

Article

Professional and Personal Well-Being Among Members of a Christian Organization for Healthcare Providers: A Cross-Sectional Study

Stephanie L. Harris * , Ted Hamilton, Hong Tao and Carla Gober Park

AdventHealth Research Institute, AdventHealth, Orlando, FL 32803, USA; ted.hamilton@adventhealth.com (T.H.); hong.tao@adventhealth.com (H.T.); carla.park@adventhealth.com (C.G.P.)

* Correspondence: stephanie.harris@adventhealth.com

Abstract: Objectives: To determine the aspects of religion and spirituality among those who belong to an organization for Christian healthcare providers that may contribute to personal and professional well-being and protect against burnout. **Participants:** Members and affiliates of the Christian Medical and Dental Association (n = 450). **Study Method:** A cross-sectional study based on survey results of validated instruments and original questions that measured aspects of faith, professional fulfillment, personal fulfillment, and mental health. **Findings:** This sample of Christian healthcare providers experienced lower rates of burnout than the general population of healthcare providers. Personal aspects of religion and spirituality were negatively associated with anxiety and depression and positively associated with personal flourishing. **Conclusions:** Calling, virtues, and belonging are possible attributes of Christian faith that are associated with well-being and may be protective against burnout and mental health conditions. Future research can explore these findings among providers of other faith traditions.

Keywords: well-being; burnout; physicians; Christianity; religiousness; spirituality; mental health



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1. Introduction and Background

The well-being of healthcare providers (HCPs) is of utmost importance to healthcare organizations, as a healthier workforce supports improved patient care and satisfaction and is more likely to avoid the cost of turnover and decreased productivity (Salyers et al. 2017; Shanafelt et al. 2017; Tawfik et al. 2019). The World Health Organization defines wellness as a multifaceted state of optimal health that encompasses physical, mental, spiritual, social, and economic aspects (Smith et al. 2006). Exploration into mechanisms of wellness and well-being in healthcare providers is an area of research interest, as poor well-being has an impact on patient safety and quality of care (Garcia et al. 2019; Tawfik et al. 2019).

Religiousness and spirituality (R/S) in physicians and other HCPs has received increased attention in recent years as a contributing factor to well-being and a potentially protective factor against burnout. Burnout is an occupational condition marked by exhaustion, cynicism, and decreased feeling of accomplishment or inefficacy due to prolonged exposure to workplace stressors (Maslach et al. 2001). Reports of burnout prevalence in physicians vary, but recent research posits that about half of surveyed physicians have symptoms of burnout (Ortega et al. 2023). R/S and use of religious coping strategies have been associated with decreased burnout in healthcare workers (Chirico et al. 2023; Doolittle et al. 2013; Wachholtz and Rogoff 2013; Whitehead et al. 2023). In addition, R/S

has been noted to increase resilience, or the ability to recover from stressful situations (Schwalm et al. 2022).

Although burnout in physicians—the etiology, prevention, mitigation, and treatment—has been explored extensively, the research on the impact of R/S on burnout and well-being in physicians is somewhat limited. Whitehead et al. (2023) conducted a systematic review of R/S and burnout in doctors and reported, with the caveats of high heterogeneity and low quality among reviewed papers, that there was a positive association between spiritual health and lower levels of burnout. A scoping review (Chow et al. 2021) described similar findings among physicians in residency, also noting that spiritual well-being was associated with lower burnout. Similarly, other studies indicate that those who score higher on measures of R/S also perceive higher levels of personal accomplishment (Doolittle et al. 2013) and engage in fewer maladaptive behaviors (Salmoirago-Blotcher et al. 2016). Palmer Kelly et al. (2020) used a mixed-methods approach to demonstrate that HCWs utilize R/S as a means of coping with the work-related stressors that can contribute to burnout.

Chow et al. (2021) note that a limitation of research on the association between burnout and R/S in physicians is its lack of cultural and religious diversity, with the preponderance of research focusing on the West and Christianity. Koenig (2019) reviews this association among other physicians of other faiths. He notes that the associations are consistent among those who practice Islam and Judaism, but there is a dearth of research among physicians who practice Hinduism and Buddhism.

The correlation between R/S and well-being in healthcare providers may manifest as a sense of meaning and purpose in their work. In physicians, a stronger sense and practice of R/S is often associated with a stronger sense of calling to the profession, and that a sense of calling contributes to greater meaning and commitment to patient care (Tak et al. 2017; Yoon et al. 2015). Greater meaning in work contributes to both organizational outcomes, such as job satisfaction, and greater organizational citizenship, as well as personal well-being outcomes, supported by elements of growth, autonomy, and mastery (Soren and Ryff 2023). In addition, satisfaction with one's R/S beliefs has been shown to increase general life satisfaction and fulfillment (Wills 2009).

Research to explore which domains of R/S most significantly impact health and well-being is ongoing. Behavioral, social, psychological, and physiological mechanisms, distinctly and in combination, may influence well-being (Fetzer/National Institute on Aging Working Group 1999). Factors intrinsic to R/S experience and practice that support well-being include religious coping, social support, religious practice, meaning and purpose, etc. (Fatima et al. 2018; Fetzer/National Institute on Aging Working Group 1999; Kim-Prieto and Miller 2018; Villani et al. 2019). There is evidence that stronger identification with religious faith has been associated with greater well-being (Park et al. 2013; Tix et al. 2013). In Christians, specifically, spiritual revitalization and elements of church life and community may provide coping resources to address burnout and promote well-being and resilience (Chang et al. 2021; Frederick et al. 2018; Perry 1998). There is an opportunity to explore further which aspects of faith/belief and R/S across religions and among specific faith traditions may have the most profound influence on personal and professional well-being.

1.1. CMDA

The Christian Medical Association and Christian Dental Association comprise the Christian Medical and Dental Associations (CMDA), a not-for-profit professional organization with an international membership of more than 10,000 healthcare professionals (CMDA 2024). While individual beliefs are respected within the CMDA, the organization's "statement of faith" aligns with core tenets of Christianity (CMDA 2024). In support of

membership, the CMDA features a Center for Well-being that offers coaching, resources, and faith-based support (CMDA 2024).

1.2. Current Study

To explore the R/S factors that contribute to personal and professional well-being in a sample of Christian HCPs who belong to the CMDA, surveys were administered to voluntary participant members of the CMDA.

2. Results

Participant demographics are described in Table 1.

Table 1. Participant demographics.

		n	%
Sex	Female	193	42.9
	Male	251	55.8
Age	Under 25	1	0.2
	26–35	40	8.9
	36–45	55	12.2
	46–55	80	17.8
	56–65	130	28.9
	66–75	118	26.2
	76+	24	5.3
Race	American Indian or Alaska native	1	0.2
	Asian	22	4.9
	Black or African American	9	2.0
	White	400	88.9
	Multi-racial/Multi-heritage	14	3.1
Ethnicity	Hispanic/Latino(s)	8	1.8
	Non-Hispanic/Non-Latino(a)	420	93.3
Degree	MD/DO	283	62.9
	DDS/DMD	23	5.1
	APP	37	8.2
	Other	25	5.6
Specialty	Family Medicine	114	25.3
	Internal Medicine	36	8.0
	Pediatrics	37	8.2
	Emergency Medicine	17	3.8
	General Dentistry	17	3.8
	General Surgery	17	3.8
	Ob/Gyn	11	2.0
	Orthopedics	10	2.0
	Other	103	23
	Did Not Respond	88	20
Years	Less than 1	22	4.9
	1–5	22	4.9
	6–10	30	6.7
	11–20	70	15.6
	21+	300	66.7

Table 1. *Cont.*

		n	%
Location	North America	417	92.7
	Africa	10	2.2
	Europe	1	.2
	Asia	9	2.0
	Other	9	2.0
Setting	Inpatient Med/Surg	47	10.4
	Inpatient ICU	8	1.8
	Emergency/Urgent Care	25	5.6
	Outpatient/Clinic/Ambulatory	246	54.7
	Academic/Education	14	27.3
	Student	5	1
	Administration/Leadership	8	2
	Mission Work	6	1
	Retired	6	1
	Multiple settings (e.g., Inpatient/Outpatient)	35	8
	Other	45	10
Status	Full-time	246	54.7
	Part-time	91	20.2
	Retired	102	22.7
	Volunteer	28	6.2

2.1. Burnout, Professional Fulfillment, and R/S

Overall, those with less engagement with R/S practice and belief tended to report more symptoms of burnout. Those with burnout, compared to those without, reported greater use of negative religious coping, fewer daily spiritual experiences, and lower scores on measures of forgiveness and meaning (Table 2).

Table 2. Significant differences in R/S measures between those with and without burnout.

	Burnout		t	p
	Yes mean (SD)	No mean (SD)		
Daily Spiritual Experiences *	2.52 (0.91)	2.10 (0.76)	−4.16	<0.001
Values and Beliefs *	1.44 (0.45)	1.34 (0.37)	−2.19	0.030
Forgiveness *	1.64 (0.48)	1.36 (0.38)	−6.00	<0.001
Private Religious Practice *	2.61 (0.88)	2.57 (0.94)	−0.45	0.665
Organizational Religiousness *	2.50 (0.89)	2.49 (0.85)	−0.15	0.878
Meaning *	1.46 (0.53)	1.23 (0.38)	−4.11	<0.001
Positive Religious Coping	23.95 (3.41)	24.24 (2.95)	0.782	0.435
Negative Religious Coping	10.87 (3.68)	9.37 (2.54)	−3.871	<0.001

* Note: items are scored from more frequent/stronger agreement to less frequent/stronger disagreement. Lower scores are consistent with more frequent/stronger agreement.

Higher scores on an overall self-rating of spirituality were negatively associated with interpersonal disengagement ($r = -0.11, p < 0.05$) and positively associated with professional fulfillment ($r = 0.15, p < 0.01$).

There were statistically significant positive associations between professional fulfillment and measures of daily spiritual experiences, values and beliefs, forgiveness, private religious practice, and meaning. There was no statistically significant relationship with organizational religiousness (i.e., participation in formalized church-based religious activities). Additionally, there were statistically significant negative relationships between work exhaustion and increased values for daily spiritual experiences, values and beliefs, forgive-

ness, and meaning. The same associations are significant for interpersonal disengagement (Table 3).

Table 3. Correlation between R/S measures and the Professional Fulfillment Index.

	Professional Fulfillment	Work Exhaustion	Interpersonal Disengagement
Daily Spiritual Experiences	0.41 **	−0.270 *	−0.36 **
Values and Beliefs	0.22 **	−0.12 *	−0.16 **
Forgiveness	0.35 **	−0.34 **	−0.35 **
Private Religious Practice	0.14 **	−0.07	−0.06
Organizational Religiousness	0.09	−0.03	−0.09
Meaning	0.41 **	0.21 **	−0.29 **

** $p < 0.01$, * $p < 0.05$. Note: items are scored from more frequent/stronger agreement to less frequent/stronger disagreement. To reflect the nature of associations, scoring valence has been reversed.

In addition, positive religious coping was positively associated with professional fulfillment ($r = 0.18$, $p < 0.01$) and negatively associated with interpersonal disengagement ($r = -0.16$, $p < 0.01$). The inverse was true of negative religious coping, as it demonstrated negative associations with professional fulfillment ($r = 1.31$, $p < 0.01$) and positive associations with work exhaustion ($r = 0.27$, $p < 0.01$) and interpersonal disengagement ($r = 0.30$, $p < 0.01$).

2.2. R/S and Mental Health

There was a positive association between religious practice and belief and better scores on measures of mental health. Higher frequency or agreement with daily spiritual experiences ($r = 0.29$, $p < 0.01$), forgiveness ($r = 0.35$, $p < 0.01$), meaning ($r = 0.24$, $p < 0.01$), and private religious practice ($r = 0.11$, $p < 0.05$) were associated with lower anxiety scores. Similarly, higher frequency or agreement with daily spiritual experiences ($r = 0.31$, $p < 0.01$), values and beliefs ($r = 0.09$, $p < 0.05$), forgiveness ($r = 0.30$, $p < 0.01$), and meaning ($r = 0.28$, $p < 0.01$) were associated with lower depression scores.

2.3. R/S and Flourishing and Belongingness

There were statistically significant positive associations between measures of R/S and all subscales of the Harvard Secure Flourish, including happiness and life satisfaction, mental and physical health, meaning and purpose, character and virtue, close social relationships, and financial and material stability. Associations between the total score on the Harvard Secure Flourish and BMMRS subscales are as follows: daily spiritual experiences ($r = 0.54$, $p < 0.01$), values and beliefs ($r = 0.25$, $p < 0.01$), forgiveness ($r = 0.51$, $p < 0.01$), private religious practice ($r = 0.21$, $p < 0.01$), organizational religiousness ($r = 0.16$, $p < 0.01$), meaning ($r = 0.48$, $p < 0.01$), self-rating for overall religiousness ($r = 0.10$, $p < 0.05$), and self-rating for overall spirituality ($r = 0.18$, $p < 0.01$).

In addition, there were significant relationships between measures of R/S and belongingness, with positive associations on the acceptance/inclusion subscale and negative associations on the rejection/inclusion subscale. All associations were statistically significant, with the exception of acceptance/inclusion and self-rated religiousness.

2.4. Self-Rated Religiousness and Self-Rated Spirituality

Significant correlations between self-rated religiousness, self-rated spirituality, and other measures were examined in full-time workers only, to determine if there were any differences in measures of professional well-being between those who identify as spiritual versus religious. No significant correlations were found between well-being measures and self-rated religiousness or spirituality. There were significant negative associations between

congregational support and self-rated religiousness ($r = -0.141, p = 0.032$) and self-rated spirituality ($r = -0.191, p = 0.003$) and significant positive associations between values and beliefs and self-rated religiousness ($r = 0.144, p = 0.025$) and self-rated spirituality ($r = 0.324, p < 0.001$).

2.5. Predictors of Burnout, Depression, and Anxiety

Multiple linear regression was used to test which significant variables predicted burnout, depression, and anxiety, as indicators of poor professional and/or personal well-being (Table 4).

Table 4. Regression: depression, anxiety, burnout.

Dependent Variable	Independent Variable	B	Beta	t	p
Anxiety F(7, 223) = 21.036, $p < 0.001$; $R^2 = 0.398$	Happiness and Life Satisfaction	-0.108	-0.266	-3.042	0.003
	Forgiveness	0.181	0.156	2.573	0.011
	Organizational Religiousness	-0.139	-0.159	-2.950	0.004
	Mental and Physical Health	-0.066	-0.158	-2.011	0.046
	Meaning and Purpose	-0.073	-0.179	-2.231	0.027
	Self-rated Religiousness	0.103	0.057	1.057	0.292
	Self-rated Spirituality	-0.146	-0.065	-1.183	0.238
Depression F(5, 228) = 32.407, $p < 0.001$; $R^2 = 0.415$	Happiness and Life Satisfaction	-0.121	-0.413	-5.590	<0.001
	Meaning and Purpose	-0.063	-0.215	-2.887	0.004
	Negative Religious Coping	0.040	0.119	2.093	0.037
	Self-rated Religiousness	0.037	0.029	0.558	0.577
	Self-rated Spirituality	-0.168	-0.104	-1.978	0.049
Burnout F(4, 222) = 43.737, $p < 0.001$; $R^2 = 0.441$	Happiness and Life Satisfaction	-0.081	-0.381	-6.211	<0.001
	Character and Virtue	-0.083	-0.367	-5.892	<0.001
	Self-rated Religiousness	-0.075	-0.078	-1.506	0.134
	Self-rated Spirituality	0.004	0.003	0.060	0.952

It was found that happiness and life satisfaction ($\beta = -0.266, p = 0.003$), mental and physical health ($\beta = -0.158, p = 0.046$), meaning and purpose ($\beta = -0.179, p = 0.027$), and forgiveness* ($\beta = 0.181, p = 0.011$) were negatively associated with anxiety, whereas organizational religiousness* ($\beta = -0.159, p = 0.004$) positively predicted anxiety. For depression, happiness and life satisfaction ($\beta = -0.413, p = 0.000$) and meaning and purpose ($\beta = -0.215, p = 0.004$) were negatively predictive, whereas negative religious coping was positively predictive ($\beta = 0.040, p = 0.037$). For the burnout model, only happiness and life satisfaction ($\beta = -0.381, p = 0.000$) and character and virtue ($\beta = -0.367, p = 0.000$) were predictive, and both were negatively associated. In all models, self-rated religiousness and self-rated spirituality were not significant (* items are reverse-scored, i.e., 1 = more forgiveness; 4 = less forgiveness).

2.6. Original Questions

The purpose of these questions was to explore more deeply aspects of Christian faith and the connection to well-being. As described above, they investigate thoughts on the notion of work as a calling, charitable works, the sabbath/day of rest, and mindful behavior.

There were statistically significant differences in responses between those with burnout and those without burnout for recognizing work as a calling (mean [SD], respectively, 5.23 [1.16], 5.51 [0.94]; $p = 0.014$), for engaging with charitable works without expecting a reward

(5.09 [0.90], 5.35 [0.91]; $p = 0.006$), for taking a day of rest (3.85 [1.4], 4.42 [1.3]; $p < 0.001$), and acting in accordance with religious beliefs (5.10 [0.70], 5.47 [0.64]; $p < 0.001$).

2.7. Spiritual Health Indicators

There were positive associations between measures of R/S and the responses to questions regarding love, peace, and joy. The BMMRS is reverse-scored; therefore, more religious belief/observance/agreement results in lower scores (closer to 1). In addition, these were associated with measures of social support, depression, and anxiety. See Table 5.

Table 5. Association between R/S and spiritual health indicators.

BMMRS Subscale	Love				Joy				Peace			
	YES Mean [SD]	NO Mean [SD]	t	p	YES Mean [SD]	NO Mean [SD]	t	p	YES Mean [SD]	NO Mean [SD]	t	p
Daily Spiritual Experiences	12.66 [4.64]	14.87 [5.19]	4.486	0.037	11.69 [4.03]	15.74 [5.07]	9.006	<0.001	11.34 [3.91]	14.78 [5.06]	8.044	<0.001
Values and Beliefs	2.68 [0.71]	2.96 [0.90]	3.602	<0.001	2.61 [0.69]	3.00 [0.86]	5.335	<0.001	2.61 [0.69]	2.89 [0.83]	3.663	<0.001
Forgiveness	4.22 [1.23]	4.66 [1.44]	3.309	0.001	4.01 [1.10]	4.86 [1.42]	6.897	<0.001	3.83 [1.07]	4.74 [1.34]	7.692	<0.001
Private Religious Practice	12.84 [4.76]	12.92 [4.19]	0.166	0.868	12.35 [4.68]	13.54 [4.37]	2.706	0.007	11.83 [4.55]	13.57 [4.48]	3.980	<0.001
Organizational Religiousness	4.86 [1.63]	5.06 [1.83]	1.124	0.261	4.87 [1.55]	5.01 [1.88]	0.208	0.416	4.67 [1.51]	5.09 [1.80]	2.579	0.010
Meaning	2.49 [0.77]	3.03 [1.13]	5.145	<0.001	2.37 [0.70]	3.06 [1.06]	7.775	<0.001	2.31 [0.64]	2.90 [1.03]	7.454	<0.001
Overall Religiousness	1.64 [0.82]	1.69 [0.78]	0.646	0.519	1.62 [0.82]	1.70 [0.80]	0.994	0.321	1.62 [0.84]	1.67 [0.78]	0.592	0.554
Overall Spirituality	1.35 [0.61]	1.53 [0.68]	2.646	0.006	1.32 [0.61]	1.53 [0.65]	3.514	<0.001	1.29 [0.56]	1.49 [0.67]	3.544	<0.001

2.7.1. Love

For those who answered yes (strongly agree) to “I have someone who loves and cares for me” compared to those who answered no, there were statistically significant differences in daily spiritual experiences, values and beliefs, forgiveness, meaning, and overall spirituality. When the analysis expanded to include those who agreed with those who strongly agreed, none remained statistically significant. This item was positively associated with congregational support, but not with belongingness or close social relationships.

2.7.2. Joy

There were statistically significant differences in measures of R/S for those who answered yes (strongly agree) compared to those who answered no on the question “I have a source of joy in my life” for daily spiritual experiences, values and beliefs, forgiveness, private religious practice, meaning, and overall spirituality. In the second analysis, with strongly agree and agree (5–6) as a positive response, private religious practice was no longer significant. Joy was significantly and negatively associated with depression.

2.7.3. Peace

For the item “I have a sense of peace today”, there were statistically significant differences between those who answered yes (strongly agree) and those who answered no in the R/S subscales daily spiritual experiences, values and beliefs, forgiveness, private religious practice, organizational religiousness, meaning, and overall spirituality. The analysis that included agree with strongly agree resulted in values and beliefs, organizational religiousness, and overall spirituality that were no longer statistically significant. Peace was significantly and negatively associated with anxiety.

3. Discussion

This study sought to determine the aspects of faith among members of a Christian organization for HCPs that support personal and professional well-being and may be protective against professional burnout and mental health conditions. While the associations between R/S and positive/negative professional and personal outcomes have been investigated among HCPs, this study explored these in practitioners who self-identify as Christians and elected to join an organization specifically aligned with the support and well-being of Christian HCPs.

3.1. Burnout

The results of this study indicate that there may be factors inherent in faith that are protective against professional burnout. Study participants reported a burnout rate of 32.4% in active (non-retired) HCPs. Recent research indicates that burnout rates among physicians during and immediately after the COVID-19 pandemic's height were upwards of 50% (Macaron et al. 2022; Ortega et al. 2023), and the American Medical Association reported that rates of burnout are at 48% (Berg 2024).

The reduced rate of burnout in this study sample may be attributable to a strong sense of calling among Christian HCPs in this organization, as statistically significant differences were noted in burnout rates between those who felt a sense of calling to their careers and those who did not. This is consistent with other studies that demonstrate the association between a sense of calling and decreased burnout (Jager et al. 2017; Yoon et al. 2015). The professional lives of Christians are tied to a sense of meaning and purpose, and great personal and professional satisfaction are associated with fulfilling this calling (Bott et al. 2015; Frederick et al. 2018). The preponderance of literature regarding burnout and a sense of calling in Christians focuses on clergy; however, physicians with a stronger religious orientation tend to recognize their sense of calling (Yoon et al. 2015), and the calling from God to work is grounded in a Christian religious context (Bott et al. 2015). In light of these findings, it is possible that a sense of calling to clinical work among Christian HCPs may be a protective factor.

The regression model indicates that measures of happiness and life satisfaction and character and virtue are negative predictors of burnout. Research indicates that across faiths, Christians (Protestants) are the highest in a measure of subjective well-being, and both Protestants and Catholics were more likely to experience happiness as a part of their faith than members of other religions (Cohen 2002; Ngamaba and Soni 2018). In addition, there is evidence that virtues (e.g., forgiveness, humility, gratitude) are the mechanism through which religiousness and well-being are associated (Jankowski et al. 2022; Sharma and Singh 2019). Though there are cautions regarding tautology in the study of well-being, happiness, virtues, and faith, in this sample, it is possible that happiness and virtue as facets of faith may be sources of resilience that counter the negative impact of professional burnout.

3.2. Mental Health

In this study, measures of personal faith were positively associated with lower anxiety and depression scores, the nature of which has been discussed at length in the extant literature (Brown et al. 2013; Koenig 2009; Weber and Pargament 2014). However, the regression model shows negative mental health ramifications, wherein the organizational religiousness subscale was predictive of increased anxiety, and use of negative religious coping was predictive of increased depression. There is evidence that aspects of organized religion and other sociological components (e.g., congregational criticism, perceived pressure) and personal religious struggles may contribute to depression and anxiety (Beeman et al. 2024;

Nooney and Woodrum 2002; Sternthal et al. 2010). While it is intuitive that a negative relationship with facets of faith would be associated with poorer mental health, it is important to note this occurrence within this sample of Christian HCPs. Experiences with both R/S and mental health are on a continuum that can include negative experiences, even in those of professed faith.

3.3. Well-Being

There was an association between higher R/S scores and higher scores on measures of personal flourishing and belongingness. This supports previous evidence that R/S supports eudaemonic well-being as well as multiple components of human flourishing (McEntee et al. 2013; Ryff 2021). Though there is sparse literature specifically regarding Christianity and current concepts of flourishing (VanderWeele 2017), a Christian world view has been weakly linked to mental well-being (Knabb and Donovan 2024). Although the links to flourishing are multifaceted, the spiritual aspect likely involves supportive social relationships, often found among religious congregations (VanderWeele 2017), and individuals who receive social support from their religious congregations are more likely to use positive religious coping (Krause et al. 2001). Furthermore, this general sense of belonging to a community and connectedness contributes to an overall sense of well-being and health in church congregants (Krause and Wulff 2005).

3.4. Spiritual Health Indicators: Love, Joy, and Peace

These spiritual health indicators are a supplemental aspect of this study and are intended to be used in both inpatient and outpatient settings to “trigger” a consult with a chaplain or other sources of spiritual support. Chapman (1987) defines spiritual health, in part, as the ability to “learn to experience love, joy, peace and fulfillment” (p. 12). In this context, the questions about sources and states of peace, love, and joy were compared to a validated measure of R/S to assess their ability to capture the state of spiritual well-being. There has been a call for easy, brief screenings for spiritual health assessment appropriate for a multidisciplinary audience to administer (Cadge and Bandini 2015). There is also a desire for spiritual health assessments to be pluralistic in nature (Balboni 2013). Despite their Biblical origin, these questions do not promote a particular theology, and they provide the ease of a checklist screening (Balboni 2013). These spiritual health screening questions also help screen for other health indicators within the context of secular healthcare, i.e., love as social support or isolation, joy as depression or anhedonia, peace as anxiety or distress.

It is important to note the differences that emerged from the two methods of analysis (i.e., using 5 or 6 as the “yes” cutoff). There were notable differences in the results when those who agreed were analyzed with those who strongly agreed. As responders to Likert scales are able to distinguish clearly the distinction between strongly agree and agree (Willits et al. 2016), it appears that only those who most greatly agreed with these spiritual health indicators also reported high measures of R/S; however, as proxy measures for social support, depression, and anxiety, they remained significant at both cutoff points.

3.5. Limitations

This study includes several limitations, foremost of which is the homogenous sample on which this study is based. However, like many studies of religious groups, this exploration is intended to magnify the beliefs of a specific faith tradition that may or may not include diverse followers. This particular study of a faith-based professional organization is limited in generalizability and is reflective of the population sampled rather than that of the global physician workforce. Other limitations include the cross-sectional design that limits the conclusions that can be drawn regarding causality and directionality of relationships between R/S and outcomes. Although the survey was anonymous, social desirability

bias and survey fatigue from the length may have impacted accurate reporting of results. Retired practitioners were included in the analysis with the exception of the reporting of the Stanford Professional Fulfillment Index, so the reflection of those in the current workforce may have been skewed. Lastly, this study often combines the distinct concepts of R/S (religiousness and spirituality) into the concept of faith. While it is recognized that these are discrete but related concepts, for the purposes of the study on Christian HCPs, these concepts are not discussed separately, other than reporting self-rated religiousness and spirituality.

4. Materials and Methods

4.1. Design

This was a cross-sectional survey-based study hosted on REDCap (Research Electronic Data Capture) (<https://project-redcap.org/>, 19 November 2024), a secure web-based platform designed to collect data for research (Harris et al. 2009, 2019). Survey responses were collected for one month (mid-April to mid-May 2023).

4.2. Sample

Participants were members of the CMDA contact list. Inclusion criteria were engagement with the CMDA (paid members, workshop participants, donors), ability to read and understand English, and ability to access an online, web-based survey.

4.3. Sample Size

The minimum sample size of 370 is based on an estimated organizational membership (population) of 10,000 with a 5% error rate and 95% confidence. The survey closed when 450 responses were received. All questions were optional, and data could be analyzed for 450 participants.

4.4. Ethics

This study was approved by the Institutional Review Board, and a consent statement was displayed prior to survey initiation, wherein the participant could elect to continue or decline to participate.

4.5. Recruitment

Recruitment occurred during the CMDA annual meeting and via an invitation email to the CMDA listserv to over 10,000 contacts worldwide. At the meeting, an invitation slide was presented with a QR code to the survey, and the QR code and link were available in the conference app. The email to the CMDA contact list was distributed after the end of the conference and contained a link to the survey. All surveys were administered electronically.

4.6. Survey Instruments

1. The Brief Resilience Scale (BRS) is a 6-item instrument that measures the ability to bounce back from stress. Initial validation reported a Cronbach's alpha between 0.80 and 0.91 (Smith et al. 2008).
2. GAD-2 is a 2-item screening measure for generalized anxiety disorder. The GAD-2 has been validated as an abbreviated version of the full Generalized Anxiety Scale-7 (GAD-7). A cutoff score of 3 or greater has a sensitivity of 86% and specificity of 83% for a diagnosis of generalized anxiety disorder (Kroenke et al. 2007).
3. PHQ-2 is a 2-item screening measure for depression and measures low mood and anhedonia. It is a valid, abbreviated version of the Patient Health Questionnaire-9 (PHQ-9). A cutoff score of 3 or greater has a sensitivity of 83% and a specificity of 92% for major depressive disorder (Kroenke et al. 2003).

4. The Religious Support Scale—Congressional Support subscale measures social and religious support from members of a religious congregation. This subscale contains 7 items (out of 21 total for the complete scale), and the internal consistency was $\alpha = 0.91$ for the subscale (Fiala et al. 2002).
5. The Brief RCOPE is a 14-item instrument with 7-item subscales to measure positive and negative religious coping with life stressors. Items for positive religious coping assess a positive relationship with a greater power, a connection with others on a spiritual level, and a generally positive world view, whereas items for negative religious coping assess spiritual struggle internally, externally, and with a greater power. Based on a compilation of studies using the scale, the median Cronbach's alpha for the positive religious coping subscale was 0.91, and the median for the negative religious coping subscale was 0.81 (Pargament et al. 2011).
6. The General Belongingness Scale is a 12-item measure to assess a feeling of achieved belongingness across multiple contexts (e.g., interpersonal, societal, transcendent) through a two-factor structure: acceptance/inclusion and rejection/exclusion. The internal validity in the validation study was 0.92 (Malone et al. 2012).
7. The Stanford Professional Fulfillment Index is a 16-item scale intended to measure healthcare professionals' professional fulfillment and burnout. There are three subscales: professional fulfillment, work exhaustion, and interpersonal disengagement. The combination of the work exhaustion and interpersonal disengagement subscales comprises the burnout measure. Burnout is a dichotomous variable with a score of 1.33 as a cutoff. The Cronbach's alphas in the initial validation were 0.91 (professional fulfillment), 0.86 for work exhaustion, 0.92 for interpersonal disengagement, and 0.92 (burnout) (Trockel et al. 2018). These questions were administered to those who are actively working, and questions were not asked of retired practitioners.
8. The Harvard Secure Flourish Measure or Secure Flourish Index is a 12-item instrument that measures 6 domains of human flourishing: happiness and life satisfaction, mental and physical health, meaning and purpose, character and virtue, close social relationships, and financial and material stability. The Cronbach's alpha in a workplace validation study was 0.86 (VanderWeele 2017; Weziak-Bialowolska et al. 2019).
9. The Brief Multidimensional Measurement of Religiousness and Spirituality (BMMRS) is a composite measure of 11 dimensions of religion and spirituality. Two questions to self-rate overall spirituality and overall religiousness were used in addition to the dimensions of daily spiritual experiences (six items), values and beliefs (two items), forgiveness (three items), meaning (two items) private religious practice (five items), and organizational religiousness (two items) (Fetzer/National Institute on Aging Working Group 1999).
10. Original questions: four original questions were scored on a 6-point Likert scale from strongly disagree (1) to strongly agree (6) and include the following: (1) my work is a calling, (2) I engage in acts of service without expecting anything in return, (3) I generally observe a weekly day of rest (Sabbath), and (4) I act in a way consistent with my religious beliefs.
11. Spiritual health indicators: three questions, based on a verse from Galatians, are used as a general assessment of spiritual well-being in a faith-based healthcare organization. The questions were adapted from a yes/no question format used with patients to statements that could be assessed by level of agreement on a Likert scale with providers. The statements—I have someone who loves and cares for me; I have a source of joy in my life; I have a sense of peace today—were scored on a 6-point Likert scale from strongly disagree (1) to strongly agree (6). These items were scored using two strategies. First, they were scored dichotomously, so that only a response

of strongly agree (6) is considered a “yes” and 1–5 is considered a “no”. This was intended to distinguish only those with complete agreement, as others would present an opportunity for intervention. The second permutation scored these as triads, where 1–2 was a “no”, 3–4 was neutral, and 5–6 was a “yes”. Again, for analysis, only 5–6 was considered a “yes” and ≤ 4 was a “no”.

4.7. Analysis

All data were analyzed using IBM SPSS for Windows version 26 (Armonk, New York, NY, USA). Descriptive statistics, including means and standard deviations for all continuous variables and frequencies and percentages for categorical variables, were calculated. Differences between group means were assessed by an independent *t* test. Pearson’s correlation coefficient was calculated to assess the degree of association between two continuous variables. Multiple linear regression models were generated to estimate the relationship between independent variables and the outcome variables.

5. Conclusions

This paper lends a unique perspective to the ongoing discussion about the nature of R/S as a contributing factor to well-being and a protective factor against burnout. Delving into these concepts from the perspective of Christian HCPs offers an exploration based on concepts of calling, virtue, and belonging. As the relationship between spiritual health and psychological health continues to be explored, this study lends some insight into the nature of this association in Christianity and serves as a point of comparison for those of other faith orientations and along the spectrum of belief and non-belief.

Burnout and well-being continue to be paramount in any discussion of the future of healthcare, as a healthy workforce is instrumental to quality and safety in patient care. As spiritual health is recognized as an integral component of overall well-being, it is important to explore the impact of R/S factors on the well-being of those who often deal with the end of life, suffering, and distress. Interventions that offer spiritual support that may be faith orientation-specific and pluralistic are important to investigate in the future.

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Abbreviations

The following abbreviations are used in this manuscript:

MDPI	Multidisciplinary Digital Publishing Institute
DOAJ	Directory of open access journals
TLA	Three-letter acronym
LD	Linear dichroism

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