and challenge it. This chapter also introduces key themes and frameworks which later chapters develop.

Meier, O'Connor and van Katwyk propose that the relationship between healthcare and religion and spirituality has historically been, and continues to be, characterised by four qualities: antagonism, dialogue, integration and separation.[11] The analytical chapters together highlight all four. As such, this thesis challenges Baker and Wang's observation that 'rather than being of reciprocal influence,

[10] James Davison Hunter, *Evangelicalism: The Coming Generation* (Chicago: University of Chicago Press, 1987), p.57; Mathew Guest, *Evangelical Identity and Contemporary Culture: A Congregational Study in Innovation*, Studies in Evangelical History and Thought (Eugene, OR: Wipf & Stock, 2008), p.3. James M. Penning and Corwin E. Smidt, *Evangelicalism: The next generation* (Grand Rapids, Mich.: Baker Academic, 2002), p.71; Anna Strhan, *Aliens & Strangers?: The Struggle for Coherence in the Everyday Lives of Evangelicals* (Oxford: Oxford University Press, 2015), pp.51-52. Wright, *Reflections on Spirituality and Health,* pp.5-6.

[11] Augustine Meier, Thomas St. James O'Connor and Peter L. VanKatwyk, 'Introduction' in *Spirituality and Health: Multidisciplinary Explorations*, ed. by Augustine Meier, Thomas St. James O'Connor and Peter L. VanKatwyk (Waterloo, Ont.: Wilfrid Laurier University Press, 2005), 1-10 (p.2).

religious beliefs influence clinical practice, but not vice versa.'[12] It does, however, overwhelmingly echo their observation that it is important to conceive of the faith consequences of healthcare work as 'fluctuating' and complex.[13]

Across all nine chapters, and the 'faith consequences' they explore, this thesis traces a consistent desire and drive for work-faith affinity. With this comes a related desire and drive to resolve tensions and dissonances emerging at the interface of work and faith. However, we will also see that some tensions were important for the participants. In sum, they thus balanced affinity with tension. In answer to the second research question, these observations are echoed in how the participants presented their identity. On the one hand, they consistently aspired to and sought a consonant sense of identity: to be 'Christian doctors' (or nurses). On the other hand, they also maintained a hierarchy of identity, in which the faith-self was prioritised: they were Christians first, and doctors (or nurses) second.

These dual aspirations to consonant and hierarchical identities, and affinity-with-dissonance, echo Christian Smith's famous sociological observations of American evangelicalism. He concludes his influential 1998 work, *American Evangelicalism: Embattled and Thriving,* as follows:

> Evangelicalism thrives in pluralistic modernity […] because it possesses and employs the cultural tools [necessary] to create clear distinction from, and significant engagement with, other relevant outgroups, short of becoming counter-cultural […] Distinction-with-engagement appears to be the most effective strategy for maintaining religious vitality.[14]

There are important differences between American and UK evangelicalism, not least in terms of political and numerical significances, and approaches to some of the medical ethical issues upon which this thesis touches.[15] Yet, as Strhan's work has shown – and as we shall explore further in the next chapter – Smith's observation resonates in the UK context.[16] This thesis continues in Smith and Strhan's vein. Working at the level of individual identity, rather than sociological resilience, it observes that evangelical medics thrive because of affinity-with-dissonance.

In addition to answering the two research questions, three theoretical themes also recur throughout this thesis. First, as a result of its observations concerning affinity-with-dissonance, this thesis urges scholarly caution before quickly associating evangelicalism with protest and resistance to 'the world.' A second theme highlights the central importance of emotion for understanding the

[12] Martyn Baker and Michael Wang, 'Examining Connections Between Values and Practice in Religiously Committed U.K. Clinical Psychologists', *Journal of Psychology and Theology*, 32.2 (2004), 126–136 (p.134).
[13] Ibid, pp.133-134.
[14] Christian Smith, *American Evangelicalism: Embattled and Thriving* (Chicago, Ill.: University of Chicago Press, 1998), p.218.
[15] Guest, *Evangelical Identity and Contemporary Culture,* pp.2-3 and 50.
[16] Strhan, *Aliens and Strangers,* pp.40 and 74.

participants' experiences, and thus proposes that emotion be given a more central focus within lived religion scholarship. Thirdly, this thesis demonstrates the value of a flexible conceptualisation of personal worldviews as both holistic and piecemeal entities. Each of these theoretical themes is introduced in depth in the next chapter, and summarised in 'Summary and Recommendations.' Appendix A is a list of participants by pseudonym, briefly noting their key demographic characteristics, for reference.

Readers should also note the following preferences and stylistic choices. First, I opt for the terms 'healthcare practitioners' and 'medics' over 'doctors,' since not all participants trained or worked as doctors. Second, this project's lived religion approach allies itself to a preference for writing in the emic present, and quoting participants extensively, recognising that the participants are best placed to articulate their own experiences and feelings. This also allows readers to evaluate my analyses and interpretations, without my having put words into the participants' mouths.[17] I have tried to signal where I move into etic analyses, and hope that these are not so distant from their emic views as to be incommensurable, but rather add depth or comparative insight.[18] I draw specific attention to the subjective ways in which participants evaluate scenarios and experiences as needed, particularly in 'Compromising.' The nature of working with literature and data concerning people's experiences means that what is presented as findings or insight may, from an emic perspective, appear glaringly obvious. Yet for the purposes of completeness within this study, which seeks to understand a variety of potential faith consequences, it is essential to begin with and build upon experiences familiar to many, since they are unfamiliar and strange to the etic audience.

As noted, the next three chapters lay our groundwork. 'Taking Stock' synthesises existing scholarship, highlighting the value of this study while setting out the scholarly shoulders upon which it stands. 'On Work and Worldviews' sets out this thesis's theoretical approaches and interests, along with key definitions. The Methodology charts the design, development and deployment of the autobiographical elicitation methodology used to collect the rich qualitative data at the heart of this thesis.

[17] Catherine Houghton et al., 'Rigour in Qualitative Case-Study Research', *Nurse Researcher*, 20.4 (2013), 12-17 (pp.13-14).
[18] Jane Ribbens, 'Interviewing - an "Unnatural Situation"?', *Women's Studies International Forum*, 12.6 (1989), 579–592 (p.587).

Taking Stock

Introduction

This chapter and this thesis stand on many scholars' shoulders, even as they also do a new thing. This thesis is original both because it synthesises existing scholarship, and because it uses that synthesis as a springboard for a new, focussed study. This chapter accomplishes the synthesising work, collating and organising existing scholarly insights as to the potential consequences of healthcare work for religious and spiritual practitioners. Answering this project's first research question, however, also requires insights from a second literature. Therefore, this chapter also draws upon scholarship concerning Christian and evangelical faith and identity, and the interactions of these with different social and cultural contexts and life stages.

Based on these literatures, this chapter establishes a heuristic framework which underpins this thesis, grouping the consequences of healthcare work into two main dynamics. It suggests religion and spirituality can be 'deployed in' life; and 'shaped by' life. Within both dynamics, I highlight several specific consequences. By developing this framework based on both literatures in parallel, we can be confident that it is relevant to the evangelical healthcare practitioners in this study.

Where things stand

Existing literature and scholarship tends to centre on three themes when considering religion and spirituality among healthcare practitioners (as opposed to patients). The first concerns medics' opinions as to the place spirituality ought to have in patient care and medical training.[1] Both Craigie and Hobbs and Ellis and Campbell's qualitative studies with family physicians in the USA exemplify small-scale empirical work on this topic.[2] Research on this theme is commonly undertaken in dialogue with scientific research as to the health benefits of faith, religion and spirituality.[3] The second theme concerns the place of religion and belief within a predominantly secular profession

[1] Curtis W. Hart, 'Pastoral Care and Medical Education', *Journal of Religion and Health*, 38.1 (1999), 5–14.

[2] Mark R. Ellis and James D. Campbell, 'Concordant Spiritual Orientations as a Factor in Physician-Patient Spiritual Discussions: A Qualitative Study', *Journal of Religion and Health*, 44.1 (2005), 39–53; F. C. Craigie and R. F. Hobbs, 'Spiritual Perspectives and Practices of Family Physicians with an Expressed Interest in Spirituality', *Family Medicine*, 31.8 (1999), 578–585.

[3] Jeanne McCauley et al., 'Spiritual Beliefs and Barriers among Managed Care Practitioners', *Journal of Religion and Health*, 44.2 (2005), 137–146 (p.138); Christopher C.H. Cook, 'Controversies on the Place of Spirituality and Religion in Psychiatric Practice' in *Spirituality, Theology and Mental Health: Multidisciplinary Perspectives,* ed. by Christopher C.H. Cook (London: SCM Press, 2013), 1-19 (p.2).

which privileges scientific epistemologies.[4] Much of the work in this area remains hypothetical and theoretical, rather than empirical.[5]

The third theme concerns the ways in which healthcare practitioners' religious and spiritual lives affect their work, and vice versa. Here, there has been some important empirical work alongside theoretical and reflective insights. For example, Martinez and Baker found that the eight Christian UK psychodynamic counsellors they interviewed felt their faith had matured because of their practice, but no longer constituted a key motivation.[6] Contrastingly, Cheever et al's small-scale quantitative USA-based study of surgeons' religious habits and perceptions of responsibility concluded that surgeons' faiths had limited impact upon their work.[7] Cadge's *Paging God: Religion in the Halls of Medicine* is an important and substantial qualitative contribution in this area. Working with doctors, nurses and chaplains in intensive care units in the USA, she explores the ways in which religious beliefs, attitudes and practices are integrated into their work. Cadge shows these healthcare practitioners forming hybrid coping techniques and plausibility structures, blending religious, non-religious and scientific elements.[8] It is a (consciously) limited study: it concerns medical practitioners working in a particularly high-intensity environment, in a setting where Catholics are over-represented.[9] Resultantly, the focus falls very heavily upon coping with death and suffering. While such matters are highly significant in medical practice, this excludes important dimensions, particularly the primary task of healing.

Within this third theme, conspicuously more attention has been awarded to the influence of religion and spirituality upon work, rather than the reverse.[10] This is particularly true in England.[11] It is rare for healthcare work's consequences to be the sole, or even a significant, focus of academic publications. Often, the ways in which healthcare practitioners' religious or spiritual lives might be affected by their work are raised as little more than a passing comment or anecdote. There is need for both focussed study of this topic, and an organised presentation of existing insights: at present, there is no synthesis of the insights to be gained from either empirical or theoretical work on this topic, and investigations require extensive exploration of a disparate literature. This thesis addresses

[4] Vanderpool and Levin, 'Religion and Medicine: How are They Related?', p.10.
[5] John F. Peppin, 'Physicians' Values and Physician-Value Neutrality', *Journal of Religion and Health*, 34.4 (1995), 287–299; Bonnie J. Miller-McLemore, 'Thinking Theologically about Modern Medicine' in *Journal of Religion and Health,* 30.4 (1991), 287-298; Goldman, 'The Placebo and the Therapeutic Uses of Faith.'
[6] Sheila Martinez and Martyn Baker, '"Psychodynamic and Religious?" Religiously Committed Psychodynamic Counsellors, in Training and Practice', *Counselling Psychology Quarterly*, 13.3 (2000), 259–264 (pp.260-262).
[7] Kerry H. Cheever et al., 'Surgeons and the Spirit: A Study on the Relationship of Religiosity to Clinical Practice', *Journal of Religion and Health*, 44.1 (2005), 67–80 (pp.73-78).
[8] Cadge, *Paging God,* pp.165-170.
[9] Ibid., pp.2-5.
[10] Ibid*.,* p.4; Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.16; Puchalski and Ferrell, *Making Health Care Whole,* p.165.
[11] Cook, 'Controversies on the Place of Spirituality and Religion in Psychiatric Practice,' p.2.

the underexplored question of healthcare work's worldview consequences; this chapter provides a synthesis of existing answers.

'Deployed In'

As religious and spiritual worldviews interact with different life contexts, they are deployed and employed in new ways.[12] Scholars suggest this, broadly, takes two different forms. Thus Taves, Ihm and Asprem differentiate between 'enacted' (or 'implicit') and 'articulated' worldviews.[13] 'Enacted,' worldviews are those which are utilised, in often taken-for-granted ways, without conscious reflection or articulation, forming default interpretive lenses.[14] By contrast, articulated worldviews are consciously 'expressed in language.' The lines between 'enacted' and 'articulated' deployment are not always clear. For example, Astley and Ammerman both suggest that while individuals might deploy religious beliefs to provide meaning amid crises, so too can beliefs provide underlying interpretive lenses amid mundane routine.[15]

It is explicit, 'articulated' deployments which most commonly feature in healthcare literature. In particular, scholars widely note that healthcare workers use religious and/or spiritual worldviews as resources, engaging in meaningful practices and seeking spiritual support and connections. Sims and Cook, of the UK's Royal College of Psychiatry's 'Spirituality and Psychiatry Special Interest Group,' suggest that for many psychiatrists, religion and spirituality are important sources of support, guarding against 'existential despair' and bolstering wellbeing.[16] Puchalski and Ferrell, significant advocates for incorporating spirituality into clinical practice in the USA, variously note that religion and spirituality can: mitigate burn-out; help practitioners deliver good spiritual and medical care; give meaning to healthcare work; and aid stress management.[17] Hsiao et al's quantitative survey study of Taiwanese nurses noted that those with higher spiritual health were more likely to engage in 'meaning-making' in challenging scenarios, giving them 'hope and motivation to cope with difficulties.'[18] Several nurses in Cadge's study found comfort in payer, in beliefs in a higher power to

[12] Sonya Sharma and Mathew Guest, 'Navigating Religion Between University and Home: Christian Students' Experiences in English Universities', *Social & Cultural Geography*, 14.1 (2013), 59–79 (p.66).
[13] Ann Taves, Egil Asprem, and Elliott Ihm, 'Psychology, Meaning Making, and the Study of Worldviews: Beyond Religion and Non-Religion' in *Psychology of Religion and Spirituality*, 10.3 (2018), 207–217 (p.210).
[14] Roman R. Williams, 'Constructing a Calling: The Case of Evangelical Christian International Students in the United States', *Sociology of Religion*, 74.2 (2013), 254–280 (pp.266 and 271).
[15] Jeff Astley, *Ordinary Theology: Looking, Listening and Learning in Theology* (Aldershot: Ashgate, 2002), p.39;
[15] Nancy T. Ammerman, 'Introduction,' in *Everyday Religion: Observing Modern Religious Lives*, ed. by Nancy T. Ammerman (New York: Oxford University Press, 2007), 3-19 (p.5).
[16] Andrew Sims and Christopher C. H. Cook, 'Spirituality in Psychiatry', in *Spirituality and Psychiatry,* ed. by Christopher C.H. Cook, Andrew Powell and Andrew Sims (London: RCPsych Publications, 2009), 1–15 (p.9-10).
[17] Puchalski and Ferrell, *Making Health Care Whole*, pp.165 and 175.
[18] Ya-Chu Hsiao et al., 'Spiritual Health, Clinical Practice Stress, Depressive Tendency and Health-Promoting Behaviours among Nursing Students: Spirituality and Health among Nursing Students', *Journal of Advanced Nursing*, 66.7 (2010), 1612–1622 (p.1618).

whom they could 'turn things over,' and in a potential afterlife.[19] Others used their religious and spiritual beliefs and upbringings as resources for creating meaning amid apparent meaninglessness.[20] Thus, existing scholarship highlights various forms of positive religious coping among healthcare practitioners. Positive religious coping is variously defined as including: benevolent religious appraisals; seeking spiritual support or a spiritual connection with God or a higher power; and engaging in meaningful religious practices.[21] This framework has been used extensively across healthcare literature, not least because it has been widely argued that positive and negative religious coping respectively correlate with better and weaker adjustment to stressful and traumatic events.[22]

Cadge's study also describes medics' senses of vocation.[23] Where scholars present religion and spirituality as resources, supplying necessary solace for coping, a negative tone often predominates. Cadge's work, and Puchalski and Ferrell's observation that spirituality can bestow meaning upon healthcare work, serve as reminders that, even when treating religious and spiritual worldviews in this somewhat functionalist manner, a negative tone should not dominate. Just as religion and spirituality might help practitioners cope with the vicissitudes of their work, so too might these provide the 'meaning' or vocation that inspires that work.[24] Wright, in his *Reflections on Spirituality and Health,* similarly links work that is done as a means of 'serving God' with 'work that offers […] purpose, meaning, fulfilment.'[25] Not least from his observations at 'The Sacred Space Foundation,' a UK charity with retreat facilities for those experiencing burnout, Wright suggests problems arise 'when [healthcare practitioners] lose sight […] of the core purpose and meaning' of their work.'[26] Both Cadge and Wright also note the value of rituals, observing that some healthcare practitioners find these cathartic means of managing patient deaths and 'restor[ing] their capacity' to care.[27]

[19] Cadge, *Paging God,* pp.143, 152 and 164-166.
[20] Ibid.*,* p.166.
[21] Gil Zukerman et al, 'Avoidance Behavior Following Terror Event Exposure: Effects of Perceived Life Threat and Jewish Religious Coping,' *Journal for the Scientific Study of Religion*, 55.3 (2016), 516–530 (p.517). See also David H. Rosmarin et al., 'Religious Coping among Jews: Development and Initial Validation of the JCOPE', *Journal of Clinical Psychology*, 65.7 (2009), 670–683 (p.671); and Kenneth I. Pargament et al., 'Patterns of Positive and Negative Religious Coping with Major Life Stressors', *Journal for the Scientific Study of Religion*, 37.4 (1998), 710-724 (pp.712 and 721).
[22] Pargament et al., 'Patterns of Positive and Negative Religious Coping,' p.721.
[23] Cadge, *Paging God,* p.168.
[24] Ibid.; Puchalski and Ferrell, *Making Health Care Whole,* pp.165 and 175.
[25] Wright, *Reflections on Spirituality and Health*, p.23.
[26] Ibid., p.115.
[27] Ibid., p.32. See also Cadge, *Paging God,* p.152.

'Shaped By'

Turning the tables, religion and spirituality can also be 'shaped by' life. For example, amid a lengthy quantitative questionnaire, Bilgrave and Deluty asked 237 clinical and counselling psychologists in the USA whether their clinical practice had influenced their religious beliefs.[28] They found that:

> Seventy-two percent of the psychologists claimed that their religious beliefs influenced their practice of psychotherapy at a moderate or higher level; *66% claimed that their practice of psychotherapy influenced their religious beliefs.*[29]

66% agreed that their beliefs had been shaped by their work, giving impetus to those who would ask this question of healthcare more generally. The statistic is tantalising, however, because no qualitative exploration is given, nor any indication of *how* practice had influenced these counselling psychologists' beliefs. Building on Bilgrave and Deluty's work, Baker and Wang carried out a qualitative interview study with a small group of Christian NHS clinical psychologists. They observed that 'rather than being of reciprocal influence, religious beliefs influence clinical practice *but not vice versa.*'[30] However, they suggest this was due to wariness about the 'encroachment of the professional practice of clinical psychology upon Christian values' and a resultant desire to 'protect the religious beliefs.'[31] Thus, Baker and Wang's participants recognised - and were nervous about - the possibility that their work might shape and influence their faith.

Several specific 'shaped by' consequences recur in the literature. For example, scholars observe that their work can cause healthcare practitioners to question or doubt their religious or spiritual worldviews, or parts of these. Moss thus describes professionals working across human services, including healthcare, who found their religious worldviews were challenged by repeated exposure to loss.[32] Likewise, Sims and Cook note that psychiatrists may develop existential and spiritual 'difficulties,' doubting the validity of their worldviews in light of their experiences at work.[33]

In this respect, Guest et al's study with Christian UK university students is an interesting parallel. Some participants found that encountering other students' perspectives on religion provoked a 'testing' or 'interrogation' of their Christian faith. [34] In particular, Sharma and Guest describe

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[28] Dyer P. Bilgrave and Robert H. Deluty, 'Religious Beliefs and Therapeutic Orientations of Clinical and Counselling Psychologists' in *Journal for the Scientific Study of Religion,* 37.2 (1998), 329-349 (pp.330-333).
[29] Ibid., p.334 (emphasis mine).
[30] Baker and Wang, 'Examining Connections Between Values and Practice,' p.134.
[31] Ibid, pp.132-134.
[32] Bernard Moss, *Religion and Spirituality*, Theory into Practice (Lyme Regis: Russell House Publishing, 2005), p.49.
[33] Sims and Cook, 'Spirituality in Psychiatry,' p.9.
[34] Mathew Guest et al, *Christianity and the University Experience: Understanding Student Faith* (London: Bloomsbury Academic, 2013), pp.128-131.

students who came to 'question the model of Christian faith' with which they had grown up.[35] Some found these experiences unsettling: in particular, some evangelical students perceived them as potential threats to their faith. Indeed, as a result of such questioning, some ultimately reached a 'make or break' point in which 'decisions about whether to continue with their religious beliefs and practices were negotiated.'[36] Pearce and Denton similarly observe that, among adolescents, critical life experiences may threaten childhood religious identity, instigating questioning or interrogation. However, they also show that such critical life experiences may ultimately bolster religious identities.[37]

Like Pearce and Denton, some scholars observe that healthcare work can bolster, confirm, and sustain religious worldviews. Haynes and Kelly's volume, *Is there a God in Health Care?,* collates the authors' insights into and experiences of the added value religious belief can bring to medicine. They describe mutual reinforcement of faith and healthcare work, and note that physicians often find their faith strengthened or confirmed by their work.[38] As noted above, Martinez and Baker's study noted that some Christian psychodynamic counsellors felt that their faith had matured as a result of their work.[39] Beyond healthcare, Strhan's study shows conservative evangelicals nurturing religious identity and belonging through discourses and practices designed to frame them as distinct from surrounding culture – that is, as 'aliens and strangers.'[40] This, in turn, affirmed their 'sense of their dependence on God and each other.'[41]

This bolstering and confirmation consists neither wholly of stasis nor of substantial disjuncture: there is a sense of development and growth, but no clear point of discontinuity with that which has gone before. However, other 'shaped by' consequences involve discontinuous change.[42] Here, we

[35] Sharma and Guest, 'Navigating Religion,' p.68.
[36] Ibid.
[37] Pearce and Denton, *A Faith of Their Own,* pp180-181.
[38] William F. Haynes Jr. and Geffrey B. Kelly, *Is There a God in Health Care?: Toward a New Spirituality of Medicine*, Religion and Mental Health (New York: Haworth Pastoral Press, 2006), pp.196-197.
[39] Martinez and Baker, 'Psychodynamic and Religious?', p.261.
[40] Strhan, *Aliens & Strangers?,* p.200.
[41] Ibid.
[42] Delineating different forms of change is complex and, to an extent, subjective. For example, Sinclair, drawing on ethnographic work with Canadian end-of-life clinicians, describes healthcare professionals who felt that, across their careers, they had gained a greater sense of spiritual integration, and a clearer sense of perspective. This growing sense of integration is, on the one hand, a change of relationship between work and worldview; on the other hand, it could be framed as continuity for their religious worldviews – see Shane Sinclair, 'Impact of Death and Dying on the Personal Lives and Practices of Palliative and Hospice Care Professionals', *Canadian Medical Association Journal*, 183.2 (2011), 180–187 (pp.183-184). Additionally, Miller and C'de Baca's *Quantum Change,* for example, differentiates between the 'dramatic moments of transformation' (or 'quantum changes') and 'the usual, gradual changes that characterise people's lives.' See William R. Miller and Janet C'de Baca, *Quantum Change: When Epiphanies and Sudden Insights Transform Ordinary Lives* (New York: Guildford Press, 2001), p.X. In this thesis, I instead use the admittedly imperfect

might distinguish two different subtypes: shifts from religion to irreligion; and reshaping and reconfigurations.

However, not all such discontinuous changes are so negative. For example, while Pearce and Denton challenge assumptions that adolescence leads young people to either shun or avoid religion, or lessen their engagement, they acknowledge the potential for subtler forms of change. They describe adolescents expressing their religion in 'adaptive' ways, making 'refinements' to their religious identities.[43] Similarly, Guest et al found that while some Christian students underwent a transition from 'religion' to 'irreligion' during their time at university, others, more subtly, re-evaluated and re-negotiated their faith.[44] They note, though, that this 'challenging and reconfiguring of pre-existing assumptions' was often a 'source of conflict and personal upheaval.'[45] Others experienced a 'broadening' of their religious views, or of openness towards other views as a result of encountering religiously plural university contexts.[46] Thus, just as university can reinforce Christian identities, it can also realign and reshape them.[47]

Certainly scholars have observed shifts to irreligion among healthcare workers. Both Sabo and Moss's reflective work suggest that religious and spiritual identities and beliefs can be reframed and reshaped as a result of healthcare practice.[48] Moss acknowledges that, where this is stimulated by loss and grief, such reforming may well be very emotionally painful.[49] Sabo, similarly, links nurses' experiences of vicarious traumatisation with the 'transformation' of 'personal and professional belief systems.'[50] Franzen cites numerous studies which suggest that healthcare work can lead individuals to struggle with, and perhaps lose, their religion.[51] Martinez and Baker note some counsellors' fears that their faith might not 'survive' their training and work.[52] Thus, where Balboni and Balboni ask, rhetorically, whether the practice of medicine might 'lead to irreligion,' they echo both popular

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distinction between 'continuous change' (or, growth, development) and 'discontinuous change,' primarily in, respectively, 'Growing' and 'Changing.'

[43] Pearce and Denton, *A Faith of their Own*, pp.173-174, 176, 181.

[44] Sharma and Guest, 'Navigating Religion,' pp.61-69.

[45] Ibid., p.69.

[46] Guest et al, *Christianity and the University Experience,* pp.130-131; Sharma and Guest, 'Navigating Religion,' p.69.

[47] Sharma and Guest, 'Navigating Religion,' pp.61 and 69.

[48] Moss, *Religion and Spirituality,* pp.45-47; Brenda M Sabo, 'Compassion Fatigue and Nursing Work: Can We Accurately Capture the Consequences of Caring Work?', *International Journal of Nursing Practice*, 12.3 (2006), 136–142 (p.138).

[49] Moss, *Religion and Spirituality,* p.46.

[50] Sabo, 'Compassion Fatigue and Nursing,' p.138.

[51] Aaron B. Franzen, 'Is this Relevant? Physician Perceptions, Clinical Relevance and Religious Content in Clinical Interactions' in *Journal for the Scientific Study of Religion,* 55.3 (2016), 438-464 (pp.441-442).

[52] Martinez and Baker, 'Psychodynamic and Religious?,' p.261.

impressions and academic suggestions.[53] Perhaps less extreme are McSherry and Puchalski and Ferrell's suggestions that healthcare work can leave people with a sense that their spiritual resources are depleted.[54] Puchalski and Ferrell link this to a 'loss of a professional sense of meaning and purpose.'[55] While Cadge notes that many of her study participants deployed their personal faith and spirituality to *provide* meaning, she also notes that some struggled with meaninglessness.[56] Religious coping is, thus, a two-sided coin among healthcare workers: while it can take positive forms, it can also take negative forms. Negative religious coping includes: religious discontent; the questioning of one's religious beliefs, faith and practices; conflicts over spiritual matters with God or a higher power; and elevated mistrust in God.[57] A number of these dimensions are highlighted above. Indeed, some scholars have noted that healthcare practitioners might engage in compartmentalisation in order to manage the relationship between their work and their faith, and avoid engaging in negative religious coping. They argue that some medics create separate 'self-states' inside and beyond work, not least for the sake of protecting or defending their religious identity and worldview.[58]

Healthcare literature, however, also contains examples of positive change, and of reshaping and reconfigurations. Puchalski and Ferrell, for example, tell one story of a worldview positively renewed and replenished with meaning, purpose and a sense of vocation:

> [A]s he listened to her deep suffering, he felt tears well up in his eyes. Her story touched him deeply and awakened a part of him that had been shut down for years […] Dr Samuels' call to help others and bring hope to their lives was reignited. For the first time in many years, he found profound meaning in service to others and remembered the reason he became a doctor and a healer.[59]

Scholars also urge caution when exploring religious change, in several senses. Firstly, it is important to not merely use a framework of 'positive' and 'negative.' Rather, it is important to consider how individuals interpret such changes and continuities. While to one person 'interrogating' their faith is

[53] Michael J. Balboni and Tracy A. Balboni, 'Spirituality and Biomedicine: A History of Harmony and Discord' in *The Soul of Medicine: Spiritual Perspectives and Clinical Practice,* ed. by John R. Peteet and Michael N. D'Ambra (Baltimore: John Hopkins University Press, 2011), 3-22 (p.3).
[54] Wilfred McSherry, *Making Sense of Spirituality in Nursing and Health Care Practice: An Interactive Approach*, 2nd edn. (London ; Philadelphia: Jessica Kingsley Publishers, 2006), p.29.
[55] Puchalski and Ferrell, *Making Health Care Whole,* p.172.
[56] Cadge, *Paging God,* pp.162-164; Wendy Cadge and Clare Hammonds, 'Reconsidering Detached Concern: The Case of Intensive-Care Nurses', *Perspectives in Biology and Medicine*, 55.2 (2012), 266–282 (p.274); Siedine Knobloch Coetzee and Hester C. Klopper, 'Compassion Fatigue within Nursing Practice: A Concept Analysis: Concept Analysis of Compassion Fatigue', *Nursing & Health Sciences*, 12.2 (2010), 235–243 (pp.237-238).
[57] Zukerman et al, 'Avoidance Behavior,' p.517.
[58] Michael J. Balboni et al, 'Religion, Spirituality, and the Hidden Curriculum: Medical Student and Faculty Reflections', *Journal of Pain and Symptom Management*, 50.4 (2015), 507–515 (p.512); Franzen, 'Is This Relevant?', p.442.
[59] Puchalski and Ferrell, *Making Health Care Whole*, p.168.

a positive or neutral development, to another it is a 'threat.' Certainly it seems an undue leap to necessarily categorise 'questioning one's religious beliefs' under negative religious coping. Moreover, apparently 'positive' and 'negative' consequences can inform one another. In particular, healthcare literature includes medics' descriptions of experiencing painful or negative short-term changes which ultimately facilitated positive consequences in the long-term. Sabo and Moss's accounts of transformation through painful experiences of loss or vicarious traumatisation are useful examples. Wright suggests that having one's worldview shaken by working in healthcare, while difficult in the short-term, can lead healthcare workers to beneficially abandon potentially harmful notions of 'superhood.'[60] Similarly, Haynes and Kelly explain that while exposure to suffering, grief and loss may, in the first instance, painfully disintegrate parts of a healthcare practitioner's religious worldview, that worldview is often subsequently repaired or renewed. As such, in the long-term, there is either no net change, or there is change for the better.[61]

Secondly, scholars warn against over-emphasising linear conceptualisations of change and continuity. Such presentations have obvious appeal and utility, not least since people experience, and thus often describe, the interface between their life and their religious identity chronologically. Thus, Scheitle assessed the effects of studying different subjects on USA college students' religious worldviews using four quantitative scales, measuring increases and decreases in: religious commitment; spiritual questing; religious struggle; and religious scepticism.[62] Linearity helps when exploring narratives of worldviews shaken but subsequently repaired, strengthened and bolstered. However, Guest and Sharma and Pearce and Denton alike suggest that we ought to resist the widespread tendency to frame religious identity and its dynamics in primarily linear terms, particularly of intensification and diminishment.[63] An example from Cadge's study highlights the need for such caution, citing a doctor who felt he could believe in God or a higher power on some days but not others.[64] This is not linear progression, but ongoing fluctuation. Neither is it a case of simply assenting or not to propositional beliefs; rather, it is a more analogue mode of conviction.

Additionally, caution is needed in relation to homogenised terms such as 'religion' and 'faith.' As we will see in the next chapter, there is growing scholarly suggestion that it is more helpful to conceive of personal faith and worldviews as the sums of parts than as singular entities, not least for the sake

[60] Wright, *Reflections on Spirituality and Health*, p.44.
[61] Haynes and Kelly, *Is there a God in Health Care*, pp.96 and 104.
[62] Christopher P. Scheitle, 'Religious and Spiritual Change in College: Assessing the Effect of a Science Education', *Sociology of Education*, 84.2, (2011), 122-136 (p.125).
[63] Sharma and Guest, 'Navigating Religion,' p.61; Pearce and Denton, *A Faith of their Own,* p.174; Guest et al, *Christianity and the University Experience*, p.119.
[64] Cadge, *Paging God,* p.163.

of subtler analysis.[65] Scheitle seemingly avoids the tendency to merge distinct worldview facets by using four separate scales to measure religious commitment, questing, struggle and scepticism. However, in his discussion, he asserts that science degrees could not be correlated with 'decreasing religious belief.'[66] In compressing commitment, questing, struggle and scepticism into 'belief,' Scheitle flattens his own analysis. Guest et al, by contrast, highlight the complex, multifaceted nature of personal faith by, for example, focussing specifically upon moral change.[67] Similarly, Puchalski and Ferrell detail different facets when they suggest that healthcare work 'can change the clinician – his or *her values, priorities or beliefs* can be altered by the experience.'[68]

Scholars have also observed that healthcare work can force religious and spiritual individuals to make what they perceive to be compromises. For example, in Baker and Wang's study, one participant 'imagined herself having to stand before God, to give an account of why she had allowed her National Health Service paymasters to gag her religious duty.'[69] More broadly, they observed participants' senses that taking a cautious approach to sharing their faith in the clinic represented 'compromised religious integrity.'[70] Strhan's study highlights that compromise is a broader concern among evangelicals. Her participants 'work[ed] on themselves and each other to form themselves as exiles, to be different from those around them.'[71] Yet they had ongoing concerns, particularly because of the urban context in which they lived and worked, that they might compromise this distinctiveness.

There is a temptation, and tendency in the literature, to respectively frame 'shaped by' and 'deployed in' dynamics as, respectively, passive and active dynamics. Curlin observes this tendency within healthcare literature.[72] For example, healthcare practitioners are described as having been 'altered by' their experiences.[73] However, we must not overstate Curlin's observation. In the first place, examples of compromise in the literature do not simplistically portray healthcare practitioners passively. For example, Patel and Shikongo note that, perceiving an anti-religious bias, the South African Muslim psychology students they interviewed 'deliberately change[d] their behaviour and

[65] André Droogers, 'The World of Worldviews,' in *Methods for the Study of Religious Change: From Religious Studies to Worldview Studies,* ed. by André Droogers and Anton van Harskamp (Sheffield, England ; Bristol, Connecticut : Equinox, 2014), 17-42 (p.25); Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' pp.212-213.
[66] Scheitle, 'Religious and Spiritual Change in College,' p.134.
[67] Guest et al, *Christianity and the University Experience,* pp.100-101.
[68] Puchalski and Ferrell, *Making Health Care Whole,* p.166 (emphasis mine).
[69] Baker and Wang, 'Examining Connections Between Values and Practice,' p.132.
[70] Ibid., p.131.
[71] Strhan, *Aliens & Strangers?*, pp.199-201.
[72] Farr A. Curlin et al, 'Religious Characteristics of U.S. Physicians: A National Survey', *Journal of General Internal Medicine*, 20.7 (2005), 629–634 (p.632).
[73] Puchalski and Ferrell, *Making Health Care Whole*, p.166.

dress to appear "professionally acceptable".'[74] This caused them 'tension and distress,' feeling they had compromised their religious integrity.[75] Yet Patel and Shikongo emphasise their deliberateness.

Moreover, the literature also highlights healthcare practitioners negotiating with, and sometimes firmly opposing, aspects of medical practice and culture, and at times seeking to effect change.[76] Knight and Kim, exploring the extent to which spirituality ought to affect healthcare practice from a Christian perspective, reflect that Christian doctors in particular may feel the need to speak out for or against changes in medical culture.[77] This observation is borne out by others, and beyond Christianity. Grant, Cain and Sallaz describe nurses learning to 'artfully negotiate' the relationship between their faith and their work, 'creatively mixing moral images [and] modes of self-presentation.'[78] Wright notes that many nurses dislike and thus question dominant medical discourses, finding them alienating, dehumanising and bureaucratised.[79] Participants in Cadge's study, similarly, privately questioned the expectation that emotion and personal spirituality would not influence their clinical work.[80] Both McSherry and Jamieson's study of British nurses and Patel and Shikongo's study also show participants questioning their fields' under-emphasis on patient and practitioner spirituality.[81] In particular, the literature contains several examples of religious and spiritual medics negotiating – in diverse ways - with expectations and restrictions surrounding prayer and evangelism.[82]

Thus, even as medical culture is a powerful socialising force, scholars observe that healthcare practitioners actively engage with it, as well as being passively 'shaped by' it. In this, the literature broadly echoes Droogers' admonition, to view individuals as both agentic and creative, and subject

[74] Cynthia Joan Patel and Armas E. E. Shikongo, 'Handling Spirituality/Religion in Professional Training: Experiences of a Sample of Muslim Psychology Students', *Journal of Religion and Health*, 45.1 (2006), 93–112. (pp.103-104).
[75] Ibid.
[76] Howard Saul Becker et al., *Boys in White: Student Culture in Medical School* (Chicago, Il: University of Chicago Press, 1961), p.44.
[77] John R. Knight and Walter Kim, 'Christianity,' in *The Soul of Medicine: Spiritual Perspectives and Clinical Practice,* ed. by John R. Peteet and Michael N. D'Ambra (Baltimore: Johns Hopkins University Press, 2011), 96-115 (pp.104-107).
[78] Don Grant, Jeff Sallaz, and Cindy Cain, 'Bridging Science and Religion: How Health-Care Workers as Storytellers Construct Spiritual Meanings', *Journal for the Scientific Study of Religion*, 55.3 (2016), 465–484 (p.482).
[79] Wright, *Reflections on Spirituality and Health,* pp.20-21.
[80] Cadge, *Paging God,* pp.152-153.
[81] Wilfred McSherry and Steve Jamieson, 'An Online Survey of Nurses' Perceptions of Spirituality and Spiritual Care', *Journal of Clinical Nursing*, 20.11–12 (2011), 1757–1767 (pp.1764-1765); Patel and Shikongo, 'Handling Spirituality/Religion in Professional Training,' p.102.
[82] Haynes and Kelly, *Is There a God in Health Care?,* pp.XIX and 195; Martinez and Baker, 'Psychodynamic and Religious?', pp.261-262. See also Edward P. Shafranske and H. Newton Malony, 'Clinical Psychologists' Religious and Spiritual Orientations and Their Practice of Psychotherapy', *Psychotherapy: Theory, Research, Practice, Training*, 27.1 (1990), 72–78 (p.75).

to powerful margins and cultural constraints.[83] Building upon Berger and Luckmann, he depicts a dialectic, between the power of socialisation in shaping individual worldviews, and the exercise of agency in relation to such socialisation.[84] 'Followers [of a worldview] play the twin roles of being both active subject and passive object. They are both subject and subjugated.'[85]

Conclusion

The above has gathered existing scholarly insights as to how particular contexts and life-stages can affect religious and spiritual worldviews, synthesising existing answers to the question, 'How can working in healthcare affect religious worldviews?' It grouped these within a broad, heuristic classificatory device, whereby religious worldviews are either 'deployed in' life and particular contexts, including work, or 'shaped by' them. Existing literature shows that healthcare work can affect religious worldviews by causing them to be deployed as interpretive lenses, and as resources, not least in the form of positive religious coping. Religion and faith can also be 'shaped by' healthcare work: for example, by stimulating questions and doubts; encouraging compartmentalisation; effecting change; causing compromise; or encouraging negotiation and opposition. Healthcare work can also bolster and affirm religious and spiritual worldviews and identities. This heuristic framework is also a useful conceptual tool for considering the ways in which evangelical faith interacts with different life events and contexts, making it especially relevant for this study.

As a heuristic device, this classification draws neat lines which do not always reflect nuances found in reality. This thesis therefore employs it flexibly, showing that the two dynamics often blur and overlap, as do the consequences categorised within them. This thesis also attends to different perspectives and time frames, not abandoning linear conceptions of religious identity, but neither applying them rigidly. It avoids flattening, homogenising or over-simplifying complex individual religion, even as it makes a case for simultaneously conceptualising these holistically.

As noted above, there is some discord as to how religious individuals ought to be framed, particularly regarding the balance of agency and passivity. It is beyond the capacity of this small-scale, focussed study to offer extensive critical comment on the nature of agency. That said, this thesis attends to agency insofar as it highlights instances where individuals engage creatively and critically with 'official' religious (and, indeed, medical) discourses and ideas. It notes the powerful effects of social and institutional pressures, and the medics' negotiations and engagements with

[83] Droogers, 'The World of Worldviews,' p.40.
[84] Ibid., pp.24-26.
[85] Ibid., p.25.

these, and with other experiences and contexts. As such, it allies itself to Droogers' dialectic conceptualisation of religious individuals as both active subject and passive object.[86]

This thesis will follow the evangelical medics as they experience many of these consequences, as their faiths are both 'deployed in' and 'shaped by' life, beginning with the former ('Calling;' 'Resourcing;' 'Opposing') before coming to emphasise the latter ('Questioning;' 'Changing;' 'Compartmentalising;' 'Compromising;' 'Negotiating;' 'Growing.') We will revisit the themes and scholarship in this chapter again as we examine these in detail in relation to this study's findings. Before exploring these consequences, the next chapter two chapters set out the theoretical frameworks utilised, and the qualitative methodology designed and used to capture dynamics and complexities within individual narratives.

[86] Ibid., p.25.

On Work and Worldviews

Introduction

The previous chapter set out existing scholarship which forms the foundation upon which this thesis builds its original insights and contribution. Before the following chapter delves into the methodology, this chapter introduces this thesis's theoretical framework, which blends 'lived religion' and 'worldview' approaches. It uses this framework to conceptualise evangelical medics as dually inhabiting two significant worldviews. It then gives a brief introduction to evangelicalism, before introducing two other significant themes and arguments which this thesis will advance, regarding emotion, and how best to conceptualise individual religion and worldviews.

From Lived Religion to Worldview Studies

This project resonates closely with what are variously termed 'lived religion,' 'everyday religion' and 'personal faith' approaches to religious studies. Such approaches are interested in how individuals translate religion and spirituality into their daily lives, including their workplaces. In recent years, these approaches have been closely associated with Nancy Ammerman and Meredith McGuire. Their research moves intentionally away from the secularisation paradigm, towards an exploration of, as Ammerman writes, 'how spiritual resources are generated, nurtured, and deployed' in everyday life.[1] This incorporates interest in narrative, meaning-making, and ritual, and the forms these take in diverse spheres of life.[2] In focussing upon the individual, both counteract what McGuire designates the 'Western image of religion as a unitary organisationally defined and relatively stable set of collective beliefs and practices.'[3] Alternatively, McGuire suggests thinking of 'religion, at the individual level, as an ever-changing, multifaceted, often messy – even contradictory – amalgam of beliefs and practices that are not necessarily those that religious institutions consider important.'[4] Like McGuire, Ammerman highlights the inadequacy of assuming that religion can be understood in terms of 'strict' beliefs and practices, which individuals adopt 'all or nothing.'[5] In questioning the 'assumption that individuals will commit (or refuse to commit) wholesale, to an

[1] Nancy Tatom Ammerman, *Sacred Stories, Spiritual Tribes: Finding Religion in Everyday Life* (New York: Oxford University Press, 2014), p.7.
[2] Ibid.
[3] Meredith B. McGuire, *Lived Religion: Faith and Practice in Everyday Life* (Oxford: Oxford University Press, 2008), p.186.
[4] Ibid., p.4.
[5] Nancy T. Ammerman, 'Studying Everyday Religion: Challenges for the Future' in *Everyday religion: Observing Modern Religious Lives,* ed. by Nancy T. Ammerman (New York: Oxford University Press, 2007), 219-238 (p.224); Ammerman, *Sacred Stories, Spiritual Tribes,* pp.2 and 300.

'entire, single package of beliefs and practices of an official religion,' McGuire, Ammerman and others thus begin with the individual rather than the institutional.[6]

While such approaches have gained currency in recent decades, they have clear antecedents in mid-twentieth century scholarship, with anthropological work in this vein evident long before the title 'lived religion' became familiar. For example, from the late 1960s, extensive discussion began around 'implicit' versus 'explicit' religion, in an attempt to, as Hutch puts it, 'broaden […] understanding of the nature and dynamics of religion in the individual life.'[7] Godfrey Lienhardt's mid-century work on 'vernacular Christianity' argued that '[r]eligious beliefs were the product not simply of traditional teaching, but of the will, and the reason, being brought to bear upon that teaching in the context of experience.'[8] Lienhardt used this framework to challenge previously dominant binary oppositions between 'primitive' and 'universal' religions, products of early anthropology's colonial milieu.[9]

Also writing in the 1950s, in his *The Individual and His Religion,* Gordon Allport noted secularisation theory's dominance, and sociologists' resultant tendency to focus upon institutional religion, failing to 'think of the participant.'[10] Allport's suggestions mirror those of Thomas Luckmann, one of the first to challenge 'strong' forms of secularisation theory.[11] Drawing heavily on Troeltsch, Luckmann's 'privatisation thesis' suggested that the changes occurring in western religion could be explained by realising that, while necessarily social, religion is not purely institutional.[12] Rather than viewing churches as 'islands of religion' shrinking to disappearance in a quickly secularising world, Luckmann argued that religion was changing, becoming 'invisible' and 'privatised.'[13] He advocated beginning with this 'invisible' religion, rather than inferring as to its nature by analysing shrinking institutions.

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[6] McGuire, *Lived Religion,* pp.11-12; Ammerman, Sacred Stories: Spiritual Tribes, p.2; see also Joska Samuli Schielke and Liza Debevec, 'Introduction' in *Ordinary Lives and Grand Schemes: An Anthropology of Everyday Religion*, ed. by Joska Samuli Schielke and Liza Debevec (New York: Berghahn Books, 2012), 1-16 (p.1).

[7] Hutch, *The Meaning of Lives*, p.2.

[8] Wendy James and Douglas H. Johnson, 'Preface' in *Vernacular Christianity: Essays in the Social Anthropology of Religion,* JASO Occasional Papers ; No.7, ed. by Wendy James and Douglas H. Johnson (Oxford: JASO, 1988), vi-viiii (p.vii).

[9] Ibid; Wendy James and Douglas H. Johnson, 'Introductory Essay: On 'Native' Christianity,' in *Vernacular Christianity: Essays in the Social Anthropology of Religion,* JASO Occasional Papers ; No.7, ed. by Wendy James and Douglas H. Johnson (Oxford: JASO, 1988), 1-12 (p.1-2).

[10] Gordon W. Allport, *The Individual and His Religion: A Psychological Interpretation* (London: Macmillan, 1960), p.28.

[11] Peter Beyer, 'Globalisation and Glocalisation' in *The SAGE Handbook of the Sociology of Religion,* ed. by James A. Beckford and N.J. Demerath (London: SAGE, 2007), 98-118 (p.105).

[12] Ibid., p.99; N.J. Demerath, 'Secularization and Sacralization Deconstructed and Reconstructed' in *The SAGE Handbook of the Sociology of Religion,* ed. by James A. Beckford and N.J. Demerath (London: SAGE, 2007), 57-80 (pp.60-61); Thomas Luckmann, *The Invisible Religion: The Problem of Religion in Modern Society* (New York: Macmillan, 1967), pp.69-70.

[13] Seth D. Kunin, *Religion: The Modern Theories* (Edinburgh: Edinburgh University Press, 2005), p.82; Luckmann, *The Invisible Religion,* pp.p.23, 76, 86-88, 90-98, 100-106.

Similarly, in his 1962 *The Meaning and End of Religion,* Wilfred Cantwell Smith famously differentiated between 'personal faith' and 'cumulative tradition,' highlighting the often substantial differences between individual and corporate forms of religion.[14] Both personal faith and cumulative tradition, he suggested, must be understood as dynamic and changing.

This 'lived' agenda, with interests in the individual as religious agent and the complexity and dynamism of individual faith, overlaps with a recent, significant turn towards a 'worldview' approach within the study of religion. Again, this is an established idea enjoying recent renaissance. Weber worked extensively with the notion of subjectively meaningful 'orientations to the world.'[15] Freud lectured in 1932 on 'The Question of a *Weltanschauung*' ('outlook on the world' or 'worldview') defined as 'an intellectual construction which solves all the problems of our existence uniformly on the basis of one overriding hypothesis, which, accordingly, leaves no question unanswered and in which everything that interests us finds its fixed place.'[16] Droogers and van Harskamp's 2014 edited volume, *Methods for the Study of Religious Change,* is a significant contribution to the re-ignition of a worldview approach. Their goal in moving from religious studies to worldview studies is to incorporate non-religious meaning-systems within fields of inquiry which concern human meaning-making and meaning-seeking.[17] Droogers uses 'culture' to refer to humans' ability to 'develop and assimilate knowledge and thereby attribute meaning to their natural and social worlds' and answer 'ultimate questions.'[18] Worldviews are, then, both a 'human capacity and the result of exercising that [cultural] competence.'[19] Religions, in turn, are a subcategory of worldviews: 'part of a larger field in which people struggle with and for meaning,' alongside, for example, secular ideologies.[20]

Having connected worldviews to the human propensity to seek and create meaning, Droogers explores 'the existential questions that constitute [worldviews'] raw material.'[21] Borrowing from Hijmans and Smaling, he describes five 'basic and ultimate questions that humans universally ask':

- What is considered beautiful (aesthetics)?
- What is morally good behaviour (ethics)?

[14] Wilfred Cantwell Smith, *The Meaning and End of Religion* (London: SPCK, 1978), p.194.
[15] Andrew M. Koch, 'The Ontological Assumption of Max Weber's Methodology' in Texas Journal of Political Studies, 17.1 (1994), 5-21 (p.6). See also Max Weber, *Economy and Society*, ed. by Guenther Roth and Claus Wittich, vol. 1 (Berkeley and Los Angeles, 1968), p.499.
[16] Sigmund Freud, *New Introductory Lectures on Psychoanalysis*, The Pelican Freud Library ; v.2 (Harmondsworth: Penguin, 1973), p.193.
[17] André Droogers and Anton van Harskamp, 'Introduction' in *Methods for the Study of Religious Change: From Religious Studies to Worldview Studies,* ed. by André Droogers and Anton van Harskamp (Sheffield, England ; Bristol, Connecticut : Equinox, 2014), 1-12 (p.2).
[18] Droogers, 'The World of Worldviews,' pp.18 and 23.
[19] Ibid., p.21.
[20] Ibid., pp.17 and 22; Droogers and van Harskamp, 'Introduction,' p.2.
[21] Droogers, 'The World of Worldviews,' p.22.

- Why do humans live and die (ontology)?
- What can be trusted as true (epistemology)?
- How can groups and individuals, in answering these questions, distinguish themselves from others as authentic human beings (identity strategies)?

Droogers suggests worldviews are 'the variety of answers given, in religions, secular worldviews, ideologies and spiritualities' to such questions.[22] He embellishes this by suggesting Ninian Smart's 'seven dimensions' of religion will also characterise any worldview[23]:

- The practical and ritual dimension
- The experiential and emotional dimension
- The narrative or mythic dimension
- The doctrinal and philosophical dimension
- The ethical and legal dimension
- The social and institutional dimension
- The material dimension

Droogers suggests focussing upon such dimensions allows scholars to map and compare worldviews, and to ground explorations of meaning-making firmly in people's lives and practices.[24] These 'basic questions' and seven dimensions could be explored and compared at the level of institutional religion, or 'cumulative traditions.' However, Droogers, like lived religion scholars, places a great deal of emphasis upon the individual.

Taves, Asprem and Ihm build upon Droogers and van Harskamp's approach, commending it for facilitating 'focus on both the explicit, highly rationalized attempts to address ultimate questions often studied by philosophers and scholars of religion and the answers implicit in taken-for-granted ways of life more commonly studied by anthropologists.'[25] Thus they too present worldview studies as means of exploring everyday meaning-making.[26] Taves, Asprem and Ihm, however, propose that worldviews answer a different set of 'big questions': (1) ontology (what exists, what is real); (2) epistemology (how do we know what is true); (3) axiology (what is the good that we should strive for); (4) praxeology (what actions should we take); and (5) cosmology (where do we come from and where are we going).[27] They recognise answers may be fragmentary and contradictory, a conclusion with clear similarities to McGuire's.[28]

[22] Ibid., p.23.
[23] Ibid.; Ninian Smart, *The World's Religions,* 2nd edn (Cambridge: Cambridge University Press, 1992), pp.12-22.
[24] Droogers, 'The World of Worldviews,' pp.23-24.
[25] Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.208.
[26] Ibid., p.212.
[27] Ibid., p.208.
[28] Ibid, pp.208 and 212; McGuire, *Lived Religion,* pp.4 and 15.

Medicine as Worldview

Given this thesis' interests in religious individuals and their day-to-day lives, it might seem that a shift to 'worldviews' offers little to this study which is not already offered by a lived religion perspective. However, precisely because this project is interested in evangelical Christians' translations of their religion into a medical workplace, a worldviews framework is tremendously useful, because it enables us to present medicine as a worldview.

Lecturing on 'Science as a Worldview,' Weber described its devotees as 'disciples' who work in its service.[29] By embracing the scientific vocation, he suggested, one embraces its *Weltanschauung.* Freud, similarly, identified a unique scientific *Weltanschauung.*[30] Many have since compared Western medicine to a religion, acknowledging that, far from being an objective, natural system, Western medicine is a subjective, contingent, culture.[31] Miller-McLemore and Goldman, respectively, frame medicine as a 'religion' and a 'cult' in which both patients and practitioners participate.[32] Vanderpool and Levin argue that 'physicians predicate their analyses and actions upon a worldview affirmed to be uniquely realistic and true,' further suggesting that it is at times 'uncritically worshipped,' and that the doctors who embody and enact it are bestowed with 'apostolic authority.'[33]

Certainly contemporary Western medicine has features and characteristics which answer the 'big questions' and resembled the seven dimensions listed above. A biomedical framework and related epistemologies remain dominant, constituting a 'doctrinal and philosophical dimension.' As Meakes and O'Connor assert, '[t]he modern age, influenced by the scientific revolution that began during the Enlightenment, has made empirical evidence the norm for truth.'[34] Vanderpool and Levin similarly explain that, as a result of this inheritance, 'scientific medicine is taught and practiced from within the framework of a by-and-large naturalistic view of the world.'[35] Knowledge and evidence must be garnered empirically, following protocols and procedures granted legitimacy by a larger scientific

[29] Max Weber, *The Vocation Lectures: 'Science as a Vocation': 'Politics as a Vocation,'* ed. by David Owen and Tracy B. Strong, trans. by Rodney Livingstone (Indianapolis: Hackett Publishing Company, 2004), p.29.
[30] Freud, *New Introductory Lectures,* p.193.
[31] Allen E. Bergin, 'Psychotherapy and Religious Values' in *Journal of Consulting and Clinical Psychology,* 48.1 (1980), 95-105 (p.95); Medard Boss, *Existential Foundations of Medicine and Psychology* (New York; London: J Aronson, 1979), p.xxviii.
[32] Miller-McLemore, 'Thinking Theologically about Modern Medicine,' p.289; Goldman, 'The Placebo and the Therapeutic Uses of Faith,' pp.106-107.
[33] Vanderpool and Levin, 'Religion and Medicine: How are they related?', pp.10 and 15. See also Harold Y. Vanderpool, 'Religion and Medicine: A Theoretical Overview' in *Journal of Religion and Medicine*, 19.1 (1980), 7-17 (pp.8-11).
[34] Thomas St.James O'Connor and Elizabeth Meakes, 'Towards a Joint Paradigm Reconciling Faith and Research' in *Spirituality and Health: Multidisciplinary Explorations,* ed. by Augustine Meier, Thomas St.James O'Connor and Peter I. VanKatwyk (Waterloo, Ont.: Wilfred Laurier University Press, 2005), 11-22 (p.11).
[35] Vanderpool and Levin, 'Religion and Medicine: How are they Related?', p.10.

community. Life and death are presented as biological occurrences, any other potential meanings or significances deemed the purview of other worldviews (except insofar as medicine strives, in most cases, to preserve life). Thus this 'doctrinal' dimension in turn answers two key questions: ontology (why do humans live and die?); and epistemology (what can be trusted as true?).

Western medicine also has significant social and institutional dimensions. Practitioners must be schooled - not least in biomedical doctrine - at recognised institutions, following accredited training paths. Medical school begins one's socialisation into medical culture which, as per Berger and Luckmann's account of the social construction of reality, is subsequently internalised.[36] Upon qualification, professional bodies and institutions 'prescribe standards' and 'endorse certain values over others,' Baker and Wang suggest, shaping and controlling the medical worldview.[37] Their description of the American Psychological Association might also apply to the UK's General Medical Council (henceforth GMC) and specialist medical colleges. Such bodies codify 'ethical and legal dimensions,' thus addressing ethical, axiological and praxeological questions.

These codes legitimise and delegitimise particular medical interventions, regarding ethical issues such as abortion and euthanasia, and expectations around behaviour. As Galanter, Larson and Rubenstone write:

> The incorporation of religious belief into treatments used in psychiatric practice is […] a step beyond sensitivity to patients' beliefs. In taking such a step the practitioner must *depart from the norms for training learned in the officially sanctioned specialty training*.[38]

Consider, for example, recent NHS moves towards condemning so-called 'gay conversion therapy,' a formal change of stance on something which was once condoned.[39]

Insofar as such codes and professional bodies delineate legitimate medical interventions and scientific truths, behaviours and practices, medicine is also concerned with identity strategiesIt differentiates authentic practices, behaviours, attitudes and values from those which are illegitimate, clarifying medicine's authentic practitioners and engaging in boundary maintenance. Sanctions are specified for those who breach such codes. Behavioural codes might also overlap with Smart's 'practical and ritual dimension,' although we should be cautious about overstating the extent to which behavioural codes or particular patterned procedures are in fact 'rituals.'

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[36] Peter Berger and Thomas Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (London: Penguin Books, 1966), pp.78-79.
[37] Baker and Wang, 'Examining Connections Between Values and Practice,' p.126.
[38] Marc Galanter, David Larson and Elizabeth Rubenstone, 'Christian Psychiatry: The Impact of Evangelical Belief on Clinical Practice', *American Journal of Psychiatry*, 148.1 (1991), 90–95 (p.94) (emphases mine).
[39] BBC News, '"Gay Conversion Therapy" to be banned as part of LGBT equality plan,' 3rd July 2018 <https://www.bbc.co.uk/news/uk-44686374 > [Last Accessed 16/06/2020].

Speaking particularly to the UK context, Wright suggests:

> People who work and believe in the values of, for example, a state-funded health service are acting out their values based on their beliefs. Indeed, it could be argued that the NHS is itself a spiritual expression - a practical application of a set of values concerning social cohesion, welfare and equality of provision.[40]

Davies has similarly argued that the NHS has taken on quasi-religious connotations in its provision of cradle-to-grave care, not least amid physical and emotional crises.[41] Thus, in the UK, there is particular endorsement of a medical worldview which defends state-funded healthcare, free to all at the point of need. This cluster of values is relevant to several of the dimensions and big questions: it certainly presents accessible healthcare as authentic and a moral good, and thus speaks to a deeper philosophy of medicine's purpose and goals. Davies suggests that a 'value' is an idea imbued with emotion: 'ideas that have come to be invested with emotion […] become values […] these may assume the status of beliefs as they help in developing a sense of identity in people.'[42] Commitment the NHS's value thus suggests a worldview with particular emotional dimensions, and the potential to contribute to both personal and national identity.

One Self: Two Worldviews

One can thus present Western medicine generally, and medicine within the NHS context particularly, as a worldview. Through its institutions and organisations, teachers, training, leaders, codes of practice and significant documents, a medical worldview, like a religion's 'official' theology, takes on an apparently objective reality. Unlike many non-religious worldviews, it is not overtly self-conscious or, named, as, say, Socialism or Humanism. It does not speak to all of the 'big questions' or dimensions. However, as Taves, Asprem and Ihm note, against Freud, this is commonly the case. They thus describe atheism and agnosticism as 'partial answers' to big questions; exploring them alongside other worldviews can facilitate exploration of 'to what extent worldviews of atheists and agnostics otherwise overlap with the worldviews of theists (and vice versa), and what the implications of these worldview differences might be.'[43]

This question of overlapping worldviews is precisely that with which this project engages. Of those who describe medicine as a religion or worldview, we must ask what the consequences are when another, distinct, potentially rivalling worldview exists alongside and interacts with it. In this case study, that second worldview is evangelical Christianity. The participants in this study can thus be viewed as inhabitants of *two* socialised worldviews: evangelical Christianity; and Western medicine.

[40] Wright, *Reflections on Spirituality and Health*, p.6.
[41] Davies, *Mors Britannica,* pp.18, 100 and 141.
[42] Ibid., p.349. See also pp.120-121.
[43] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' p.208.

Each participant's sense of self is significantly contributed to by both constituent worldviews. We can explore the dynamisms of each; how each contributes to this sense of self; and how these two constituent worldviews relate to each other.

Though this view of single 'selves' at the interface of two different worldviews is a step further than Droogers goes, he hints at such an avenue of exploration. He notes, '[m]ore and more people use two or more cultural and religious repertoires to negotiate their path through the global world,' not least because of the 'current context of interaction between cultures.'[44] Taves, Asprem and Ihm, in noting that different worldviews may be concerned with different 'big questions,' suggest that it is 'clear that they can be combined with various answers to the other "big questions".'[45] By beginning with lived worldviews, they note that one can explore how individuals socialised in multiple and potentially overlapping 'systematized' worldviews combined these, in dialogue with their lived experiences.[46] Like Droogers, and Taves, Asprem and Ihm, this thesis is interested in worldview dynamics, studying 'the meaning-making processes through which people create and develop worldviews over time.'[47] It contributes to such discussions, particularly, by exploring how individuals combine multiple, 'systematized' worldviews.

However, this presents a terminological problem. Since this thesis explores relationships and intersections of two 'systematized worldviews,' it would be confusing to use the term to refer both to the resultant, composite worldview and to both of its constituent parts. As such, this thesis primarily refers to the two constituent worldviews, respectively, as 'work' and 'faith.' With reference to the evangelical medics I opt for 'faith' as opposed to 'religion' primarily because this is the term most of the evangelical participants used to describe their religious worldview and socialisation. It also has the advantage of evoking, simultaneously, Cantwell Smith's 'cumulative tradition' and 'personal faith:' the evangelical medics moved between the two, but use 'faith' to refer to both.

Dynamic Identity

Without wholly eliding worldviews and identity, it is essential to note that the two are closely related, for one's worldview significantly informs one's sense of self. Taves, Asprem and Ihm closely link 'meaning-making' and 'self-making,' presenting identity as 'the internalized and evolving story of the self,' the term 'internalized' capturing these stories' dually social and individual natures.[48] Droogers explains:

[44] Droogers, 'The World of Worldviews,' pp.20-21.
[45] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' p.208.
[46] Ibid., p.212.
[47] Ibid., p.210; Droogers, 'The World of Worldviews,' pp.24-26.
[48] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' pp.208 and 214.

> In raising and answering the five basic questions, and giving form and content to the seven worldview dimensions, people position themselves and determine their identity. Simultaneously however, people with particular worldviews are also perceived by others, and this partially also constitutes their identity.[49]

Both approaches to identity resemble Davies' intentionally broad view. He defines identity as 'the way people understand themselves in relation to other persons, to the world around them' and, given his religious remit, 'to supernatural realms.'[50] It is a consequence of humans' self-consciousness and self-reflection, both upon who they are, and what it is that makes them who they are.[51] Like Droogers, and Taves, Asprem and Ihm, Davies notes that identity is made all the more complex and multifaceted by the social nature of human life, which profoundly shapes individuals' senses of self.[52]

Davies' conception of identity expressly accommodates and accentuates dynamism and change.[53] In *Bishops, Wives and Children,* Davies and Guest thus argue that 'religious identities [are] both present convictions and evolving journeys.'[54] Taves, Asprem and Ihm note that worldviews – and, with them, senses of self – are co-constructed 'in ways of life,' and thus 'evolving.'[55] Since life is not static, and 'change and events happen, the organism must continually make sense of, and adapt to, situations (what is) and events (what is happening).'[56] They thus emphasise processes of questioning and revising information alongside, and indeed above, stability or coherence in exploring worldviews.[57] Droogers notes that individual worldviews are 'influenced by societal change and changing personal circumstances' and thus even 'in a constant tension between continuity and change.'[58] Lived religion scholarship, similarly, emphasises the changeability of individual religion, not least as it interacts with varied life experiences. For example, as we have seen above, McGuire describes individual religion as 'ever-changing,' continuing to deem it 'malleable […] always changing, adapting and

[49] Droogers, 'The World of Worldviews,' p.36.
[50] Douglas James Davies, *Death, Ritual and Belief: The Rhetoric of Funerary Rites*, 3rd edn. (London: Bloomsbury, 2017), p.8.
[51] Ibid., pp.8-9.
[52] Davies, *Mors Britannica,* p.53. See also Douglas James Davies and Mathew Guest, *Bishops, Wives and Children: Spiritual Capital across the Generations* (Aldershot: Ashgate, 2007), p.41.
[53] Davies, *Mors Britannica,* p.52; Douglas James Davies, *Anthropology and Theology* (Oxford: Berg, 2002), p.71; Davies and Guest, *Bishops, Wives and Children*, p.129-130.
[54] Davies and Guest, *Bishops, Wives and Children,* pp.129-130.
[55] Taves, Asprem and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' pp.209 and 214.
[56] Ibid.
[57] Ibid., p.208
[58] Droogers, 'The World of Worldviews,' pp.24-25.

growing.'[59] Speaking particularly to Christian faith, Astley notes that 'the experience of life helps to form and change [people's] theology.'[60]

Evangelicalism

Having explored medical worldviews, this section offers a brief introduction to evangelical worldviews in particular. Beyond Bebbington's historical study, a great deal of scholarly interest in evangelicalism has concerned its engagement with pluralist modernity.[61] During the heyday of secularisation theory, there was a tendency to analyse evangelicalism in a binary fashion, exploring the ways in which groups either resisted or accommodated such cultural contexts in Europe and North America.[62] Peter Berger suggested that processes of subjectivisation and secularisation presented religious groups with a choice between these two 'strategies.'[63] Given accommodation appeared to correlate with decline, there developed a strong association between 'successful' evangelicalism and resistance, protest and opposition to modernity and its cultures.[64] Thus Guest describes UK evangelicalism as a significant 'flash of colour' in the nation's religious landscape, a movement 'whose doctrinally conservative, vehemently defended beliefs are constructed in opposition to a vision of Western culture as morally and spiritually bankrupt.'[65]

In addition to these exogenous origins, associations between evangelicalism and protest also have endogenous roots. Both historically and contemporarily, evangelicalism has been characterised by a distinctive rhetoric of 'the world.'[66] Hunter argues that 'worldly' has long 'been a symbol having immediate and universal meaning for conservative Protestants' who understand 'the world' 'to be tainted by moral impurity.' Thus evangelicalism has often emphasised separation from 'the world.'[67] The 'Farewell Discourse' in John's gospel is an important source for this theological framework. In John 15, Jesus says to his disciples:

> **18** "If the world hates you, keep in mind that it hated me first. **19** If you belonged to the world, it would love you as its own. As it is, you do not belong to the world, but I have chosen you out of the world. That is why the world hates you. (NIV)

John 17 then distinguishes between authentic followers of Jesus and 'the world':

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[59] McGuire*, Lived Religion*, pp.4-5 and 12. See also p.185.
[60] Jeff Astley, *Ordinary Theology: Looking, Listening and Learning in Theology* (Aldershot: Ashgate, 2002), p.24.
[61] Strhan, *Aliens and Strangers?,* p.38.
[62] Ibid.; Penning and Smidt, *Evangelicalism: The Next Generation*, pp.28-29 and 35.
[63] Peter Berger, *The Social Reality of Religion* (London: Penguin Books, 1967)*,* p.156*;* Peter Berger, *A Rumour of* Angels: Modern Society and the Rediscovery of the Supernatural (London: Allen Lane, 1970), pp.19-21 and 25-27; Strhan, *Aliens and Strangers?,* pp.37-38.
[64] Penning and Smidt, *Evangelicalism: The Next Generation,* pp.36-37.
[65] Guest, *Evangelical Identity and Contemporary Culture,* p.3.
[66] Ibid.; Hunter, *Evangelicalism: The Coming Generation,* p.57; Penning and Smidt, *Evangelicalism: The Next Generation,* p.71.
[67] Hunter, *Evangelicalism: The Coming Generation,* p57.

> [14] I have given them your word and the world has hated them, for they are not of the world any more than I am of the world. [15] My prayer is not that you take them out of the world but that you protect them from the evil one. [16] They are not of the world, even as I am not of it. (NIV)

Strhan, drawing on Sennett, also notes the importance of Biblical themes of exile which encourage evangelicals to see God's people as 'not "at home" in this world.'[68]

In recent decades, evangelical scholarship has moved away from an accommodation versus resistance framework, exploring nuances this binary does not capture. Berger embellished his own paradigm, suggesting instead that different religious groups might exhibit accommodation and resistance tendencies to different extents. He came to propose four different means of responding to the 'cognitive contamination' of plural modernity: cognitive bargaining; cognitive surrender; offensive cognitive retrenchment; and defensive cognitive retrenchment.[69] Penning and Smidt, following Hunter, then suggested that other options – particularly 'adaptation' – could also potentially characterise evangelicalism. The point, Penning and Smidt suggest, is that positing 'that the only two possible responses to modernity are acceptance (accommodation) or maintenance of the status quo (resistance) can easily lead to a misinterpretation of change.'[70]

Smith's work on American evangelicalism was particularly significant in pushing beyond the either/or tenor of resistance versus accommodation.[71] His 'sub-cultural identity theory' hinges upon 'engaged orthodoxy': the suggestion that *both* cultural engagement with *and* the maintenance of distinction and boundaries from plural modernity underpin evangelicalism's relative vitality in the USA.[72] More recently, Strhan – focussing upon individuals rather than institutional thriving - has similarly observed the presence of 'complex forms of simultaneous connection with and separation from "secular" others' among conservative evangelicals in London.[73] The participants in her study were 'simultaneously oriented *towards* and sometimes *against* the world.'[74] Strhan thus suggests that standard sociological approaches to evangelicalism fail to capture the ways in which these 'contradictory currents' and 'tensions' shape individual evangelicals' senses of self.[75] Importantly, Strhan's work confirms that moving beyond the accommodation versus resistance binary is as

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[68] Strhan, *Aliens and Strangers?,* pp.51-52; Richard Sennett, *Flesh and Stone: The Body and the City in Western Civilization* (London: Penguin, 2002), p.130.
[69] Peter Berger, *A Far Glory: The Quest for Faith in an Age of Credulity* (New York: Free Press MacMillan Inc., 1992), pp.41-42.
[70] Penning and Smidt, *Evangelicalism: The Next Generation,* pp.36-37; James Davison Hunter, *American Evangelicalism: Conservative Religion and the Quandary of Modernity* (New Brunswick, N.J: Rutgers University Press, 1983), pp.15-16.
[71] Strhan, *Aliens and Strangers?,* p.39.
[72] Ibid.; Smith, *American Evangelicalism*, p.89.
[73] Strhan, *Aliens and Strangers?,* p.40.
[74] Ibid., p.74 (emphases original).
[75] Ibid., p.75.

valuable when considering English evangelicalism in the 21st century as when considering late 20th century American evangelicalism.

Such scholarship has begun disrupting the ease with which evangelicalism can be associated with protest, resistance and opposition. This thesis continues in this vein, particularly following Smith and Strhan. There is an important extent to which resistance and protest shape the narratives and analyses which follow. However, ultimately, this thesis argues that we should avoid over-emphasising protest and give due attention to affinities, which are of equal, if not greater, importance for understanding lived evangelicalism in relation to healthcare work. This observation is closely related to the vocational, medical work explored. It is no coincidence that these evangelicals chose to work in a field to which they felt called, and which they recognised had affinity with Christianity – themes we explore further in 'Calling.' Thus we are not dealing with what Hunter observed when he suggested that 'what is already well known about the place and value of work for Evangelicalism – that work has lost any spiritual and eternal significance.'[76] None of the participants chose to work in medicine for the sake of resistance or opposition. Rather, they managed the tensions and challenges which arose in relation to their faith, while seeking out affinity and consonance, and appreciating the ways in which these occurred naturally. Thus 'Summary and Recommendations' calls for further research to test this thesis' observation - that evangelical medics are as concerned with affinity as with protest - in other fields and contexts.

Observing the complexity and changeability of individual meaning-making, several lived religion theorists emphasise the internal heterogeneity of religious traditions.[77] McGuire proposes that there is 'enormous diversity among individuals within [a] movement – even within the same prayer group.'[78] Certainly British evangelicalism is a diverse phenomenon.[79] In this study, such heterogeneity is particularly significant in two ways. First, it is important in relation to differences between the participants' views, and 'official' or 'authoritative' discourses. In this instance, participants encountered such discourses primarily in their churches, or organisations such as the Christian Medical Fellowship (henceforth CMF). Second, heterogeneity is significant in relation to differences between participants, despite their shared 'evangelical' identification, particularly regarding their conservatism. Arweck and Beckford describe the emergence in late 20th century Britain of 'relatively conservative forms of Christianity […] [with] emphasis on having a personal

[76] Hunter, *Evangelicalism: The Coming Generation,* p.56.
[77] Nathal M. Dessing et al., 'Introduction', in *Everyday Lived Islam in Europe*, ed. by Nathal M. Dessing, Nadia Jeldtoft, Jorgen S. Nielsen and Linda Woodhead (Farnham; Burlington, VT: Ashgate, 2013), 1–8 (p.2). Droogers and van Harskamp, 'Introduction,' p.4; Droogers, 'The World of Worldviews,' pp.19-20; Astley, *Ordinary Theology,* p.40; Allport, *The Individual and His Religion,* pp.29-30.
[78] McGuire, *Lived Religion,* p.4.
[79] Guest, *Evangelical Identity and Contemporary Culture,* p.20.

relationship with Christ […] the truth of the Bible and following strict codes of personal morality.'[80] Many would consider a personal relationship with Christ, emphasis upon the Bible, and strict moral codes basic tenets of all evangelicalism, not merely its conservative strains. Certainly many who emphasise such facets would not consider themselves conservative, reserving this title for those with particular moral stances on issues of gender and sexuality, or more literal interpretations of the Bible. Brown and Lynch's framing is therefore more helpful, defining conservative religion as:

> movements and ideologies which emphasize an authentic expression of religious tradition over its modern reinterpretation [and] tend to hold conservative social positions regarding gender, sexuality and individual autonomy, and engage in various forms of religious and political activism often oriented towards demonstrating the truth of their core convictions.[81]

Some participants in this study considered themselves conservative evangelicals; some determinedly eschewed this label. I avoid applying labels such as 'conservative' except where the participants do so. The exception to this is the CMF which, as I note in the methodology, has a known conservative emphasis. It is important to acknowledge this, for several participants delineated their own and others' conservatism according to whether or not they associated with the CMF, or with some of its particular ethical positions.

Emotion

In exploring constructions of self, meaning and worldview, it is important to attend to emotions. This observation is an old one: the relationship between religion and emotion has been a scholarly concern since the earliest days of religious studies.[82] Both Otto and Schleiermacher placed feeling at the heart of their respective claims that the essence of religion is a '*sensibility* of the numinous' and a '*feeling* of absolute dependence.'[83] Emotion was fundamental for William James, who argued that the immediacy and subjective authority of feelings rendered emotion 'the pivot around which religion revolves.'[84] His work on conversion experiences demonstrated powerful, intimate

[80] Elisabeth Arweck and James Beckford, 'Social Perspectives' in *Religion and Change in Modern Britain,* ed. by Linda Woodhead and Rebecca Catto, (London: Routledge, 2012), 352-372 (pp.356-357).
[81] Callum Brown and Gordon Lynch, 'Cultural Perspectives' in *Religion and Change in Modern Britain,* ed. by Linda Woodhead and Rebecca Catto, (London: Routledge, 2012), 329-351 (p.347).
[82] Gabriele Marranci, *Faith, Ideology and Fear: Muslim Identities within and beyond Prisons* (London ; New York: Continuum, 2009), pp.90-91.
[83] Hans Schilderman, 'Religion and Emotion: Notes on Their Relationship', *Journal of Empirical Theology*, 14.2 (2001), 85–96; Fraser N. Watts, 'Psychological and Religious Perspectives on Emotion', *The International Journal for the Psychology of Religion*, 6.2 (1996), 71–87 (p.75) (emphases mine).
[84] Watts, 'Psychological and Religious Perspectives,' p.75; Gerald E. Myers, 'William James on Emotion and Religion,' *Transactions of the Charles S. Peirce Society*, 21.4 (1985), 463–484 (pp.475 and 480); John Corrigan, 'Introduction: A Critical Assessment of Scholarly Literature in Religion and Emotion' in *Emotion and Religion: A Critical Assessment and Annotated Bibliography,* ed. by John Corrigan, Eric Crump, and John M. Kloos (Westport, CT ; London: Greenwood Press, 2000). 1-19 (p.6).

connections between beliefs and emotions.[85] Geertz's famous definition of religion hinges on its ability to engender 'powerful, long-lasting moods.'[86] Contemporary scholars such as Davies and Corrigan continue to argue that religion cannot be understood without reference to emotion.[87] Yet, for much of the twentieth century, sociologists dominantly conceived of and analysed religion under three headings: belief; practice/activity; and attendance/membership, with much ink spilled over the latter in particular.[88]

Lived religion scholarship expressly seeks to redress the imbalance caused by heavy focus upon attendance and membership, and pay closer attention to what is going on 'on the ground' in individuals' lives.[89] Emotion overlaps very clearly with such scholarship's interest in the individual, their narratives and experiences, and their embodied and material practices.[90] In the mid-20th century, Allport wrote that an individual's religion 'must be viewed as an indistinguishable blend of emotion and reason, of feeling and meaning [as] emotion and logical thinking fuse.'[91] More recently, in her study with young people exploring religion, Collins-Mayo observed 'both a commitment to understanding the objective aspects of the faith tradition and subjectively engaging with it both cognitively and emotionally.'[92] Droogers, of worldview studies, similarly notes the importance of attending carefully to emotion, explaining that while a 'focus on meaning-making may sound as if a worldview is both a rational and perceived system […] experience, behaviour and emotion nourish the form it takes as well.'[93]

Providing an overview, Neitz concurs that interest in the felt dimension of religious meaning-making is profoundly consonant with lived religion, yet notes that empirical emphasis has fallen most heavily

[85] Myers, 'William James on Emotion,' p.473.
[86] Schilderman, 'Religion and Emotion,' p.91.
[87] Douglas J. Davies, *Emotion, Identity, and Religion: Hope, Reciprocity and Otherness* (Oxford: Oxford University Press, 2011), p.9; John Corrigan, 'Introduction: The Study of Religion and Emotion' in *The Oxford Handbook of Religion and Emotion*, ed. by John Corrigan (New York ; Oxford: Oxford University Press, 2008), 3-13 (p.12).
[88] Ammerman, 'Introduction,' p.4; Ammerman, 'Challenges for the Future' p.223; David Voas and Abby Day, 'Recognizing secular Christians: Toward an unexcluded middle in the study of religion', *The Association of Religion Data Archives* (2010) <http://www.thearda.com/rrh/papers/guidingpapers.asp>, p.4. [Last accessed 15/06/2020].
[89] Mary Jo Neitz, 'Lived Religion: Signposts of Where We Have Been and Where We Can Go From Here' in *Religion, Spirituality and Everyday Practice,* ed. by Giuseppe Giordan and William H. Swatos Jr. (Dordrecht ; New York: Springer, 2011), 45-55 (pp.46-54).
[90] McGuire, *Lived Religion,* pp.4 and 12-13.
[91] Allport, *The Individual and His Religion,* p.18.
[92] Sylvia Collins-Mayo, 'Choosing My Religion: Young People's Personal Christian Knowledge', in *Religion and Knowledge: Sociological Perspectives*, ed. by Mathew Guest and Elisabeth Arweck (Farnham ; Burlington, VT: Ashgate, 2012), 149-164 (p.162).
[93] Droogers, 'The World of Worldviews,' p.22.

upon belief, materiality and practice.[94] Many lived religion scholars thus expressly reject suggestions that personal religion is purely cognitive, even though few expressly explore or emphasise emotion.[95] For example, both Ammerman and McGuire note that religion is not wholly cognitive, yet they stop short of drawing attention to emotion, instead emphasising belief and practice. Ammerman, drawing on Bruner, describes narratives as 'account[s] of what one thinks one did in what settings in what ways for what felt reasons,' and considers religious and mystical experiences, rituals, and crises, but stops short of exploring feelings *per se.*[96] Though she mentions the importance of emotion and embodiment, and refers to values, perceptions and commitments, the definitional refrain which runs through McGuire's work is religious 'beliefs and practices.'[97]

This thesis will show that by focussing explicitly and centrally upon emotion, alongside beliefs and practices, our understanding of lived evangelicalism can be greatly enriched. As such, throughout this thesis I emphasise the significance of emotions, not *alongside* practice and beliefs, as if of secondary importance, but on an equal footing. Full answers to this thesis' research questions require exploration of emotions as well as beliefs and practices, understanding the three as dynamic, interrelated dimensions of individual worldviews. Just as lived religion research emerged from the need to emphasise that which was already there, so this study suggests we must recover emotion from its current under-emphasis in order to fully appreciate everyday religious belief and practice.

Emotion is no easy thing to define, either in itself or in relation to thoughts and behaviours.[98] The following chapters refer primarily to 'emotions,' 'beliefs' and 'practices.' While this draws apparently clean lines between the three, this is for the sake of analysis, and in order to expressly highlight the importance of emotion. Really, the three are closely and often dynamically interrelated. As de Waal writes, '[p]erhaps the greatest misunderstanding about emotions is that they are the opposite of cognition […] the two actually go together and cannot operate without each other.'[99] As noted above, Davies highlights this insofar as he defines a belief as an emotionally-laden idea.[100] However, I

[94] Neitz, 'Lived Religion,' pp.46-51.
[95] Linda Woodhead, 'Tactical and Strategic Religion', in *Everyday Lived Islam in Europe*, ed. by Norman Dessing et al. (Farnham ; Burlington, VT: Ashgate, 2013), 9–22 (p.14); Astley, *Ordinary Theology*, p.6; Robert A. Orsi, 'Afterword: Everyday Religion in the Contemporary World: The Unmodern or What was Supposed to have Disappeared but Did Not' in *Ordinary Lives and Grand Schemes*: *An Anthropology of Everyday Religion*, ed. by Joska Samuli Schielke and Liza Debevec (New York: Berghan Books, 2012), 146-161 (p.153).
[96] Ammerman, *Sacred Stories, Spiritual Tribes,* p.13. Ammerman, 'Introduction,' p.5; Ammerman, 'Challenges for the Future,' pp.219 and 226-227.
[97] McGuire, *Lived Religion,* pp.3-5, 12-13, 16-17 and 185.
[98] Watts, 'Psychological and Religious Perspectives,' p.76; Schilderman, 'Religion and Emotion: Notes on Their Relationship,' p.87.
[99] F. B. M. de Waal, *Mama's Last Hug: Animal Emotions and What They Teach Us about Ourselves* (London: Granta, 2019), pp.204-205.
[100] Davies, *Mors Britannica*, p.349. See also pp.120-121.

intentionally substitute 'belief' for Davies' 'idea' to refer to the thought dimensions. This is because these were rarely merely ideas to the medics in this study, as the following analyses will demonstrate. That is, the thought ideas explored do indeed perform the identity-forming and identity-bestowing functions Davies identifies. Again, therefore, we do well to note the blurred lines between beliefs and emotions in particular, even as I render them logically distinct. Additionally, scholars working on emotion, following Damasio, often differentiate between emotions (bodily reactions to internal and external stimuli) and feelings (the private, internal experience of emotions, as mental representations.) This distinction is not followed closely in this thesis, precisely because the participants themselves did not utilise any such contrast. Thus the term 'feelings' is, in places, used alongside 'emotions.'[101]

Conceptualising Worldviews

This thesis will also consider how best to conceptualise worldviews and personal faith. Several scholars have suggested that, at the level of individuals, worldviews and religion are messy to the point of being incoherent, inchoate or incomplete.[102] Droogers, for example, suggests that worldviews may be used fragmentally, and for any given individual their worldview may be more or less choate or consciously relied upon.[103] He writes:

> Meaning seems to come to light in an ad hoc manner, in the course of living the experience. It may even remain implicit, without being directly verbalized, as an intuitive model or script that is readily available for future use. It may be filed away to be retrieved again one day, usually in fragments, when it is needed.[104]

In this Droogers echoes Martin Stringer. Stringer is foremost among scholars who have suggested that individual faiths are better understood as the sums of parts than as systematic or comprehensive wholes. In *Contemporary Western Ethnography and the Definition of Religion*, his goal is to form 'a new definition [of religion] that is rooted in people's unsystematic use of belief statements, their intimate relationships with the non-empirical other, and their need to cope pragmatically with everyday problems.'[105] Drawing on Ahern's work, he emphatically argues that:

> What is important is not the system, but the individual statement made at a particular time for a particular purpose […] for most ordinary people in England, the idea of a coherent system of beliefs held by each individual is meaningless.[106]

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[101] See Marranci, *Faith, Ideology and Fear,* p.95, and de Waal, *Mama's Last Hug,* pp.204-205.
[102] Droogers, 'The World of Worldviews,' p.22.
[103] Ibid., pp.22 and 37. See also Stephen Kliewer and John W. Saultz, *Healthcare and Spirituality* (Oxford: Radcliffe, 2006), p.15.
[104] Droogers, 'The World of Worldviews,' p.25.
[105] Martin D. Stringer, *Contemporary Western Ethnography and the Definition of Religion* (London: Continuum, 2008), pp.113-114.
[106] Ibid., p.51.

In Stringer's view, very few 'ordinary people' see their beliefs as part of holistic, comprehensive, 'grand' or integrated systems: '[I]ndividuals do not have to construct grand theories […] [t]hey do not need to understand the detailed [workings].'[107] Rather, beliefs are held in isolation.[108] Consequently, individuals may hold totally contradictory beliefs, using them in different circumstances for different purposes.[109] Writing several decades before Stringer, Allport likewise suggested that most individuals:

> are not sufficiently contemplative […] to adopt in toto the explanation offered by any one master theologian […] In times of acute desire, it is not the perfection of a system as a whole that satisfies but some aspect of it that renders intelligible and supportable the needs of the moment.[110]

Rather than seeking a systematic, comprehensive personal worldview, individuals are satisfied for their worldviews to be rather messier, drawn upon primarily in the form of particular facets. McGuire typifies this movement away from the expectation that worldviews will be systematic or comprehensive, arguing that individual religion 'is not fixed, unitary or even coherent' and 'only a small and unrepresentative proportion [of religious people] struggle to achieve tight consistency among their wide-ranging beliefs, perceptions, experiences, values, practices and actions.'[111] Echoing Stringer, she suggests that it is not logical coherence between these many and diverse facets which matters, but the practical coherence and effectiveness of a worldview as used in everyday life.[112]

This school of thought regarding how best to conceptualise individual worldviews, religion and faith will be important in the coming chapters, not least as we explore different forms of compartmentalisation. However, this thesis hesitates to therefore assert that personal faith and worldviews are unsystematic, piecemeal constructions. Even insofar as this conceptualisation will prove useful, we will also see the importance of being able to understand worldviews as holistic entities, and of being able to move between these analytical levels. As such, it comes to echo Taves, Asprem and Ihm, who pragmatically hypothesise that 'worldviews occupy a middle ground that is neither completely episodic (situation dependent) nor completely coherent (situation independent) with considerable variation between these extremes.'[113]

[107] Ibid., p.109.
[108] Ibid., p.49.
[109] Ibid., p.39.
[110] Allport, *The Individual and His Religion,* p.19.
[111] McGuire, *Lived Religion*, pp.12 and 16.
[112] Ibid., p.15.
[113] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' p.212.

Conclusion

The above has set out foundations on which this thesis rests, and parts of what it seeks to build upon them. Noting close similarities between 'lived religion' and 'worldview' approaches, this thesis begins with the individual, exploring how they construct their worldviews in conversation with experiences in their day-to-day lives. In particular, it proposes that evangelical medics simultaneously inhabit two worldviews: evangelicalism and Western medicine. This thesis is concerned with the formation of a single 'self' at the interface of these two social phenomena, and in conversation with experiences of healthcare work. This chapter also introduced three theoretical bases from which this thesis will make critical observations, regarding: the associations between evangelicalism and protest; the centrality of emotion for understanding lived religion; and how best to conceptualise individual worldviews. The next chapter charts the development and deployment of a methodology specifically designed for this project.

Methodology

Introduction

The Study of Religion has no single or dominant methodology. Rather, as Hart aptly puts it, it has something 'akin to a smorgasbord, as scholars choose from a variety of often pre-existing techniques or skills to construct their own methodological amalgam' both theoretically and practically appropriate for the study at hand.[1] As such, the Study of Religion is well-poised for creativity: method is not a 'straitjacket' but a site for originality, creativity, improvisation and *bricolage*.[2]

Social science researchers have what May deems 'a duty to themselves and to others to reflect upon and acknowledge both the strengths and weaknesses of the different methods that they employ.'[3] I use this chapter to do as May as suggests, reflecting on the methodology developed for this project, which was indeed a product of *bricolage*, creativity and improvisation. I first detail the aims and rationale which underpinned this 'autobiographical elicitation' methodology. I then set out the recruitment and data-collecting processes, followed by the analytical processes, presenting these transparently, to facilitate evaluation of the processes used to move between data and conclusions.[4] Finally, I reflect on the methodology's outcomes and my own positionality, so that readers can assess this thesis's claims and analyses in light of these.

Aims and Rationale

As explored above, this project blends a lived religion approach with a worldviews framing in order to explore relationships between faith, working life and identity among evangelical Christians. This approach places individuals, and their day-to-day lives and work, squarely in focus. Four methodological aims emerged from this theoretical approach. First, a qualitative methodology was clearly necessary, in order to gain deep insights into experiences, opinions, values and meanings.[5] As

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[1] Patrick Hart, 'Theory, Method, and Madness in Religious Studies', *Method & Theory in the Study of Religion*, 28.1 (2016), 3–25 (p.14); Catrien Notermans and Heleen Kommers, 'Researching Religion: The Iconographic Elicitation Method', *Qualitative Research*, 13.5 (2012), 608–625(pp.608-609 and 621).

[2] Michael Stausberg and Steven Engler, 'Introduction: Research methods in the study of religion/s' in *The Routledge Handbook of Research Methods in the Study of Religion*, ed. by Michael Stausberg and Steven Engler (Abingdon, Oxon: Routledge, 2011), 3-20 (p.5).

[3] Tim May, *Social Research: Issues, Methods and Process*, 4th edn. (Maidenhead: McGraw-Hill/Open University Press, 2011), p.158.

[4] Martyn Denscombe, *The Good Research Guide for Small-Scale Social Research Projects*, 2nd edn. (Maidenhead: Open University Press, 2003), p.274; Alan Bryman and Robert G. Burgess, 'Developments in Qualitative Data Analysis: An Introduction' in *Analyzing Qualitative Data*, ed. by Alan Bryman and Robert G. Burgess (London ; New York: Routledge, 1994), 1-17 (p.11).

[5] Kathleen Gerson and Ruth Horowitz, 'Observation and Interviewing: Options and Choices in Qualitative Research' in Qualitative Research in Action, ed. by Tim May (London: SAGE, 2002), 178-200 (p.178); Droogers and van Harskamp, 'Introduction,' pp.4-5; McGuire, *Lived Religion,* p.17; Astley, *Ordinary Theology,* p98.

Ammerman suggests, it is very difficult to richly capture the complexity of individual lived religion in quantitative measures.[6] By contrast, small-scale qualitative research usefully facilitates the in-depth study of real-world phenomena, capturing complexities and relationships, painting a rich and detailed picture of the particular instance under consideration.[7]

Second, the research themes and agenda had to be shaped by participants. It is always important that researchers do not unduly impose pre-conceived categories or ideas upon participants. However, it is especially pressing when using lived religion or worldview approaches, given their emphases upon learning from people's experiences, and taking seriously their agency and knowledge.[8] Though less liable to fall into such difficulties than quantitative, standardised measures, there is no guarantee that qualitative methodologies will be truly guided by what is relevant and meaningful to those being studied.[9] McGuire suggests that 'it is simply impossible to construct a research instrument that anticipates all the possible elements individuals might choose to weave into their own personal beliefs and practices.'[10] However backhandedly, this affirms the importance of being data-led, participant-led and open in lived religion research. As Astley highlights, this involves examining – and seeking to remove – 'a priori conceptualizations,' which can restrict both researcher and researched.[11]

Third, balanced against participant direction, the resultant data needed to be comparable, and focused upon the project's central themes, in order to facilitate analysis and theorising. I sought the advantages that May sees in semi-structured interviewing, which he describes as 'allow[ing] people to answer more on their own terms than the standardised interview permits, but still provid[ing] a greater structure for comparability over that of the focused or unstructured interview.'[12] Fourthly and finally, the process needed to be convenient and flexible for busy participants. This was not a purely practical consideration: it was important that the project was not so demanding as to preclude those with extensive demands upon their time.

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[6] Nancy T. Ammerman, 'Introduction,' p.14). See also Ammerman, 'Challenges for the Future', p.224.
[7] Ammerman, 'Challenges for the Future,' p.226; Denscombe, *The Good Research Guide*, pp.30-31.
[8] Stringer, *Contemporary Western Ethnography*, p.29; *The Individual and His Religion*, p.6; Schielke and Debevec, 'Introduction,' p.3; Woodhead, 'Tactical and Strategic Religion', p.12.
[9] Karen Henwood et al., 'Researching Risk: Narrative, Biography, Subjectivity', *Historical Social Research / Historische Sozialforschung*, 36.4 (2011), 251–272 (pp.252-253); David Gauntlett and Peter Holzwarth, 'Creative and Visual Methods for Exploring Identities', *Visual Studies*, 21.1 (2006), 82–91 (p.84).
[10] McGuire, *Lived Religion,* p.17.
[11] Astley, *Ordinary Theology,* pp.99-100.
[12] May, *Social Research,* p.135.

In view of these four aims, semi-structured interviewing appeared a suitable method.[13] However, pilot work using a prototype semi-structured interview schedule highlighted two limitations. First, I had fallen into the trap of defining the research parameters, topics and themes myself, embedding these in the interview schedule, rather than allowing the pilot participants to tell me what was important. Secondly, the limits of what can be communicated within a short interview became very evident: the participants had not explicitly considered the topics before, and were thus thinking on their feet, occasionally grappling for hypothetical answers, especially where I had raised a topic of little relevance to them. One participant rang me the next day, explaining that after further thought, and a difficult day, he would now give completely different answers. Many scholars have similarly noted that semi-structured interviews often produce limited data, since participants are asked for immediate responses, and have no time for reflection.[14] While I considered sending participants questions in advance as a corrective, this would not ensure I shaped the interviews according to what the participants deemed important.

In order to maximise their potential for generating rich qualitative data, I looked to complement semi-structured interviews with other methods, and shape the whole methodology to be more participant-led. A mixed methodology would also afford the advantages of triangulation and a larger dataset.[15] Moreover, particularly in recent years, social researchers have been rapidly developing methodologies which emphasise participants' frameworks and meanings, giving those researched greater control over the research process and its products.[16] There was, therefore, a wealth of participant-focused options from which to draw inspiration, and develop a methodology which fulfilled my four aims while avoiding the pitfalls I had noted of semi-structured interviewing. The result was a *bricolage*, drawing particularly on two interrelated developments in methodological theorising and practice: the narrative turn; and elicitation interviews.

During and beyond the 1970s, many academic disciplines experienced a 'narrative turn.' Scholarship came, increasingly, to recognise the previously-neglected importance of narrative and storytelling, treating these as primary means by which humans relate, make sense of, and find meaning in their

[13] Jennifer Rowley, 'Conducting Research Interviews', *Management Research Review*, 35.3/4 (2012), 260–271 (p.262). See the almost identical phrasing in May, *Social Research,* p.131.
[14] Marilys Guillemin and Sarah Drew, 'Questions of Process in Participant-Generated Visual Methodologies', *Visual Studies*, 25.2 (2010), 175–188 (p.181); Gauntlett and Holzwarth, 'Creative and Visual Methods,' p.84.
[15] Houghton et al., 'Rigour in Qualitative Case-Study Research,' pp.12–17; Anna Bagnoli, 'Beyond the Standard Interview: The Use of Graphic Elicitation and Arts-Based Methods', *Qualitative Research*, 9.5 (2009), 547–570 (p.568).
[16] See, for example, Wendy Hollway and Tony Jefferson, 'Eliciting Narrative Through the In-Depth Interview', *Qualitative Inquiry*, 3.1 (1997), 53–70; Gauntlett and Holzwarth, 'Creative and Visual Methods,' pp.82-89; Guillemin and Drew, 'Questions of Process,' p.178.

experiences.[17] For example, in Theology and the Study of Religion, scholars proposed multiple ways in which to utilise 'reflection on religious claims embedded in stories.'[18] Indeed, of narrative theology, Comstock claims this was so significant and diverse a turn that it cannot be described as a single movement, rather a 'loose family of Christian scholars' who utilised varying definitions and conceptualisations of narrative to descriptive, explanatory and justificatory ends.[19] The narrative turn has had profound consequences for methodological practice and theorising, inspiring creativity within and beyond religious social research.[20] In particular, it has fostered the development of methodologies which are participant-led, or emphasise participants' agency. Researchers work closely with individuals' stories and representations of their experiences, and relinquish 'strict control' over the research's direction, instead turning a measure of control over to participants.[21] Their aim is to create optimal conditions for people to narrate their stories.[22]

In this vein, lived religion scholars have advocated particular qualitative methods and methodologies, variously recommending: narrative analysis; ethnography and participant observation; grounded theory; photo-elicitation; life history interviews; and oral, autobiographical diaries.[23] While interviewing remains a dominant method, researchers have adapted and embellished it.[24] Often borrowing from biographical and life-history methodologies, questions are deliberately open, and often tailored for particular interviewees, with a flexible structure which

[17] Nancy T. Ammerman and Roman R. Williams, 'Speaking of Methods: Eliciting Religious Narratives through Interviews, Photos, and Oral Diaries', in *Annual Review of the Sociology of Religion*, ed. by Ole Riis and Luigi Berzano (Leiden: Brill, 2012), 117–134 (pp.117-118); David Yamane, 'Narrative and Religious Experience', *Sociology of Religion*, 61.2 (2000), 171–89 (p.182); Arthur P. Bochner, 'Narrative's Virtues', *Qualitative Inquiry*, 7.2 (2001), 131–157; Wade Clark Roof, 'Religion and Narrative', *Review of Religious Research*, 34.4 (1993), 297–310, (pp.298-301) .

[18] Gary L. Comstock, 'Two Types of Narrative Theology', *Journal of the American Academy of Religion*, 55.4 (1987), 687–717; George W. Stroup, 'Bibliographical Critique', *Theology Today*, 32.2 (1975), 133–143 (p.133).

[19] Comstock, 'Two Types of Narrative Theology,' p.689.

[20] Susan E. Chase, 'Narrative Inquiry: Still a field in the making' *The SAGE Handbook of Qualitative Research*, ed. by Norman K. Denzin and Yvonna S. Lincoln, 4th edn. (London: SAGE, 2011), 421-434 (p.421); Ammerman and Williams, 'Speaking of Methods,' pp.117-118; Yamane, 'Narrative and Religious Experience,' pp.172-174; Roof, 'Religion and Narrative,' pp.298-301.

[21] Henwood et al, 'Researching Risk,' p.257. See also Chase, 'Narrative Inquiry,' p.423.

[22] Ammerman and Williams, 'Speaking of Methods,' pp.119-120; Hollway and Jefferson, 'Eliciting Narrative,' p.60.

[23] Ammerman, 'Challenges for the Future,' pp.226-229; Ammerman, *Sacred Stories, Spiritual Tribes,* pp.13-14; Stringer, *Contemporary Western Ethnography,* p.29; Roman R. Williams, 'Space for God: Lived Religion at Work, Home and Play', *Sociology of Religion*, 71.3 (2010), 257–279 (pp.260-261).

[24] Ammerman and Williams, 'Speaking of Methods,' pp.120-121; Robyn Fivush, 'Religious Narratives, Identity, and Well-Being in American Adolescents', in *Religious Voices in Self-Narratives*, ed. by Marjo Buitelaar and Hetty Zock (Berlin, Boston: De Grutyer, 2013), 105-128 (pp.117-118).

allows the participant substantial control.[25] As Ammerman and Williams explain, whether researchers invite comprehensive 'life histories' or more 'episodic' narratives around particular themes, the goal is to elicit specific accounts, rather than only gathering generalisations.[26] Elicitation interviews – particularly photo elicitation interviews – have grown in significance. Researchers have utilised them as opportunities to put participants' stories at the heart of the methodology, in order to 'illuminate important aspects of lived experience that might otherwise have been overlooked.'[27] Most commonly, photo elicitation interviews involve inviting participants take photos which illustrate a key research theme in significant ways for them as individuals, perhaps over the course of several weeks. These photos are then used as a stimulus for discussion in follow-up interviews.[28] Provided with more or less broad instructions, participants can decide what they photograph, as well as what they subsequently share regarding the meaning and inspiration behind the images.[29] Additionally, these methodologies often produce much richer data than traditional interviews, not least because of the time provided for reflection and consideration, allowing participants to consider their views and explanations in advance of the interview.[30]

Since incorporating photographs in a study of healthcare work in patient-focussed environments was inappropriate, I explored diaries and autobiographies as alternative creative outputs which could underpin elicitation interviews. Written diaries facilitate reflection on day-to-day life. Used as a research method, they can yield rich data, balancing guidance as to particular topics of interest with participants' decisions regarding what to incorporate.[31] Moreover, writing a diary is relatively

[25] Hollway and Jefferson, 'Eliciting Narratives,' pp.60-63; Henwood et al, 'Researching Risk,' pp.256-257; Steph Lawler, 'Narrative in Social Research' in *Qualitative Research in Action,* ed. by Tim May (London: SAGE, 2002), 214-228 (p.215).

[26] Ammerman and Williams, 'Speaking of Methods,' pp.120-122. See also Hollway and Jefferson, 'Eliciting Narrative,' p.67; and Henwood et al, 'Researching Risk,' pp.259-260.

[27] Guillemin and Drew, 'Questions of Process,' p.176. See also Sarah L. Dunlop and Pete Ward, 'Narrated Photography: Visual Representations of the Sacred among Young Polish Migrants in England', *Fieldwork in Religion*, 9.1 (2015), 30–52 (pp.33-34); Ammerman and Williams, 'Speaking of Methods,' p.123; Cindy Dell Clark, 'The Autodriven Interview: A Photographic Viewfinder into Children's Experience', *Visual Studies*, 14.1 (1999), 39–50 (p.40).

[28] Guillemin and Drew, 'Questions of Process,' p.176; Clark, 'The Autodriven Interview,' p.40.

[29] Dunlop and Ward, 'Narrated Photography,' pp.34-35; Bagnoli, 'Beyond the Standard Interview,' p.566; Asma Mustafa, 'Faith and Photography: Using Auto-Photography in Eliciting Perceptions of Religious Identity' in *Fieldwork in Religion,* 9.2 (2014), 166-181 (p.171).

[30] Roman R. Williams and Kyle Whitehouse, 'Photo Elicitation and the Visual Sociology of Religion', *Review of Religious Research*, 57.2 (2015), 303–18 (pp.311-315); Notermans and Kommers, 'Researching Religion,' p.610; Guillemin and Drew, 'Questions of Process,' p.181; Gauntlett and Holzwarth, 'Creative and Visual Methods,' pp.84-86; Mustafa, 'Faith and Photography,' p.171.

[31] Julia Bennett, 'Researching the Intangible: A Qualitative Phenomenological Study of the Everyday Practices of Belonging', *Sociological Research Online*, 18.4 (2013), para.3.2; Ammerman and Williams, 'Speaking of Methods,' p.124.

unobtrusive and familiar, especially for highly literate professionals.[32] Indeed, given increasing emphasis upon reflexive practice within medical training, such an exercise would be relatively familiar to healthcare practitioners.[33] Day-to-day reflections, however, would not necessarily capture memories or past accounts. The more longitudinal perspective of an autobiography would better achieve this, and could be usefully blended with the convenient and familiar diary format.[34]

As such, I invited participants to record autobiographical reflections, supplying a list of broad, relevant themes, and encouraging them to tell stories and provide examples. Following an initial discussion about the project, I suggested participants take four weeks to record reflections at their own pace (though I suggested adding regular entries). I then received and analysed these reflections, and used them to design a flexible semi-structured interview schedule for each individual. To my knowledge, such an 'autobiographical elicitation' methodology has not been used before in the Study of Religion. It has clear consonance with the lived religion agenda and worldviews frameworks: it takes seriously individuals as agentic religious practitioners, treating their narratives as reflections and expressions of their worldviews. It can generate rich qualitative data around specific research interests in what Ammerman and Williams summarise as a 'guided but self-directed fashion.'[35] Following a second pilot study with six evangelical doctors, which demonstrated the method's effectiveness, I continued recruiting and utilising this methodology, incorporating these six participants in the final sample.

Access and Data Collection

I recruited participants in two ways. In the first place, regional CMF groups often provided useful points of access. The CMF is a Christian medical organisation, with a strong evangelical ethos. I used their website to contact the local representatives by email, and we met so that I could explain my research, and they could ask me any questions. They then acted as gatekeepers, passing on project information to those likely to volunteer interest. Secondly, I recruited through large evangelical churches, several of which had many doctors and nurses in their congregations, often by virtue of their proximity to significant teaching hospitals. It was important to use this second recruitment strand in order to broaden the sample, so as to not exclude evangelical doctors who found the CMF's conservative ethos dissuaded them from membership. In addition to their affiliation to these

[32] Bennett, 'Researching the Intangible,' para.3.2.

[33] Kirsti Malterud and hanne Hollnagel, 'Avoiding Humiliations in the Clinical Encounter' in *Scandinavian Journal of Primary Health Care*, 25.2 (2007), pp.69–74 (72).

[34] Davies and Guest, *Bishops, Wives and Children,* p.125.

[35] Ammerman and Williams, 'Speaking of Methods,' p.128. See also Roof, 'Religion and Narrative,' pp.302-308; and Marjo Buitelaar and Hetty Zock, 'Introduction: Religious Voices in Self-Narratives,' in *Religious Voices in Self-Narratives: Making Sense of Life in Times of Transition,* ed. by Marjo Buitelaar and Hetty Zock (Berlin, Boston: De Grutyer, 2013), 1-8 (pp.1-3).

evangelical organisations, most participants expressly identified themselves as evangelical. However, British evangelicalism is a diverse phenomenon.[36] Ammerman and Woodhead both note that, when seeking to explore individual religion and spirituality, researchers are reliant upon participants' self-descriptions as religious (or not) but must also question why they have chosen that description, how, and to what effect.[37] This was borne in mind throughout.

I expanded the sample with a combination of snowball and purposive sampling.[38] Snowball samples begin with a small number of people, and grow as those participants invite others in their networks to participate.[39] As we will see below, snowball sampling is not without risks: however, it also affords a range of benefits. As May 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.'[40] One is awarded a degree of social capital by virtue of knowing members of a network, which helps facilitate access. This project used several small 'snowballs,' each developing around either a particular location or medical specialty, as those I had interviewed offered to connect me with others.

Generalisability is a difficult and contentious question in small-scale qualitative research. This project was not designed or intended to provide representative or generalisable data.[41] It was, however, important to recruit purposefully, in order to avoid excluding significant voices or creating an unduly homogenous sample.[42] This was particularly important given the tendency for snowball sampling to implicitly exclude certain voices, as participants recommend others with similar characteristics and experiences to their own.[43] I therefore reviewed the sample's composition continually, monitoring several demographic characteristics, combining snowballing and purposive sampling strategies (see

[36] Guest, *Evangelical Identity and Contemporary Culture,* p.20; Rob Warner, *Reinventing English Evangelicalism, 1966-2001: A Theological and Sociological Study*, Studies in Evangelical History and Thought (Milton Keynes: Paternoster Press, 2007), pp.1-35.
[37] Ammerman, 'Challenges for the Future,' p.225; Woodhead, 'Tactical and Strategic Religion,' p.12.
[38] See Mustafa, 'Faith and Photography,' p.169 for a similar approach; Lynn Davidman and Arthur L. Greil, 'Characters in Search of a Script: The Exit Narratives of Formerly Ultra-Orthodox Jews', *Journal for the Scientific Study of Religion*, 46.2 (2007), 201–216 (p.204); Christy D. Moran, 'The Public Identity Work of Evangelical Christian Students', *Journal of College Student Development*, 48.4 (2007), 418–434 (p.421).
[39] W. Lawrence Neuman, *Basics of Social Research*: *Qualitative and Quantitative Approaches*, 3rd edn. (London: Pearson Education, 2011), pp.149-150.
[40] Tim May, *Social Research*, p.145.
[41] Denscombe, *The Good Research Guide,* p.172
[42] Mustafa, 'Faith and Photography,' p.169; Valeria Lo Iacono, Paul Symonds, and David H.K. Brown, 'Skype as a Tool for Qualitative Research Interviews', *Sociological Research Online*, 21.2 (2016), 1–15 (p.3, para 2.5).
[43] May, *Social Research*, pp.145-146; Anna Davidsson Bremborg, 'Interviewing,' in *Routledge Handbook of Research Methods in the Study of Religion,* ed. by Michael Stausberg and Steven Engler (Abingdon: Routledge, 2011), 310-322 (p.314).

Figure 1).[44] Additionally, as Neuman suggests, purposive recruitment is particularly useful for studies such as this, whose aim is to explore previously under-researched topics.[45]

In particular, I set out to capture a variety of medical specialties within the sample, as healthcare is not all of a piece. This project is interested in how evangelicals respond to, interact with, and accommodate different everyday life experiences within their worldviews. As such, it needed to attend to the ways in which different areas of healthcare might generate different kinds of experiences. As this thesis will reinforce, medical specialties do not all expose practitioners to death, illness and suffering in the same ways or to the same extents; they do not all deal with the body in the same ways; they do not all deal with ageing; they do not all have the same relationship with religion and spirituality. 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) (see Figure 1). Additionally, the sample included several people who had left medicine to change career, or begun work in another capacity alongside medicine.

Different career stages also present different experiences and challenges. It was thus 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 (see Figure 1). By ensuring a spread of career stages, I was also able to capture varying levels of seniority, as well as historical changes within medical culture, law and training since the late 1960s. By controlling for career stage, I could also control for age.

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 resulting sample consisted of 13 males and 12 females. Three participants were BAME and one of mixed heritage. Participants also practised and lived in variety of locations across England, thereby accommodating variations in experience according to location.[46]

[44] Neuman, *Basics of Social Research*, pp.149-151.
[45] Ibid.
[46] Locations are either omitted or disguised.

GENDER		CAREER STAGE				REGION (ENGLAND)			
MALE	FEMALE	TRAINEE	JUNIOR	SPECIALIST	RETIRED	North East	North West	Midlands	South East
13	12	4	5	10	6	8	1	7	9
WORK PATTERN[47]		ETHNICITY		SELF-IDENTIFIED AS EVANGELICAL?		SPECIALTIES[48]			
Full Time	Part Time	White British	Non-White British	Yes	No	Psychiatry or child psychiatry		5	
20	5	21	4	23	2	General Surgery		1	
						General Practice (GP)		8	
						Accident and Emergency (A&E)		1	
						Neurology		1	
						Palliative Medicine		2	
						Geriatric Medicine		1	

FIGURE1 - DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE AT TIME OF INTERVIEW

While most methodologies are demanding of researchers, this one is particularly demanding of participants, certainly by comparison attending a single interview: there are more meetings, more communications, and an autobiographical exercise. One of the doctors who withdrew explained that he was too busy to participate, and early on it was conspicuous that the most willing volunteers were either retired, or worked part-time. It was therefore essential to emphasise the flexibility built into the methodology's design, so as not to discourage those who worked full-time.

In addition to 22 evangelical doctors, retirees, and medical students, I also worked with three other participants. Amelia is a paediatric nurse who was raised in the Roman Catholic tradition. Thea is a retired psychiatrist who identifies as a Christian, but affiliates with several of different denominations, evangelicalism not significant among them. Finally, Mel is an evangelical Christian who formerly worked as an A&E nurse. I incorporate their narratives in my thesis at certain points, with care, for two reasons: first, because instances in which their experiences bear close similarity to

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

[48] 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 25.

the evangelical doctors' should give pause for thought regarding what it is which underpins that similarity; secondly, and relatedly, because these examples hint at the broader applicability of some of the ideas under consideration, extending this thesis' observations into other Christian denominations, and other healthcare professions. While this by no means equates to generalisable points, it does valuably illustrate areas for future comparative work, which I highlight in 'Summary and Recommendations.' In sum, the sample comprised 25 individuals, 23 of whom self-identified as evangelical. Appendix 1 details basic information about each pseudonymised participant, for ease of reference. Figure 1 gives an overview of the sample's demographic characteristics. Interviews were an average of 54 minutes long, and in all but two cases these were preceded by a period of autobiographical reflection, resulting in a written or audio-recorded output by the participant.[49]

Participants compiled their autobiographical reflections over several weeks. While the instructions suggested a four-week period, I did not apply this rigidly, favouring flexibility. I proactively contacted participants I suspected had forgotten, and ensured the agreed timeframes suitably accommodated busy schedules and holidays.[50] Since I wanted to hear about anything the participants felt was important or relevant, and not constrain them, the instructions balanced guidance against explication that I wanted to learn from the participants and their experiences.[51] The instructions were 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?

[49] Amelia's interview was part of the initial pilot study; Ben wrote a list of themes to discuss in an interview, rather than a set of reflections. We worked through his suggested themes as his interview.
[50] Guillemin and Drew, 'Questions of Process,' pp.181-182.
[51] For studies which struck a similar balance, see ibid., p.180, Bagnoli, 'Beyond the Standard Interview,' p.555; and Hollway and Jefferson, 'Eliciting Narrative,' p.66.

Upon receiving the reflections from each participant, I then designed individual semi-structured interview schedules.[52] These were designed to probe for greater depth, seek clarifications and further examples, and test emerging ideas, while remaining open to the participants' direction, expressly noting that they must not let me 'put words in their mouths.'[53] Because I used them to test emerging ideas, the interviews were both an opportunity to focus upon individual participants and their narratives, and a more traditional exercise in gaining comparative responses around a set of relevant themes and ideas, even where not directly raised by the participant being interviewed.[54] The interviews were audio-recorded and transcribed verbatim.

Analysis

Lived religion research and worldview approaches lend themselves to inductive reasoning. Thus, rather than beginning with abstractions, Droogers and van Harskamp recommend an iterative, inductive approach to qualitative data analysis. Having encouraged participants to tell complex and dynamic stories, unveiling their individuality and idiosyncrasies, '[researchers] must move back and forth between the abstract generalisations and he concrete cases' to make sure emerging analyses truly reflect individual, everyday realities.[55] In addition to sitting within this theoretical milieu, this study also set out to generate and broaden theory. My analysis thus needed to support such generative, illustrative goals, alongside a commitment to participant-led, inductive reasoning. After each wave of data collection, this process of generating theory and ideas grounded in the participants' narratives began with open, inductive thematic coding, followed by purposive coding. I managed and stored data using qualitative data analysis software NVivo11. [56]

As each set of reflections was returned to me, and each interview transcribed, I updated and refined a list of thematic codes, returning to previous data sources to ensure that the whole data set was

[52] Unfortunately, due to illness, I was not able to conduct Philip's follow-up interview.

[53] Hollway and Jefferson, 'Eliciting Narrative,' p.66; Gerson and Horowitz, 'Observation and Interviewing,' p.192.

[54] Bennett, 'Researching the Intangible,' para. 3.4; Hollway and Jefferson, 'Eliciting Narrative,' p.55; Charlotte Aull Davies, *Reflexive Ethnography: A Guide to Researching Selves and Others*, 2nd edition. (Abingdon, Oxon ; New York: Routledge, 2008), pp.105-106.

[55] André Droogers and Anton van Harskamp, 'Introduction to Part I,' *Methods for the Study of Religious Change: From Religious Studies to Worldview Studies,* ed. by André Droogers and Anton van Harskamp (Sheffield, England ; Bristol, Connecticut: Equinox, 2014), 13-17 (p.13). See also Astley, *Ordinary Theology*, pp.100-106. This bears clear similarities to grounded theory: see Lisa Burkhart and Nancy Hogan, 'An Experiential Theory of Spiritual Care in Nursing Practice', *Qualitative Health Research*, 18.7 (2008), 928–938; and Greg Guest, Arwen Bunce, and Laura Johnson, 'How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability', *Field Methods*, 18.1 (2006), 59–82.

[56] Denscombe, *The Good Research Guide,* pp.275-276; Alan Bryman and Robert G. Burgess, 'Reflections on Qualitative Data Analysis' in *Analyzing Qualitative Data,* ed. by Alan Bryman and Robert G. Burgess (London and New York: Routledge, 1994), 216-226 (p.221).

eventually coded using the same, full list.[57] During this iterative process, I noted observations and potential hypotheses, refining these in light of each new data source, going back and forth from the data until I was confident these were robust. In particular, I considered whether the emerging frameworks helped to explain not only the data set as a whole, but also applied equally well to the reflections and interview transcripts separately, thereby ensuring that they were supported by multiple sources.[58] After completing open thematic coding, I returned to the data for purposive coding and analysis. I looked specifically at those themes seeming significant and worthy of further exploration, comparing their manifestations across the data. I repeated this process throughout the study as needed. The open and purposive analytical phases shed light upon each other, resulting in a richer picture than either phase alone would have generated.

Among my purposive analyses was an exploration of emotion. To analyse its role, I coded specifically for emotions and feelings, to see what could be learned from placing these at the centre of attention. Here, it was important to not only read the transcripts and reflections, but, where possible, to listen to them again, since many of the emotional nuances were captured in tone of voice as much as in explicit 'feeling words.' I focused upon instances where the participants' religious identities were interacting with their work (since medicine can be emotional and emotive of itself). I also took care to distinguish between different types of narrative. As Schilderman notes, one must differentiate between different timeframes, for emotions operate very differently at micro (seconds/minutes) meso (days/weeks) and macro (months/years) levels.[59] In this case, it was particularly important to differentiate generalisations drawn across whole careers from the more nuanced emotions associated with particular instances and incidents, or groups of similar instances.

Studying emotion poses particular challenges, which bring into sharp focus some of the broader challenges of social research.[60] Social researchers must grapple with the limited extent to which any of us can know ourselves, let alone articulate such knowledge.[61] This is of particular note when it comes to the retrospective study of emotion: people can reshape the emotional contours of their memories, whether for better or worse.[62] As Gwen said in her interview: 'Maybe I've forgotten the

[57] May, *Social Research,* pp.152-153.
[58] Bagnoli, 'Beyond the Standard Interview,' p.568.
[59] Schilderman, 'Religion and Emotion: Notes on Their Relationship,' p.87.
[60] John Corrigan, 'Introduction: Emotions Research and the Academic Study of Religion' in *Religion and Emotion: Approaches and Interpretations,* ed. by John Corrigan (Oxford: Oxford University Press, 2004), 3-31 (p.18).
[61] Woodhead, 'Tactical and Strategic Religion,' pp.12-13.
[62] Richard J. Davidson and Paul Ekman, 'Afterword: What Is the Relation Between Emotion and Memory' in *The Nature of Emotion: Fundamental Questions*, ed. by Paul Ekman and Richard J. Davidson (New York: Oxford University Press, 1994), 316-318.

angst because it's now in the past.' Davies and Guest note this, suggesting that researchers ought to be conscious that they are specifically handling retrospective narratives.[63] Thus, the ever-present problematic of memory takes on particular significance in a study which deliberately emphasises emotions. Personality types and emotional registers also have an effect.[64] When placing emotion squarely at the centre of empirical work, a researcher is forced to reflect further on the ways in which different research instruments facilitate emotional openness. They must also consider the different degrees to which people are in touch with their emotions, or willing to express them. In this study, some participants were very open about their feelings and emotions, while others kept their reflections and responses on more intellectual, factual, or hypothetical planes. In sum, though, the dataset for this study was rich in emotion, suggesting that its two-stage autobiographical elicitation process was well-suited to a project concerned with emotions. While not necessarily comprehensive, the emotional recall this project did elicit was certainly extensive.

Since the data was collected using a method inspired by the narrative turn, it was sensible for analysis to be governed, additionally, by a narrative framework. As Yamane highlights, there are multiple ways in which we can take 'individuals' narratives as our data in studying religious experience,' whether as a single analytical method, or as part of a larger analytical toolkit.[65] The literature reveals a spectrum of narrative analytical approaches, ranging from the less technical to the highly technical.[66] At the most technical end of the spectrum are those which remain closest to the narrative turn's origins in narratology and literary studies, focussing closely on the construction of narratives, particularly in written forms, and often defining narratives in quite narrow terms.[67] However, Roof suggests that most narrative analysis is now commonly undertaken in a broader vein, without so much attention to 'semiotics or hermeneutics or deconstruction.'[68] These forms of analysis rely, instead, upon a broad definition of narrative, and an equally broad interest in elements common to many narratives: plot; characters; causality; genre; audience; personal impressions; moral judgements; and the ways in which coherence is sought or found across varied events and

[63] Davies and Guest, *Bishops, Wives and Children,* p.130.
[64] Richard J. Davidson and Paul Ekman, 'Afterword: How Do Individuals Differ in Emotion-Related Activity? *The Nature of Emotion: Fundamental Questions*, ed. by Paul Ekman and Richard J. Davidson (New York: Oxford University Press, 1994), 342-342.
[65] Yamane, 'Narrative and Religious Experience,' p.176.
[66] Peter Collins, 'Congregations, Narrative and Identity: A Quaker Case Study' in Mathew Guest, Karin Tusting, and Linda Woodhead, *Congregational Studies in the UK: Christianity in a Post-Christian Context*, Explorations in Practical, Pastoral and Empirical Theology (Aldershot: Ashgate, 2004), 99-112 (pp.99-101); Chase, 'Narrative Inquiry,' pp.421-423; Ammerman and Williams, 'Speaking of Methods,' pp.117-118.
[67] Collins, 'Congregations, Narrative and Identity,' p.100; Chase, 'Narrative Inquiry,' pp.421-423.
[68] Roof, 'Religion and Narrative,' p.297.

interactions.[69] Within the Study of Religion, particular attention is given to individuals' negotiations with culturally available religious and spiritual narratives: analyses focus specifically upon the ways in which religious and spiritual actors use, adapt or eschew the religious and spiritual narratives to which they are exposed.[70] At the least technical end of the spectrum, are those approaches which define 'narrative' in the broadest of terms: materials are classified as narratives simply because they are being narrated.

I took a 'Roofian,' mid-spectrum approach to the narrative elements within the data. As we have seen, lived religion research expressly allows for people's religious and spiritual narratives to be incoherent, complex, and even contradictory. As such, it was essential not to employ a narrative framework which anticipated the 'achieving of coherence' or the seeking of resolution.[71] I paid attention to narrative features, and particularly characters, causation and plot, moral judgements and the presence and absence of coherence, as well as considering the ways in which the participants were, consciously and unconsciously, appropriating extant religious narratives.

Outcomes and Positionality

This autobiographical elicitation methodology yielded rich qualitative insights, comprising of comparable data, centred on individual narratives and experiences. Participants recorded unique stories and experiences in their autobiographical reflections, raising things they felt were important, and things I had not anticipated. Equally, because each of them had referred to my instructions, their diverse narratives and comments remained conducive to comparison. Because they derived from the reflections, even the unique follow-up interviews continued to build a comparable picture of those same themes.

Since the interviews were based on both the intimacy and prior knowledge afforded by my having read each person's reflections, and having communicated with (and, often, met) them beforehand, they built upon the qualitative depth already provided, while also providing space to explore ideas emerging from other people's reflections and my preliminary analyses.[72] The reflection period successfully facilitated deep thinking: in interviews, participants referred back to ideas they had considered during the autobiographical exercise, and very rarely struggled for answers. Importantly, they were comfortable telling me when something I asked about was simply not relevant, or was

[69]Ibid., pp.298-299; Collins, 'Congregations, Narrative and Identity,' pp.100-101; Lawler, 'Narrative in Social Research,' p.217; Ammerman and Williams, 'Speaking of Methods,' pp.117-118; Yamane, 'Narrative and Religious Experience,' pp.183-184.

[70] Roof, 'Religion and Narrative,' p.302; Buitelaar and Zock, 'Introduction,' p.1; Davies, *Reflexive Ethnography,* pp.5-6.

[71] McGuire, *Lived Religion,* pp.3-4.

[72] Mustafa, 'Faith and Photography,' p.179; Bennett, 'Researching the Intangible,' p.3, para. 3.4.

framed wrongly, an honesty perhaps partly facilitated by our having communicated previously. Elicitation and interview methodologies can suffer from participants' inclinations to present socially acceptable or unrepresentatively positive accounts.[73] While it is impossible to be certain that the participants were wholly truthful or honest, that they blended the wonderful with the difficult, and successes with failures, suggests that this study suffered from no particular problems in this sense. They also knew in advance that their accounts would be pseudonymised, with identifying details removed.

The effects of participating in qualitative research have been a topic of growing interest in recent decades. Scholars have discussed the potential therapeutic, reflexive, and consciousness-raising value of such encounters.[74] I enquired about how the participants found taking part, eliciting useful feedback and enthusiastic interest in future contact. The feedback suggested that the participants had consistently found the process not only feasible and convenient, but also interesting, useful, and enjoyable:

> Gwen: Can I be simple-minded and say I've enjoyed it? Because honestly! I've found it quite – quite useful […] you don't usually sit down and have a look at the last fifty years of your life.
>
> Martha: [Y]eah – not too difficult. Not at all. Um, and I think you were very understanding of constraints. […] It's made me think about my work and faith more, definitely, and I think that's – it's a good thing. There's not much 'press pause' time in medicine, so actually it's been good for me as well […] even just recognise that, yeah, I do want to talk to more Christian medics, or you know, how am I going to deal with my guilt about not being perfect!
>
> Richard: I've found it enjoyable. It's been interesting, it's been stimulating to think about things – and, um, write them down, and formalise them […] You came along and you explained things to begin with, which was super, and the statements you put down as questions on the sort of areas I might want to cover I thought were really helpful, but you made clear that you weren't expecting me to say anything about those, and that was actually just to facilitate my thinking

It is worth noting that, while most participants chose to type their autobiographical reflections, several preferred to hand-write or to audio-record them, clear that they would not happily have used another method. This highlights the importance of allowing multiple different means of recording. Additionally, it is perhaps no coincidence that one of the participants who withdrew from the project was someone I had not met in person. While using video-conferencing software can save time and resources, potentially increasing engagement and participation, it is important to

[73] Bennett, 'Researching the Intangible,' p.3, para 3.5; Guillemin and Drew, 'Questions of Process,' p.180.
[74] Guillemin and Drew, 'Questions of Process,' p.178; Gauntlett and Holzwarth, 'Creative and Visual Methods,' p.82.

deliberate whether these benefits are worth sacrificing some of the interpersonal connection, trust, rapport and honesty afforded by face-to-face meetings.[75]

Connolly notes that, 'insiders and outsiders face rather different challenges' when studying religion.[76] Coar and Sim conclude that 'the insider's understanding of a professional culture is neither better nor worse than that of an outsider – the appropriate approach relates to the objectives of the study.'[77] As Wilson summarises:

> Questions of researcher identity have traditionally been framed in terms of […] "outsiders" and "insiders." […] In religious studies, the debate concerned whether an "outsider" could truly understand religion and whether an "insider" could be objective enough to engage in academic research on their own faith.[78]

However, as Wilson continues, 'the debate has now become considerably more sophisticated than this simple dichotomy suggests […] both individual identity and societal structures are considerably more complex than a binary distinction can allow.'[79] Thus, we ought to nuance Connolly's approach, and reflect on the challenges inherent in a researcher's complex status as both insider and outsider. Indeed, more broadly. Wilson concludes that all researchers must consider the 'complexity of [their] own position' in relation to their participants.[80]

As an evangelical Christian, with no experience of working in healthcare, these questions were important to consider throughout the project. I was very clearly an 'outsider' to my participants, in that they knew I did not have any personal experience of healthcare work. I made this clear in written documents given to participants, and in personal introductions when we met. This 'outsider' status was extremely useful. The participants were expecting to explain medical culture and terminology to me, and consistently did so. Given the project's aims of understanding the relationship between evangelicalism and healthcare practice from an insider's perspective, it was

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[75] Hannah Deakin and Kelly Wakefield, 'Skype Interviewing: Reflections of Two PhD Researchers', *Qualitative Research*, 14.5 (2014), 603–616 (pp.604-605 and 612); Sally Seitz, 'Pixilated Partnerships, Overcoming Obstacles in Qualitative Interviews via Skype: A Research Note', *Qualitative Research*, 16.2 (2016), 229–235 (p.229); Iacono, Symonds and Brown, 'Skype as a Tool,' paras. 1.4-1.8; Ammerman and Williams, 'Speaking of Methods,' pp.121-122. Of course, this methodology and literature both relate to a pre-COVID context. Time will tell whether the observed and perceived disadvantages of videoconferencing will soon change substantially, since so many have so quickly adapted to videoconferencing as a medium for communicating and relationship-building in recent months.

[76] Peter Connolly, 'Introduction', *Approaches to the Study of Religion,* ed. by Peter Connolly (London and New York: Cassell, 1999), 1–9 (p.2); Denscombe, *The Good Research Guide,* p.169.

[77] Luan Coar and Julius Sim, 'Interviewing One's Peers: Methodological Issues in a Study of Health Professionals', *Scandinavian Journal of Primary Health Care*, 24.4 (2006), 251–56 (p.255).

[78] Tim Wilson, 'Researching Lived Islam as an Evangelical Anglican Minister: How Truthful, How Forthright and How Static Should I Be?', *Fieldwork in Religion*, 10.1 (2015), pp.97–114 (p.106).

[79] Ibid., p.106.

[80] Ibid., p.107.

important that the 'obvious' was not left unsaid by virtue of being assumed. Moreover, the participants were thus clearly positioned as experts within the research relationship, empowering them to share their knowledge, in line with the aim of allowing them to shape the research agenda.

As for religion, the situation was more complex. I am an evangelical Christian and attend an evangelical Church of England church. My religious affiliation, and in some cases the churches I have attended, were known to many of the participants, and when asked about my faith I was open about it. Significantly, my evangelical identity afforded a shared discourse. I was able to communicate with the participants freely and easily, neither party concerned about framing questions or answers using Biblical references, theological concepts, or terms such as 'home-group' or 'quiet time.' Relatedly, our shared faith facilitated rapport and trust. Coar and Sim, reflecting on interviewing their peers within healthcare practice, note that insider-interviewers 'can gain potentially rich insights by capitalising on a shared culture and a common stock of technical knowledge, as well as feelings of collegial trust.'[81] Certainly the participants' language and discourse indicated that they perceived me to have a 'common stock of [*religious*] knowledge' and 'shared [*religious*] culture'. Though the participants were, for the large part, not well known to me, it was valuable to be able to capitalise on a shared culture and shared knowledge, gaining rich insights, based on a trust borne out of a known mutual religious empathy.

It is still common in religious research, and social research more broadly to see assertions such as Denscombe's, suggesting researchers should be 'neutral […] passivity and neutrality are the order of the day' and 'should as far as possible suspend personal values and adopt a non-judgemental stance.'[82] Similarly, Neuman writes that, in order to help 'respondents feel they can give a truthful answer,' the interviewer must 'build rapport' yet 'remain neutral and objective […] non-judgemental […] not reveal personal opinions, verbally or nonverbally.'[83] In this study, however, my religious non-neutrality allowed me to both build rapport *and* facilitated truthful answers, based on empathy deriving from mutual understanding. My personal contacts at large evangelical churches, which facilitated purposeful snowball sampling, were another advantage afforded by my insider status within English evangelicalism.

That said, because of the breadth and diversity of English evangelicalism, I was not simplistically a religious 'insider.' In particular, many of the participants came from a more conservative position than I did, evident from the churches they attended, their self-descriptions, or their stances on

[81] Coar and Sim, 'Interviewing One's Peers,' p.255. See also Hutch, *The Meaning of Lives,* pp.16-17.
[82] Denscombe, *The Good Research Guide,* pp.171 and 178.
[83] Neuman, *Basics of Social Research,* pp.197-198.

particular ethical issues. Thus, while total neutrality may inhibit good interviewing and research relationships, Neuman and others are quite correct in noting that adopting a 'non-judgemental' stance and 'not reveal[ing] personal opinions' remain important interviewing skills in some contexts.[84] Certainly it would have risked undermining rapport and trust had I been very precise about exactly where I stood on particular theological and ethical issues, or had I shown, visibly or verbally, that I disagreed with certain viewpoints.

Moreover, it was important to combine this complex religious 'insider' status with appropriate critical detachment. As Roof notes:

> much attention in religious studies over the years has been given to the "insider-outsider" debate, to verstehen (modelling individual perspectives), *epoché* (suspension of belief), "bracketing" of truth claims, "methodological agnosticism," and, more recently, self-reflexivity, all in an effort to minimise bias or misrepresentation on the researcher's side.[85]

Similarly, Coar and Sim note that 'familiarity of the "insider" with the area of study may dominate the process of data analysis and prevent novel insights.'[86] In this regard, my complex insider-and-outsider relationship with my participants, and thus with their experiences, was of further advantage. While I could reap the benefits of rapport and shared discourse, I was genuinely learning from scratch about how evangelical faith translated into healthcare contexts. This certainly meant I was much less likely to risk over-familiarity. Moreover, building on several years of empirical and theoretical work on evangelical Christianity, I was also able to bring a critical, open mind, borne of experience balancing my own evangelical commitments against analytical rigour. This often required conscious efforts at detachment, supported by triangulating my analyses with those who did not come from an evangelical perspective. Connolly writes:

> students [of religion] should bring to their enquiries neither a commitment to the truth or accuracy of one or more religious views of the world nor a conviction of their falsity or inaccuracy. An open mind is the primary requisite.[87]

While I may have personal commitments to the truth of an evangelical worldview, I feel Connolly creates a false dichotomy in suggesting that one cannot thus be open-minded.

Conclusion

Social science research is not best conducted by simplistically re-applying tools from one project to another. For this project, the autobiographical elicitation methodology I developed had the

[84] Ibid.
[85] Wade Clark Roof, 'Research Design,' in *The Routledge Handbook of Research Methods in the Study of Religion,* ed. by Michael Stausberg and Steven Engler (Abingdon, Oxon: Routledge, 2011), 68-80 (p.76).
[86] Coar and Sim, 'Interviewing One's Peers,' p.254.
[87] Connolly, 'Introduction,' p.2.

undeniable strength of placing participants centre-stage, allowing their experiences, narratives and ideas to significantly shape the research, eliciting rich and comparable qualitative data. This highlights this methodology's clear consonance with lived religion and worldview framings. We can thus move, confidently, into exploring the Christian medics' narratives, experience and identities, beginning with their conceptions of 'calling.'

Calling

"When I work, I feel that I am fulfilling my calling. I feel God equipped me to do medicine and do it well."

Introduction

'Vocation' has become an unfamiliar term in contemporary western culture and scholarship: it is used infrequently and imprecisely.[1] Where 'calling' and 'vocation' are used in academic literature exploring religion and healthcare work, they receive little exploration, as though self-evident in meaning.[2] Yet in certain circles – evangelicalism included – calling and vocation are significant discursive concepts, deserving of thorough investigation.[3]

This chapter begins exploring the relationship between healthcare work and evangelical faith and identity by examining calling and vocation. It highlights the participants' varied language and experiences, evident within a widely-shared evangelical logic, operating on macro, meso and micro levels. While it finds clear echoes of the largely benign portrayals found, for example, in Williams' or Fowler's work, it suggests that in order to fully capture the subtleties and significance of calling and vocation, we must recover a Weberian approach. While a sense of godly calling can be positive for evangelical medics, it can also be burdensome.

Medicine: The Meso-Calling

Several participants embraced discourses of 'vocation' or 'calling' to articulate their belief that medical work was God's purpose for their lives. Ginny described her 'strong sense' that medicine was a '[v]ocation not a job,' echoing others' suggestions that a vocation is *more* than a job.[4] She had felt God speaking clearly at a time of career transition: '[I] sat in the churchyard to pray and looked up – the inscription at the bottom of the gravestone was 'peace after pain.' [I] felt this was God

[1] Ammerman, 'Challenges for the Future,' p.233; Robert N. Bellah, Habits of the Heart: Individualism and Commitment in American Life (Berkeley: University of California Press, 1985), p.66.
[2] Cadge, *Paging God,* pp.168-169 and 186-187; Puchalski and Ferrell, *Making Health Care Whole,* p.175. Ying Chen et al, 'Sense of Mission and Subsequent Health and Well-Being Among Young Adults: An Outcome-Wide Analysis,' *American Journal of Epidemiology*, 188.4 (2019), 664–73 (pp.664 and 669). The authors acknowledge their measures of 'a sense of mission and purpose' were insufficiently precise.
[3] Williams, 'Constructing a Calling,' p.255.
[4] James W. Fowler, *Weaving the New Creation: Stages of Faith and the Public Church* (San Francisco: Harper Collins, 1991), pp.119-120.

speaking to me re picking up palliative medicine again.' Goodluck explained that after applying to study medicine:

> I felt very challenged, I was about to make the largest decision of my life to date, and at no point had I consulted God in this process […] and – so we prayed about it! […] And the spirit of God listens to what you're saying even when you're not praying, in that as soon as hands were laid on me and I closed my eyes, I had a very very clear picture of – in the darkness, a stake being placed in the ground and two snakes wrapping themselves round it. And that is one of maybe two images I've ever had in my life […] real, religious experience. And so after ten seconds I told them to stop praying, and I knew that this is – this is my life. And I've got to say, ever since, actually, that I'm doing what God wants me to do.

The 'clear picture,' received as a teenager and reinforced 'ever since,' left Goodluck certain God had 'called' him to a medical 'life.'

Martha and Simon both also had strong senses of vocation, but not as the result of religious or prophetic experiences. Simon had 'no doubt at all in my mind that [medicine] was a vocation' and 'what God wanted me […] to do.' He had felt this way throughout his career, but believed it 'even more so' with retrospect. In part, he inferred his sense of God-given vocation from 'a number of directions which were […] redirected.' Explaining her motives for pursuing medicine, Martha divorced her sense of vocation from 'any kind of, prophetic thing,' but nevertheless 'definitely felt it was vocational' and 'felt really deeply that that was where everything was pointing.' She continued, explaining 'as I grew up and learnt more about who I was, I felt like the qualities and characteristics God gave me were very well fitted for medicine.' Indeed, she measured her future career aspirations against these qualities:

> There are [areas] where I don't think I would be using the gifts God has given me. […] I wouldn't want to do something that is hands off, like radiology, [and] I wouldn't want to be a surgeon – it's not what I'm gifted at.

Several participants, though cautious about the terms vocation and calling, shared Martha's belief that God had given them gifts particularly suited to medicine. Jeremy had 'tried to […] look at the person that I think that God has made me, and find a career that best suited those attributes. And that's why I picked medicine.' While he felt 'having […] a personal calling is overplayed in the modern Christian scene,' and thus queried the discourse, Jeremy embraced the logic of calling. He found it 'joyful to be able to spend so much time exercising the gifts that God has given me.' Similarly, Martha explained that working in medicine had 'encouraged me in my faith as when I work, I feel that I am fulfilling my calling. I feel God equipped me to do medicine & do it well, so I feel encouraged & blessed to live this out.'

Others simply had strong underlying senses that their medical work was part of God's purpose and plans for their lives. While also avoiding the language of calling, Peter was clear that 'God's led me here […] I love it, and I definitely think it's where God's put me.' David tried not to 'ponder' vocation 'too much, because I think you can get a bit big-headed if you start thinking, "Oh here you are, you've become this *wonderful* doctor with God-given purpose."' Yet he nevertheless described his career-long strategy of:

> hoping that by my faith, using prayer […] that it will become obvious that I'm not in the right place. Umm. And I don't seem to have had that message over the years […] whether you've got a faith or not, you sometimes look at a crossroads and think that was a mighty strange coincidence, that all that just fell into place neatly […] and if you have got a faith you might say well, there was maybe something there just nudging me in the right direction.

John's sense of assurance in God's plan for his career had helped him overcome obstacles:

> God had a plan for me to pursue, uh, medicine, and I had to take some drastic measures, like going to [a different continent] and then [to] a country where, uh, I don't know the language, people, food, weather, culture and medicine! Everything was, sort of, against me. Um. But I felt that that was God's plan for me.

Of his decision to pursue surgery, he explained that, with retrospect, he could 'see now why that initial desire was there,' and trace how everything had 'fallen into place.' He expanded, 'you can't just, sort of say it has happened by chance […] [it was] God […] using me for his purpose.' Akua similarly described God 'open[ing] doors, and clos[ing] different ones, at the right time, and I very much feel like I'm where I'm supposed to be.' Akua and John's words echo Harrison and Innes' suggestion that a sense of vocation, even in secular contexts, often involves belief that 'special factors' have 'intervened.'[5]

While Hannah 'never felt […] a clear calling' she felt reassured during university by a sense that 'God's put me here […] this is probably where I […] should be.' Her sense of calling had since 'gradually' grown in significance, and she had come to 'see, on a daily basis, that I think this is where God wants me.' Like Hannah, Elizabeth reverse-engineered a sense of assurance in God's purpose for her life while at university. She explained that she never 'felt particularly *called* to medicine […] not that I consciously thought about,' but that she nevertheless felt 'assured that I was called[from] the fact that I was succeeding […] and enjoying it, and all the rest of it, actually I was in the right place, and God had brought me to that place.'

[5] Jamie Harrison and Robert Innes, 'Medical Vocation and Generation X', *Grove Ethics Series* (Cambridge: Grove Books Limited, 1997), p.18.

While their language varied, an underlying logic of vocation was thus consistently significant for the participants. God's plan, control and providence were significant themes as they described their careers, motivations and aspirations. This was true whether they described clear communication from God, 'felt deeply' that medicine was right for them, or saw a medical career as the outworking of God-given skills. This logic closely echoes Williams' presentation of calling among evangelical international students in USA universities. He defines calling as an 'interpretive lens,' grounded in belief that God is active in the world, leading believers to see themselves and their work as part of God's 'plan.'[6]

There are echoes of Weber's work on vocation in these conceptualisations of calling and vocation. *The Protestant Ethic and the Spirit of Capitalism* contains Weber's most famous presentation of calling (*Beruf),* integral in his non-Marxist history of the emergence of Capitalism. We find his broader understanding, divorced from this specific historic argumentation, in the 'Vocation Lectures' of, respectively, 1917 and 1919: *Science as Vocation* (*Wissenschaft als Beruf)* and *Politics as Vocation* (*Politik als Beruf).* In *Wissenschaft* Weber discusses scientific vocations in relation to contemporary German university structures and postgraduate academic prospects.[7] *Beruf's* felt dimensions come across strongly in *Wissenschaft,* where Weber describes the scientist's 'devotion,' 'passion' and 'strange intoxication,' divorcing these emotions from technical, utilitarian scientific outcomes.[8] In *Politik,* he poses the 'general question of what politics is as a vocation and what it can mean.'[9] Taken together, these lectures confirm that Weber both divorced *Beruf* from specific religious frameworks, and recognised its relevance for individuals alongside its historical social significance. We can thus take an individualised framing of *Beruf* and locate it within Weber's complex social argument in the *Protestant Ethic.* There Weber describes *Beruf* as 'systematic work in a worldly calling,' a 'task set by God' for an individual's life within 'a definite field.'[10] Weberian *Beruf,* then, involves other-worldly purpose embedded in a specific, but every-day, worldly activity: as he explains, this 'inevitably [gives] every-day worldly activity a religious significance.'[11]

Believing God had called them to work in the 'definite field' of medicine, the evangelical medics echoed both Weber and Williams' depictions of 'vocation,' seeing their everyday worldly work as

[6] Williams, 'Constructing a Calling,' pp.258, 264-265 and 273-275).
[7] Weber, *The Vocation Lectures,* p.1.
[8] Ibid., pp.8-9 and 14.
[9] Ibid., p.32.
[10] Max Weber, *The Protestant Ethic and the Spirit of Capitalism* (CreateSpace Independent Publishing Platform, 2013), p.35.
[11] Ibid., p.36.

'religiously significant.'[12] We find further overlap between these scholars' presentations and the medics' conceptualisations by exploring the implications of calling within working life. In *Politik* Weber describes one who lives 'for' politics, making it 'his "life" in an *inward sense'* and whose 'inner equilibrium and […] self-esteem' are bolstered by 'the consciousness that by serving a "cause" he gives his own life meaning.'[13] Williams asserts that a sense of calling can offer 'strength, support and guidance.'[14] Fowler similarly suggests that vocation can give 'coherence and larger purpose […] integrity, zest and meaning' and thus support and sustain.[15] We have already seen that several participants derived joy and encouragement from their callings, echoing Weber, Williams and Fowler. Others relied upon them for resilience and perseverance. Hannah explained that 'I continue to see friends and colleagues quit […] where that's the case, and where you have a horrible rota, and consistent horrible days […] because I have the belief that it's my calling […] I'm kind of more reassured.' Her sense of God-given calling provided meaning and strength, and an 'interpretive lens' to re-frame 'consistent horrible days' and 'nightmare scenarios or cases, where it feels like you want to give up.' Similarly, Martha described her colleagues 'questioning 'Why am I doing this, what's the point, it's so hard'.' However, she explained 'I just don't feel that way – I feel like this is what I'm called to do […] I feel a lot of purpose, and I think purpose is really good for, kind of, sustenance, perseverance, morale.' In turn, she could:

> zoom out and be, like, that was a really tough shift, and I need to work on how I better manage my stress [in] those situations, but I can still – kind of, come out of it, and see something positive.

These positive consequences of calling are also observed in healthcare literature. Puchalski and Ferrell note that 'by being attentive to one's own spirituality and especially one's sense of sacred call to service [clinicians may] find more meaning in their work and hence cope better.'[16] Several participants in Cadge's study cited their 'sense of vocation […] a feeling that they were called or destined by a higher power to become a physician' as a comfort, fostering assurance that 'this is where I should be.'[17] In particular, several chaplains framed their work as a calling, part of God's purposes. Coupled with a sense of 'an intimately present God,' this helped them avoid burnout.[18]

Several evangelical medics also used calling as a lens on the future. Considering potential medical specialties, Martha felt drawn to cardiology, but contentedly recognised that 'God [c]ould want me

[12] Ibid., p.35; Williams, 'Constructing a Calling,' pp.258, 264, 273-275.
[13] Weber, *Vocation Lectures,* p.40 (emphases original).
[14] Williams, 'Constructing a Calling,' p.257.
[15] Fowler, *Weaving the New Creation*, p.120.
[16] Puchalski and Ferrell, *Making Health Care Whole,* p.175.
[17] Cadge, *Paging God,* p.168.
[18] Ibid.

to choose a different career path. […] I'm not really concerned about it, because I feel that […] God will show me where he wants me to be.' David, who was at the other end of his career, pondered:

> If you do feel that this has been a God-led career […] what do you do now? What are you going to do – isn't job done? […] But of course, if you've got a good strong faith, you just say, 'I'm ready and waiting.'

Like the students in Williams' study, having seen God's facilitation of his purposes for their lives, these doctors felt confident of future direction.[19]

Macro and Micro Callings

Seeing medicine as God's purpose for their lives was not the only sense in which the participants used the language and logic of 'calling.' On a grander scale, they referred to 'calls' made of all Christians, often directly referencing biblical commands. This echoes Fowler's framework, in which he links an individual's specific work and circumstances with God's work in the world, describing vocation as 'a purpose […] that aligns your life with the purposes of God […] as disclosed in Jesus Christ.'[20] In turn, the participants then considered how to translate these callings and commands into particular scenarios. Between these grand (macro) and particular (micro) levels was their medical work: a 'meso-calling' explored above, akin to Weber's 'definite field.' The participants thus recognised three 'levels' of calling (Figure 2): macro-callings made of all Christians; a meso-calling to medicine; and the micro-level, on which they discerned precisely how to enact macro-callings within their meso-calling.

Macro-calling	Things all Christians are 'called' to do (e.g.: serving God; sharing the gospel)
Meso-calling	The particular arena in which it is believed God wants them to enact those macro-callings (e.g.: medicine; a specific medical field)
Micro-calling	Enacting macro-callings in specific scenarios and ways within the meso-calling (e.g.: how to best show love to 'difficult' patients)

FIGURE 2 - MACRO, MESO AND MICRO CALLINGS

The participants certainly saw medicine as an arena in which they could live out Christian macro-callings. Echoing numerous scholars and studies, many specifically emphasised calls to love,

[19] Williams, 'Constructing a Calling,' pp.264-267.
[20] Fowler, *Weaving the New Creation,* p.126.

compassion and care, and to imitate Christ's healing example.[21] Martha described medicine as 'in keeping with the life Jesus calls me to,' particularly as a site for showing compassion. She thus described medicine as her 'platform [from] which I can easily interact with people who need […] God's love, and support, and care.' Akua explained:

> Jesus very much taught everyone that we are called to care for each other, and that was really integral. […] I definitely think that [medicine is] in line with how God wants us to treat each other […] it's the idea of trying to solve disorder, and to relieve people of pain. […] Jesus never told us why pain was there, but he did come and relieve people of it [and] treat it. And I think […] that's what we're here to do.

Richard described being a GP as a 'privileged employment' because it had allowed him to 'act out his faith' by 'loving my neighbour, supporting the vulnerable, affirming the fearful that they are loved and valued, and as in 2 Corinthians, comforting others with the comfort with which I had been comforted.' Simon, similarly, framed medical work as 'partnering with God' in 'meeting human needs.' He found this 'joyful.' Goodluck spoke about performing God's healing work:

> One of the joys of my job is that I am performing God's miracles every day. And my – that's why I enjoy my job, I'm following my calling, I'm doing God's work. […][That] will look like arrogance. I am saying I am a miracle worker. [But] on a personal level, I know that God has supported me through school, medical school, and my jobs. I'm not here on my own. So it's not that I'm arrogant, it's that God has put me in this place as part of his work – and how humble that makes me feel cannot be underestimated.

There are intense emotions at work here. Doing 'God's work' through his meso-calling underpinned great joy and humility for Goodluck.

Like Fowler, several medics particularly associated vocation with being 'urged into the world' in 'service.'[22] As for Goodluck, this consistently had important felt dimensions. Ruth explained that it had 'taken time' for her to see psychiatry as a vocation, initially wondering whether she could truly 'live out' the gospel in a secular workplace. However, she had come to feel that 'actually, this is a really powerful service. God needs us out in the workplace.' Moreover, she felt her 'sense of service to God' bolstered her resilience, helping her to reach out to troubled patients 'without being completely unhinged emotionally.' Philip linked the macro-call to service with the specific 'position' he believed God had given him in which to enact it, describing being a Christian medic as 'an amazing opportunity to serve people […] it's just amazing that God put me in this position.' Ben felt joyful that he could 'serve God' in his job. Ginny's strong sense of vocation was closely 'related to […]

[21] Linda M. Chatters, 'Religion and Health: Public Health Research and Practice', *Annual Review of Public Health*, 21 (2000), 335–367 (p.345); Knight and Kim, 'Christianity,' pp.112-113. See also Haynes and Kelly, *Is There a God in Health Care?*, p.197.
[22] Fowler, *Weaving the New Creation,* p.50.

serving others.' James described 'serving people as a doctor,' but explained that 'I think the whole purpose is that you're serving humanity […] even if it's not being a doctor, I would say that it's still a vocation.' Martha felt that the Christian call to 'service' ought to translate into working specifically in public healthcare, explaining, 'I've questioned my very strongly negative attitude to private healthcare, but I do really feel that if we're called to be servants, and serve people who need it […] why would we be called to serve in private medicine?'

Like Cadge's chaplains, the participants thus saw themselves as channel[s] for divine love' in patients' lives, translating God's call to love into specific scenarios.[23] Lewis explained:

> As a Christian I am commanded to love my neighbour as myself, to go the extra mile, to carry my cross. So I need to be the best doctor I can be – fully up-to-date (if only), fully attentive to the patient, her carers and family. I need to be wise in my clinical judgements and careful to do no harm.

Lewis translated Christian 'commands' into the micro-settings and specific scenarioes of his work, in seeking to be 'fully up-to-date […] fully attentive […] wise in my clinical judgements.' For Akua, and others, the call to be a wise steward meant careful use of medical resources: for example, 'feeling less comfortable with having to open a second packet of something.' For Philip, trying to 'be as much like Jesus in my work as I can' meant specifically showing compassion to both staff and patients. Ginny noted that this often contravened the 'ethos in hospitals' used to pass 'awful jobs to those at the bottom of the food chain.' She also noted her underlying

> Christian ethos of […] valuing the dignity of those with mental health problems, dementia, learning disability, physical disability – and others rejected by society. For me, that leads to compassion for all, and behaviours which show value to those who are often marginalised [: for example] including someone with learning disability in a discussion.

Nigel, similarly, suggested that psychiatric work meant 'fulfilling Christ's commandment to work for those on the periphery of society,' because of stigma surrounding mental illness. This macro-calling shaped the minutiae of his work.

Because it operated on three levels, calling was a significant framework even where participants were unsure of their meso-calling. Liam, in his first year as a junior doctor when we met, felt it was 'too early to say' whether medicine was indeed his vocation. He found this uncertainty unsettling: while the evangelical discourse and narrative of calling to a 'definite field' was familiar, it was a source of some concern, given his uncertainty as to whether he fit this normative pattern. However, while the meso-level was absent for Liam, the other levels of the evangelical logic of calling were

[23] Cadge, *Paging God,* p.187.

present. He described 'feeling called to be an example of Christ at work, but not exactly sure what that looks like still.' Despite having no confident sense of meso-calling, Liam nevertheless sought to enact macro-callings as a doctor, and to discern what these meant within the micro-contexts of his work.

Elective Affinity and Identity

Within the participants' language and logic of calling there was a relationship of mutual reinforcement between work and faith: their meso-callings to medical work thus enabled the participants to enact and uphold Christian macro-callings; equally, as we have seen, their senses of calling aided and encouraged them. This mutuality echoes elective affinity (*Walhverwandtschaft)*, another of Weber's significant theoretical legacies.

Howe notes that, despite its fame, precise understanding of Weberian *Wahlverwandschaft* is elusive: Weber's usage was diverse, infrequent and informal.[24] The clearest articulation, Howe suggests, came in *Economy and Society*, where Weber described 'the degree of elective affinity between concrete structures of social action and concrete forms of economic organization […] whether they further or impede or exclude on another – whether they are "adequate" or "inadequate" in relation to one another.'[25] On the basis of Weber's usage in *The Protestant Ethic,* Scott and Marshall's *Dictionary of Sociology* defines it as follows:

> [T]he resonance or coherence between aspects of the teachings of Protestantism and the ethos of the Capitalist enterprise: the contents of one system of meaning engender a tendency for adherents to build and pursue the other system of meaning. The concept […] has been used loosely by other sociologists, often in situations where it seems likely that there is an association or connection between systems of belief operating in different spheres of life.[26]

Löwy summarises:

> Elective affinity is a process through which two cultural forms […] who have certain analogies, intimate kinships or meaning affinities, enter in a relationship of reciprocal attraction and influence, mutual selection, active convergence and mutual reinforcement.[27]

Affinity, then, concerns the manner of relationship between two phenomena exhibiting mutuality, reciprocal attraction, resonance or coherence. The participants' conceptions of calling demonstrated mutuality, and thus affinity, between work and their faith. Being a term ultimately indebted to

[24] Richard Herbert Howe, 'Max Weber's Elective Affinities: Sociology Within the Bounds of Pure Reason', *American Journal of Sociology*, 84.2 (1978), 366–385 (pp.366-367 and 369).
[25] Ibid., p.369. Max Weber, *Economy and Society*, p.341.
[26] 'Elective Affinity' in *A Dictionary of Sociology* (3rd rev. edn.), ed. by John Scott and Gordon Marshall (Oxford ; New York: Oxford University Press, 2009).
[27] Michael Löwy, 'Le concept d'affinité élective chez Max Weber' [The Concept of Elective Affinity in Max Weber's Work] *Archives de sciences sociales des religions*, 127 (2004), 93–103 (p.100).

Chemistry, applied to social relationships by Goethe, and then adapted by Weber, there is no necessary sense in which affinity is positive: it describes the existence, not the quality, of relationship.[28] In the above examples, however, work-faith affinity was something for which participants were grateful, bolstering them as both Christians and doctors.

Both vocation and affinity have important implications for identity. Weber describes a calling's contribution to a 'person of vocation's' (*Berufsmensch's) '*self-feeling.'[29] In *Wissenschaft,* he allies vocation with the 'soul' and 'destiny,' evoking religious identity and ultimate purpose.[30] Williams, developing McAdams' concept of 'personal myth,' frames calling as an evolving psychological structure, which infuses life with unity and purpose, and shapes how self-narratives are constructed from socially-available materials.[31] Fowler identifies intrinsic links between vocation and 'the fulfilment of the identity process,' suggesting that 'pressed far enough all questions of identity become questions of vocation.'[32]

The participants, similarly, connected their senses of calling and their senses-of-self, echoing Jeremy's suggestion that 'ultimately my career is an outworking of my identity; God's calling for me is to serve.' John, of being a doctor, explained 'that's who you are, that's the will of God. And that's why you're on this earth.' Ruth drew links between her 'identity in Christ, knowing that I am loved […] and a sense of service to God.' Ginny connected faith, work and identity, explaining that her faith 'informs every aspect of what I do […] it's who I am.' Many participants described themselves as 'Christian doctors,' an identity with two parts, whose affinity meant they formed a coherent whole. When Goodluck said, 'this is my life,' 'this' was, precisely, his being a Christian called to medicine. These descriptions of their identity highlight the positive, consonant senses-of-self that these participants experienced, their senses of calling facilitating work-faith affinity.

Beyond Benign Vocation

The positive consequences and resulting, consonant relationships of work-faith affinity depicted above were important elements of the participants' understandings and experiences of calling. However, they were not the full picture. In addition to echoing Williams' and Fowler's profoundly benign depictions, the participants also evoked more ambiguous, and at times negative,

[28] Howe, 'Max Weber's Elective Affinities,' pp.367 and 370-372.
[29] Weber, *Vocation Lectures,* p.40. This translation uses 'self-esteem,' but the German *das Selbstgefühl* could, more literally, be rendered 'self-feeling.' For the German, see Max Weber, *Politik als Beruf* (Reclam: 1992), p.16.
[30] Ibid., p.8.
[31] Williams, 'Constructing a Calling,' p.273.
[32] Fowler, *Weaving the New Creation,* p.120. See also pp.110, 121-122 and 194.

conceptualisations of calling.[33] Alongside his infamously bleak view of the future amid modernity's 'iron cage of rationality' at the end of *The Protestant Ethic,* Weber notes potentially damaging effects among the 'far-reaching psychological consequences' of *Beruf*.[34] Harrison and Innes similarly identify reasons for wariness. Though their concern is with medical vocation in general, rather than specifically with medicine as a Christian vocation, theirs is a rare, critical exploration of the topic.[35] Like Weber, they encourage critique of solely benign presentations of medical calling.

A Stick With Which to Beat You(rself)?

Lewis described medicine as his vocation on several occasions, but emphasised its dual potential to both bolster resilience and add burdens. Offering advice to new Christian doctors, he wrote, 'a sense of calling or vocation may help you through the hard times. But it can also be a stick to beat you with (by others or yourself).' He painted this hypothetical picture:

> [Say] you say you're "called," and I'm your boss, so I say "Great, she says she's called, you know – so she can do every Friday night on call – she can do the extras, she can see the difficult patients […] because that's her – her calling."

Recognising the challenges of achieving work-life balance and treating 'difficult' patients, Lewis suggested a doctor's calling might become a stick with which others could beat them. This echoes Weber's suggestion that *Beruf* can facilitate exploitation, insofar as the evolution of Protestant Asceticism ultimately 'legalized the exploitation of this specific willingness to work.'[36] Harrison and Innes note a similar risk, suggesting their commitment and willingness to be self-sacrificial in a vocation can lead to junior staff in particular being placed under 'unfair pressure' by senior staff.[37]

Moreover, Harrison and Innes also suggest doctors may also put unfair pressure upon themselves, tolerating longer hours and more stressful shifts than they ought, with adverse potential consequences for themselves and their patients.[38] Lewis similarly suggested the likelier risk was that someone might use their calling as a stick with which to beat themselves, explaining, 'you can beat yourself up about it as well. If I'm called to this people, then I must spend every possible hour, minute, day serving them.' This self-inflicted pressure to fulfil a calling, potentially at one's own expense, was also latent in Philip's reflections:

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[33] This benign framing also characterises presentations of vocation in Cadge's *Paging God* and Puchalski and Ferrell's *Making Healthcare Whole.*

[34] Weber, *The Protestant Ethic*, p.92

[35] Harrison and Innes, 'Medical Vocation' p.21.

[36] Weber*, The Protestant Ethic*., p.106. See also Harrison and Innes, *Medical Vocation,* p.19. See also Miroslav Volf, *Work in the Spirit* (Oxford: Oxford University Press, 1991), pp.107.

[37] Harrison and Innes, *Medical Vocation,* pp.11-12.

[38] Ibid, pp.11-12 and p.23.

> I've got to live [my calling] out as well as possible. You know, making the most of every opportunity that I'm given by God to serve him in the area that I'm given to serve. […] I wouldn't be able to sustain my work ethic, of working really, really hard, without that Christian basis. Certainly I wouldn't be […] starting early and staying late unless I cared deeply.

Philip's desire to serve 'as well as possible,' making 'the most of every opportunity,' drove him in a potentially burdensome way.[39] This evokes Weber's presentation of calling as a double-edged sword which, while edifying, can become an exclusive and burdensome duty, perceived as '*[t]he only way* of living acceptably to God […] *solely* through the fulfilment of the *obligations imposed* upon the individual by his position in the world. That was his calling.'[40] Additionally, in the *Vocation Lectures,* Weber suggests this calling-obligation risks diminishing all else in life, as one becomes 'wholly devoted to his subject' and 'live[s] only for' it.[41] In *The Protestant Ethic,* he notes that Puritans harboured suspicion and hostility towards all 'impulsive enjoyment' beyond one's calling, presenting it as 'the enemy of rational asceticism.'[42] Similarly, Harrison and Innes cite Volf's concern that vocation encourages 'divinisation' of work, whereby it becomes valued at the expense of other aspects of life.[43] This risk had occurred to Lewis, who pointedly noted the importance of enacting Christian callings beyond medical work, as well as within it.

As we have seen above, Martha's sense of vocation bolstered her morale. However, she also struggled with guilt, writing:

> When colleagues talk badly and unsympathetically about each other behind each other's backs - I am conscious of the different attitude we have as Christians re: forgiveness, turning the other cheek, looking compassionately on others, showing grace. And - when I am tempted to join in, or do join in, I feel guilty as I think of the grace Jesus calls us to.

Martha acknowledged Christian calls to compassion, grace, and 'turning the other cheek,' and felt guilty where she did not enact these. She made similar points about patience and compassion. Falling short of these macro-callings burdened Martha with guilt. Sarah upheld a biblical ideal of 'loving all patients' through her psychiatric work. However, she felt this 'unfortunately [got] eroded by events' and over time. She found herself asking 'Why am I bothering with this? Because it's not going to change anything.' Similarly, Hannah felt the culture of cynicism and disillusionment cultivated by some of her NHS colleagues inhibited her ability to show love, and thus, at times, she doubted her ability to 'live out' her faith as a doctor. The participants' medical meso-callings often facilitated the translation of macro-callings into micro-contexts, creating a sense of work-faith

[39] It is unfortunate that I could not conduct Philip's follow-up interview, as I had hoped to explore this further.
[40] Weber, *The Protestant Ethic*, p.36 (emphases mine).
[41] Weber, *Vocation Lectures,* pp.7 and 10.
[42] Weber, *The Protestant Ethic*, p.98.
[43] Harrison and Innes, *Medical Vocation,* p.19. Volf, *Work in the Spirit,* p.107ff.

affinity: at other times, they created disjuncture between the two. Instances where their medical meso-callings did not function as a catalyst created significant negative feelings of guilt, doubt and worry. Williams and Fowler identify no such negative emotional dimensions of 'calling.' For several of the above participants, these were important dimensions of their experiences, even as their calling also affirmed work-faith affinity. We can thus take a leaf from Weber's work, and its contemporary echoes of caution in Harrison and Innes' discussion, viewing *Beruf* with a degree of suspicion, and an eye to its potentially negative consequences within lived evangelicalism.

Theological Tensions – and Relief

Further ambiguities and complexities were revealed where the evangelical logic of calling interacted with two other significant evangelical narratives: the potential for re-calling; and the risks of idolatrous identities.

Both Peter and James emphasised the importance of holding lightly to medicine as their meso-calling. This was partly because they believed that God might call them to something else.[44] James cited the biblical precedent for re-calling:

> I might just one day have to drop out of medicine. Because I have to be called to something else, you know! [Laughs]. There's so many people in the Bible that did something else […] Don't get comfortable, you know – Jesus was a carpenter, David was tending his sheep […] and I think it's the same. And you just have to be attentive.

Peter, similarly explained:

> I would never want to get to a point where I didn't feel comfortable with the idea of leaving the medical profession if God wants me to […] – what God calls me to, I want to be able to do […] I want to be open to the fact that I may get to 30 and may think God's saying "I want you to drop medicine."

Thus Peter recognised that medicine might only be God's *current* plan for his life. He reflected that God is a 'lamp to our feet […] [He] doesn't illuminate a nice map throughout all of our life […] sometimes he shows us the next step only when he wants to.' Fowler's work is helpful here, for it portrays vocation as process, rather than as static.[45] He describes 'ongoing discernment of one's gifts […] [and the] means and settings' in which they are to be used.[46] This allows for vocations to change and shift, important dimensions for understanding Peter and James' concerns.

[44] Here, Weber's 'definite field' ought to be plural 'definite fields.'
[45] Fowler, *Weaving the New Creation,* pp.50, 118 and 121.
[46] Ibid., p.121. This also allows us to incorporate those like Liam who, we saw above, felt he was still in the process of discerning his meso-calling.

Amid these discussions, Peter and James ruminated on the relationship between work, faith and identity. They noted, with others, the potential for medical careers to become all-consuming. James said, 'Doctors are different […] that person *is a doctor.* When you ask someone maybe if they run a business […] it's not that they *are* a business […] it's an identity facet that culture's now put on doctors.' In a similar vein, Peter divorced vocation from religion, applying the term to his surgical colleagues:

> [I]t's amazing – their passion, and interest in that, and in driving that profession forward is – is great, but I think a lot of that is because […] for them, it's their vocation, it's what they do and ultimately it's who they are, it's their identity.

Alongside admiration, Peter was wary, keen to avoid reaching 'a point where medicine is too much my life and too much my idol […] And I suppose that comes back to identity – people being committed only to medicine.' Employing the framework of idolatry, Peter recognised that medicine might become important to his faith's detriment, inhibiting his ability to follow God's callings elsewhere. Where he saw his surgical colleagues' vocations facilitating their careers and self-direction, Peter's vocation allied him instead to following God's direction. Similarly, James hoped to always be 'a Christian first and a doctor second' lest medicine become an all-consuming identity at his faith's expense. Here, Weber's caution about callings which 'diminish all else' is embedded within evangelical logic: for Peter and James the risk was that the meso-call might diminish its own other-worldly significance, instead becoming an idol.

Equally, however, several participants found their faith, and Christian identity, afforded relief from pressures to chase medical success. Peter reflected further on his surgical colleagues:

> [B]eing a surgeon means everything to them […] it's interesting contrasting that with knowing that my hope is in Christ, and knowing that I don't have to go there and make my job the best thing and the most important thing.

The surgeons' passion, drive and wholeheartedness impressed Peter: and yet, that these were divorced from, rather than bound up with, a sense of religious vocation meant that he did not wish to emulate his colleagues. If he were to find a similar driving passion, he wanted it to come from his faith, and remain ranked below his faith, not superseding it in his priorities.

Like Peter, Jeremy was 'very glad to not have to strive to be anyone/anything; as [being a doctor] isn't the most important thing in my life.' He contrasted this with those whose

> sense of being a doctor is a massive part of their identity [who] have to 'be someone' […] to feel a sense-of-self-worth. If you're a Christian, that works the opposite way […] your sense-of-self-

> worth is nothing to do with you, it's defined by God's attitude towards you […] so there's less pressure.

Thus even as the participants felt they *must* hold lightly to their medical callings, lest they become idols, and too much of their identity, they were also relieved that they *could* hold lightly, amid pressure to pursue medical excellence and ambition above all else. They could reap the dual benefits of confidence in and resilience from their calling, and relief that their identity was not tied solely to their career.

We saw above that the participants understood their identities in relation to their calling: it was God's plan that they do medicine, and thus *be* a doctor.[47] Therefore, in a significant sense, their medical identities were inextricably bound up in their religious identities and senses of calling. Indeed, the former often derived from the latter, where the medics believed their careers were the outworking of God-given skills, inclinations or opportunities. The above evangelical narratives, however, introduce tension into this consonance and work-faith affinity. Whether because God might re-call them, or because their medical identity might become idolatrous, several participants felt it imperative to hold their medical calling, and thus the medical elements of their identity, lightly. Their meso-calling was thus simultaneously significant and integral to their identity, and not allowed to become *too* significant. Recognising that their medical identity risked distracting or detracting from their Christian identity, the participants saw it as secondary.

While both identities were intimately related, the participants' Christian senses-of-self were placed above their medical senses-of-self within an implicit hierarchy. This hierarchical conceptualisation of identity had a permanent shadow: the risk of an inverted hierarchy, in which medical identity was improperly prioritised. Participants saw this risk manifest in their colleagues' strivings for career excellence. These hierarchical conceptualisations are seemingly at odds with a consonant conceptualisation. Indeed, we might thus call them dissonant identity conceptualisations (see Figure 3).

IDENTITY		
Consonant	Dissonant	
	Hierarchical	Inverted Hierarchical

FIGURE 3 - IDENTITY CONCEPTUALISATIONS

[47] Thus the participants echoed Fowler, who observes that vocation includes being called to *be* and to *do* – *Weaving the New Creation,* p.122.

This model of identity conceptualisations echoes Baker and Wang's observations regarding Christian psychologists working in the NHS. On the one hand, many of Baker and Wang's participants articulated moments of 'integration,' 'unity' and 'fusion' between the roles of Christian and clinical psychologist.[48] On the other hand, these moments 'alternat[ed] with an ordinal relationship between the two (the psychologist role prioritised over the Christian or vice versa.)'[49]

Fowler's presentation similarly hints at the potential for a vocation to sustain both consonant and dissonant identity conceptualisations. He explains: 'Vocation is bigger than job or occupation or career. [It] refers to the centring commitments and vision that shape what our life is really about.'[50] This suggests that 'centring commitments' and 'vision' rightly supersede a career. These, not specific careers (or, meso-callings) are the essence of vocation. Yet, Fowler continues: 'To be in vocation is to find a purpose for one's life that is part of the purposes of God.'[51] This involves all of relational, public and working life: 'In vocation, all these aspects of our lives find orchestration and coherence.'[52] Within a page, Fowler moves from allying vocation to a hierarchical ordering of identity, to identity coherence.

Like Fowler, the participants did not consider this dual conceptualisation problematic or paradoxical. Rather, they held these identity conceptualisations in parallel, and moved freely between them, unconcerned by their potential contradiction. This relates to a second point: the fact that the hierarchical identity conceptualisation, though it highlighted tension and dissonance between participants' medical-selves and faith-selves, was nevertheless perceived positively. In Peter and James's examples, there was aspiration to always be 'a Christian first and a doctor second.'

Identity Implications

Ginny and Nigel's narratives reveal a final difficulty inherent in linking work and identity. Even as her calling had helped her to 'keep going' amid difficulties, a period of redundancy became a crisis-of-self: in losing work, Ginny felt she lost a significant part of her identity. Rather than re-calling, Ginny's difficulties related to a temporary absence of calling. By contrast, Nigel had recently completed ordination training, and thus faced decisions about how to divide his time, and whether to leave medicine. The prospect of setting his vocation aside felt difficult. Despite having grown in confidence that God would direct him, this caused him ambivalence and anxiety, not least in relation to his sense-of-self:

[48] Baker and Wang, 'Examining Connections Between Values and Practice,' pp.133-134.
[49] Ibid., p.133.
[50] Fowler, *Weaving the New Creation,* p.120.
[51] Ibid.
[52] Ibid.

> [H]aving been a doctor so very long, um, it feels like part of who I am. […] How ready [am I] to let go of something that has been such a huge part of [my identity]? And I don't know where that will take me. I don't know how long I will continue working. […] I don't know – […] I haven't got a clear sense.

Harrison and Innes respond to Volf's suggestion that Lutheran conceptualisations of calling make insufficient room for the modern tendency to regularly change jobs, or have 'plural employment.'[53] They argue that vocation must not be used 'to justify a static notion of work, but must be open to the possibility of one's work developing and changing.'[54] This is an important observation, since several participants in this study recognised, or had experienced, dramatic developments and changes to their work and thus their sense of calling. What Harrison and Innes do not capture, however, is the complex emotionality inherent in such possibilities, such as Peter and James' ambivalence surrounding a central part of their identity, and Ginny and Nigel's uncertainties and anxieties.

Conclusion

This chapter has explored conceptions of calling and vocation among evangelical medics, and their consequences for their work and identities. Amid varied language, participants had a shared logic of calling, operating on three levels. Medical work was seen as a God-given purpose, but this meso-calling was also an arena for enacting macro-callings made of all Christians. The participants translated these macro-callings into micro-scenarios within their meso-calling. Many derived reassurance, resilience and joy from their senses of calling, and their belief that they were fulfilling these. Thus their calling resourced them for their work, a theme we continue exploring in the next chapter.

Others, however, recognised darker sides to calling. Thus, while this chapter found significant support for Williams' presentation of calling among evangelicals, and Fowler's broader Christian understanding, it also urged caution: conceptualisations of calling ought not to be so benign that they lose sight of potentially negative consequences. Rather, we should take Weber's heed, extending a cautious eye over evangelical constructions of calling.

This chapter also introduced ideas and identity conceptualisations which will appear throughout this thesis. The participants' logic of calling highlighted elective affinity between work and faith, which, in turn, informed consonant conceptualisations of their identities. Work-faith affinity and consonance were not exclusively in evidence, however. The more negative implications of calling complicated

[53] Harrison and Innes, *Medical Vocation,* p.19; Volf, *Work in the Spirit,* p.107.
[54] Harrison and Innes, *Medical Vocation,* p.19.

matters, since the very calling at the heart of work-faith affinity and consonant identity could also become a source of burden. Some participants sought not to cling too tightly to their medical meso-calling, lest it become an idol, rendering them incapable of following a potential calling elsewhere. Several participants thus moved between consonant conceptualisations of identity and a hierarchical, divided, dissonant model, in which the two facets of their identity competed. Within this hierarchical conceptualisation, their religious identity was afforded greater personal significance than their medical meso-calling. They held these models in parallel, with no sense of tension or contradiction. Moreover, despite highlighting potential tension between work and faith, the hierarchical conceptualisation was nevertheless considered positive and aspirational. We will see in coming chapters that not all identity dissonances and tensions were seen in this way.

Fowler emphasises the social nature of vocation, noting the paradoxical logic whereby one becomes a 'true individual […] through community' and through 'recogni[sing] ourselves to be dependent.'[55] With this in mind, we move to explore 'Resourcing' in the next chapter, noting the medics' reliance upon God, community, and other aspects of their faith to develop and thrive in their callings.

[55] Fowler, *Weaving the New Creation,* p.122 and 158.

Resourcing

"That gives us something remarkable"

Introduction

'Being a Christian definitely helps with the stress of the job,' wrote Sarah. Similarly, David explained that 'having faith to turn to' had often 'helped [him] through tough times.' Liam 'drew on' his faith, finding it a 'source of support […] when the going gets tough.' Nigel, describing working with seriously ill children and their families, wrote, 'I look back on this time and wonder how I would have got through each day of difficult situations and conversations if I had not had my faith.'

In many ways, Sarah, David, Liam and Nigel spoke on behalf of all the participants in this study. In utilising their faith as a resource, they echoed widespread scholarly observations and suggestions that religious and spiritual worldviews can sustain healthcare practitioners.[1] This chapter examines the various forms of 'positive religious coping' in which participants engaged, and the implications of these for their senses of work-faith affinity, and for their identities. It begins by exploring the support and sustenance participants found in particular beliefs, before exploring prayer, and Christian fellowship. This chapter thus continues exploring how participants 'deployed' their faith in their work, suggesting that, in multiple ways, working in healthcare contexts led them to draw upon their faith as a resource.

Resourced by Beliefs

Ruth described her faith as 'the reason that I see my job quite in the way that I do […] it gives me my unique perspective on the work.' In broad terms, she articulated a faith-based resource common to all of the evangelical medics: the use of beliefs as interpretive lenses. In the previous chapter, we saw participants deriving joy, encouragement, resilience, and relief from their senses of calling, using their beliefs about God's purpose and plans as interpretive lenses. The below extends this observation to other beliefs.

[1] Sims and. Cook, 'Spirituality in Psychiatry,' pp.9-10; Puchalski and Ferrell, *Making Health Care Whole,* pp.165 and 175; Ya-Chu Hsiao et al, 'Spiritual Health, Clinical Practice Stress,' p.1618; Cadge, *Paging God,* pp.152-153 and 164-168; Stephen Mann, 'On Sacred Ground – The Role of Chaplains in the Care of the Dying: A Partnership between the Religious Community and the Healthcare Community' in *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and* Dying, ed. by Christina M. Puchalski (New York: Oxford University Press, 2006), 115-128 (p.119).

Belief in God's providence and control, love and grace aided many of the participants, beyond the specific frameworks of calling and vocation. Ben described God 'directing' difficult consultations and scenarios 'behind the scenes.' Knowing God was 'with him' and was provident over all situations meant James felt he could 'give more to others,' and find peace amid various 'issues' and 'pressures' at medical school. In particular, he explained that 'relying on God's grace […] gives me the freedom to actually have a break and enjoy it without worrying,' because he felt assured that God was in control. Peter, similarly, found it 'very comforting' to know that God had a plan for him, and that if that plan meant failing medical school, God's 'view of [him]' would not change, and thus his identity was secure. John found he could 'just keep calm [and] know that God is in control.' Indeed, he believed God had specifically gifted him the ability to stay calm in stressful situations, suggesting it was a 'combination of my personality and my faith that helps me manage stress.' Goodluck and Jeremy both similarly believed God had taken control in acutely stressful situations by bestowing calm. Catherine had sensed God at work through scripture during long, on-call shifts, explaining 'I would never go on-call without my Bible because […] there would always be a passage that would come into my head that would help with what was going on.'

Ruth felt that knowing God's enabled her, in turn, to show that love in the micro-contexts of patient interactions. Sarah explained that, working alongside psychiatric patients whom she believed were searching for 'love, value and security,' she recognised her fortune in 'being a Christian as of course I know that I am loved and valued.' Richard explained that when things

> knocked me, and it would be very easy to lose confidence in myself, it's good to feel that […] I'm loved by God […] there was that underpinning love, and that really [was] a resource, in emotional sort of things.

Richard's example highlights the significance of emotion for understanding how beliefs function as resources. His beliefs were an emotional resource, used when he might otherwise feel 'knocked.' He had emotional reasons for utilising his beliefs, and doing so had positive emotional consequences. The same pattern was evident for others. For example, Gwen particularly relied upon knowing God's love and forgiveness in order to find peace when she made mistakes. She explained, 'I wouldn't have been able to practice medicine […] without – without the – the love of God, and the forgiveness of God. Because sometimes – you know you got something completely wrong.' Similarly, Martha explained:

> [A]s doctors you do have a lot of responsibility, to influence people's lives, to better people's lives, or to fail to better people's lives. But as Christians we also know that ultimately God is in control […] God can use you as part of his healing, in someone's life, but you can't develop a God-

> complex where you think that's your responsibility or that you have the ability to do that, I think that would be damaging to – you, in terms of your ego – and the weight of responsibility you feel.

By believing that God is in control, the 'weight of responsibility' Martha and Gwen might otherwise have felt as doctors was assuaged. In a cycle of interplay between beliefs and emotions, worry, the emotional weight of medical responsibility, and, particularly in Gwen's case, retrospective feelings of guilt were mitigated by peace and relief. These examples echo Cadge's observations that many intensive care practitioners rely upon, and derive comfort from, beliefs in a higher power to whom they can 'turn things over.'[2]

Using beliefs to manage responsibility and its attendant emotions also took on evangelistic framings. Discussing conversations about faith and religion with hospice patients, Elizabeth explained:

> I find it very hard when […] the door gets shut, slammed, like, and I can see – and I think, 'You're dying? You're going to meet your maker in the next, you know, hours, or days. And, actually, you are *totally* rejecting God, in my face.' Umm. So, I find that hard. Um. And I think the way that I resolve that is that I pray for those people. Just like, 'Actually, Lord, I've asked them those questions, you know their hearts, you're the person who saves, I'm just going to commit them to you?'

Amid frustration, and concern for such patients' salvation, Elizabeth 'resolved' burdensome feelings of evangelistic responsibility by relying upon beliefs in God's sovereignty, and the efficacy of prayer.

Prayer was a significant resource for many. Here, the line between belief and practice blurs: for these evangelicals, prayer presupposed and closely interrelated with beliefs in its efficacy, and about God's nature, providence and control.[3] The frequency with which the participants discussed prayer highlights its significance in their lives, and for how they managed their work.[4] Again, emotions were significant as both stimuli and consequences. For example, Sarah prayed to relieve worries in anticipation of particular consultations. Fellow psychiatrist Simon did similarly, asking God for 'insight' and for patience to be 'able to love and understand […] people who were particularly complex and particularly challenging.' Martha, conscious that she sometimes struggled to show love and patience, prayed for energy to show grace, and to view people 'as Jesus did.' She believed her faith 'sometimes [gave] me more energy to be more patient' when feeling exasperated. David, similarly, found God 'provided' him with the strength 'to go the extra mile.' Thus David and Martha both believed God resourced them to live-out macro-callings at work. Ginny described using 'arrow

[2] Cadge, *Paging God,* p.143.

[3] The phrase 'for these evangelicals' is important here, because reading medical memoirs by non-Christians does, occasionally, reveal the paradoxical idea of 'praying to a God I don't believe in' amid medical crises. Adam Kay's 'This is Going to Hurt' is a good example – Adam Kay, *This is Going to Hurt: Secret Diaries of a Junior Doctor* (London: Picador, 2017), p.129.

[4] We explore prayer in clinical and workplace contexts more specifically in 'Negotiating.'

prayers' during consultations and amid other challenges: 'quick prayers sent up at difficult times and in difficult situations e.g. exhaustion, complex consultation, communication challenge.' She had particularly relied upon prayer during 'a time of burnout' while working as a GP. She described 'praying desperately […] for God's strength to get me through the day which loomed ahead and that I would manage 'primum non nocere' at the very least.'[5]

Goodluck linked persistent prayer to his sense of vocation, saying: 'I need to keep praying, you know. Because I'm doing God's work so I need to keep in tune with him so that I can continue that.' Similarly, Jeremy's hyperbole, '[t]o be honest, I don't really know how other people do it without a faith' was closely related to consistent prayer. He prayed while walking to work, explaining:

> I pray for my patients in a general way […] I pray for individuals, most of the time I'm just praying in general – a kind of 'what's going on' way. I pray that I don't lose perspective, that I don't get locked in and lost in my work, and that I remain, sort of, in touch with, with God throughout my shift.

While Jeremy prayed in anticipation of challenges, as well as 'in a general way,' he also described his 'desperate' prayers when handling acute emergencies during nightshifts, akin to Ginny's 'arrow prayers.' Nigel, similarly, explained 'I have spent time in prayer in hospital chapels whilst working through the night, when awaiting the results of investigations. Spontaneous prayer is something that I incorporate into my daily work routine.' He had found it an effective resource when his work left him wondering, 'What am I going to do about this? And how am I going to respond to this impossible situation […] Not really knowing […] I will hold those things in prayer. And – doors open? […] things, come about.'

Hannah, like others, prayed regularly for circumstances, patients, their families, and her own resilience. She also described a particular, desperate, scenario which had prompted her to re-evaluate:

> There was a particularly difficult case, where a child was really, really unwell […] at high risk of dying. […] One of my [Christian colleagues] just got a sense that evening […] that this is probably a challenge for you to pray? Because I think – and having not really talked about it much then, I think that you have some issues with that […] because I find, like, healing a really difficult topic, where I think – I believe it, but I – I haven't seen it […] In this case, though [it was] all or nothing. And so I prayed that night, and I just really think that worked […] I just can't believe that this child is better, basically.

Hannah explained that this was the only 'really good example' of her praying for miraculous healing. The experience, however, 'really […] pushed me to think about' her beliefs on this topic further.

[5] 'First, do no harm', part of the Hippocratic Oath.

We have already seen that both prayer and belief in God's control were important resources for Elizabeth. This was equally true when she prescribed medication whose precise operations were uncertain. She explained that, though 'the percentages are hazy […] I'm just going to trust that to God.' Similarly, when she feared had made errors:

> [T]here are some times when I come home, and I am *not* at peace about something […] And I will pray about that, and I will be like, you know, if I've not, if I've missed something, let that patient be alright, and if I need to do something different, Lord let me see […] in those situations I feel very aware that I am just […] a fallible human doctor and actually, Lord, help – help me, with this? So that I can do the best that I can for this patient.

Elizabeth's beliefs in God's providence and human fallibility converged, and she sought comfort in prayer. Lewis wrote about the importance of being 'honest with yourself' and 'learn[ing] that it is not your responsibility to save the world, the NHS or your neighbour.' Ruth felt her faith helped her achieve this. Her recognition that 'we are not divine' helped her to set boundaries and expectations, noting that many of her colleagues, by contrast, struggled with unpredictability:

> I'm mindful that I can only do so much, I'm mindful that I, umm, can't treat everybody, I'm mindful that I have my own limitations. And […] there's wisdom in that, in realising that we are not divine, in realising that, umm, there's a lot we can't see, realising that there's a lot that's unpredictable and a lot that's out of our control.

She was also aided by her belief in 'God being a constant […] and God's character not changing.'

Relatedly, several participants used 'the fall' as an interpretive framework. This significant theological notion was familiar to the participants. Because of her work, Elizabeth was often 'reminded that we live in a fallen world and Jesus is the only answer. I ache with people who struggle with depression, anxiety, addiction and abuse and thank God for his love in sending Jesus.' Fellow GP Richard often similarly felt 'aware of a lot of stresses/suffering problems of our fallen world'. Resultantly, he 'prayed for situations and people silently […] when they left, or before and during seeing them,' and did 'what he could' to resolve brokenness. Chatters, reviewing research on spirituality and health, notes scholarly suggestions that beliefs in original sin and human fallibility correlate with negative emotions of guilt, shame and anxiety, a sense of imperfection, and low-self-worth.[6] Similarly, Puchalski and Ferrell suggest that recognising their fallibility can challenge medics, presenting it as something they must 'deal with.'[7] Far from either suggestion, Elizabeth and Richard felt able to interpret and understand the brokenness to which medicine exposed them. Certainly Ruth and Elizabeth's recognition of their fallibility did not pose a spiritual challenge. Indeed, Ruth's

[6] Chatters, 'Religion and Health,' p.347.
[7] Puchalski and Ferrell, *Making Health Care Whole,* pp.171-172.

reflections on her 'limitations' more clearly bear out Wright's observation that religious and spiritual nurses' beliefs may mean they 'abandon superhood,' thus avoiding the potentially negative consequences of frustration at their inability to 'fix' everything.[8]

Finally, the participants' beliefs helped them to address death and suffering. There are plentiful suggestions in the literature that extensive and repeated exposure to death leads some healthcare professionals to struggle with meaninglessness.[9] Though death remained challenging, the participants in this study consistently found that their faith helped them to manage it, reframing and thus couching its emotional challenges.[10] Akua found patients' suffering easier to manage knowing that God, in Jesus, had also suffered and experienced death. Jeremy found comfort amid death

> [b]ecause I do believe that there's some sort of perspective beyond the earthly life. […] And I think that that is comforting to a lot of people [and] it's important to me, as well, because I realise that this isn't the be all and end all.

Gwen explained that she had found encountering death difficult, and she often grieved for patients. However, because of her faith, she felt she could 'grieve with hope.' Similarly, Richard explained that it had been important to 'let go and accept that whereas death's an enemy […] what comes after is better!' In both examples, grief and hope are intertwined: grief does not erase hope, nor hope grief; rather, each assuages the other. Echoing Richard, Goodluck affirmed death as part of a God-ordained 'rhythm' or 'order' of life. Gwen, along with Lewis, also used the idea of 'carrying one's cross' to render encounters with death and suffering meaningful, helping to manage them. Gwen recalled a colleague's advice: that, to manage in medicine, she must not 'look at the glamorous bits, but work out which cross you can bear.' Repeated exposure to children's deaths and suffering was not one such cross: thus this theological lens also led her to work in general practice, not paediatrics.

Ruth recognised the risk of becoming emotionally 'unhinged' because of the suffering she witnessed in her work. She explained that her 'secure hope' and 'sense of perspective on suffering,' as well as her 'sense of calling,' helped to 'ground' her:

> I think if we […] can know that there is such a thing as truth, if we can know that, umm, there is life beyond this one, if we can know that we have a secure hope in heaven, if we have a sense of

[8] Wright, *Reflections on Spirituality and Healt*h, pp.43-44.

[9] M. Aase, J. E. Nordrehaug, and K. Malterud, '"If You Cannot Tolerate That Risk, You Should Never Become a Physician": A Qualitative Study about Existential Experiences among Physicians', *Journal of Medical Ethics*, 34.11 (2008), 767–771 (p.768).

[10] See Margaret Holloway, 'Death: The Ultimate Challenge' in *Spirituality and Mental Health: A Handbook for Service Users, Carers and Staff Wishing to Bring a Spiritual Dimension to Mental Health Services*, ed. by Peter Gilbert (Brighton: Pavillion, 2011), 269-280 (p.271). That is not to say faith was their only resource in this vein: participants had various non-faith-based resources for managing death, including their increased familiarity and emotional distancing.

> calling, umm, if we have a sense of perspective on our suffering, and a sense of perspective on the suffering of other people, umm, that can help to ground us. And hope […] So there are elements of my emotional state that enhance the work that I do. By being stronger internally and inwardly, I'm in a better place to give, I'm in a better place to listen.

As noted in 'Taking Stock,' Sims and Cook have suggested that religion and spirituality can bolster psychiatrists' wellbeing, and help guard against 'existential despair.'[11] Ruth's faith not only helped guard against despair, and becoming 'unhinged,' but also, she believed, enabled her to do her work well. More broadly, Ruth saw her faith as an effective source of meaning, saying 'having a Christian worldview […] gives us an explanation that is meaningful […] a stretcher that's reasonable and intelligent and […] biblically-grounded explanations for why we are why we are.' She thus 'retain[ed] a sense of being able to make […] sense of it all.' Similarly, Philip explained that he would 'rely' on his faith 'for meaning and purpose' in a variety of contexts.

Resourced by People

As Zukerman et al summarise, positive religious coping includes: benevolent religious appraisals; seeking spiritual support or a spiritual connection with God or a higher power; and engaging in meaningful religious practices.[12] The above has shown positive religious coping at work, highlighting 'benevolent religious appraisals' and 'spiritual connection with God' through prayer, and trust in divine control, among other significant beliefs. We now explore the medics' uses of other 'meaningful religious practices;' and their 'seeking spiritual support' by meeting with other Christians.

Participants consistently emphasised and explained the importance of church.[13] Richard gratefully described the support and teaching he had received at 'good, evangelical churches.' David, similarly, explained that he had 'been very fortunate that I've been attached to strong churches and strong fellowships that have helped carry me through tough times and changing times.' Catherine advised other Christian doctors to 'have Christian support you can trust, read the Bible and pray about difficult situations.' For Gwen, churchgoing had particular emotional motives: she explained, 'sometimes – at church – […] yes, you would worship God, but to be honest it was just sort of […] sometimes it was just to recharge the batteries! Peter made similar observations of his 'quiet times,' describing time spent alone, praying and reading scripture as an emotional resource akin to mindfulness. He explained 'It's a very helpful emotional resource […] When you're dealing with

[11] Sims and Cook, 'Spirituality in Psychiatry,' pp.9-10.
[12] Zukerman et al., 'Avoidance Behavior Following Terror Event Exposure,' p.517.
[13] While churchgoing is practical, it is also belief-based: it is a site for reinforcing and exploring beliefs, and based on belief that it the practice is valuable and Biblical.

those struggles […] resetting yourself, having a daily quiet time […] stopping to reset in the morning, recharge, think about what's right.'

Ruth, like Gwen, found church an important site of 'inward renewal,' a place to seek strength from God and 'indwelling' from the Holy Spirit. The support of her church community also bolstered her resilience. In particular, Ruth echoed ideas concerning medical identity which we explored in the previous chapter. She was thankful that church gave her a focus beyond her job, helping to ensuring her identity did not become too heavily entwined with her work:

> [I]t's also thinking about being part of a church community, because I believe God's given that to Christians and that it's a biblical concept that we have the support and the nurturing and the sharing. Umm. And Love. […] I think shaping our identity as psychiatrists is important not to be done purely on the basis of our work [because] that leaves us very vulnerable […] So I think basing our identity around our Christianity […] and nurturing and building on our friendships and family relationships outside of work is also very important.

Others echoed Ruth's ideas, particularly regarding the support they found in church communities. Peter gratefully described his as 'really supportive, really encouraging, really helpful.' Several participants saw them as means through which God supported them. James described his church as a 'very good support network,' noting the importance of such relationships: 'people have to help you to get to where you need to be […] bonding in church, with different types of people [is a way] God has allowed people to work in my life.' More unusually, Ginny described God working through what she called the 'Christian mafia,' Christians whose connections and networks had aided her during career transitions. But she also explained her gratefulness that she was 'part of a community who will pray for you, and [give you] a focus other than the NHS.' Thus, as for Ruth, church afforded Ginny a measure of work-life balance. Jeremy, similarly, explained that:

> [G]oing to church grounds you in the community of believers, who can help keep you in check, um, and encourage you when you need encouraging, pick you up when you need picking up […] And certainly being part of a small group as well as a church is important for me because you know, if I'm working Sunday night, I'm less likely to be working Wednesday night, so, you know, most weeks I can go to one of those things – SOMETHING – yeah, some sort of dedicated time when you invest in your faith with a group of other people.

Mid-week 'small groups' and 'home groups' were significant for many participants, particularly those junior doctors whose shift patterns made regular Sunday commitments difficult. Liam was thus grateful to have connected to a church quickly after starting work as a junior doctor:

> Sometimes the schedule of an FY1 feels like a barrier to building community at church.[14] I'm lucky to have gotten connected at [church] early on when I was on my paed[iatric]s job and wasn't working any weekends or evenings. Now that I am on a busier job, it is more common that I am busy Sunday evening or Wednesday evening when my small group meets. […] I would advise to get connected in a church early if possible and have a community there. It's so helpful having people to speak to and support you.

Liam was grateful for his small group's support, and recalled specifically asking for prayer in anticipation of his rotation in vascular surgery, which he was expecting to find both emotionally and technically challenging.

For many, church was also somewhere to connect with other Christian medics, whose support and dual empathy participants particularly valued. Liam turned to other junior doctors in his church and small group to discuss and pray about challenges he encountered, and to seek wisdom on 'how to mix our faith and work.' Ruth described Christian doctors who could 'strengthen and motivate/inspire' her because they 'share[d] common experiences.' Hannah particularly valued empathy regarding the ways her work problematised regular church commitments. Goodluck similarly noted that he was 'very close to a Christian doctor, and discussions with him, involving both faith and work, are universally cathartic.' In particular, he valued his friend's understanding of 'what it's like to think that you've killed someone? By making an error. Um. Something that I don't think even most vicars would be able to [understand].' Philip regularly met with other Christian doctors for breakfast, welcoming the chance to reflect and pray in empathetic company. He had thus considered seeking out Christian colleagues in his specialty. Simon described a similar 'accountability relationship,' something he encouraged others to consider establishing:

> [W]e would meet and we would pray, so for our fellow and our clinical leaders, and non-clinical leaders. And we did think it was extremely important – our experience of prayer as we prayed for colleagues was that it seemed to make a big difference […] [W]e saw things which, um, appeared to be quite dramatic, and direct answers, to prayer, in those difficult situations. So I think it gives you that sense of – agency. […] [I]t's – it's an advantage – just to be able to share with another colleague! But also to be able to bring those things to God.

Additionally, many were grateful for other Christians in their workplaces. Gwen believed God had always 'put in place' Christian colleagues to support her, so that she was 'never alone,' including during difficult on-call shifts in the small hours. Nigel had been part of a small hospital prayer group, which met 'just one morning a week, and it – it was good. To come together. With some of the issues that we were all having, some of the things – and having that, and I – I found it a nurturing space.' David described one of his GP training supervisors, a fellow Christian who had helped him

[14] FY1 stands for Foundation Year 1, the first of two years that constitute the bridge between medical school and specialist training for doctors in the UK.

explore how to appropriately share his faith in the clinic. Richard advised that support from 'older Christian doctors is likely to be very helpful especially in the early years.'

Many participants also valued the CMF, often advocating it to others, not least as a further forum in which to meet other Christian medics. Philip had welcomed the chance to speak with more experienced colleagues:

> [T]he Junior Doctor Conference [was] very helpful because I got to talk to also registrars and consultants as well, and that was just a vital time [and] focus on what my career was going to open up [and] reflect on the challenges ahead.

Others similarly found the CMF helpful for addressing particular challenges. Richard had found their magazine, conferences and regional groups helpful, particularly early in his career. He mentioned that '[their] booklet 'Dying, the greatest adventure of my life' [was] helpful in discussing [and] preparing for death.' John described CMF as a manifestation of Matthew 18:20, saying, 'CMF is when two or three come together […] and share their struggles, burdens and spend time praying for each other.' He was grateful for 'fellowship with likeminded people who know exactly what you're going through, both from a faith point of view as well as from [a] medicine point of view.' Hannah had recently joined her local CMF group, where they 'pray[ed] for each other, and we do also keep each other updated on […] cases, and problems.' Elizabeth also discussed the value of CMF groups in relation to medical ethics, recognising these could be particular sites of tension between medicine and evangelical perspectives. She explained, 'that's why I'm linked in with the Christian Medical Fellowship […] to support one another, so we can chat about these things […] we've got other people that we can […] go to.'

In addition to finding its conferences and literature - particularly on Christian perspectives in mental health - an important source of motivation and support, Ruth also appreciated the CMF's role in public affairs:

> [They] help us to feel as though we have […] a voice in the public arena, so the campaigning they do for, umm, Christian doctors, the, the kind of sense of the ethical work that they do, seeing to lobby the government, that kind of positive pressure, as it were, representation, I think is healthy.

Affinity Resources

Though research findings are not unambiguous, it is widely suggested and reported that, within patient populations, religion and spirituality can improve health outcomes.[15] The social support

[15] David B Feldman, Robert A. Gressis, and Ian C. Fischer, 'Does Religious Belief Matter for Grief and Death Anxiety? Experimental Philosophy Meets Psychology of Religion', *Journal for the Scientific Study of Religion*,

afforded by religious communities is often presented as particularly significant in this sense.[16] The above suggests that the social dimensions of religion can also have a protective and resourcing effect among healthcare practitioners. This is not to suggest that participants relied solely upon their faith to resource and sustain them. They noted many others resources, including friendships and supportive colleagues, being able to 'leave work at work,' and simply enjoying their jobs. But it is nevertheless significant that they so extensively described ways in which they did use their faith as a resource. They used it as a cognitive, practical and emotional resource in their work, particularly in times of difficulty. While this thesis cannot demonstrate that Christian medics are more or less resilient than their non-religious counterparts, or colleagues from other religions and traditions, it does illustrate the many resources these participants felt they had because of their faith.

These faith-based resources also further illustrate work-faith affinity. The medics' faiths resourced them to do their work, and to manage its challenges. This bolstered their perceptions of a consonant relationship between their work and their faith: the two went hand-in-hand. In particular, this evoked a sense of mutuality between the 'faith-self' and 'medical-self.' Participants felt more secure as medics – indeed, as Christian medics – because of the support offered by and found in their faith. Thus, as in the previous chapter, work-faith affinity was not merely neutral, but a positive force in the participants' lives. Drawing on faith resources was an important means of achieving a consonant sense-of-self, albeit one in which the medical and faith facets of their identity were often depicted as distinct-yet-related. Of course, the above also shows that, in some cases, the participants' Christian faiths created the need for such resources: that is, that challenges associated with being a Christian in medicine were significant among those needing to be managed and resourced.

Furthermore, in the above examples, work-faith affinity was evident not despite such challenges, but precisely because of them. The participants' engagement in various forms of positive religious coping shows that work-faith affinity and consonant identity conceptualisations existed even when challenges risked disrupting these. The literature shows that death and suffering, uncertainty, failures and fallibility, and tension between work and faith expectations all have the potential to stimulate challenges, difficulties and troubling emotions. In turn, these might encourage Christian

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55.3 (2016), 531–539 (p.532); Gil Zukerman and Liat Korn, 'Post-Traumatic Stress and World Assumptions: The Effects of Religious Coping', *Journal of Religion and Health*, 53.6 (2014), 1676–1690 (p.1678); Crystal L. Park, 'Religiousness/Spirituality and Health: A Meaning Systems Perspective', *Journal of Behavioral Medicine*, 30.4 (2007), 319–328 (p.319).

[16] Brick Johnstone et al., 'Relationships Among Spirituality, Religious Practices, Personality Factors, and Health for Five Different Faith Traditions', *Journal of Religion and Health*, 51.4 (2012), 1017–1041 (p.1018); Bernard Moss and Peter Gilbert, 'Flickering Candles of Hope: Spirituality, Mental Health, and the Search for Meaning: Some Personal Perspectives', *Illness, Crisis & Loss*, 15.2 (2007), 179–191 (p.190).

medics to see the medical and evangelical facets of their identity less as 'mutual' and more as competing or in tension. Such tension-based dissonant identity, unlike the hierarchical model introduced in 'Calling,' was not seen in aspirational terms. Yet, in the above examples, such tensions were kept to a minimum, for they had resources which guarded against this. Thus, it was not only that the participants experienced work-faith affinity through their faith-based resources, but that through these, they avoided potentially problematic dissonances. For example, I asked Lewis if his work had ever challenged his faith. He explained that while his work had been challenging, it had never challenged his 'theological framework.' Because, he explained, 'it seemed to work.' His faith was an effective resource for managing challenges which otherwise might have created dissonance. Thus when Moss, Clarke and Moody observe that worldviews can 'sustain' in times of difficulty, this is, in part, because the resources they afford, and the work-faith affinity they foster, can keep problematic dissonance at bay.[17]

By contrast, for some participants, their faith also provided resources which nurtured the'hierarchical identity conceptualisation (which, as we saw in the previous chapter, was both dissonant and aspirational to the evangelical medics.) Strhan's work with conservative evangelicals showed that participants 'work[ed] on themselves and each other to form themselves as exiles, to be different from those around them.'[18] This chapter shows that meeting with other Christians often had the opposite effect for the participants in this study: they sought support and advice, not least in the hope of more effectively integrating their faith and their work. Yet some participants, such as Ruth and Elizabeth, *also* valued the CMF, in both its local and national forms, much as Strhan's participants did – as a space in which to bolster their sense of opposition and distinctiveness with regards to controversial topics in medical ethics. In addition to functioning as an affinity resource, meeting with fellow Christian medics, for some participants, also served to sustain a hierarchical identity conceptualisation. As such, this chapter echoes the examples in 'Calling' whereby participants aspired to both a consonant model of identity (or, to be 'Christian medics') and a hierarchy of identity, in which the faith-self was prioritised (to be 'Christian first, and medic second.')

Limited Resources

The foregoing has shown participants utilising beliefs, practices, and particularly prayer, to resource them for their work. Many such faith-based resources were used in relation to particular challenges, including uncertainty, failures and errors, weighty medical responsibilities, and exhaustion.

[17] Bernard Moss, Janice Clarke and Ivor Moody, 'Educating for Spiritual Care' in *Spirituality and Mental Health: A Handbook for Service Users, Carers and Staff Wishing to bring a Spiritual Dimension to Mental Health* Services, ed. by Peter Gilbert (Brighton: Pavilion, 2011), 281-296 (p.281).
[18] Strhan, *Aliens and Strangers?,* p.200.

Particularly when facing challenges associated with death, suffering and brokenness, their evangelical faiths provided participants with meaningful interpretive frameworks. This bears out specific suggestions that healthcare practitioners use their religious and spiritual worldviews as resources for creating meaning, and guarding against crises of meaning.[19] While they acknowledge that worldviews might be utilised in a fragmentary way, Taves, Asprem and Ihm also note widespread suggestions that 'the ability to maintain a sense of meaning across situations is critical to a sense of wellbeing.'[20] The above examples are analogous: the participants maintained the ability to make meaning out of challenging situations by using their faith. This fostered their wellbeing, and aided them at work.

The significance of emotion in such meaning-making and relief is clear: where beliefs were deployed in response to challenges, this had important emotional antecedents and consequences, for the participants were hoping to respond to and relieve negative emotions. This affirms Vanderpool and Levin's suggestion that 'religious worldviews can help healthcare practitioners to 'make sense of and feel relieved from the chaotic or tragic features of life, and [to] find measures of peace.'[21] Equally, though, faith-based resources were used to sustain quite apart from particular problems: in particular the above shows that the participants used prayer both as a response to challenges, and as a quotidian resource. Ruth articulated this when she described the 'steady influence of her faith,' which helped her to 'stay well emotionally,' functioning more as a cognitive and emotional 'protective shield' than a last-ditch defence.

We should, however, be cautious, for often faith provided valuable resources, but did not thus resolve difficulties. We have seen that Gwen still found death emotionally painful, even as she grieved 'with hope.' Ruth managed the emotionality of her work, but nevertheless believed God allowed her to, valuably, suffer alongside people:

> God promising to be with us through all things and to be with us through the whole of our lives, that gives us something remarkable. [But] I think God does allow us to suffer, so I think there's an element whereby we cry with people […] there's an element whereby we need to empathise, because the compassion side of things is to feel motivated to make a difference.

In Lewis' discussion of failure and forgiveness, we see that even as he was comforted by his belief in forgiveness, his guilt was not fully assuaged. Rather, guilt and relief were intermingled:

> [C]atastrophic failures from the past also appear into the conscious mind from time to time. Perhaps 'what might have been' is always there. […] Faith offers forgiveness for those who

[19] Cadge, *Paging God,* pp.165-168.
[20] Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.213.
[21] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.10.

> repent, but calls for the best of efforts. Perhaps the greatest failing is not keeping up to date in the past – that might have avoided major errors for one or two folk at least. I do regret not being as good as I might have been as a clinician.[22]

As we will explore in more depth later, Nigel found that his work as a child psychiatrist presented him with troubling questions about suffering. Prayer, and his belief in God's love, helped him: indeed, he said '[t]here have been times when hearing about the experiences of some patients has been hard to listen to and to manage the impact of these accounts has only been possible because of my faith in a loving God.' Like Ruth, he cited knowing 'where he stood' in relation to a loving God as an important source of security for his identity amid potentially destabilising encounters. However, neither this faith in a loving God nor his 'awareness' of his 'lack of knowledge, and […] limited human perspective' fully resolved his struggles with suffering. In these examples, positive religious coping is not a zero-sum game; resourcing and relief were often incomplete. Even as we observe that faith functioned as an important and significant resource for these evangelical medics, we must allow for such complexities and nuances.

With this in mind, it is important to note that the above faith-based resources did not 'work' universally. In particular, turning to other Christians was not, in every medic's experience, always entirely helpful. Even as Hannah valued her local CMF group, and found that CMF forums helpfully informed her ethical thinking, she often disagreed with the organisation's 'party line.' While she affirmed their stance against prenatal eradication of genetic diseases, she explained that 'with regards to the CMF's approach on abortion, I would probably not join with them on that.' She described Northern Ireland and Malta's anti-abortion laws as a 'really sad outcome of conservative Christian views. I think there's a role for having a clear line, but I think that line is wrong.' More broadly, she found the diversity of Christian views on abortion distressing:

> [M]eeting um, Christians, that are approaching things very differently, like on specific ethical issues – sometimes that can, like, make me doubt, like, am I doing the right things, but also doubt whether – do I believe, like, in the same god as you? [And] doubting that I'm repping being a Christian well.

Sarah was similarly conscious that some of her views differed from her fellow congregation members', explaining that 'the assumption is, in our church, that abortion is wrong. I mean […] – that's not coming from the front, but when you talk to people and they always assume.' She wrote:

> My views on such moral issues as end of life care/resuscitation/abortion are different from most Christians', most of whom would be strongly against euthanasia and abortion. I, on the

[22] This episode also highlights the complexity of emotional recall: memories of success in turn aroused memories of failure and complex attendant emotions.

> other hand, feel that euthanasia, or at least less interventionist resuscitation/prolonging of life in terminal conditions, should be discussed, being aware of the pitfalls [and] I am strongly of the opinion that women should have access to abortion, though [be] encouraged to explore all alternatives. I do not believe that an embryo is a human being - rather a potential human being. I do not share my views on these issues very often in my church circles.

Sarah found this difficult, instead 'taking things' to a Christian colleague and friend who was also a medical professional, knowing she would listen empathetically, even if she held different views. For both Hannah and Sarah, meeting with other Christians was not always or necessarily a resource: it could also be deeply troubling.

Such perceived Christian 'groupthinks' meant that some participants felt they had nowhere to voice ethical dilemmas and concerns. Amelia, conscious of official Catholid stances on many topics in medical ethics, felt 'reluctant' to go to her priest. She continued: '[W]hen I talk about religion, I see it more as a Catholic - Catholicism underpins it – but my life experience informs my own personal beliefs. And […] that can create tensions with someone who is […] representative of the church.' Similarly, perceiving that evangelical Christians were likely to uphold particular, conservative ethical views, Martha struggled with the absence of a 'safe forum.' Thus, where others felt supported by Christians with whom they could voice ethical uncertainties and difficulties, Martha experienced the opposite:

> I find it very, very difficult that there is no safe forum to discuss these things. Because if I discuss them with non-Christians, they'll probably think that I, even my views are, like, really conservative. And when I discuss it with Christians they, you know, you'll already be told how you should think. So I've found that difficult.

Martha experienced ethical silencing, and this troubled her.

Quite apart from ethical difficulties and the barriers of apparently unquestionable group discourses, Thea also felt let down by churches. She described times in her career when she had felt sustained by Christian 'practices, particularly with respect to prayer, forms of communal and individual worship and self- reflection.' However, issues arose when she felt her church ceased to support her. Coupled with challenges at work, she felt that 'everything was depleted' and 'all my resources and everything that had sustained me […] was now in negative balance […] everything was being stretched.' Much as Thea had been grateful for faith-based resources, as they fell away she felt acutely that her resources were 'depleted.' Similarly, for many of the junior doctors, church's

importance for their wellbeing and resilience at work was backhandedly affirmed when regular church commitments became difficult.[23] Hannah recalled her A&E rotation, saying:

> [S]ometimes a rigid rota can be really gruelling, and I think my mental health suffered […] part of that was not being able to see friends and part was, like, not being at church on a regular basis. […] I think I probably miss the community, which I guess is part of spiritual support.

Thus, both generally, and particularly regarding ethics, faith-based resources can be double-edged. Just as a sense of calling can both sustain and burden a medic, so too can Christian communities both resource and burden. This was not everyone's experience, nor was it the case in every instance: indeed, we have seen that Hannah welcomed CMF's wisdom on some topics, but struggled with it on others. For others, the extent to which they needed a resource was clear only when it ceased to be available. However, just as it is important to recognise that resources will not always mean resolutions, it is important to note this potential experience of faith-resources, if only so that Christian communities might be encouraged to consider the ways in which their actions and discourses may leave some without important sources of sustenance.

Conclusion

Moss, Clarke and Moody argue that we 'all need a world view that sustains us in times of difficulty.'[24] In this, they echo broader observations that healthcare work, and particularly its challenges, often leads its practitioners to draw upon spiritual or faith-based resources. This chapter has explored the forms this took among the evangelical medics in this study. It has not claimed that 'times of difficulty' therefore did not remain, or that evangelical medics struggle less than their non-religious counterparts. Nevertheless, this chapter shows that the participants had – and, moreover, perceived themselves to have – what Gwen called, 'additional resources.' They felt that their faith, as Ruth noted, gave them 'something remarkable.'

The participants used many such faith-based resources in their work. Their beliefs enabled them to process, interpret and re-frame challenging scenarios, turning to God, and finding meaning in the 'chaotic' and 'tragic' things they encountered.[25] They prayed in many and varied situations, and keenly met with other Christians. Turning to faith-based resources had both emotional antecedents and consequences, transmuting 'times of difficulty' into measures of peace and relief. Indeed, the significance of all of belief, practice and emotions in the above provides a more precise understanding of Moss, Clarke and Moody's suggestion, and of how positive religious coping can

[23] We explore this further in 'Compromising'.
[24] Moss, Clarke and Moody, 'Educating for Spiritual Care,' p.281.
[25] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.10.

operate in healthcare contexts among evangelical medics.[26] Individual faith and worldviews are dynamic systems of interplay between emotion, practice and belief, not reducible to belief and practice alone.

However, this chapter also offered words of caution. It has shown that faith-based resources did not always result in wholesale resolutions. Furthermore, it highlighted that, to some extent, faith created the problems which the participants then used it to address. Finally, it noted that participants did not all feel they had access to all of the above resources, and saw the difficulties experienced when these were absent, either for a short time or in the long-term. While this chapter has emphasised work-faith affinity, and consonance between healthcare work and evangelical faith, it has also highlighted such wrinkles, as well as noting the ways in which faith resources also, for some, sustained a hierarchical identity conceptualisation. Moving on, dissonance and its implications for the individual will become more significant. For example, in the next chapter, we see the participants deploying their faith in opposition to particular ethical trends.

[26] Moss, Clarke and Moody, 'Educating for Spiritual Care,' p.281. See also Michael J. Balboni, 'Everyday Religion in Hospitals', *Society*, 52.5 (2015), 413–417 (p.414).

Opposing

"As a Christian doctor I am against the principle"

Introduction

'"How can I be a Christian and a doctor?" I hope the answer is "it's possible, but with challenges".' Many participants echoed Lewis's question, and his answer, and topics in medical ethics were often at the heart of the 'challenges' they identified. Catherine explained that 'some of the roles in your job are inherently just challenging as a Christian, aren't they? […] the very difficult things like, um, some – the terminations that happen.' Akua, who was at medical school when we met, anticipated that medical ethics would likely pose challenges in the future: 'Because I'm in medical school, at my level of training I don't really have to make moral decisions, which is a time I'm sure I would be conscious of my faith.'

Bergin suggests that religious and spiritual psychotherapists may have to 'harmonise' their personal and professional values.[1] This sentiment is echoed for many areas of healthcare, as scholars highlight the potential for individuals' religious and spiritual worldviews to conflict with the values and practice of medicine. As Vanderpool and Levin put it, '[d]epending upon time, circumstance, subject, and interpreter, religious and medical ideas and methods complement, compete with, or conflict with each other.'[2] The two preceding chapters have primarily illustrated 'complementing,' highlighting harmony and affinities between evangelicalism and healthcare work, not least as the participants utilised their faith as a resource. This chapter focusses instead upon instances in which participants were acutely aware of tension between their faith and medicine - that is, in which a 'conflicting' interaction seemingly dominated.

In particular, this chapter shows participants deploying their faith in opposition to norms and trajectories in medical ethics. It observes two different 'modes' of ethical engagement. In the first, ethical opposition stems from firmly-held Christian beliefs and principles. In the second, opposition is apparent, and principles firmly held, but these are hedged amid, and complicated by, awareness of ethical 'shades of grey.' This chapter suggests that, amid opposition and conflict, instincts towards work-faith affinity were nevertheless apparent, balanced against a useful degree of tension which stopped short of collapsing consonant identity. More broadly, this chapter therefore reinforces

[1] Bergin, 'Psychotherapy and Religious Values', p.102.
[2] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.14.

suggestions that scholars should avoid over-associating evangelicalism with resistance and protest, instead exploring drives towards both tension and affinity.[3]

Operationalised in Opposition

While we have seen that the participants drew upon firmly-held Christian beliefs as resources, these were not always a source of relief, peace or comfort. Rather, in some circumstances, the participants operationalised their beliefs in opposition, particularly against norms and trajectories in medical ethics, creating a sense of difference and distinction on account of their Christian identities. For instance, I discussed several ethical topics with James. Of abortion, he explained: 'In a nutshell, I'm against it, because I think the Bible shows that it's not permissible. So. That's my red line. […] I always go by what's in the Bible.' Explaining his stance on same-sex partnerships and marriages, he said:

> I almost have a firm stance on this one, in that I'm quite against it. From – but again, it's, you hate the sin, not the sinner. That's the big issue. And I think that a lot of the time in situations of phobia, homophobia – I think that's not my stance at all. I think it's that I don't agree with the action, with the act of sin, but I do support people that have been oppressed […] But I feel like it's still a sin that needs to be addressed. And we need to act out of grace, we need to show love to those people, but yeah, in a – I'm against it. As a concept. [Because] you cannot be complicit in that.

Oppositional logic suffused James's explanations: he 'disagreed' with practices he deemed 'not permissible' or 'crossing a red line,' according to his reading of the Bible. He linked this to a broader oppositional biblical rationale, presenting himself as an extension of God's light in 'situations of darkness':

> [O]ne scripture that I have latched on to is Matthew 5:13-16; we are called to be the Salt - preservation of the Earth. I interpret this as we need to be in the world, but not of the world. […] it is my responsibility to be a light in what may truly be a dark place […] for example, dealing with matters of life and death, same sex marriage, abortion and euthanasia […] the challenges we face in this world present opportunities for us to extend the unmerited Grace that we get from our Lord God, in situations of darkness.[4]

Peter 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

[3] Smith, *American Evangelicalism*, p.89.

[4] Except where specificity is important, I use 'euthanasia' as a broad term, encompassing all actions taken by medics with the intention of ending someone's life, or hastening its end. This echoes how the participants used the term.

> 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.

Discussing the prenatal detection of Down's Syndrome, Lewis 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,' made him feel 'chilled' and angry, firmly at odds with those advocating the eradication of Down's Syndrome. Like Peter, his faith informed deductive moral reasoning – that is, he derived what he deemed a morally correct stance from general principles of his faith.[5] Hannah similarly viewed recent Icelandic legal changes with concern:

> I have an issue around prenatal testing […] I'm really clear in my head that I completely disagree with it. Because you're undermining the value of a child based on, like, what is actually just their – their uniqueness. [And] in the case of Down's Syndrome […] you're getting to the point where, like, Iceland have no babies born in the last two years with Down's Syndrome, it's just – like, tragically sad.

Like Lewis, Hannah could not reconcile prenatal eradication of Down's Syndrome with her belief that everyone, uniquely, was made in God's image. She explained that if such laws were proposed in the UK, she would write to her MP as a 'concerned Christian doctor,' and that 'if I was ever needed to contribute, to debate on it, that I'd be pro-not-having-it.'

Catherine also opposed prenatal genetic testing, particularly because she felt treatment was synonymous with termination which she 'wasn't really prepared […] to do.' She described the culture among her colleagues whom, she felt, 'ha[d]n't really thought about [abortion] and just d[id] as they're expected.' As a former GP, she had not been able to avoid the issue entirely, but had 'g[o]t round [it] with, you know, supportive colleagues. And I mean I would never have gone into obstetrics for that reason.'

Interestingly, Catherine did not explain why 'as a Christian' she opposed abortion. Rather, she allied herself to a broader community of opposition, using 'Christian' to summarise it. Similarly, David

[5] Jonathan Kelley, M. D. R. Evans, and Bruce Headey, 'Moral Reasoning and Political Conflict: The Abortion Controversy', *The British Journal of Sociology*, 44.4 (1993), 589-612 (pp.591-592). Kelley, Evans and Headey suggest deductive and 'authoritative' (based on authoritative moral teaching) modes are distinct. Surely, though, they are closely related: the authoritative can be the source of deductive principles; the individual can be socialised to think deductively in line with authoritative ideas. James' reasoning, for example, twinned deductive and authoritative modes of moral reasoning

simply said, 'as a Christian doctor I am against the principle.' Early in his career, he felt abortion was a big 'tripping point' of tension between expectations at work and his faith, because of 'pressure' to sign documentation, though did note that he was 'allowed to decline.' He continued, explaining, '[f]ortunately, for Christian doctors, we're no longer expected to sign forms like that.' Again, David implied all 'Christian doctors' might be grateful of the protection afforded by such conscience clauses. As Brown and Lynch note, the English context has no direct equivalent to the 'culture wars' of the USA, in which moral issues achieve national political significance. Yet abortion has nevertheless been a significant issue around which UK evangelical subcultures have rallied, often attracting significant media attention.[6] This, perhaps, helps to explain Catherine and David's suggestion that 'Christians' in general resist abortion. This may also relate to my openness with participants about my Christian faith: they perhaps assumed I would have a shared understanding, or empathy, as to why 'as a Christian' they opposed terminations, removing any need to explain their faith-based deductions in detail.

Elizabeth also resisted abortion, and challenged the relaxed way she felt some medics approached it. She wrote the following about her time at medical school:

> I conscientiously objected to attending a Termination of Pregnancy surgical list (which I needed to be signed off for attendance). The surgeon doing the list said something like 'no one likes doing abortions bit you have to' [and] I think I replied 'no you don't - I won't witness it.' [Later on,] [i]n a lecture from a Gynaecology consultant (specialising in foetal medicine & 'birth control') He handed around the lecture room different surgical instruments used to terminate pregnancy, tools used to remove limbs & crush skulls to allow an abortion. I got up & walked out of the lecture.

Discussing these episodes, Elizabeth had '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.' Describing how she handled consultations later in her career, as a GP, she said:

> I'd feel much more confident if someone walks in and asks for a termination [now] than I did five years ago, because I've kind of felt, I know where I'm at with this, and I feel quite solid in where I'm coming from, and I feel quite confident in – in being able to share that, as a believing Christian – and that's kind of what, what I would say to people, […] 'As a believing Christian'. You know, I'm nailing my colours to the flag [sic].

Because she confidently believed abortion was wrong, she was willing to firmly 'nail her colours to the [mast]' and act defiantly and distinctively. Given the significance of hierarchy in medical culture, such defiance was potentially costly, highlighting the vigour with which Elizabeth held her beliefs.

[6] Brown and Lynch, 'Cultural Perspectives,' pp.340-343. See also Warner, *Reinventing English Evangelicalism,* pp.31-32; and Guest, *Evangelical Identity and Contemporary Culture,* p.2.

Elizabeth also moved from discussing the specific issue of abortion to discussing her identity as a 'believing Christian.' Her ethical stance on this topic implicated her entire religious identity. In this sense, abortion functioned as a significant identity marker.[7] The importance of identity markers, or 'boundary markers,' in evangelicalism is well-known. These are issues, usually theological or moral, which are seen to symbolically classify people as inside or outside 'true' Christianity depending on their stance. For example, Penning and Smidt note that, among American evangelicals, abortion remains a moral boundary marker of critical importance.[8] Several participants demonstrated this tendency to draw boundaries around what they felt represented 'true' Christianity. For example, Liam explained, 'In my experience, around 10% of the medics I've known are "practicing" Christians (by that I mean going to church and identifying as a Christian).' Elizabeth's phrase 'as a believing Christian' is interesting and ambiguous. It delegitimises non-believing Christianity, and suggests Elizabeth may have considered those with differing stances on abortion beyond the bounds of 'true' Christianity. Such logic might also help to explain why Catherine and David allied opposition to abortion with 'Christianity,' seeing such opposition as the mark of a true Christian. Equally, the phrase de-universalises Elizabeth's statement, perhaps indicating a desire to present her opinion as one which she recognises others may not share.

Fifty Shades of Grey's Anatomy

The above examples show participants operationalising their faith in order to resist both existing norms and potential trends in medical ethics. They bear out Knight and Kim's observation that religious doctors may feel the need to speak up where they sense changes must be made or resisted in medical culture.[9] They also illustrate the significance of and emphasis placed upon distinctiveness from surrounding culture within evangelicalism, a theme we will explore at several points again.[10] Some, additionally, demonstrate the instinct to draw boundaries around 'true' Christianity on moral grounds. In Lewis, Catherine, David and Elizabeth's cases particularly, such resistance, and the principles upon it was based, had remained stable, or even strengthened, across their careers, despite resulting in a sense of opposition and difference. Deploying faith in opposition appeared to go hand-in-hand with its continuity and consolidation.

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[7] See Hunter, *Evangelicalism: The Coming Generation,* pp.63-64; Daniel V.A. Olson, 'Fellowship Ties and the Transmission of Religious Identity,' in *Beyond Establishment: Protestant Identity in a Post-Protestant Age*, ed. by Jackson Carroll and Wade Clark Roof (Louisville Ky.: Westminster/John Knox Press, 1993), 32-53 (p.38); Jackson Carroll and Wade Clark Roof, 'Introduction' in *Beyond Establishment: Protestant Identity in a Post-Protestant Age*, ed. by Jackson Carroll and Wade Clark Roof (Louisville Ky.: Westminster/John Knox Press, 1993), 11-27 (p.21): Nancy T. Ammerman, 'Religious Identities and Religious Institutions,' in *Handbook of the Sociology of Religion,* ed. by Michele Dillon (Cambridge: Cambridge University Press, 2003), 207-224 (p.211).

[8] Penning and Smidt, *Evangelicalism: The Next Generation,* p.28 and pp.70-71.

[9] Knight and Kim, 'Christianity,' pp.104-107.

[10] Strhan, *Aliens and Strangers,* p.200.

In apparent contrast to such resoluteness, many participants described ways in which healthcare work had increased their awareness of the complexity of medical ethics, and of the difficulties of directly applying Christian principles in many scenarios. Several described this as a shift from 'black and white thinking' to 'seeing in shades of grey.' That is, deductive moral reasoning was not always straightforward: many participants recognised a variety of ethical perspectives, options and complexities. Even Elizabeth's resolute anti-abortion stance was somewhat tempered as such. Though she refused to sign paperwork to allow abortions, she grappled with the fact that, in referring patients onwards, as per NHS requirements, she was nevertheless facilitating them. Recognising this grey area, she prayed for those patients, handing the situation over to God's control. Similarly, James's Bible-based convictions were moderated by his awareness that, as a medical student, he had not yet fully explored many ethical topics. While he instinctively opposed abortion, and could support this with biblical frameworks, he explained:

> I haven't had the time yet to think [abortion] over to be honest. […] So if I was a doctor making a decision, my first instinct would be – no abortion, I'm against abortion. But um – I don't know the different layers to it […] But I would go on what the Bible says.

Richard, like Lewis and Hannah, resisted movement towards eradicating genetic disorders such as Down's Syndrome. He felt the church must 'challeng[e] the medical profession and the government' on all forms of prenatal screening for genetic diseases, and the assumption that expectant parents would want a termination should they be detected. However, Richard went on to reason around the topic, conscious of ethical 'shades of grey.' While ultimately convicted that such developments must be resisted, this conviction co-existed with recognition that caring for those affected by genetic diseases could be very challenging, indicating understanding of different views. Similarly, Mel resisted suggestions that termination should be encouraged in all cases of prenatal detection of foetal abnormality. However, experience had taught her to be wary of judging others' ethical decisions:

> [Some] will have abortions because there is some massive defect that is found with their foetus, with their baby, and again I just think it's really easy for people to make a decis- make a judgement on that without knowing what it's like […] you don't know what you don't know. And I think unless you've been in that position, I just have to say, well – [pause] personally I believe that life is very sacred in ways that we probably don't understand. But I don't think I could ever… but I don't think, I don't think we're to judge! God judges. And God knows completely everything that's gone into that decision.

The same dynamic was consistently evident around euthanasia and assisted suicide, issues of direct relevance for those participants with experience working in hospice and palliative contexts. Many clearly articulated their rejection of euthanasia, and thus their resistance towards any liberalising of

UK laws. For example, Richard wrote that any such change would be 'very harmful and should be resisted.' Gwen feared that euthanasia was 'rearing its head' in the UK, a development she could not 'tally' with her belief in the 'sanctity of life.'[11] Others similarly backed-up their resistance with Christian, biblical principles. Thus Elizabeth was:

> very clear that life isn't ours to take. Umm. It's God that takes life, and it's God that knows when your time is going to end. […] So – no, I'm very clear that euthanasia is wrong, life is not ours to take, and actually that's why I've got *my job*, to try and make it as… so we don't need to resort to that, umm, because it's not right.

Deductive moral reasoning, based upon beliefs about the sanctity of life, God's love, and being made in God's image significantly shaped the participants' perceptions of euthanasia. Where many ethical discussions and discourses delineate the differences between passive and active, or voluntary and involuntary, forms of intervention to end life, it was striking that these differences very rarely concerned the participants in this study.[12] They were aware of such terminology, and complexities surrounding the 'law of double effect,' but only raised these ideas in order to dismiss them as largely irrelevant in forming their opinions. Biblical principles rendered these subtleties tangential: all forms ultimately involved taking the life of another, valuable human being, and were thus rejected.

Conviction, however, was combined with concern. Certainty that euthanasia should be resisted was intermingled with sadness, discomfort and ambivalence, not least as participants sympathised with the complexities, difficulties, and emotional and physical pain attendant in such situations:

> Elizabeth: [A]ctually, yes, the stage that you're in is really hard, and no one wants you to be in pain and no one wants you to be distressed and it's my job to ensure that isn't the case. And so I'm going to try to the best of my ability to make sure that isn't the case. We know we can't always fully deal with people's pain […] being very honest with patients that this is *really rubbish* and this is really hard.
>
> Ginny: [W]e can't manage every symptom, I'm not being unrealistic, there are people whose symptoms I cannot manage to the extent that they have the totally peaceful death that we would probably all want […] I cannot take away the pain from someone who is twenty-four and realises she is dying of gynaecological cancer. That is always going to be challenging and […] distressing for her, for her family, for everybody.

[11] 'The sanctity of life' was an important ethical principle for many. Yet, as noted in 'Resourcing,' several participants – including Gwen – also saw death as part of a natural, God-ordained life course. They thus resisted defending 'life at any price' even as they resisted euthanasia in its more extreme forms. This apparent ethical contradiction was maintained by several participants, affirming McGuire's suggestion that individual worldviews may well be apparently contradictory. See McGuire, *Lived Religion,* p.4.

[12] Hans-Henrik Bülow et al., 'Are Religion and Religiosity Important to End-of-Life Decisions and Patient Autonomy in the ICU? The Ethicatt Study', *Intensive Care Medicine*, 38.7 (2012), 1126–33; Clive Seale, 'Hastening Death in End-of-Life Care: A Survey of Doctors', *Social Science & Medicine*, 69.11 (2009), 1659–1666 (p.1660).

Indeed, Richard admitted that he could see why assisted suicide might well be the right course in some contexts. In his interview he described:

> the difficult cases one occasionally sees where you can't help feeling, well, surely this person should be helped in their suffering […] I don't feel that it's [an] unforgiveable sin or anything like that if someone does take their own life. I would be very [sighs] sympathetic, if I discovered that somebody was – was helped by a relative, although you've got to have a law to protect people, because that can so easily again… But I certainly – you know, I – I wouldn't want to be condemning them and saying, 'Oh, this is a terrible thing to do,' I mean they've taken a terrible decision, but out of enormous sort of pain and concern […] there's got to be as much understanding as possible.

Richard recognised that opposing euthanasia was, in some senses, difficult and problematic. His pauses and sighs highlight the emotionality inherent in this discussion. A similar mixture of opposition and uncertainty characterised his written reflections:

> While I sympathise with those who are not able to receive good symptom relief […] and I would never want to criticize those who may have taken that action in extremis, I believe there would be much harm in any acceptance of the practice. […] The whole basis of the doctor patient relationship would be altered with loss of trust of many older patients in what the motivations of their doctors might be, believing that I might be tempted to encourage them to end their lives.

We should note that such grappling between multiple perspectives and 'grey shades' did not only occur around contentious ethical topics. Elizabeth recognised that, while she believed that 'God ordained' that certain patients saw her, rather than other doctors, this was not the only way of understanding such events. However, despite recognising this shade of grey, she nevertheless remained certain of her convictions:

> [A]ctually, God knew you were coming to see me! Because you could have seen someone else. Umm. And you could say, 'Oh well the receptionist just booked you in the next slot, and you didn't particularly ask to see a female doctor or whatever else – but actually that's beside the issue: God knew exactly.

Non-Negotiability

Thus in both mundane matters and complex ethical contexts, participants remained certain of their standpoints, despite being aware of complexities and 'shades of grey.' Framed differently, faith-based convictions managed to cut through ethical complexities, and myriad perspectives and emotions. They enabled participants to forge firm – albeit not necessarily untroubling – moral stances on topics such as euthanasia. These principles rendered their stances non-negotiable. Thus, these non-negotiable principles could be understood as a means by which they felt able (or, perhaps forced) to articulate certain viewpoints on complex, emotional ethical topics.

This echoes Hans Mol's theory of sacralisation. Mol proposes that people sacralise those things which confer a sense of identity upon them.[13] He writes, 'There is a close affinity between identity-defence and sacralization […] The inevitable process that safeguards identity when it is endangered by the disadvantages of the infinite adaptability of symbol-systems. Sacralization protects identity.'[14] This process consists of four mechanisms: objectification; commitment; ritual; and myth.[15] Commitment involves emotional attachment, which wraps such elements in 'don't touch sentiments,' thereby safeguarding and reinforcing them.[16] Mol's 1976 *Identity and the Sacred* looms large in Davies' work, particularly his 2015 *Mors Britannica*.[17] As Davies expands, sacralisation involves the 'ascription of strongly positive properties to phenomena' such that people cherish them and are willing to 'defend [them] if attacked, for, in a sense, those phenomena comprise part of ourselves.'[18] Sacralised identity-conferring phenomena were, for Mol, primarily physical symbols – persons, places and things. Davies extends this to include intangible symbols – beliefs and practices. Deeply-held convictions were rendered non-negotiable, or in Mol's terms untouchable and sacralised, by the participants in the above examples. Elizabeth, for instance, sacralised her belief that life is 'not ours to take,' and thus defended it, determinedly, through a range of actions. The same non-negotiability was evident in Lewis's attitudes: to promote the eradication of genetic diseases represented a misunderstanding of 'what it means to be made in the image of God,' which he could not countenance. The non-negotiability of this principle sustained his opposition.

This should not be taken to suggest that the participants relied solely upon Christian principles in determining oppositional ethical standpoints. Rather, it should highlight the weightiness of Christian principles amid other ethical authorities and influences. Ginny, for example, explained that she thought most euthanasia advocates assumed that the elderly and infirm were unhappier than, in fact, they were. She suspected most calls for legal liberalisation were therefore premised on misunderstanding. Peter, similarly, questioned those who assumed that having dementia necessarily correlated with a bad quality of life. As noted above, Richard's concerns about euthanasia were deduced from both biblical principles and from his fears that 'the whole basis of the doctor patient relationship would be altered.' He added his concern:

[13] Davies, *Mors Britannica,* pp.40, 97 and 180-181. See also Davies, *Death, Ritual and Belief*, p.10.
[14] Hans Mol, *Identity and the Sacred: A Sketch for a New Social-Scientific Theory of Religion* (New York: Free Press, 1977), pp.5-6.
[15] Ibid., pp.11-15.
[16] Ibid., pp.12 and 15.
[17] Davies, *Anthropology and Theology*, p.151; Davies, *Mors Britannica*, pp.99-100.
[18] Davies, *Mors Britannica*, p.99.

> that a change in the law would actually – umm - have a very negative, sort-of, rolling impact on how we viewed disability, quality of life, whether one was being a burden, whether one was being too expensive for the health service – all sorts of things.

John summarised, '[I]t's not justifiable […] from a medical point of view, let alone from a faith or ethical point of view.' Working as a doctor had heightened Goodluck's concerns that legalising euthanasia would result in 'eugenics of the old.' His own impatience with elderly dementia patients confirmed his wariness, making him conscious of his and others' 'frailty.' He explained, 'God challenges me on [that.] Because I don't think I match up with God's standards on that particular level.' He weighed these factors alongside the 'sanctity of life within the Judeo-Christian […] tradition.'

Thus several participants took critical views of ethical trends as much *qua doctor* or *qua concerned citizen* as *qua Christian,* echoing the consonant identity conceptualisation observed in previous chapters. The participants' medical perspectives had significant ethical authority, alongside faith, in shaping their ethical standpoints.[19] Often themes such as the doctor-patient relationship factored into participants' moral deductions as though they were as non-negotiable as Christian principles. What is significant about Christian principles and values is not their sole significance, but their consistent significance: they had significant weight, enabling participants to decide where they stood on contentious topics.

Towards Affinity

On the basis of research interviews with religious psychologists, Ragan, Malony and Beit-Hallahmi argued that '[r]eligion and science seemed to act as competing value systems for those who held to either strongly.'[20] In this they echo broader popular sentiment and scholarly suggestion that medical science, in various ways, can conflict with, or challenge, religious worldviews. While this thesis will challenge the general applicability of this statement, the notion of 'competing value systems' can help map aspects of the relationship between lived evangelicalism and healthcare work, provided it is couched conditionally and contextually. The above examples show that where medical developments, advances and procedures sit ill-at-ease alongside evangelical medics' faith-based convictions, this can create conflict and tension. Indeed, rather than competing, in many of the above examples religion and medical science are in tension insofar as religious values are clearly

[19] We might, embellishing Bourdieu, frame this in terms of capital. In these examples, the doctors derive ethical resources – or personal ethical capital - from the two cultural fields into which they are socialised: medicine and evangelicalism. Are they thus better able to advance in the ethical 'field,' with dual confidence in their ethical stances?

[20] Claude Ragan, H. Newton Malony, and Benjamin Beit-Hallahmi, 'Psychologists and Religion: Professional Factors and Personal Belief', *Review of Religious Research*, 21.2 (1980), 208-217 (p.215).

preferred, a manifestation of the hierarchical, dissonant identity conceptualisation. As we saw in 'Calling,' this tension evidences participants' prioritising of their faith-self. While dissonant, this identity conceptualisation was nevertheless considered aspirational.

It is important to explicate that to have only explored beliefs in the above narratives would have masked the varied, complex emotional consequences that holding such beliefs stimulated. Thus Lewis felt 'chilled' that some advocated the eradication of Down's Syndrome. Elizabeth's amalgam of horror and confident defiance in responding to abortion illustrates this further. Discussing euthanasia, several participants experienced certainty mixing with sadness, discomfort, ambivalence and uncertainty. Just as lived religion research expects religious belief and practice to be messy, these examples show we must also expect to find messy, complex emotions in everyday evangelicalism among healthcare professionals.[21]

We must not flatten these tensions and conflicts, or the emotional intensity with which they were felt. However, amid dissonance and tension, instincts towards work-faith affinity and consonant identity were nevertheless evident. The rest of this chapter explores these instincts, from three angles. Together, they suggest that consonant identity was maintained by the evangelical medics, both through working to create and identify affinity amid conflict, and through balancing affinity with tension.

Creating Affinity: Resistance Reframed

First, participants often reframed actual and hypothetical scenarios, thereby assuaging some of the discomfort caused by their resolute oppositional stances. This was a further way in which participants deployed their faiths as a resource, deriving from them the theological materials with which to carry out this reframing. For example, while they all opposed any greater lenience towards euthanasia in UK law, Elizabeth, Gwen, Ginny and Richard instead determinedly advocated greater investment and research into pain control and symptom management. They framed this as a means of showing Christian love, finding a way to enact that macro-calling despite their ethical opposition. As we have seen, Elizabeth explained that the pain and suffering which led some to advocate euthanasia was 'why I've got my job [in palliative care, because] there is so much else that we can do.' Peter, still a medical student, had reached the same conclusion. Rather than delineate scenarios in which euthanasia might be acceptable, he explained:

> I want to create a society where we bend over backwards and do all we can to give [patients] the best quality of life that we can for as long as we can – not to say, your desire to end your life is understandable, let's help you to do it.

[21] McGuire, *Lived Religion,* p.4.

Richard, Ginny and Elizabeth applied analogous logic to abortion requests. While they conscientiously objected to signing abortion paperwork, they were confident that, by encouraging patients to take time and consider their decision before seeing another doctor, they were better able to show compassion, and help those women reach the right decision. Ginny described such consultations as 'opportunities to show Christian love and care.' Indeed, she believed that these consultations had preserved life on some occasions:

> There are a handful of babies who may not have been here if I hadn't explained to women that they had a bit more time and space to think than they realised and that there were other support options out there. Gratifying to think that I have saved at least a few lives.

Similarly, Richard explained:

> 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.

In a similar vein, David suggested that the most important thing was to support abortion patients, irrespective of their decision. He described this as 'the mark of a Christian doctor':

> [F]or me the most important thing was to support that poor woman. Because I don't think I've ever met a woman who felt happy about having an abortion, she may well have felt it was the correct decision, but that was not to say for one moment that she was happy about it, and often very traumatised. And – I feel, and 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.

Thus David and others reframed such scenarios, so that they did not only evoke tension, but also presented opportunities to love and care for patients. These doctors could thus see themselves, consonantly, as Christian medics, creating work-faith affinity *alongside* tension.

Identifying Affinity: Medical Diversity

Second, participants recognised that the diversity of medical culture, and breadth of ethical perspectives within it, meant that rejecting particular ethical standpoints did not require them to reject 'medicine' wholesale. Participants were instead conscious of where they stood within multifaceted medical culture, delineating the specific interventions and developments which they resisted and opposed. Put differently, they could identify as much affinity with medicine as tension. Moreover, because of the provision of conscience clauses, those doctors who refused to facilitate abortions remained within the margins of medical acceptability and expectation, even as they felt at-

odds with widespread norms and assumptions. Confirming this backhandedly, Elizabeth explained that should those conscience clauses be removed, she would find it very difficult to carry on as a GP. Catherine and David echoed this. Vanderpool and Levin's note, that the nature of the relationship between religion and medicine is a matter of both perception and circumstance, is, therefore, an important one.[22]

Additionally, several participants had made career decisions to avoid unworkable levels of tension between work and faith. Elizabeth, for example, felt she would have struggled too extensively with expectations around abortion had she chosen to specialise in obstetrics and gynaecology. She extended this beyond herself, saying: 'I think we [Christian doctors] probably partly self-select in the careers that we pick? Umm, so, it would be interesting to know how many Christian obstetric and gynaecologists there are.' Catherine explained that '[w]hen I was at medical school [I] had a keen interest in genetics but avoided that route because prenatal diagnosis led to terminations and I felt it would be a very difficult field to work in,' as someone who opposed abortion. These examples suggest that homogenising 'medicine' risks losing important nuances pertaining to particular people, specialties, and scenarios.[23] Evangelicalism can, in some contexts, conflict with particular applications of medical science: yet in the above examples, the participants felt at once distinct from and part of a broader medical culture. Thus, in this case, Ragan, Malony and Beit-Hallahmi's claim that '[r]eligion and science […] act as competing value systems' is too homogenised.[24] Provided they could accept tension with certain ethical viewpoints, or avoid encountering ethical tensions, the participants did not have to sacrifice their sense of affinity with medicine more broadly.

Regarding euthanasia in particular, several participants also explicated that it was not only Christians who resisted greater liberalisation, thereby reducing the size, and altering the demographic, of the 'medical' constituency which they opposed. Hannah echoed others in suggesting that the present legal situation should remain in place, allowing doctors to withdraw unnecessary and uncomfortable treatments to facilitate a peaceful death, but not to actively bring about death. But she suspected that 'a load of colleagues who aren't Christians would agree with me?' Ginny recalled visiting Dutch doctors, whose advocacy of physician-assisted suicide made all of her English colleagues uneasy, suggesting that divisions might be drawn more down cultural or national than down religious lines.[25] Moreover, though they feared euthanasia might be, as Gwen put it, 'creeping in slowly,' the

[22] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.14.
[23] Becker et al, *Boys in White* , pp.403-405; Ragan, Malony and Beit-Hallahmi, 'Psychologists and Religion,' pp.213-214.
[24] Ragan, Malony, and Beit-Hallahmi, 'Psychologists and Religion,' p.215.
[25] J Cohen et al., 'Influence of Physicians' Life Stances on Attitudes to End-of-Life Decisions and Actual End-of-Life Decision-Making in Six Countries', *Journal of Medical Ethics*, 34.4 (2008), pp.247–253.

participants widely agreed that the current English legal situation, in which active euthanasia and assisted suicide are illegal, was consonant with their viewpoints. It was any change to this which they resisted. All participants, in some form, feared a 'slippery slope.'

Balancing Affinity and Tension: Embattled and Thriving?

These selective tensions with particular aspects and applications of 'medicine' hint at a final, dual dynamic, whereby opposition and affinity together sustained both the participants' religious identities, and their consonant identities as Christian medics. To understand this third point, we must briefly explore scholarship on evangelical identity dynamics.

As explored in 'On Work and Worldviews,' evangelicalism and evangelical identity have consistently been associated with resistance, protest, and opposition, particularly against modern culture and morality.[26] However, this association was famously embellished and challenged by Christian Smith in his 1998 *American Evangelicalism: Embattled and Thriving.* Here, Smith presents his theory of 'engaged orthodoxy,' positing that:

> American evangelicalism […] is strong not because it is shielded against, but because it is – or at least perceives itself to be – embattled with forces that seem to threaten it. Indeed, evangelicalism […] *thrives* on distinction, engagement, tension, conflict and threat.[27]

He concludes that American evangelicalism:

> thrives in pluralistic modernity […] because it possesses and employs the cultural tools [necessary] to create clear distinction from, and significant engagement with, other relevant outgroups, short of becoming counter-cultural […] Distinction-with-engagement appears to be the most effective strategy for maintaining religious vitality.[28]

Oppositional vitality is generated as evangelicals encounter a variety of negative outgroups, and thus experience distinction and tension, which serve to reinforce significant boundaries.[29]

It is important to note that Smith is not primarily concerned with the individual, but with neo-evangelical 'sub-cultures,' and their encounters with religious pluralism.[30] Conflict serves to clarify *group* boundaries and thus solidify *group* identity. A group's conflict with 'negative reference groups'

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[26] Guest, *Evangelical Identity and Contemporary Culture*, pp.1-3.
[27] Smith, *American Evangelicalism*, p.89 (emphasis original).
[28] Ibid., p.218.
[29] Penning and Smidt, *Evangelicalism: The Next Generation*, p.16.
[30] Smith, *American Evangelicalism,* p.218. Smith traces neo-evangelicalism to the 1940s, and a 'group of mostly young, moderate fundamentalists who by the early 1940s had grown weary of […] fundamentalist negativity and isolation' – p.9. Their vision for the transformation of evangelicalism emphasised the spread of the gospel, and thus required engagement with 'the world.' In a sense, where Smith specifies neo-evangelical, he refers to what most now consider mainstream evangelicalism, at least in the UK context. I differentiate instead between 'conservative' and 'liberal' evangelicalism, terms with greater contemporary relevance.

reinforces distinctions and boundaries, a process integral to identity formation.[31] Smith indicates, however, that his theorising is applicable to individuals. He notes: 'We have observed that *individuals and groups* define their values and norms and evaluate their identities in relation to specific, chosen reference groups.'[32] Moreover, Smith's later work with Snell clearly expands such oppositional logic to individual religious identity formation. In *Souls in Transition*, a study of religion among young people in the USA, they argue for a causal correlation between cognitive deviance in teenaged years, and higher emerging adult religiosity.[33] In particular, they suggest that where teenagers engaged in 'cognitive resistance to modern secular assumptions' by believing in miracles, this was indicative of a broader orientation which relativised modern scientific epistemologies, instead 'express[ing] faith in a powerful God actively at work in the world.'[34] They note that:

> All of this, of course, relates to the process of *religious belief and desire reinforcement* […] a substantively significant faith-defending position [and] an indicator of a kind of larger cognitive position that prioritizes religious authority claims and is prepared to live with dissonance arising from the conflict of these claims with competing authority claims.[35]

Strhan's UK-based work also explores oppositional evangelical identity on an individual level. As we have seen already, her study highlights the important evangelical dynamic of framing and forming oneself as an 'alien and stranger' in the world – that is, of being counter-cultural.[36] We noted in 'On Work and Worldviews' that 'the world' is a significant rhetorical outgroup in evangelicalism, evoking and encapsulating those moral, behavioural and doctrinal elements to be opposed in any given time, from which evangelicals wish to render themselves distinct.[37] The world is seen to be corrupted by the fall, and thus something in which the believer should not be entangled, but also in need of redemption and the gospel, which they are to bring to it. It is the ever-incomplete, ongoing process of 'turning away' from the world, and inner tension between their religious and modern-urban selves, which stimulates vitality, as Strhan's participants seek to maintain fragile boundaries.[38]

Thus, on both a group and an individual level, and in both the USA and the UK, scholars suggest that it is not the eradication of tension with the surrounding context which is significant for evangelical identity, so much as the existence of tension. The same appears to be true in this study. The

[31] Ibid., pp.219-220.
[32] Ibid., p.219 (emphasis mine).
[33] Christian Smith with Patricia Snell, *Souls in Transition: The Religious and Spiritual Lives of Emerging Adults* (New York: Oxford University Press, 2009), p.238.
[34] Ibid., pp.238-239.
[35] Ibid., p.239 (emphasis original).
[36] Strhan, *Aliens & Strangers,* pp.200-204.
[37] Hunter, *Evangelicalism: The Coming Generation,* pp.62-64; Guest, *Evangelical Identity and Contemporary Culture,* p.3; Penning and Smidt, *Evangelicalism: The Next Generation,* pp.70-71.
[38] Strhan, pp.200-204.

participants' experiences of tension between their religious beliefs and values, and certain medical trends and sub-cultures, rendered religious identity acutely salient, insofar as it was deployed in opposition, leaving them with a perception of difference and distinction. The significance of abortion as an identity marker for Elizabeth is an important example. Certainly, then, we can understand how these medics' religious identities might be affirmed and strengthened through opposition.

This affirmation of religious identity is not, however, the same as work-faith affinity. That said, using Smith's work, and the above point regarding the breadth of medical culture, we can theorise as to how oppositional elements of evangelical identity might serve to neutralise the potentially deleterious effects of tension and conflict, even if they do not directly create affinity. While Smith emphasises the importance of opposition and deviance in both *American Evangelicalism* and *Souls in Transition,* his argument moves one step further. In *American Evangelicalism,* he notes that evangelical identity is defined and evaluated in relation to 'specific, chosen reference groups,' a selective form of opposition.[39] That is, we can conclude from Smith's work that evangelical religious identity might be strengthened through the maintenance of a cognitive position which is prepared to live with dissonance with *specific, chosen reference groups only.*

Certainly selective opposition was significant in this study. The medics were dually engaged in seeking in affinity, and in cognitive deviance and opposition. In line with evangelical theological expectations – and sociological observation – some oppositional tension, distinctiveness, and a sense of being 'aliens and strangers,' was beneficial to these medics. Too much, however, might have forced a wedge between their faith and their work in such a way as to undermine their ability to continue working in healthcare. This would represent the unwelcome, unworkable forms of work-faith dissonance we explored in 'Resourcing.' Here, the breadth encapsulated within medical culture is crucial. The evangelical medics opposed specific ethical perspectives – in Smith's terms, 'chosen reference groups' – on religious grounds. They could thus reap the religious-identity-bolstering benefits of opposition. However, this opposition, and resultant tension, was rendered beneficial, rather than problematic, precisely because it was *specific* and limited: enough to affirm their religious identity, without thus undermining their consonant identity as Christian medics. Again, we see the participants dually conceiving of their identity in consonant, mutual terms (whereby medicine and faith bolster one another) and in hierarchical terms (in which medical identity is considered less important or valuable than religious identity and commitments). Neither opposition nor affinity alone captures the ethical engagements observed above. A cognitive position of specific dissonance and opposition is underpinned by the affinity and identity consonance otherwise

[39] Smith, *American Evangelicalism,* p.219 (emphasis mine).

experienced between work and faith. Even in these examples, which have significant tension at their core, lived evangelicalism must not be associated solely, even primarily, with protest, but with an admixture of opposition and the seeking of affinity.

By way of further caution against over-associating evangelicalism with protest against, or resistance to 'the world,' it is important to note that several participants also resisted, and often vocally and publically opposed, ethical opinions espoused in certain Christian circles. Richard had voiced his 'support of welcoming transgender members of our congregations, also in the church supporting the consensus statement against sexuality conversion therapy.' He stood against those who used Christian principles justify both transphobia and homophobia. Hannah, similarly, challenged her Christian peers who opposed abortion:

> I guess I would […] challenge them on, like […] letting down, like, vulnerable… that you're, like – your profession of service, but also, like, your care for vulnerable women having these abortions. Because even by saying "I can't even have this discussion with you" you're, like, judging.

Conclusion

Where previous chapters have highlighted harmonies between lived evangelicalism and healthcare work, in this chapter these were less obviously evident. The participants deployed their faith, operationalising it in order to resist particular medical and ethical developments. This opposition occurred in two modes. In the first place, we saw the participants resisting ethical trends and norms regarding topics such as euthanasia, abortion and prenatal screening for genetic diseases. They cited Christian principles or their identity 'as Christians,' as the bases for their opposition. In other cases, opposition occurred in spite of the fact that, as a result of their work, the participants were aware of 'shades of grey' which complicated their ethical reasoning. In these instances, their Christian worldviews enabled them to take a stance despite such complexities, some element of their faith having been deemed non-negotiable. In both modes of opposition, there was intense emotionality at work.

None of this bore obvious resemblance to elective affinity, and its associated 'intimate kinships,' 'reciprocal attraction,' resonance and mutuality.[40] Tension, conflict and opposition seemed to place the participants' senses of consonant identity into question, instead highlighting identity dissonance. It was suggested, however, that the participants managed to retain consonant identities both in spite of, and because of, such tensions. In some cases, they achieved this by reframing difficult scenarios in such a way as to highlight consonances alongside tensions. They also recognised that,

[40] Löwy, 'Le concept d'affinité élective chez Max Weber', pp.98-100.

because legal provisions, twinned with the breadth of perspectives evident within medical culture, taking particular oppositional ethical stances did not leave them at odds with 'medicine' in general. Rather, they identified affinity beyond specific dissonances. Finally, drawing on Christian Smith's work in particular, we suggested that some tension between work and faith was beneficial to these evangelicals, provided it was selective. In thus identifying and creating affinity between work and faith, and balancing affinity with tension in such a way as to reap the benefits of both, and not allow either to become problematic, the participants' maintained consonant identities as Christian medics. We might thus say that consonant identity was constructed of both affinity and tension, and constituted, in part, by identity dissonance. This supports suggestions that it is distortive to associate lived evangelicalism too heavily with protest and resistance to 'the world.' There are subtleties and complexities intertwined with such resistance, even in the contested examples in this chapter.

In observing that healthcare work rendered many of these evangelical participants more aware of complexities and 'grey shades' in ethical matters, this chapter has also introduced something which we will revisit several times going forward, and the theme of the next chapter: the capacity for healthcare work to change practitioners' worldviews. However, in this chapter, change has been observed alongside its opposites: certainty, steadfastness and imperviousness to change, even where the potential for alternatives was noted. Thus as we move from focussing primarily upon ways in which faith is *deployed* within medical work, to incorporating ways in which faith is *shaped by* medicine, it is important to remember that change and stability are not binary concepts. Rather, they can be co-present.

Changing

"Over the years of practising, my views have changed"

Introduction

As we saw in 'Taking Stock,' it is widely recognised that healthcare work can change people's religious and spiritual worldviews. Puchalski and Ferrell argue that working with patients – and particularly being present to their suffering – 'can change the clinician – his or her values, priorities, and beliefs can be altered by the experience.'[1] As noted in 'On Work and Worldviews,' McGuire proposes that religion should be conceptualised as 'malleable' and 'ever-changing,' for individuals' beliefs, practices and values 'adapt' and 'grow.'[2] Astley, similarly, suggests that '[t]he experience of life helps to form and change [people's] theology,' and, resultantly, '[w]e need to acknowledge how much [people] change [in] beliefs, attitudes and values.'[3] Droogers echoes this, suggesting worldviews are 'in constant tension between continuity and change,' because of both social and personal developments.[4] Thus, in emphasising changeability, lived religion and healthcare literatures converge. Change, we have suggested, can be discontinuous or continuous.[5]

This chapter will both bear out and broaden Puchalski and Ferrell's suggestion, illustrating stimuli for discontinuous change beyond patients' suffering, taking us firmly into the realms of faith being *shaped by* healthcare practice. It first focusses upon instances wherein participants' ethical perspectives were either changed, or held up for re-evaluation. It then examines the consequences of such changes for the participants' senses of identity and work-faith affinity. Finally, it also highlights subtler changes of emotional relationships to beliefs.

Changed Perspectives

Recall Hannah feeling 'pushed' to re-evaluate her scepticism surrounding prayer for miraculous healing. Her experiences stimulated a process of re-evaluation, and, in turn, a change of perspective. Several participants described similar perspective changes in relation to medical ethics. We have already seen participants operationalising their faith in order to critically evaluate and oppose

[1] Puchalski and Ferrell, *Making Health Care Whole,* p.166.
[2] McGuire, *Lived Religion,* pp.4-5, 12, and 185-186.
[3] Astley, *Ordinary Theology,* p.21.
[4] Droogers, 'The World of Worldviews,' pp.24-25.
[5] Continuous change – i.e. growth and development – is explored in 'Growing.'

particular ethical viewpoints, norms and trends. In this chapter, we will see the reverse dynamic: often, their work led the participants to question, critique, and at times reject, both their own previously-held viewpoints, and what they understood to be wider Christian norms and attitudes.

Gwen and I discussed abortion extensively. In principle, she believed abortion rates should be kept as low as possible, because, like many of the other participants, she believed 'life is sacred.' The more we talked, however, the clearer it became that Gwen's beliefs and feelings on the topic were more complex than such a statement suggests. Her pauses and sighs as she explained her views augmented her words, affirming that grappling with abortion remained emotionally demanding, even several years post-retirement. Gwen was conscious that, as a result of her medical career, her views had changed. In particular, she felt they had shifted such that they were different to other Christians':

> I know this is a little – [pause] out of sync with what people mainly say now, you know, I think Christians say, now, […] 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.

Gwen first began medical training shortly after abortion was legalised in England and Wales in 1967, and cared for a small number of patients who underwent backstreet abortions. She became visibly moved as she told the story of a teenager whose uterus was punctured during such a procedure. The emotionality of this work, and of confronting death and suffering, was evident. 'I won't go into the gore,' she told me, 'but it was very gory,' requiring a swap of her surgical clogs for Wellington boots.

The young woman died on the operating table. 'You never forget something like that,' Gwen told me, and it was clear she had not forgotten the experience, or how it made her feel.[6] It left her convinced, for the remainder of her career, that abortion requests should be assessed on a case-by-case basis. As a result of this formative experience, she balanced her belief that 'life is sacred' against conviction of her duty of care for the vulnerable, and realist acknowledgement that abortions in some form would always take place. Weighing up these factors, she concluded that at times it was right to facilitate safe, legal abortions, as the lesser of two evils. Thus it was only when Gwen was asked to sign paperwork without having spoken with the patient that she 'drew the line,' and refused to facilitate terminations. In an ideal world, she would have upheld the sanctity of life and opposed abortion; in reality, this was untenable. Somewhat paradoxically, Gwen held absolute

[6] Hannah described shadowing doctors in an abortion clinic as 'the most graphic exposure I've had to the reality of what it is.' Though her perspective did not change, she recognised the potential for this exposure and emotional experience to affect doctors' views.

principles, yet engaged with abortion situationally.[7] Cadge concludes that healthcare practitioners often blend meaning systems, even where these appear counter-intuitive.[8] On the basis of this study, we could posit that they may also blend modes of ethical reasoning in apparently counter-intuitive ways.

Like Gwen, Mel also struggled with the gap between ethical ideal and medical reality, though hers was an inherited ideal. Mel grew up in what she called a 'conservative evangelical home.' She said, 'I hadn't really given [abortion] a lot of thought […] I was brought up to think it was wrong and that was the end of it.' As a nursing student, Mel completed a placement in a gynaecological theatre. While she elected not to be present during abortion procedures, she was tasked with accompanying patients to the anaesthetist, and with cleaning up afterwards. On the one hand, she 'was now in no doubt about the violence of an abortion procedure upon what is most certainly not just a blob of unrecognisable cells.' She also remained concerned where she saw abortion used as an equivalent to the 'morning after' pill. However, her experiences:

> didn't push me further into the thinking of my upbringing. I think the reason for this was that 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 […] in most cases their stories as I listened were really moving and I was humbled by them […] It made a big difference.

The 'big difference' was that Mel could no longer treat abortion in the 'black and white' way her parents had. Her experiences, particularly talking with patients and hearing their stories, led her to question and to re-evaluate her previously-held views. Her resulting stance, like Gwen's, was situational, recognising that in some circumstances abortion was an appropriate course of action. Here Mel shifted from 'black and white' ethical reasoning to recognising and dwelling in the shades of grey between, balancing her experiences alongside her belief in the value of life from conception.

Later, Mel's placement in an HIV clinic effected similar changes. Speaking with patients challenged the view with which she had been brought up: that AIDs was God's punishment for sexually promiscuous lifestyles. In these conversations, she saw the harm caused by Christian suggestions that such men were 'bound for hell,' and the patients' resultant acceptance that 'the church wasn't a place for people like them.' She was also struck by the 'covenantal love' exhibited between patients and their partners. Summarising, Mel explained, 'it was a challenging environment and did cause some tension with parents especially when my views were obviously once again changing.' These changes had significant emotional dimensions. Mel felt 'a sense of shame and embarrassment

[7] John Habgood, *A Working Faith: Essays and Addresses on Science, Medicine, and Ethics* (London: Darton, Longman and Todd, 1980), p.112.
[8] Cadge, *Paging God,* p.154.

that these young men facing so much […] should die thinking that there was an angry God in heaven waiting to condemn them with glee.' Her emotional relationship to previously un-questioned beliefs changed: what she felt now sat ill-at-ease with views adopted during her upbringing. This shift of emotion, from acceptance to shame and embarrassment, in turn precipitated a change of ideas, and of ethical perspective.

Like Mel and Gwen, Richard's experiences at work changed his ethical stance. He explained in his reflections:

> Over the years of practising my views have changed on sexuality […] I have had many gay and lesbian patients, most in long term faithful relationships. I have found it very difficult to recognise in these relationships the situation described by Paul in Romans 1 regarding idolatry and rebellion. Scientific research has I believe shed new light on orientation, especially that it isn't a lifestyle choice but seems to be hard wired at an early stage of development. This is one of the main areas where my medical experience has shaped my faith rather than vice versa. I now believe that Paul writing today would very likely not have used this example.

Richard's encounters with patients, twinned with scientific insights, compelled him to move away from what he considered the 'traditional' Christian view on homosexuality. Richard's example both confirms and extends Vanderpool and Levin's suggestion that medicine can 'impact' traditional religious ideas.[9] While they particularly focus on the ways in which scientific medical advances can challenge religious traditions, Richard's example also highlights the effects of interpersonal interactions on the individual.

Interpersonal encounter had also affected Liam's attitudes towards end of life care. His rotation in vascular surgery had a similar effect to Gwen's early, graphic encounter with abortion. He wrote, 'I have come to understand the importance of [end of life] care and why it is not always best to try everything for a patient.' This shift of perspective was closely linked to Liam's experiences treating a patient, whose progressive irreversible lung disease had left him dependent upon noisy, uncomfortable high flow oxygen, distressing for the patient, his family, and his medical team. Thus Liam recognised that palliating this patient – in this instance, arguably a form of passive euthanasia – was appropriate and compassionate, despite his previous conviction that life should always be preserved.

Understanding Change

The above examples of changed perspectives affirm that healthcare work can, indeed, stimulate discontinuous change among evangelical medics. They also confirm Puchalski and Ferrell's

[9] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.12.

suggestion that being present to others' suffering is an important stimulus for such changes.[10] This was clearly demonstrated in both Liam and Gwen's stories. Mel similarly found that talking to patients in complex and vulnerable medical contexts significantly affected her perspectives. However, these examples also broaden Puchalski and Ferrell's suggestion, for Richard's story was similarly one of impactful interpersonal encounter, quite apart from suffering and death. While patients' suffering can stimulate change, this was not the only stimulus in this study.

Cowleys' work offers a broader theoretical and explanatory lens on the above examples. In his 2008 *Medical Ethics, Ordinary Concepts and Ordinary Lives,* he distinguishes between experiential and propositional knowledge:

> 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.[11]

Cowley uses euthanasia as an example, arguing, '[I]t 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.'[12] Affirming Cowley, the above examples all show that experience, and particularly its emotional and interpersonal dimensions, can profoundly shape ethical 'knowledge' and perspectives. In particular, for Mel and Gwen, it was a shift from propositional to experiential knowledge of abortion which effected their changes of perspective. Relatedly, the above examples also show again the importance of paying deliberate attention to emotion in seeking to understand lived evangelicalism. In *Ordinary Theology,* Astley argues that conversion is most likely to come about through a shift in attitude or emotion.[13] The above suggests we should expand this idea: emotion can also be central to understanding why people's religious beliefs and practices change in non-conversion contexts. The changeability of personal faith is a core observation of lived religion research, but it is important to appreciate the role emotions can play in it.

Ethical Authority

The above examples also give us pause to consider the relationship between ethics, faith and worldviews. In some evangelical interpretations and presentations, shifts of ethical perspective are

[10] Puchalski and Ferrell, *Making Health Care Whole,* p.166. Of course, interpersonal interactions are both cognitive and emotional.
[11] Christopher Cowley, *Medical Ethics, Ordinary Concepts and Ordinary Lives* (Basingstoke; New York: Palgrave Macmillan, 2008),p.xiii.
[12] Ibid., p.177.
[13] Astley, *Ordinary Theology*, p.42.

considered a compromise of faith. For example, Peter Saunders, former CMF Chief Executive, acknowledges that 'it is not medical ethics that cause the downfall of most Christian junior staff.'[14] Yet he implies that a compromise on ethical stances in order to 'conform' is indicative of a broader likelihood to ally oneself to 'increasingly secular society.'[15] Certainly he suggests ethical shifts *might* cause 'downfall.' Relatedly, consider the examples in 'Opposing,' whereby participants identified authentic Christianity with the holding of particular views (resisting abortion) or the performance of particular actions (going to church.)

When scrutinised from an etic perspective, however, such emic interpretations appear to flatten important nuances and subtleties. In the above examples, to note that participants' perspectives on particular issues changed as a result of their work is not to therefore say that either their 'faith' or their identity as Christians changed. It is more accurate and useful to argue that the significances of and interactions between faith and other constituent parts of the participants' worldviews changed. As we suggested in 'On Work and Worldviews,' among evangelical Christians, 'faith' is a significant constituent part of an individual's worldview, itself complicated and multifaceted. However, it is not the only constituent part: other parts contribute alongside – and, sometimes, against – faith. For the evangelical medics, experiences at work, medical culture (and, within that, a scientific perspective) were also significant constituent parts, interacting with faith in multiple ways. Each of these constituent parts informed their outlook[s], all in relation, and relative, to one another. We highlighted this in 'Opposing,' observing the weightiness of Christian principles amid other ethical authorities and influences as the participants opposed particular trends in medical ethics. In the above examples in this chapter, the relative authorities of different constituent parts of the participants' worldviews changed in such a way as to shift their outlooks on particular ethical topics – that is, parts of their worldviews.

In light of this, Gwen's above narrative could be interpreted in several different ways. For example, it shows her shifting from a more absolutist mode of ethical engagement to situational negotiation. Where initially Gwen adopted what she considered the 'Christian approach,' rejecting abortion as contrary to life's sacredness, experience taught her to treat each case on its own terms.[16] We can also interpret this as a shift in the balance of authorities informing her views. At the outset of her

[14] Peter Saunders, *Surviving the Foundation Years: How to thrive as a Christian doctor* (London: Christian Medical Fellowship, 2012), p.33. Available at: <http://admin.cmf.org.uk/pdf/juniors/surviving_the_foundation_years.pdf >[Last Accessed 03/06/2020]. Indeed, Saunders's line of reasoning implies that changing one's ethical stance inverts the hierarchical identity model, subordinating faith to work.

[15] Ibid.

[16] Cowley, *Medical Ethics,* pp.xiii, 102 and 177.

career, dominant, traditional Christian views held primary authority in shaping her perspective. These traditional views were themselves shaped by awarding ultimate authority to significant principles, such as the sacredness of life, and believing that God 'knits together' the unborn in the womb.[17] For Gwen, the authority of these dominant views was weakened, relative to other ethical authorities, not least because her early experiences came to hold *greater* authority. Those experiences had both cognitive and emotional significance in forming and changing Gwen's perspective. While, initially, rejecting abortion was a tenable position, the experience of failing to save the young woman rendered it untenable. While belief in life's sacredness remained, its relative significance was diminished.

We can make similar observations of the other examples. Initially, a 'traditional' Christian view, awarding significant authority to particular interpretations of certain biblical passages, held highest authority in shaping Richard's stance on homosexuality. The authority of that view, and especially of particular readings of New Testament passages, diminished in light of Richard's experiences as a medic. Relatedly, the relative authority of scientific interpretations and interpersonal experiences increased, becoming significant determinants of his outlook. This was not at the expense of his Christian convictions and identity: rather, Richard opted for a *different* perspective which he nevertheless considered authentically 'Christian.' Mel's experience was similar, but it is important to emphasise that her initial standpoints were those with which she was raised and had not significantly questioned. The plausibility of these standpoints diminished because of her experiences, such that they could not remain unquestioned. Experience was a significant stimulus for questioning and, subsequently, for change.

Liam's example is subtler, but nevertheless instructive. His discomfort derived from choosing not to 'try everything' for a patient, and to palliate instead. The imperative to 'try everything' carried significant Christian *and* medical ethical authority: as Liam and others consistently highlighted, it is a doctor's job to preserve life, not to end it. In choosing to deviate from this course of action, Liam did not have to reduce the significance of the authority of either his Christian faith or medical culture. Rather, he had to alter the relative significance of particular principles deriving from both sources of ethical authority. The imperative to minimise suffering, in this case, weighed more heavily than the imperative to 'try everything.' Recognising those imperatives might well recurrently be found in tension, Liam changed his outlook on end of life care.

[17] Psalm 139:13-14

Addressing Dissonance

To understand these examples more fully, cognitive dissonance theory provides a useful theoretical lens. Cognitive dissonance describes the mental or psychological discomfort experienced when someone holds contradictory beliefs, ideas or values. The theory was first proposed by Leon Festinger in 1957, and has since gained considerable popular and academic currency. He defined dissonance as 'the existence of nonfitting relations among cognitions […] By the term *cognition* […] I mean any knowledge, opinion or belief about the environment, about oneself, or about one's behaviour.'[18] Festinger proposed several kinds of dissonance, particularly: contradictions within certain 'clusters' of beliefs, attitudes and opinions; and contradictions 'between what a person knows or believes, and what he does.'[19]

Festinger highlighted a number of potential sources of dissonance. Significant among them were logical inconsistency, and cultural mores.[20] In the latter instance, dissonance arises from acting in a way deemed inconsistent with cultural norms.[21] Smith's *Souls in Transition* draws further attention to this. He uses the term 'cognitive-emotional dissonance' to describe the struggles experienced by teenagers who engaged in sexual activity before marriage despite their religious tradition advocating abstinence.[22] Where those who practised abstinence experienced little dissonance, their sexually-active peers experienced 'discomfort,' which often correlated with a subsequent move away from religion.[23] Thus Smith describes 'the tendency toward *increased cognitive-emotional dissonance with serious religious identity and practice that teenage […] sexual activity generates*.'[24] The combination of sexual activity and the knowledge that such activity was prohibited in their religious tradition led them to 'feel increasingly uncomfortable attending religious services, praying, and hanging out with other highly religious people.'[25]

Smith and Festinger both emphasise the human drive for identity continuity and internal psychological consistency and, resultantly, both posit a related drive to reduce dissonance, and create coherence. In Smith's study, dissonance reduction lay in removing or minimising one or either facet – sexual activity and religious activity.[26] Where the latter was reduced, this explained young

[18] Leon Festinger, *A Theory of Cognitive Dissonance*, (Stanford, Calif: Stanford University Press, 1985), p.3 (emphasis original). See also p.12.
[19] Ibid., p.1.
[20] Ibid., pp.13-14.
[21] Ibid., p.14.
[22] Smith with Snell, *Souls in Transition,* pp.239-240; Davies, *Emotion, Identity, and Religion,* p.130.
[23] Smith with Snell, *Souls in Transition,* pp.239-240.
[24] Ibid., p.239 (emphasis original).
[25] Ibid.
[26] Ibid., p.240.

people's 'pulling away from religion, in part because of the mental and emotional dissonance that wilfully having sex on an ongoing basis causes in the religious contexts of their lives.'[27] Festinger similarly noted that, broadly speaking, cognitive dissonance is reduced by changing one of the two dissonant elements.[28] The notion of dissonance reduction sits somewhat at odds with suggestions in lived religion scholarship that individuals are perfectly capable of holding contradictory beliefs, without resulting dissonance.[29] Before applying it to this study, it is thus useful to bear in mind Guest et al's suggestion that while some Christians do struggle with logical contradictions between their faith and behaviours, scholars must not *assume* that they will.[30] Equally, neither should scholars assume that they will feel at ease about such contradictions. Rather, the ways in which contradictions are experienced can vary subjectively from person to person. That contradictions might be unproblematic should not lead us to gloss over instances where they are problematic for the individual in question (and vice versa).[31]

Bearing this in mind, the changes above can be seen as attempts to reduce problematic dissonance by changing one of two dissonant elements, and thereby achieve greater work-faith affinity. Richard's shift of perspective on homosexuality closely fits Festinger and Smith's patterns of dissonance reduction. He expressly noted the irreconcilability of his experiences treating 'gay and lesbian patients […] in long term faithful relationships' and suggestions that such relationships represent 'idolatry and rebellion.' Changing his perspective resolved this irreconcilability. As we have seen, this shift was facilitated by Richard's confidence that it was both scientifically and theologically valid, not least given contemporary understanding of the Pauline context. Thus, *qua* both doctor and Christian, Richard had the cognitive resources with which to navigate a change of perspective on homosexuality, and thus create greater work-faith affinity with regards to this particular topic.

For Gwen, dissonance emerged between her initial ethical perspectives on abortion, and her experiences. Much as she might have wished to consistently uphold the sanctity of life, reality rendered this problematic. Gwen similarly fit Festinger's pattern of reducing dissonance by changing one of two dissonant elements. By moving to a more situational mode of ethical engagement, she could create greater affinity – or 'fit' – with the realities of her work. However, that is not to say that with such affinity came ease, peace or closure. Indeed, we have already seen the emotionality with which Gwen discussed her change of perspective on abortion. While she experienced greater affinity

[27] Ibid.
[28] Festinger, *A Theory of Cognitive Dissonance,* p.18.
[29] McGuire, *Lived Religion,* p.4; Stringer, *Contemporary Western Ethnography,* pp.39 and 51; and Schielke and Debevec, 'Introduction,' p.1.
[30] Guest et al, *Christianity and the University Experience,* p.24.
[31] This observation will also be important when exploring compartmentalisation.

(or, perhaps, less dissonance) between her work and her faith, her change of ethical perspective, and particularly her distinctiveness from what she perceived to be the Christian ethical norm, caused Gwen some disquiet. This disquiet spilled over into her consonant identity as a 'Christian doctor.' While she moved towards greater identity consonance, she remained at least somewhat uncertain over whether that move was correct, and whether she had always exercised situational judgement correctly.

The same was true of Liam, amid his somewhat uneasy change of perspective on end of life care. Despite concluding that in some cases, it was better to palliate than to continue treatment, he felt 'still uncomfortable, sometimes, to think that we might be playing God.' The goal of preserving life was no longer one he awarded supreme authority in all scenarios, leading him to a more situational view. But concerns about 'playing God' nevertheless continued to weigh upon him. The result was a more uncomfortable ethical shift than Richard articulated. While dissonance was reduced, it was not fully ameliorated. On the basis of both Gwen and Liam's examples, we must be prepared for efforts against cognitive dissonance, and towards work-faith affinity, to be accompanied by measures of uncertainty and ambivalence.

Mel's response to dissonance was mixed. We will see in the next chapter that, in part, she responded as many in Smith's study did: by pulling away from faith. This was a painful period of her life which, like Gwen and Liam's narratives, highlights the extent to which dissonance reduction can stimulate negative emotions, even as it also reduces discomfort in favour of affinity and consonance. However, like Richard and Gwen, Mel also moved away from the ethical views with which she had been raised, towards those which better 'fit' with her experiences as a nurse. Thus she echoed both Richard's wholesale perspective-change on homosexuality, and Gwen's shift to a more situational, person-centred approach to abortion.

As we observed in 'Resourcing,' Taves, Asprem and Ihm note the importance of maintaining meaning across situations, a suggestion reminiscent of Smith and Festinger's suggestions about psychological consistency. They thus explore how people respond to 'meaning violations,' in which experiences do not match expectations, and strategies are needed to 'restore a sense of familiarity.'[32] They draw on Proulx and Inzlicht's work, suggesting that there are three mechanisms by which people do so: (1) resolving or masking the meaning violation itself; (2) fluid compensation, or looking for meaning elsewhere and (3) 'meaning making,' or assembling new meaning frameworks.[33] This is a further means of framing the above narratives. The participants' experiences contradicted rather than

[32] Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.213.
[33] Ibid.

matched their ethical expectations and frameworks, forcing them to respond. Gwen, Mel, Richard and Liam could not mask the meaning violations their work created. Rather, they had to assemble new 'meaning frameworks' in order to reduce the dissonance caused by such violations. Fowler's observation is perhaps also helpful here, when he suggests that faith is about both 'making and maintaining meaning in life.'[34] As we saw in 'Resourcing,' maintained meanings were important to these Christian medics, but so too was an ability, when necessary, to make new meaning.

Parts and Wholes

Gwen, Mel, Richard and Liam all described changes of ethical perspective. Rather than 'changes of faith,' these can be viewed as changes to the relationships between different sources of authority in ethical decision-making, and to the relative significance of particular ethical principles. Similarly, in working to reduce cognitive dissonance, the participants did not thus change their 'faith:' rather, it was particular faith-related convictions which were removed or reduced in significance. This is a further reason to resist the homogenised framework of 'changed faith.'

Mol's work again provides a helpful explanatory lens here. He conceptualises identity as a process dialectically informed by both change and stability.[35] Thus in *Identity and the Sacred,* he summarises that understanding individual and communal identities requires 'a framework of countervailing processes: an inexorable tendency towards conservation and integration is cross-cut by a similar inexorable tendency towards change and differentiation.'[36] While conscious of change, and of distance from particular Christian standpoints, the participants remained, self-consciously, Christian. Their shifts of ethical perspective did not counteract these participants' senses of being 'Christian,' or lead them to feel that their 'faith' in toto had changed.[37] Their views changed *within* the realms of valid Christian possibility, rather than moving beyond them. They felt able to critically evaluate particular ethical perspectives while retaining a sense of affinity with Christianity at large. Thus changes to their perspectives, and within their faiths, occurred both alongside and *because of* otherwise extensive stability.[38] This is Mol's dialectic embodied. As such, contrary to some

[34] James W. Fowler, *Stages of Faith: The Psychology of Human Development and the Quest for Meaning*, (San Francisco: HarperSanFrancisco, 1995), p.xii.
[35] Mol, *Identity and the Sacred,* pp.14-15.
[36] Ibid, p.262.
[37] Mel is an important exception. In coming chapters, we will see that her ethical doubts and questioning contributed to a period in which her faith seemed to go 'AWOL.'
[38] This closely echoes observations in the previous chapter that opposition bolsters identity only insofar as it occurs amid affinity and consonance. None of the chapters in this thesis alone presents a comprehensive answer to its research questions: all of the faith consequences must be viewed as part of a complex and interrelated whole.

evangelical interpretations, it seems *aspects of faith* can be changed without 'faith,' per se, changing. Indeed, this is perhaps precisely how changes come about.

We saw in 'On Work and Worldviews' that Stringer, with significant support, argues that individual religion is best understood as the sum of many parts, upon which people draw as they require, not needing or wanting to perfect a systematic or comprehensive Durkheimian 'unified system.'[39] The suggestion that personal faith and worldviews might be better conceptualised as the sums of parts, rather than as logically consistent and coherent wholes is useful in relation to the above narratives. It enables us to conceptualise particular ideas, principles and ethical authorities as sufficiently distinct that they can change, both in isolation and in relation to one another, without knock-on effects for the 'whole.' Thus ethical perspectives can change without an evangelical medic's entire faith changing – or, following Mol, precisely because their faith as a whole does not change. In this vein, Puchalski and Ferrell helpfully note that clinicians' 'values, priorities or beliefs' might be altered in accordance with their experiences.[40] Rather than conflating values, priorities and beliefs – to which we might add 'ethical standpoints' – the above examples show we can build a more nuanced picture by examining quite which values, priorities and beliefs are re-evaluated, and why. In subsequent chapters, we will see that treating worldviews only as the sums of disparate parts can become distortive and unhelpful. Nevertheless, Stringer's suggestion here helpfully highlights the importance of distinguishing between changes to faith as a whole, and to particular parts of faith.

Cognitive-Emotional Dissonance

The above sections have largely focused on changes to beliefs, perspectives and ideas, and their relative significances, not least when weighed against emotive and interpersonal experiences. We have also previously noted practical changes, in which medical work disrupted patterns of church attendance and involvement. In the examples below, we again see Christian beliefs being re-examined and re-evaluated through the lens of medical experience, but view them through the specific lens of emotionality.

Philip chose to audio-record his reflections. Being able to hear his voice accentuated the emotions at work as he described 'grappling' with death and judgement:

> [M]y work particularly has affected my faith in that I've really had to grapple with, do I really believe that judgement after death is real, when I see people die and I know from my Bible reading that the next thing that they will face after they've seen me is the Lord Jesus in judgement. And I remember going crazy about that a number of times when I was younger […] Even though they know that they're dying, it's - so they don't care what comes afterwards.

[39] Stringer, *Contemporary Western Ethnography,* pp.39, 49-51 and 113-114.
[40] Puchalski and Ferrell, *Making Health Care Whole*, p.166.

> They're hoping for nothing, they're hoping for oblivion. And that work has affected my life because it can't not do – it does mean that when I think about it I'm more urgent about my evangelism.

As a result of his work in geriatric medicine, Philip often felt highly conscious of his belief in judgement after death. However, he was conscious of it insofar as it was troubling: 'what can you do with that information other than go completely crazy?' In particular, it was troubling precisely because of the certainty with which he held it. Philip did not feel he could change his beliefs, since they were 'constrained by the Bible':

> I suppose one issue that I haven't addressed is whether it has […] changed my doctrine or my understanding of the Christian faith. And I'd have to say no it hasn't because my Christian faith is based on the Bible, not experience per se, so even though my experiences at work may mean that the teachings are sometimes less palatable, or I find it hard, doesn't mean I change my faith because I can't do, it's constrained by what I read in the Bible.

The consequences of this grappling were complex. In a sense, Philip remained certain about his beliefs. Yet precisely because he did not change his convictions, his emotional relationship to them changed in light of his experiences. His belief in judgement after death became 'less palatable,' something unhealthy to 'ponder on.' We have already seen that Mel's emotional relationship to her ethical stances changed, precipitated by embarrassment. For Philip, this change in emotions was additionally complex, because it involved clear imperviousness to change. Using Taves, Asprem and Ihm's framework, where Gwen and others assembled new meaning frameworks, we might suggest that Philip instead 'masked' the meaning violation in cognitive terms, but could not fully mask it emotionally.[41] That said, some change did flow from this combination of emotionality and imperviousness. The emotional pain Philip experienced when watching people whom he believed were unsaved die made him 'more urgent' in his efforts to evangelise outside work. It also strengthened the certainty with which he believed that 'unless God moves in people's lives they're not going to change.'

Though Smith's theory explicitly draws attention to it, Festinger's work on cognitive dissonance also makes room for emotion. Dissonance itself is an emotional phenomenon, a sense of discomfort created at the disjuncture between two elements. For Festinger, those elements may well be behavioural, and within behaviour he includes 'feelings.' As he explains, by changing an action *or feeling,* the individual may bring it into line with a cognitive element, thereby reducing dissonance.[42] Smith's theory is predicated upon the idea that engaging in sexual activity leads teenagers to '*feel*

[41] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' p.213.
[42] Festinger, *A Theory of Cognitive Dissonance*, p.19 (emphasis mine).

increasingly uncomfortable attending religious services, praying, and hanging out with other highly religious people.' This highlights the emotional weight of social expectation and its role in creating cognitive-emotional dissonance.[43] Taken together, Smith and Festinger's suggestions allow us further insight into Philip's experiences. Philip's beliefs, particularly in their immutability and significance for his faith and identity, became dissonant with his feelings towards them. In cognitive, logical terms, Philip's beliefs remained consonant, particularly insofar as he presented death and judgement as biblical and thus true and immutable. What no longer fit in this 'cluster' were his feelings towards these beliefs. In this case, work-faith affinity was seemingly absent. Rather, the interaction of work and faith created cognitive-emotional dissonance.[44] This is an important observation: while the drive for work-faith affinity was consistently evident or striven for in this study, it was not universally evident.

Importantly, there was also a normative dimension at work. Philip experienced dissonance not only between his beliefs and his feelings, but between what he felt, and what he perceived he ought to (and, indeed, used to) feel. Here, the social dimension hinted at by Festinger, and emphasised by Smith, is significant. Philip's socialisation in evangelicalism, in which the truth of the Bible is paramount, created this disjuncture. He perceived that he ought to feel confident, or at least content, in his convictions. However, as a consequence of his work, he instead feared he would go 'crazy' and found beliefs about death and judgement much 'less palatable.' These are emotional symptoms of a dissonance with both social and emotional causes.

Amelia experienced and expressed something similar to Philip, whereby the very stability of her position on abortion created discomfort. Referring to ongoing debates about whether elective abortions should be facilitated beyond the current legal limit of 24 weeks, she explained:

> [Abortion is] of particular note at the moment because of the ethical arguments involved in neonatal care. Umm. We've now got babies being born at 24 weeks that are surviving, umm, and there's a lot of debate […] and personally I have quite strong feelings about it, and again whether they line up with the NHS constitution and medical law is tricky sometimes.

Having 'quite strong feelings' that the abortion limit should not be changed created emotional discomfort, insofar as Amelia's views did not 'line up' with what she perceived was the likely direction of ethical travel. Amelia's Catholic upbringing, she explained, had informed – though not dictated – her views of abortion. As such, it seems cognitive-emotional dissonance on account of

[43] Smith with Snell, *Souls in Transition,* p.239 (emphasis mine).
[44] We pick up this example in 'Compartmentalising,' highlighting how Philip stopped this dissonance from disrupting work-faith affinity.

unwillingness to abandon socialised religious perspectives is not an experience unique to evangelical medics.

Conflict?

In line with expectations in lived religion, worldview and healthcare scholarship, the above examples show that their experiences working in healthcare can change evangelical medics' worldviews. In the first place, personal ethical convictions can profoundly change, not least because of emotive, interpersonal experiences. We have also seen that even where beliefs and their significance do not change, the emotions associated with these can shift.

Participants did not necessarily feel entirely at ease with such change. We saw that Liam and Gwen remained somewhat uneasy with their 'new' outlooks. Mel experienced conflict with her parents. For Philip, there was emotional distress, and internal conflict, as his beliefs were brought under a critical light. For Richard, Mel, and Gwen there was an additional consideration, for changes left them conscious that they had distanced themselves from either a previously-held view, or from what they considered the dominant, normative religious perspective. There was a sense of often uneasy difference and distinction, even if this was, in most cases, accompanied by an amelioration of cognitive dissonance, and a shift towards greater work-faith affinity. In 'Resourcing,' we also noted several examples whereby, despite their views not having changed, participants felt conscious that they had different ethical stances to their medical and Christian peers. Sarah felt silenced by a perceived ethical 'groupthink' in her church against abortion and euthanasia. Similarly, Martha felt silenced by being 'told how you should think.' This highlights an observation which this thesis, more broadly, sustains: that within apparently homogeneous religious labels, there can be immense variety in how people think, feel and 'live.'[45]

Though broadly united in acknowledging the changeability of individual worldviews, lived religion scholarship is more divided over the implications of change. Some argue that change causes conflict for the individual, as they become conscious of being different and distinct from mainstream, traditional or official religious viewpoints. However, Stringer urges caution, questioning whether and to what extent such conflict really arises.[46] In light of the above examples, we need to engage carefully with this point. In the first place, we must echo Stringer insofar as re-evaluating 'traditional' Christian viewpoints did not always create a sense of conflict for the medics. Richard recognised that his attitudes towards human sexuality differed from what he called a 'traditional' viewpoint, but embraced it nevertheless. Importantly, he reported neither a sense of inner conflict, nor of conflict

[45] McGuire, *Lived Religion,* pp.4-6; Allport, *The Individual and His Religion,* pp.28-30.
[46] Stringer, *Contemporary Western Ethnography*, p.47.

with other Christians. By contrast, Gwen clearly articulated both types of conflict, her personal unease emerging alongside recognition that her views on abortion made her 'a bit different' to her Christian peers. It seems such changes of ethical perspective *can* stimulate conflict, even if they do not *necessarily* do so. Moreover, in both Gwen and Philip's cases, the word 'conflict' is potentially unhelpful, for it masks subtleties. Philip clung to his biblical beliefs despite how 'unpalatable' they had become, resulting in an apparently contradictory mixture of certain conviction and discomfort. Similarly, Gwen's sense of distinction, of distance from particular Christian perspectives, did not simplistically manifest as conflict. It might be better grasped by describing a complex and apparently illogical mixture of confidence and disquiet, not least concerning whether or not she had always made the correct situational judgements. Sarah, not unlike Gwen, was determinedly steadfast in her own pro-euthanasia and pro-abortion viewpoints. And yet this too was accompanied by an uncomfortable sense of being silenced by the majority view within her church.

As such, it seems wise to echo Stringer in questioning whether, and to what extent, individuals engaged in re-evaluating traditional religious perspectives experience 'conflict,' but without excluding the possibility. Additionally, we can express some concern over the word 'conflict.' Philip and Gwen's examples show that a myriad of emotions can be in play, not easily reducible to single words. Rather, we should explore the variety of emotions at play in such scenarios, rather than only exploring whether conflict is present or absent.

Conclusion

While previous chapters have highlighted continuity and consolidation of faith, this chapter has shown that medical work can encourage discontinuous changes within faith, and, particularly, of ethical perspectives. While patients' suffering was among the stimuli for such changes, so too were patients' loving relationships, the complexities of individual cases, and, indeed, the imperviousness with which particular Christian principles were held. Thus Puchalski and Ferrell's suggestion that being present to a patient's suffering can change a clinician is both borne out and broadened.[47]

It is important, however, to couch these conclusions in conditional language. To observe that such changes were significant for these participants is not to claim that medical work *will* have such effects upon evangelical medics. Additionally, it is perhaps unhelpful to gather this chapter's observations under the singular heading 'Changing.' Change took the form of rejection of previous stances and shifts to situational negotiation. Moreover, we also saw that Philip struggled with but could not abandon his belief in judgement after death, with the result that holding this belief

[47] Puchalski and Ferrell, *Making Health Care Whole,* p.166.

became ‘less palatable.’ His emotional relationship to his belief changed, creating cognitive-emotional dissonance, but his belief, per se, did not. Thus, even as we present change as a potential consequence of healthcare work, we must recognise nuances and complexities. By viewing worldviews as complex, multifaceted systems in which beliefs, emotion and practice interrelate, we can see that change and imperviousness to change are not necessarily mutually exclusive.

This chapter considered the implications of such changes for these participants’ senses of identity and work-faith affinity. Using Festinger and Smith’s work on cognitive dissonance, it suggested that shifts of ethical perspective could be understood as means of reducing, if not wholly removing, cognitive dissonance. While this thesis observes that some tension between faith and work can be significant and valuable for evangelical medics, it is important to emphasise that by no means all dissonances were welcomed. Rather, the participants demonstrated a consistent desire and drive for work-faith affinity, and thus to resolve tensions, with some exceptions. In reducing cognitive dissonance, participants were in turn able to achieve greater work-faith affinity, and thus a more consonant sense of identity. Where in previous chapters, work-faith affinity has been either perceived or conspicuous in its absence, in this chapter we have seen participants working to achieve it. It is telling that these examples were all in the interests of greater work-faith affinity, and were effected by a shift away from ‘black and white’ or absolutist ethical engagement. This chapter thus further challenges any easy elision between evangelicalism and protest, particularly insofar as protest relates to polarised ethical topics. In ‘Questioning’ we will see again that medical work tended to encourage people away from ethical absolutism.

Philip’s example was more complex. While his beliefs remained logically ‘fitting,’ his emotional relationship to them changed as a result of his work. As such, the very imperviousness of his beliefs resulted in cognitive-emotional dissonance. His resolution was to avoid pondering these beliefs and their implications too much, lest he ‘go crazy.’ This is one of several reminders in this thesis that, while affinity was consistently either perceived or achieved, at times it was neither found nor achieved. While certain tensions and dissonances were significant for some participants, at other times these caused distress and discomfort. In the next chapter, we explore ‘questioning,’ a further source of discomfort and, indeed, distress, for some participants.

Questioning

"God hasn't told us why it's happening"

Introduction

Questioning is, itself, a complex question. Christian traditions, including evangelicalism, have framed questioning and doubt in a mixture of ways. Smith's *American Evangelicalism* cites a survey which suggested evangelicals, by comparison to Christians from other denominations, had very low indices of doubt, with 71% reporting 'never' having doubted their beliefs.[1] As noted in 'Taking Stock,' the Christian clinical psychologists in Baker and Wang's study were anxious that their 'religious beliefs influence clinical practice *but not vice versa.*'[2] The prospect that their faith might be shaped by their work, as well as deployed within it, was, for some, unsettling. Mark Pickering, current CMF Chief Executive, wrote in a 2001 edition of the CMF's student magazine, *Nucleus*: 'As we are asked difficult questions about our faith that we have seldom considered, we can end up confused and shaken.'[3] Pickering suggests that healthcare work, by generating unsettling questions, challenges faith in a potentially damaging way. While Pickering does not imply those with faith will not have questions and uncertainties, he does suggest that encountering them may well be uncomfortable.

With a more positive framing, Fowler suggests that '[c]ritical reflection upon one's beliefs and values' is an ordinary and beneficial aspect of faith development, locating it within his 'individuative-reflective' stage, typically beginning in young adulthood.[4] He suggests that this stage 'opens the way for critically self-aware commitments in relationships and vocations.'[5] This has close parallels with Pearce and Denton's work with young adults in the USA. As we saw in 'Taking Stock,' they observed that interrogating faith can, ultimately, bolster adolescents' religious worldviews and identity.[6] Among Strhan's conservative evangelical participants, questioning, doubt and perceptions of God's

[1] Smith, *American Evangelicalism,* p.29.
[2] Baker and Wang, 'Examining Connections Between Values and Practice,' p.134 (emphasis original).
[3] Mark Pickering, 'Surviving & Thriving at Medical School', *Nucleus* (2001) <https://www.cmf.org.uk/resources/publications/content/?context=article&id=393> [last accessed 8th July 2020].
[4] Fowler, *Weaving the New Creation*, p.18.
[5] Ibid.
[6] Pearce and Denton, *A Faith of Their Own*, p.180.

absence were normalised as parts of discipleship, with sermons dedicated to 'keeping going' through such experiences.[7]

Already, therefore, there is precedent for diverse interpretation of questioning and doubt, both across Christian traditions and within evangelicalism. This was echoed in this study. This chapter continues exploring how the participants' faiths were 'shaped by' their work, showing that healthcare work can stimulate questions, uncertainties and doubts among evangelical medics. This also echoes existing literature: as we saw in 'Taking Stock,' some scholars have argued that working in healthcare can encourage negative religious coping. Negative religious coping has been variously defined as including: religious discontent; questioning of religious beliefs, faith and practices; conflicts over spiritual matters with God or a higher power; and elevated mistrust in God.[8] Questioning and doubt are thus presented as potential difficulties, arising at the interface of healthcare work and religious faith. The participants in this study articulated and described questioning, doubt and uncertainties in diverse ways. In some instances, they found such experiences profoundly challenging, and the below explores examples of far-reaching doubts, and loss and distancing of faith. Others, however, perceived them more positively, and many participants had developed multiple means of managing the questions, doubts and uncertainties which their work raised. As such, this chapter suggests that questioning ought not, as some have suggested, be considered a form of 'negative religious coping,' at least not without careful consideration of how individuals perceive such experiences.

Distant Faith

In the previous chapter, we saw that working as a nurse led Mel to both question and change her stance on several ethical topics. Her work also stimulated other questions and doubts. In her reflections she told this story, from her time working in A&E:

> We had a young male brought in […] he had been in a car [accident] with friends, he was bleeding out. He was also, according to family members who arrived within a few minutes of his arrival, a Jehovah's Witness. They were adamant that he should not receive any replacement blood products at all […] I was not the one on whose shoulders the decision-making rested, but I do remember the awfulness of his family saying no to treatment, and of course he couldn't be asked as he was unconscious, he was to my recollection a couple of months under 16yrs of age. There was much discussion as to how we might know whether the faith of his family was also his faith and if it was to the extent that he would have been happy with the decisions they were making about his care. The family were firm in their thinking that God's will would work it all out and that

[7] Strhan, *Aliens and Strangers?,* pp.185-195.

[8] Zukerman et al, 'Avoidance Behavior, p.517. See also Sherman A. Lee, Laurin B. Roberts, and Jeffrey A. Gibbons, 'When Religion Makes Grief Worse: Negative Religious Coping as Associated with Maladaptive Emotional Responding Patterns', *Mental Health, Religion & Culture*, 16.3 (2013), 291–305 (pp.291-293).

> if their son were to have a transfusion, he would cease to be their son – effectively the kid was given a death sentence however things panned out.

The boy died from his injuries, having received no blood products. Afterwards, Mel recalled questioning, 'How can it be God's will that if there are people that, in a moment, could preserve the preciousness of this life, that it's not his will that it's kept?' More broadly, she came to ask:

> How God's will […] fits into the whole practice of medicine and surgery. Do they work hand in hand or can we at times be almost pushing the hand of God with our supposed best knowledge of what is right and what time is right and when it's OK for someone to die?

In A&E Mel faced what she described as 'days full of situations like [that]' in which 'good people' suffered. Her childhood faith failed to provide meaning, resources, or answers to emerging questions. In particular, 'this burning question [of suffering] that I struggled to find any comfort in answering might well have been one of the reasons my faith seemed to go AWOL for a season.' Questioning and uncertainty fed a holistic loss of faith, not least because Mel felt she had no outlet:

> [I]n regards to questioning faith, I don't know really whether I ever really talked to anybody about it. Which probably wasn't incredibly helpful, and I probably made lots of excuses. But [sighs] maybe sometimes because I thought, um, I was worried that maybe I was losing my faith, and that's – if you've come from that, really, kind of church-y background it's something that – that you just – that just didn't happen. So you didn't talk about it. You know. So, you know, I wasn't brought up to question it, because other people with brains had obviously come up with this, and, so you don't question it, you accept it. […] So I think looking back, I – I realised that probably I didn't, ever, say to somebody, "you know what, I really – I struggle at work sometimes, when this, this, and this happens." And I [pause]… yeah.

When she did seek out advice, she found other Christians' approaches to suffering unhelpful:

> Talking to other Christians about this, it seemed to me that they could see where God was when things got sorted and we managed to save people – focus on the good stuff they'd say – God was there and at work then. Unfortunately, this didn't really cut the mustard for me at all. What about all the hopeless ones? What about when it went wrong? What about people who ended up topping themselves by accident? What about people blighted by mental health issues who seemed never to have any peace with themselves?

This period of questioning, and of her faith subsequently going 'AWOL,' was painful for Mel: 'At the time I just thought, everything I believed is a lie. And this is bunkum! […] I felt like God was playing games with me.' Thus for Mel, questioning and doubt did indeed represent and feed negative religious coping. While she was keen to emphasise that her work was not the only contributing factor, she nevertheless firmly agreed that it 'played a part' in her faith going 'AWOL.'

In 'Changing,' we considered Taves, Asprem and Ihm's suggestions regarding how individuals respond to 'meaning violations.' Droogers, similarly, highlights the importance of considering how individuals' worldviews and faiths respond to challenges and crises. He explains:

> [When] routine actions fail to solve a problem, reflection is demanded […] New meanings must be discovered or given, or at least old meanings must be applied to new situations, demanding some adaptation of the old and familiar […] It is possible that a crisis might have such devastating consequence that reflection is simply not possible […] Whatever kinds of meaning-making remain possible [...] are not recognizable as answers to the questions that emerge from the crisis situation.[9]

In Mel's case, work stimulated a crisis, and she seemed to have no 'recognisable answers.' In addition to her faith going 'AWOL,' Mel avoided the problem of suffering for some time, explaining, 'It wasn't until [much later] that this skeleton came out of the closet and I had to address it.' As we saw in the previous chapter, Smith argues that some will 'pull away from religion' because of cognitive and emotional dissonance.[10] Mel pulled away from her faith, finding it increasingly dissonant with her work because of the questions and doubts it was stimulating. Across this study, a drive towards work-faith affinity was consistently evident in the participants' narratives: but it was not permanently evident. At times, it was conspicuously absent. Indeed, Mel's narrative shows the precise opposite of work-faith affinity at work. This, in turn, demonstrates that it was only some tensions and dissonances between work and faith which enabled participants to thrive as 'Christian medics.' Some were profoundly problematic.[11]

Hannah also described a period during which she felt distant from her faith and from God. Like Mel, she was clear that work was not the sole cause, but had played a part, owing to a combination of feeling able to 'rely upon herself,' and being in what she described as a 'not very Christian' workplace. Despite feeling 'really, still excited to be talking about my faith at that time […] I was aware that I felt a distance from God.' This sense of distance is nuanced and complex. Despite it, Hannah nevertheless retained a firm belief in God, and was still keen to share her faith. She also described feeling well supported by church and Christian friends at this time. Goodluck also felt distant from his faith for a time:

> [A]t the beginning of my third year as a doctor, that's when politics got involved […] And that was a troubling time because I was so busy. So – I was still working full time at this time, so I mean, I was working 7 day weeks. A – um, 8 day weeks, considering how much I was putting in […] [I]t

[9] Droogers, 'The World of Worldviews,' pp.37-38.
[10] Smith with Snell, *Souls in Transition,* pp.239-240.
[11] We do, however, pick up Mel's story again in 'Growing.' There we explore her faith's growth and development, highlighting that hers was a story of both tension and eventual transformation.

> was that point that my faith really – that year was quite bad for my faith – sheer busyness, and just forgetting? And walking away from a lot of friends, relationships, and just by being busy. It wasn't particularly a good… […] [The next year] I started rebuilding, um, kind of – relationships with both my friends and with- with God. And yeah, it was just a slow process of coming back together.

Squeezed out between his work as a junior doctor and time invested in politics outside of work, Goodluck's faith diminished in significance. These periods of distances from their faith disrupted the identity conceptualisations which both Hannah and Goodluck considered aspirational: the hierarchical model was inverted; and work-faith affinity was disrupted, senses of mutuality, coherence and consonance between work and faith with it.

For Hannah and Goodluck, the drive towards work-faith affinity was diminished for a time, but was not wholly absent. Its persistence was evident in the disquiet with which they experienced and expressed its absence. Much like the participants in Strhan's study, both recognised that it was normal to have peaks and troughs in the closeness with which faith was felt.[12] However, these instances in which their faith had a diminished role nevertheless troubled them. Thus Goodluck 'admitted' struggling to juggle work and church; described the year as 'bad' for his faith; and felt he had to 'rebuild' it. Both he and Hannah were grateful that they had come through these periods, not allowing distance from their faith to become a long-term norm. Additionally, the temporary inhibition of Hannah and Goodluck's drives towards work-faith affinity in turn stimulated their re-ignition. Goodluck thus described the 'slow process' of 'rebuilding […] relationships with both my friends and with- with God.' Hannah turned to support from her church and Christian friends. Again, both the hierarchical and the consonant identity conceptualisations are important here. In rebuilding consonance between their work and their faith, Hannah and Goodluck also corrected the inversion of the ideal hierarchy of identity. These apparently opposing identity conceptualisations existed in parallel, rather than in tension. The ideal of work-faith affinity, and of a work-self which cohered with, rather than threatened, the faith-self, was evident in its absence; the drive towards it was rekindled through that absence.

Questions, Doubts, Uncertainties

In the above examples, Mel, Hannah and Goodluck experienced questioning, doubts and uncertainties as a result of their work. These were challenging and, to varying extents, destabilising for their faiths. Here, negative religious coping is a useful framework, insofar as this is how the participants understood and presented these episodes. In other cases, however, participants presented questioning, doubts and uncertainties less negatively. This challenges suggestions that

[12] Strhan, *Aliens and Strangers?,* pp.185-195.

questioning one's faith ought to be classified as a form of 'negative religious coping' without thorough consideration of how the individual, subjectively, perceives it. The below explores participants' ethical questions and uncertainties, followed by other specific doubts. It then presents the multiple ways in which participants responded to these experiences. Between these varied perceptions, and means of responding, I thus suggest that questioning, doubt and uncertainty can just as well evoke work-faith affinity and consonant identity as they can negative religious coping.

Ethical Uncertainties

This thesis has already explored both oppositional and changed ethical stances. Additionally, some participants either became or remained uncertain about ethical topics because of their work. For example, both Martha and Liam felt profoundly uncertain about abortion, acutely aware of complexities, including ethical 'shades of grey.' Their uncertainty partly related to lack of exposure: both felt they lacked experiential knowledge from which to fully form opinions.[13] Neither had ambitions to specialise in obstetrics and gynaecology, nor much experience of abortion in their training:

> Liam - Reflections: 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 - Interview: 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 […] yeah, I don't really have a firm stance.
>
> Martha – Interview: The way that I've thought about them is – to be honest – avoidance! […] I basically don't want to articulate an opinion because I – I haven't fully formed my opinions.

Indeed, Martha proclaimed that she had her 'head in the sand' on the topic. Interestingly, even as she remained uncertain, Martha rejected 'very, very conservative' approaches to abortion, which she felt were harsh and unloving:

> [M]aybe even if it is truth, it's truth without love. And I've found it really hard to – have, to feel like you have to force yourself to associate with conservative Christian ethics on – say, abortion, when, again, probably my soft, and compassionate heart has seen too many women really struggle in, like, a broken world […] I feel like a lot of Christians tell me how I should think, but what I see and experience is that the world doesn't necessarily – I don't find it easy to match it up with that view, in […] practical terms. Like I feel like I do understand the values about life […] But I feel like these never, ever, ever, never, abortion is *always* wrong [perspectives], I feel, well, how does that work in our world where not everyone is a Christian, and how do – how can we force that on people. I don't know.

[13] Cowley, *Medical Ethics,* p.xiii.

Martha both recognised 'values about life' and felt compassion for women's struggles in a 'broken world.' Thus, as in 'Changing' and 'Opposing,' multiple, conflicting ethical principles informed her thinking. Akua experienced a similar blend of certainty and uncertainty, and likewise repudiated 'simplified' approaches to abortion:

> My friend […] was struggling because a Christian couple he knew had chosen to terminate their pregnancy because the baby had no spinal cells in the neck, two holes in the heart and Down's Syndrome. […] [H]e said, 'I can't play God with life […] I know that's not God's heart for people.' And I said, 'Well, in that argument […] when someone, when a baby has a condition that […] they are physically going to die of when they are born, and suffocate, in their mother's arms, and when that woman is questioning God, you're essentially saying that God's heart for her baby is that he would die in pain and suffering with several malformations and mutations.' That clearly isn't – it's too simplified an answer […] babies die all the time and God hasn't told us why it's happening, but he died in pain, so it can't be that he doesn't care. But he also isn't saving them. So you saying that we are [pause] we are getting the way of God, I'm like – the babies are still dying? God clearly has a bigger picture than just saving all the dying babies. Otherwise he'd be doing it. And we can't boil it down to that.

Intriguingly, several participants presented or described themselves as uncertain about ethical topics despite apparently having firm opinions. They were seemingly so conscious of complexities surrounding these sensitive themes that they felt a need to be - or to present themselves as being - more uncertain than they were. For example, Akua explained of euthanasia:

> [T]he debates now are so complicated […] it's been very difficult for me to debate that recently because - how much of a brain needs to be left for someone to still connect with God? […] But at the same time, [pause] I sort of – I worry that we hold on to this time too much, and I think letting them go, in my mind, it's agonising when I feel like the person doesn't know God… and it – but it makes me more frustrated, in feeling like, I wish you just did know God, and then you'd be – and then there would be a bit more peace? And then it would be ok if you left. […] Like, holding onto the life itself, I don't have as much of a tie to it. […] I don't really know. It's a very muddled area of my brain […] it's – it's one of those spiral topics […] if everyone was a Christian I don't think I would mind who died.

On the one hand, Akua felt euthanasia was a 'complicated,' 'muddled' topic. On the other hand, her rationale – that if someone was 'connected to God,' there was no need to 'hold onto this time too much' – seemed clear. Hannah, similarly, juxtaposed apparent clarity with an assertion that she was 'not 100% clear on' LGBT matters:

> Because of the nature of the work in [my sexual health fellowship], most of the patients I dealt with were men who have sex with men, who may or may not identify as gay or bisexual, also quite a lot of transgender patients. Umm and – it's, this area is obviously hotly spoken about […] And I think that m – me working in that place, umm, I – I think I have a lot of love, and – love for, and some limited, like, kind of increased level of, sort of, understanding of the difficulties that, that LGBTQ people still have. […] I'm actually not 100% clear on my view, but I do think my view

> has been influenced by the amount of not only just patients but friends I have who are, um, lesbian or gay or transgender, from my time working there.

Jeremy paired 'firmly sitting on the fence' with an apparently clear stance on euthanasia:

> I sit on the fence, firmly, about it. If it were to be legalised I wouldn't necessarily be against it, I just think it's going to be abused. Probably by a minority. But inevitably. […] And so I think for that reason I would probably err on the side of staying where we are? […] because it allows doctors a bit of flexibility, for, like, the double principle thing – or the law of double effect. That allows us some umm, leeway, to look after our patients and make them comfortable well, without scrutiny that we're killing people. Umm. And I think letting some doctors in a team context have that power is a good thing. But to go any further than that I think would be dangerous.

As in 'Changing,' it is notable that these ethical uncertainties led participants to look less favourably on absolutist and conservative standpoints. In this study, ethical changes and uncertainties tended towards circumspection and liberalisation, rather than absolutism and conservatism.[14] Future research would usefully explore the extent to which this is more generally true among evangelical doctors in England.

It is important to explicate that ethical uncertainties were often based, at least in part, on concerns stemming from outside the participants' faiths. Indeed, this is clear in several of the above quotes. Consider Akua's questions about brain activity and euthanasia, and babies' medical viability after birth. Transgenderism was particularly significant in this respect. Nigel and Simon both articulated uncertainty about transgenderism and gender transition, highlighting complexities and their ruminations at some length. These complexities related to their faith, but had as much – if not more – to do with medical uncertainty. Nigel elaborated on his uncertainties:

> God made us all. How people choose to express themselves, in many ways, um, uh, is not necessarily for me to judge?! Uh – um – but if people are suffering, or feeling like they're being persecuted for it, that to me makes me feel like I need to be supportive for them, and to be there. […] I do struggle with getting it right when I see young people who are exploring, uh, gender identity issues […] [O]ne thing I am aware I do clinically is – is I don't rush at starting people on medication and sending them off, fast-tracking them to gender reassignment. That might be wrong. And I may look back on my life and say "that was your own prejudices." Because there is a part of me that thinks, it is a time of fluidity, it is a time of change. And – and I want to say, "We will support this, and we will see where this journey takes us," in as supportive a way as I can, amid all the distress in their lives which may be going on around this. Um. But without saying this is right or wrong. […] [But then] I think – am I, am I a bit slow, in pushing people in the right… There was a big pressure from uh, the transgender community, to say get them on hormone tablets early […] and I don't do that […] and it's because I don't know the answers. But I think I can be open to say I don't know the answers, and therefore I equally don't know what

[14] This echoes Guest et al's observations of Christian students at UK universities – *Christianity and the University Experience,* pp.99-103.

> harm I'm causing by doing this. Am I causing more harm by doing nothing? Maybe. Maybe. Maybe not. […] Well. I will discover in the fullness of time how right or wrong I was on that one.

Nigel's uncertainty derived substantially from medical ambivalence as to whether acting quickly or exercising caution represented the less harmful intervention. Simon's uncertainty similarly oriented around harm, balanced against his recognition that, for some patients, gender transition was the most appropriate course of action:

> [Y]ou've got this complex interaction between the physical expression [of] biological sex; you've got […] internal gonads; you've got the hormonal expression. [And] societal and psychological modulation of that. You've got a very complex multi-dimensional system. Is it possible, therefore, theoretically, in a – in a broken world where we know stuff doesn't always line up – for people to be in a situation where they very strongly feel that the way in which they look at the world is different from their external and biological gender – well I think you've got to say it would be surprising if that was not the case, given the – the complexities in which we live. So I'm absolutely – I'm not one of these individuals who say this is, you know, something which doesn't exist, it's all a spiritual issue – far from it, I absolutely think there are folk for whom […] their best interest could well be, um, transition.
>
> However. It is extraordinary that we have moved from a situation in which that was very unusual to something where it is now coming through in flood-loads […] [M]y profound concern is that many young people […] have broad identity disorder, um, and they are now labelling it as a gender identity disorder. They are then meeting people who seem to be extremely enthusiastic about accelerating them through a transition process that will make an irrevocable change […] you've got to have a thorough assessment before you do stuff which is irrevocable. Otherwise you are doing them serious harm. And my concern is that we are actually, because we are fast-tracking, we are encouraging and facilitating this concept in a way which I think is probably doing harm to large numbers of young people. So that's the difficult balance we've got here. Um, to try – try and wrestle with.

For Simon, as for Nigel, from both biblical and medical perspectives, transgenderism and gender transition needed to be treated with love and care. His uncertainties were related to the 'complex multi-dimensional system.' Faith and medical concerns and ethical principles are intimately entwined in these examples. As such, it is helpful to frame them in the same way as in the previous chapter, recognising that ethical uncertainties are not synonymous with faith uncertainties, though both exist within individuals' complex worldviews.

Doubt

In addition to ethical questions, some found that their work stimulated other specific doubts and questions in relation to their faith. Hannah explained:

> A few things at work […] feed into doubt – [like] when you see people die. Um. When you let, um, like, sinful conversations, and certain negative relationships, and like, long days, shape your approach to your relationship with God.

Several of the things which 'fed' doubt for Hannah had to do with the culture and conditions of her work, such as conversations and relationships which were not, in her view, conducive to her faith. In these examples, she seemingly blamed herself for 'letting' such things affect her relationship with God, and feed doubt. She also singled out death in particular challenge and source of doubt, and recalled the sudden, unexpected death of a patient in her mid-30s. Having expected to discharge her, Hannah explained '[t]hat was a place where I was like – like, just really questioning why […] It's not that I doubt the existence of God, it's that I would doubt my […] well, I would just say "why?".' Similarly, Nigel said:

> For many years I worked in paediatrics, in addition to treating the children there was a role supporting parents and carers of children and young people. Some with terminal, life threatening and chronic illnesses […] I look back on this time and wonder how I would have got through each day of difficult situations and conversations if I had no faith. That is not to say that there have been times when the question "why God?" hasn't come up in my prayers.

Hannah and Nigel's examples show that, at times, death and suffering stimulated questions to which the medics felt they had no answers. Both questioned 'why,' temporarily at a loss to find meaning. Liam similarly explained: 'Certainly I have moments of [feeling] a bit helpless to human suffering […] questions about – why bad things happen […] and it is tough sometimes.' This provoked related questions about the impact of prayer and faith: 'You do sometimes wonder […] how much prayer does and how much people's faith has an impact on these things.'

Akua echoed Liam's musings. Describing treating heroin addicts, she said, sadly, 'I [remember] thinking, like, what [has] life been like, and […] how good a chance is there that praying would make a difference? And I remember really thinking hard about that.' Nevertheless, she juxtaposed this questioning with her joy at praying for and with other patients, asserting that 'it's definitely something I should do more.' From Akua, Liam, Hannah and Nigel's examples, it seems that functioning as a resource does not render worldview facets immune from being questioned. At times, they doubted the efficacy and value of prayer.

Managing Doubt and Uncertainty

We have, thus, seen several examples of specific doubts, questions and uncertainties raised by healthcare work. The below considers what we can learn from how the evangelical medics both perceived and responded to such experiences, focussing particularly upon the implications for the medics' identities. It identifies six reactions to uncertainty and questioning. Together, these challenge suggestions that ethical questions and other specific questions, uncertainties and doubts are indicative of 'negative' religious coping. Correspondingly, the evangelical medics' reactions and

responses to questioning also provide further evidence of the participants seeking and finding work-faith affinity, and consonant identity as 'Christian medics.'

In the first place, many participants considered questioning valuable and beneficial. For example Jeremy found his psychiatry rotation fascinating but challenging. While treating patients with religious delusions put him 'on the back foot,' this:

> caused me to examine my own life and what's different about my beliefs to those people who I know are delusional […] that's positive in that it's caused me to think about that and self-examine again, which is always a good thing […] I think a faith that you can't question and justify is a waste of time.

Jeremy found examining his faith edifying because he had 'either been able to answer [every question]' or been 'comfortable that there are answers.' Akua presented her greater willingness to question her faith as a significant change effected by her time at medical school. She felt it had 'made my faith more open ended in a good way. I am more willing to say "How does that work God?" when something confuses me. I'm more inquisitive.'[15] James similarly found himself 'willing to question and to probe things,' rather than fearful of doing so. Thus where some would expect questioning to challenge these medics, or to cause them difficulties in relation to their faith, for Jeremy, Akua and James the opposite was true. Rather than perceiving questioning negatively, they welcomed it. Put differently, questioning did not create problematic dissonance, or disrupt work-faith affinity: rather, it evoked consonance, representing a way in which work enhanced their faith. However, it is telling that both Jeremy and Akua felt the need to clarify that questioning was a 'positive' or 'good' thing, suggesting they were aware that some might consider it negative or perilous.

Secondly, doubt and questioning often touched the medics' faiths in partial rather than holistic ways. For example, while both Hannah and Nigel asked 'why?,' both differentiated between this acute questioning and questioning their faith in general. Hannah clarified that she did not 'doubt the existence of God,' and that her experiences had 'never made me doubt Jesus' – that is, the salvific heart of evangelical faith. Nigel juxtaposed questioning God with his faith's important role in getting him 'through each day of difficult situations.' Thus, amid questioning, he also used his faith as a resource, turning to prayer: 'probably because actually to witness such suffering is – it's hard not to want to do something.' Akua, as we saw, also juxtaposed her questions about prayer with her determination to use it more: even as she questioned prayer, she turned to it. Liam explained that the many questions his work had stimulated had not affected his faith more broadly (adding, 'Not

[15] We revisit Akua's open, questioning faith in more depth in 'Growing.'

yet, at least.') As for Nigel and Hannah, questioning affected particular parts of his faith in relative isolation. Similarly, Ginny, noting that her colleagues often cited degenerative illnesses as stumbling blocks to religious belief, explained:

> So [sighs] while it's – it's potentially challenging to see people dying slowly of the progressive neurological diseases people do think of, or with a lot of pain, it hasn't changed, you know, turned me away from faith.

Though progressive neurological diseases did 'challenge' her, stimulating questions and negative emotions, Ginny experienced no loss of faith.

Certainly such questions were challenging to Hannah, Nigel, Ginny and Akua. However, the circumscribed nature of these challenges meant, in turn, that work-faith affinity was not disrupted wholesale. In creating uncertainty, their work simultaneously aided and disrupted their striving for work-faith affinity. The drive remained, even as it encountered challenges and barriers. This circumscribed questioning also shows that it is valuable to differentiate – as the participants did – between specific questions, and those which call into question faith more generally. Again, Stringer's suggestion that individual faith needs to be conceptualised as the sum of multiple parts is meritorious.[16]

To frame Nigel and Hannah's experiences in particular, it is useful to consider the Judeo-Christian tradition of lament. Old Testament scholar Anderson notes a persistent pattern whereby the biblical Psalms of lament incorporate both lament and praise, locating uncertainties *within* faith, not beyond it.[17] Very recently, New Testament scholar NT Wright, writing in TIME magazine, evoked lament in response to the Covid-19 crisis, defining it as 'what happens when people ask "Why?" and don't get an answer,' not least in relation to suffering.[18] Applying this to the pandemic, he suggests, 'It is no part of the Christian vocation, then, to be able to explain what's happening and why. In fact, it *is* part of the Christian vocation *not to be able* to explain – and to lament instead.'[19] John Swinton's *Raging with Compassion* echoes both Wright and Anderson, suggesting both that 'lament is prayer […] a very particular form of prayer […] that takes the brokenness of the human experience into the heart of God' and that '[l]ament is […] an act of faithfulness in situations where faith and hope are

[16] Stringer, *Contemporary Western Ethnography,* pp.113-114.
[17] Bernhard W. Anderson, *The Living World of the Old Testament*, 4th edn. (Harlow: Longman, 1988), p.555.
[18] N T Wright, 'Christianity Offers No Answers About the Coronavirus. It's not Supposed to' in TIME, 29th March 2020, <https://time.com/5808495/coronavirus-christianity/> [Last accessed 14/05/2020]
[19] Ibid (emphases original).

challenged.'[20] Both Hannah and Nigel, amidst suffering, addressed challenging questions from within their faith. While they did not cite lament as a rationale, their experiences echo this tradition.

Swinton argues that lament has lost significance and prevalence within the contemporary evangelical church.[21] He writes, 'there seems to be an assumption that faith should not embrace negativity, that to acknowledge the reality of pain and sadness somehow diminishes God and threatens God's control over things.'[22] This closely links to the observations above regarding the mixed and, often, negative ways in which questioning, doubt and uncertainty are approached by evangelicals. Swinton's is a powerful treatise for the recovery of lament not just for individuals, but for the church collectively, in order to normalise uncertainty, as faith converses with experience.[23] Certainly in recent years, those exploring Christian approaches to mental health have found lament a useful, promising framework.[24] Hannah and Nigel's experiences hint at its utility as a lens for the exploring relationship between religion and healthcare work beyond current explorations in theology and mental health. We consider this point again in 'Summary and Recommendations.'

Thirdly, some participants managed their uncertainty through avoidance, approximating those medics who, as we saw in 'Opposing,' eschewed particular medical specialties in order to avoid ethical dissonance. Martha's response to abortion – that is, keeping her 'head in the sand – could also be framed as a form of partial compartmentalisation, which we explore in the next chapter, suggesting it is a strategy for avoiding potentially damaging dissonance. However, alongside present avoidance, both Martha and Liam also anticipated reaching firmer ethical stances in due course. They managed present uncertainty by locating greater certainty in the future. Liam explained how he expected to go about this, saying, 'I think my faith would be one [factor], and kind of teachings of the church and the Bible, and – and we do talk about them at – at things like the Christian Medical Fellowship.'

Fourthly, and also echoing previous chapters, participants used theological resources to manage uncertainties, drawing upon evangelical culture, narratives and discourses with which they were familiar. For example, Jeremy confidently asserted that 'if the Christian gospel is true, it will stand up to any amount of examination.' This all-encompassing theology of questioning granted him peace with some of the unresolved questions his work stimulated. Other common evangelical resources,

[20] John Swinton, *Raging with Compassion: Pastoral Responses to the Problem of Evil* (Grand Rapids, Mich. ; Cambridge: Eerdmans, 2007), pp.104 and 109.
[21] Ibid., pp.114-115.
[22] Ibid., p.115.
[23] Ibid., pp.110 and 118.
[24] Ben Ryan, *Christianity and Mental Health: Theology, Activities, Potential* (London: Theos, 2017), p.24.

such as beliefs about the finitude of human perspectives, and God's total knowledge, aided other participants. As highlighted above, Akua's belief in God's 'bigger picture' ameliorated her ethical uncertainty:

> God hasn't told us why it's happening, but […] God clearly has a bigger picture than just saving all the dying babies. Otherwise he'd be doing it. And we can't boil it down to that.

She continued: 'We've never got the complete picture. I find it interesting to explore God and how He fits into all these parts of life.' Taves, Asprem and Ihm suggest scholars must further explore whether 'worldviews [are] made in the moment or generated on the basis of relatively stable sets of schemas that generate some degree of coherence across situations'.[25] In this study, participants seemingly drew upon 'stable schemas' capable of generating 'coherence' amid uncertainty, both despite *and because of* challenging questions.

Thea, who did not describe herself as an evangelical, wondered 'had I not been versed in psychiatry and medicine [whether] my beliefs might well have been less subject to rigorous questioning in the face of various sources of alternative information and scientific evidence' and whether she might therefore have felt more at home in the church. For Thea, questioning her beliefs did have what she considered negative consequences. Additionally, such questioning undermined a sense of belonging in a church, which other participants found a valuable social and theological resource. Future research might valuably explore not only whether evangelical theology particularly facilitates an ability to manage questioning, but particularly examine the extent to which religious social networks contribute to questioning not becoming a negative form of religious coping.

We have already seen that Nigel acknowledged his limited human perspective in relation to transgenderism. He addressed suffering in the same vein. This theologically-informed lens helped him move towards acceptance:

> I do struggle with that suffering bit. You know, just, why does God allow suffering? And, well, I don't know! […] I come at this very much with an awareness of my – my, my own lack of knowledge, and my own limited human perspective on things, and it means making sense of the bigger questions in life, is not always easy! […] I hate suffering, and I wish it wasn't! But – but – do I sometimes just have to accept that there is suffering…? […] because [I] don't see the bigger picture. And I see myself as a child in some ways, who doesn't have a – incredible capacity to see the bigger picture. […] And I think – um – and I think you have to be prepared for things that will come and that will really challenge your faith. And I think – dealing with some of the horrors that go on, dealing with people that are assaulted, child abuse. Of absolutely dreadful things that happen. And – and, of feeling, "How?!" […] I don't- I don't know that there's always a theological answer. […] I still do a lot of sitting and thinking "Why did that happen to that person?" It was

[25] Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.212.

> just – should never have. [Sighs]. And because – why is there evil in the world? I – I don't know! But I'm going to do the bit that I can.

Nigel had not ceased to struggle with suffering, nor had his questions been resolved. However, believing in an inherently limited human perspective ameliorated his struggles. Similarly, while Ben felt he had partial answers, he too acknowledged that the 'question of suffering' remained. He turned to beliefs in God's sovereignty, and that God draws alongside the suffering, but ultimately acknowledged that such things were 'beyond comprehension.' These examples resonate with Swinton's suggestion that one of the 'task[s] of the practice of lament is to produce a form of character that can live with unanswered questions […] active acceptance of the reality of evil and suffering and the love of God in the midst of it.'[26]

Nigel also responded to his uncertainty about suffering by 'do[ing] the bit that I can.' In this sense, Nigel responded to uncertainty with action. Such action represented a fifth means of managing questions and uncertainties. He responded similarly to 'LGBT issues.' His uncertainty was also ameliorated by acceptance that he did not necessarily 'know the answers' and would find out the truth in the 'fullness of time.' However, he also focussed upon his comparative certainty about what he could do, linking this to the macro-calling to love others:

> The one thing that I am sure about is that we have to love people. And not – uh – and not make them feel terrible. And if they're getting it wrong then hey, who am I to say?! I get enough of my own stuff wrong, I don't need to be… yes, big enough logs in my own eye to get rid of first, thank you. […] in the fullness of time [others] may be proved right and I'll be wrong. But I'll know I will have loved people, and I have gone back to loving them.

As we saw above, Martha similarly felt grounded by the certainty of macro-callings towards love and compassion, even as she felt uncertain about her stance on abortion.

Richard recalled his long-term uncertainty about the relationship between prayer and healing. On the one hand, he believed there was 'no question that we should be praying for healing,' and had 'no difficulty believing that God *can'* heal miraculously. However, he was cautious: 'We *don't* understand prayer, we don't understand why it's sometimes answered and it sometimes isn't answered, and sometimes it's not answered in […] the way we expect.' He continued, explaining that he was content to remain uncertain on the matter. Believing God's ways were often beyond human comprehension neutralised the discomfort this uncertainty could have caused. Richard expected uncertainty and incomplete answers, thus these did not pose a problem.

[26] Swinton, *Raging with Compassion,* p.113.

Similar logic underpinned Richard's discussions of demonic possession. Writing in his reflections about a patient's suicide, he said: 'It is situations like that that make me wonder about such issues as demonic involvement, although I suspect that is often invoked too readily in areas we would now understand as being physically caused by mental illness or epilepsy.' Richard's uncertainty was, again, ameliorated by his belief that understanding was 'beyond us':

> I've always felt a little bit uncertain about the issues of demon possession. […] I certainly would believe that there are overarching ev-evil powers that do seek to influence us, and that probably they do that through many physical routes, and through our own weaknesses. […] I mean, there are lots of ways of trying to understand […] the interface between […] spiritual things, and spiritual powers […] and the scientific understanding of things that we see now. I mean, quite how that interface works, how the interface between heaven and earth works, you know, these are things which I think are – are really, um, beyond us, and so we work with a model, and we try and do the best we can.

Richard was not the only participant who voiced their uncertainty and wariness about demon possession. This uncertainty was consistently built upon both religious and medical foundations. Thus once again, the evangelical medics' dual socialisation was significant, both sustaining their scepticism and affording them a further means of responding to uncertainties. On the one hand, it was because they recognised that some symptoms could have either – or indeed both – spiritual or physical causes that their uncertainty existed. On the other hand, being both scientist and Christian enabled participants to respond to patients in a less harmful way by, as Richard framed it, not invoking demon possession 'too readily' as a cause. Ben explained: 'I don't believe that depression is a spiritual problem, per se – which, unfortunately, sometimes, in some Christian circles is the thing. I don't believe that – I believe there's an organic illness which you need to treat.' Similarly, Peter said: 'as a Christian I absolutely believe in the demonic, *and* I am extremely sceptical whenever anyone says, that, in a situation, this person is possessed by a demon – I think that scepticism's very healthy.' The participants also showed scepticism towards suggestions that illnesses were caused by sin. They were consistently clear that a scientific understanding of illness was to be preferred, insofar as they also believed this was the correct interpretation from a Christian perspective. Akua described with horror what 'some religious people do, they go to the mother, and say this [illness] is because of a sin you've done.' Simon, when teaching Christian psychiatry students, made it 'explicit' that specific sins should never be considered the causes of mental health problems. He clarified: 'it's not specific individual sin, it's just the generality that we live in a fallen and broken world.'

As well as being a sixth means of managing uncertainty, this dual engagement as 'Christian medics' was also a manifestation of work-faith affinity, and consonant identity. It recurred for a number of other topics. Since she strongly opposed abortion, and was concerned that some emergency

contraceptives worked by terminating viable pregnancies, rather than preventing conception, Elizabeth felt she needed to 'work out her position' on prescribing them. It was after speaking to a contraceptive expert, to better understand the scientific workings of these medications, that she felt able to make a decision.[27] Hannah similarly described researching abortion and contraception so that her stance was thoroughly informed by both scientific knowledge and Christian values. Simon's uncertainty around transgenderism was partly due to it being:

> poorly understood at every level. So the research evidence, from a psychiatric and biological point of view, is poor. That is not getting any better […] So I don't claim to have a well thought-out position on this, in as much as I don't think there is the evidence on which you could have a well thought-out position.

He felt on much more secure ground with 'the issue around intersex [which] is – is a clear, well-recognised, biologically-determined one.'

Questioning and Consonance

The above has analysed six different ways in which the participants responded to specific questions, doubts and uncertainties: seeing these as positive and edifying; recognising that these only affected parts of their faith; avoidance; theological framing; action; and drawing upon their medical socialisation and knowledge. Together, these show that the participants had multiple means of managing the questions and uncertainties stimulated by their work. Many of these were indicative of a persistent drive towards work-faith affinity, and, relatedly, aspirations towards consonant identity. As in 'Opposing' and 'Resourcing,' work-faith affinity and a correlating sense of consonant identity was bolstered as participants utilised their faith to manage their work and its challenges. Insofar as questioning, doubt and uncertainty necessitated reliance upon such faith-based resources, and upon both their evangelical and medical socialisations, this affinity was evident both despite and because of challenges presented to it. Moreover, some of the medics' theological resources also limited the extent to which uncertainties and doubts had the potential to disrupt work-faith affinity by introducing tensions and dissonances.

These six means of managing doubt and uncertainty should also encourage us to critique suggestions that questioning, discontent or disquiet ought to be classified as 'negative' forms of religious coping. Greater subtlety and qualitative sensitivity are needed. The participants' varied feelings about and perceptions of questioning faith together suggest that we must exercise caution

[27] Caution is needed here. On the one hand, the scientific workings shifted Elizabeth's ethical goalposts and perspectives. On the other hand, her faith remained the arbiter: it was whether or not the scientific workings met the ethical mandates imposed by her faith (i.e. of not killing a viable, implanted foetus) that determined acceptability in her eyes. Again, we see the hierarchical and consonant models existing side-by-side.

about including 'questioning' within definitions of 'negative religious coping.' It is too presumptive to add adjectival qualifiers before exploring how individuals felt about, and responded to, these faith or worldview consequences.

Conclusion

This chapter has shown that healthcare work can stimulate questions and doubts, and both create and sustain uncertainties for evangelical medics. Though these did not always affect the participants' faiths holistically, they were nevertheless sometimes challenging and troubling. However, the participants had multiple means of addressing and responding to them. The circumscribed effects of questioning, doubts and uncertainties upon their faiths, and the resources with which they addressed them, indicate that a drive towards work-faith affinity remained present amid both apparent and potential dissonances and tensions. As in 'Opposing,' this affinity was not so much self-evident as pursued: achieved, rather than perceived.

Other examples, however, showed that healthcare work can challenge faith on a more holistic level. Mel's faith went 'AWOL' when her work stimulated troubling questions, and she struggled to make meaning amid suffering. Hannah and Goodluck both described periods during which their faith felt distant. While they nevertheless strove towards work-faith affinity in response, they found these periods in their lives difficult. While certain dissonances were welcomed by participants in this study, not all were. Hannah, Mel and Goodluck's experiences of doubting and distance from faith are good examples.

On the basis of these varied experiences of questions, doubts and uncertainty, it seems prudent to reconsider what we incorporate within the term 'negative religious coping.' The ways in which faith accommodates and responds to challenges are important considerations, and positive and negative religious coping can prove useful theoretical lenses.[28] However, assuming that certain religious responses, or worldview consequences, such as questioning, are inherently negative, is unhelpful. Certainly some participants found questioning and uncertainty painful; others did not. It is surely more helpful to add labels such as 'positive' and 'negative' only once we have understood how individuals subjectively experience such consequences.

In the next chapter, questions and uncertainties remain in view, as we explore compartmentalisation.

[28] Taves, Ihm and Asprem, 'Psychology, Meaning Making and the Study of Worldviews,' pp.212-214; Droogers, 'The World of Worldviews,' pp.36-37.

Compartmentalising

"I have at times to create two quite different people in me"

Introduction

Compartmentalisation is a quasi-popularised notion, whose broad connotations of dividing a whole into distinct parts have been used in areas as diverse as fire safety, cell structure, and cyber security. Scholarship exploring religious faith and medical practice typically uses the term in two ways, describing: a strategy used to overcome 'irreconcilable conflict' between the epistemological underpinnings of science and religion; and the psychological delineation of separate 'selves' in relation to different contexts, for the sake of coping. This chapter explores evangelical medics' experiences in relation to both of these uses. The first part critiques easy assumptions as to the irreconcilability of religion and science, on the basis of the participants' narratives. The second part highlights four forms of self-compartmentalisation: work-life-balance; avoidance behaviours; inadvertent compartmentalisation; and the creation of two 'selves.' In each case it considers why the medics engaged in such practices, and their significance for their senses of identity. It suggests that where participants did compartmentalise, this should be taken seriously as a form of identity defence.

Religion and Science

Scholars often cite compartmentalisation when discussing how medical science and medics' religious faiths relate. This theme is significant for Grant, Cain and Sallaz, who comment that many have assumed 'spiritual understandings […] to be at odds with Western, rationalized medicine with its emphasis on objective science.'[1] They suggest 'knowledge experts' emphasise the epistemological incompatibility of science and religion, creating a presupposition that 'ordinary people' – including healthcare professionals – cannot 'fit them together.'[2] The supposed result is 'irreconcilable conflict between science and religion that forces health professionals to compartmentalise their spiritual understandings,' setting them aside at work.[3]

[1] Grant, Sallaz, and Cain, 'Bridging Science and Religion,' p.466.
[2] Ibid., p.482.
[3] Ibid.

However, many have questioned the extent to which such compartmentalisation and sequestration really occurs. Indeed, Grant, Cain and Sallaz's narrative study confirmed that 'many hospital nurses creatively mix moral images […] to depict spirituality in a positive, plausible light […] enabl[ing them] to think that spirituality and medicine are complementary.'[4] Similarly, Ragan, Malony and Beit-Hallahmi argue that 'few psychologists compartmentalize' their religious from their scientific thinking, rather integrating the two.[5] When Balboni and Balboni rhetorically ask, 'Is the practice of medicine congruent with a spiritual worldview, or does it lead to irreligion?' they suggest, in turn, that this presumed irreconcilability owes more to historic, normative presumptions than to empirical reality.[6]

Affirming this scholarly scepticism, the participants in this study firmly offset suggestions of an 'irreconcilable conflict between science and religion that forces health professionals to compartmentalize.'[7] Indeed, we have already observed their blending of religious and scientific ideas and worldviews in 'Opposing,' 'Changing,' and 'Questioning.' These examples have echoed Cadge and Bergey's suggestion that religious healthcare practitioners and patients commonly blend religious and biomedical knowledge.[8] The evangelical medics' contentedness to draw upon and blend religion and science often had its roots in their theologies of creation. Thus Richard explained that the idea of a conflict:

> [d]oesn't bother me at all, I feel that – that the two go together […] there's not going to be a conflict, if the Christian faith is true and it's God's world […] and if there seems to be […] then we need to dig deeper, and try and understand more.

Similarly, Hannah said 'I'm usually just, like, "Wow, this, this is great, this is so cool, God made this." You know? Rather than, uh, it really conflicting at all.' Additionally, many participants cited an early love of science as significant motivation for pursuing a medical career. Nigel explained that training in medicine 'made sense in terms of, um, my academic interests, and kind of science interests, doing A Levels.' Similarly, Goodluck 'had an interest in the human body throughout the entirety of school […] I found it all very fascinating.' Jeremy believed God had 'predisposed' him to a career in medicine by giving him a love for science and an aptitude for 'questioning stuff.' Explaining why she decided to become a doctor, Gwen said: '[T]he whole business of science and the human body and medicine

[4] Ibid.
[5] Ragan, Malony, and Beit-Hallahmi, 'Psychologists and Religion,' p.214.
[6] Balboni and Balboni, 'Spirituality and Medicine,' pp.3 and 14-15.
[7] Grant, Sallaz and Cain, 'Bridging Science and Religion,' p.482.
[8] Wendy Cadge and Meredith Bergey, 'Negotiating Health-Related Uncertainties: Biomedical and Religious Sources of Information and Support', *Journal of Religion and Health*, 52.3 (2013), 981–990 (pp.982 and 988); Byron J. Good, *Medicine, Rationality and Experience: An Anthropological Perspective* (Cambridge: Cambridge University Press, 1994), pp.155-156.

fascinated me. And it still fascinates me. And of course as I became a Christian, the added thing – this is created – this has been created by God.'

While they were untroubled by the relationship between faith and science, several participants recognised that others did presume a conflict existed. For example, Hannah explained, 'I have some interaction[s] with colleagues that are like "LOL, you're a scientist and you're a Christian?"' Liam similarly thought that:

> a lot of people are, like, dismissive of religion. Not – not everyone, of course, and there's a lot of Christians who are scientists – and vice versa – but you can get some people who think you're not very intelligent if you have a faith, in something like that.

Martha had the same impression, and noted that it could present a barrier to discussing her faith with some of her colleagues:

> I think nowadays the majority of doctors are scientific atheists. […] I would find [faith] very hard to bring up, with my colleagues […] I think they find it quite odd that I could be a rational, scientific person, and also believe in God.

In sum, while they recognised that others might expect competition or conflict, the evangelical medics instead found medical science profoundly consonant with their faith, drawing upon both epistemologies and sources of knowledge. Thus these medics disrupt any easy assertion of tension between scientific and evangelical religious epistemologies. It is important, therefore, to treat suggestions that religious healthcare practitioners compartmentalise religious from scientific thinking with caution, as many have already suggested. Equally, though, it is important not to homogenise. While the participants did not articulate fundamental epistemological conflicts between their evangelical faith and the medical science in which they were trained, they did delineate particular types, schools and applications of medical science with which they had some concern. This has been clear in previous chapters, where some participants have opposed particular, controversial applications of medical science, such as the prenatal detection of genetic disease, and euthanasia. In a similar vein, Simon differentiated between Rogerian counselling, and Cognitive Behavioural Therapies:

> Cognitive behavioural therapy in my view is a truth-based therapy, you are challenging wrong ideas that people have about themselves and their environment and you're helping them have a more truthful and accurate view. So […] that's in my view an entirely safe thing to be doing as a Christian. […] If, however, you're talking about Rogerian counselling, um, there you've got a lot more spiritual value, you've got lots of potential problems if you've got someone who's not a Christian, and some counselling models, particularly counselling models which take a more significantly […] anti-gospel line.

Simon found no fundamental conflict between 'science' and his faith, but was concerned about particular therapeutic schools' fit with the gospel (and thus, in his view, with truth.) Such examples demonstrate that, while it can be unhelpful to posit conflicts between the homogeneous categories 'science' and 'religion,' or 'faith,' more specific tensions do exist.

Forms of Self-state Compartmentalisation

Balboni et al suggest that, in order to cope with the emotionality of their work, healthcare professionals may rely upon compartmentalisation, which they define as 'a strategy where self-states are kept separate.'[9] Franzen builds upon these ideas, describing compartmentalisation as 'erecting a sort of cognitive and emotional partition' between one's work 'self' and 'the rest of their life.'[10] Within 'the rest of life,' religion looms large, not least in line with expectations that healthcare practitioners can – or ought to – leave such aspects of their identity 'at the door' of work.[11] It is of note that Balboni et al describe this form of compartmentalisation as a 'negative' psychological coping strategy, categorising it alongside emotional repression.[12] Taken together, these definitions have significant bearing upon this thesis' central interest in how evangelical medics conceptualise their identities at the interface of two worldviews. While these two worldviews can integrate within a coherent whole, we have observed already that participants often saw their 'work' and 'faith' as distinct. Thus, we can understand this form of self-state compartmentalisation as a strategy whereby distinction between the 'faith- self' and the 'work-self' is heightened.

As above, scholars are also sceptical as to the prevalence of this form of compartmentalisation among religious healthcare professionals, particularly insofar as they might leave their 'faith-self' at the door of work. Thus Franzen suggests that the 'universalizing meaning-making role of religion in some physicians' lives […] could counter such compartmentalizing.'[13] Indeed, Vanderpool consistently refutes any notion of 'crisp compartmentalization' between religion and medicine.[14] Rather, he emphasises 'constant interaction' and 'interdependencies' on both personal and cultural levels.[15]

Interestingly, though, few scholars dismiss compartmentalisation among religious and spiritual healthcare practitioners entirely. Balboni et al, for example, found that more non-

[9] Balboni et al, 'Religion, Spirituality, and the Hidden Curriculum,' p.512.
[10] Franzen, 'Is This Relevant?,' p.442.
[11] We explore these expectations more thoroughly in later chapters.
[12] Balboni et al, 'Religion, Spirituality and the Hidden Curriculum,' p.513.
[13] Franzen, 'Is This Relevant?', p.442.
[14] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.14.
[15] Harold Y. Vanderpool, 'Is Religion Therapeutically Significant?', *Journal of Religion and Health*, 16.4 (1977), 255–59 (p.256); Harold Y. Vanderpool, 'Religion and Medicine: A Theoretical Overview,' p.9.

religious/nonspiritual than religious/spiritual healthcare practitioners agreed that compartmentalisation between work and the 'rest of life' was a legitimate coping mechanism: but some religious/spiritual participants also advocated such a tactic.[16] Similarly, while Ragan, Malony and Beit-Hallahmi found that 64% of their sample of religious psychologists agreed that their work and their beliefs were related, 36% did not.[17] As well as demonstrating the blending of religious and biomedical knowledges, Cadge's work incorporates several anecdotal examples of compartmentalisation by healthcare practitioners, who prefer to leave their religion at home.[18]

Below, we explore four different forms of self-compartmentalisation. These were significant, particularly because they highlighted identity negotiations occurring at the interface of work and faith. They also cast critical light upon existing presentations of compartmentalisation in healthcare literature, particularly insofar as these tend to operate on the homogenised planes of religious and medical 'self-states.' Before exploring the examples, however, it is important to differentiate between language and cognitive practice. Nigel, for example, at times articulated his identity in terms of two selves. Discussing prayer for miraculous healing, he said, 'there's this recurrent thing where they all get together and pray and the seizure stops. I think – well, wonderful for her, fantastic […] with my doctor head on.' Equally, however, he was concerned as a Christian, explaining:

> Where does that leave your faith in God if the seizure doesn't stop? And – and there's a sort of implicit way in which you're not praying hard enough, and I think – really?! So actually then you are ending up being burdened with guilt that you didn't do it *well enough?* And that I really struggle with.

While Nigel described moving between his 'doctor head' and a Christian outlook, this articulated his moving between prioritising two distinct perspectives, both of which were important to him as he approached this issue. We must not unduly read into this language any cognitive or emotional compartmentalisation. While Nigel was conscious of having two distinct perspectives, both were important to him: neither, in this example, was sequestered.

Work-Life Balance

As in Balboni et al's study, many of the evangelical medics found it important to compartmentalise their working and non-working lives in order to strike a work-life balance, and avoid burnout. Thus Liam tried to 'leave thoughts about work behind once I have left the hospital. It is difficult to find the

[16] Balboni et al, 'Religion, Spirituality and the Hidden Curriculum,' p.513.

[17] Ragan, Malony and Beit-Hallahmi, 'Psychologists and Religion,' p.214. Caution is needed, as their sample was not selected for religious characteristics: indeed, religion was a dependent variable in their study. It is conceivable that the remaining 36% simply had no religious beliefs: they do not present this statistic. However, they later go on to comment that 'Religion and science seemed to act as competing belief systems for those who held to either too strongly' (p.215) which suggests that they link competition with compartmentalisation.

[18] Cadge, *Paging God,* pp.143-144 and 152-154.

balance between being compassionate and not being burnt out by the emotional demands of work.' Hannah, similarly, felt that 'on the whole I was quite good at – and I think it's a useful strategy – at, like, leaving specific situations at work.'[19] Peter, linking work-life balance to his determination to ground his identity primarily in his faith, not his work, framed healthy separation as a Christian goal:

> [M]any medics get a huge amount of their identity from their profession in a way that I think is unhealthy. And not only that, but I think can allow and perpetuate a lot of unhealthy work/life balances. [Pause]. And hopefully as Christians we can stand against […] this idea that medicine is the be-all and end-all and our career is the be-all and end-all of our lives that I worry many in the profession have.

Similarly, when I asked David whether he had ever compartmentalised his work, he explained:

> I suppose I do in a way, insofar as one of the things I have realised, with time, is one of the gifts you can have as a doctor is to be able to switch off when you walk through the front door. And I worry for doctors who can't do that. Some doctors just can't switch off, and they let their worries of their patients carry on. And I have always regarded myself maybe as rather ruthless, because I can walk through the front door, and I'm far more interested in bath time for my children or […] I think that is a very valuable survival tool […] that I happen to have.

Ben advocated such separation for the sake of doctors' families, advising that: 'You've got to be able to go home and, and enjoy your family […] And if you let [work and family] come too far overlapping with each other, you're at risk [of] one way suffering.'

Ruth had reduced her working hours in order to spend more time with her family, and to focus more on church commitments. For others, church presented a challenge to their work-life balance. Ben recalled conversations at church, wherein he had to avoid giving medical advice outside work:

> [T]here still has to be some sort of dividing line. […] There has to be that bit, of the medical side of things, to say, "Well […] I can't talk to you about that now, or I'm not going to, but if you want to talk to me about it, well, make an appointment, come and see me."

Hannah felt more uncertain about how church and medicine ought to relate, explaining:

> Sometimes on a Sunday you don't know how much of a doctor to be. […] I'm going to start being the safeguarding officer for the church. And I think I'm, like, medicalising what's going on. […] I think that's going to be a tricky thing that I'm going to be learning.

In his early years as a GP, David struggled being in a congregation with his patients, and moved church so that he could avoid bringing work and church into contact. Broadly speaking, Nigel also

[19] Akua explained the importance of being able to 'dissociate very quickly' from particular patients in order to manage emotionally, particularly since medical students very rarely got to know patients for long periods. Rather than creating a separate self-state, she engaged in specific avoidances, avoiding thinking about or becoming attached to particular patients. Thus work-life balance and avoiding burnout also occurred via more partial forms of compartmentalisation.

tried to avoid wearing his 'doctor hat' at church, and was grateful that his large congregation meant he could avoid close contact with patients and their families. However, he did not enforce this barrier too firmly, recognising that he could often offer useful advice when pastoral issues arose: 'I think one of the other things I do find is that – uh, I've sort of become a resource for people who are experiencing things.' Catherine had gradually developed a similar attitude, explaining that:

> [W]hen I first qualified I used to find it really difficult that, basically, I'm always a doctor, you can't get away from it. [But now] I'm sort of at peace with that. So I know that when I go on holiday or bump into people that I'm giving advice and I – I don't mind. I used to really hate it.

Even as some were happy to let this divide be somewhat porous, several participants did 'erect a sort of cognitive and emotional partition' between their work and the 'rest of their life' for the sake of work-life balance. This decision often had spatial and temporal dimensions, as non-medical spaces, times and social contexts were demarcated as non-work zones. These medics clearly did not, as Balboni et al, consider this form of compartmentalisation a negative coping strategy. Indeed, the opposite was true: they recognised it as necessary and healthy, a 'survival tool' which helped them to avoid burnout, and to invest in their church and family lives.

Significantly, in each of the above examples, the medics curtailed their 'work-self' for the sake of balance and wellbeing. Throughout this thesis, we explore many different ways in which faith significantly influenced participants' 'work-selves' and work lives. However, while faith was allowed to move across the threshold between work and the 'rest of life,' work's freedom to traverse this boundary was carefully restricted and monitored. The medics curtailed their 'work-selves' for the sake of wellbeing, family, and investment and involvement in church. As such, compartmentalisation contributed to their striking a work-life balance: but it was work which was restricted, not faith. Where Franzen suggests that the 'universalizing meaning-making role of religion in some physicians' lives […] could counter such compartmentalizing,' the opposite is true in the above examples. Here, compartmentalising took the form of restricting the remit of their 'work-self.'[20] Work-life *balance,* therefore, is perhaps a misleading term, for there is a clear imbalance of restriction. In these examples it is perhaps more helpful to describe one-directional compartmentalisation of the 'work-self.'

This one-directional compartmentalisation reflects a broader evangelical 'universal' logic of identity, whereby faith is expected to characterise one's entire life. Warner, drawing upon Marsden, has suggested supplementing Bebbington's famous quadrilateral definition with 'the transformed life,' capturing persistent and widespread evangelical emphasis upon the importance of faith profoundly

[20] Franzen, 'Is this Relevant?', p.442.

shaping individual lives.[21] This is also an important theme in Strhan's *Aliens and Strangers*, which focusses on conservative evangelicals' 'material practices and everyday interactions.'[22] These Christians' core concern is '[T]heir sense of relationship with God which they saw as central to both their individual and communal identities.'[23] They carry their faith throughout life's domains, with 'particular social and subjective effects.'[24] Strhan traces these effects 'across the spaces of church, home and workplace,' as the evangelicals seek coherence in their lives 'according to a unified Christian ideal.'[25] Both Strhan and Warner's observations echo what Franzen, building upon Johnson-Hanks et al, terms a 'deep scheme,' or 'universal' religious worldview:

> Whether or not one's personal beliefs and values cross cognitive domains and impact professional role perceptions, beliefs, and values would likely depend on whether the personal beliefs are "deep" or "shallow" schemes (Johnson-Hanks et al. 2011). If the religious beliefs are deeper and more universal in terms of the individual's worldview, then they are much more likely to be interwoven with his or her profession.[26]

The evangelical medics articulated the 'deep' and 'universal' effects that they felt their faith ought to have. Goodluck explained that he tried to 'let my Christian faith shape everything that I do. […] I don't separate – uh – church is not just for Sundays.' Martha said, 'being a Christian is […] it's how you live your whole life.' Sarah reflected, 'Well, I think it should be you're a Christian doctor, because it should go through your whole life, you should be a Christian whatever. A Christian teacher, you should be a Christian mother, a Christian everything.' Catherine made it particularly clear that this universal logic countered the instinct to sequester faith from particular fields of life. Describing her faith as 'a major part of me,' she expanded:

> I sort of feel it's innately – it's innately part of me. […] It's, uh – I don't regard it – it's just – it's sort of, me, so it's the same as anything else about me really. […] – it's just, it's part of me. It's a massive part of me. So […] I don't know that you can separate it. […] you know, it's always there in your head, isn't it, so it's sort of impossible to – I mean I […] didn't mention anything about Christianity at work today at all. But, umm, I don't think that you can – I don't think you can separate it really.

Alongside aspirations to consonant identity, the medics thus also aspired to the normative evangelical expectation of a universal faith-identity. According to this logic, they could circumscribe

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[21] Warner, *Reinventing English Evangelicalism*, p.17; George Marsden, 'Introduction' in *Evangelicalism and Modern America,* ed. by George Marsden (Grand Rapids, Mich: Eerdmans, 1984,) pp.vii-xix (ix-x).
[22] Strhan, *Aliens & Strangers?*, p. 4.
[23] Ibid., p.5.
[24] Ibid., p.10. This relates closely to evangelicalism and Protestantism's historically characteristic emphasis upon the individual and their relationship with God, and thus, often, personal morality.
[25] Ibid.
[26] Franzen, 'Is this Relevant?', p.442; Jennifer Johnson-Hanks et al., *Understanding Family Change and Variation: Toward a Theory of Conjunctural Action* (Dordrecht; New York: Springer, 2011) , pp.3-5.

their 'work-self' in particular contexts, times and spaces, they could not do the same with their 'religious-self.' Insofar as faith, not work, was allowed to move between different 'realms' of life, faith was a more significant aspect of the evangelical medics' identities than medicine. As such, this universal identity logic also evokes the hierarchical identity conceptualisation.

However, there were nevertheless instances in which participants compartmentalised and curtailed their faith-selves, against the logic of a universal faith and religious identity. This took three different forms: avoidance behaviours; inadvertent compartmentalisation; and creating two 'selves.' Each of these is bound up with participants' drives and desires to simultaneously protect and prioritise both their religious identities *and* their senses of consonant identity as 'Christian medics.'

Avoidance Behaviours

In 'Changing,' we saw Philip grappling with his beliefs about judgement after death. He described going 'crazy' thinking that 'the next thing [my patients] will face after they've seen me is the Lord Jesus in judgement.' We observed that Philip's emotional relationship to his beliefs changed, even as his convictions, in a cognitive sense, did not. In response to this cognitive-emotional dissonance, rather than dividing two different 'self-states,' Philip sequestered and avoided certain faith-based considerations:

> [T]hat is just not something that I found healthy to ponder on because, what can you do with that information other than go completely crazy. I'm not able to deal with that. And so I've chosen not to! Not to think about it too much.

Where Balboni et al present emotional repression and compartmentalisation as distinct coping strategies, here they are closely linked.[27] Philip assuaged the difficulty and tension that his changed emotional relationship to his beliefs created by sequestering a group of particular questions and problems from frequent consciousness and consideration. He erected a 'cognitive-emotional partition,' but not in the homogenised sense suggested by definitions of compartmentalisation found in existing literature. Rather than separating self-states, Philip separated off particular facets of his faith, insofar as these interacted problematically with his experiences at work.

The same was true for Akua, for similar issues. As in Philip's example, the emotionality at work is significant. She described her 'agony' which makes pondering the afterlife 'very unhelpful.'

> [I]t's agonising when I feel like the person doesn't know God […] The agony is that, um, oh, they're not – they've not got it yet – I don't know what's happening after. Because I genuinely don't think about heaven, and hell, and life after death much, because it's something I just can't know, and I find that very unhelpful to think about. So I don't actually think about that a lot. But I

[27] Balboni et al, 'Religion, Spirituality and the Hidden Curriculum,' p.513.

> just know that I think in this time before you go, I think that really matters. I don't know why and I don't know what it looks like afterwards, but I really feel it matters, and I feel that agony when life isn't [pause] – it's not with God.

Partial compartmentalisation was also evident in relation and response to questions and uncertainties. In the previous chapter, we saw Martha and Liam's uncertainties about medical ethics, particularly abortion. In response, Martha did not compartmentalise her faith from work, per se. Rather, she avoided contemplating abortion in particular. As for Philip and Akua, this specific sequestering had emotion at its heart: abortion was not merely a cognitive problem, but one Martha found, emotionally, 'too difficult.' For both Martha and Liam, avoiding *thinking* was bound up with avoiding *doing*, since they had had little direct involvement with abortion.

We saw in 'Opposing' that some participants avoided particular career paths, anticipating difficult ethical tensions. Others avoided particular specialties in order to avoid troubling considerations, another way of 'avoiding doing.' Ginny recalled the difficulties she experienced on a forensic psychiatry placement, encountering patients with religious delusions who believed God had told them to harm others. She said, '[T]hat I did find difficult […] just that thinking around what is delusion, what is faith?' By avoiding specialising in psychiatry, she avoided grappling with her faith in this particular way. Thus, both practically and cognitively, Ginny compartmentalised this particular problem. Simon observed similar avoidance among some Christian medical students, explaining, '[t]hey had a worldview which assumed that people who had hallucinations were demonically possessed. And, this was getting them into significant trouble in their attachments. This meant that they were choosing to ignore psychiatry as a career.' As a corrective, he 'developed material to help medical students – and others – think through the issues of mental health within a biblical worldview.'

We can helpfully understand such avoidance-based compartmentalisation as a form of identity defence. Festinger notes that, in some instances, cognitive dissonance can be reduced through avoidance for the sake of identity continuity.[28] Such avoidance can be both behavioural and cognitive: that is, one can mitigate dissonance by 'avoiding thinking' and 'avoiding doing,' the two often closely related. Similarly, in 'Changing, 'we explored Taves, Asprem and Ihm's suggestion that some respond to 'meaning violations' by masking them.[29] As we have seen in previous chapters, they also echo Festinger's observations about identity continuity, writing, 'One of the most reliable findings in social psychology is that humans are motivated to maintain frameworks that afford a

[28] Smith with Snell, *Souls in Transition*, pp.238-240; Festinger, *A Theory of Cognitive Dissonance*, pp.18 and 29.
[29] Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.213.

sense of personal agency and value within a comprehensible world.'[30] In the above examples, Martha, Liam, Akua and Ginny, along with Simon's struggling psychiatry students, sequestered and avoided particular tensions arising at the interface of their work and faith. These medics compartmentalised, but in a partial rather than a homogenised way. This avoidance-based compartmentalisation, moreover, enabled them to sequester negative emotions and cognitive dissonances. Following Taves, Asprem and Ihm, this form of partial compartmentalisation could also be viewed as partial masking of those dissonant elements which risk disrupting meaning in a more holistic manner. As in 'Questioning,' and 'Opposing,' that tensions only affected certain, circumscribed parts of the medics' faiths was important. This meant that work-faith affinity was not disrupted wholesale, and instead only partially disrupted. Beyond specific tensions, consonance remained. The key difference in the above examples is that these participants very intentionally erected cognitive and practical barriers around particular troubling considerations.

The same was true for Philip. In 'Changing,' we suggested that his cognitive-emotional dissonance around death and judgement was a notable exception to this thesis' overarching observations about work-faith affinity. Here, we can nuance this suggestion a little further. While he experienced cognitive-emotional dissonance, by not thinking 'too much' about problematic considerations, he could otherwise preserve work-faith affinity. Change may not have resolved Philip's dissonance, but compartmentalising limited its effects. Here, as in the other examples, affinity and dissonance co-existed, and both contributed to the participants' experiences of being 'Christian medics.'

In addition to preserving consonant identity such avoidance-based compartmentalisation also specifically defended the participants' religious identities. We have already utilised Mol's work on stability and change within identity, along with Davies' expansion of Mol's sacralisation theory to include defence of identity-bestowing beliefs and practices.[31] Clydesdale makes similar observations, suggesting that first year college students in the USA often place their religious identities in an 'identity lockbox,' leaving them unexamined and unquestioned, compartmentalised from university life and academic interrogation.[32] This is done, in part, to protect these religious identities from potential 'intellectual and moral tampering.'[33] While Clydesdale remains on the homogenised level of 'religious identity' versus 'rest of life,' this suggestion nevertheless bears close resemblance to Davies and Mol's propositions. If adjusted to focus upon specific elements of religious 'selves,' as in

[30] Ibid.
[31] Davies, *Mors Britannica,* p.99; Mol, *Identity and the Sacred,* pp.5-6 and 262.
[32] Guest et al., *Christianity and the University Experience,* pp.24 and 131. Tim Clydesdale, *The First Year Out: Understanding American Teens after High School* (Chicago, IL: University of Chicago Press, 2007), pp.60-61 and 175-178.
[33] Guest et al, 'Christianity and the University Experience,' p.131; Clydesdale, *The First Year Out,* pp.60-61.

Mol and Davies' work, Clydesdale's suggestion offers further precedent for recognising that religious people, in certain contexts, may store away elements of their 'religious-self' for safekeeping.

Baker and Wang observe a similar phenomenon in their study of Christian NHS clinical psychologists, describing 'conscious mechanisms of defence in place to organise their cognitions and their activities.'[34] These were used both to avoid 'head-on confrontation' between work and Christian values, and particularly to 'protect religious beliefs from being […] influenced.'[35] As we have already noted in 'Questioning' and 'Taking Stock,' Baker and Wang also observed their participants' clear preference for deploying their faith in their work, rather than allowing faith to be 'shaped by' work. Thus, where they observed one-directional compartmentalisation, it was, analogously to our above observations, the work-self which was curtailed for the sake of the religious-self.[36] However, this had to do with religious belief and identity defence, not with work-life balance.

Certainly in Philip's case, compartmentalisation was bound up with religious identity defence. This was at risk insofar as pondering judgement after death forced him to scrutinise core tenets of his evangelical faith. As he explained, he could not adjust these, because they were 'constrained' by the Bible. Scrutinising Bible-based beliefs risked placing his entire identity as a Bible-believing evangelical in jeopardy. By avoiding thinking further about things which had the potential to alter – and perhaps, damage – his faith, Philip sacralised them, placing them somewhere 'safe' where they were sheltered from 'tampering.' By avoiding particular problematic questions related to religious delusions, and sacralising the related beliefs, Ginny's religious identity was also defended and kept safe. In both examples, it is of note that compartmentalisation was seen as a preferable alternative to change. While 'Changing' demonstrated that not all participants echoed such concerns, it is important to note that some medics, in some cases, were troubled by the prospect of their faith changing, and avoided it, opting instead for partial compartmentalisation.

Inadvertent Compartmentalisation

The above examples illustrate deliberate - even strategic - curtailing of parts of the 'faith-self.' However, some participants occasionally left their whole Christian faith and identity 'at the door' of work quite accidentally. Or, more precisely, they found faith had been absent from their consciousness, inadvertently compartmentalised from their work. Thus Goodluck wrote, 'taking part in this study has made me realise that I often go a working day without even thinking about my faith, and this has led me to feel guilty at times.' He explained in his interview that 'then it's often a

[34] Baker and Wang, 'Examining Connections Between Values and Practice,' p.132.
[35] Ibid, pp.132-133.
[36] Ibid, p.134.

patient or something like that who reminds me: Oh actually, I am a Christian.' Jeremy found that it was easy to get 'locked in and lost' in fast-paced and stressful medical work, and to lose sight of his faith, Christian identity, and Christian outlook. He thus prayed on his way into work that he would 'remain […] in touch with God throughout my shift,' and was grateful when '[l]ots of worship music [was] played on one of the wards overnight' as it 'prompted me to slow down and pray.' Sarah explained:

> I think it, in, uh – because I'm not a very good Christian! I think it does get compartmentalised a bit. And I think it does in life – you remember on a Sunday, you remember in the morning, you remember in the evening, but during the day, do you remember you're a Christian?

Unintentionally, Goodluck, Jeremy and Sarah kept their 'self-states' separate at work. Moreover, this evoked concern and 'guilt,' not only that they had not been 'Christian medics' in these settings, but also that, in those instances, their 'faith-selves' had lowered in salience and significance by comparison to their 'work-selves.' As Sarah put it, she felt she was 'not a very good Christian.' They had shifted to an inverted hierarchical model of identity, in which the 'work-self' dominated, and the 'faith-self' retreated such that they inadvertently compartmentalised and sequestered it. Their aspirations to both consonant identity as 'Christian medics,' and to a universal faith-self which characterised their whole lives, were backhandedly evident in the negative emotions and frameworks with which they articulated this inadvertent compartmentalisation.

Importantly, in response, both removed their 'faith-selves' from the identity lockboxes in which they had, in Goodluck's case, unintentionally placed them, and, in Jeremy's case, feared placing them. Jeremy turned to prayer. Goodluck explained that for him, 'the way to assuage that guilt is to – just focus a bit more on my faith. I will make sure that I […] pray that day, and read my Bible […] it's more of a reminder.' These corrective actions closely resemble our observation in 'Questioning,' whereby Hannah and Goodluck both took corrective steps when they felt distant from their faith for a time. Here, participants actively countered inadvertent compartmentalisation through prayer and other faith-based practices. They thus reasserted the universal significance of their religious identity when they feared their medical identity was gaining greater significance amid the stress and busyness of their work.

Creating Two Selves

I asked Akua about her fears for the future as a Christian doctor. She explained:

> I think my brain worries about my faith becoming a background thing in my life. And medicine becoming the foreground thing. Because I don't – I wouldn't want that to be my identity. […] I think relationships and staying involved in churches [are] quite key to that […] And it's almost that conscious effort to not take every second and give it to medicine […] and am I like,

> overlapped enough, rather than keeping them in two compartments. So that – that's my biggest concern.

Akua aspired simultaneously to consonant and hierarchical models of identity, in which her faith would be 'the foreground thing' even as it 'overlapped' with her work. However, she feared that the demands of medicine might lead her to compartmentalise her faith, rather than have medicine and faith 'overlap.' In turn, she was concerned that her faith might become 'a background thing.' She did not want to compartmentalise her faith into an ever-smaller box, thereby assuming an inverted hierarchy of identity.

Such holistic self-state compartmentalisation was, for some, a reality rather than a future fear. Amelia is not an evangelical Christian, but I include her experiences here because she typifies suggestions that healthcare work can lead religious individuals to deliberately compartmentalise between different 'selves' as a coping mechanism. Her narrative enables us to better understand the small handful of Balboni et al's participants who were religious and advocated compartmentalisation of 'self-states' as a legitimate means of coping.[37]

At the time of our interview, Amelia was training as a paediatric nurse, but had worked previously as a healthcare assistant in geriatric care. She explained:

> [B]efore I went into healthcare I was a lot more black and white, so for me there was [sic] quite clear answers to a lot of questions. But since going into healthcare it's become a lot muddier. Umm, things aren't as clear-cut […] when you see it up close and personal, it challenges things that you kind of believe, or certainly that I believed.

This shift of perspective, and greater awareness of the 'shades of grey,' had 'caused a lot of problems' for Amelia. She was particularly aware of tensions between her religious perspectives and the norms and expectations of her workplace. As a consequence, she explained:

> I think [pause] I have at times to create two quite different people in me – in my mind, know that if I'm at work I'm in my work mind which means that I have to go with the NHS policies […] [pause] and by creating the two mind-sets, it's easier for me. So – but – when I think about it later it sometimes – well, it makes me think.

A framework of 'work side' vs 'religious side' underpinned many of her interview responses:

> [C]ertain situations from my religious side don't sit well – but from my, kind of, healthcare side make perfect sense. And it's kind of balancing the two – obviously when you're at work, personal view doesn't come into it, so whatever I feel doesn't – shouldn't – affect actions or advice I give. Umm. So it's [pause] – for me it was more being able to be that person at work, and then reconciling it with myself when I'm not at work.

[37] Balboni et al, 'Religion, Spirituality and the Hidden Curriculum,' p.513.

Amelia created two 'selves,' both in order to conform to 'NHS policies,' and to help her set aside concerns and misgivings while working. In this sense, she differed from the other participants: her creation of two distinct selves was deliberate, not inadvertent; and it operated at the level of total religious and work 'selves,' rather than particular parts or problems. Amelia not only avoided thinking about particular problems, or doing particular problematic tasks. Rather, she avoided *being religious* while at work. Additionally, where we have suggested that others engaged in avoidance behaviours in order to maintain consonant identity and work-faith affinity, Amelia instead created two 'selves,' the very opposite consequence. Amelia's compartmentalising may well have to do with defence of her religious identity, but it is difficult to establish this from the data.[38] However, it certainly has to do with Amelia seeking a workable way forward, having experienced troubling tensions at the interface of her work and faith. The emotionality with which she felt this was clear when, at the very end of her interview, she explained that it 'causes a lot of problems in my head.'

It is perhaps significant that Amelia, who is not an evangelical, was the participant who most clearly articulated this creation and compartmentalisation of two 'selves.' Certainly she did not articulate a universal identity ideal. Indeed, she specified that she understood her Catholic faith more as 'what I take from it':

> [A]lthough I am Roman Catholic, it's more of what I take from it, if that makes sense – so I don't adhere to everything the church believes, I don't agree with everything the church has in place, but kind of, it, just, underpins my personal belief.

In the absence of a normative model wherein faith characterises all areas of life, perhaps Amelia, more than other participants, felt able to fully compartmentalise her work and religious 'selves.' Among the evangelical medics, such a strategy would undermine aspirations, both to be 'Christian medics,' and to have their faith characterise their whole lives. A partial form of compartmentalisation, manifest in avoiding doing, or avoiding thinking about particular problems, represented the closest available option. While Amelia demonstrates compartmentalisation of religious and work 'selves,' it is perhaps telling that this more total form of compartmentalisation did not represent a valid coping mechanism among the evangelical participants. Further work is needed here to test whether this hypothesis is generalisable, not least by seeking out examples of self-state compartmentalisation among evangelical healthcare practitioners, and seeking to understand their rationales.

[38] Amelia's interview was part of the initial pilot stage, before the development of the autobiographical elicitation method. As such, while insightful, it presented fewer opportunities to probe emerging ideas and theories than later rounds of interviewing.

Interestingly, though, one evangelical participant did describe a more total division of work and religious 'selves.' When I asked Peter whether he aspired to be a Christian doctor, or a Christian and a doctor, he replied:

> That's a good question, that's a good question. Umm. [Pause] I'm going to interpret that as 'Christian doctor' being not necessarily Christian first, but being when I'm a doctor I'm still a Christian and that influences what I do, or they're kind of separate.

However, much as he recognised that it was important to bring his Christian faith and identity into all areas of his life, including his work, Peter differentiated between different medical contexts. In particular, he anticipated certain medical scenarios in which 'being a Christian or not a Christian doesn't really alter your clinical judgement.' Perceiving that his Christian faith would make for little distinction in some scenarios, Peter compartmentalised his 'work' and 'religious' selves quite apart from any threat to either. Thus while compartmentalisation, as shown, may often be related to identity defence, Peter's example suggests that this is not true in all cases. Rather, Peter felt it appropriate and unproblematic, as both Christian and trainee doctor, to leave his religious-self out in some scenarios. That he did this only in certain contexts, however, ought, again to warn us against homogeneous presentations of compartmentalisation among evangelical healthcare practitioners.

Conclusion

Vanderpool decries the 'myth that the practice of medicine can be isolated from […] religious behaviour and beliefs.'[39] He speaks for numerous scholars who have critiqued presumptions that psychological compartmentalisation is common among religious healthcare practitioners.[40] Insofar as it has demonstrated that participants rejected any fundamental opposition between science and religion, this chapter has continued in this vein. However, just as Balboni et al suggest, there are exceptions to Vanderpool's pronouncement, which we must incorporate if we are to build the fullest possible picture of the consequences of healthcare work for evangelical faith and identity.[41] To that end, this chapter has engaged with a number of examples and forms of compartmentalisation evident in the evangelical medics' experiences. In addition to compartmentalisation for the sake of work-life balance, this chapter explored three types of compartmentalisation in which faith, or aspects of the faith-self, were sequestered. These are summarised in Figure 4:

[39] Vanderpool, 'Religion and Medicin: A Theoretical Overview,' p.9.
[40] Grant, Cain and Sallaz, 'Bridging Science and Religion,' p.482.
[41] Balboni et al, 'Religion, Spirituality and the Hidden Curriculum.' p.513

	Deliberate	Inadvertent
Holistic	Creation of 'two selves' (Amelia; Peter)	Accidental sequestering of Christian identity (Goodluck; Sarah; Jeremy)
Partial	Avoidance Behaviours (Philip; Akua; Martha; Liam; Ginny; Simon's Psychiatry students)	

FIGURE 4 - FORMS OF COMPARTMENTALISATION

This chapter has thus observed that compartmentalisation, in the forms of 'erecting cognitive and emotional barriers' and creating separate self-states, does occur among evangelical medics, against the logic of having faith shape all areas of one's life. However, this often meant that particular religious ideas, identity facets, and related considerations and problems were sequestered and avoided, rather than 'faith' or 'religion' in a more holistic sense. This further affirms the value of conceptualising individual faith as the sums of interrelated parts.[42] In line with Davies' expansion of Mol's sacralisation theory, Clydesdale's observations of religious college students, and Festinger's work on cognitive dissonance, this chapter has proposed that such avoidance behaviours may well show the medics engaging in partial compartmentalisation for the sake of defending elements of their faith. These elements were significant for their religious identities, and, in turn, for their senses of consonant identity as Christian medics.

Where this chapter has focused upon identity defence and one-directional compartmentalisation, the next chapter offers a reciprocal perspective. It explores times when the participants perceived that they had compromised their faith because of their work, perhaps filling the final quadrant of Figure 4 with partial forms of inadvertent, or non-volitional, compartmentalisation. These represent the absence, however temporary, of identity defence mechanisms and drives, allowing faith to be 'shaped by work' in ways the evangelical medics deemed negative and detrimental.

[42] Stringer, *Contemporary Western Ethnography*, pp.49-51, 109, and 113-114.

Compromising

"Lord, what am I going to say?
What am I going to do?"

Introduction

The CMF's current mission statement is 'uniting and equipping Christian doctors and nurses to live and speak for Jesus Christ.' If their resources aimed at junior and trainee doctors are an indicator, 'equipping' involves preparing these medics for threats to their faith. In 1998 *Nucleus,* their magazine for medical students, contained the article 'Medical School – A danger to your faith!'[1] Their 2012 booklet *Surviving the Foundation Years* discusses the 'pitfalls' and 'compromises' which see some Christian medical students 'losing their faith during the clinical years of training.'[2] Three threats are singled out: colleagues' lifestyles, which might cause medics to 'fall' into morally compromising habits;[3] secular ethical attitudess which dominate in medical contexts, and might cause a Christian medic to question what are deemed the correct ethical correlates to evangelical faith, particularly surrounding controversial topics such as abortion and euthanasia;[4] and the dominant ethos of keeping faith a private matter, which might lead a Christian medic to either deny or compromise their faith for the sake of fitting in.[5] Confirming the CMF's concerns, scholars have indeed observed that healthcare work can lead religious practitioners to compromise their 'religious integrity' or 'gag' their worldviews.[6] For example, as we saw in 'Taking Stock,' one participant in

[1] T. Lyttle, 'Medical School – A Danger to your faith!', *Nucleus* (1998) < https://www.cmf.org.uk/resources/publications/content/?context=article&id=663 > [Last accessed 15/06/2020].
[2] Saunders, *Surviving the Foundation Years,* pp.6-8. Importantly, risks and threats are accompanied by suggestions that the foundation years are often a time during which God helps and teaches medics.
[3] Ibid., pp.5 and 19.
[4] Ibid., p.33.
[5] Ibid., p.15.
[6] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131; Patel and Shikongo, 'Handling Spirituality/Religion in Professional Training,' p.104. Patel and Shikongo's study with South African Muslim psychology students has many significant contextual, theological and professional differences from the present study. However, as we saw in 'Taking Stock,' they too observed that participants made compromises in relation to their religious faith which seriously troubled them: they felt 'tension and distress' when they 'deliberately change[d] their behaviour and dress to appear 'professionally acceptable.'

Baker and Wang's study 'imagined herself having to stand before God, to give an account of why she had allowed her National Health Service paymasters to gag her religious duty.'[7]

Several of the evangelical medics in this study were certainly nervous that their work might lead them to compromise their faith. Thus Martha explained that she had not *yet* been, but might eventually be, involved in ethical scenarios in a way that 'would cause me to have to compromise faith.' Ben, proffering advice to a prospective Christian doctor, said: 'Don't let work take your faith, or denigrate your faith. Very easy.' Importantly, what constituted 'compromise' varied between individuals. This subjectivity echoes 'Changing,' in which we noted that different medics interpreted changes to ethical stances in multiple ways. Change was, for some, an important way of reducing cognitive and emotional dissonance: others, like Philip, viewed it as a compromise of timeless truths. Similarly, some considered questioning and doubts unsettling, not least because they might result in change or compromise. Thus Ben suggested the question of suffering might have deleterious knock-on effects: 'once you allow yourself to struggle with it, then you have a problem. Because then it magnifies itself.' In 'Calling' and 'Compartmentalising' we have seen participants' fears that they might idolise their work, thereby making it more important than their faith, and compromising the latter. Periods of feeling distant from faith, or of inadvertently compartmentalising, might be viewed as temporary compromises of faith's significance, and of the drive to carry faith into all realms of life.

With this subjectivity in mind, in this chapter we follow the participants' own language, descriptions, interpretations and emotions particularly closely. We follow the participants as they made *what they perceived to be* compromises of faith, because of their work. These related to church, medical culture, and ethics. In conversation with evangelical narratives and frameworks, the medics had come to frame particular decisions and behaviours as compromises (though that is not at all to say the participants interpreted such behaviours and compromises in the same ways). To others, with other perspectives, these would not represent compromises at all. I reiterate throughout, therefore, that the 'compromises' depicted are in the eyes of specific beholders. This chapter also reflects throughout on the implications of these experiences for the participants' identities. While observing that healthcare work can force what the participants considered to be compromises, it also highlights the participants' persistent drives towards work-faith affinity.

Compromising Fellowship

In 'Resourcing,' we observed both the importance of church for the evangelical medics, and the difficulties some participants therefore encountered when this resource was unavailable to them. In

[7] Baker and Wang, 'Examining Connections Between Values and Practice,' p.132.

this vein, several of the evangelical medics framed regular faith-based activities as something they had to compromise because of their work. Goodluck described his regret that:

> [S]hift work and the intensity of work really affect my ability to develop a spiritual routine. I used to be at church every Sunday without fail, and would never miss a mid week group. Missing church services due to work means church begins to feel optional. I must admit to not going to church because, quite frankly, I've needed to rest at home. Staying late at work, plus fatigue, mean I rarely make it to mid week groups.

Hannah, similarly, explained:

> It's difficult really to create […] good rhythms and community [...] when you're working one in four, or one in three […] your presence on a Sunday really suffers. And so your ability to be regularly committing to, like, a children's team, or just generally being really part of […] what's going on with teaching, and stuff, is a lot more difficult. Umm. Which can be tough.

Ginny made similar points regarding church attendance and involvement. She wrote about the difficulty of being:

> [O]n call and long working week (90+ hours) or shift work as a junior doctor led to feeling of being disconnected from church […] More recently, have done on call again which has meant some absence from Sunday worship […] I do find it disappointing that I was not able to engage with [the fellowship and community] and that there was little or no recognition of challenges I faced as a full time working spouse when I was [there].

David 'very much sympathise[d] with young Christian doctors because that – it is quite disruptive. And quite challenging – you've got a whole new world you're starting, and you're desperately trying to find some fellowship that can be supportive.' Philip talked at length about how difficult it had been when work disrupted his regular faith-based activities. As a junior doctor, he had had limited control over his shift patterns, and thus felt these compromises were forced upon him. This was exacerbated by regularly moving around the country for his rotations and thus often needing to seek out new local fellowship. Without regular church support and fellowship, he experienced what he described as 'emotional and spiritual' difficulties during the 'really difficult time of being a junior doctor.' Indeed, his faith as a whole felt depleted in the absence of the support and sustenance afforded by regular fellowship. These were important to Philip, and when they were jeopardised he felt the consequences. He felt churches could do more 'to be more sympathetic' to others in his position. Similarly, Martha explained that:

> Working in medicine makes me very tired and burnt out, which sometimes means I don't feel as able to invest in church community and activities […] Additionally, the rota constraints mean I often have to miss [mid-week groups] or church, which makes me feel less part of the church community. Sometimes friends at church aren't so understanding of this!

She explained that this could create 'difficult feelings' as she felt she was compromising on the 'church's priorities.'

Akua was determined not to let lapsed spiritual rhythms become an issue as her career progressed. In 'Compartmentalising,' we noted her concerns about faith becoming a 'background thing.' When I asked what advice she might give to another new Christian doctor, she seemed to set out her own agenda for the future: 'Mak[e] sure that you're taking time in your personal life to strengthen and cultivate your faith, giving that time and attention, because medicine will [otherwise] take both.' This meant trying to attend church on Sundays, but where that was difficult, ensuring she set aside other dedicated time with God, and time to explore other Christian resources, such as sermon recordings and podcasts.

Compromising regular spiritual rhythms and fellowship evoked 'difficult feelings' and felt 'tough.' Some of the evangelical medics felt they were 'desperately trying' to find a source of support, or felt 'disconnected.' Others experienced regret. These were not compromises which were felt lightly: indeed, that they were framed as compromises, or sacrifices, indicates the seriousness with which the participants interpreted their absence. Rather, these compromises caused emotional distress. Nor were such practical compromises made lightly. The participants either had no choice in the matters, constrained by rotas and shift patterns, or made choices from a place of burnout or exhaustion. As in 'Compartmentalising' and 'Questioning,' these intense, negative emotions backhandedly highlight the importance of work-faith affinity for the evangelical medics: in its absence, they experienced discomfort. Importantly, they also assuaged such practical compromise as much as they could, a further indication that the participants strove for the greatest feasible extent of work-faith affinity available. While, ideally, these medics would have been deeply committed to both their work and to faith-based activities, reality rendered this impractical or impossible. They thus took steps to ensure they limited the potentially deleterious consequences of spending less time in Christian worship and fellowship than they would have liked. Thus Liam explained that, as his rotas had become gradually more demanding over his FY1 year, it was:

> a case of when I *can* go to something, I definitely try to prioritise it then. Whereas before, it would have been, oh, if I had double-booked myself, I might choose something over going to church, but now it's like, if I'm free on a Sunday, I should be going to church. And [if] I can't make it to church or small group, then it's a case of just trying to meet up with someone that I know has a faith, and talking about things. Or even listening to podcasts and things, so like sometimes I listen to the sermons […] just finding different sources.

Compromising Distinctiveness

Beyond disrupted faith rhythms and practices, some participants experienced a mismatch between how they believed they should act as Christians, and how they actually acted. We explored this idea in 'Calling,' where we saw Hannah, Martha and others struggling, at times, to enact Christian macro-

callings at work. Additionally, several participants described feeling 'swept along' by aspects of medical culture which they considered contrary to their Christian values. Martha commented on medical professionals' tendency towards '[g]lorifying yourself, for want of a better phrase. It's very rare to meet people who don't care about that.' Though Martha disliked this aspect of medical culture, believing it contrary to Christian macro-calls to selflessness and humility, she also acknowledged that it was tempting to slip into such self-aggrandisement. Martha also described being 'swept into' medical culture as her 'failing to be distinct.' Commenting on colleagues' occasional unkindness towards patients and one another, she felt 'conscious of the different attitude we have as Christians,' as well as guilty when she was tempted to join in, or did so. Hannah made similar observations. She explained that, as a junior doctor, '[w]orking in a stressful environment I think there was a culture of – of drinking and of, like, getting together in that cynical place.' She was concerned about how easily she fell into 'that cynical place' and failed to show love to patients and colleagues within it. By embracing these aspects of medical culture, Hannah felt she was failing to fulfil the biblical macro-calling to be 'in the world not of the world.'

As we have seen the call to be distinctive, or 'in but not of the world,' is a significant motif in evangelicalism. Thus Strhan's study with conservative evangelicals in London observed them 'work[ing] on themselves and each other to form themselves as exiles' and as 'aliens and strangers,' with a 'strong sense of belonging to a bounded community and of the symbolic lines of division marking out the boundaries of their belonging.'[8] This relates to evangelical emphasis upon conversion, which generates both an imperative to evangelise, and a related commitment to a 'changed life.'[9] Thus, evangelical distinctiveness has to do not only with opposition to 'the world,' but also with being distinctive in a positive way, evoking theological themes of God's redemption and transformation.

Hannah and Martha found that the ideal of distinctiveness did not always manifest in reality. According to other interpretations, these scenarios might merely represent expected variations in mood, behaviour or outlook. Yet Hannah and Martha framed them as compromises, or errors to be redressed. This echoes Festinger and Smith's observations about cognitive-emotional dissonance, explored in previous chapters.[10] Here, the participants' evangelical faiths set normative expectations – indeed, high standards – while their experiences at work disrupted the 'fit' between these and reality. It is important to acknowledge this cognitive-emotional dissonance. Equally, though, it is

[8] Strhan, *Aliens & Strangers?*, pp.199-201.
[9] Bebbington, *Evangelicalism in Modern Britain,*pp.2-3 and 5-7. See also Rob Warner, *Reinventing English Evangelicalism*, p.16.
[10] Festinger, *A Theory of Cognitive Dissonance,* p.1; Smith with Snell, *Souls in Transition,* p.240.

possible to view Hannah and Martha's experiences in additional, less negative lights. As above, attending to the emotional registers of their narratives is important. Both felt guilty, and regretted those episodes in which the culture and conditions of their work had caused them to compromise distinctiveness, and instead be 'swept along.' Indeed, they framed their emulation of norms in medical culture as succumbing to 'temptation,' and 'failing' to be positively distinctive. Once again, we can see these negative emotions as a backhanded indication of the importance participants put by work-faith affinity. Moreover, Martha in particular responded to her feelings of guilt and regret by praying for God's strength to act more distinctively in the future. Like those who took steps to minimise the extent to which they had to compromise on church activities and fellowship, Martha took corrective action, indicative of a drive for work-faith affinity, though borne of work-faith dissonance.

This desire for distinctiveness was also indicative of the seemingly contradictory way in which the drive for work-faith affinity manifested in participants seeking to be at variance to the norms and culture of their work. This is a counter-intuitive blending of a drive for affinity with a desire for a positive form of tension. Ruth explained her belief that 'we're to be in this world but not of this world […] to be different, distinctive in the best possible way. And to shine like stars for God.' James described being a medic as a 'blessing' precisely because he felt he could 'always be a light,' in the sense of being positively distinctive amid the often 'dark' circumstances which medics encountered.[11] Echoing Martha, he described his desire not to compromise his Christian distinctiveness in the future by getting 'swept up.' He explained:

> I need to have that discernment to know what's right and what's wrong. Because it can be very easy to just get swept up in the current […] to compromise on certain things. That's not what I'm there to do […] I'm not going to get swept up by things.

Instead, James wanted to distinctively follow what he considered 'God's' ideals: 'as a doctor I would never go by the culture, I would always go by what I think God is telling me to do […] as a doctor that's what I'd like to practice.' This related to his broader identity rationale: that being a Christian 'comes above any other profession […] So I always say that I'm always a Christian first and a doctor second.' John echoed many of James' sentiments, summarising that faith should affect 'the way you act, which is not [in line with] the usual "norm" of the world.' He similarly suggested that the goal was to be 'Christian first and medic second […] then wherever you go, the work is not going to have influence [over] who you are […] but it's the other way round, the role that I have to play as a

[11] Also echoing Matthew 5:13-16, Simon coined the phrase 'medicalised salt' during his interview, invoking the call to be 'salt and light' – that is, distinctive – in his particular line of work.

Christian at the work place.' When it came to certain lifestyle choices – particularly drinking to excess, as some of his colleagues did – John felt this meant being 'excluded for the right reasons' because sticking to 'biblical principles' made him distinctive. Equally, by acting distinctively, he found he created opportunities to 'discuss [his] faith' with his colleagues, facilitating his desire to spread the gospel at work.

John described the particular challenges being distinctive as a surgeon. Here, the challenges lay not in being 'swept along,' but in capitulating to stress, and the negative behaviours which he felt high-intensity surgical environments often encouraged.[12] He explained:

> Being a surgeon means working in a very high intens[ity] environment […] work culture is very stressful. [But I've known] Christian surgeons who have been an excellent role-model, in how you should do things, and bring your faith, at work, with you, every time. And – and show that love and compassion to – even the fellow […] colleagues and consultants, as well as to the students and the patients. And – and people think that, well, you don't fit with being a surgeon. [But I think] more important for me is for me to share my faith and display my faith at that workplace […] But, um, as I say, I have to […] thrive in this environment where everything around me seems to be going completely against what I believe […] and sometimes it is difficult to, to stay on track […] sometimes, uh, you know, you snap - […] and you just feel that, why did I do that?"

John admired those Christian surgeons he knew who managed to remain distinctive, and aspired to emulate their positive examples. Their ability to 'bring [their] faith, at work' by enacting macro-callings to compassion particularly struck him. He admitted that he sometimes struggled to 'stay on track,' snapping or failing to show compassion. In his reflections, he said there were 'times when I struggle to display that image [of Christ]' and Christ-like love. Like Martha and Hannah, he felt guilty about these 'compromises,' and took corrective steps, apologising to those colleagues with whom he snapped. He noted that this took them by surprise: apologising and swallowing one's pride, John suggested, were also unusual, distinctive actions among surgeons. In apologising, we see John's desire for work-faith affinity in the particular, though seemingly contradictory, form of seeking to uphold the macro-calling to positive distinctiveness.

As we have seen in several previous chapters, participants often used their beliefs as reframing resources. John used theological rationales to explain his failure to be distinctive, suggesting, 'that's sort of part and parcel of me being human […] living in a fallen world.' Several others similarly used beliefs about fallibility and humanity's fallen nature in order to rationalise such compromises. Martha felt she failed to live up to Jesus' macro-calling of grace within her meso-calling, and felt

[12] It was telling that Akua was interested in becoming a surgeon, but cautious because she disliked 'the idea of a lifestyle of a surgeon' and the stressful and belligerent personalities she associated with the specialty.

guilty when she was not, distinctively, gracious towards colleagues. She also sometimes found it 'difficult to be patient with patients from marginalised groups who are displaying "challenging" behaviour; [it] makes me realise my own fragility.' Similarly, Ruth explained her belief 'that we live in aid of grace and […] God does not expect me to be perfect […] I [don't know] how anybody can work as a psychiatrist and be a perfectionist.' Though the participants believed God had called them to medicine and to enact Christian macro-callings in the workplace, this sat alongside recognition of their incapability of fully living-up to such meso-callings or macro-callings. This cluster of beliefs acted as an interpretive, explanatory lens, enabling the medics to see their compromises and failures as inevitable. They recognised that they did not live in an ideal world, but in a fallen reality, thereby normalising imperfection. In turn, they relied upon beliefs about redemption and forgiveness, and God's being at work in Christians to redeem and transform them and their actions. Indeed, we could perhaps take this a step further, tracing a hope that God, in redeeming their actions and mistakes, would in turn redeem their identity, preventing future inversions of the hierarchical identity ideal. Thus these medics drew upon evangelical beliefs and narratives as emotional and behavioural resources, finding work-faith affinity amidst tension.

Ethical Compromise

In his reflections, Ben wrote: 'Same sex adoption application – too long to write! How do I respond?' I asked him to expand upon this enigmatic entry in his interview. He told me the following story, about a new male patient with whom he was completing the paperwork for an adoption medical examination:

> [The last] question was, "Is there anything which in your opinion would lead you to, uh, believe this person is not a suitable adoptive parent?" It's a fairly open question. […] And so I said, "I don't know you, perhaps you'd like to tell me a bit about yourself?" Now I've done the medical bit, let's just get the social bit. Um, uh – and so we yacked a bit. And then I said, what about your partner? And perhaps I shouldn't have said it – in this day and age I probably shouldn't have said it – but I said, "Has she been for her medical because I don't – you know, I've not seen her. To my knowledge, I've not done an adoption medical for a little while, so presumably she hasn't?" "Oh yes, *he* came last week." [Long pause]. And immediately, what do you do?[13] […] And – and, think – "Lord, what am I going to say? What am I going to do?" I can't sign this! Umm. As being OK. I don't believe in that! So I can't do it honestly! [So I] thought of another excuse, just to postpone it a bit – and that was, "Oh […] you'll have to come and see my secretary, unfortunately she's not in tomorrow, uh, but she'll be in on Monday." […] [N]ext morning I rang my defence union. And long and short of it was, after two or three phone calls, uh "[Doctor] if you don't sign that form,

[13] Ben surmised that I would follow and understand his logic, and know why he found being presented with a homosexual couple applying for adoption problematic, hence this lacuna. His tone suggested he might also have expected me to share his view, not least since we both used to attend the same church, which maintains a conservative approach to such topics. As it happens, I have no theological or moral misgivings about adoption by homosexual couples.

> don't expect us to defend you in court." […] [Now] I've got a weekend to drive myself demented. And – and go to the elders in the church where I was and said, Look, I've got a major, major problem. Because I know that if this ends up in court – which it has the potential to do! Um – I could lose my job over this. Umm. And – and, so, you're going to have to pray. And I don't know WHAT answer I'm going to come up with. Either I'm going to be dishonest before the Lord, or, something – you're going to provide, the Lord's going to provide an answer to it.

Ben was caught. On the one hand, he knew the expectations of his job, and feared a potentially career-ending court case. On the other hand, he had a Christian conviction that homosexual parenting should not be supported: 'I can't sign this […] As being OK. I don't believe in that!' Therefore, to sign the paperwork would represent 'dishonesty before the Lord.' Ben's work and faith priorities were directly conflicting. He turned to prayer. The resultant resolution was, Ben believed, a miraculous intervention:

> The Lord provided the answer – do you know, he never came back for his form. [Pause] Never. A month later, because it had a month's notice, I shredded it, quickly! Every day, I would pray – "Please Lord, please don't let him come back for it." Don't let him come back for it. And he never came back for it. […] But – that was a real challenge to me, in terms of, what do I do in that situation? I haven't an answer. I don't know. Had he come back, I don't know. Umm. All – one thing I do know is that I said to my practice manager never, ever am I going to do an adoption medical again. Give it to somebody else.

This outcome removed the need for Ben to make a difficult decision and, potentially, to compromise his ethical convictions because of his work. Others, however, had found themselves in similarly conflicting situations, and made choices which had, to them, represented ethical compromises. For example, Richard expressed regret at his actions in the following episode:

> I have opposed [abortion] except in the case of threat to life or very serious and urgent harm to the mother's health […] In my obstetric Senior House Officer job 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 […] 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.

Similarly, Ginny recalled:

> [On] one occasion I did have a lady come in and request a termination of pregnancy […] she came back to see me later that day or the next day […] to say she couldn't have it done because I hadn't signed the form. […] So I felt bad because I'd – having said I wouldn't sign the forms, I then ended up – that was the only one I ever signed, because this lady didn't have that much money, and I'd just cost her extra train fares.

Despite believing that abortion should only be facilitated in specific, limited situations, both Ginny and Richard acted contrarily to their views. These episodes are further examples of cognitive

dissonance, with strong attendant emotions, between what a person believes, and how they act.[14] In both cases, there was an important interpersonal stimulus: Richard was *made to feel* as though he had no choice; Ginny felt responsible and guilty towards her patient. These examples enable us to both affirm and expand suggestions by Sinclair and Puchalski and Ferrell that the interpersonal nature of healthcare can have particularly significant impact upon practitioners' worldviews.[15] Sinclair suggests multiple ways in which being present to other people's mortality affects palliative and hospice healthcare practitioners' spiritual lives, including 'fostering acceptance of the unknown' and 'caus[ing them] to ask themselves the same questions about the meaning and purpose of life that their dying patients were reflecting on.'[16] Puchalski and Ferrell, as we have seen, argue that being present to suffering 'can change the clinician – his or her values, priorities or beliefs can be altered by the experience' just as the patient's experience of illness or disability may change theirs.[17] Ginny and Richard's examples suggest that interpersonal dynamics can be significant for healthcare practitioners' spiritual and religious identities, as Sinclair and Puchalski and Ferrell suggest, but not only in relation to patient mortality. Indeed, taking this a step further, it is notable that Ben, Ginny and Richard's experiences also had to do with interpersonal expectations, explicit and implicit, that they would be compliant with particular ethical interventions. We thus see again that, despite the legal position created by the provision of conscience clauses, cultural norms and assumptions surrounding abortion were powerful forces. The distance between legal and cultural expectations was troubling for several participants.

Again, it is important to consider the subjective interpretations in play. In Ginny, Richard and Ben's examples, particular, conservative ethical outlooks informed their ethical stances. Coming from a more liberal perspective, another Christian doctor might view their decisions as a coming to terms with the limits of conservative medical ethics when enacted in practice, or as a step towards greater practical ethical wisdom. Indeed, as we saw in 'Changing,' several of the participants interpreted their own changes of ethical perspective in such lights. This is not to diminish Ginny, Richard and Ben's interpretations, in which a more conflictual lens was applied. Rather, it is to reinforce the complexity and subjectivity inherent in such ethical reasoning.

In these examples of ethical compromise, work-faith affinity was seemingly in short supply. Work, it seemed, had forced, or threatened to force, Ginny, Richard and Ben's hands, placing their work-selves and faith-selves into conflict. These conflicts also represented an inversion of the ideal

[14] Festinger, *A Theory of Cognitive Dissonance*, p.1.
[15] Sinclair, 'Impact of Death and Dying, pp.183-185; Puchalski and Ferrell, *Making Health Care Whole*, p.166.
[16] Sinclair, 'Impact of Death and Dying,' pp.183-185.
[17] Puchalski and Ferrell, *Making Health Care Whole*, p.166.

hierarchy of identity. Rather than faith-based priorities winning out in Ginny and Richard's examples, these were overlooked in favour of contrary priorities which weighed heavily in these particular scenarios. However, again, a focus upon emotions is revealing. The emotionality with which these doctors recalled their actual and potential ethical compromises illustrated the difficulties such conflict, compromise and tension caused them. Ginny and Richard's stories were tinged with regret, not least evident in their tone of voice, sighs and pauses. Ben articulated his dilemma in strongly emotional terms, his pauses, emphases and exclamations revealing the extent to which the episode made him feel 'demented.' Ethical compromise and tensions were not felt lightly. These medics struggled where work-faith affinity was not realised or evident, and the hierarchical identity ideal was inverted.

It is also important to have a sense of scale. As noted in 'Taking Stock,' several scholars have suggested that it is valuable to differentiate between the long- and short-terms when considering healthcare work's religious and spiritual consequences. In particular, the literature cites examples of painful or negative short-term consequences which ultimately result in renewed, repaired or strengthened faith.[18] Differentiating between the long- and short-term consequences is also important for contextualising Ginny and Richard's experiences. Their compromises were single occurrences, anomalous against the backdrop of their general ethical attitudes. Moreover, Richard specified that he learned from this episode, and, like Ben, took steps to avoid being placed in similar scenarios again, thus consolidating his ethical perspective. In the short-term, these examples of ethical compromise uphold findings that healthcare work can lead religious and spiritual practitioners to compromise or 'gag' their worldviews.[19] The same was not true in the long-term. It seems compromise can take both the long-term form observed in other studies, and the short-term form observed here. Again, we see here that personal ethics and ethical narratives include subtleties and intricacies, deserving of close qualitative attention.

In other cases, rather than taking decisions which would represent compromises of their Christian values or ethical standpoints, participants opted for alternative interventions which were consonant with their faith. We have already seen that since, as Christians, they resisted any greater lenience regarding euthanasia, Elizabeth, Gwen, Ginny and Richard instead firmly supported pain control and symptom management, as means of showing Christian love to those in dire physical need. By advocating these alternative actions, they thereby reframed these emotional scenarios, presenting

[18] Haynes and Kelly, *Is There a God in Health Care?,* pp.96 and 104; Wright, *Reflections on Spirituality and Health*, p.44.
[19] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131.

them as opportunities to live out the macro-calling to love their neighbours. Again, we have seen that many made analogous decisions regarding abortion requests, presenting supporting patients as an opportunity to show 'Christian love and care,' even where their ethical convictions meant they did not facilitate terminations. In these instances, the participants reframed the situation from one of tension, to one in which they were able to love and help their patients as Christian medics. Phrased differently, we can say that, rather than make what they would frame as compromises, they sought out affinity, by looking for opportunities to live out Christian macro-callings.

Wholes and Parts: Revisited

In light of the above, we must briefly revisit our discussion as to how individual faith and worldviews are best conceptualised. At several intervals, we have noted the value of suggestions that individual worldviews and faith ought to be conceptualised as the sums of parts, rather than as unified wholes. Here, we must introduce a caveat alongside agreement.

Several of the above examples show the participants moving between discussing particular facets of their faiths, and their faith as a whole. When Philip's demanding schedule as a junior doctor compromised his regular rhythm of faith practices, his faith as a whole felt depleted. John articulated the 'role that I have to play as a Christian at the work place' in terms of particular, distinctive behaviours, and was troubled when he failed to enact these. As in previous chapters, it is important to consider the relationship between ethics and faith: though not synonymous, they are closely related. For example, Martha explained that she had not *yet* been, but might eventually be, involved in ethical scenarios in a way that 'would cause me to have to compromise faith.' Martha thus scaled up from particular ethical scenarios, to 'compromising faith' in general. The examples of ethical compromise echo this logic. Ginny and Richard compromised on an ethical stance they felt best reflected their Christian faith, hence their otherwise conviction in it. Ben moved between a particular ethical dilemma, and a more general sense of 'dishonesty before the Lord.' Returning to previous chapters, Goodluck's period of feeling distant from his faith, explored in 'Compartmentalising,' was partially caused by his pulling away from church commitments because of a busy work schedule. Thus particular practical compromises had a knock-on effect for his faith more generally. In 'Opposing,' we explored Elizabeth's perception that her entire religious identity was implicated in her stance against abortion. Again, a particular ethical stance is presented as indicative and representative of faith more holistically. Indeed more broadly, in interviews, participants freely and easily moved between discussing particular facets and discussing their 'faith.'

In order to reflect how the evangelical medics conceptualised their faith, we need to be able to approach these not only in terms of interrelated parts, but also as singular, holistic entities.

Researchers, like participants, need to be able to move between these planes, seeing individual faith and worldviews both as the sums of distinct facets and interconnected wholes. Scholars ought to hold both conceptualisations in tension, moving between them, and using them to counterbalance one another so that neither leads to distortion. Though Stringer and others helpfully sound a call to attend to the complex and multifaceted nature of personal worldviews, we must not thus lose sight of worldviews as wholes. To this end, Taves, Ihm and Asprem's more pragmatic conceptualisation is helpful. They echo Stringer when they write: 'lived worldviews may be more fragmentary, episodic, and situation dependent than formal, systematized worldviews would lead us to expect.'[20] They advocate balance, however: 'We anticipate that enacted worldviews occupy a middle ground that is neither completely episodic (situation dependent) nor completely coherent (situation independent) with considerable variation between these extremes.'[21]

Contradictions

The above examples of compromise occurred at the interface of healthcare work and evangelical faith, the former manifesting in multiple ways, from cultural norms to rotas. By contrast, in the below examples, compromises were forced between two good, but mutually-exclusive, options or principles which could not coalesce in practice. Indeed, we have already observed this in relation to ethical reasoning, wherein participants felt caught between two valid ethical principles. For example, several participants felt called to both uphold the sanctity of life and to show compassion and care to those in need: but it was not always possible to do both. This was true in relation to both abortion and euthanasia. This relates to the above examples of alternative interventions. By choosing, for example, to care for patients, but not sign abortion paperwork, several participants both assuaged their concern about conscientious objection, and avoided being confronted with a choice between compassion and the sanctity of life. They were able to uphold both macro-callings, as well as protect their consciences. They avoided cognitive emotional dissonance, and in doing so avoided having to critically re-evaluate their evangelical ethical viewpoints in light of clinical realities.

In other cases, however, participants had to choose. We explored Gwen's shifts of viewpoint on abortion in 'Changing.' Here, however, it is important to explore how she managed her decision to facilitate abortions in certain situations. Recognising that, in doing so, she had waived any absolute commitment to the sanctity of all life, she explained: 'I struggled with it. […] Umm. And I felt bad about it. But I – I couldn't see – I couldn't personally, I couldn't see the point of just shovelling it on to someone else.' Of those who simply refused to sign any abortion paperwork, she said, 'well it's

[20] Taves, Asprem and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' p.212.
[21] Ibid.

wrong to say they're taking the easy way out. [Sighs.] You're not struggling with it. So I struggled with it. Umm. And – [pause] umm – well, I suppose you would say with mixed results.' Indeed, she went on to say, 'putting an absolute veto on [abortion] – [sighs] – it looks after your own conscience, but it doesn't help the situation. It doesn't help women. It doesn't help babies.' Once again, the emotionality at work is significant. Gwen chose to privilege the sanctity of life below the importance of caring compassionately for individual patients, but had not ceased to 'struggle with' that choice, her sighs indicative. Her compromise felt costly, and she confessed that she was still often troubled, wondering whether she had made the right choice in every case.

Mel wrote the following about her experience treating the young Jehovah's Witness whose parents' refusal to allow him to have a blood transfusion resulted in his death:

> As a Christian in this situation it was difficult. I wanted to respect their beliefs but where does that end with respect to the life and care of another human being, especially if with regard to your own faith you think they are wrong? I watched the team around this situation really torn, I watched them trying to get a ward of court in place so they could save the lad. In the end I stood and watched him die and found myself questioning whether this really was the will of God when a simple transfusion of blood could have saved him?

Mel, like Gwen, felt caught between two good goals: wanting to 'respect their beliefs,' but also wanting to respect 'the life and care of another human being.' Like Ben, Mel did not have to resolve this conflict: as she explained, hers were not the shoulders upon which the decision rested. She nevertheless struggled to console herself at the time:

> This apparently blinkered, narrowly focussed expression of faith meant we weren't even afforded the opportunity of trying to do all we could, which at the very least when you go home after something like this you could console yourself with the thought of.

Moreover, as we have seen, this was a consequential chapter in her medical career. The questions stimulated by this episode meant Mel felt, for some time, distant from her faith.

In such scenarios, there was a sense in which the participants could not win, though, equally, they could not wholly lose. Siding with either principle, or 'good,' was to choose something consonant with and significant within their evangelical faith, and simultaneously sacrifice the same. In some cases, they felt able to make a decision: for example, by advocating alternative interventions surrounding abortion and euthanasia. In others, they simply had to make a difficult decision, and move forward, often without a sense of ease or peace. The sacrificed good influenced their emotions and memories as much as the chosen good.

Conclusion

This chapter has explored episodes and scenarios in which the evangelical medics felt they had to compromise. Together, these provide further insights into the ways in which faith can be shaped by healthcare work. Particularly during early career stages, rotas, shifts and regular changes of job can jeopardise regular rhythms and practices of faith. The interpersonal, emotional nature of patient-facing work, as well as interpersonal encounters with colleagues, and medical cultures and norms, can lead evangelical medics to compromise on their behaviours and values, including their ethical standpoints. Such was the case, on occasion, for Ginny, Richard, Martha, Hannah and John, whose resultant feelings of guilt and regret we noted above. Ben's story saw him torn between compromising his faith to keep his job, and sacrificing his job to maintain moral integrity. In many of these examples of compromise, the participants in turn feared inverting the ideal hierarchy of identity, by allowing their faith to be damaged, depleted or dominated by their work. Finally, the chapter explored instances in which opting to honour one 'good' option or macro-calling required compromise on another 'good.' Thus, in answer to this project's first research question, it is clear that medical work *can* lead evangelical medics to make, or feel they must make, what they perceive to be compromises in relation to aspects of their faith. These feelings represented their particular interpretations of events, not least in line with what they saw to be the normative demands or expectations of their faith.

Such compromises do not obviously echo the consonant identity model observed elsewhere, and have seemingly little to do with the drive towards work-faith affinity. In one sense, this is an important observation in itself, for it shows that participants were confronted with challenges, tensions and difficulties as 'Christian medics,' and that affinity was by no means always self-evident. Difficult compromises, and barriers to affinity, should not be papered over or ignored. If we are to map as extensive a picture as possible of the potential consequences of healthcare work for evangelical faith and identity, we must include challenges and compromises. We need to understand what people do, and how they manage, when the drive towards work-faith affinity is inhibited. Yet there were nevertheless indications in the above episodes that a drive towards work-faith affinity was present even as it was challenged. As in previous chapters, this was clear from the strong, negative emotions evident when participants described compromises. This is a further reminder of the importance of emphasising emotion when studying lived evangelicalism. The drive for affinity was also evident where the medics did as much as they could to mitigate the challenges presented by restrictive and demanding rotas, or when they turned potential compromises into opportunities to fulfil macro-callings. Several also took steps to prevent compromising scenarios arising again. In

these examples, they sought out identity consonance and work-faith affinity in ways which incorporated, or proceeded in spite of, conflict between medicine and faith, not least where these demanded compromise of each other.

Complexly, in order to live out the macro-calling to distinctiveness, participants needed to forego affinity in particular respects and contexts: not being 'swept along' by surrounding cultures, for example. However, by seeking this particular, positive dissonance, the medics could thereby enact their faith more fully at work, facilitating work-faith affinity. Thus somewhat paradoxically, distinctiveness required both a drive for, and partial sacrifice of, work-faith affinity. This highlights again that the balance of work-faith affinity with selective tensions was important in these medics' experiences. This observation remains important as we explore 'Negotiating' in the next chapter, observing the medics as they again encounter both affinity and dissonance at the interface of work and faith.

Negotiating

"Do you want me to pray with you?"

Introduction

In 1998, the World Health Organisation stated that '[t]oday the spiritual dimension of health is increasingly recognised.'[1] This was indicative of a trend, beginning in the 1980s, of growing interest in, and advocacy for, spirituality within a holistic model of medicine.[2] Some four decades later, religion and spirituality remain contentious topics in western healthcare, and resistance to the spiritual care agenda persists.[3]

In the USA, Sloan is a vocal critic.[4] Closing *Blind Faith: The Unholy Alliance of Religion and Medicine,* he writes, '[b]reaking down the wall between religion and health [is] fraught with perils […] it's hard to think of a worse idea.'[5] Emphasising religion and medicine's distinct spheres of sovereignty, he suggests that when medics 'use the authority of their position to offer advice beyond their area of expertise, they violate the accepted norm of their relationship and run the risk of manipulating or even coercing the client.'[6] In particular, he argues that proselytisation by medics represents a 'program of covert manipulation [designed] to pursue the doctor's agenda, not the patient's.'[7] While Sloan acknowledges that '[m]ost proponents of closer ties between religion and health make it clear that they believe that proselytizing by physicians is inappropriate and unethical,' he claims it occurs nevertheless, and that the spiritual care agenda heightens the risk.[8]

More broadly, many who support the spiritual care agenda nevertheless agree that the physician's role should not exceed 'acknowledgement' and 'respect,' their own religion or spirituality never

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[1] World Health Organisation, *Health Promotion Glossary* (1998). Available online at <https://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf> [Last accessed 10/04/2020].
[2] McSherry and Jamieson, 'Nurses' Perceptions of Spirituality and Spiritual Care,' pp.1758-1759 and 1765; Cook, 'Controversies on the Place of Spirituality and Religion,' pp.2-6.
[3] Robert Connelly and Kathleen Light, 'Exploring the "New" Frontier of Spirituality in Health Care: Identifying the Dangers', *Journal of Religion and Health*, 42.1 (2003), 35–46 (p.36); Mabel Aghadiuno, *Soul Matters* (Oxford; New York: Radcliffe Publishing, 2010), pp.XIII-XIV.
[4] See Cook, 'Controversies on the Place of Spirituality and Religion,' pp.6-7.
[5] Richard P. Sloan, *Blind Faith: The Unholy Alliance of Religion and Medicine*, (New York: St Martin's Griffin, 2008), p.260.
[6] Ibid., p.194. See also p.265. For similar concerns regarding psychiatry in the USA some 17 years earlier, see Galanter, Larson and Rubenstone, 'Christian Psychiatry: The Impact of Evangelical Belief on Clinical Practice.'
[7] Sloan, *Blind Faith*, p.202.
[8] Ibid., pp.196 and 206.

intruding.[9] Baker and Wang trace this discourse to Freud, writing 'the psychologically–oriented helping professions have generally [since] linked good practice with a relative invisibility of the professional's personal issues.'[10] Connolly and Light, also writing from the USA, similarly note the 'danger that professionals, especially those from evangelical religious backgrounds, may with all the best intentions share their beliefs without invitation to people who are too sick or polite to protest.'[11] They also critique 'assumptions' that it is always beneficial to bring patients' 'religious conflicts or struggles […] out into the open.'[12]

In sharp contrast, Haynes and Kelly describe their book, *Is There a God in Health Care?,* as a collection of 'stories that illustrate the ways in which medical healing is enhanced when […] physicians are able to incorporate faith, prayer, and their inner spirituality into the process.'[13] They argue that '[t]he relationship of the health care provider to the patient can only be enhanced when [it] is one of love, compassionate care, and intercessory prayer,' noting that Haynes openly prayed with his own patients [14]

Though they have generated less literature than the USA, debates on these topics also resonate in the UK context.[15] Cook suggests this is particularly true within psychiatry.[16] Certainly Poole, debating with Cook in 2011, wrote that prayer within psychiatric treatment has 'little to do with the practitioner's specific therapeutic expertise.'[17] He thus deemed it 'inimical to [their] fundamental responsibilities,' creating 'obvious and significant hazards,' and representing an 'unequivocal breach of the boundaries of appropriate professional behaviour.'[18] Poole and fellow resisters thus echo Sloan's concerns for the UK, highlighting – as Cook summarises – 'the potential risks of [spiritual] interventions, notably in the case of the patient with religious delusions or of the clinician with an agenda for proselytizing. The possibility of praying with patients [has proved] especially controversial.'[19] Dein, Cook, Powell and Eagger, less adversely, suggest that 'psychiatrists should

[9] James L. Griffith, 'Psychiatry and mental health treatment' in *Oxford Textbook of Spirituality in Healthcare*, ed. by Mark Cobb, Christina Puchalski, and Bruce Rumbold (Oxford: Oxford University Press, 2012), 227-233 (p.228).
[10] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131.
[11] Connolly and Light, 'Exploring the "New" Frontier,' pp.40-41.
[12] Ibid., p.39; see also Simon Dein et al, 'Religion, Spirituality and Mental Health', *The Psychiatrist*, 34.2 (2010), 63–64 (p.64).
[13] Haynes and Kelly, *Is There a God in Health Care?,* p.XIX.
[14] Ibid., pp.195-196 and xix.
[15] Cook, 'Controversies on the Place of Spirituality and Religion,' pp.4-7.
[16] Cook, 'The Faith of the Psychiatrist', pp.13-14.
[17] Rob Poole and Christopher C. H. Cook, 'Praying with a Patient Constitutes a Breach of Professional Boundaries in Psychiatric Practice', *British Journal of Psychiatry*, 199.2 (2011), 94–98 (p.94).
[18] Ibid.
[19] Cook, 'Controversies on the Place of Spirituality and Religion,' p.8.

respect their patients' religious and spiritual beliefs, and that these beliefs should be given thoughtful and serious consideration in the clinical setting.'[20] They advocate sensitivity, acknowledging 'significant ethical dilemmas' even if, with some patients, they believe prayer can 'strengthen the therapeutic alliance.'[21] They estimate, however, that '[t]he issue of praying with patients will always be contentious.'[22]

In 'Resourcing,' we highlighted the importance of prayer to the evangelical medics in this study. Yet prayer and proselytising also presented significant dilemmas. The participants believed in the power of prayer and the importance of spreading the gospel, yet recognised restrictions around these practices in clinical contexts.[23] This chapter explores the evangelical medics' engagement with this mesh of expectations, and the 'tactics' they developed to engage with and manage it. Where Grant, Cain and Sallaz observe that healthcare professionals 'artfully negotiate' the relationship between science and religion, so this chapter suggests artful negotiation also occurs in relation to prayer and evangelism.[24]

The Dilemma

The participants consistently commented upon workplace constraints related to their faith, particularly prayer and evangelism. Citing formal dictates, John noted GMC regulations which, he said, 'forbid you speaking clearly and effectively about your faith.' Martha suggested that when it came to discussing her faith with '[p]atients – I – you're not actually, I don't think, allowed to talk about it?' She continued: 'to be honest, I'm quite scared of bringing it up [because I] [w]ould be worried about crossing a line.' Such restrictions meant Akua stopped short of describing medicine as her 'calling:'

> I wouldn't have said it was a calling for me […] I'd probably say that if we were allowed and encouraged to pray for people on the wards, then I would say, 100%, it completely links up and [it] would definitely be a calling. That would be amazing.

Echoing Martha and others' spatial metaphors, Akua instead found herself 'wonder[ing] how open is too open, and the extent to which I am allowed to let my patients know where I stand.'

[20] Dein et al, 'Religion, Spirituality and Mental Health,' p.63.
[21] Ibid, p.64. See also Cook, 'The Faith of the Psychiatrist,' p.14.
[22] Ibid.
[23] I echo the participants' varied discourse of 'sharing the gospel'; 'evangelising'; 'sharing faith'; and 'witnessing.' While there are differences between these terms, the participants were not concerned by them. Moreover, they appreciated that I would recognise them as a 'family' of related terms common within evangelical discourse.
[24] Grant, Sallaz, and Cain, 'Bridging Science and Religion, p.482.

Perceiving more abstract, cultural constraints, James described a 'taboo' around discussing personal faith, and suggestions that to do so would be 'unprofessional.' Nigel described a 'kind of social pressure that you don't talk about your own beliefs.' He described psychiatry as a 'fairly hostile environment' in which to be openly religious. James, similarly strongly, said **'**[t]hey're actually oppressing Christians much more than they used to […] our views on things like homosexuality and whatnot are now deemed inappropriate.' James articulated strongly what others hinted at: a sense of being persecuted in their secular workplaces. In *American Evangelicalism,* Smith notes some USA evangelicals' 'perception of a double-standard in American public discourse that discriminates against Christians […] [their] feeling of being […] suppressed by a selectively liberal mainstream.'[25] Strhan echoes this for the UK in *Aliens and Strangers,* citing her participants' concerns about articulating conservative viewpoints on 'those issues where the church is felt as rubbing up against broader norms of equality.'[26] Though most participants stopped short of labelling it 'oppression' or 'persecution,' there was nevertheless an extent to which several felt excluded by a dominant secular ethos, which silenced particular Christian convictions and expressions.

Several of the evangelical medics shared James' perception that obstacles had increased. Nigel mentioned his 'sense working in the NHS that there is a growing intolerance of expressions of faith.' Ben felt that early in his career he had 'great opportunities to […] live out what you profess to be […] in an atmosphere generally of acceptance. Latterly things changed.' He recalled his disappointment when a local hospital chaplaincy requested that he remove Gideon Testaments in order to foster a more religiously-neutral environment. David said 'I think possibly I've noticed the NHS as a whole, shall we say, being less tolerant,' citing media episodes wherein nurses had been forbidden from wearing cross necklaces work.[27] While he welcomed increased sensitivity to patients' religious and spiritual needs, David wondered whether there had been correlated decline in respect for doctors' faiths. Having once encouraged a patient to re-explore their faith, he clarified, 'I think what I said […] all those years ago I don't think I could say today.'

David was not alone in citing media coverage and 'hearsay' as grounds for concern. Jeremy explained, 'I think all Christians who are evangelical are worried that [talking about their faith] will become more difficult in the future […] there's been a few scares in the media.' Peter referred to 'bits of hearsay around […] doctors have been punished or disciplined for trying to pray with

[25] Smith, *American Evangelicalism,* p.140.
[26] Strhan, *Aliens and Strangers?,* p.101.
[27] David did not cite a specific example, but may have had coverage such as this in mind: Jonathan Wynne-Jones, 'Nurse faces the sack for refusing to take off her cross,' *Telegraph,* 19th September 2009, available at <https://www.telegraph.co.uk/news/religion/6209892/Nurse-faces-the-sack-for-refusing-to-take-off-her-cross.html> [Last accessed 4th September 2020].

Christian patients.' Sarah, who wondered whether she should have brought her faith up more at work, ultimately concluded: 'no, you know, you're a professional person so you can't. And somebody would have complained, they do, you see it in the paper all the time. And um, it's inappropriate, and you shouldn't. Yeah. So I didn't.' In her reflections, she wrote, 'one cannot in one's professional capacity share that faith with patients or help them to find God – one would be struck off!!!'

Thus, on the one hand, participants recognised such regulations and restrictions, and the consequences breaching these could have. On the other hand, they took seriously biblical commands to disclose and share their faith. James explained: '[W]e are called to share the good news, share the gospel […] people need to be saved, you need to be doing that, otherwise you're not doing what God's called you to do.' Thus James presented evangelism as a macro-calling upon all Christian lives. John 'want[ed] my colleagues to know that the real cause of my existence is to share the gospel […] I feel that as a Christian medic, our primary goal is to share faith. The profession and other activities are pretty secondary.' Jeremy found it '[v]ery difficult to reconcile my faith-based duty/desire to evangelise with my GMC duty to remain professional.' He described tension between 'directives' to pray and to spread the gospel, and suggestions that to do so represented abuse of the unequal power relationship between doctor and patient. Richard also noted this 'powerful constraint':

> I felt, probably excessively, constrained in talking with patients about faith and offering prayer. There were occasions when I did and I suspect others when I should have, but there was a very powerful constraint in the expected professional attitude and not abusing the Dr-Patient relationship.

Many participants emotively and intensely expressed their concerns and dilemmas surrounding these themes, linguistically and otherwise. Thus we have seen that Nigel perceived a 'fairly hostile' environment, and James suggested Christians were being 'oppressed,' or silenced by 'taboo.' Ruth explained, '[m]y impression is that any religion claiming to have sole authority over the truth is presented as extreme and bigoted and simply won't be tolerated.' Jeremy was 'worried' that sharing faith would become more difficult, and cited 'scares' in the media. He had found the dual imperatives to evangelise, and to act appropriately in the clinic, 'very difficult to reconcile.' Indeed, concern and fear led to exaggeration in places. Thus Martha suggested she was 'not allowed' to share her faith with patients, where the GMC's guidance in fact offers more space for manoeuvre.

Sarah claimed confidently that she did not 'think you'd even be allowed to wear a cross now,' where others in this study did, without encountering problems.[28]

The Christian participants in Baker and Wang's study described similar tensions between 'a general stance among professional clinical psychologists of relative non-disclosure' and their '*desire* to disclose religious values and orientation as part of their Christian care for others.'[29] In this study, the latter had a particular conversionist emphasis. Outlining his quadrilateral, Bebbington argues that in early British evangelicalism '[t]he line between those who had undergone the experience [of conversion] and those who had not was the sharpest in the world.'[30] This emphasis remains, and resonated with the evangelical medics in this study.[31]

'The Right Way'

Prayer and evangelism thus presented the participants with conflicting priorities. Yet even as they described and struggled with these, they had also developed means of responding. As for Baker and Wang's Christian psychologists, these responses meant differentiating between patients and colleagues.[32] In relation to the former, the majority of participants shared James' sentiments: 'I think we need to just find out those ways to do it the right way.' The participants prayed and shared their faith with patients only under certain, closely delineated conditions which they felt represented 'the right way.'

Lewis explained: '[V]ery rarely would I pray with a patient, and then it would be someone I knew from church. And it would be in the context of their permission.' Sarah, similarly, made rare exceptions to her general reluctance to pray or share her faith in the clinic where she knew the patient personally, and knew they shared a faith. Ben described being 'sensitive to the situation' questioning, 'Is it appropriate […] are these the sorts of people who would be accepting of it?' Like Lewis, he always asked the patient's permission. David discussed his faith only 'if [patients] have made it absolutely crystal clear to me that they go to church and have a faith [and] they are clearly comfortable with it.' This was easiest where the patient initiated such conversations.

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[28] We might compare these exaggerations to Brown and Lynch's observations of 'imagined' opposition, evident within subcultural groups: their 'opposition to an *imagined* cultural mainstream' and the fact these '*imagine* themselves to be marginalized' (pp.340-341, emphases mine). While in many ways this chapter suggests the opposite of subcultural oppositional identity at work, it is interesting that this sense of resistance to an imagined, exaggerated opponent (that is, restrictions) nevertheless arose. Brown and Lynch, 'Cultural Perspectives,' pp.340-341.

[29] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131 (emphasis original).

[30] Bebbington, *Evangelicalism in Modern Britain,* p.5.

[31] Guest, Olson and Wolffe, 'Christianity: Loss of Monopoly' p.61; Guest, *Evangelical Identity and Contemporary Culture*, p.1.

[32] Baker and Wang, 'Examining Connections between Values and Practice,' p.131.

Following patients' leads was a key rationale for many. Liam said 'I probably wouldn't speak to a patient about personal beliefs unless they brought it up first.' Similarly, Martha made exceptions to her fear:

> [W]hen people bring it up with me, I don't mind […] one woman was miscarrying, and she mentioned something about faith. So I said, "Are you a Christian?" And she said yes – and I said, "Do you want me to pray with you?" That's the only time I've ever prayed with a patient. And recently a woman was in her last days of life, and her daughters mentioned that she's Catholic, and wanted a priest. So that kind of, had a platform for me to say something reassuring from a faith point of view.

When patients receiving difficult diagnoses had enquired about her faith, Catherine had felt compelled to answer honestly, and agreed to pray with them. She clarified that they must have 'specifically asked for it. But I don't think that would happen these days.'

Others focussed upon how helpful such interventions would be. Liam explained 'I don't think I have ever discussed my faith with any patients before but I did tell [one woman] I would pray for her as it felt like something she would appreciate.' Ruth discussed faith with patients where it was 'in their best interests,' 'part of their life,' and she was confident it would 'help their recovery.' She had resultantly 'had some very, very meaningful discussions with people about their faith, but it's always been very patient-led.' Peter felt strongly that prayer could be beneficial, and ought to be utilised:

> [I]t can sometimes feel like what we're meant to do is not let our faith influence our clinical practice at all, rather than say 'It does and it should and let's celebrate that but do it appropriately.' […] It's been really helpful for me as a Christian doctor to say, well, I'm happy to pray about this with you right now […] a non-Christian doctor can't have that relationship.

Rather than violating trust, Peter and others felt bringing faith overtly into clinical contexts would enhance trust within the doctor-patient relationship.

Where the conditions they set out were met, participants found it deeply edifying to be able to share their faith or pray openly. This closely echoes Baker and Wang's observation of their Christian psychologists' 'overt pleasure' at opportunities to disclose their faith to a client.[33] Thus David found that '[o]ne of the most rewarding areas [of work] for me [is] sharing my faith with fellow Christians.' Martha wrote '[o]ccasionally when a patient or colleague has shared with me that they have a Christian faith I have felt blessed to disclose my own faith.' Goodluck, similarly, described 'one instance where it was clearly therapeutic to introduce our mutual faith' with a patient. Having done so, he prayed with them, which he described as a 'real privilege.' Sarah reflected that when she had

[33] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131.

brought her faith into consultations with Christian patients, it had helped them to 'open up,' and benefitted their psychiatric care.

Martha speculated that faith might 'most naturally [come up] in end of life discussions, because you are actively encouraged in palliative care [to ask] "do you have a faith that's important to you?" So that's a bit easier.' Confirming Martha's suggestion, Elizabeth appreciated what she referred to as palliative care's 'open door' to faith and spirituality, explaining: 'I love working as a palliative care doctor as I am expected and allowed to ask about faith and belief, and if patients are happy I can say I will be praying for them.' Ginny and Richard had similarly found palliative medicine pleasingly open to faith. Akua was considering training as a GP because she hoped it would allow her to 'really build relationships with people, and support people in their faith.'

Of all the participants, Ben most consistently articulated this edification, even as he also highlighted his concerns in relation to prayer and evangelism. He explained, 'I can think of *many* situations where clearly God brought someone in for a purpose.' He told several such stories, many specifically related to conversion. Ben noted that it could be particularly difficult to know how to bring up faith with dying patients, despite his belief that conversion was particularly pressing in such scenarios. He ruminated: '[d]ying patients […] tough. How do you share your faith in, umm near to death, with people who know they're dying?' He told this story:

> [R]ightly or wrongly – and I've asked myself a thousand times, those questions, I just happened to open the drawer of my desk, and there on top of the drawer was a Gideon Testament […] I don't remember putting it there at all. It certainly wasn't a deliberate act to put it there. I must have put it there – I guess – I don't know, unless… I don't know. It doesn't matter. "So there, [Jim] I want to give you that. Just – read it. You know – you've got time, just read it. And – and, um, you know, I trust it will help you." And off he went. And he died a few days later. And [his wife, on t]he day of the funeral, she came to me with a Gideon Testament, and she said, "Did you give [Jim] this?" And I said, "Well, yeah, I did, actually, but why have you got it back?" And she said "Look." And she opened it up, and on the back page of the Gideon Testament, there's a bit on the back page about coming to faith. And she said "Look, he's signed it, the day before he died. And I thought you'd want to know." And that was so humbling, really.

As Ben explained, he had 'asked himself' many times whether he had acted 'rightly' or 'wrongly,' indicative of a dilemma between his faith's demands and clinical expectations. Ben recognised that he had acted, arguably, 'wrongly' with regards to bringing faith into a consultation and a doctor-patient relationship. However, he believed God had directed him, and this scenario, for the sake of the patient's salvation. The emotionality of this story was clear in Ben's tone of voice as he concluded this narrative, and his assertion of how 'humbling' he had found the experience.

However edifying such positive experiences were, the participants also accepted that, often, 'the right way' meant 'not at all.' Jeremy acknowledged that 'as someone who's essentially serving the patient, I think you've got to respect whether they want to talk about it or not.' David was 'more than aware that the patient may not have the slightest bit of interest in my religious beliefs and I must clearly respect that.' He acknowledged that some patients did 'not need […] me wading in' and that it often was 'not my job or place.' He recalled with fond embarrassment offering to pray with an elderly Catholic patient, who declined firmly, since she 'had a priest for that.' Thereafter David concluded that if 'I know [Christian patients have] got fellowship and support, I know there's a lot of prayer going on there,' he was content for God 'just' to use him as a doctor.

Simon summarised his approach as trying to be 'natural about who you are and what you believe' without always being in 'proselytising mode - but neither are you minimising it either […] if it's something that's very important to you, people are clear that it's a very important part of you and what you do.' He referred to CMF's resource *Saline Solution,* designed to 'support people in being able to talk about their faith but in a way that cannot be seen as aggressive or imposing values.'[34] As we saw in 'Compromising,' the CMF's current mission statement is 'uniting and equipping Christian doctors and nurses to live and speak for Jesus Christ.' Together, this statement and publication shows that the concerns and negotiations described in this chapter are of interest beyond this study's sample.

Martinez and Baker's study found that Christian psychodynamic counsellors generally felt it was inappropriate to overtly share faith with clients.[35] The evidence above requires a less generalised view, for the evangelical medics' decisions and approaches were contextual and situational. In their commitment to finding 'the right ways' to pray and evangelise, these evangelical medics echoed Dein et al's call for caution and sensitivity.[36] They sought to uphold their faith commitments without breaching regulations or trust. Where they were confident that it would not be harmful, that they shared a faith, and that the patient had consented to, or invited, such interventions, they might pray, or disclose their faith. Otherwise, they exercised significant caution.

Alternative Interventions

Alongside stipulating precise circumstances in which they might openly share their faith or pray in clinical contexts, the participants also advocated alternatives. In 'Compromising,' alternative

[34] See Christian Medical Fellowship, *Saline Solution.* Available at <https://www.cmf.org.uk/doctors/saline-solution/> [Last accessed 16/06/2020].
[35] Martinez and Baker, '"Psychodynamic and Religious?", pp.261-262. See also Shafranske and Malony, 'Clinical Psychologists' Religious and Spiritual Orientations,' p.75.
[36] Dein et al, 'Religion, Spirituality and Mental Health,' p.63.

interventions enabled the medics to reframe conflictual, or potentially conflictual, scenarios into those where they could identify and enact Christian macro-callings. Subtly differently, in the below examples, alternative actions were intended to achieve *similar* ends, but in a more professionally acceptable way.

For example, the vast majority of participants prayed for patients, even where they did not pray with them. They thus championed prayer, but located it safely beyond the clinic. Ruth commended medics who prayed with patients, describing it as a 'gracious, gracious, beautiful thing to do.' But she felt more comfortable praying for patients in her free time, conscious of 'some of the harsher aspects of secularism […] holy intentions could be misunderstood or misrepresented.' While some told patients they were praying for them, Nigel avoided this: 'I don't know quite what effect that would have […] it feels like that would be crossing a boundary.'

Others used physical symbols to passively denote their faith, though some felt this too was becoming more difficult. Sarah said, '[t]hat's got worse now of course. I don't think you'd even be allowed to wear a cross now. I always wore a cross and never was I told not to.' David described 'greater sensitivity over […] even what you've got on display in your room.' He nevertheless felt 'able to have items in my room that may hint at my belief.' He noted that these had helped some patients raise their faith in consultations, facilitating what he felt were important conversations. He added: '[f]ortunately, I have never had any complaints about this.' Ruth made 'it reasonably clear at work that I'm a Christian' by occasionally wearing a cross necklace and using Christian phrases such as 'God willing' and 'bless you.' She qualified this, saying 'I don't feel the need to *have* to wear a cross you know, it's my heart is who I am, and Christ needs to come through who I am rather than what I wear.'

Like Ruth, many participants hoped to 'witness' to their faith through their behaviour. Often, this related to being positively distinctive, a macro-calling we have explored previously. Martha thus admired her Christian nursing colleagues, who showed what described as 'really distinctive' and 'inspiring' patience, kindness and generosity. John explained that, in medicine: '[t]here are so many people that you can have an impact [upon] and that can be purely by how you behave […] how you allow yourself to display […] God's love and the image of Christ.' John particularly emphasised the importance of showing Christ-like compassion and 'agape love' to both patients and colleagues. When I asked Nigel whether he found healthcare work conducive to living out the gospel, he responded:

> Yes and no. Um. In – in some ways, in terms […] of walking alongside people, about, um, caring for people. Yes, it's most conducive to that. But can I do that overtly? And say "I'm doing this for you as a Christian?" No! And we live in such a time that even talking about your faith in the workplace has [become] very difficult.

Even as he could distinctively and valuably be a 'listening ear' to patients' spiritual concerns, Nigel nevertheless felt a 'professional need to keep personal beliefs out of conversations with patients.'

These examples reflect a recent, broader shift within British evangelicalism towards so-called 'friendship evangelism.' In this form of sharing the gospel, the end-goal of conversion remains, but methods have become 'less confrontational and less strident.'[37] As Guest elucidates, this term's multiple definitions all relate to recognition that 'traditional proselytising strategies can often have the opposite effect to that intended.'[38] Instead, proponents make 'an effort to be sensitive to the suspicions of non-Christians and respectful of them as people, within an evangelism that takes place not via confrontational encounters, but through longer-term relationships.[39] This often includes an emphasis upon 'demonstrating, as well as preaching, God's love.'[40] Guest et al observed a preference for friendship evangelism among Christian university students in the UK, noting that 'a majority […] expressed some discomfort with evangelism,' fearing 'alienating' their peers.[41] They were happier to respond when others enquired about their faith, or aspects of their behaviour, and consistently preferred 'living faith through actions - rather than through combative conversation.' [42] Recognising that their context, role and regulations did not readily lend themselves to 'traditional proselytising strategies,' the evangelical medics similarly found alternative means of modelling, and thus sharing, their faith at work.

Such alternative interventions also characterised the participants' interactions with colleagues. By comparison to patients, most found it relatively easy to share their faith openly with colleagues. Hannah found that there were 'quite natural discussions about faith' and remarked at 'how unusually acceptable that is, in most circumstances, perhaps compared to another workplace.' She found she could easily 'be a witness in those conversations.' Jeremy agreed, saying 'proximity to death opens up these conversations more than in normal life.' He also speculated that medics' resultantly intense workplace relationships might be a 'good thing […] as it is easier to speak to people about faith if you are closer to them.' However, some felt differently. Liam felt that 'being a

[37] Guest, *Evangelical Identity and Contemporary Culture,* p.41.
[38] Ibid., p.40
[39] Ibid.
[40] Ibid., p.41.
[41] Guest et al, *Christianity and the University Experience,* p.120.
[42] Ibid.

Christian in medicine is still hard to sometimes to speak openly about.' Ruth described other 'Christian workers who are fearful of sharing their faith for fear of being mocked.' Martha had found talking to her colleagues about her faith 'really difficult,' and Akua found it 'difficult to feel freedom' in such contexts. Thus, as in Baker and Wang's study, while the participants felt *more* comfortable about sharing their faith with their colleagues than with patients, there were nevertheless some difficulties in relation to the former.[43] In these contexts, witnessing through behaviour provided a viable, valuable alternative. Like John, Liam aspired to witness among his colleagues through distinctive behaviour, writing, 'I feel like I could show more of an example of what being a Christian doctor looks like. I'm not sure exactly what sets me apart from my colleagues otherwise.' Similarly, Catherine explained '[p]eople aren't going to pick up the Bible randomly, they're going to pick up and read your life [which] holds me to account.'

Significantly, some participants saw medical excellence as an important element of witnessing through behaviour. Ruth explained, '[t]here's an element of sharing [our faith] when we are Christ-like [so] who you are matters when you're at work and how well you do your job matters.' Philip reflected that 'it's very hard to honour Jesus when you're incompetent.' More positively, we have already seen that Lewis felt that, in order to love his neighbour, he needed 'to be the best doctor I can be – fully up-to-date […] fully attentive […] wise in my clinical judgements.' Gwen explained, '[t]he CMF […] always used to say [that] firstly you had to be a good, up-to-date doctor […] to be a good witness.' James wrote, 'Being a medic is a blessing. And you can always be a light […] if you're an excellent doctor especially.' He believed his medical excellence would show others that Christ was empowering him.

Others seriously questioned this perspective. Hannah did not feel medical excellence could necessarily distinguish Christians, since '[e]very doctor has a professional obligation to strive to be excellent.' Jeremy perceived that it was '[h]arder to stand out in medicine […] people work extremely hard and are passionate about serving patients regardless of their faith/worldview.' He expanded in his interview, saying 'as a doctor if you are diligent, hard-working, professional […] that doesn't identify you as a Christian – because lots of doctors who aren't Christians still exhibit all of those attributes.' David, similarly, felt there were 'a lot of very kind, very loving doctors and nurses out there who've got no faith at all,' or who came from other faith backgrounds, who all, like him, felt compelled to 'go the extra mile.' Several others made the same observation.

[43] Baker and Wang, *Examining Connections Between Values and Practice,* p.131.

However, some participants did feel they could be medically both distinctive and excellent by offering empathetic spiritual care. Ruth felt well-placed to attend to patients' spiritual needs, noting 'I really, really find that often patients really welcome these sorts of questions [and] being thought of as a whole person.' She felt this beneficially distinguished her from a '[t]endency for many working in healthcare with a secular mindset to be quite blinkered to the spiritual needs of the people that they serve.' Moreover, Jeremy enquired about patients' spiritual needs as a further means of 'find[ing] ways around' the dilemma of sharing faith at work, since it 'mean[t] the patient will direct you.' He described this as a 'tactic.' McSherry and Jamieson echo broader observations that, 'despite a great deal of attention,' many UK healthcare practitioners remain nervous and uncertain about spiritual care, in need of more education and guidance.[44] In addition to remaining controversial, as per the Sloan school of thought, spiritual care also remains patchy, with gaps between ideal and reality. In light of this, it is notable that the evangelical medics felt well-equipped to offer spiritual care.

Negotiated Affinity

The above has explored regulations and expectations surrounding faith in clinical contexts, and shown participants responding to these in two different ways: first, they delineated conditions in which they felt confident praying and overtly sharing their faith at work; secondly, they found alternative ways of engaging in prayer and evangelism. These observations closely resemble Baker and Wang's study with UK Christian clinical psychologists. Their participants demonstrated 'great caution' before sharing anything of their faith with clients.[45] They were happy to respond when asked for information about their beliefs, but 'even then with caution.'[46] They felt more at ease with a 'facilitative approach,' wherein they could encourage patients to consider religion or spirituality 'without over-influencing.'[47] Following Shafranske and Malony, Baker and Wang thus differentiate between implicit and explicit ways in which religion can inform the practice of clinical psychology and psychotherapy.[48] The conclude that their participants 'describe[d] considerably more of the implicit than the explicit,' suggesting that the ways in which the participants deployed their faith at work '[were] always spoken of as highly masked from public view.'[49] Rather than overt, explicit means, which might be deemed problematic in their workplaces, the evangelical medics similarly devised alternative, subtle, and implicit ways of sharing and enacting their faith at work.

[44] McSherry and Jamieson, 'Nurses' Perceptions of Spirituality and Spiritual Care,' pp.1757-1759 and 1765.
[45] Baker and Wang, 'Examining Connections Between Values and Practice,' p.131.
[46] Ibid.
[47] Ibid.
[48] Ibid., p.134.
[49] Ibid.

Baker and Wang interpret their findings with a suggestion that the demands and expectations of the Christian psychologists' roles 'had temporarily superseded that of immediately discharging the obligation to the "divine imperative" – that is, to enact their faith at work.[50] This interpretation closely echoes the inverted hierarchical model of identity observed across previous chapters. Indeed, relatedly, Baker and Wang emphasise their participants' 'sense of compromised religious integrity' which accompanied implicit faith.[51] In some cases, the evangelical medics echoed such readings, framing their responses to clinical expectations and regulations in similarly negative lights. We explored above the intense emotionality with which participants discussed prayer and evangelism in the clinic, pointing to the seriousness with which they approached these topics. Some invoked discourses of being oppressed, where many others were clearly fearful. This emotionality highlights that some, did, indeed, see 'implicit' and 'masked' means of enacting their faith as compromises. In particular, Goodluck seemed embarrassed as he explained, of sharing his faith with patients: 'It's – it's a – I play it safe. I know that some people push it a little bit more, but I play it safe.'

In other cases, however, the evangelical medics' responses should encourage us to challenge Baker and Wang's interpretation. Rather than solely emphasising difficulties, compromise, or the inverted hierarchical identity model, we can identify other forces in play. In particular, we can observe the participants' drives towards work-faith affinity and consonant identity, manifest in 'artful negotiation.'[52] In the first place, it is important to reiterate the observation from the previous chapter that compromise is subjective. While Baker and Wang's participants, perhaps like Goodluck, viewed implicit forms of evangelism as a compromise, many medics in this study did not. Rather, they sought and found solutions which, as far as possible, were passable to them as both medics and Christians. Though precise and carefully delineated, they identified contexts and scenarios in which they felt they could safely pray, and confidently be open about their faith. When context did not allow for this, they sought alternative solutions. Rather than seeing these as second best options, many participants presented these as valuable, significant means of enacting their faith at work. As we have seen, Martha found her colleagues' distinctive behaviour 'very inspiring.' John noted that there were 'so many people' that he could impact through witnessing to his faith behaviourally. Some, further, hoped their distinctive behaviour might encourage others to enquire about the faith that prompted it. While more implicit than 'traditional' or overt proselytising, the participants

[50] Ibid.
[51] Ibid., p.131.
[52] Grant, Sallaz and Cain, 'Bridging Science and Religion,' p.482.

nevertheless valued these alternatives extensively. These solutions satisfied their evangelical desire to share their faith, without posing a problem from a medical perspective.

Thus, rather than simply yielding, the medics negotiated with restrictions around prayer and evangelism, developing 'tactics' whereby they could uphold both Christian and medical expectations. These 'tactics' certainly made demands of their faith, requiring them to curtail or change its expression in many contexts and scenarios. They also required the medics to push some medical expectations further than many others would be willing to, albeit within the carefully characterised conditions explored above. Viewed from the reverse perspective, though, neither did the evangelical medics allow either faith-based or work-based expectations to dominate. If either had dominated, this would call to mind the dissonant identity models, whether in the ideal or inverted hierarchical form. Instead, the evangelical medics consistently negotiated, not settling for 'compromise,' or an inversion of the hierarchical identity ideal. In these examples of negotiation, the mutuality inherent in affinity is particularly apparent, for both the faith-self and the work-self could make demands, but also had to yield.[53]

Secondly, moreover, just as they did when engaging with complex ethical topics, several of the participants approached prayer and evangelism as much *qua* medic - or *qua* professional - as *qua* Christian. It was not only that they wanted to engage in these practices meaningfully, while avoiding retribution: rather, as medics, they concurred that, in some contexts, prayer and evangelism with patients in particular was, indeed, inappropriate, and potentially harmful. As Richard explained, used inappropriately, prayer could represent abuse of the doctor-patient relationship. Ruth appreciated the importance of 'GMC guidance that we do not cause harm, or that there's no bias or [that we] aren't in any way exploitative of vulnerable people.' Nigel, concerned about the effect it might have upon vulnerable patients, did not tell them he was praying for them. By contrast, as noted, participants felt confident praying or sharing their faith with patients when assured it would aid them, either by fostering spiritual care, or improving their therapeutic relationship. Several participants told stories of medics whom, they felt, had 'crossed the line' or acted inappropriately. Gwen recalled a colleague who had been, she felt, appropriately disciplined for praying very explicitly and aggressively with patients. Liam described 'doctors who go too far […] really press their beliefs on patients, which I wouldn't agree with.' The art, he felt, was 'finding the middle ground' between honouring faith and respecting patients. Turning to inter-colleague relationships, Martha

[53] Similar negotiations also took place in other situations. In Ben's case, for example, said the following about engaging with abortion as a GP: 'I think the skill is actually to take your Christian beliefs and make them meet what you believe, but also to make them meet the need of the patient.' This echoes the situational, pragmatic ethical approaches observed in previous chapters.

described a 'really evangelical' doctor who had used 'mailing lists to spam people about Christianity.' She agreed it was inappropriate to 'really strongly push that in someone's face in that way,' especially given her workplace's religious diversity.

Participants thus both recognised and shared concerns around prayer and evangelism in the clinic. They engaged in negotiation, partly, because they acknowledged and affirmed the appropriateness of such concerns, regulations and expectations. They sought tactics and solutions not simply as Christians, restricted by their medical context, but precisely as Christian medics. Negotiation thus drew upon their consonant identities as the participants strove for feasible solutions. This artful negotiation, which the participants engaged in as both medical professionals and as people of faith, points as much to affinity and consonance between work and faith as it does to dissonance and tension.

In light of these two points, it is worth noting that the participants' approaches closely mirrored the GMC's guidance, which reads as follows:

> [29] In assessing a patient's conditions and taking a history, you should take account of spiritual, religious, social and cultural factors, as well as their clinical history and symptoms […] It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them. [30] During a consultation, you should keep the discussion relevant to the patient's care and treatment. If you disclose any personal information to a patient, including talking to a patient about personal beliefs, you must be very careful not to breach the professional boundary that exists between you. These boundaries are essential to maintaining a relationship of trust between a doctor and a patient. [31] You may talk about your own personal beliefs only if a patient asks you directly about them, or indicates they would welcome such a discussion. You must not impose your beliefs and values on patients, or cause distress by the inappropriate or insensitive expression of them.[54]

We have seen that the participants consistently avoided: putting pressure on patients; straying beyond topics relevant to the patient's care; or disclosing their personal faith to patients, except in a very limited number of circumstances, actively conscious of a 'professional boundary.' The limited circumstances in which they did disclose their faith were those where they were sure it was prompted or welcomed, and they were not 'imposing.' While participants may have presented these means of enacting their faith the 'right way' as 'tactical,' the result was an approach very close to the GMC's recommendations. We might present this as a quasi-institutional manifestation of the consonant identity model.

[54] General Medical Council, *Personal beliefs and medical practice*, (London: General Medical Council, 2013).

As a final point, it is important to clarify that, viewed from an emic perspective, work-faith affinity was not an immediate motive: the medics were, rather, immediately concerned about disciplinary action, keeping their jobs, and maintaining positive relationships with their patients and colleagues. That is not to say that the drive for affinity was not a persistent and significant undercurrent. Moreover, the participants' more immediate concerns can themselves be taken as evidence of work-faith affinity: the desire to keep a job which participants saw as meso- and macro-vocational; and a drive to be 'Christian medics' by not having the expectations of either role in conflict with the other, rather requiring each 'self' to give and take. While it might not have been the medics' conscious or immediate motive, affinity was an important underlying drive.

Conclusion

On first glance, this chapter concerns tensions between evangelicalism and the practice of medicine. It focuses upon regulations and cultural expectations which restrict certain religious expressions by medics, particularly prayer and evangelism. Both were significant faith-based practices for the evangelical medics. The participants recognised, and had to respond to, these tensions, dilemmas created by the mesh of expectations – indeed, the mesh of worldviews – which they inhabited as evangelicals working in healthcare. They developed 'tactics' with which they could negotiate regulations and expectations, allowing them to act as – indeed, to be – both Christian and medic in the clinic. This meant finding 'the right ways' in which to pray and evangelise in the workplace, often by seeking alternatives to 'overt' displays or demonstrations of their faith. Thus, in answer to the first research question, as a result of healthcare work the evangelical medics negotiated means of expressing their faith within medical norms and expectations. They thus struck a middle path. Like Sloan and Poole, they were concerned about inappropriate encroachments of religion into the medical workplace, and thus took steps to make theirs appropriate, or 'right.' Yet, with Dein et al, they recognised that appropriate 'encroachments' could be powerful and valuable.

The challenges at the heart of this chapter can also be framed as challenges of identity negotiation. Work and faith gave the participants competing priorities surrounding prayer and evangelism. This evokes the dissonant models of identity, in which one or other of faith and work is subordinated. The 'tactics' they developed could be interpreted in several different ways. Rather than framing these 'tactics' primarily as compromises of faith, or the faith-self, they can also be seen as 'artful negotiations.' By thus navigating dilemmas around prayer and evangelism, the evangelical medics negotiated and created work-faith affinity within imposed boundaries. They worked to make their faith and work consonant. Affinity was, in some senses, restricted, but the participants nevertheless sought it out as far as possible. This affinity was achieved, rather than self-evident, but nevertheless

offers an important observation not highlighted by Baker and Wang. Both their religious and medical selves were important as the evangelical medics developed these 'tactics.' Medicine's boundaries were pushed as far as they reasonably could be in order to satisfy calls to prayer and sharing faith; the styles and extents of these faith-based practices were adjusted to meet these margins.

This is an opportune point to pause, and consider these medics' relationships with the NHS. As we noted in 'On Work and Worldviews,' Davies presents the NHS as a core British 'cultural frame,' explaining, '[t]he NHS has become its own manifestation of core cultural values and in that sense stands as a potentially sacred institution.'[55] The 'institutional' nature of the NHS comes across particularly strongly in this chapter, manifest in professional regulations and expectations. Above, the medics viewed the NHS as 'sacred' insofar as they were wary of how their faith corresponded with its expectations, and of potential consequences. Alongside negotiation, this often evoked negative emotions, rather than positive values. Elsewhere in their reflections and interviews, some, as we have seen, commented gratefully that the NHS being a universal healthcare system, free at the point of need, coalesced with their Christian values of compassion and care for the vulnerable. It seems, that for this group of evangelicals, it was their faith, rather than their national identity, which acted as arbiter over their perceptions of the NHS. Equally, however, this chapter has presented further reasons to resist over-associating the evangelical medics with protest against, or tension with, mainstream society, as manifest in the established, institutional NHS. Participants were wary of restrictions, yet negotiated with these, seeking out affinity. This is an interesting nuance to Davies' proposal, suggesting that further research into the relationship between evangelicalism, national identity and 'establishment,' particularly the NHS, remains very welcome.

Whether primarily out of fear of breaking regulations, genuine conviction that the regulations were appropriate and important, or both, in this chapter the participants sought and found solutions which satisfied them as both medics and Christians; or, indeed, as Christian medics. As we move to the final substantive chapter, and explore how their work enhanced the participants' faiths, this sense of synthesis and synergy as Christian medics remains at the forefront.

[55] Davies, *Mors Britannica,* pp.98-100. Indeed, I write this during the COVID-19 pandemic, on a Thursday, with some two hours before the nation will stop to 'clap for carers,' a new ritual embodying such values at a time of national crisis.

Growing

"My faith deepened"

Introduction

This final analytical chapter focusses upon what the evangelical medics felt were positive ways in which their work had shaped their faiths. These took several forms: holistic and specific growth; growth through change; and growth in 'synergy.' In order to explore growth, this chapter also revisits other themes from previous chapters, particularly the use of faith as a resource, calling, changing and questioning, considering how these relate to growth. It thus begins tying this thesis together, noting the interrelatedness of several faith consequences. It also offers further comment on how worldviews might be usefully conceptualised. A final section considers the relationship between stability and dynamism.

It is important to reiterate that this study does not capture the experiences of those who permanently lost or abandoned an evangelical faith as a consequence of healthcare work. Such consequences are important potential answers to this project's first research question, with implications for the second, which the sampling methods used did not facilitate. This does not invalidate the experiences presented in this chapter, or in this thesis as a whole. Rather, it properly acknowledges their partial nature.

Growing in Faith

Many of the evangelical medics felt their faith had grown, developed, or been enriched because of their work. The below examples echo Martinez and Baker's observation that some of the Christian psychodynamic counsellors in their study felt their faith 'matured' as a result of their work.[1] For example, John described his faith 'deepening' when he began medical training, explaining:

> I grew up in a Christian family […] So the faith was there, but […] I don't think I sort of, dug deep into my faith. But it was actually when I went to [medical school] – that's where I actually, my faith deepened, and I actually found a purpose of why medicine is important in the first place, as a Christian medic.

John linked this deepening of faith with realising a 'purpose' for his life. Several others similarly linked growing in faith with their senses of calling. We have already seen that Ruth gradually felt

[1] Martinez and Baker, 'Psychodynamic and Religious?', p.261.

'empowered' to see her work as a vocation and 'powerful service.' Martha felt 'encouraged' because her work facilitated her calling. She wrote, 'when I work, I feel that I am fulfilling my calling. I feel God equipped me to do medicine & do it well, so I feel encouraged & blessed to live this out.' Equally, as we have seen, Martha's awareness of her calling was also heightened where she felt she failed to enact macro-callings to patience, forgiveness and compassion. In turn, though, this sense of failure challenged her, and made her 'realise my own fragility and need for the Holy Spirit.' She thus turned to God to ask for help. This was an additional way in which Martha felt her work had helped her faith to develop.

Martha was also encouraged by her Christian colleagues, particularly because she could 'often spot that they are Christians and this is an encouragement to my own personal faith.' Catherine, similarly, described it as 'always encouraging' to hear that patients went to church. Both Philip's faith as whole, and his sense of vocation specifically, were bolstered through caring for Christian patients in their final days:

> I still find it a joy to be able to serve people in their moment of need, particularly with Christians […] the ones that are more memorable are the ones I've seen approaching their deaths, and it's been amazing to see the dignity in which they do so, with the Bible in their bed […] they're there reading their Bible and singing, you see the joy in their faces, because they've had sixty or seventy years of doing that. And it's just joyful to see that.

Simon explained:

> In many ways, working in medicine has strengthened […] my faith. Because it has required me to engage more intensively with the Bible. I've had to think through what the Bible teaches, both in terms of a theology of illness, and about being, uh, a leader.

Simon's work led him to seek out biblical frameworks and insights, focussing particularly upon illness and leadership. He believed growing in understanding in these specific ways had 'strengthened' his faith as a whole. This nurtured his perception that Christianity and psychiatric practice were compatible, and, as we noted in 'Compartmentalising,' he developed materials he hoped would encourage others to see this. As we saw in 'Resourcing,' Richard, among others, developed an understanding of death as both enemy and 'great hope.' Thus like Simon, Richard developed a framework in which his medical experiences and his evangelical theology cohered. The resultant framework was, in turn, a resource upon which Richard could draw when he encountered death at work.

A spiritual experience mid-way through her career had a significant impact upon Gwen:

> [You] agonise over what you think were possibly your medical mistakes. [I always used to worry] that I would get to heaven and have this queue of patients saying, "Why didn't you do this, why didn't you listen to me?!" […] I'd looked after a friend's mother […] and I went to the funeral […] And then half way through it, I remember thinking, "I hope I did everything right for her." And then, very clearly – you know, you do occasionally […] feel you get a very clear message – and it said, "[Gwen] you are forgiven. You are forgiven everything." And it was just like a load had dropped off my – […] my shoulders – "[Gwen], you are forgiven everything." […] [A]nd just a load dropped off – you are forgiven everything. Medical mistakes and all. There's no queue waiting for you. And I really did think there would be a queue waiting for me! […] you are truly forgiven.

The experience of hearing voices has attracted a great deal of research interest from numerous disciplinary perspectives.[2] Cook, exploring voice-hearing both scientifically and theologically, notes the potentially 'creative and transformative impact of divine speech in the world through the receptivity and responsiveness of human agents' within traditions where such experiences are normative.[3] Certainly for Gwen, this experience was transformative and edifying, these words (rather than an experience within healthcare work *per se*) encouraging and reassuring her. Resultantly, forgiveness became a more salient resource for Gwen. Her belief was reinforced and deepened, and became more significant. Her emotional relationship to her failures also changed, leaving her more certain and assured, even if worry did not wholly disappear. Similarly, Martha's belief about the world's 'need for Jesus' did not change, but her work had made her more 'acutely aware' of it:

> Working in medicine has made me see the ugly and broken up close - which sometimes makes me feel more cynical, and sometimes makes me acutely aware of the need for Jesus. Seeing brokenness up close makes me […] want conservative Christians to see how broken people's upbringing and lives can be - and open there [sic] eyes to see people with the softness and grace Jesus does.

Others described growing assurance in God's providence and control. Ginny developed a strong sense of God's guidance over her career, not least through witnessing a number of career changes fall into place. Gwen similarly reflected back on the ways in which God, she believed, had directed her career, including through what she called 'circuitous routes' and 'apparent setbacks.' She did, however, note, with several others, that her confidence in God's providence was firmer with hindsight, even as it had grown throughout her career. Nigel felt his faith was 'still' developing in this area, but he thought he was 'getting better' at trusting in God's ability to 'open doors.' He expanded:

> [I]t's clearly – when I look on back on [my career so far] – ooh, all these dots join up and it hasn't always been for my efforts, and I feel that when it has been for my efforts ah – it's, been

[2] Christopher C. H. Cook, *Hearing Voices, Demonic and Divine: Scientific and Theological Perspectives*, (London ; New York: Routledge, 2018), p.17.
[3] Ibid., p.17. See also pp.226-228.

> miserable! Prayers get answered. I'm just not very good at listening. […] And I'm not very good at doing it in a prospective way. But I'm getting better at being more accepting of this is where I am at the minute, this is what's happening, and – umm – and I don't know what's round the corner, but it will be ok.

This growing trust was emotionally significant, not least as it related to Nigel's sense of purpose within his medical meso-calling. While we noted in 'Questioning' that being a resource does not necessarily render beliefs impervious to doubt, it seems there are my also be close links between functioning as a resource and growth.

As we have noted, Stringer is foremost among scholars who emphasise the situational, fragmented nature of worldviews, suggesting that particular beliefs and facets gain significance and salience according to contextual needs.[4] The participants' descriptions of growth certainly support Stringer's suggestion. Thus Martha grew acutely aware of the world's 'need for Jesus,' and forgiveness took on new and particular gravity for Gwen. However, importantly, the evangelical medics described growth in relation to both particular aspects of their faiths, and in relation to their faith as a whole. For example, both Martha and John linked growing senses of calling with more holistic growth 'in faith.' Similarly, Simon linked his strengthened faith to deeper engagement with the Bible in particular. This is important with respect to debates as to how individual worldviews are best conceptualised. The above should not, however, encourage us to wholly follow Stringer and conceptualise personal faith as though it consists *only* of isolated parts.[5] Rather, these examples bolster the suggestion in 'Compromising' that individuals' evangelical faiths are helpfully conceptualised as *both* coherent and fragmented, and that scholars ought to move between these conceptualisations, holding them in tension. Certainly the participants in this study conceived of their faith in both ways, juxtaposing growth in general and particular terms, and moving easily between these planes.

Growth Through Change

The above examples of growth and development could also presented as examples of 'continuous change,' developments in intensity and salience standing in continuity with that which had gone before in the participants' faiths. This distinguishes them from the examples in 'Changing,' in which the medics articulated clearer breaks and discontinuities with their own previously-held perspectives. In some cases, however, growth occurred as a consequence of more discontinuous

[4] Stringer, *Contemporary Western Ethnography,* pp.49-51 and 109; Taves, Asprem, and Ihm, 'Psychology, Meaning Making, and the Study of Worldviews,' pp.212-213; Droogers, 'The World of Worldviews,' pp.24-25.
[5] Stringer, *Contemporary Western Ethnography,* pp.49-51 and 109; Allport, *The Individual and His Religion*, p.19; McGuire, *Lived Religion,* pp.4, 12 and 15-16.

changes. For Akua, for example, growth was closely tied to questioning, and resultant reconfigurations of her faith:

> [M]edicine has made me less willing to be bothered about certain things in my religious practice and made my faith more open ended in a good way. I am more willing to say "How does that work God?" when something confuses me. I'm more inquisitive and the advantage is I'm able to think more broadly […] This has made me more willing to think about how different people will experience the same God and how not everyone will experience God the same way. I've become more relaxed in my faith without things needing to follow a strict pattern. It's refreshing.
>
> […] Medicine has made me more interested in these things, the basics of things, our makeup and who we are rather than the religious sides of things and questions about practice. When you see people in this really raw state you think the God thing must be more about the basic stuff. It must be less about the flowery extra things […] I tie my faith more to the everyday experience and sometimes the other sides of it can feel separated. However, I think that's why I've become more discerning about practices of religion that I can relate to. I can tell better if I am uncomfortable in a religious context, if I feel they are too far removed from the basics of life. Medicine puts you in the situation where you see people in their most vulnerable state so it's very important for me to know my faith is applicable.

Akua described a shift towards 'questioning,' 'becoming more discerning,' and 'being more inquisitive,' as well as 't[ying] […] faith more to the everyday.' In her interview, she depicted a shift towards essentialising her faith:

> [W]hen someone would say "This isn't allowed" in our religion […] I'm more likely now to say, I interpret it this way, and I understand that you might interpret it differently, and therefore I don't think it's key to the point of the faith […] [Because I] worry about what people who don't know these things – what – so, does it – does one have to know it to believe the right thing, how – what if they don't believe the right thing, umm. So theologians can make such distinctions between phrasing, of – and I just sort of start to think, like, well someone on the street's not going to get the difference! Does that invalidate their faith?! So! So it's sort of almost like, it's interesting, but it can't be essential. So, umm, and I think for me, understanding where – like, faith in a practical sense has become much more essential.

While the changes she describes might, to others, represent continuous changes, it is significant that Akua interpreted and presented them as indicative of a significant qualitative change in her religious outlook. As we have noted, Sharma and Guest observe that some find such 'reconfiguring' unsettling, even precipitative of a 'make or break' decision about faith.[6] Yet Akua framed these changes as both significant and positive, describing them as 'refreshing' and 'an advantage.' She felt her faith was more grounded in, and relevant to, her day-to-day experiences of healthcare as a result, something she considered 'important.' By galvanising such changes and developments,

[6] Sharma and Guest, 'Navigating Religion between University and Home,' pp.65 and 69; Guest et al, *Christianity and the University Experience*, p.203.

Akua's time at medical school had, positively, helped her faith to grow.[7]

Mel, like Akua, experienced growth as a result of questioning and changing. We have already explored Mel's experiences working with abortion patients, and witnessing the death of a young Jehovah's Witness, both of which made significant impressions upon her, and upon her faith. These, and other emotive episodes in her nursing career, contributed to her faith 'seem[ing] to go AWOL for a season.' In the short term, this was acutely painful for Mel. However, in the long-term, it both transformed and strengthened her faith. She wrote:

> A&E for me was the most challenging, scary, and at times faith killing places to have worked, but it was also the most fulfilling, humbling, and glorious places I have ever worked that in hind sight [sic] has gifted me more that has built my faith than lots of safe church Christianity things have.
>
> Through A&E I encountered the truth of a God who suffers and can be found in utter hopelessness. In A&E people hurt, weep, their lives are changed forever and usually it's because they have known and experienced, given and received and sometime lost love in some measure. In A&E the things that truly matter matter. As an evangelical I think at times we spend too long on focussing on the triumphant glorious Jesus and don't hold in tension the Jesus acquainted with grief and suffering.
>
> Through working in A&E I realised if I couldn't find God there then the God I say I believe isn't really worth knowing!
>
> I also learnt that to do the job well I couldn't make rash judgments about others, there'd always be one bit of info I would find that might make sense of how they were just at that moment. Listening to other people's stories is a privilege and shouldn't ever be rushed or taken for granted. Most people are really good and there is a lot of good in this world even in tragedy.

Through shorter-term challenges, Mel's work ultimately 'built' and transformed her faith. Her experiences fostered an increased willingness to question, and heightened awareness of both a God who 'suffers and can be found in utter hopelessness,' and of the importance of not 'making rash judgements.' Mel's time as a nurse, and the journey it led her on, also affected how she approached the Bible. She felt she could no longer uncritically adopt her previous, conservative approach:

> [I]t came down again to [questioning] an evangelical approach to scripture and how we must iron out all the creases and demystify all faith things and push forward a God of the gaps who can't ever be questioned or argued with or held to account.

While she still felt that she had not found fully satisfactory answers to some of her questions, Mel nevertheless came to a place of trust. Reflecting on the death of the young Jehovah's Witness, she said:

[7] Change was, again, in favour of greater work-faith affinity.

> I don't think I've ever really come to anything that […] I don't think that will ever sit comfortably with me […] I just have to trust that, at the end of the day – and when we talk about God's will being done, I just have to trust that at the end of the day, that God's love for all of us involved in that […] prevailed in some way […] because the alternative is that I [was] part of something […] that actually was an abhorrence to God.

Thus Mel, like several others, eventually found within her faith resources which helped her, to an extent, to manage her uncertainties. Mel also believed her experiences in both A&E and the HIV clinic had bolstered her subsequent vocation to ministry. With hindsight she saw godly purpose in what she described as initially a circumstance-based decision to train in nursing, and the challenges it had presented:

> [A]ctually everything I'd been involved in then was going to be really helpful […] we've been round to see somebody and they're dying [or a] person died […] that's really quite normal, for me […] that doesn't hold *any* fear […] and people in crisis […] if you've been in an A&E department, you, there's not a lot that really shocks you […] That calm – even if inside you're going "Oh God what's going on!?" […] all of that has been like, really, really very helpful. […] I think that it's helped with dealing with people.

> [The HIV clinic] had a huge impact on me and my thinking about faith, and also now, being in ministry has hugely impacted my theological thinking […] and definitely in hindsight I can see that I was in fact through these experiences being led deeper into the reality of this God's love acceptance and grace. It was the first place that made me question whether God could possibly be more in evidence within this environment than in the comfort and cosiness of the church life and faith I had been brought up with.

Such questions and changes contributed her faith's transformation, which Mel considered and presented as a form of growth.

Mel's narrative affirms the importance of taking both long- and short-term views of faith consequences, and recognising that short-term negative changes can, ultimately, lead to positive outcomes. We noted this in 'Taking Stock,' citing Haynes and Kelly's observation that some Christian clinicians' faiths are shaken by their work, but in the long-term are repaired and strengthened; Sabo and Moss make similar observations.[8] Moreover, as we have seen previously, Pearce and Denton conclude that interrogating their faith can, ultimately, bolster adolescents' religious worldviews and identities.[9] It seems we might extend this cluster of observations to evangelical medics.

Growing in Affinity

The above has added a final, significant answer to the first research question: the evangelical medics consistently felt that their faith had developed positively or 'grown' thanks to their work. The

[8] Haynes and. Kelly, *Is There a God in Health Care?,* p.104; Moss, *Religion and Spirituality,* pp.45-47; Sabo, 'Compassion Fatigue and Nursing Work, p.138.
[9] Pearce and Denton, *A Faith of Their Own,* p.180.

medics' perceptions of growth were often related to other faith consequences explored in this thesis, particularly calling, resourcing, questioning and changing. In Mel's case, experiences which challenged her faith ultimately left her with a sense that her faith had been positively transformed by her experiences working in healthcare.

Growing also evokes again work-faith affinity and the consonant identity model. Certainly a 'relationship of reciprocal attraction and influence […] and mutual reinforcement' was prevalent in the above examples. Through growing in faith, many participants felt better equipped for their medical work, just as they considered their work conducive to their faith's edification and enhancement.[10] For example, Simon grew in faith as he grew as a leader, and in understanding of illness, and both had proved valuable frameworks across the course of his career; Martha felt sustained both spiritually and professionally by her sense of calling; Akua felt that her faith had become more relevant to her work. These examples recall Haynes and Kelly's suggestion that healthcare work can reinforce faith and, in turn, create a sense of mutual reinforcement between faith and work.[11]

While many of the above examples of growth thus also highlighted work-faith affinity, Ruth specifically emphasised the latter, describing a growing sense of 'synergy' as a Christian psychiatrist. In her reflections, she wrote: 'It has taken me time to be able to grow and mature as a Christian as well as a psychiatrist, best when this is simultaneous, aiming for a synergy.' She explained:

> [I] think it's possible to reconcile a Christian worldview with psychiatric practice. I don't think that in the individual happens overnight. […] I think I have to have a synergy in my mind and in my heart. The one way that I've sought to bring that out is through my own personal growth and understanding. […] one has a drive and a motivation to become more mature as a Christian and also more mature as a psychiatrist.

Ruth's faith developed, but she also saw this as an investment in her work, and in her sense of work-faith synergy. She linked these forms of growth to her developing sense of vocation, and time devoted to church and Christian literature. Ruth also anticipated future growth, explaining 'I know I have many, many, God-willing, years left, of growth, of learning to do, and I'm hoping I'm going to grow in wisdom.'

Conceptualising Growth

As the quotes above show, the participants used a diverse vocabulary to articulate the positive ways their work had shaped their faith. Some described their faith, and particular aspects of it, as

[10] Löwy, 'Le concept d'affinité élective chez Max Weber,' p.100.
[11] Haynes and Kelly, *Is there a God in Healthcare?,* pp.196-197. See also pp.96-97.

'growing.' Others used spatial images, for example 'moving' or 'being led' to deeper understanding, or 'building' their faith. Many described their faith being 'strengthened,' 'deepened' or becoming 'more mature.' Some felt 'equipped' or 'encouraged.' Several reported being made 'acutely aware,' or made to 'realise' or 'see' particular facets of their faith with particular vividness or clarity. Others felt 'reminded' or reflected upon particular things 'more.' Nigel described 'getting better' at trusting God's providence.

Conceptualising growth in linear terms is helpful in relation to much of this linguistic variety, especially where the medics' expressions evoke sequence, progress, or cumulative development. However, in some cases, linear conceptualisations risk flattening nuances. For example, Nigel certainly articulated linear or cumulative growth: 'times when I've been moved "up" a step, and, and I have grown in understanding and awareness.' Equally, however, he described fluctuating interactions between work and faith:

> Perhaps there are days when I just go and do the job. And it's about going through all the processes. And there are days when I think, actually, God was really at work in this, in that conversation, in that relationship.

Though Nigel depicted overall growth, he also described his faith's fluctuating significance. The latter is more difficult to capture within a linear model. As we saw in 'Compartmentalising,' Goodluck also experienced such fluctuation, whereby he could 'often go a working day without even thinking about my faith.' We have also explored his feeling 'distant' from his faith, when he 'let other things get in the way […] it wasn't conscious choice, it was just busyness.' Hannah described her faith 'journey' in the year prior to our interview, the period during which, as we have seen, she too felt 'distant' from God. Both, as we saw, had come through these difficult periods. A linear narrative alone would mask such complexities, whereby they perceived that they had grown in faith even as they felt 'distance' from God.

In relation to their respective studies of faith's interactions with particular life contexts, Sharma and Guest and Pearce and Denton critique the widespread tendency to frame religious identity in primarily linear terms, particularly with narratives of intensification or diminishment.[12] Certainly Hannah, Nigel and Goodluck's accounts suggest that thinking only in linear terms risks oversimplification, omitting fluctuations within overarching narratives of faith's growth. That is not to say linear frameworks are wholly unhelpful: as the quotes above show, people experience and thus often describe the interface between their life and their religious identity chronologically. When

[12] Pearce and Denton, *A Faith of their Own,* p.174; Guest et al, *Christianity and the University Experience*, p.119.

mapping narratives such as Mel's, of short-term disintegration ultimately fostering long-term growth, chronology is requisite.[13] Linear frameworks must be used lightly, expectant of and intertwined with due attention to dynamisms, fluctuations and nuances.[14] Indeed, this is precisely Fowler's admonition. Fowler's work on faith development – a 'theory of seven stagelike, developmentally related styles of faith' – emphasises the sequential and ineluctable nature of developmental stages.[15] Yet even he acknowledges that 'the reality of any such complex process will not be exhaustively contained' in such a model.[16] He recognises both the 'unique features and […] predictable stages' of faith.[17] However useful linear conceptualisations may be, these ought not lead researchers to lose sight of complexities, fluctuations and idiosyncrasies.

This linear-yet-nuanced conceptualisation is also particularly valuable in relation to broader evangelical narratives of faith development. Two particular linear portrayals of growth are important in evangelical discourse: those emphasising single moments of conversion; and, as Guest describes them, those 'conceiving faith as a journey and emphasis[ing] growth and discipleship over dramatic transformation.'[18] While many evangelicals attribute great significance to personal conversion experiences, and subsequent personal transformation, discipleship journeys can either follow the former, or exist without any such rupturing moment.[19] The question of which to emphasise has, at times, divided evangelical camps.[20] Within both narratives, evangelicals typically emphasise God's role in transforming the individual.[21] As Guest notes, from the mid-20th century, 'sanctification' became an important framework among British evangelicals, emphasising renewal and growth through the Holy Spirit's indwelling within the individual.[22] Sanctification brings with it an expectation, perhaps tacit, of progress, of becoming 'more-Christ-like,' 'more obedient' or even 'less worldly.'[23] Particular significance is also awarded to spiritual experiences. As Smith explains, these

[13] Haynes and Kelly, *Is there a God in Healthcare?,* p.104.
[14] Baker and Wang, 'Examining Connections between Values and Practice,' p.134; Pearce and Denton, *A Faith of their Own,* p.174.
[15] Fowler, *Stages of Faith,* p.xiii.
[16] Ibid.
[17] Ibid., p.xiv.
[18] Guest, *Evangelical Identity and Contemporary Culture,* p.37.
[19] Smith, *American Evangelicalism,* pp.28 and 173; Strhan, *Aliens & Strangers?,* p.85.
[20] Guest, *Evangelical Identity and Contemporary Culture,* p.37.
[21] Strhan, *Aliens and Strangers?,* pp.130, 138 and 185.
[22] Guest, *Evangelical Identity and Contemporary Culture*, p.37. Among American evangelicals in particular, sanctification often takes on social significance, in the hope for 'an aggregation of individual spiritual conversions and moral improvements as the pathway to true redemptive social change.' See Smith, *American Evangelicalism*, pp.190-192.
[23] Strhan, *Aliens and Strangers?,* pp.28, 112 and 172; Smith, *American Evangelicalism,* p.132.

'serve as epistemological anchors […] verifying and validating many people's religious faith.'[24] We have seen precisely this in Gwen's story of attending her patient's funeral.

These linear narratives, however, are consistently interspersed with acknowledgment of failure. This comes across strongly in Strhan's *Aliens and Strangers*. Her conservative evangelical participants at once felt they were 'becoming disciples' and experienced 'ongoing struggles' with this formational task.[25] Alongside significant narratives of growing, developing and progressing in discipleship was a persistent expectation of shortcoming, because of humanity's fallen nature.[26] For example, while they hoped to gradually form a 'disposition of obedience' to God's will, they recognised this would be inhibited by 'idolatry of a cultural norm of self-determination.'[27] Progress and growth were desirable, achievable through God and the Spirit, and yet also fundamentally thwarted.[28] Citing a sermon she listened to during her fieldwork, Strhan dubs this 'wobbly discipleship.'[29] As we observed in 'Questioning,' that this term and acknowledgement came from the pulpit is important, for it normalised failures and fluctuations within discipleship journeys.[30] This, Strhan suggests, challenges 'standard academic' analyses of evangelicalism, which 'ha[ve] not drawn attention to this complex dialectical interrelation of having and not-having, belief and unbelief, that many […] experience as an everyday tension.'[31] In several of the foregoing chapters, we have seen the evangelical medics similarly utilising beliefs in the fall, fallibility, and the inevitability of failure to rationalise both difficult experiences and what they felt were their shortcomings (though this is not to say they felt resultantly easy about them).

Strhan suggests these narratives of gradual growth and failure perpetuate one another: following inevitable failure, '[evangelicals'] learnt sense of guilt serves to bind them more closely in their sense of relationship with God in an ongoing process.'[32] Moreover, the narrative of inevitable shortcoming is met with significant emphasis upon God's forgiveness and redemption. Redemption thus becomes a past, salvific reality, and a critical element of present and future discipleship.[33] Certainly Martha's experience of turning to the Holy Spirit's transforming power echoes Strhan's observation.

[24] Smith, *American Evangelicalism,* pp29-30 and 173-175.
[25] Strhan, *Aliens and Strangers?,* p.5.
[26] Ibid., pp.85, 169-171 and 190.
[27] Ibid., pp.111-112.
[28] Ibid., pp.110-111; 130-131.
[29] Ibid., pp.112 and 195.
[30] Ibid., pp.187-188.
[31] Ibid., p.172. See also p.185.
[32] Ibid., p.28. See also pp.172 and 189.
[33] Ibid., p.189.

As such, both the growth articulated by the evangelical medics, and broader evangelical narratives of growth and discipleship with which the medics were familiar, are best conceptualised as simultaneously linear and fluctuating. Figure 5 is one means of depicting this conceptualisation. Narratives of 'journey,' discipleship or growth, and of 'fallibility,' and inevitable failure, are interrelated, even spurring one another on like cogs in a machine, as Strhan suggests. The 'journey' narrative may or may not be related to the additional propelling narrative of 'conversion.' While growing and developing are presented as aspirational ideals, the evangelical medics, in tune with evangelicals more broadly, recognised that these were intimately linked to the fluctuating, complex reality of the human condition.

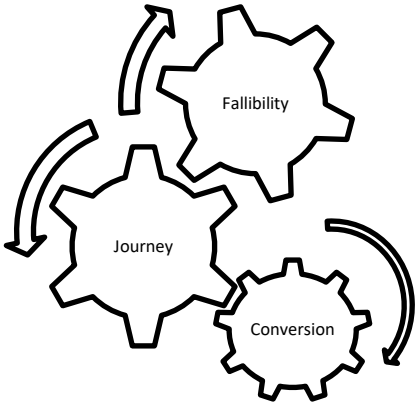

FIGURE 5 - EVANGELICAL CONCEPTUALISATIONS OF GROWTH

Two additional notes are important. In the first place, not all felt that their work had – or had yet – helped their faith to grow or develop. Indeed, Liam divorced his faith's development from his work, explaining 'I've found myself growing more in my faith this year but am still not exactly sure what this looks like at work.' Certainly he did not cite work as a significant contributor to this growth. Secondly, it is also important to note, as the participants did, that work was not the sole stimulus of their faiths' development. Simon described a significant period of development before starting medical school. When serious illness prevented him from taking his A Levels, he felt it was 'miraculous' that he was admitted to train as a doctor:

> [T]hat actually had quite a substantial effect on me from a spiritual point of view […] I came from a Christian home, and I would have said I had made a commitment, but I don't think it was real to me. And then in the sense of, apparently, everything being swept away – and then […] them

> offering me a place without condition, did seem to me a fairly miraculous intervention. And that was the sense of moving from actually "this is all about me" to thinking, beginning to think that actually this is not just all about me, this is about - about something which is rather bigger than me.

Similarly, Goodluck described growing in faith and 'as a person' at medical school, attributing this as much to churches' and friends' support as to his studies. Hannah, describing her growing sense of calling to medicine, attributed it to 'grow[ing] […] in - like, maturity! [Laughs] Obviously. But also in […] faith, and like, - and in the [medical] context.' Nigel, reflecting upon the importance of 'knowing oneself' in order to be a resilient child psychiatrist, suggested it was important to have:

> good […] understanding of where your faith is at […] If you know that love of God [then] whatever comes will be challenging […] [But] you know you'll find a way through […] It is about knowing yourself, but as part of that, knowing where you sit with God.

Nigel's faith was strong and stable insofar as it served as a resource. However, he implied it needed to be thus *for* his work, rather than directly suggesting that his faith had grown *through* his work. Jeremy's sense of calling led him to reflect on spiritual growth, articulating affinity between medicine and 'the traits that I believe God has given me/is growing in me.' This phrasing does not explicitly suggest that medicine was the cause of this growth, but rather the site of growth. James, who had converted to Christianity during his first year of medical school, suggested '[t]he key difference for me is not what my life is like, but how I go through it on a day-to-day basis. I constantly see God using all things for His will.' Again, it was not that medical school strengthened his faith, or that any particular element of medicine had caused him to see God at work: rather, James interpreted work through a post-conversion hermeneutic, which in turn strengthened his faith in God's providence and control. It is worth noting that many participants attributed their faith's growth to God. James talked about God using everything for *His* will. Jeremy described the traits that *God* was growing in him. Whether attributed to healthcare work or not, participants consistently viewed their growing in faith as God's work, in line with broader evangelical narratives and theologies of sanctification.

Development and Constancy

The above has explored the evangelical medics' narratives and perceptions of growth and development, both of their faith in general, and of the significance and salience of particular facets. Such growth highlighted and affirmed work-faith affinity: indeed, Ruth articulated a growing sense of synergy between work and faith. This chapter has also reinforced the importance of viewing individuals' faiths as both the sums of parts and coherent wholes, and of taking both long- and short-term perspectives. Linear narratives are helpful in articulating growth, but need to accommodate

and anticipate fluctuations and complexities. Additionally, we have seen the participants' recognition that medical work was not the only reason that their faith had grown or developed. Equally, that is not to say it was not an important contributing factor for many of the evangelical medics.

Growing joins the other faith consequences portrayed in previous chapters to sketch a map of the potential ways in which healthcare work can affect evangelical medics' faiths and identities. Together, these highlight the dynamism of evangelical faith as it interacts with medical work, substantiating Baker and Wang's suggestion that the consequences of healthcare work are fluctuating and complex, and not stable or static.[34] Yet it is important to highlight the obvious but significant point that all of the dynamisms in this study – both of faith, and of the circumstances which the medics' faiths encountered – occurred against a backdrop of stability. This study does not capture the experiences of those who lost faith permanently as a result of healthcare work, for whom healthcare work was profoundly destabilising from a faith perspective. For Mel, this occurred in a time-bound manner, her faith's eventual growth and transformation precipitated by a period of instability. Since this study focusses upon those who retained an evangelical faith, we should not be surprised that stability significantly characterised the relationship between participants' work and faiths. Amid all of its dynamisms, most of the evangelical medics in this study were never without their faith.

Certainly participants articulated growth and development alongside their faith's stability.[35] For example, Simon felt his faith 'matured' across his career, yet depicted its constancy, saying, 'I was a Christian – my primary identity was as a Christian.' Richard reflected that had always 'felt confident as a Christian in medical practice. It always seemed very much in keeping as a caring profession with Christ's command to love our neighbour, and his example of healing.' When I asked whether his faith had been stable across his career, he juxtaposed this with periods of fluctuation:

> JR – Is it fair to infer, by and large, that your faith has been quite stable across your career?
>
> Richard - I mean, I'm – it, it has. There have been times when, umm, uhh, I've not been as good at, umm, uhh, practicing it, or I've gone through a sort-of uhh – low spells, from the point of view of, umm, uh – sort of, actually sort of living the faith, or feeling sort of uplifted by it, but I've never had, uhh, serious doubts or, or wobbles.

[34] Baker and Wang, 'Examining Connections Between Values and Practice,' p.134.

[35] It is important to differentiate between constancy and stasis, and stagnation: where Goodluck felt he allowed his faith to stagnate through busyness and distraction, many participants articulated the beneficial manner in which their faith had remained a constant throughout their careers.

Nigel intertwined growth and stability when he explained: 'Having always been a Christian […] certainly [there have been] times when I've been moved 'up' a step and I have grown in understanding and awareness but, um, it – it is part of who I am.'

Indeed, for some, their faith's constancy was inherent to its development, particularly insofar as it had functioned as a stable resource, or prevented their work from destabilising their faith. As we have already seen, Ruth emphasised the sense of stability and security provided by 'retaining my sense of identity as a Christian,' and being 'secure' in her 'identity in Christ' and 'hope of heaven.' She used and depended on her faith's stability at work, even as she also expected it to grow. Alongside its growth, Martha depicted her faith as stable insofar as she could rely upon it: 'When things have been hard […] then turning to God has been something which has carried me through.' Sarah cited having a stable, resourcing faith among the joys of being a Christian in medicine: 'Having a strong faith means you have the power of God in your life when things are difficult.' Ruth, Martha and Sarah were grateful for their faith's constancy and stability amidst challenges.

As we saw in 'On Work and Worldviews,' Taves, Asprem and Ihm, following Droogers, suggest that worldview research should concern 'the meaning-making processes through which people create and develop worldviews over time.'[36] They specify that this will involve studying 'both the emergence of new worldviews and the maintenance of established ones.[37] This thesis, by exploring a range of faith consequences, has explored both the maintenance and development of evangelical faith, considering diverse ways in which faith is both deployed in and shaped by healthcare work. Thus, when Taves, Asprem and Ihm suggest that worldviews must be studied insofar as they are both maintained and developed, it seems we must expect maintenance and dynamism not only to both occur, but to co-exist and inform each other.[38] The participants' faiths were shaped by and deployed in their work only insofar as they also remained constant. In turn, the medics' drives towards work-faith affinity, and senses of consonant identity, derived from a faith at once inherently dynamic and permanent.

Indeed, well beyond the confines of this study, faith needs to be dynamic in order to be constant and stable, in order to weather and face life's dynamics. Fowler describes faith as 'a person's or a group's way of moving into the force field of life. It is our way of finding coherence in and giving meaning to the multiple forces and relations that make up our lives.'[39] This thesis certainly echoes

[36] Taves, Asprem and Ihm, 'Psychology, Meaning Making and the Study of Worldviews,' p.210.
[37] Ibid.
[38] Ibid.
[39] Fowler, *Stages of Faith*. *Stages of Faith*, p4.

Fowler's presentation, recognising faith as a source of meaning and coherence even as evangelical medics met 'multiple forces and relations' in the 'force field of life.'

Conclusion

This chapter has added a final significant stroke to this thesis's portrait of how healthcare work can affect evangelical worldviews. It has explored ways in which healthcare work enabled the evangelical medics' faiths to, as they perceived it, develop in positive ways, or 'grow.' It has considered growth, both on a holistic level and of more particular areas. Both forms were evident as consequences of questioning and changing, as well as closely related to senses of calling, and of being resourced by faith. It suggested that these different forms of growth contributed towards the medics' senses of work-faith affinity. Indeed, some described a growth precisely in work-faith affinity, or 'synergy,' between their roles and identities as medics and Christians. Thus, amid the multiple ways in which the evangelical medics framed and interpreted their 'worldly' work, they also saw it as a site in which their faith could grow and be nurtured. Finally, this chapter juxtaposed growth with stability. Even as the participants presented their faith as growing, developing and dynamic, they also – gratefully – noted its constancy. Far from being opposite forces, dynamism and stability were related processes in these medics' faiths. Both were important to their senses of work-faith affinity and consonant identity, and both fostered their faiths' development.

It is important to treat these narratives of growth with care. The participants often did not attribute growth solely to their work, but rather saw their medical experiences as one of several factors contributing to their faith's development. Others, often in addition to an overarching narrative of growth, described nuances and fluctuations in their journeys of faith. In this, they closely mirrored broader evangelical conceptualisations and expectations of growth. As such, it is important to avoid imposing linear frameworks where these would serve to obscure such details, which contribute to a richer understanding of how faith is 'deployed in' and 'shaped by' healthcare work.

A final note before the next chapter draws together the final threads. It is perhaps tempting to see several of the faith consequences explored in this thesis as issues not only of discipleship and faith development, but of 'growing up' more broadly. More specifically, they could be taken as experiences of coming to terms with the sometimes harsh reality of adult, professional life, within the medical world. Consider, for example, participants' disappointment that they could not use prayer in the clinic as they wished, or in ways they felt would help. Recall their frustration and sadness at difficult ethical situations, in which 'black and white' evangelical ethical discourses were apparently insufficient, or two important Christian values could not coalesce. Failures and compromises saw the medics fall short of what they perceived to be good ideals, which they hoped

their medical meso-callings would enable them to embody. Childhood and student days of regular church involvement and attendance were consistently and often painfully disrupted by the demands of full-time work outside a regular 9-to-5 pattern. Many struggled working in a health service they felt was often under-resourced, in which time was at a premium, and people and their needs overlooked.

While some of the lessons the participants learnt through healthcare work could be presented as part and parcel of 'growing up,' we must not *reduce* their experiences in this vein. In the first place, it would be unhelpful, since many of the experiences to which it might apply – particularly of failure and compromise – occurred at a variety of ages and career stages. In the second place, this is not how the participants presented these consequences. Rather, they utilised the cultural narratives available to them through their evangelical socialisation: those of living in a fallen world; of 'wobbly discipleship;' or being 'in but not of the world.' They presented particularly evangelical readings of the process of developing as a professional in healthcare work.

As a middle way, perhaps it is helpful to frame such faith consequences as the participants grappling with the gap between ideal and reality. In many ways, this gap is at the heart of the transition from childhood to adulthood. Yet it also relates to evangelical conceptions of living caught between eschatological ideal and worldly reality. Indeed, the 'wobbly discipleship' they experienced saw them striving for biblical and Christ-like (macro-)ideals against the backdrop of fallen reality, even as they felt assured that they would met by God's forgiveness. Equipped with learnt narratives of fallenness, calling, and being 'aliens and strangers,' the evangelical medics gave their own particular interpretations and readings of this broader, human narrative of transition and of coming-to-terms with reality.

Summary and Recommendations

Recognising the relative paucity of research into the consequences of healthcare work for religious and spiritual medics, this thesis has explored how evangelical faith interacted with healthcare work for a sample of medics in England. Following the Introduction, three chapters laid important groundwork. 'Taking Stock' synthesised existing scholarship concerning healthcare work's consequences in religious and spiritual practitioners' lives. 'On Work and Worldviews' demonstrated the value of blending lived religion and worldview approaches in order to conceptualise evangelical medics as dually socialised agents, inhabiting two worldviews, both of which were important to their identities. The Methodology set out the study's 'autobiographical elicitation' methodology, detailing the data-gathering and analysis processes used to collect and collate the evangelical medics' narratives and insights. This chapter summarises the contributions made in the nine following analytical chapters, answering this thesis's two research questions and summarising its insights in relation to three additional theoretical themes: evangelicalism; conceptualising worldviews; and emotion. It then makes several practical recommendations, and calls for future research.

Faith Consequences

This thesis's first research question asked: 'How can working in healthcare affect evangelical faith?' Each analytical chapter has focussed upon one of the several potential 'faith consequences' identified in this study. Together, they build a cumulative answer to the first research question. This cumulative answer incorporates both ways in which the evangelical medics 'deployed' their faith in their work, and ways in which their faith was 'shaped by' their work.

We began by exploring 'Calling,' particularly noting that while the medics often deployed their senses of vocation as resources, these could also become burdensome. 'Resourcing' further showed the evangelical medics deploying their faith as a resource, not least in response to challenges of death, suffering, meaninglessness and loss. In 'Opposing,' the participants deployed their faith in order to resist trends in medical ethics. Additionally, though, we observed that healthcare work rendered many participants more aware of ethical complexities and 'grey shades.' These 'grey shades' remained important in 'Changing,' where we focussed primarily upon how faith can be 'shaped by' healthcare work. Participants addressed tensions at the interface of faith and work – in this case, oriented primarily around contentious medical ethical issues – by changing particular

aspects of their faith. In 'Questioning,' we noted that healthcare work can stimulate both holistic and circumscribed uncertainties and doubts among evangelical medics.

The following chapter showed that compartmentalisation, in the forms of 'erecting cognitive and emotional barriers' and creating separate self-states, occurs among evangelical medics, against the logic of having faith shape all areas of life. We suggested that where compartmentalisation occurred, it was an important form of identity defence. 'Compromising' observed that healthcare work can cause what participants considered to be compromises, a source of emotional discomfort. 'Negotiating' explored the contentious topics of prayer and evangelism, observing the 'tactics' the medics used to uphold both Christian and medical commitments in the clinic. We suggested that working in healthcare had encouraged the participants to negotiate within a mesh of expectations hailing from both their religious and medical socialisations. Finally, in 'Growing,' we examined the evangelical medics' perceptions that their work had helped their faith to grow and develop.

This range of faith consequences, in which faith was both 'deployed in' and 'shaped by' healthcare work, takes us some distance from Baker and Wang's finding that 'rather than being of reciprocal influence, religious beliefs influence clinical practice, but not vice versa.'[1] However, alongside this monodirectional relationship, Baker and Wang also observed that their participants' 'sense of identity as Christian psychologists – the experience of "the connections" between work and religious commitment – was one of fluctuation, rather than of static position.'[2] The diverse faith consequences which characterised the evangelical medics' narratives and experiences allow us to draw an analogous conclusion in this study. Across the broader range of English healthcare contexts explored above, the evangelical medics experienced connections between their work and faith in numerous and diverse ways. In observing and exploring Calling, Resourcing, Opposing, Changing, Questioning, Compartmentalising, Negotiating and Growing, this thesis has begun mapping the broad contours of healthcare work's potential consequences for religious and spiritual healthcare practitioners. Other researchers might now supplement, adjust and challenge these initial landmarks in light of further research.

Identity Implications

The second research question asked what the implications of such faith consequences were for evangelical identity. 'Calling' introduced three identity conceptualisations: consonant; hierarchical; and inverted hierarchical (see Figure 3). The consonant identity model, indicative of work-faith affinity, was consistently significant. In this respect, 'Resourcing' and 'Growing' were two sides of the

[1] Baker and Wang, 'Examining Connections Between Values and Practice,' p.134.
[2] Ibid.

same coin, each emphasising one half of a mutual relationship between work and faith. In 'Resourcing,' faith supported the medics' work; in 'Growing,' their work supported and bolstered their faith. In 'Questioning,' one of several places where we saw the medics acting and reasoning both *qua* Christian and *qua* medic, affinity and consonance were further evident, these two significant constituencies of the participants' identities cooperating and cohering. This chapter also critiqued suggestions that questioning ought to be considered a form of negative religious coping. Instead, it highlighted several participants' perceptions that questioning posed no challenge to their consonant senses of identity. Where affinity and consonance were perceived, or perhaps self-evident, in 'Resourcing' and 'Growing,' these were *achieved* in 'Changing.' Here, we suggested that the medics sought to reduce cognitive dissonance by changing their perspectives or viewpoints on ethical topics, and thereby achieve greater work-faith affinity and consonance: a better 'fit' between their work and faith.

In other chapters, identity consonance co-existed with a more dissonant, divided conceptualisation. For example, we noted that the medics' senses of vocation highlighted profound affinity and consonance between their work and their faith: yet these equally raised concerns that a meso-calling might become an idol, inappropriately inverting an ideal 'hierarchy' of identity in which the faith-self is prioritised. Importantly, the participants aspired to *both* the consonant and the hierarchical identity conceptualisations. That is, they aspired to be both 'Christian medics,' and – as James and John phrased it – 'Christian first and a medic second.' This was latent in Simon's suggestion that he wanted to 'work first for the Lord.' He saw medicine as a space in which he could work 'for the Lord,' yet must also, carefully, put the Lord 'first.'

In 'Opposing,' the hierarchical conceptualisation was particularly important, as many participants prioritised Christian commitments amid complex ethical reasoning. However, this chapter also suggested that drives towards work-faith affinity and consonant identity were nevertheless to be found, not least insofar as opposition was selective. This closely echoed Smith's suggestion that, for evangelicals, a mixture of engagement and distinction is theologically important.[3] In 'Opposing,' the hierarchical, dissonant identity conceptualisation required a backdrop of consonance and affinity to remain workable. Thus in this chapter, it was particularly clear that consonance, hierarchy and affinity were all essential features of these medics' identities, enabling them to thrive as 'Christian medics' who were also 'Christians first, and medics second.' Similarly, in 'Negotiating,' we suggested that consonance and work-faith affinity were to be found even amid apparent tensions.

[3] Smith, *American Evangelicalism,* p.218.

In ‘Compartmentalising,’ the participants echoed a broader evangelical universal identity logic, expecting their faith to feature in and characterise all parts of their life. In seeking work-life balance they evoked the hierarchical conceptualisation, for it was the work-self which was to be curtailed, not the faith-self. Thus, again, the medics had theological reasons for aspiring to a hierarchical identity conceptualisation. Exploring other forms of compartmentalisation, we suggested these were employed for the sake of identity defence. Significantly, it was both the participants’ consonant identities as ‘Christian medics’ *and* their faith-selves in particular which were defended.

From an etic perspective this dual aspiration appears illogical. However, this was not a concern among the participants. Indeed, they moved freely between these identity conceptualisations, not recognising that they were potentially contradictory or at odds. Additionally, the participants often firmly articulated their aspirations towards both conceptualisations. We suggested at several intervals that it was precisely this apparently illogical simultaneous drive for both consonant and hierarchical identities that sustained and animated the evangelical medics. Without explicating it, they held the goals of being ‘Christian medic’ and ‘Christian first, and medic second’ in an aspirational parallel. This echoes Smith and Strhan’s suggestions that it neither distinction, nor engagement, but precisely distinction-with-engagement, which vitalises evangelical engagement with ‘the world.’ Both affinity and dissonance, consonance and hierarchy, drove these evangelical medics as they navigated the realities of being both Christian and medical.

Baker and Wang specifically noted that it was their participants’ senses of identity which fluctuated, rather than remained static.[4] Similarly, in this study the variety of faith consequences they experienced meant that the evangelical medics inhabited two different conceptualisations of their own dual identities. The participants aspired, often simultaneously, to be both ‘Christian medics’ and ‘Christians first, medics second.’ Both identity conceptualisations fuelled their work, and both are important if we are to explain and understand the range of faith consequences explored above. This dual aspiration and drive is a step further than Baker and Wang’s ‘fluctuation’ takes us.

Meier, O’Connor and van Katwyk’s suggest that the relationship between healthcare and religion and spirituality has historically been characterised by four qualities: antagonism; dialogue; integration; and separation.[5] Meier, O’Connor and van Katwky make their observations at the level of cultural and institutional norms. This study suggests that individual evangelical medics may well experience all four of these qualities. ‘Opposing,’ for example, highlighted significant areas of antagonism; ‘Negotiating’ important dialogue, as well as integration; ‘Calling,’ ‘Resourcing’ and

[4] Baker and Wang, ‘Examining Connections Between Values and Practice,' p.134.
[5] Meier, O’Connor and VanKatwyk, ‘Introduction,’ p.2.

‘Growing’ further integration; and ‘Compartmentalising,’ separation. The consonant identity model lends itself to dialogue and integration, whereas the hierarchical model incorporates antagonism.

Antagonism merits further comment. Jeremy suggested that he and his peers must be prepared for moments when faith and work would ‘collide.’ Certainly we have seen some significant collisions and antagonisms. A number involved what Gwen termed ‘fraught’ topics, medical ethics, prayer and evangelism significant among them. While Gwen considered herself a ‘Christian doctor,’ she explained that these ‘fraught’ things had made negotiating consonant identity more difficult. Lewis, similarly, found it ‘self-evident’ to ‘integrate’ his work and has faith, but noted it could be more ‘challenging’ in relation to particular ethical issues.

Finally, collisions, antagonisms and challenges characterised these medics’ experiences alongside the persistent drives towards work-faith affinity, identity consonance, and theologically advantageous and meritorious dissonances. In the first place, at several points, the inverted hierarchical model was also significant, even as the participants sought to avoid it. Our portrayal of the identity implications of healthcare work would be incomplete if we did not acknowledge that, at times, healthcare work created scenarios in which the evangelical medics felt their work had superseded their faith. This inversion of an ideal hierarchy of identity was particularly important for understanding ‘Compromising.’ Here, the participants’ nervousness about actual and potential compromises reflected concerns that healthcare work would lead them to prioritise work over their faith. In ‘Questioning,’ we explored times when the medics’ faiths felt distant, or went ‘AWOL.’ While their concern about, and attempts to redress, such compromises and distance further evidenced their aspirations to consonance and hierarchical identities, it is also important to note those periods in which participants felt they dwelt within an inverted hierarchy of identity.

Similarly, while some dissonances and tensions were important and galvanising, we must also acknowledge those tensions and dissonances with which the evangelical medics struggled. Doubts arose but were not always resolved; faith-based resources aided the evangelical medics, but struggles, questions and uncertainties absolutely remained; many participants found that their faith was resilient, but several experienced periods in which it failed to make meaning or provide the support they needed. Their drive towards work-faith affinity played an important role in responding to and, indeed, overcoming many of the dissonances and tensions which the evangelical medics encountered at the interface between their work and their faith. But despite its significance and persistence, this drive did not mean that they did not encounter difficulties and challenges. Work-

faith affinity was a significant motif and theme in the portrait we have painted of these medics' experiences: but darker hues had their place as well.

We noted in 'On Work and Worldviews' the importance of recognising that identity is dynamic. This would, likely, always have been an important observation as participants developed into medical professionals, encountering successes and joys as well as failures and disappointments. Yet emphasising the dynamic nature of identity is all the more important in this study, as the participants navigated between and within two significant worldviews. Theirs was the task of developing not only as professionals, but specifically as evangelical professionals. Work-faith affinity and consonance, twinned with selective dissonances and a striving to be 'Christian first and medic second,' all contributed to this task, and enabled the participants to develop and to thrive, despite challenges.

Further Theoretical Contributions

Evangelicalism

For much of the 20th century, scholarship exploring evangelical engagement with 'the world' was framed in the binary terms of accommodation versus resistance, resulting in close associations between evangelicalism and protest, resistance and opposition. Scholars subsequently moved to nuance this framing, recognising the importance of both resistance and accommodation, on both social and individual planes. Such scholarship began disrupting hasty associations between evangelicalism and protest against 'the world.'

This thesis reflects this later, more nuanced approach. This is not to claim that tension, opposition and protest were not important themes in this study. In 'Compromising' we examined the importance for the evangelical medics of being 'distinctive' and 'in but not of the world.' Markedly, 'Opposing,' explored participants' resistance to and protest against a number of ethical developments and trajectories. Yet even in 'Opposing,' it proved unhelpful to focus on protest alone. Both affinity and protest were important, as participants sought an admixture of selective opposition within affinity. Similarly, in 'Negotiating,' we observed both the participants' frustrations with restrictions around prayer and evangelism in the clinic, and their negotiations with these, as they sought out work-faith affinity to the greatest extent possible. 'Changing' first observed the participants working to create work-faith affinity, and lessen tensions. More broadly, the arguments presented across this thesis also highlight a consistent desire and drive for work-faith affinity, balanced against theologically important dissonances and tensions. This balance was echoed in participants' aspirations to be both 'Christian medic' (the consonant model) and 'Christian first, medic second' (the hierarchical model).

Medical vocation forms a significant backdrop against which tensions and protest must be viewed, by both researchers and participants. As we noted in 'On Work and Worldviews,' the medics did not choose to work in healthcare for the sake of tension, protest or resistance. Indeed, instead, the participants – echoing a great deal of scholarship – appreciated the consonances and overlaps between themes and motivations common to many religious traditions and medicine. Thus 'Calling' explored the medics' perceptions that their worldly work was religiously significant, and healthcare conducive to living out Christian macro-callings. Both their decision and the nature of medicine decrease the likelihood that tension would not also be accompanied by affinities in these evangelicals' lives. It would be interesting to examine the relationship between being 'in and not of the world' and in light of other 'worldly' vocations in order to better understand the relationships between evangelicalism, protest, affinity and worldly work.

Conceptualising Worldviews

At several points, this thesis explored how we might best conceptualise worldviews and individual faith, having introduced a school of thought arguing that they are better viewed as piecemeal, rather than holistic, entities. 'Changing,' 'Questioning' and 'Compartmentalising' all highlighted the utility of this conceptualisation, as we observed that participants variously changed, questioned or compartmentalised particular aspects of their faith in relative isolation. Moving on, however, drawbacks of this piecemeal conceptualisation were also evident. 'Compromising' and 'Growing' both highlighted the ease with which participants moved between the general and the particular when discussing their faith and identities. This illustrated the value of conceptualising these medics' individual worldviews not merely as the sums of parts, but also as significant wholes, and of being able to move between the two.[6]

In sum, this thesis comes to echo Pearce and Denton's conceptual approach. Pearce and Denton use a mosaic as a metaphor for religious identities.[7] This metaphor is useful in several senses. First, it emphasises the multifaceted nature of religious identities, akin to other academic suggestion that individual religion consists of distinct pieces and facets.[8] Pearce and Denton suggest different coloured tiles represent 'the different dimensions and aspects of religiosity.'[9] They can vary in shade, reflecting the significance of particular a dimension within a person's religious worldview and

[6] Schielke does just this in relation to capitalism as worldview, focussing upon specific features of capitalism in contemporary Egypt as a means of reflecting upon capitalism more broadly. Joska Samuli Schielke, *'Capitalist Ethics and the Spirit of Islamization in Egypt'* in *Ordinary Lives and Grand Schemes: An Anthropology of Everyday Religion,* ed. by Joska Samuli Schielke and Liza Debevec (New York, Oxford: Berghahn, 2012), 131-145 (p.134).
[7] Pearce and Denton, *A Faith of Their Own*, p.4.
[8] Ibid., p.174.
[9] Ibid., p.19.

identity.[10] Finally – and here, perhaps, the metaphor weakens – they explain that adolescents are constantly modifying their mosaics, some more than others.[11] Thus Pearce and Denton emphasise the dynamism of individual religious worldviews.[12] However, this metaphor has one further use which Pearce and Denton do not press: the fact that mosaics are significant and distinctive because they are both holistic entities, and the sums of constituent parts. It is this final application of the mosaic metaphor which this thesis comes to depend upon, arguing that it is useful to conceptualise individual worldviews as holistic entities, formed of multiple parts.

This thesis can only make observations in relation to individual evangelical worldviews, within a sample of highly educated professionals, all of whom put significant emphasis upon being part of a church. Each of these peculiarities will have affected how the individuals presented their faith and identity. Evangelicalism, along with its broader Protestant family, tends to heavily emphasise propositional beliefs, making it relatively easy and intuitive for the individual to pinpoint particular facets, ideas and issues. Sermons series and small groups are likely to encourage this particularising, while also teaching individuals to see particular issues in relation to their 'faith' and the Christian 'faith' more broadly. Future research might valuably explore where else this balance of holistic and piecemeal conceptualisation proves useful.

Emotion

Despite recognition of its significance since the earliest days of Religious Studies, emotion has received little explicit attention within lived religion scholarship. This thesis' methodology, particularly its purposive analytical elements, was designed to correctively place emotion squarely in focus. This study has demonstrated the importance of beliefs and practices in its efforts to understand the faith consequences of healthcare work for evangelicals: but it has also consistently drawn attention to significant emotional dimensions. Emotional antecedents and consequences of using faith as a resource were central in 'Resourcing.' In 'Opposing,' attending to the emotions inherent in the medics' ethical reasoning allowed us to present a deep and nuanced account of evangelical ethical opposition. Emotionality was at the heart of changes, not least when viewed using cognitive dissonance as a theoretical lens. Additionally, by focussing on emotions, we could observe how the medics responded to their own changes of perspective. In both 'Changing' and 'Growing,' we suggested that in some cases where the participants' beliefs had not changed, their emotional relationships to them had been affected by their work. This important experience for several participants would not have been accessible had beliefs and practices alone been analytical

[10] Ibid.
[11] Ibid., pp.4 and 19.
[12] Ibid., pp.20-21.

foci. This thesis's central concerns with identity and affinity also have important emotional dimensions. The participants sought harmony and affinity, and avoided troubling and disconcerting dissonances.

In this study, emotion was no mere added-extra, but essential to understanding the ways in which participants' religious identities interacted with their working lives. Lived religion and worldview scholarship might valuably consider of whether this is also the case beyond this thesis' medical interests. Equally, by focussing upon emotion, scholarship concerned with the broader faith or worldview consequences of healthcare work might also be enhanced. When Bilgrave and Deluty posed the question of whether healthcare practice had affected people's religious *beliefs*, it seems they were capturing but one part of a dynamic system.[13] Similarly, when Vanderpool and Levin assert that healthcare work can affect or challenge traditional religious *understandings*, they too perhaps remain on too cognitive a plane.[14]

Future Research

While conscious of its limitations, thanks to its synthesising and expanding of existing scholarship, this thesis has the potential to stimulate further work and research. First, both 'Changing' and 'Questioning' offered some evidence that where healthcare work prompts either changes of perspective, or greater uncertainty in relation to ethical topics among evangelical medics, these tend to be in favour of more liberal perspectives, rather than conservatism. On the basis of this small-scale study, we can only make such suggestions and comparisons with extreme caution. Future work, ideally with a quantitative component, might usefully test this hypothesis with larger, representative samples, facilitating generalisable conclusions.

In 'Negotiating,' we observed that, for this sample of evangelical medics, it was religious rather than national identity which acted as primary arbiter over their evaluations of the NHS (though that is not to say these were not accompanied by consistent concerns about lack of time, over-stretched resources, and funding.) This is a small sample, but this suggestion resonates with broader themes of tension with, and wariness of, 'the world' on account of a religious affiliation. Further work exploring this on a broader scale, in relation to the NHS in particular, would be hugely welcome, not least since the COVID-19 crisis has served to radically re-emphasise and reinvigorate the close relationship between British identity and its health service.

[13] Bilgrave and Deluty, 'Religious Beliefs and Therapeutic Orientations,' pp.331-333 (emphasis mine).
[14] Vanderpool and Levin, 'Religion and Medicine: How Are They Related?', p.12 (emphasis mine).

‘Growing,’ reiterated that this thesis omits consideration of medics who, because of their work, lost an evangelical faith. Future research could add important additional features to this thesis’ portrait of healthcare work’s potential faith consequences by seeking out those with such experiences, and analysing their narratives with care. This might, in turn, embellish the practical utility of the research conducted for this project.

Relatedly, ‘Compartmentalising’ observed that Amelia was the only participant who engaged in wholesale self-state compartmentalisation as a defensive mechanism. Given she hailed from a Catholic background, we suggested that the absence of normative evangelical identity logic might go some way towards explaining this. Further work is needed to test this suggestion. By exploring compartmentalisation and its absence more thoroughly with medics from diverse religious and non-religious backgrounds, scholars might evaluate the significance of the universal identity logic. While characteristic of evangelicalism, this identity logic is not unique to it. Additionally, scholars might seek larger samples of evangelical medics, exploring the experiences of those who *do* engage in self-state compartmentalisation.

As noted in the Methodology, this thesis incorporated narratives from non-evangelicals, on occasion, in order to illustrate areas for future comparative work. Compartmentalisation is one example. In both ‘Resourcing’ and ‘Changing’ we noted that Amelia, much like some evangelical participants, found addressing particular ethical topics difficult. In ‘Resourcing,’ we saw that for Amelia, as for Martha, the absence of a religious context in which she felt comfortable voicing religious queries and uncertainties was troubling: she too experienced ‘ethical silencing.’ In ‘Changing,’ we saw the emotional discomfort she experienced as a result of dissonance where her Roman Catholic upbringing did not cohere with NHS expectations. ‘Ethical silencing,’ and difficulties where reluctance to chance a perspective creates cognitive-emotional dissonance, thus seem issues worthy of further exploration beyond evangelicalism. Thea also featured in both ‘Resourcing’ and ‘Questioning’ in relation to the absence of resources. Her examples might prompt investigation of how religious and spiritual medics who have weaker institutional ties than most in this study manage the challenges presented by their work, including questioning.

Mel, a former A&E nurse, as opposed to a doctor, appeared in five of the nine analytical chapters. In ‘Opposing,’ we saw that she shared others’ experiences of growing in awareness of ethical ‘shades of grey,’ yet equally felt clear of her own convictions that detection of a foetal abnormality should not result in abortion being encouraged. In ‘Changing,’ we saw Mel engaging further with medical ethics. As well as a shift to a more situational style of reasoning, we saw that working in an HIV clinic

proved emotive and impactful, effecting a change of perspective on human sexuality. In 'Compromising' we saw that she, with her colleagues, had felt caught between the conflicting goods of respecting others' religious beliefs and preserving life while treating the young Jehovah's Witness. Mel's time working as a nurse stimulated serious questions and doubts, and negative religious coping: as she put it, her faith 'went AWOL.' In the long-term, however, Mel felt such difficulties ultimately both transformed and strengthened her faith.

That Mel experienced many faith consequences in common with the doctors in this study suggests there may well be extensive similarity between the effects of healthcare work among both evangelical doctors and nurses working in the NHS. This clearly requires further testing on a larger scale, not least since Mel's narrative provides two reasons to temper this tempting hypothesis. First, Mel's was the clearest example of faith 'going AWOL.' As Mel noted, this consequence was multifactorial. It may have had a great deal to do with dissonances between her upbringing and her experiences, and the particular areas of nursing she was exposed to, and less to do with the fact she worked as a nurse rather than as a doctor. Nevertheless, further work with evangelical nurses might provide more secure comparative grounds for considering the relationship between evangelical faith and identity and the nature of nursing work in particular. Secondly, we might consider Mel's explication, quoted in 'Questioning,' that decision-making in relation to the young Jehovah's Witness patient did not fall to her. Her presentation suggests that this would have been a burdensome additional factor. Comparing the faith consequences of healthcare work between evangelical doctors and nurses with a particular focus upon decision-making responsibility might prove particularly profitable.

Finally, this thesis utilised an original autobiographical elicitation methodology, designed to be participant-led, and to facilitate deep qualitative insights. This innovative methodology proved hugely effective for this study. In order to evaluate its efficacy more broadly, it must be used for other studies of similar scale and with similar interests. Such research might specifically enquire whether it is as useful without the facilitating factor of a shared religious identity and discourse, or when working with a research population less highly educated and less well-acquainted with reflexive practice.

Practical Recommendations

The small-scale nature of this study cautions against making grand practical recommendations. Some, however, might be entertained on the basis of their consistent significance in this study, and the likelihood that they can be implemented easily. In particular, it was striking how many participants found the support of churches and fellow Christians invaluable. This was also

backhandedly noticeable where such sources of support were absent. Churches who care for healthcare practitioners might valuably reflect on this, perhaps particularly those located near large teaching hospitals which attract high volumes of trainee and junior doctors. The medics in this study were conspicuously grateful for midweek 'small group' gatherings, since combining these with Sunday worship made it less likely that rotas would leave them without an opportunity to encounter supportive Christian fellowship for several weeks. Churches should encourage medics to find nurturing within such contexts, just as medics might do well by themselves by making church and fellowship a priority. 'Resourcing' also highlighted the value of meeting and praying with other, dually empathetic, Christian medics. Moreover, the Covid-19 pandemic has seen churches adapt to online and mixed-media provisions.[15] On the basis of this project, I would encourage churches to continue considering and evaluating such provisions beyond the requirements of the pandemic. They may well prove important for and beyond those, such as medics, who work beyond the normal 9-to-5 pattern.[16] Within and beyond small groups, churches should attend carefully to medics' senses of calling, aware that these can create difficulties even as they provide valuable support. This echoes Fowler's admonition that churches ought to equip people for their vocations, and might well prove an important recommendation beyond healthcare work.[17]

In all such contexts, due consideration should be given to the atmospheres created, particularly in relation to questioning. Among the most troubling sections of my data, for me, were those where the medics felt 'ethically silenced' or had no outlet in which they felt they could voice troubling questions, considerations and experiences. By contrast, Strhan's work has highlighted the normalising power of acknowledging 'wobbly discipleship.'[18] It is notable that Swinton emphasises the importance of small groups for recovering the practice of lament, presenting these as spaces where deep relationships can be formed, and individuals' experiences and needs receive focussed attention.[19] In light of the medics' articulations of lament, mixed experiences of questioning and uncertainty as both individuals and parts of Christian communities, and gratefulness for small groups, perhaps Swinton's suggestion is particularly relevant here. Perhaps small groups could be designated as spaces which not only provide fellowship outside of the regular Sunday pattern, but specifically as places for learning to lament, locating this practice within faith rather than – as

[15] Sophie Smith-Galer, 'Churches Live-Stream to Connect with Congregations', *BBC News*, *12th April 2020* <https://www.bbc.com/news/av/technology-52236555/coronavirus-churches-live-stream-to-reach-worshipers> [Last accessed 16/06/2020].
[16] Tim Hutchings, *Creating Church Online : Ritual, Community and New Media* (New York: Routledge, 2017), pp.14-15, 68-69 an 97-98.
[17] Fowler, *Weaving the New Creation,* p.159.
[18] Strhan, *Aliens and Strangers?,* pp.112 and 195.
[19] Swinton, *Raging with Compassion,* pp.121-122.

Swinton puts it – allowing the 'experience of evil, grief and suffering [to be] condemned as faithlessness.'[20] By acknowledging the widespread reality of questioning, doubts and uncertainties, and recovering group responses to these, such spaces would advocate both truth and compassion.

Final Words

Throughout this thesis, I have often quoted participants at length, for they are far better able to articulate their experiences and emotions than I am. I thus close in the same vein, with some words from Martha. They capture her dynamic and fluctuating sense of identity, and her hope that consonance and affinity will grow as she grows into her profession. They also highlight the faith that she prioritises and seeks to carry into her 'whole life.' They illustrate some of the tensions she experiences at the interface of her work and faith. They also draw attention to something the UK has recognised with such intensity in recent months: that the NHS needs to be nurtured, resourced and cared for if it is to work for those who need it, and for those who work in it.

> I think at the moment [I'm] a Christian and a doctor, because I've found it hard to – [pause] fully – I know that, being a Christian is like your whole – it's how you live your whole life, but I actually find living Christian values at work difficult, and – at the moment I'm working out what it looks like to be a Christian doctor. Because practically I can say all these things about how I would love to care for people if I had all the free time, and if the people around me let me care that much. But in reality, we're in a system which people, patients are almost – sometimes forgotten, and it's just, get people in, get people done, get them out, deal with the problem. So actually what it looks like to be a Christian doctor in practical, real terms, I'm still figuring out.

[20] Ibid., p.119.

Appendix A

Akua is a medical student and is in her early twenties.

Amelia is a paediatric nurse, though has experience working in geriatric nursing. She is in her mid-twenties.

Ben is in his seventies and retired over a decade ago. He used to work as a general practitioner.

Catherine is in her fifties. She previously worked as a general practitioner, and is now a neurologist.

David is in his late fifties and works as a general practitioner.

Elizabeth is in her early forties. She works part-time in both general practice and in palliative medicine.

Ginny is in her mid-forties. She has previously worked in general practice, but currently works in palliative medicine.

Goodluck is in his late twenties, and is just about to start his training in cardiology.

Gwen is in her seventies and retired five years ago. She spent most of her medical career in general practice, though also had roles in obstetrics and gynaecology and psychiatry.

Hannah is in her mid-twenties and works as a junior doctor, but took a year out of training to do a fellowship in sexual health, and to work abroad in paediatric medicine.

James is in his early twenties and his early years of medical school.

Jeremy is in his mid-twenties and works as a junior doctor.

John is in his early forties and works as a surgeon.

Lewis is in his mid-sixties. He is retired from a career in general practice, but continues to teach in university posts and advises the government on medical recruitment.

Liam is in his mid-twenties and works as a junior doctor.

Martha is in her mid-twenties and works as a junior doctor.

Mel is in her forties. She worked as an A&E nurse until twenty years ago, when she left to pursue a different career. She is now a minister.

Nigel is in his early fifties, and works as a child psychiatrist, and has also recently completed ordination training.

Peter is in his twenties, and in his later years of medical school.

Philip is in his mid-thirties and works as a consultant geriatrician.

Richard is in his mid-sixties and recently retired from his career in general practice.

Ruth is in her early forties and works as a middle grade psychiatrist.

Sarah is a retired psychiatrist in her sixties.

Simon is in his late fifties and works in psychiatry, in addition to holding significant management duties in his NHS trust.

Thea is a recently retired psychiatrist in her late fifties.

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