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Religiosity/Spirituality of German Doctors in Private Practice and Likelihood of Addressing R/S Issues with Patients

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Abstract This study examined the self-assessed religiosity and spirituality (R/S) of a representative sample of German physicians in private practice ($n = 414$) and how this related to their addressing R/S issues with patients. The majority of physicians (49.3 %) reported a Protestant denomination, with the remainder indicating mainly either Catholic (12.5 %) or none (31.9 %). A significant proportion perceived themselves as either religious (42.8 %) or spiritual (29.0 %). Women were more likely to rate themselves R/S than did men. Women (compared to men) were also somewhat more likely to attend religious services (7.4 vs. 2.1 % at least once a week) and participate in private religious activities (14.9 vs. 13.7 % at least daily), although these differences were not statistically significant. The majority of physicians (67.2 %) never/seldom addressed R/S issues with a typical patient. Physicians with higher self-perceived R/S and more frequent public and private religious activity were much more likely to address R/S issues with patients. Implications for patient care and future research are discussed.

Keywords Religion · Spirituality · Health · Counseling · Physicians · Education

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Introduction

There is a growing interest in the influence of religiosity and spirituality (R/S) on well-being and health. Despite the lack of a common definition, most researchers agree that religion and spirituality are overlapping but conceptually distinct constructs (Büssing et al. 2005; Piedmont 2005; Zinnbauer and Pargament 2005). While religiosity is characterized as a system of organized beliefs and practices, spirituality is defined as an individual search for meaning and purpose in life that might or might not involve the Transcendent (Büssing et al. 2009). Dimensions of religiosity include organized religious activities (ORA; e.g., church attendance) and non-organized religious activities (NORA; e.g., private prayer) (Cheever et al. 2005; Koenig and Büssing 2010). For spirituality, dimensions such as self-perception and quest, search for inner peace, relatedness have been described (Brown et al. 2007; Büssing and Koenig 2010; Zwingmann et al. 2011). A vital spiritual experience can be the core of formal and institutionalized religious activity (i.e., church attendance), although it may also indicate a more individualistic 'search' for meaning and purpose in life which involves non-organized and private forms of spiritual activity (e.g., meditation).

R/S has been associated with better mental and physical health (Koenig et al. 2012). Research has shown that R/S beliefs and practices are important for coping with chronic or terminal diseases, even in secular societies (Büssing et al. 2009; Rippentrop et al. 2006, 2005). Attendance at religious services has been associated with higher social support, less depression, lower use of health services, and greater longevity (Koenig 2008; Koenig et al. 2012). The relationship between private religious activity and depression is less consistent, although strong associations exist with social support (Koenig et al. 1997b). However, in German in-patients with depressive and addictive disorders, reliance on God's Help, as a measure of intrinsic religiosity, was not significantly associated with depressive symptoms (Büssing and Mundle 2012).

In the USA, the majority of patients would like their physicians to ask about their R/S needs, but most indicate that their physicians infrequently do this (Balboni et al. 2007). Only 34 % of US gynecologists frequently or always take a R/S history (Ramondetta et al. 2011). More than three-fourths (83 %) of patients agreed or strongly agreed that surgeons should be aware of their religiosity and spirituality, 63 % agreed that surgeons should take a spiritual history, and 64 % indicated that their trust in their surgeon would increase if they did so (Taylor et al. 2011).

The R/S beliefs and practices of physicians are not well known, especially in European countries. Most of the current information on the beliefs and practices of physicians comes from studies conducted in the USA. For example, 75 % of one hundred internists and psychiatrists in Virginia used religious activity as a coping resource (Ayele et al. 1999). In a small sample of surgeons ($n = 35$), 47 % attended religious services at least once a week and 44 % were involved in private religious activities (e.g., prayer) at least once a day (Cheever et al. 2005). However, a much lower percentage of US pediatric oncologists said they believed in God without doubt compared to the general population (27 vs. 60 %) and attended services at least 2–3 times per month (24 vs. 40 %) (Ecklund et al. 2007).

Europe has been described as an increasingly secular and individual centered society (Ziebertz and Kay 2006). The influence of organized religion has been decreasing. Nevertheless, individual forms of spiritual expression remain widespread (Büssing et al. 2010, 2012). For example, a study among German pain patients reported that 23 % would like to talk with a priest or chaplain about their spiritual needs, whereas 37 % wanted to talk with their medical doctor about these issues (Büssing et al. 2009). Almost a quarter of German psychotherapists reported that their patients mentioned R/S issues during therapy

(Hofmann and Walach 2011). Moreover, the majority of German tumor patients wanted their doctor to be interested in their spiritual orientation (Frick et al. 2006).

Studies on the R/S attitudes and beliefs of European doctors and therapists are rare. One study involving a small unrepresentative sample of psychotherapists ($n = 74$) found that 74 % believed in a transcendent reality and 46 % reported that R/S issues were of moderate or greater relevance for their work (Ludwig and Plaum 1998). In another study of 78 psychologists and 253 physicians, 30 % did not belong to a religious denomination and one-third described themselves as non-religious (Demling et al. 2001). In a recent study that involved a near-representative sample of psychotherapists ($n = 895$), 64 % believed in some type of higher or transcendent reality and 57 % regarded themselves as either religious or spiritual. Furthermore, two-thirds thought addressing R/S issues in patient care should be part of the postgraduate and/or graduate curriculum. However, 34 % described themselves as secular and 41 % did not belong to a religious denomination (Hofmann and Walach 2011). In a non-representative sample of various health professionals in psychiatry and psychotherapy at Freiburg University Hospital, Lee et al. (2011) investigated the meaning of R/S from the staff's perspective and found that "staff regarded the influence of religious/spiritual contents generally positive to patients," while "staff did not use religious/spiritual elements in their therapy methods."

Research suggests that doctors who practice a healthy lifestyle (e.g., control their weight, do not smoke, exercise regularly) are more likely to encourage a similar lifestyle in their patients and are more effective with their recommendations (Frank 2004; Frank et al. 2010). This has also been described for addressing R/S issues by physicians in the USA (Curlin et al. 2006; Ramondetta et al. 2011). No such research, however, has examined in representative samples whether or not the R/S involvement of German physicians influences their addressing of R/S issues with patients.

We examine here the R/S beliefs and practices of a representative sample of doctors in private practice in a northern state of Germany and the impact of R/S on likelihood of addressing R/S issues with patients.

Method

Sample Description

Data were analyzed from the second wave (T2) of a longitudinal study. A stratified, random sample of physicians in private practice was drawn from the Medical Association of Schleswig-Holstein, Germany. From a population of 3,935 physicians, 900 physicians were initially identified for the study. At T2 conducted in 2010, 770 participants were re-surveyed. Reminders were sent after 4 and 8 weeks to non-responders. To ensure anonymity, a random bar code was used to identify non-responders. The study was approved by the Ethical Committee of the Medical Faculty of the University of Freiburg.

Besides assessing religious denomination/affiliation, we asked two items from the SpREUK questionnaire (SpREUK is an acronym of the German translation of "Spiritual and Religious Attitudes in Dealing with Illness") to distinguish religious and spiritual self-perceptions (Büssing 2010), i.e., "I regard myself as a religious person," and "I regard myself as a spiritual person." The items were scored on a 5-point scale from disagreement (0) to agreement (4). The respective responses were categorized as both religious and spiritual (R+ S+), religious but not spiritual (R+ S−), not religious but spiritual (R− S+), and neither religious nor spiritual (R− S−).

Also administered were two questions from the Duke University Religion Index (DUREL), a five-item measure of religious involvement (Koenig et al. 1997a; Koenig and Büssing 2010): (1) organizational or public religious behavior (ORA; e.g., church attendance), and (2) non-organizational or private religious behavior (NORA; e.g., prayer or meditation). Items were scored on a six-point scale from more than once/week to never for ORA and from more than once/day to seldom or never for NORA. The questionnaire also included an item regarding the frequency of addressing R/S in patient care: "How often do you address R/S with a typical patient." Possible responses were never/seldom (1), sometimes (2), and usually/always (3).

Statistical Analysis

Analyses were conducted with SPSS for windows Version 15.0 (SPSS Inc., Chicago, IL, USA). We report univariate statistics as means and standard deviations for continuous variables and percentages for categorical variables. Associations between categorical variables were analyzed using χ^2 tests. For continuous variables, data were analyzed using two-tailed t tests and analyses of variance in a general linear model. The associations of age, sex, and R/S variables to physicians' quality of life (SF-12) were analyzed using linear regression.

Results

A total of 414 interviews were completed (53.8 % response rate). There were no significant differences in age and specialty between responders and non-responders, although a higher percentage of females versus males participated (61.3 vs. 38.7 %, $p < 0.01$). Table 1 presents the sample characteristics. The sample was comprised of 60 % male and 40 % female physicians, and the mean age was 53.7 (SD 7.3) years.

Religious and Spiritual Orientation, Organized and Non-organized Religious Activities

Half of the physicians were Protestant (49.3 %), whereas 12.5 % were Catholic and 31.9 % indicated none (Table 1). There were no significant gender differences. With regard to self-perceptions of religiosity, 42.8 % described themselves as religious and 42.0 % as non-religious (Table 2). A significantly larger proportion of female physicians (48.8 %) compared to male physicians (38.8 %) perceived themselves as religious. This difference was also seen for perceived spirituality but was not as large (36.4 % of females vs. 24.2 % of males perceived themselves as spiritual). Of all physicians 19.7 % reported themselves as both religious and spiritual (R+ S+), 23.4 % as religious but not spiritual (R+ S−), 9.5 % as not religious but spiritual, and 47.5 % regarded themselves as neither religious nor spiritual (R− S−). Only 4.3 % of physicians attended services (ORA) once a week or more, whereas 46.2 % attended once per year or less. For non-organized religious activities (NORA), 14.2 % participated in private religious activities at least daily or more often, whereas 61.6 % seldom or never did so. There were no significant gender differences in organized or non-organized R/S activities.

The majority of Protestant (54.2 %), Catholic (47.1 %), and non-Christian (40 %) reported attending religious services just a few times per year. Quite similar proportions for frequency of religious attendance were reported by those who perceived themselves as religious (37.9 % a few time per year, 32.8 % a few times per month) or spiritual

Table 1 Demographics of German physicians in private practice

	Physicians (n = 414)
Age	
M (SD)	53.7 (7.3)
Age groups (%)	
<40	1.7
40–49	31.6
50–59	43.5
≥60	23.2
Gender (%)	
Female	40.0
Male	60.0
Specialty (%)	
General medicine	35.5
Medical specialty	35.5
Surgical specialty	29.0
Denomination (%)	
Protestant	49.3
Catholic	12.5
None	31.9
Free church	1.7
Non-Christian	1.2
Others	3.4

(47.9 %/20.0 %). The most common response for frequency of private religious activities was seldom or never among Catholic physicians (58.0 %), Protestant physician (52.0 %), non-Christian physicians (40.0 %), and other physicians (46.2 %). More than half of those who perceived themselves as religious or spiritual reported private religious activities daily or more (56.1 % religious, 55.5 % spiritual).

Addressing R/S in Clinical Practice

A majority of physicians (67.2 %) seldom or never addressed R/S with patients (Table 2). A significant larger proportion of female physicians reported that they usually/always did so (12.1 %) compared to male physicians (4.1 %). Physicians who reported affiliation with a Free church or non-Christian denomination were significantly more likely to address R/S issues compared to those with Catholic, Protestant, or no denominational affiliations.

Doctors who strongly agreed that they regarded themselves as religious or spiritual more often addressed R/S in clinical practice at least sometimes (50.0 % religious, 56.8 % spiritual) or usually/always (17.2 % religious; 29.5 % spiritual) compared to those who considered themselves neither religious (usually/always 6.2 %) nor spiritual (usually/always 2.3 %; Table 3). Physicians who attended religious services at least once/week or participated in private religious activities at least once/day addressed R/S among patients more often (47.6 % usually/always for ORA, and 50.3 % for NORA) than those who engaged in religious activities less frequently (9.7 % for those attending religious services once/year or less, 8.3 % for those engaged in private religious activities less than sometimes/month).

Table 2 Religiosity and spirituality in German physicians

	Men (%; $n = 243$)	Women (%; $n = 161$)	Total (%; $n = 404$)	p_{mf}
Self-assessment: religious				0.040
Strongly disagree	19.0	21.3	19.9	
Disagree	27.3	14.4	22.1	
Cannot say	14.9	15.6	15.2	
Agree	26.4	31.3	28.4	
Strongly agree	12.4	17.5	14.4	
Self-assessment: spiritual				0.035
Strongly disagree	37.1	26.4	32.8	
Disagree	24.2	18.9	22.1	
Cannot say	14.6	18.2	16.0	
Agree	15.0	22.6	18.0	
Strongly agree	9.2	13.8	11.0	
Grouped R/S				0.006
R+ S+	17.1	22.8	19.7	
R− S−	54.6	37.3	47.5	
R+ S−	21.3	26.6	23.4	
R− S+	7.1	13.3	9.5	
Organized religious activities				0.130
>Once/week	0.4	1.2	0.7	
Once/week	1.7	6.2	3.5	
Some/month	8.7	11.2	9.7	
Some/year	40.9	38.5	40.0	
Once or less/year	25.6	20.5	23.6	
Never	22.7	22.4	22.6	
Non-organized religious activities				0.311
>Once/day	3.3	5.6	4.2	
Daily	10.4	9.3	10.0	
Two or more/week	5.8	8.1	6.7	
Once/week	4.2	7.5	5.5	
Some/month	10.8	13.7	12.0	
Seldom or never	65.4	55.9	61.6	
R/S in counseling practice				0.002
Never/seldom	72.7	58.6	67.2	
Sometimes	23.1	29.3	25.6	
Usually/always	4.1	12.1	7.3	

Discussion

We examined religious and spiritual attitudes of medical doctors in private practice and their relationship to whether or not they addressed R/S issues in their treatment of patients. To our knowledge, this is the first such report on a representative sample of German physicians in private practice.

Table 3 German physicians' addressing R/S issues

	Never/ rarely (%)	Sometimes (%)	Usually/ always (%)	Total [*n* (%)]	*p*
Doctors' denomination versus doctors R/S counseling					0.031
Catholic	70.0	30.0	0.0	50 (12.4 %)	
Protestant	66.8	25.6	7.5	199 (49.5 %)	
Free church	28.6	42.9	28.6	7 (1.7 %)	
Non-Christian	20.0	60.0	20.0	5 (1.2 %)	
Other	50.0	33.3	16.7	12 (3.0 %)	
None	72.1	20.9	7.0	129 (32.1 %)	
Doctors' self-assessed religiosity versus doctors R/S counseling					<0.001
Strongly disagree	72.8	21.0	6.2	81 (20.3 %)	
Disagree	85.4	11.2	3.4	89 (22.3 %)	
Cannot say	72.9	13.6	13.6	59 (14.8 %)	
Agree	63.7	33.6	2.7	113 (28.3 %)	
Strongly agree	32.8	50.0	17.2	58 (14.5 %)	
Doctors' self-assessed spirituality versus doctors R/S counseling					<0.001
Strongly disagree	84.7	13.0	2.3	131 (32.9 %)	
Disagree	79.5	18.2	2.3	88 (22.1 %)	
Cannot say	73.0	20.6	6.3	63 (15.8 %)	
Agree	45.8	44.4	9.7	72 (18.1 %)	
Strongly agree	13.6	56.8	29.5	44 (11.1 %)	
Doctors' grouped R/S versus doctors R/S counseling					
R+ S+	25.6	59.0	15.4	78 (19.6 %)	
R− S−	82.7	13.1	4.2	191 (48.1 %)	
R+ S−	75.8	23.1	1.1	91 (22.9 %)	
R− S+	51.4	27.0	21.6	37 (9.3 %)	
Doctors' organized religious activities versus doctors R/S counseling					0.001
>Once/week	0.0	66.7	33.3	3 (0.7 %)	
Once/week	35.7	50.0	14.3	14 (3.5 %)	
Some/month	52.6	36.8	10.5	38 (9.5 %)	
Some/year	62.7	29.8	7.5	161 (40.1 %)	
Once or less/year	78.7	14.9	6.4	94 (23.4 %)	
Never	76.9	19.8	3.3	91 (22.7 %)	
Doctors non-organized religious activities versus doctors R/S counseling					<0.001
>Once/day	23.5	41.2	35.3	17 (4.3 %)	
Daily	42.5	42.5	15.0	40 (10.0 %)	
Two or more/week	44.4	51.9	3.7	27 (6.8 %)	
Once/week	42.9	38.1	19.0	21 (5.3 %)	
Some/month	67.4	28.3	4.3	46 (11.5 %)	
Seldom or never	78.2	17.7	4.0	248 (62.2 %)	

Doctors Denomination, Religiosity, Spirituality, and Organized/Non-organized Religious Practice

More than two-thirds of the study group reported a denominational affiliation. Public data for the general population in Schleswig-Holstein were not available. However, Catholic and Protestant church reports for the general population of the German northern states indicate a proportion of 7 % Catholics and 36.5 % Protestants (Kirchenamt der EKD 2012; Sekretariat der deutschen Bischofskonferenz 2012). Compared to these data, the physicians in our sample were more likely to be Protestant or Catholic compared to the general population of Schleswig-Holstein.

Despite the fact that approximately two-thirds of physicians had a denominational affiliation, this appeared to have little impact on their perceived religiosity or spirituality, or on their frequency of religious attendance or private religious activities. Almost 60 % regarded themselves as not religious and more than 70 % as not spiritual (including "do not know"). Compared to a sample of German pain patients, a higher percentage of these physicians regarded themselves as neither religious nor spiritual (48 % physicians vs. 42 % patients) (Büssing et al. 2009). Accordingly, only about 4 % reported attending religious activities at least weekly and 14 % being engaged in private religious activities at least daily. The self-perceived R/S and level of religious practice is thus much lower than their religious affiliations were suggested. This discrepancy between a high frequency of denominational affiliation and a low personal involvement in religion is consistent with a strong secular trend in Western European countries (Bruce and Glendinning 2010; Pollack and Pickel 2007; Ziebertz and Kay 2006), although this trend has also been shown in US psychotherapists (Bergin and Jensen 1990) and German patients with chronic diseases (Büssing et al. 2009, 2012).

Studies from the United States have reported high rates of R/S involvement by the general population. More than 90 % believe in God, more than 50 % pray regularly, and about 40 % attend to services weekly (Princeton Religious Research Center (1994) in Albani et al. 2002). US physicians and psychotherapists also seem to be less religious or spiritual than the general population or other health care workers (Flannelly and Galek 2006; Stern et al. 2011). Only about one-quarter of US pediatric oncologists believe in God without doubt (27 % compared to 60 % of the general population) (Ecklund et al. 2007). Physicians cope without God twice as likely as the general population (Curlin et al. 2007). Psychologists are also less religious than the general community (Delaney et al. 2007). This is consistent with the notion that because physicians and psychotherapists are highly educated, they are more strongly influenced by a scientific worldview that usually excludes God or supernatural forces (Larson and Witham 1998).

Physicians R/S Orientation and Addressing Spiritual Issues

The majority of these German doctors (67 %) never or seldom addressed spiritual issues with patients. This is consistent with the findings of Demling et al. (2001) that only 10 % of German psychotherapists regularly address R/S issues in their practice. Lee et al. (2011) also stated that health professionals in a psychosomatic and psychotherapy unit at a university hospital regarded the influence of R/S positive to patients, but did not use R/S elements in their therapy.

A number of reasons have been proposed for this apparent reserve. R/S may often not be asked because is considered too private or personal (Koenig 2013). Some critics argue that religion should be separated from the medical practice (Sloan et al. 2000). More than half

of counselors in a university setting were unsure whether addressing these issues would positively influence health (Mrdjenovich et al. 2012). Although the majority of physicians in one study indicated that R/S had an influence on health (56 %), only a few (6 %) agreed that R/S changed "hard" medical outcomes (Curlin et al. 2007). Rather, the majority of physicians believed that R/S helps patients to cope (76 %), gives patients a positive state of mind (75 %), and provides emotional and practical support via the religious community (55 %) (Curlin et al. 2007). Another study also indicated a strong belief that R/S should only be addressed if it is of interest to the patient (Mrdjenovich et al. 2012). Many doctors and psychotherapist feel that they are not trained to address R/S issues that patients may have (Demling et al. 2001; Hofmann and Walach 2011). However, others propose that it is not lack of knowledge but rather marginalization of the topic that prevents physicians from addressing patients' R/S needs (McVittie and Tiliopoulos 2007).

We found here that there was a strong relationship between doctors' personal R/S practices and the extent to which they addressed patients' R/S issues. Doctors who regarded themselves as religious and/or spiritual and who engaged in public and private religious activities were more likely to address these issues. This has also been reported from studies in the USA. In the largest study to date of US physicians, those who identified themselves as more religious or more spiritual, particularly Protestants, were significantly more likely to engage in different ways of addressing R/S in the clinical encounter (Curlin et al. 2006). Physicians with high religiosity were significantly more likely to report that patients often mention R/S issues (36 vs. 11 %), believed that R/S strongly influences health (82 vs. 16 %), and interpreted the influence of R/S in positive rather than negative ways, compared to less religious physicians (Curlin et al. 2007). Hofmann and Walach (2011) found that the majority of German psychotherapists (56 %) acknowledged that their own R/S orientation influenced addressing of spiritual issues in their practice of psychotherapy.

It seems natural that those physicians with greater religious involvement themselves would be more likely than less religious doctors to value R/S issues in their clinical practice. This has also been described for other health behaviors such as doctors' nutrition, exercise, or smoking habits and whether they addressed these issues with patients (Frank 2004; Frank and Segura 2009). Nevertheless, we need to question whether it is appropriate for physicians' personal beliefs to influence these practices to such a great degree. Healthcare should be patient-centered, not physician-centered. It should not be about how much value the physician places on a topic, but rather how important this issue is for patients and their health. Many studies have found that R/S is an important coping behavior for patients with medical illness (Büssing et al. 2009; Eckersley 2007; Koenig et al. 2012, pp. 94–122; Koenig et al. 2001; McCullough and Larson 1999). In addition, it has been shown that religious patients wish doctors to address this important part of their life (Frick et al. 2006; King and Bushwick 1994; Taylor et al. 2011). In contrast, only 34 % of gynecologists frequently or always take a R/S history (Ramondetta et al. 2011) and this drops to 10 % among physicians of all specialties (Curlin et al. 2006). Therefore, German (and other European and North American) physicians with little or no personal religious or spiritual involvement may need education to alert them to the important role that R/S factors play in the lives of many patients and the need to address these as part of the medical encounter (particularly among religious patients with severe, chronic, or terminal illnesses).

Strength and Limitations

We examined a representative sample of physicians in private practice in one federal state of Germany, so our results may not be representative of all German physicians. Compared

to other physician survey response rates (41 % for Frank and Segura 2009; 31 % for Bestmann et al. 2004), the response rate for the present study was reasonable (54 %) although still represented only about half of available physicians and could introduce a response bias (i.e., these results could represent a best-case scenario since non-responders may have been less interested in the topic, which might reflect their personal R/S beliefs and practices.

Conclusion

In a representative sample of German physicians in private practice, we found that they were frequently affiliated with a religious denomination, but they were much less likely to perceive themselves as R/S or engaged in R/S practices. Low rates of addressing R/S issues in clinical practice were associated with physicians' personal R/S beliefs and attitudes, since those who were more R/S were more likely to address R/S issues. Because R/S has been found in many studies to be an important way that patients cope with illness, particularly religious/spiritual patients, German physicians (as well as those in other parts of the world) need training and education on how to address these R/S issues when they are important to patients.

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