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Religious Characteristics of Family Physicians and their Perception of religious and spiritual Issues in the Doctor-Patient Relationship

A Survey of Family Physicians in the Canton of Berne

Master Thesis submitted by

Robin Münger

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Supervisor: Prof. Dr. med. Jean-Marc Burgunder

University Clinic for Neurology, Inselspital Berne, Medical Faculty of the University of Berne

Co-Advisor: Dr. med. René Hefti, Lecturer for Psychosocial Medicine

Medical Faculty of the University of Berne and Research Institute for Spirituality and Health

Table of Content

1. Introduction 4
1.1. Background 5
1.2. Definitions 5
1.3. Objectives of the master thesis 6
2. Methods 7
2.1. Survey 7
2.1.1. Construction and validation 7
2.1.2. Selection of participants 7
2.1.3. Means of contact 8
2.1.4. Short questionnaire 8
2.2. Statistics 8
2.3. Weighting 9
2.3.1. Original questionnaire 9
2.3.2. Short questionnaire 10
2.4. Survey response 10
2.4.1. Original questionnaire 11
2.4.2. Short questionnaire 11
2.5. Centrality of Religiosity 12
3. Results 14
3.1. Comparison of respondents and non-respondents 14
3.2. Medical education and practice 15
3.3. Religious characteristics 15
3.3.1. Religious affiliation 16
3.3.2. Religious history 16
3.3.3. Religious self-concept 16
3.3.4. Intrinsic religious orientation 16
3.3.5 Centrality of religiosity groups compared with the Swiss population 17
3.4. Observations and interpretations 18
3.4.1. General observation 18
3.4.2. General interpretation 19
3.4.3. Potential positive and negative influence of R/S 20
3.5. Correlations 21
4. Discussion 23
4.1. Religious characteristics 23

4.2. Physicians' perspective 23
4.3. Influence of R/S characteristics on observation and interpretation 24
4.4. Limitations 25
4.5. Conclusion 25
5. Executive Summary 27
6. References 29
Appendix 30
Original questionnaire 30
Short questionnaire 39
Letter of invitation 41
General information 42
Declaration 43

1. Introduction

Over the last decades, spiritual care has become a growing field of research. Many studies have been carried out on how religiosity and spirituality (R/S) might or might not influence health[1], including physical as well as mental health[2]. Since patients' R/S influences have a significant impact on decision-making and coping with disease, it should be integrated into a patient-centred medicine[3].. The focus so far has been laid mainly upon the patient perspective[5]. However, the physician-patient relationship is shaped both by the patient and the physician. Despite this fact, there are only few attempts to investigate the physicians' perspectives and attitudes on R/S in patient care[6-8]. The physicians' perspectives should be of equal interest, because it largely influences physicians' decision-making and dealing with existential questions, maybe even his clinical practice. So, patient care varies in relation to the R/S characteristics of their physician. Physicians themselves should reflect on this influence for the purpose that each patient receives the best possible care.

Vermandere et al. found that in general practice "many GPs [general practitioners] see it as their role to identify and assess patients' spiritual needs, despite perceived barriers such as lack of time and specific training".[8] The study pointed out that for most physicians spiritual care is an important part of patient-centred care, however, many see their role limited to listening to and actively participating in what the patient eventually tell by themselves. Many physicians admitted experiencing feelings of discomfort discussing R/S issues and a lack of knowledge on how to support their patients coping with disease by integrating religious or spiritual resources. However, the more alike the concepts of R/S of the patient and the physician, the easier the discussion of R/S issues will be.[8]

The Swiss Catalogue of Learning Objectives for Undergraduate Medical Training (SCLO, 2nd edition, 2008[a]) names two objectives concerning religion and spirituality:

- G ME 8: "The physician takes into consideration relevant context and background of the patient, including family, social, cultural and spiritual factors"
- G PR 2: "The physician shows awareness of cultural, societal and spiritual/religious issues that impact on the delivery of care"

Thus, Swiss physicians should be aware of R/S issues and take them into consideration.

[a] http://sclo.smifk.ch/sclo2008/fulltext/general (14.11.2016)

1.1. Background

In the Torah God says to his people, "[…] I am the LORD that healeth thee."[b] Instructions on how to deal with disease and illness can be found throughout the Torah, the first five books of the Holy Scripture of both Jews and Christians. Muslim faith is rooted back in these books and has additional advices on how to deal with health, e.g. food instructions. Also, Eastern religions deal with health and healthiness, which we find today for example in so traditional Chinese medicine (TCM). In many tribal religions throughout the entire world, the same person handles spirits and disease. Hence, it may be stated that religion, and spirituality have an interaction with health rooted back to the very beginnings of written history. Also today when people struggle with health and illness many use "religious" or "spiritual" resources to cope. How does this impact physicians' beliefs and practices?

Especially family physicians with long lasting physician-patient relationships are in a unique position to witness the influence of R/S on health. How do they perceive the interaction between religiosity, spirituality and health? Are they aware of the possibly strong connection? Do they put R/S aspects into account when it comes to decision making in their everyday practice?

1.2. Definitions

The terms *religiosity* and *spirituality* are ambiguous. In the last few decades, a trend towards studying *spirituality* rather than *religiosity* was observed[6]. *Spirituality* is often understood as including a wider range of aspects than *religiosity*. *Spirituality* may be defined as an integrated aspect of humanity, that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.[2] This definition is used as the working definition in palliative care. Following this definition *spirituality* corresponds very strongly with *relationship*; hence every human being can be described as spiritual, being at least in a relationship with him- or herself.[8] The present master thesis builds on a questionnaire that doesn't define *religiosity* nor *spirituality*, allowing physicians to apply his or her own working definition.[9] As consequence, the terms *religiosity and spirituality* are use exchangeable and abbreviated as "R/S".

[b] Exodus 15 :26 (King James Version)

1.3. Objectives of the master thesis

The goal of this thesis is to provide a baseline description of the R/S concepts of family physicians in the Canton of Bern, Switzerland. Little is known about the perception of physicians concerning this topic, especially in a western European context, concretely Switzerland. So the aim of this master thesis is to shed light on this topic. The results shall provide a background for further investigations, i.e. whether adjustments of the current curriculum of medical studies in Switzerland concerning R/S are required.

Detailed objectives are as follows:

1. Describe the religious profile of family physicians of the Canton of Bern and compare them with the general Swiss population.
2. Describe the observations and interpretations of these physicians on the interaction between R/S and health care and compare them with US-American physicians' observations and interpretations.
3. Describe to what extend the physician's religious characteristics influence his or her observations and interpretations.

My hypothesis is that

1. The religious profile of family physicians is not significantly different from the religious profile of the general population, even though it is often postulated otherwise.
2. Most physicians encounter aspects of R/S in their physician-patient relationships. Therefore, this topic is considered in the patient care by most family physicians (certainly in relation to end of life issues).
3. The extent to which physicians integrate R/S into daily business is associated with the physicians' personal religious profile. The more important R/S is in the physicians' personal life, the more those aspects will be integrated in patient care

2. Methods

A defined sample of all family physicians of the Canton of Bern was chosen from a register of the FMH (Swiss Medical Association) was surveyed by means of a questionnaire

2.1. Survey

Curlin and colleagues from the University of Chicago[6] created a questionnaire to measure physicians' observations and interpretations of the influence of R/S on patients' health as well as their attitudes and self-reported behaviours regarding R/S issues in clinical settings.

2.1.1. Construction and validation

The original questionnaire was constructed with the help of the existing literature and previous qualitative surveys conducted on this topic.[7] The questionnaire was tested via multiple iterations of expert panel reviews. It was subdivided into three sections asking for A) the physician's perspective on R/S in the context of medicine, B) the physician's religious background and C) sociodemographic data of the physician (see Appendix). The version used for this master thesis was translated into German by Lee and colleagues[10] in order to use it for a pilot study in Germany. Lee and colleagues adapted the questionnaire to the European context by integrating questions from the "Religionsmonitor 2008"[c]. After elaboration it was revised by a team of professionals.[11]

2.1.2. Selection of participants

The aim was to have the questionnaire completed by at least 50 family physicians of the Canton of Bern. From earlier experience with this questionnaire in the Cantons of Basel-Stadt, Basel-Landschaft and Aargau, the presumed response rate was around 25%. Therefore, at least 200 family physicians had to be contacted to acquire the 50 questionnaires. According to the register of the Swiss Medical Association (FMH), there are around 1000 family physicians registered in the Canton of Bern[d]. The sample of participants was defined by choosing every fifth family physician in this register, beginning with the first address. The chosen physicians were listed in an Excel file. Every contact was given a personal code for the online questionnaire. In addition to this code, the full name, sex, address of the office, canton of residence and phone number were filled in. Year of birth, year of graduation and the academic title were added if available. Since the physicians are free to decide what information they will display on the register of the FMH, the year of birth and graduation could not be registered for some of the contacts.

[c] www.religionsmotor.de (24.10.2016)
[d] www.doctorfmh.ch (11.02.2016)

After contacting 219 physicians the actual response rate was lower than expected and it was decided that another 200 physicians were selected from the list. Thus, in total 436 physicians were registered in the study file.

2.1.3. Means of contact

After listing, each contact was called by telephone and asked whether he or she was willing to participate in the survey. In most cases the indicated phone number was the physician's office. Hence, an assistant (MPA) of the physician usually answered the phone. If the physician or the assistant agreed to have at least a closer look at the questionnaire, they indicated their email address which was then listed on the Excel file. Afterwards, they received a letter of invitation (see Appendix) and a description of the project by email (see Appendix). These documents contained a short explanation of what the project was about and a guide on how they could participate. In addition, the code for online participation was communicated. The participant could either fill in the online questionnaire, ask for a printed copy by mail, answer the questions via telephone or in the context of a short personal interview. If the physician was not willing to complete the original questionnaire, he or she was asked to fill out the short questionnaire introduced in chapter 2.1.4.

After participating in the online questionnaire, the physicians were asked to indicate their personal code. This code was saved separately to identify the physicians who participated in the survey. This code couldn't be linked with the answers so that anonymization was guaranteed. As a reward, each physician who completed the questionnaire received a short summary of his or her religious profile compared to the mean Swiss population.

The questionnaires filled out by hand or by the interviewer during a personal interview or a phone call were also entered in the online databank. The interviewer was always the same person to ensure it had been done always in the same way.

2.1.4. Short questionnaire

The short questionnaire was designed to assess and characterize the non-responding group. The non-responding participants were asked their age and sex as well as their religious affiliation and their self-concept of religiosity and spirituality. Furthermore, they had to indicate the reason for not filling out the original questionnaire (see Appendix).

2.2. Statistics

All calculations have been done by "IBM SPSS Statistics 24.0" for Windows.

Beforehand, the data was weighted according to the instructions of "Survey Methodology"[12]. Chapter 10 "post collection processing of survey data" was followed. Women were a slightly more likely to answer the questionnaire than men thus the ratio between women and men was

adjusted to the ratio of all registered family physicians of the Canton of Bern, indicated by the FMH.[e] Further explanation is given in Chapter 2.3. Missing data, i.e. not answered items, were excluded from each calculation separately. Thus, the number of participants (n) varies from calculation to calculation.

Most of the data were calculated by *frequencies* giving the percentage of different answers for each characteristic. Thus, estimated proportions for all the survey items were generated, some of which are presented in Chapter 3.

Correlations between the religious characteristics of the physicians and their understanding of the religion and health link were calculated using the Spearman's rho for ordinal measure of correlation.

2.3. Weighting

From the total of 822 practicing family physicians in the Canton of Bern (ambulant setting) 243 are women, resulting in **29.6% women** (Table [1])**.**

Table [1]: Family physicians by sex in the Canton of Bern[f]

Sector	**Male**	**Female**
Ambulant	579	243
Stationary	157	175
Other	17	5
Total	753	423

2.3.1. Original questionnaire

25 women and 54 men participated in the survey resulting in **31.6% women** (Table [2])**.** Thus, women are overrepresented among the respondents by **2.0%**. To correct this, every answer of a woman was multiplied by **0.935** and every answer of a man was multiplied by **1.030**.

Table [2]: Characteristics of respondents to original questionnaire (n=79)

Characteristic	Answers	Frequency (n)	Frequency (%)
Sex	Male	54	68.4
	Female	25	31.6

The ratio has been calculated as follows: 29.6% of 79 is 23.3, therefore the 25 answers of the women must equal 23.3 answers, they are thus multiplied by 0.935. The 54 answers of men must represent 70.04% of 79. Their answers are thus multiplied with 1.030.

[e] http://www.fmh.ch/politik_themen/aerztedemographie.html (14.11.2016)
[f] http://aerztestatistik.myfmh2.fmh.ch/ (11.11.2016)

2.3.2. Short questionnaire

81 physicians completed the short questionnaire. Six of them were excluded from the analysis because they were not part of the targeted population (3), they did not indicate their sex (2), or they had already participated in the original survey (1) Conclusively, 75 sets of answers were analysed. The distribution between men and women is shown in Table [3].

Table [3]: Demographics of respondents to short questionnaire (n=75)

Characteristic	Answer	Frequency [n]	Frequency [%]
Sex	Male	50	66.7
	Female	25	33.3

Out of the responding physicians, 33.3% are female, while in the original population, 29.6% are female. Hence, we have an overrepresentation of women of **3.7%**. To correct this, answers of women were multiplied by **0.888** and answers of men by **1.056**.

The ratio was calculated as follows: 29.6% of 75 is 22.2, therefore the 25 answers of women must equal 22.2 answers, they are thus multiplied by 0.888. The 50 answers of men must represent 70.04%, that means 52.2 answers, their answers are thus multiplied by 1.056.

2.4. Survey response

According to "Survey Methodology"[12], the response rate may be calculated as follows:

$$RR = \frac{I}{I + R + NC + O + e(UH + UO)}$$

- I = total number of answers
- R= refusal and breakoff
- NC = Noncontact
- O = other eligible
- UH = unknown if part of target population
- UO = unknown eligibility, other
- e = estimated proportion of cases of unknown eligibility that are eligible

  e may be estimated by

$$e = \frac{I + R + NC + O}{I + R + NC + O + IE}$$

- IE = ineligibles chosen into sample

This calculation is needed because the FMH-list is not up to date. Therefore, physicians with other subspecialties or retired physicians were taken into the sample. It is assumed that those

who answered the questionnaire are part of the target population, some physicians answered by informing that they are not part of the target group. Those are the ineligibles chosen into sample (IE). Many physicians did not answer at all. It remains unclear how many of them belong to the target population. As an approximation, it is estimated that the percentage of ineligibles among the unknown (UH) equals the percentage of ineligibles among the respondents. This may not be exact but it is the best approximation possible.

2.4.1. Original questionnaire

The response rate for the original questionnaire is calculated in the following way: 436 physicians have been recorded. The total number of answers was 79 (I=79); 37 physicians communicated that they did not want to fill out the questionnaire, thus they are the refusals (R=37); 26 physicians could not be reached, e.g. because the phone number was not up to date, they are the group of "noncontact" (NC = 26); 75 physicians did not fill out the original survey but the short questionnaire, they are thus other eligible (O=75); 30 physicians were not part of the target group, they are either not family physicians, already retired or practice outside of the Canton of Bern, so they are the ineligibles chosen into the sample (IE=30); 183 physicians didn't answer at all, so they are the unknown (UH=183).

$$e = \frac{79\,[I] + 37[R] + 26[NC] + 75[O]}{79[I] + 37[R] + 26[NC] + 75[O] + 30[IE]} = \frac{217}{247} = 0.88$$

$$RR = \frac{79[I]}{79[I] + 37[R] + 26[NC] + 75[O] + 0.88[e](183[UH] + 0[UO])} = \frac{79}{378.04} = 0.209$$

The response rate for the original questionnaire was therefore 20.9%.

2.4.2. Short questionnaire

The response rate for the short questionnaire is calculated as follows: 264 physicians neither answered the original questionnaire nor denied participation but met all inclusion criteria. If possible, they were all contacted a second time (by email), and asked to participate in the short version of the questionnaire. 81 physicians answered the short questionnaire, six of them were excluded from analysis because they were not part of the targeted population (3), they did not indicate their sex (2), or they already participated in the original survey (1). 75 eligible answer had been given (I=75); no one refused to participate (R=0); 9 were not contacted because they did not indicate their email address, so they are noncontacts (NC=9); all other physicians did not answer, their eligibility is not known (UH=174). All the physicians included here were among the UH of the first questionnaire. So, the same *e* was taken (*e*=0.88).

$$RR = \frac{75[I]}{75[I] + 0[R] + 9[NC] + 0[O] + 0.88[e](174[UH] + 0[UO])} = \frac{75}{237.12} = 0.316$$

The response rate for the short questionnaire therefore was 31.6%.

Groves says in chapter 10 of his book: *"concerning survey quality, instead of focusing on the response rate solely, the researcher should focus on whether response propensity and the survey variable are correlated."*[12] If they are correlated, we speak of a response bias because a subunit of participants chosen into the sample of the survey is more prone to answer the questionnaire than others, in other words the answers do not represent the original population. A response rate of 20.6% in the original survey strongly suggests a response bias. A possible bias could be that only those physicians already interested in R/S issues answered the questionnaire (see Chapter 3.1.)

2.5. Centrality of Religiosity

Huber[13] developed a questionnaire to measure centrality of R/S for a person assessing five dimensions and integrate them into one score, the Centrality of Religiosity Scale (CRS). Until 2012, it had been applied in more than 100 studies in sociology of religion, psychology of religion and religious studies in 25 countries with a total of more than 100000 participants. The largest single application is in the Religions Monitor with representative samples in 21 countries.[13] The results of a study conducted in Switzerland in 2008 as part of this Religions Monitor served as the mean score of the Swiss population.

The CRS exists in three forms either including one, two or three questions per dimension (CRS-5, CRS-10 and CRS-15). A scale from one to five measures each dimension. The higher the score, the more central is the referred dimension in the individual's life. The mean of the five dimensions equals the CRS-Score (see Table [4]).

To adapt the CRS for cross-cultural studies, some dimensions, the dimension of personal practice and the dimension of R/S experiences had to be made more inclusive. Therefore, the new score is more facetted, e.g. somebody's private practice may be more of a direct talk with a counterpart as in prayer (dialogical pattern of R/S) or may be more of a reference to the self and/or an all-pervasive principle as in meditation (participative pattern of R/S). Hence, the newest version of the CRS-5, the CRSi-7, includes seven questions, two for private practice, two for experience and one question for each of the remaining three dimensions. For the private practice and the experience dimension, only the question with the higher score is

considered. Therefore, it includes five answers per individual.[13,14] The possible answers are transformed into the five-scale system of the CRS as described in Table [5].

Table [4]: Dimensions of the Centrality of Religiosity Scale (CRSi-7)

Dimension	Description	Question
Intellect	Thinking about religion, religious concepts, bodies of mind	- How often do you think about religious issues?
Ideology	Belief and relation to an existence of a transcendent reality of the individual	- To what extent do you believe that God or something divine exists?
Public practice	Public participation in religious rituals	- How often do you take part in religious services?
Private practice	Devotion of the individual to the transcendent in private	- How often do you pray? - How often do you meditate?
Experience	"One-to-one-experiences" as well as "the experience of being in one with all"	- How often do you experience situations in which you have the feeling, that God or something divine impresses in your life? - How often do you experience situations in which you have the feeling that you are in one with all?

Table [5]: Transformation of answers into CRSi-7

Score	Intellect and Experience	Ideology	Public practice	Private practice
5	- Very often	- Very much so	- More than once a week - Once a week	- Several times a day - Once a day
4	- Often	- Quite a bit	- One to three times a month	- More than once a week
3	- Occasionally	- Moderately	- A few times a year	- Once a week - One to three times a month
2	- Rarely	- Not very much	- Less often	- A few times a year - Less often
1	- Never	- Not at all	- Never	- Never

According the CRS, the physicians can be categorized into three groups: not religious (score 1.00-2.00), religious (score 2.01-3.99) and highly religious (score 4.00-5.00). For highly religious persons, R/S takes a central position in their personality; religious persons have an individual R/S concept, but it plays only a minor role in their life; not religious persons scarcely recognize R/S contents or practices in their life. To have a comparable variability in all three groups, a central group of "religious" persons is built (score 2.50-3.50), this class is said to represent the R/S attitudes of the whole "religious" group most adequately.[14] Empirical evidence for the validity of these classes have been published on several occasions.[15-17] For each physician, the centrality of religiosity score was calculated and he was classified into one of the three groups mentioned

3. Results

3.1. Comparison of respondents and non-respondents

To exclude a response-bias the two groups must be compared related to their main characteristics. As mentioned in Chapter 2.4., the differences between the religious measures of respondents and non-respondents are of special interest. If there exist significant differences, a considerable responds bias between respondents and non-respondents must be postulated. If no significant differences exist, there is no evidence for a response bias with the available data.

Table [6] Comparison of respondents and non-respondents			
Characteristic		Respondents n=78	Non-respondents n=75
Age [years]		54.35 (9.69)	53.80 (10.34)
Sex	Male [%]	68.4	66.7
	Female [%]	31.6	33.3
Religious affiliation	Christianity [%]	83.7	62.9
	Judaism [%]	2.6	0
	Islam [%]	1.2	0
	Hinduism [%]	1.2	0
	Buddhism [%]	1.2	2.8
	No religious affiliation [%]	10.2	29.1
Self-concept	Religious [mean]	2.58 (1.14)	2.25 (.95)
	Spiritual [mean]	2.65 (1.20)	2.42 (1.33)

As shown in Table [6], the two groups have approximately the same size (n= 79 vs. n=75). Both groups indicated age, sex, as well as religious affiliation and the self-concept of religiosity and spirituality. The answers were corrected for sex and religious affiliation and afterward compared by a t-test for Equality of Means. The results are presented in Table [7].

Table [7]: Independent samples test					
Characteristic	t	df	Sig. (2-tailed)	95%-CI	
				Lower	Upper
Age	-0.334	146	.739	-3.80702	2.70705
Self-concept “religious”	-1.926	151	.056	-.66942	.00859
Self-concept “spiritual”	-1.148	151	.253	-.64284	.17038
95%-CI: 95% Confidence Interval of the Difference					

The results indicate that there is no significant difference between respondents and non-respondents, neither in age nor in religious or spiritual self-concept. Hence, there is no evidence for a response bias.

The non-respondents also have been asked for the reason for not answering the original questionnaire: 41% mentioned "lack of time", 12% "no interest" and another 12% "other reasons" (e.g. "too many questions in the original questionnaire"). 35% said they do not know why they had not participated in the original questionnaire.

3.2. Medical education and practice

Of the 79 physicians answering the original questionnaire, 70 received their medical education completely in Switzerland, three completely in Germany and the remaining six studied in Switzerland and abroad (Brazil, Chile, Germany (2), France (3), Zimbabwe) (Table [8]).
The average age of all physicians is 54.49 years with the youngest being 34 and the oldest 79 years old (Table [6]). 43.9% are between 56 and 65 years old, 7.6% are older than 65 years. The physicians have in average 26.45 years of work experience (Table [8]). 50% of all physicians have 30 or more years of practice.

Table [8]: Medical education and practice (n=79)

Characteristic	Answers	[n]	[%]	**Characteristic**	Mean	Min	Max
Country of medical education	Switzerland	70	88.6	**Years of practice**	26.45 (9.85)	6	53
	Abroad	3	3.7	**Number of patients treated per week**	92.3 (66.57)	0	500
	Both	6	7.7				

On average, the physicians treated 92.3 patients per week. The variance was very large reaching from 0 up to 500, resulting in a standard deviation (SD) of 66.57 (Table [8]). 67.8% of all physicians treat 100 or less patients per week.

3.3. Religious characteristics

In this chapter, the religious characteristics ("profile") of the family physicians is presented using different categories. Data also are compared with the general Swiss population.

3.3.1. Religious affiliation

83.7% of all the physicians indicated in the survey either to belong or relate to Christianity. 10.2% do not feel linked to any religious community, 2.6% are Jews, 1.2% Muslims, Hinduists, and Buddhists respectively (Table [6]: Religious affiliation). Of the physicians related to Christian denomination, 27.8% are catholic, 40.6% are protestant, 5.2% evangelical, 1.3% orthodox and 4.7% indicated another one, e.g. Seventh-day Adventist Church or not defined.

3.3.2. Religious history

60% of the physicians received a religious education in their childhood, 30% experienced a religious or spiritual turning point in their life, and 40% of the physicians said, their current religious or spiritual worldview differed from the one they were raised in (Table [9]).

Table [9]: Religious history of physicians (n=79)

Characteristic	Response	Frequency [n]	Frequency [%]
Religious upbringing	Yes	46	58.3
	No	31	39.1
	Don't know / no answer	2	2.6
Religious turning point	Yes	24	30.6
	No	55	69.4
Religious consistency	Yes	48	60.7
	No	31	39.3

3.3.3. Religious self-concept

20% of the physicians considered themselves not religious at all, 55% said they were little or medium religious, around 19% considerably religious and only 3.8% very religious. 18% said they were not spiritual at all, 55% said they were little to medium spiritual, 20% considerable spiritual and 5% very spiritual (Table [6]: Self-concept).

3.3.4. Intrinsic religious orientation

Calculating the distribution of the answers to the Centrality of Religiosity Scale (CRS) the following picture appeared: Only 5% never reflect on R/S, almost 50% do so occasionally, 28% often and 9% very often. 39% of the physicians are strongly convinced that there exists a God, Deities, or something divine. 69% answered the question with "medium" to "very much". 60% of all physicians attend less than several times per year a religious service, 9% once per week or more. 20% of all physicians pray once a day or more, 28% never pray. Almost three

quarters of all physicians have registered an impact of God or a divine force in their life, 34% register such an influence occasionally, 13% often and 6% very often.

Table [10]: CRS dimensions and mean CRS Score		
Dimensions	**Items (n)**	**Mean [SD]**
Intellect	How often do you think about religious issues? (n=78)	3.27 [.94]
Ideology	To what extent do you believe that God or something divine exists? (n=72)	3.54 [1.56]
Public practice	How often do you take part in religious services? (n=79)	2.47 [1.10]
Private practice	How often do you pray? How often do you meditate? (n=77)	3.04 [1.47]
Experience	How often do you experience situations in which you have the feeling, that God or something divine impresses your life? (n=68) How often do you experience situations in which you have the feeling that you are in one with all?	3.01 [1.12]
	Mean CRS-Score (n=62)	**3.10 [1.00]**

Table [10] presents the mean scores of the five dimensions of the CRS as well as the total CRS-score. Intellect and ideology show the highest values whereas public practice the lowest. The mean CRS-score equals 3.10 and fits therefore with the religious group (see 3.3.5)

3.3.5 Centrality of religiosity groups compared with the Swiss general population

According the Centrality of Religiosity Scale the family physicians can be categorized into three groups: the not religious [CRS 1.0-2.0], the religious [CRS 2.5-3.5], and the highly religious [CRS 4.0-5.0]) as presented in Table [11] and Figure [1]. In between are the "intermediate religious" with CRS 2.01-2.49 (intermediate 1) and 3.51-3.99 (intermediate 2).

Figure [1] Comparison between family physicians and Swiss population

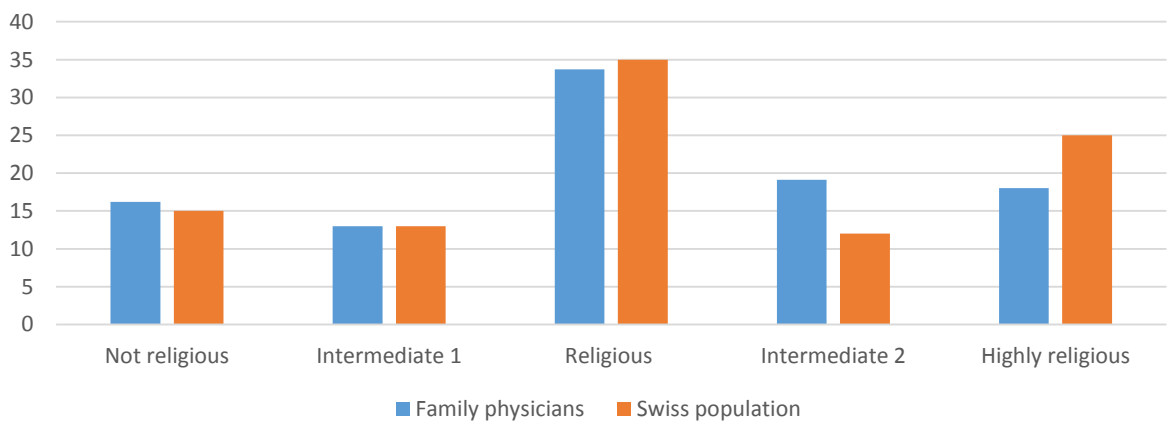

Table [11]: Comparison of Centrality Groups and Centrality Scores				
	Swiss family physicians (n = 62)		Swiss general population[13] (n = 965)	
CRS-Groups	Percent	Cumulative Percent	Percent	Cumulative Percent
Not religious	16.2	16.2	15	15
Intermediate 1	13.0	29.2	13	28
Religious	33.7	62.9	35	63
Intermediate 2	19.1	82.0	12	75
Highly religious	18.0	100.0	25	100
Total	100.0		100	
	Mean (SD)	Std. Error of Mean	Mean (SD)	Std. Error of Mean
CRS-Score	**3.10 (1.00)**	0.13	**3.15 (0.97)**	0.02

For comparison, the results of the Swiss general population gained by the "Religion Monitor 2008" are presented[13] (percentages). No main differences are found between the two groups. Only the highly religious are numerous in the Swiss general population. This is against the general opinion that physicians are less religious than the general population.

3.4. Observations and interpretations

In this chapter the answers to the following questions are presented: How do family physicians perceive religion and spirituality in their daily work? What do they observe and how do they interpret it? In order to compare the results of the Swiss survey with results of previous studies in the United States, exactly the same questions have been used. The answers of the US-American study have been grouped into three categories rather than five, so we grouped our results accordingly, see Tables [12] - [14].

3.4.1. General observation

80% of the physicians think that the experience of illness increases the patients' awareness of and focus on R/S "occasionally" or even "often". However, 56% of the physicians say, patients never or rarely mentioned R/S issues in their consultations, only 55% of the physicians ask their patients about R/S issues (Table [12]).

US physicians perceive more often that illness increases the patients' awareness of and focus on R/S. Most Swiss physicians mention that this is occasionally the case, most US physicians report this happens often or even always. It seems as if patients in the US mention R/S issues generally more often than Bernese patients. 76% of the US physicians repot that patients mentioned R/S issues occasionally or often whereas 42.6% of Swiss physicians do so.

Table [12]: Swiss physicians' general observations compared with US colleagues				
Items	Response	Frequency [n]	Frequency [%]	US Phys[9] [%]
How often does the experience of illness increase patients' awareness of and focus on R/S?	Never / Rarely	8	10.2	2
	Occasionally	42	53.2	34
	Often / Always	27	34.4	64
	No answer	2	2.4	-
How often have your patients mentioned R/S issues like God, prayer, meditation, the Bible, etc?	Never / Rarely	45	56.4	24
	Occasionally	27	34	51
	Often / Always	7	8.6	25
Do you ever ask for R/S issues of your patients?	Yes	44	55.4	-
	No	33	41.9	-
	No answer	2	2.6	-

3.4.2. General interpretation

Almost 91% of Swiss physicians think that R/S has influence on the patients' health but 61% are convinced that this influence is generally negative. The physicians are undecided if a supernatural being ever intervenes in the patients' health (Table [13]).

Table [13]: Swiss physicians' general interpretations compared with US colleagues				
Items	Response	Frequency [n]	Frequency [%]	US Phys[9] [%]
Overall, how much influence do you think R/S has on patients' health?	Very much / Much	36	45.4	56
	Some	36	45.5	35
	Little / None	7	9.1	9
Is the influence of R/S on health generally positive or negative?	Positive	29	36.4	85
	Negative	48	61	1
	Equal	0	0	12
	It has NO influence	2	2.6	2
Do you think God or another supernatural being ever intervenes in patients' health?	Yes	29	36.9	54
	No	30	37.9	28
	Undecided	20	25.2	18

Also US physicians agree in the notion, that R/S has nfluence on the patients' health, but in contrast to the Swiss physicians the big majority of US physician's belief this influence is mainly positive. Most US physicians are also convinced that God or a supernatural being can intervene in patients' health.

3.4.3. Potential positive and negative influence of R/S

95% of the physicians (US and Swiss) state that R/S helps the patient to cope with and endure illness and suffering occasionally or often, no physician said there is never an influence, However, according to over 60%, R/S never or rarely changes "hard" medical outcomes like heart attacks, infections, or death (Table [14]). Around 60% belief that occasionally or often R/S causes guilt, anxiety or other negative emotions and thus increases suffering of their patients, but more than 65% think that R/S never or rarely leads patients to refuse, delay or stop medically indicated therapy.

Table [14]: Responses regarding potential positive or negative influences of R/S

Questionnaire Item	Response	Frequency [n]	Frequency [%]	US Phys[9] [%]
R/S helps to prevent "hard" medical outcomes like heart attacks, infections or even death	Never / Rarely	51	64.4	61
	Occasionally	16	20.3	33
	Often / Always	5	6.4	6
	No answer	7	8.9	-
R/S helps patients to cope with and endure illness and suffering	Never / Rarely	3	3.9	1
	Occasionally	35	44.9	23
	Often / Always	40	51.2	76
R/S gives patients a positive, hopeful state of mind	Never / Rarely	1	1.3	1
	Occasionally	46	58.3	25
	Often / Always	32	40.4	74
How often have your patients received emotional or practical support from their religious community?	Never / Rarely	19	24.2	4
	Occasionally	40	51	41
	Often / Always	14	17.4	55
	No answer	6	7.5	-
R/S causes guilt, anxiety, or other negative emotions that lead to increase patient suffering	Never / Rarely	31	39.0	55
	Occasionally	38	48	38
	Often / Always	9	11.7	7
	No answer	1	1.3	-
R/S leads patients to refuse, delay, or stop medically indicated therapy	Never / Rarely	53	66.7	68
	Occasionally	26	33.3	30
	Often / Always	0	0	2
How often have your patients use R/S as a reason to avoid taking responsibility for their health?	Never / Rarely	57	72.0	67
	Occasionally	16	20.5	29
	Often / Always	2	2.5	4
	No answer	4	5.1	-

As described in the last paragraph, US and Swiss physicians differ strongly in their convictions related to positive or negative influence of R/S on patients' health. In more specific questions there is much more agreement. For example, almost the same percentage of US and Swiss physicians say R/S rarely or never influences "hard" medical outcomes. On the other hand, US physicians state that patients receive more often support from their religious community

or that R/S gives patients a positive state of mind, compared to their Swiss colleagues. Two thirds of both US and Swiss physicians say that R/S never or rarely prevents patients from medically indicated therapy. Even more than two thirds of both physician groups belief that patients don't use R/S as a reason to avoid taking responsibility for their health.

3.5. Correlations

This chapter will answer the question whether physicians own religious orientation influences his perception and interpretation of R/S matters in the physician-patient relationship Specific items from part A of the original questionnaire were analysed. Answers are correlated with the CRS-Scores of the physicians and as well their religious and spiritual self-concept.

Table [15]: Correlations between religious orientation and observations/interpretations

Items	N	Mean (SD)[a]	Correlation with CRS	Correlation with Self-concept	
				religious	spiritual
Patient mentions R/S issues	79	2.44 (.74)	.386**	.287*	.296**
Divine intervention	59	1.50 (.50)[b]	-.744**	-.561**	-.416**
Change of medical outcome	72	2.11 (.86)	.626**	.425**	.316**
Coping resource	79	3.48 (.59)	.341**	.304**	.246*
Negative emotions	78	2.69 (.71)	.173	.060	.194

**. Correlation is significant at the .01 level (2-tailed).
*. Correlation is significant at the .05 level (2-tailed).
[a]. Answer categories: 1= never, 2= rarely, 3= occasionally, 4= often, 5= always
[b]. Answer categories: 1= yes, 2= no

As shown in Table [15], a correlation coefficient (r) of .38 was found between the CRS-Score and the physician's perception of patients mentioning R/S issues ($p < 0.01$). Also, the religious and spiritual self-concepts are significantly correlated. A strong correlation ($r = -.74$) appears between the CRS-Score and the consideration of a divine intervention in patients' health ($p<0.01$). The picture is even clearer in Table [16]. All the "highly religious" physicians think a divine intervention is possible, whereas the big majority of the "not religious" does not. The majority of the "religious" physicians is undecided.

Another strong and significant correlation ($r =.62$) is found for the conviction that R/S of a patient can influence medical outcomes like a myocardial infarction or infections. The correlations for the idea that R/S helps patients to cope with an illness are weaker but still significant.

Interestingly, for the question whether R/S attitudes of patients can lead to negative emotions as guilt or fear and thus prolong suffering, no significant correlations could be found, neither with the CRS-Score nor the two self-concepts.

Table [16]: Cross table for CRS Groups and observations/interpretations (n=72)

		CRS Groups				
		not religious	int.1[a]	religious	int.2[b]	highly religious
Patient mentions R/S issues	Never	4	0	0	0	1
	Rarely	7	6	13	8	1
	Occasionally	3	3	8	5	6
	Often	0	0	3	1	3
Divine intervention	Yes	1	0	7	10	11
	No	13	5	6	2	0
	Undecided	0	4	11	2	0
Change of medical outcome	Never	10	1	4	1	0
	Rarely	3	7	11	5	4
	Occasionally	0	1	6	5	3
	Often	0	0	0	1	4
	Undecided	1	0	3	2	0
Coping mechanism	Rarely	2	0	1	0	0
	Occasionally	8	6	9	5	2
	Often	4	3	14	9	8
	Always	0	0	0	0	1
Negative emotions	Never	2	0	0	0	0
	Rarely	4	5	10	3	4
	Occasionally	6	3	11	9	5
	Often	2	1	2	2	2
	Undecided	0	0	1	0	0

[a]. CRS-Score 2.01-2.49

[b]. CRS-Score 3.51-3.99

4. Discussion

4.1. Religious characteristics

Two thirds of the physicians say that they underwent religious education in their childhood (Table [9]: Religious upbringing) and more than one thirds state, that their current R/S worldview is not the same anymore as the one they were raised in. One third indicates a turning point (in their life concerning R/S matters. These results indicate, that R/S issues indeed play a role in the personal history of many physicians' life influencing their recent worldview in one way or the other. It is also reflected in the fact that only 15 percent don't believe at all that God, Deities, or something divine exists (Table [10]: Ideology).

In contrast, the dimension of personal and public practice is much less relevant for the physicians: 40 percent never or rarely register an impact of R/S on their life and almost 30 percent never pray or attend a religious service. On the other hand, there is a significant interest in religious and spiritual issues (Table [10]).

As Table [11] reveals, there is no significant difference between the CRS score of the Swiss general population and the family physicians of the Canton of Berne, challenging the common belief that physicians are less religious. However, only 15 percent of physicians are "highly religious" whereas 25 percent of the general population are "highly religious". Protestant regions, as the Canton of Berne, are often said to have a more secular population than catholic regions. Maybe this could be a reason for the difference in the category "highly religious". This is supported by the notion, that the biggest denomination represented among the physicians are the protestant Christians.

4.2. Physicians' perspective

85% of the family physicians observed that the experience of illness increases patients' awareness of and focus on R/S, however, over 55% say their patients never or rarely mention R/S matters and only half of the physicians ever ask for R/S matters of their patients (Table [12]). How do the physicians know, that the experience of illness increases the patients' awareness of and focus on R/S if they do not ask about it and patients rarely or never talk about it? Physicians observations may be based more on assumptions than on real knowledge.

Over 90% of the physician's belief that R/S has at least some influence on patients' health, whereas 60% think that the influence is mainly negative. Only 3% state that they don't see any influence of R/S on health. One would expect the physicians to ask their patients about something that most of them consider to have an influence on their patients' health, even more so if the influence is generally negative.

There is a huge disagreement on whether God or a supernatural being ever intervenes in patients' health. One fourth of the physicians is undecided and half of the remaining physicians say yes and the other half no. So the interpretation, whether a health intervention of God or a supernatural being really occurred seems to rely more on the physician's own belief/ expectation than on observable facts.

The comparison with the US physicians reveals some interesting differences. According to the physicians' perspective, patients in the US mention R/S matters more often and the experience of illness seems to increase the patients' awareness on R/S more often than in the Canton of Berne. The general belief of the influence of R/S on the patients' health is similar between US and Swiss physicians, but 85% of US physicians see a positive influence whereas only 36% of Swiss physicians do so only 1% of the US physicians consider the influence to be negative compared to 61% fo the Swiss family physicians (Table [13]).

A study of the literature on this topic would lead to the conclusion, that the influence at times may be positive and at other times negative[18], so the expected answer would be, that there is a positive as well as a negative influence. But no physician from the Canton of Bern and only 12% from the US have chosen this answer. 54 percent of the US physicians think that a divine intervention on health is possible, whereas 37 percent of Swiss physicians belief that God or another supernatural being ever intervenes in patients' health. . In conclusion, US physicians register more often an influence of R/S on health and they consider it to be generally positive, where most Bernese physicians think the influence is generally negative.

Interestingly the US as well as the Swiss physicians don't belief that R/S helps to prevent/change hard medical. According to US physicians, R/S gives patients more often a positive, hopeful state of mind and patients in the US receive more often support from their religious community than in the Canton of Berne.

4.3. Influence of R/S characteristics on observation and interpretation

Correlations revealed a significant association between physician's religious orientation and their observations and interpretations of R/S issues. This is true for the observation on how often patients mention R/S issues, for the consideration of a divine intervention in health, the potential of R/S to change hard medical outcomes and the conviction that R/S is a coping mechanism. Interestingly It is not true for possible negative emotions caused by R/S. Table [16] shows that highly religious physicians as well as not religious physicians think that R/S may occasionally cause negative emotions and thus prolong suffering. In the US survey highly religious physicians support the "negative emotion hypothesis" much less. This could be understood as a neglect of possible negative consequences of R/S or as an over-critical attitude of Swiss physicians.

4.4. Limitations

The following limitations of this study must be considered:

1. The low response rate: It suggests a response bias, meaning that only physicians with a personal interest in the topic answered the questionnaire. If this would be the case, no conclusion could be drawn for the whole target population, i.e. the family physicians in the Canton of Berne. Modern statistics tends to not only consider the response rate to evaluate a response bias, but also calculate significant differences between independent subsets of the whole target population.[12]. This was the idea behind the short questionnaire. A very frequent answer to the invitation to participate the survey was "I have no time". With a short questionnaire "stealing only 3-5 minutes" of the time of the busy family physicians this excuse was opposed. A significant number of short questionnaires could be collected showing no significant differences to the respondents (see 3.1.)

2. A other limitation is the mere quantitative nature of this survey making it difficult to interpret some of the results. E.g. "why do physicians not enquire about R/S matters of their patients? A reason could be that physicians who do not inquire about R/S matters never truly understand what important role R/S can play in his or her patients' health. Hence, the approach may differ significantly between a physician emphasising R/S and one considering it to be rather irrelevant. Two physicians may differently interpret the same situation. What the physician with a low CRS-Score neglects, the physician with a high CRS-Score may exaggerate.

3. The handling of "Religiosity" and "Spirituality" as one concept is another limitation. As explained in the introduction, the questionnaire did not give any definitions on the two terms, it was up to the physicians to fill these concepts with their own understanding. Regarding the differences between the answers on the self-concept of "Religiosity" and the self-concept of "Spirituality" (Table [6] and [15]), it would be very interesting to find out, what definitions of "Religiosity" and "Spirituality" physicians are working with.

4. Comparison between Bernese physicians with the general Swiss populations is not fully correct. Significant regional differences exist in Switzerland. Some regions are mainly catholic, others mainly protestant. Thus a comparison between the general Bernese population and the Bernese family physicians would be more accurate taking into account the predominant protestant characteristic of the Canton of Berne.

4.5. Conclusion

This thesis could shed some light on the R/S characteristics and attitudes of Bernese family physicians showing that only a small proportion of physicians do not belief that R/S has impact on their patients' health. The study also showed that observations and interpretations of R/S

matters correlates with the religious orientation (CRS-Score) of the physician and therefore with presumptions and expectations the physician brings into the physician-patient relationship. It is important that physicians are aware of their attitude towards R/S to avoid neglecting or overemphasizing the in their daily practice.

The personal R/S characteristics of Bernese physicians do not differ significantly from the general Swiss population. Compared to the colleagues from the USA, Bernese physicians think the influence of R/S on the health of their patients is generally more negative. This could be a good starting point for further evaluation and training on how R/S could be beneficially integrated in the context of family medicine and other fields.

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5. Executive Summary

This master thesis has been an adventure for me. It provided me with new insights on how important clear communication and organization is to work smoothly and satisfactory for everybody involved. In the end, it has taken more time than I expected in the beginning.

Data collection was a big part of the work I had to do it and it was not an easy task to reach out to all the family physicians I had to contact. It was hard and challenging to convince as many as possible to participate in the survey. There have been encouraging talks with physicians expressing their gratitude for somebody to investigate about the topic of my master thesis. On the other hand, there have been rude reactions, some have been almost insulting me of betrayal of science based medicine by just considering that something like religion or spirituality could have an influence on patients' health. This was at times demoralizing and making me question the purpose and sense of my project. However, this questioning turned out to strengthen my conviction of the importance of this topic in health care. It also encouraged me to do it as good as possible to provide comprehensible answers to the objectives of my master thesis. The biggest part of the physicians, however, never responded on my invitations. This was frustrating.

Post-collection analysis n of data was the other big portion of work to be done. This showed me how important and complex statistical analysis can be. I began to realize how important a good concept for evaluation and analysis behind a questionnaire must be, so that the answers can be analyzed. Doing this the first time, it took me a lot of time to understand which statistical test should be applied for which kind of data and what the resulting numbers really tell us. The next big insight was, how important the presentation of your data is. The results may be relevant, but if they are not presented in a readable way, the whole effort is worthless. It made me appreciate other studies and the work standing behind them more. On the other hand, I hope it helps me in future to differentiate better between studies of good quality, i.e. diligently planned and executed, from studies of lower quality.

These things said, I would like to express my gratitude for all those who helped me in the process of this project. First, I would like to thank René Hefti from the Research Institute for Spirituality and Health who put a lot of work and time into this project and supported me with the required instructions and corrections. Many thanks also to Prof. Burgunder for his support which made this project possible and for his valuable feedback throughout the whole process. Finally, I want to thank my friends and family for their loving support, giving advice, cheering me up in hard times and including me in their prayers. Glory and honor to the LORD, who

once again showed his mercy and loving kindness providing me with the necessary wisdom and strength to do and complete my work.

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Appendix

Original questionnaire

UNIVERSITÄT BERN

Forschungsinstitut für Spiritualität und Gesundheit

Fragebogen

Religiöse Einstellungen und ärztliches Handeln

Die Teilnahme an dieser Befragung ist freiwillig.

Das Ausfüllen des Fragebogens nimmt rund 20-25 Minuten in Anspruch.

Um der besseren Lesbarkeit willen wurde im Fragebogen die männliche Form verwendet. Gemeint sind aber immer Personen beider Geschlechter.

Die Begriffe „Religion / religiös" und „Spiritualität / spirituell" können so gebraucht werden, dass sie Unterschiedliches bezeichnen. Ich verwenden sie jedoch weitgehend synonym.

Falls Sie keine oder nur sehr selten Patientenkontakt haben, beantworten Sie die Fragen bitte aus Ihrer Grundhaltung heraus im Sinne einer theoretischen Möglichkeit.

Herzlichen Dank für Ihre Hilfe und Kooperation!

Dr. med. René Hefti
Forschungsinstitut für Spiritualität und Gesundheit

Prof. Dr. med. Jean-Marc Burgunder
Universitätsklinik für Neurologie, Inselspital Bern

Die Originalversion dieses Fragebogens wurde von Curlin et al. (fcurlin@medicine.bsd.uchicago.edu) von der University of Chicago entwickelt und freundlicherweise zur Übersetzung, Adaptation und Verwendung zur Verfügung gestellt. Der Originalfragebogen wurde dem europäischen bzw. Schweizer Kontext angepasst, indem Originalfragen aus dem Religionsmonitor 2008/2013 (www.religionsmonitor.de) integriert wurden.

Sektion A: Ihre Sichtweise auf Religion/Spiritualität in der Medizin

A1: Was denken Sie, wie stark Religion/Spiritualität die Gesundheit von Patienten beeinflusst?

- ☐ sehr stark [1]
- ☐ sehr [2]
- ☐ etwas [3]
- ☐ gering [4]
- ☐ gar nicht [5]

A2: Ist der Einfluss von Religion/Spiritualität auf die Gesundheit grundsätzlich positiv oder negativ?

- ☐ grundsätzlich positiv [1]
- ☐ grundsätzlich negativ [2]
- ☐ sowohl positiv als auch negativ [3]
- ☐ Religion/Spiritualität hat keinen Einfluss auf die Gesundheit [4]

A3: Denken Sie, dass Gott oder eine andere übernatürliche Instanz jemals in die Gesundheit von Patienten eingreift?

- ☐ ja [1]
- ☐ nein [2]
- ☐ unentschieden / weiss nicht [3]

A4: Finden Sie es im Allgemeinen angemessen oder unangemessen für einen Arzt, über religiöse/spirituelle Themen zu sprechen, wenn Patienten diese zur Sprache bringen?

- ☐ immer angemessen [1]
- ☐ für gewöhnlich angemessen [2]
- ☐ für gewöhnlich unangemessen [3]
- ☐ immer unangemessen [4]

A5: Finden Sie es im Allgemeinen angemessen oder unangemessen für einen Arzt, Patienten über religiöse/spirituelle Themen zu befragen?

- ☐ immer angemessen [1]
- ☐ für gewöhnlich angemessen [2]
- ☐ für gewöhnlich unangemessen [3]
- ☐ immer unangemessen [4]

A6: Finden Sie es angemessen für einen Arzt, mit Patienten über seine eigenen religiösen Überzeugungen oder Erfahrungen zu sprechen?

- ☐ nein [0]
- ☐ nur wenn der Patient darum bittet [1]
- ☐ immer wenn der Arzt dies als angemessen empfindet [2]

A7: Finden Sie es angemessen für einen Arzt, mit Patienten zu beten?

- ☐ nein [0]
- ☐ nur wenn der Patient darum bittet [1]
- ☐ immer wenn der Arzt dies als angemessen empfindet [2]

A8: In welchem Ausmass stimmen Sie der folgenden Aussage zu oder nicht zu? „Es ist/wäre für mich stimmig, mit einem Patienten über seine religiösen/spirituellen Angelegenheiten zu sprechen, wenn der Patient diese zur Sprache bringt."

☐ Ich stimme voll zu [1]
☐ Ich stimme zu [2]
☐ Ich stimme nicht zu [3]
☐ Ich stimme überhaupt nicht zu [4]

A9: In welchem Ausmass stimmen Sie der folgenden Aussage zu oder nicht zu? „Ich empfinde es als angenehm, mit einem Patienten über religiöse/spirituelle Angelegenheiten oder Belange zu sprechen."

☐ Ich stimme voll zu [1]
☐ Ich stimme zu [2]
☐ Ich stimme nicht zu [3]
☐ Ich stimme überhaupt nicht zu [4]
☐ Derartiges kommt nicht vor [5]

A10: Wie häufig haben Patienten Ihrer Erfahrung nach …

	nie	selten	manch-mal	oft	immer	keine Angabe
a) religiöse/spirituelle Themen wie Gott, Gebet, Meditation, die Bibel etc. angesprochen?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
b) emotionale oder praktische Unterstützung durch ihre religiöse Gemeinschaft erhalten?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
c) Religion/Spiritualität als Begründung benutzt, um keine Verantwortung für die eigene Gesundheit zu übernehmen?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

A11: Wie oft verstärkt Ihrer Einschätzung nach eine Krankheitserfahrung die Aufmerksamkeit der Patienten für Religion/Spiritualität?

☐ nie [0]
☐ selten [1]
☐ manchmal [2]
☐ oft [3]
☐ immer [4]
☐ keine Angabe [5]

A12: Ihrer Erfahrung entsprechend, was meinen Sie, wie häufig Religion/Spiritualität…

	nie	selten	manch-mal	oft	immer	keine Angabe
a) Patienten hilft, Krankheit und Leiden zu bewältigen und auszuhalten?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
b) Schuld, Angst und andere negative Gefühle verursacht und damit Leiden vermehrt?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
c) Patienten eine positive und hoffnungsvolle Geisteshaltung gibt?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

d) Patienten veranlasst, medizinisch indizierte Therapien abzulehnen, zu verzögern od. zu beenden?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
e) zur Vorbeugung schwerer medizinischer Probleme beiträgt (z.B. Herzinfarkte, Infektionen oder tödlicher Verlauf)?	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

A13: Fragen Sie jemals nach religiösen/spirituellen Angelegenheiten eines Patienten?

☐ ja [1] →
☐ nein [2]
☐ keine Angabe [3]

→Wenn A13 „ja":
A13a) Wie oft kommt es vor, dass Sie danach fragen?

☐ selten [1]
☐ manchmal [2]
☐ oft [3]
☐ immer [4]

→Wenn A13 „ja":
A13b) Wie oft schienen Patienten sich bei dieser Frage unwohl zu fühlen?

☐ nie [0]
☐ selten [1]
☐ manchmal [2]
☐ oft [3]
☐ immer [4]

→ Wenn A13 „ja":
A13c: Kennen Sie den Begriff „Spirituelle Anamnese"?

☐ ja [1]
☐ nein [2]
☐ Ich habe davon gehört, weiss aber nichts Näheres [3]

→Wenn A13 „ja":
A13d: In folgenden klinischen Situationen – wie oft fragen Sie von sich aus nach Religion/Spiritualität?

Wenn ein Patient… ▼	… wie oft fragen Sie dann nach religiösen/spirituellen Belangen:					
	niemals	selten	manch-mal	oft	immer	keine Angabe
a) sich mit einer banalen Erkrankung oder Verletzung vorstellt, …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
b) mit einer Angst machenden Diagnose oder Krise konfrontiert wird, …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
c) mit dem Lebensende konfrontiert ist, …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
d) unter Angst oder Depression leidet, …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

e) zur Anamnese und körperlichen Untersuchung kommt (Check-Up), …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
f) mit einem ethischen Dilemma konfrontiert ist, …	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

A14: Welche(r) der nachfolgenden Gründe hält Sie davon ab, mit Patienten über Religion/Spiritualität zu sprechen?
(Mehrfachantworten möglich)

☐ allgemeines Unbehagen beim Sprechen über religiöse Dinge [1]
☐ ungenügendes Wissen/Ausbildung [2]
☐ zu wenig Zeit [3]
☐ Sorge, Patienten zu nahe zu treten [4]
☐ Sorge, mich der Kritik meiner Kollegen auszusetzen [5]
☐ andere: _____ [6]

A15: Wenn religiöse/spirituelle Themen in Gesprächen mit Patienten auftauchen, wie oft reagieren Sie mit folgenden Verhaltensweisen?

	nie	selten	manch-mal	oft	immer	keine Angabe
a) Ich höre aufmerksam und empathisch zu.	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
b) Ich versuche taktvoll das Thema zu wechseln.	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
c) Ich bestärke Patienten in ihren eigenen religiösen/ spirituellen Überzeugungen und Gebräuchen.	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
d) In respektvoller Weise teile ich etwas über meine eigenen religiösen Vorstellungen und Erfahrungen mit.	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]
e) Ich bete mit dem Patienten.	☐[0]	☐[1]	☐[2]	☐[3]	☐[4]	☐[5]

A16: Haben Sie irgendeine Art von Schulung oder Ausbildung bezüglich Religion/Spiritualität und Medizin erhalten?
(Mehrfachantworten möglich)

☐ ja [1] (Welche? Bitte ausfüllen): _____
☐ nein [2]
☐ Ich würde mir eine (weitere) solche Schulung oder Ausbildung wünschen. [3]

A17: Ein Patient wendet sich an Sie mit fortdauernder Trauer zwei Monate nach dem Tod des Ehepartners. Wenn Sie diesen Patienten weiter verweisen müssten, an welche der nachfolgend genannten Personen würden Sie ihn zunächst verweisen?

☐ Krankenseelsorger [1]
☐ Geistlicher bzw. Berater der betreffenden Religionsgemeinschaft [2]
☐ Psychiater oder Psychotherapeut [3]
☐ andere: _____ [4]

A18: Ihre Erfahrungen mit Seelsorgern waren:

- ☐ sehr zufriedenstellend [1]
- ☐ zufriedenstellend [2]
- ☐ nicht zufriedenstellend [3]
- ☐ überhaupt nicht zufriedenstellend [4]
- ☐ Ich habe keine Erfahrungen mit o.g. Professionen [5]

A19: Hier geht es um kontrovers diskutierte Fragen im medizinischen Bereich. Bitte geben Sie an, ob Sie Vorbehalte gegen eine der nachfolgend genannten medizinischen Vorgehensweisen haben und wie Sie diese begründen.

	Ich habe keine Vor-behalte	Ich habe religiös bedingte Vorbehalte	Ich habe nicht-religiös bedingte Vorbehalte	Ich habe religiöse und nicht-religiös bedingte Vorbehalte
a) Ärztlich assistierter Suizid (Beihilfe zur Selbsttötung)	☐[1]	☐[2]	☐[3]	☐[4]
b) Gabe stark sedierender Medikamente bei sterbenden Patienten (palliative Sedierung)	☐[1]	☐[2]	☐[3]	☐[4]
c) Beendigung künstlicher lebenserhaltender medizinischer Massnahmen	☐[1]	☐[2]	☐[3]	☐[4]
d) Schwangerschaftsabbruch bei angeborenen Fehlbildungen	☐[1]	☐[2]	☐[3]	☐[4]
e) Schwangerschaftsabbruch bei ungewollter Schwangerschaft	☐[1]	☐[2]	☐[3]	☐[4]
f) Verschreibung empfängnisver-hütender Mittel für 14-16-Jährige ohne Einwilligung der Eltern	☐[1]	☐[2]	☐[3]	☐[4]
g) Fixierung am Krankenbett	☐[1]	☐[2]	☐[3]	☐[4]

A20: In welchem Ausmass stimmen Sie den folgenden Aussagen zu?

	stimme völlig zu	stimme eher zu	stimme kaum zu	stimme gar nicht zu
a) Für mich ist das Ausüben von Medizin eine Berufung.	☐[1]	☐[2]	☐[3]	☐[4]
b) Mein religiöser Glaube beeinflusst mein ärztliches Handeln.	☐[1]	☐[2]	☐[3]	☐[4]
c) Meine Erfahrungen als Arzt haben mich dazu gebracht, meinen religiösen Glauben zu hinterfragen.	☐[1]	☐[2]	☐[3]	☐[4]
d) Es ist mir wichtig, in der Medizin einen ganzheitlichen Ansatz zu praktizieren.	☐[1]	☐[2]	☐[3]	☐[4]

Sektion B: Religionsbezogene Angaben

B1: Welcher der folgenden Religionsgemeinschaften gehören Sie an bzw. fühlen Sie sich zugehörig?

- ☐ Christentum [1]
- ☐ Judentum [2]
- ☐ Islam [3]
- ☐ Hinduismus [4]
- ☐ Buddhismus [5]
- ☐ andere Religionsgemeinschaft [6]
- ☐ keiner Religionsgemeinschaft [7]
- ☐ weiss nicht / keine Angabe [8]

B2: Wenn B1 = „Christentum": Welcher Konfession gehören Sie an bzw. fühlen Sie sich zugehörig?

- ☐ katholisch [1]
- ☐ evangelisch-reformiert [2]
- ☐ orthodox [3]
- ☐ evangelikal-freikirchlich [4]
- ☐ pfingstkirchlich [5]
- ☐ charismatisch [6]
- ☐ andere Konfession, welche_____ [7]
- ☐ weiss nicht / keine Angabe [8]

B3: Sind Sie religiös erzogen worden?

- ☐ ja [1]
- ☐ nein [2]
- ☐ weiss nicht / keine Angabe [3]

B4: Gab es in Ihrem Leben einen religiösen oder spirituellen Wendepunkt?

- ☐ ja [1]
- ☐ nein [2]

B5: Ist Ihre gegenwärtige religiöse oder weltanschauliche Zugehörigkeit dieselbe wie die, in der Sie aufgewachsen sind?

- ☐ ja [1]
- ☐ nein [2]

B6: Wie stark glauben Sie daran, dass es Gott, Gottheiten oder etwas Göttliches gibt?

- ☐ gar nicht [0]
- ☐ wenig [1]
- ☐ mittel [2]
- ☐ ziemlich [3]
- ☐ sehr [4]
- ☐ weiss nicht / keine Angabe [5]

B7: Wie oft erleben Sie Situationen, in denen Sie das Gefühl haben, dass Gott oder etwas Göttliches in Ihr Leben eingreift?

- ☐ nie [0]
- ☐ selten [1]
- ☐ gelegentlich [2]
- ☐ oft [3]
- ☐ sehr oft [4]
- ☐ weiss nicht / keine Angabe [5]

B8: Wie oft erleben Sie Situationen, in denen Sie das Gefühl haben, mit allem Eins zu sein?

- ☐ nie [0]
- ☐ selten [1]
- ☐ gelegentlich [2]
- ☐ oft [3]
- ☐ sehr oft [4]
- ☐ weiss nicht / keine Angabe [5]

B9: Wie häufig nehmen Sie an Gottesdiensten (in Kirche oder Moschee oder Synagoge oder Tempel) teil? Bzw. falls Sie einer anderen Religion angehören, wie häufig nehmen Sie deren gemeinsamen spirituellen / religiösen Handlungen teil?

- ☐ mehr als einmal in der Woche [1]
- ☐ einmal in der Woche [2]
- ☐ ein- bis dreimal im Monat [3]
- ☐ mehrmals pro Jahr [4]
- ☐ seltener [5]
- ☐ nie [6]
- ☐ weiss nicht / keine Angabe [7]

B10: Wie häufig beten Sie?

- ☐ mehrmals am Tag [1]
- ☐ einmal am Tag [2]
- ☐ mehr als einmal in der Woche [3]
- ☐ einmal in der Woche [4]
- ☐ ein- bis dreimal im Monat [5]
- ☐ mehrmals pro Jahr [6]
- ☐ seltener [7]
- ☐ nie [8]
- ☐ weiss nicht / keine Angabe [9]

B11: Wie häufig meditieren Sie?

- ☐ mehrmals am Tag [1]
- ☐ einmal am Tag [2]
- ☐ mehr als einmal in der Woche [3]
- ☐ einmal in der Woche [4]
- ☐ ein- bis dreimal im Monat [5]
- ☐ mehrmals pro Jahr [6]
- ☐ seltener [7]
- ☐ nie [8]
- ☐ weiss nicht / keine Angabe [9]

B12: Alles in allem: Als wie religiös würden Sie sich selbst bezeichnen?

☐ gar nicht religiös [0]
☐ wenig religiös [1]
☐ mittel religiös [2]
☐ ziemlich religiös [3]
☐ sehr religiös [4]
☐ weiss nicht / keine Angabe [5]

B13: Einmal abgesehen davon, ob Sie sich selbst als religiöse Person bezeichnen oder nicht: Als wie spirituell würden Sie sich selbst bezeichnen?

☐ gar nicht spirituell [0]
☐ wenig spirituell [1]
☐ mittel spirituell [2]
☐ ziemlich spirituell [3]
☐ sehr spirituell [4]
☐ weiss nicht / keine Angabe [5]

B14: Wie oft denken Sie über religiöse Themen nach?

☐ nie [0]
☐ selten [1]
☐ gelegentlich [2]
☐ oft [3]
☐ sehr oft [4]
☐ weiss nicht / keine Angabe [5]

Sektion C: Soziodemografische und arbeitsbezogene Angaben

C1. Wie alt sind Sie? _____

C2: Sie sind ☐ männlich [1] ☐ weiblich [2]

C3. Wo haben Sie Ihre medizinische Ausbildung gemacht?
(Mehrfachantwort möglich)

☐ in der Schweiz. [1]
☐ im Ausland. Wo? _____ [2]

C4. Wo sind Sie hauptsächlich beruflich tätig?
(Mehrfachantwort möglich)

☐ in einer (eigenen) Praxis. [1]
☐ in einer Klinik [2] →
→ stationär (☐[3]) oder ambulant (☐[4])?
☐ Sonstige: _____ [3]

C5. In welchem Kanton sind sie beruflich tätig? _____

C6. Wie viele Jahre (etwa) sind Sie bereits berufstätig? _____

C7. Wie viele Patienten behandeln/sehen Sie in einer durchschnittlichen Arbeitswoche? _____

Short questionnaire

UNIVERSITÄT BERN

Forschungsinstitut für Spiritualität und Gesundheit

Kurzfragebogen

zur Erfassung soziodemographischer Variabeln bei Nicht-Teilnahme

Darf ich fragen, warum Sie nicht an der Umfrage teilnehmen?

☐ keine Zeit
☐ wegen des Themas
☐ anderer Grund: _____

Darf ich Ihnen zudem noch einige allgemeine Fragen stellen?

C1. Wie alt sind Sie? _____

C2: Sie sind ☐ männlich [1] ☐ weiblich [2]

C3. Wo haben Sie Ihre medizinische Ausbildung gemacht?
(Mehrfachantwort möglich)

☐ in der Schweiz. [1]
☐ im Ausland. Wo? _____ [2]

B1: Welcher der folgenden Religionsgemeinschaften gehören Sie an bzw. fühlen Sie sich zugehörig?

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☐ Judentum [2]
☐ Islam [3]
☐ Hinduismus [4]
☐ Buddhismus [5]
☐ andere Religionsgemeinschaft [6]
☐ keiner Religionsgemeinschaft [7]
☐ weiss nicht / keine Angabe [8]

B2: Wenn B1 = „Christentum": Welcher Konfession gehören Sie an bzw. fühlen Sie sich zugehörig?

☐ katholisch [1]
☐ evangelisch-reformiert [2]
☐ orthodox [3]
☐ evangelikal-freikirchlich [4]
☐ pfingstkirchlich [5]
☐ charismatisch [6]
☐ andere Konfession, welche_____ [7]
☐ weiss nicht / keine Angabe [8]

B12: Alles in allem: Als wie religiös würden Sie sich selbst bezeichnen?

- ☐ gar nicht religiös [0]
- ☐ wenig religiös [1]
- ☐ mittel religiös [2]
- ☐ ziemlich religiös [3]
- ☐ sehr religiös [4]
- ☐ weiss nicht / keine Angabe [5]

B13: Einmal abgesehen davon, ob Sie sich selbst als religiöse Person bezeichnen oder nicht: Als wie spirituell würden Sie sich selbst bezeichnen?

- ☐ gar nicht spirituell [0]
- ☐ wenig spirituell [1]
- ☐ mittel spirituell [2]
- ☐ ziemlich spirituell [3]
- ☐ sehr spirituell [4]
- ☐ weiss nicht / keine Angabe [5]

Herzlichen Dank für Ihre Unterstützung!

Letter of invitation

Sehr geehrte(r) Herr/Frau

Ich habe vorhin in Ihre Praxis angerufen, und mit Ihrer Praxisassistentin abgesprochen, dass ich Ihnen eine Mail schreiben werde.

Ich bin Medizinstudent, und momentan an meiner Masterarbeit zum Thema "religiöse Einstellungen und ärztliches Handeln". Dafür suche ich Hausärzte im Kanton Bern, die bereit sind 20-25 Minuten einen Fragebogen auszufüllen. Am besten gleich online über diesen Link: http://www.xpsy.ch/DBMP/?categ c2=8&initial=true

Ihr Teilnahmecode wäre:
Wir garantieren Anonymität beim Onlinefragebogen. Die Codes können nicht mehr den Umfragebögen zugeordnet werden.

Ich kann Ihnen den Fragebogen auch per Post zuschicken, Sie können mich anrufen und per Telefon Ihre Antworten dazu abgeben, oder ich kann Ihnen anbieten ihre Antworten in Form eines Kurzinterviews persönlich aufzuzeichnen.
Weiter Informationen dazu finden Sie im Anhang.

Falls Sie den Fragebogen nicht ausfüllen möchten/können, dann könnten Sie unter diesem Link noch ein paar Fragen zum Thema beantworten (Zeitaufwand etwa 3 Minuten). Dies würde mir helfen bei der Datenerhebung.
https://www.umfrageonline.ch/s/272818f

Herzlichen Dank für Ihre Zeit und Ihren Aufwand!

Mit freundlichen Grüssen
Robin Münger

Medizinstudent 4. Jahreskurs
Mattenweg 9
3084 Wabern
077 450 66 89

General information

UNIVERSITÄT BERN

Forschungsinstitut für Spiritualität und Gesundheit

Februar 2016

„Religiöse Einstellungen und ärztliches Handeln"
- Eine Ärztebefragung im Rahmen einer Masterarbeit

Sehr geehrte Hausärztinnen und Hausärzte,
Ich bin ein *Medizinstudent der Universität Bern* und untersuche im Rahmen meiner Masterarbeit ein etwas aussergewöhnliches Thema, nämlich die religiösen Einstellungen von Schweizer Ärztinnen und Ärzten und deren Einfluss auf das ärztliche Handeln. Die Untersuchung wurde unter Hausärztinnen und Hausärzten der Kantone Basel-Landschaft, Basel-Stadt und Aargau bereits durchgeführt. Ich konzentriere mich nun auf Hausärztinnen und Hausärzte im Kanton Bern. Das Projekt ist eine Kooperation zwischen der Medizinischen Fakultät der Universität Bern (Prof. Dr. med. Jean-Marc Burgunder) und dem Forschungsinstitut für Spiritualität und Gesundheit in Langenthal (www.fisg.ch). Als Hausärztinnen und Hausärzte werden Sie immer wieder auch mit religiösen Fragen und Haltungen Ihrer Patienten konfrontiert. Deshalb interessiert mich Ihre Erfahrungen und Ihre Meinung. Zudem hat die religiöse Einstellung der Ärzte Einfluss auf ihr medizinisches Handeln. Das zeigen Studien aus den USA (Curlin et al.). Ich bin Ihnen deshalb sehr dankbar, wenn Sie sich ca. 20-25 Minuten Zeit nehmen, um den beiliegenden Fragebogen auszufüllen. Dazu haben Sie verschiedene Möglichkeiten:

1. *Sie füllen den Fragebogen direkt online aus*. Als unmittelbares Ergebnis erhalten Sie Ihr „religiöses Profil" im Vergleich zu der Schweizerischen Durchschnittsbevölkerung.
   Die Online-Befragung findet in Zusammenarbeit mit der Psymeta GmbH (www.psymeta.ch) statt, welche die Anonymität garantiert. Die Antworten werden unmittelbar anonymisiert und können nicht mehr den Befragten zugeordnet werden.
   Zugang zum elektronischen Fragebogen: www.xpsy.ch/DBMP/?categ_c2=8&initial=true.
   Ihr persönlicher Teilnehmercode: _____ (den Sie am Ende des Fragbogens benötigen!)
2. *Sie füllen den Fragebogen in Papierform* aus und senden ihn per Post an
   - Robin Münger, Kohlhol 6, 3053 Diemerswil
   Bitte senden Sie parallel dazu Ihren Teilnehmercode an die Psymeta GmbH: ff@psymeta.ch.
3. *Sie möchten den Fragebogen lieber telefonisch ausfüllen?* Ich rufe Sie gerne an und gehe den Fragebogen mit Ihnen durch, bitte senden Sie mir eine Email an: robin.muenger@students.unibe.ch
4. *Gerne komme ich auch in Ihrer Praxis vorbei* und mache mit Ihnen ein Kurzinterview. Bitte rufen Sie mich an: 077 450 66 89

Ich sende Ihnen anschliessend als Dankeschön meine Resultate. Sie können Ihre Antworten dann mit denen Ihrer KollegInnen vergleichen (anonymisiert). Weitere Informationen finden Sie im beigelegten Projektbeschrieb. Bei Fragen oder Anmerkungen nehmen Sie bitte mit mir Kontakt auf.
Freundliche Grüsse
Robin Münger
Robin Münger, 4. Jahreskurs Medizin
Medizinische Fakultät, Universität Bern

Declaration

Ich erkläre hiermit, dass ich diese Arbeit selbstständig verfasst und keine anderen als die angegebenen Hilfsmittel benutzt habe.

Alle Stellen, die wörtlich oder sinngemäss aus Quellen entnommen wurden, habe ich als solche kenntlich gemacht. Mir ist bekannt, dass andernfalls der Senat gemäss dem Gesetz über die Universität Bern zum Entzug des auf Grund dieser Arbeit verliehenen Titels berechtigt ist.

Datum und Unterschrift