

RELIGIOUS INFLUENCES ON TRUST IN PHYSICIANS AND THE HEALTH CARE SYSTEM*

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ABSTRACT

Objective: Aspects of the patient-physician relationship, such as trust, influence a variety of health behaviors, including adherence to treatment regimens and the use of preventive health services. While several demographic and socioeconomic factors have been found to predict levels of trust in physicians, little is known about the influence of religious beliefs and behaviors. *Methods:* The relationship between religion and medical trust was investigated within a nationally representative sample of adults in the United States ($n = 1,274$). More specifically, multivariate models were used to analyze the associations between religious affiliation, attendance, and strength of affiliation and three types of trust: personal trust in one's physician, general confidence in physicians, and trust in the health care system. *Results:* Findings reveal that religiously active individuals have higher levels of trust in physicians. For example, individuals who attend religious services frequently (42% of the sample) are significantly more likely to trust their own physician ($p < .05$) and have higher levels of confidence in physicians in general ($p < .01$), compared to individuals who never attend. In addition, levels of trust vary by religious denomination with Mainline Protestants, Catholics, and Jews reporting more trust than Evangelical Protestants. For example, Mainline Protestants have more personal trust in their physicians ($p < .01$), general confidence in physicians ($p < .05$), and trust in the health care system ($p < .05$), compared to Evangelical Protestants. *Conclusions:* This study is the first to examine religious differences in medical trust. The findings add to the

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current knowledge on factors associated with trust in health care providers and may help to explain religious differences in the use of preventive services and other health behaviors.

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Key Words: trust, patient-physician relationship, religion, health care

INTRODUCTION

Trust, a key component of the patient-physician relationship, is an important issue in health care today because it can predict a variety of health behaviors and outcomes. For example, trust is associated with various aspects of adherence [1-4], continuity of care with a particular physician [2, 5], and patient satisfaction [1-3, 6]. In addition, levels of trust are related to subsequent health outcomes, such as earlier detection of cancer [7], symptom improvement [3], and subsequent mortality rates [8]. At the societal level, trust in physicians and the health care system is important in lowering costs due to litigation, self-protection, and the development and enforcement of regulations [9], as well as the willingness of individuals to participate in research [10]. In light of these connections, recent evidence highlighting declines in trust are especially troubling. Previous studies have found that trust in physicians has declined over the last several decades [11, 12] and that trust in managed care plans is low [13]. Although these concerns have sparked interest in the determinants of physician trust, little attention has been paid to the role that cultural factors, such as religion, may play in influencing how patients feel about their physicians and the health care system.

Religion is an important factor to study because it is one of the most universal and influential social institutions for adults in the United States. For example, approximately 60% of adults say that religion is a very important part of their lives and 93% of adults identify with a specific religious preference [14]. Furthermore, approximately 40% of adults in the United States report attending religious services weekly [15]. Both the significance of religion in many adults' lives and the extent of their involvement in religious activities may help to explain the influence of religion in a wide variety of arenas, including health. In fact, hundreds of existing studies have already documented religion's effect on a diverse set of health-related behaviors and outcomes [16]. For example, religious variation has been found for physical and mental health outcomes, health behaviors such as smoking and drinking, and even the use of health care services [16]. It is possible that these relationships between religion, health behaviors, and health status may be mediated by the doctor-patient relationship. More specifically, religion may impact physician trust through its influence on a variety of beliefs and worldviews, as well as through more institutional factors, such as health-related religious

programs, and this, in turn, could affect individual health behaviors and health status. However, while the influence of religion on many health-related outcomes has been examined, no prior studies on the relationship between religion and medical trust were found.

Three different facets of religion will be tested here: organizational involvement, religious denomination, and strength of affiliation. Each of these measures may be associated with trust through different pathways. Religious involvement, measured as attendance at religious services, may influence medical trust through exposure to group norms and health-related programs, as well as through religious teachings or policies that may be related to attitudes toward health and health care. Two older studies found that religious service attendance is related to general trust in people, with more frequent attendance being associated with higher levels of trust [17, 18]. It is expected that religious service attendance will be related to medical trust in a similar manner. Denominational differences may arise from theological distinctions as well as through differing social norms. For example, previous studies of religion and trust have found that individuals belonging to certain conservative denominations have lower levels of trust than do more liberal groups [18, 19]. One possible explanation for this difference is that conservative religions emphasize the inherently sinful nature of man, and this may lead to a general distrust of people [18]. The final measure of religion, strength of affiliation, is included to capture the possible effects of personal beliefs, faith, and commitment on physician trust and attitudes toward the health care system. Individuals with a stronger affiliation to their religious denomination may have more positive feelings toward their physicians and the health care system because religious teachings may encourage more positive worldviews or a respect for authority.

The current study will investigate how these aspects of religion are associated with three different measures of trust: personal trust in one's physician(s), general confidence in physicians, and trust in the health care system. Previous studies have also shown (though somewhat inconsistently) that medical trust may vary by age, education, race/ethnicity, income, health insurance, and health status [2, 20-23]. Thus, these (and other) sociodemographic controls that may predict medical trust will be included in the analyses.

METHOD

Subjects

Data for this study come from the 1998 wave of the General Social Survey (GSS). The GSS is a nationally representative survey of U.S. households fielded by the National Opinion Research Center (NORC) [24]. In 1998, the response rate was 76.4%, which resulted in a total sample size of 2,832 (for more detailed information on the sampling, methodology, and consent, see Davis, Smith, and

Marsden [25]). However, approximately half of the respondents were not asked the questions regarding health care beliefs. Of the 1,368 that were, those respondents with missing information for the religion variables ($n = 89$) or the general trust measure ($n = 5$) were excluded. This resulted in a final sample size of 1,274.

Measures

Trust in Physicians and the Health Care System

The dependent variables of interest come from 20 questions regarding trust in physicians and the health care system. Individuals were asked to respond to the provided statements in the following manner: strongly agree, agree, uncertain, disagree, or strongly disagree [24]. Negative prompts were reverse coded so that more positive responses (agree and strongly agree) consistently reflect more positive attitudes toward the health care providers or the health care system. Those who responded, “Don’t know” were placed in the “Uncertain” category, while those who provided no answer were excluded from the analyses.

An exploratory factor analysis was done to reduce the large number of questions into a smaller number of latent (unobservable) factors. More specifically, factor analysis is a statistical method that determines, “the degree to which clusters of intercorrelated variables may represent fewer underlying, more basic, hypothetical variables” [26, p. 165]. The factor analysis was done using “proc factor” in SAS, with “promax” chosen to obtain an oblique rotation (in which the factors can be correlated with one another). The results showed four underlying constructs with eigenvalues above the commonly used cut-off point of 1.0 (one of which was 1.01). Cronbach Alpha values were then calculated to provide a coefficient of reliability for the latent factors (see Table 1). In other words, these values measure how well each group of variables represents the corresponding underlying construct. In addition to these quantitative analyses, information on past uses of these variables and previous conceptualizations of trust were gathered from the literature [6, 9, 27-30]. From this combination of sources, three indices were created: personal trust in one’s physician, general confidence in physicians, and trust in the health care system (see Table 1). It should be noted that the first index (Trust in one’s physician) is highly similar to the 11-item Trust in Physicians Scale reported elsewhere [31]. In fact, six of the seven items used here come from this validated scale.

Religion

Attendance is measured with three categories: Frequent (2-3 times a month or more), Infrequent (less than once a year to about once a month), and Never. Religious denomination includes six categories (Catholic, Evangelical Protestant, Mainline Protestant, Jewish, other religion, and non-affiliated), largely based on the Steensland et al. (2000) classification scheme [32]. According to this

Table 1. Categories of Trust from the General Social Survey (1998)

Personal Trust in One's Physician (alpha = .83)^a

1. My doctor is willing to refer me to a specialist when needed.
2. I doubt that my doctor really cares about me as a person.
3. I trust my doctor's judgments about my medical care.
4. I feel my doctor does not do everything s/he should for my medical care.
5. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.
6. My doctor is a real expert in taking care of medical problems like mine.
7. I trust my doctor to tell me if a mistake was made about my treatment.

General Confidence in Physicians (alpha = .77)

1. Doctors aren't as thorough as they should be.
2. Doctors always do their best to keep their patient from worrying.
3. Sometimes doctors take unnecessary risks in treating their patients.
4. Doctors are very careful to check everything when examining their patients.
5. Doctors always treat their patients with respect.
6. Doctors cause people to worry a lot because they don't explain medical problems to patients.
7. The medical problems I've had in the past are ignored when I seek care for a new medical problem.
8. Doctors never recommend surgery (an operation) unless there is no other way to solve the problem.

Trust in the Health Care System (alpha = .80)

1. I worry that my doctor is being prevented from telling me the full range of options for my treatment.
 2. I worry that I will be denied the treatment or services I need.
 3. I worry that my doctor will put cost considerations above the care I need.
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^aThis scale is very similar to the 11-item Trust in Physicians Scale reported elsewhere [28].

categorization, Evangelical Protestant denominations include conservative groups such as Southern Baptists, Pentecostals, and Seventh Day Adventists. In contrast, Mainline Protestant denominations include more liberal affiliations such as Methodists, Lutherans, and Presbyterians. The "other religion" category includes individuals in both non-traditional Christian groups (e.g., Christian Scientists, Jehovah's Witness, and Mormons) and non-Judeo Christian religions (e.g., Muslim, Buddhist, and Hindu). It is speculated that affiliational differences in trust may reflect where a denomination fits in the conservative-liberal spectrum. Evangelical Protestantism is the most conservative of the denominations studied here and is, thus, treated as the reference group.

Finally, strength of affiliation is measured by a question that asks, “Would you call yourself a strong (preference named in previous question) or a not very strong (preference)?” [24]. Response choices were strong, not very strong, or no religion. In addition, a significant number of voluntary responses were given for “somewhat strong.” Thus, a new variable was created, with the following categories: no religion (1), not very strong (2), somewhat strong (3), and strong (4).

Demographic and Social Factors

Demographic controls include age, gender, race, nativity, and marital status. Socioeconomic status is measured with three variables: education, income, and presence of health insurance. Income is measured with the following question: “In which of these groups did your total family income, from all sources, fall last year before taxes?” [24]. There are 23 response categories ranging from “Under \$1,000” to “\$110,000 or over.” Individuals who refused to answer or who reported that they did not know were imputed to the mean (approximately 10.9% of the sample). A missing income variable was not significant in the full models and, thus, was excluded. Individuals who have any type of health insurance are placed in the insured category. Coding for the other variables is described in Table 2.

Potential Mediators

Because religion has been found to influence physical health outcomes [16] and health status may then influence levels of trust, one global measure of health was included to control for the possible mediating effect of physical health status on medical trust. Self-rated health was measured as a scale ranging from poor (1) to excellent (4). It is also possible that any religious differences in medical trust may simply reflect religious differences in *general* levels of trust and are not specific to physicians or the health care system. To determine if religious differences in general trust explain any possible differences in medical trust, a measure of general trust in people (not related to health care) was included in the models. For this measure, respondents were asked, “Generally speaking, would you say that most people can be trusted or you can’t be too careful in life?” [24]. Individuals who responded that “Most people can be trusted” were coded as a ‘1’, while those who said “You can’t be too careful” or another answer (such as “It depends”) were coded as a ‘0’.

Analyses

Descriptive statistics provide the range and frequencies for all variables used in the multivariate models. The models are run using ordinary least squares (OLS) regression, which is appropriate for interval or “near interval” outcomes, such as those used in the current study. More specifically, the greater number of

Table 2. Sample Characteristics from the General Social Survey, 1998^a

	Mean ^b	N	Percent ^c
Religion			
<i>Service Attendance</i>			
Frequency (2-3 times/month or more)		509	42
Infrequent (once/month or less)		467	39
Never		223	19
<i>Affiliation</i>			
Catholic		305	25
Jewish		20	2
Mainline Protestant		332	28
Evangelical Protestant		329	27
Other		29	2
Not affiliated		184	15
<i>Strength of Affiliation</i> (range: 1-4)	2.77		
Medical Trust			
<i>Trust in One's Physician</i> (range: 0-35)			
Average response on Likert scale ^d	3.5		
<i>General Confidence in Physicians</i> (range: 0-40)			
Average response on Likert scale	3.2		
<i>Trust in the Health Care System</i> (range: 0-15)			
Average response on Likert scale	3.4		
Sociodemographic Factors			
Age (in years, range: 18-89)	45.5		
<i>Gender</i>			
Female		702	59
Male		497	41
<i>Race</i>			
White		961	80
Black		169	14
Other		69	6
<i>Nativity</i>			
Native born		1,105	92
Foreign born		94	8
<i>Marital Status</i>			
Married		576	48
Not married		623	52
Education (in years, range: 0-20)	13.3		
<i>Household Income</i> (range: 1-23, mean = 15.6)			
Corresponding income level (Categories 15 and 16)	\$25,000-\$34,999		
<i>Health Insurance</i>			
Yes		1,037	86
No		162	14
<i>Possible Mediators</i>			
<i>Self-Rated Health</i> (range: 1-4)			
	3.06		
<i>General Trust in People</i>			
Yes		493	41
No		706	59

^aUnweighted, N = 1,274^bMeans are presented for ordinal and continuous variables; percentages are given for dichotomous variables.^cPercentages may not add to 100 due to rounding.^dLikert scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

data points in the scales, the more likely the data will fulfill the required assumption of a normal distribution when using linear regression. In fact, a recent review of the literature in this area concluded that, “for many statistical tests, rather severe departures (from intervalness) do not seem to affect Type I and Type II errors dramatically” [33]. The estimates are presented as unstandardized regression coefficients (B). For continuous variables, these coefficients represent the change in the outcome variable per unit change in the predictor variable. For dichotomous predictors (such as the religion measures), the regression coefficients represent the differences in the outcomes for the predictor variable compared to the omitted variable.

For each of the three outcomes, the fully adjusted models are shown. More specifically, these models control for demographic, socioeconomic, and potential mediator variables. For the variables with minimal amounts of missing data (i.e., data are missing for less than 5% of the respondents), mean values are imputed for the continuous variables and mode values for dichotomous ones.

RESULTS

Descriptive statistics are shown in Table 2 and the primary independent and dependent variables are summarized here. The religious attendance distribution shows that large, and nearly equal, percentages of individuals attend services frequently (at least two to three times a month—42%) and infrequently (once a month or less—39%). Approximately one-fifth never attend. The affiliation distributions show that the majority of the sample is Catholic (25%) or Protestant (55%). Of the Protestants, respondents are almost evenly split between Evangelical and Mainline denominations. The strength of affiliation mean indicates that the average respondent considers herself/himself a “somewhat strong” member of her/his particular denomination.

Each of the three dependent variables (personal trust in one’s physician, general confidence in physicians, and trust in the health care system) was constructed by summing the responses for the relevant questions (which each have five response choices, ranging from strongly disagree to strongly agree). Thus, the means can be interpreted by determining the average answer for the questions in that category. The results show that levels of personal and general trust in physicians and trust in the health care system are all slightly positive (3.5, 3.2, and 3.4, respectively, when the mean is divided by number of questions in scale), with the average response of most respondents being between “neutral” and “agree.” For the mediators, the average respondent reports “good” health and 41% of the sample say that, on average, most people can be trusted.

Personal Trust in One’s Physician

Variables that are associated with trust in one’s doctor can be seen in the first column of Table 3. These factors include age, gender, race, income, health

Table 3. Estimated Net Effects of Religious Attendance, Affiliation, Strength of Affiliation, and Other Controls on Medical Trust (GSS, 1998; $n = 1,274$)^{a,b}

	Personal Trust in One's Physician	General Confidence in Physicians	Trust in the Health Care System
Religion			
<i>Service Attendance (Never)</i> ^c			
Frequency (2-3 times/month or more)	1.09*	1.51**	0.38
Infrequent (once/month or less)	0.89*	0.99*	0.07
<i>Affiliation (Evan. Prot.)</i>			
Catholic	1.01*	-0.05	0.14
Jewish	2.77*	0.70	1.12
Mainline Protestant	1.08**	0.82*	0.42*
Other	-2.32*	-0.40	-0.55
Not affiliated	0.93	-0.49	0.11
Strength of Affiliation	0.31	0.28	0.11
Sociodemographic Factors			
Age (in years)	0.02*	0.03**	0.02***
Female (<i>Male</i>)	-0.84**	0.02	-0.09
<i>Race (White)</i>			
Black	0.76	-0.53	0.19
Other	1.68**	0.54	0.10
Foreign Born (<i>Native born</i>)	0.03	-1.39**	-0.22
Married (<i>Unmarried</i>)	0.13	0.16	0.02
Education (in years)	0.04	0.04	0.07*
Household Income Category	-0.10**	-0.03	0.01
Presence of Health Insurance	1.55***	1.42***	1.04***
Possible Mediators			
Self-Rated Health	0.49*	0.47**	0.34***
General Trust in People	0.10	-0.07	0.05
<i>Intercept</i>	19.29***	19.45***	5.54***

^aGeneral Social Survey

^bOrdinary Least Squares regression estimates

^cReference category in parentheses

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$ (two-tailed tests)

insurance, and self-rated health. Positive (and significant) coefficients indicate that older individuals have greater levels of personal trust, as do males and members of other races (not White or Black). Additionally, those with lower incomes, some type of health insurance, and better subjective health also show higher levels of personal trust in physicians.

The association between religion and personal trust in one's physician can also be seen in the first column of Table 3. The findings indicate a positive relationship between attendance and personal trust. Specifically, both frequent and infrequent

attendance groups are significantly associated with greater personal trust compared to individuals who never attend services ($B = 1.09, p < .05$; $B = 0.89, p < .05$, respectively). Religious affiliation is also associated with the amount of personal trust in one's physician. Compared to Evangelical Protestants, Catholics, Jews, and Mainline Protestants all report significantly higher levels of trust in their physicians. In contrast, members of other affiliations report less personal trust in their physicians compared to Evangelicals ($B = -2.3, p < .05$). Finally, strength of affiliation is not significantly related to levels of personal trust in physicians.

General Confidence in Physicians

The center column of Table 3 shows the estimates for general confidence in physicians. The demographic, social, and health variables that are associated with this outcome include age, nativity, presence of health insurance, and self-rated health. Again, older individuals report higher levels of confidence than younger adults. Greater general trust in physicians is also perceived by native-born individuals, those with health insurance, and those with better subjective health.

The estimates for the relationship between religion and general confidence in physicians reveal that religious service attendance has a strong and consistent association with general confidence. As with the previous outcome, individuals who attend services at both frequency levels report greater confidence in doctors, compared to those who never attend services ($B = 1.51, p < .01$; $B = .99, p < .05$, respectively). Note the linear pattern for both the magnitude and significance of the estimates. Differences by religious affiliation are not as pronounced, though one significant finding emerges. Specifically, Mainline Protestants have higher levels of general confidence in physicians compared to Evangelical Protestants ($B = 0.82, p < .05$). As before, strength of affiliation does not appear to have a significant relationship with general confidence in physicians.

Trust in the Health Care System

The relationship between religion, covariates, and trust in the health care system is displayed in the final column of Table 3. The control variables that have a significant relationship with trust in the health care system include age, education, health insurance, and self-rated health. Being older, more highly educated, in better health, and possessing health insurance are all related to more trust in the health care system. Unlike the other types of medical trust, trust in the health care system is not significantly related to the religious attendance measures. However, individuals who belong to Mainline Protestant churches have significantly higher levels of trust in the health care system compared to Evangelical Protestants. Finally, there is no association between strength of affiliation and trust in the system.

DISCUSSION

The purpose of this study was to examine the relationship between religion and trust in physicians and the health care system. It is important to examine the predictors of medical trust because of its relevance to a wide range of health behaviors, including adherence to treatments and screenings, satisfaction with care, and even subsequent health [1-3]. Despite its significance, the determinants of trust are not fully understood. The results presented here attempt to advance our understanding of this issue by examining the role of religion in one aspect of the patient-physician relationship. The most significant findings indicate that individuals who attend religious services regularly have higher levels of trust in physicians than those who attend less frequently or never. More specifically, attendance is strongly associated with general confidence in physicians and more moderately related to personal trust in one's own physician. In addition, levels of these types of trust also vary by religious affiliation. Members of certain affiliations, such as Mainline Protestants, appear to have higher levels of trust than Evangelical Protestants. More trust in physicians by individuals with greater religious involvement and by members of certain religious groups may be an interesting pathway through which religion may be related to more positive health outcomes in the United States.

As discussed earlier, there are several possible mechanisms that may account for the relationship between attendance and trust in physicians. One possible explanation is that the provision of health-related programs by religious organizations influences levels of health care-related trust. Especially if the programs are endorsed by religious leaders, this contact with the health care system (directly or indirectly) may increase the confidence members have in the health care system. Unfortunately, no studies linking these programs to attitudes or beliefs regarding the health care system were found. Involvement with a religious organization (through attendance) may also influence individuals through religiously-based beliefs. One could speculate that religious individuals may believe that health care providers are tools of God, and thus, are trustworthy. In addition, religious organizations often foster beliefs such as a respect for authority or more positive worldviews [34], which could lead to greater trust in physicians and the health care system (though, again, no empirical evidence for this was found).

Moreover, individuals involved with a religious organization may feel they have a duty to maintain their health in order to be able to perform activities consistent with their beliefs (e.g., volunteering). This could lead to more frequent interactions with the health care system, more motivation to work with health care providers, and, consequently, higher levels of medical trust. In support of this, previous research has shown that patients who attend religious services *are* more likely to have a regular physician [35], and factors related to having a regular physician are related to levels of trust in one's physician [5]. Unfortunately, data limitations preclude testing this hypothesis in the current study. Finally, it should

be noted that the mediating role of general trust was not supported by the data. More specifically, adding the general trust variable did not change the relationship between the religion variables and the trust outcomes.

Although any, or all, of these possible mechanisms could help to account for the relationship between religious attendance and trust in physicians, it is also possible that this relationship is due to selectivity. In other words, some third factor, such as an underlying personality trait or lifestyle characteristic, may influence both attendance and trust. For example, certain individuals could be categorized as “good citizens,” because they are supportive of a wide range of social institutions from religious organizations to political groups [36]. These individuals may be more likely to support both churches (expressed through regular attendance) and health organizations (expressed through trust in physicians and the health care system). If certain personality types like this exist, it may explain part, or all, of the associations seen here. Although specific measures of these underlying personality traits are not available, one could propose that general trust in people should be related to the “good citizen” type of personality. However, as noted above, the inclusion of this variable in the models did not significantly reduce the relationship between attendance and trust. More work in this area, particularly with more precise indicators of relevant personality traits, is certainly warranted.

Trust in physicians also appears to differ by religious affiliation. Previous work in this area suggests that members of liberal denominations are more trusting *in general* than their conservative counterparts [18, 19]. Prior studies have also shown that utilization of health care services differs by denomination, often with Jewish individuals using the most services [16, 37]. This would support the results found here, in which certain denominations, such as Mainline Protestants, Catholics, and Jews, have more trust in the health care system than members of Evangelical denominations, which are generally more conservative. The connection between Mainline Protestant denominations and trust is particularly strong (and consistent). More detailed denomination categories may provide additional insight into any potential differences in levels of medical trust.

The preliminary nature of these findings, as well as the limitations of the current study, necessitate further work in this area before any conclusions are drawn. To begin, two of the three measures of trust in the current study have not been validated. Numerous scales have recently been developed to measure patient trust in physicians and health care organizations and future studies of religion and trust may benefit from this advancement [2, 4, 27, 38]. Additionally, more extensive measures of religion and additional variables that may account for the association (e.g., social support, better measures of physical health) would add considerably to this study. Measures of spirituality, in addition to religiousness, may also add important insight. Moreover, the current sample, while nationally representative, was largely white and the majority had insurance. Thus, the results may not be applicable to a minority population without easy access to medical care. Finally,

the relatively limited robustness of the data may lessen the validity of the estimates, and it highlights the need for further examination of this relationship. Despite these limitations, this study takes the first step in determining how religion may be related to trust in physicians and the health care system.

These preliminary findings add to two distinct bodies of literature, both of which are experiencing a period of rapid growth. First, the literature on religion and health will benefit from additional research on possible mechanisms linking religion to various beliefs that may influence a wide variety of health behaviors. Second, health researchers who are increasingly interested in the determinants of physician trust should recognize the possible influence of religious involvement. This may be especially important as researchers attempt to develop interventions for physicians designed to improve patient trust. Although this type of research does not lend itself to practical implications, the current lack of successful interventions may reflect the need for a greater understanding of the causes and correlates of trust [39], and gaining information on the relationships between trust and social and psychological factors, such as religion, may be beneficial as we develop a more complete understanding of this important concept. Because of the broad impact of trust on health behaviors and health care utilization, as well as the importance of religion to many Americans, this is an important topic for public health researchers to examine in greater depth.

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