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A Place to Trust: Black Protestant Affiliation and Trust in Personal Physicians
Abigail A. Sewell Rashawn Ray

A PLACE TO TRUST: BLACK PROTESTANT AFFILIATION AND TRUST IN PERSONAL PHYSICIANS

Abigail A. Sewell and Rashawn Ray

ABSTRACT

Purpose – *Past research indicates that blacks are less trusting of physicians than are whites; yet, researchers have not examined within group differences in physician trust by religious denomination – an effort that is complicated by the high correlated nature of race and religion. To better understand black-white differences in physician trust, this chapter examines heterogeneity in trust levels among blacks associated with religious designations that distinguish Black Protestants from other ethnoreligious groups.*

Methodology/approach – *Using data from the 2002 and 2006 General Social Surveys, this study adopts an intersectional (i.e., race x religion) typology of religious denomination to understand the black-white gap in physician trust. Weighted multivariate linear regression is employed.*

Findings – *Black-white differences in physician trust are identified only when religious affiliation is considered but not when religious affiliation is omitted. Blacks who are affiliated with Black Protestant churches are*

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more trusting than other religious groups, including Evangelical Protestants, Mainline Protestants, and blacks who are affiliated with other faiths.

Originality/value — *This chapter indicates that there is more heterogeneity in trust levels among blacks than between blacks and whites. Moreover, the findings suggest that religion can play an important role in bridging the trust gap between blacks and the medical sciences.*

Keywords: Race; religion; Black Protestant; trust; physicians

Social science research indicates that blacks are less likely than whites to trust "most people," racial outgroup members, and institutional actors (Alesina & La Ferrara, 2002; Glaeser, Laibson, Scheinkman, & Soutter, 2000; Hibbing & Theiss-Morse, 2001; Hughes & Thomas, 1998; LaVeist, Nickerson, & Bowie, 2000; Simpson, McGrimmon, & Irwin, 2007). One key institutional bond that has implications for health outcomes is the patient-physician relationship. Yet, researchers have not examined how social factors, such as religion, serve as important moderators of black-white differences in trusting personal physicians. This chapter draws from the prior research that shows that religion may buffer the effect of discrimination on psychological distress (Ellison, Musick, & Henderson, 2008) and, subsequently, trust attitudes toward physicians. The study attends to one dimension of religion that has been found to be associated with how an individual views and responds to racial discrimination (Lincoln & Mamiya, 1990) — religious affiliation.

Discrimination in the medical encounter and, specifically, the patient-physician relationship may be a culprit for a lack of trust among blacks (LaVeist et al., 2000; Smedley, Stith, & Nelson, 2003). For instance, although only 14 percent of blacks indicate that they personally have been treated unfairly in medical encounters due to their race or ethnicity, 35 percent indicate that either a family member or someone they know has been treated unfairly (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Comparable figures of 1 and 14 percent among whites, respectively, are of a decidedly smaller magnitude. Furthermore, blacks are over three times more likely than whites to be concerned about future discrimination toward themselves, friends, and/or their family members during medical encounters (Lillie-Blanton et al., 2000). Prior research has found that religious affiliation and orientations predict both adherence to discriminatory

attitudes toward minority groups (Kirkpatrick, 1993) as well as reactions to discriminatory views by others (Byrnes & Kiger, 1992). Fundamentalist affiliates are more likely to hold discriminatory attitudes toward minority groups but less likely to react against discriminatory views. No research, however, has examined how social factors, such as religious affiliation, are implicated in the link between discriminatory experiences in the medical encounter and trust in personal physicians.

This study situates affiliations with faith-based communities as a key moderator in the relationship between racial group membership and attitudes toward personal physician. Faith-based affiliations may be a moderating mechanism because it transforms the relationship between trusting attitudes and perceived discrimination against the individual or the group due to race. Specifically, this study works from the premise the affiliates of Black Protestant communities may harbor more trust in personal physicians because the conditions of community within these faith-based communities foster more positive views of physicians. These conditions include higher levels of religious participation, more contact with the medical system via faith-based community partnerships with physicians and public health professionals, and more contact with high-status professionals within the faith-based organization. Using data from the 2002 and 2006 General Social Survey, this study examines whether black-white differences in trust are contingent upon the type of faith-based affiliation one has. The next section reviews extant research regarding heterogeneity in blacks' views of personal physician by way of religious affiliation.

BACKGROUND RESEARCH

Researchers posit that historical instances of discriminatory practices toward blacks within social institutions, such as health care, serve as sources of collective memories regarding racial inequities transmitted across institutions and through social networks of friends, family members, and blood and non-blood relatives (Gamble, 1997; Lipset & Schneider, 1987; Washington, 2006). Furthermore, aspects of systemic racism throughout American history may contribute to distrust among blacks, including lynchings, unsolved killings in sundown towns, and the rise of the "prison industrial complex" (Alexander, 2012, Blalock, 1967; Bobo & Thompson, 2006; Marable, 1983; Roediger, 1999). Simply put, the history of racial discrimination is as long as, and embedded within, the history of America

(Feagin, 2006). Incidents such as the Tuskegee Syphilis Study and other medical abuses of blacks speak directly to the patient-physician relationship and give credence to blacks' present-day distrust in medicine and inequities perceived in other institutions and interactional spaces (Gamble, 1997; Washington, 2006). Accordingly, blacks may be less trusting of physicians not only because of present-day inequities in the quality of treatment in the health care system, but also because of collective memories stemming from a legacy of medical abuse and experimentation on black people.

Faith-based communities in the Black community serve as a key social location wherein collective memories of inequitable treatment are given space (Cone, 1984; Lincoln & Mamiya, 1990; Taylor, Thornton, & Chatters, 1987). While such collective memories can serve to buttress feelings of group discrimination, they can also serve to build community through shared experiences of constrained opportunity structures within and across institutions. By fostering social contact and identity construction, collective memories catalogue and interweave a group's historical timeline and contemporary lived experiences (Halbwachs, 1992; Zerubavel, 2003). Institutions where the networks of blacks are more dense and racially homogenous, such as faith-based organizations, may facilitate the cultural transmission of collective memories that also foster trust. Religion has always been a source of support and strength for the black community (Du Bois, 1903; Frazier, 1964; Lincoln, 1974; Taylor, Chatters, & Levin, 2004). The Black Protestant church, specifically, is a space that is often owned and operated by other blacks who are invested in the progression of the black community (Lincoln & Mamiya, 1990; Taylor, Thornton, & Chatters, 1987; Thomas, Quinn, Billingsley, & Caldwell, 1994). In fact, black churches and their leaders (e.g., Southern Christian Leadership Conference (SCLC), Martin Luther King, Jr.) were influential in shaping the discourse of the Civil Rights Movement (Morris, 1986, 1996; Williams, 1987).

Accordingly, faith-based affiliations offer an opportunity to examine whether blacks may be more likely to trust physicians in certain sociopolitical contexts, such as Black Protestant churches. There are several reasons to expect higher levels of trust among blacks who are affiliated with Black Protestant churches than among blacks who are not affiliated with Black Protestant churches. First, while integrated churches often do not incorporate the customs, leadership potentials, and/or theological preferences of blacks (Edwards, 2008), Black Protestant churches are more likely to have black clergy and leadership (Lincoln & Mamiya, 1990). Since blacks are more likely to trust ingroup members (Simpson et al., 2007), blacks affiliated with Black Protestant churches may be more likely than blacks

affiliated with other types of churches to extend trust to other institutional gatekeepers (e.g., physicians) as well. From this perspective, blacks affiliated with Black Protestant churches extend trust toward physicians because the Black Protestant arena creates a safe space that elicits trustworthy behaviors, attitudes, and norms toward institutional gatekeepers. Attachment to one institution (religion) may foster attachment to another institution (medicine) – an argument that has been made in regards to the effects of religious affiliation among working class whites (Wilcox, Cherlin, Uecker, & Messel, 2012). Second, Black Protestant churches may have historically rooted patterns of coping with discrimination from society in general (Bierman, 2006) that may lead them to, in the end, exhibit a higher level of trust than African Americans not involved in Black Protestant churches, including trust in physicians.

Third, Blacks who are affiliated with Black Protestant churches may be more trusting of physicians because recommendations to healthcare providers who treat black patients equitably may pass through the social networks of church members whom they are more likely to trust. Fourth, Black Protestant churches may be hubs for faith-based public health initiatives (Levin, 1984). In this case, black pastors may vouch for physicians and public health scholars who are conducting interventions in black communities (Levin, 1986). Fifth, black Protestants may trust physicians more because they are of lower socioeconomic status than blacks of other religious traditions (Sherkat, 2001, 2002), and persons of lower socioeconomic status have been found in some studies to exhibit more trust toward physicians than persons of higher socioeconomic status (Chu-Weininger & Balkrishnan, 2006).

Yet, prior research that has examined racial differences in physician trust and religious affiliation has not found evidence of black-white differences in physician trust (Hall, Camacho, Dugan, & Balkrishnan, 2002), even holding constant faith-based affiliations (Benjamins, 2006). We argue this is because prior research has not used a measure of religious affiliation that distinctly identifies the levels of trust among Black Protestants as distinguishable from the levels of trust among blacks who are affiliated with other faith-based organizations. Were Black Protestants to be distinguished from blacks who are affiliated with other faith-based organization, racial differences in physician trust may be identified. Specifically, heterogeneities in levels of trust among blacks might be revealed.

This chapter provides new insight over and beyond existing studies by interrogating the link between religious denomination and racial inequalities in trusting physicians. We examine whether Black Protestant affiliation

influences the race gap in physician trust between blacks and whites in the United States. This interrogation is done in a way that highlights a serious methodological challenge in studying the intersections of two correlated social conditions – ethnoracial status and religious denomination. Methodologically speaking, we reconsider the black-white physician trust gap by distinguishing religious groups by racial status using an intersectional model of ethnoreligiousity. Generally, we ask: Are blacks who attend Black Protestant churches more likely to trust physicians than other ethnoreligious groups? Accordingly, we propose three hypotheses for this study.

Hypothesis 1. Blacks are less likely to trust physicians than whites.

Hypothesis 2. Blacks who attend Black Protestant churches, compared to blacks who do not, are more likely to trust physicians.

Hypothesis 3. Blacks who attend Black Protestant churches, compared to whites, are more likely to trust physicians.

The first hypothesis extends from the long line of research that predicts lower levels of trust among blacks when compared to whites. The second hypothesis specifically focuses on heterogeneities in trust among blacks. The third hypothesis, meanwhile, entails that Black Protestants will be so different from blacks that their views on physicians are also distinct from whites. Together, these hypotheses indicate that the black-white physician trust gap is contingent upon faith-based affiliations and that faith-based affiliations, in general, are a moderator of race differences in physician trust.

DATA

Data for this study come from the 2002 and 2006 General Social Surveys (GSS) conducted by the National Opinion Research Center (Davis, Smith, & Marsden, 2007). The 2002 and 2006 GSS used a full probability sample of persons of 18 years of age or older living in non-institutional arrangements within the 48 contiguous states of the United States. Face-to-face interviews of approximately 1.5 hours were conducted between March and May of 2002 and 2006. Assessments of primary care physicians are derived from a random sub-sample of 2,728 respondents given questions that were assessed during the Mental Health Module. Black and white respondents

with invalid data on the dependent and independent variables are excluded from the analysis. Latinos, Asians, other races, and persons who do not report their race are also omitted from the analysis. The final sample size is 2,209.

Dependent Variable

This study examines racial differences in trust toward physicians using a shortened Trust in Physician Scale (Anderson & Dedrick, 1990). Trust in physicians is measured by asking a series of statements about the medical care they are receiving now (or would expect if they sought care). Anderson and Dedrick's Trust in Physician scale focuses primarily on physicians treating general health conditions (Anderson & Dedrick, 1990). The scale includes five indicators of trust: Honesty; Fiduciary Ethic; Technical Judgment; Cultural Authority; and Interpersonal Competence.

The *Honesty* dimension is assessed by agreement with the statement, "I trust my doctor to tell me if a mistake was made about my treatment." The *Fiduciary Ethic* dimension is assessed by agreement with the statement, "I trust my doctor to put my medical needs above all other considerations when treating my medical problem." The *Technical Judgment* dimension is assessed by agreement with the statement, "I trust my doctor's judgment about my medical care." The *Cultural Authority* dimension is assessed by agreement with the statement, "My doctor is a real expert in taking care of medical problems like mine." The *Interpersonal Competence* dimension is assessed by disagreement with the statement, "I doubt my doctor really cares about me as a person."

Each of the aforementioned statements was coded originally on a five-point scale (1 = strongly agree, 2 = agree, 3 = neither agree nor disagree, 4 = disagree, and 5 = strongly disagree). Respondents' answers were coded "don't know" only if they volunteered this response; these respondents are dropped from subsequent analyses. Respondents who refused to provide a response to the statements are also dropped from the analyses. Items are coded so that more positive responses reflect greater trust in physicians. Factor analysis of the five items indicates a single underlying dimension with little variation in the factor loadings (Cronbach's alpha (α) = .75). A summary scale was constructed by dividing the sum of responses by five. Table 1 presents descriptive statistics for the dependent variable and the independent and control variables detailed below.

Racial Group Membership

Racial group membership is measured by a dummy indicator variable – 1 = black non-Latino ("black"); 0 = white non-Latino ("white"). Racial group membership is classified by the respondent using procedures followed in the decennial U.S. Census. Seventeen percent of the sample is classified as black.

Religious Affiliation

Religious affiliation is measured in three ways. The first way that religious affiliation is measured is with RELTRAD designations (Steensland et al., 2000), which identifies six religious denominations – Evangelical Protestant, Mainline Protestant, Black Protestant, Catholic, Jew, Other Faith, and Non-Affiliated. The second way that religious affiliation is measured is with a simplified RELTRAD designation, which identifies four religious affiliations – Black Protestant, Protestant-Affiliated, Other-Affiliated, and Non-Affiliated. RELTRAD designations are simplified in this way due to unbalanced cell sizes by race. The simplified RELTRAD designation collapses the distinctions between Evangelical Protestants and Mainline Protestants (as Protestant-Affiliated) and the distinctions between Catholics, Jews, and members of other faiths (as Other-Affiliated). The third way that religious affiliation is measured is with an intersectional religious affiliation designation – ethnoreligious groups. This typology allows for the effect of four simplified RELTRAD religious affiliations (Black Protestant, Protestant-Affiliated, Other-Affiliated, and Non-Affiliated) to be distinct by racial group. Whites who are classified as Black Protestant using RELTRAD designations are removed from the analysis due to small sample size ($n = 31$). This leaves seven ethnoreligious groups to be evaluated.

Control Variables

To account for sources of measurement error associated with differences in the coding of the middle trust response category between the two surveys, a dummy indicator for the 2002 survey year is included as a control variable (reference category = 2006 survey year). Supplemental analyses indicate that the survey year indicator captures the effects of survey measurement error. Though the effect of year was significant ($F = 20.04$, $p < 0.001$), the

effects of correlates of trust were consistent across years of the GSS ($F = 0.67$, $p = 0.733$). Thus, the 2002 and 2006 GSS samples are pooled for the following analyses.

To assess the role of racial differences in sociodemographic correlates of trust, covariates for marital, work, and parental status, household size, gender, age, education, subjective class identification, region, parental nativity, religious service attendance, voting behavior, and political party affiliation are included (Table 1). Measures that tap sociodemographic differences between blacks and whites include marital status (1 = married, 0 = other); work status (1 = full-time worker, 0 = other); parental status (1 = have children, 0 = no children); household size (family sizes more than 10 collapsed into highest category); gender (1 = females, 0 = males); age (1st and 2nd order polynomial term for years of life lived); education (years of school completed); a categorical measure of lower or working class identification (reference category = middle or upper class); region (1 = Southerner, 0 = non-Southerner); and parental nativity (1 = has two native parents, 0 = has one or two non-native parents). Racial differences in religious attendance are measured using a nine-category ordinal variable assessing frequency of religious service attendance (0 = never, 1 = less than one time a year, 2 = about 1−2 times a year, 3 = several times a year, 4 = about once a month, 5 = 2−3 times a month, 6 = nearly every week, 7 = every week, 8 = several times a week). Racial differences in political factors are measured by voting behavior (1 = ever voted, 0 = never voted) and a categorical measure of Democratic or Republican political party affiliation (reference category = Independent or Other party).

METHODS OF ANALYSIS

Weighted multivariate regression is employed to adjust for differential sampling probabilities among individuals across survey year (WTSSALL). Robust standard errors are also employed. First, this study examines unadjusted and adjusted racial differences in trusting physicians using a dummy indicator for black respondents (white respondents are the reference category). Racial differences are then adjusted by holding constant sociodemographic characteristics. Second, religious denomination differences in trusting physicians are examined using RELTRAD designations (Steensland et al., 2000), holding constant racial differences and then sociodemographic characteristics. Third, unadjusted and adjusted religious denomination differences in trusting physicians are examined using simplified RELTRAD

Table 1. Descriptive Statistics by Race and for the Combined Sample, $N = 2{,}209$.

	Black ($N = 369$)				White ($N = 1{,}840$)				Combined ($N = 2{,}209$)			
	Mean	SD	Min	Max	Mean	SD	Min	Max	Mean	SD	Min	Max
Outcomes												
Trust in physician scale	3.93	0.75	1.00	5.00	3.98	0.76	1.00	5.00	3.97	0.76	1.00	5.00
Religious affiliation												
RELTRAD designations												
Black Protestant	0.58		0.00	1.00	–		–	–	0.10		0.00	1.00
Evangelical Protestant	0.15		0.00	1.00	0.29		0.00	1.00	0.27		0.00	1.00
Mainline Protestant	0.05		0.00	1.00	0.23		0.00	1.00	0.20		0.00	1.00
Catholic	0.07		0.00	1.00	0.24		0.00	1.00	0.21		0.00	1.00
Jewish	0.00		0.00	1.00	0.03		0.00	1.00	0.02		0.00	1.00
Other faith	0.05		0.00	1.00	0.05		0.00	1.00	0.05		0.00	1.00
Non-affiliated	0.11		0.00	1.00	0.16		0.00	1.00	0.15		0.00	1.00
Affiliation designations												
Black Protestant	0.58		0.00	1.00	–		–	–	0.10		0.00	1.00
Protestant-affiliated	0.19		0.00	1.00	0.53		0.00	1.00	0.47		0.00	1.00
Other-affiliated	0.12		0.00	1.00	0.31		0.00	1.00	0.28		0.00	1.00
Non-affiliated	0.11		0.00	1.00	0.16		0.00	1.00	0.15		0.00	1.00
Control variables												
Married (0 = unmarried)	0.30		0.00	1.00	0.51		0.00	1.00	0.48		0.00	1.00
Full-time worker (0 = not full-time worker)	0.53		0.00	1.00	0.50		0.00	1.00	0.50		0.00	1.00
No. of people in household	2.40	1.49	1.00	10.00	2.33	1.33	1.00	11.00	2.34	1.36	1.00	11.00
Parent (0 = no children)	0.80		0.00	1.00	0.71		0.00	1.00	0.72		0.00	1.00
Female (0 = male)	0.63		0.00	1.00	0.56		0.00	1.00	0.57		0.00	1.00
Age of respondent	44.22	15.82	18.00	89.00	48.14	17.38	18.00	89.00	47.48	17.19	18.00	89.00
South (0 = non-south)	0.62		0.00	1.00	0.33		0.00	1.00	0.38		0.00	1.00
Two parents born in the United States (0 = other)	0.90		0.00	1.00	0.87		0.00	1.00	0.88		0.00	1.00
Years of education	12.80	2.66	2.00	20.00	13.77	2.76	2.00	20.00	13.61	2.77	2.00	20.00

Subjective class identification												
Lower class (0 = other)	0.13		0.00	1.00	0.05		0.00	1.00	0.06		0.00	1.00
Working class (0 = other)	0.50		0.00	1.00	0.40		0.00	1.00	0.42		0.00	1.00
Middle/upper class (reference category)	0.37		0.00	1.00	0.55		0.00	1.00	0.52		0.00	1.00
Has ever voted (0 = never voted)	0.68		0.00	1.00	0.78		0.00	1.00	0.77		0.00	1.00
Political party affiliation												
Republican (0 = other)	0.06		0.00	1.00	0.35		0.00	1.00	0.30		0.00	1.00
Independent/other (0 = other)	0.31		0.00	1.00	0.38		0.00	1.00	0.36		0.00	1.00
Democrat (reference category)	0.63		0.00	1.00	0.27		0.00	1.00	0.33		0.00	1.00
Religious service attendance	4.58	2.65	0.00	8.00	3.57	2.77	0.00	8.00	3.74	2.77	0.00	8.00

Source: 2002 and 2006 General Social Survey.
Note: SD = Standard deviation.

designations. Last, unadjusted and adjusted ethnoreligious differences in trusting physicians are examined using an intersectional conceptualization of religious affiliation designations that distinguishes Black Protestants who are black from other race-specific religious affiliation designations codified with simplified RELTRAD designations.

RESULTS

Table 2 shows regression models for the effect of racial group membership on physician trust. The first model in Table 2 implies that blacks are not less trusting than whites of physicians ($b = -0.073$; $p = 0.196$). This finding counters Hypothesis 1 that blacks are less likely to trust physicians than

Table 2. Weighted Linear Regression for the Effect of Race and Religious Denomination on Physician Trust, $N = 2{,}209$.

	Model 1	Model 2	Model 3	Model 4
Racial group membership (ref. White)				
Black	−0.07	−0.10	−0.25**	−0.25**
	(0.06)	(0.06)	(0.09)	(0.09)
Religious affiliation: RELTRAD (*ref. evangelical protestant*)				
Black Protestant			0.28*	0.26*
			(0.11)	(0.11)
Mainline Protestant			0.01	0.02
			(0.05)	(0.06)
Catholic			0.03	0.05
			(0.05)	(0.05)
Jewish			−0.24*	−0.22*
			(0.10)	(0.10)
Other faith			−0.06	−0.02
			(0.10)	(0.10)
Non-affiliated			−0.11	0.02
			(0.06)	(0.07)
Controls		Included		Included
Constant	3.97***	4.07***	3.99***	4.06***
	(0.02)	(0.15)	(0.04)	(0.16)
Observations	2,209	2,209	2,209	2,209

Source: 2002 and 2006 General Social Survey.
Notes: Unstandardized beta coefficients shown; standard errors in parentheses. Reference category for RELTRAD is Evangelical Protestant. Models with controls include adjustments for subjective class identification, worker status, household size, parental status, female gender, age of respondent, Southern regional location, parental nativity, years of education, civic participation, political party identification, and religious service attendance.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$ (two-tailed test).

whites. Model 2 indicates that this non-significant relationship holds even when considering black-white differences in sociodemographic characteristics. These findings suggest that blacks are actually more heterogeneous than the literature has implied.

Model 3 in Table 2 includes variables for church affiliation using RELTRAD designations. RELTRAD designations allow a specification for members of Black Protestant churches that are not otherwise possible using other church affiliation typologies. As mentioned in the methods section, whites who could be designated as Black Protestant are not included in the sample due to small sample sizes. As such, the Black Protestant coefficient refers only to blacks who are affiliated with Black Protestant churches. When RELTRAD designations are considered, the coefficient for black group membership becomes significant and negative ($b = -0.248$; $p = 0.005$), which indicates that blacks are significantly less likely to trust physicians than whites when religious affiliation is taken into consideration. Meanwhile, the coefficient for Black Protestant church affiliation is significant and positive ($b = 0.283$; $p = 0.012$). This finding implies that blacks who attend Black Protestant churches are more likely to trust physicians than Evangelical Protestants. Collectively, these findings support Hypothesis 2 that blacks who attend Black Protestant churches, compared to blacks who do not, are more likely to trust physicians. It also suggests that Black Protestants may actually be more likely to trust physicians than whites. These findings also provide qualified support for Hypothesis 1: holding constant religious affiliation, blacks are less trusting of physicians than whites.

Fig. 1 shows unadjusted levels of physician trust by race and religious affiliation using an intersectional typology of church affiliation, as shown in Model 3 of Table 3. In this typology of religious affiliation, the differences between evangelical Protestants and mainline Protestants are collapsed, as well as the differences among Catholics, Jews, and members of other faiths. Accordingly, racial distinctions are considered for three religious groups in comparison to blacks who are Black Protestant – Protestant-affiliated, other-affiliated, and non-affiliated. Fig. 1 reveals that Black Protestants are actually more likely to trust physicians than all other groups including all other types of blacks and all other types of whites.

To further highlight this pattern, Table 3 shows regression models for the effect of religious affiliation on physician trust using a simplified RELTRAD classification scheme that collapses distinctions between Evangelical Protestants and Mainline Protestants (Protestant-Affiliated) and between Jews, Catholics, and other faiths (Other-Affiliated). White respondents who are classified as Black Protestants were removed from the sample for this study, as such by default the reference category for all

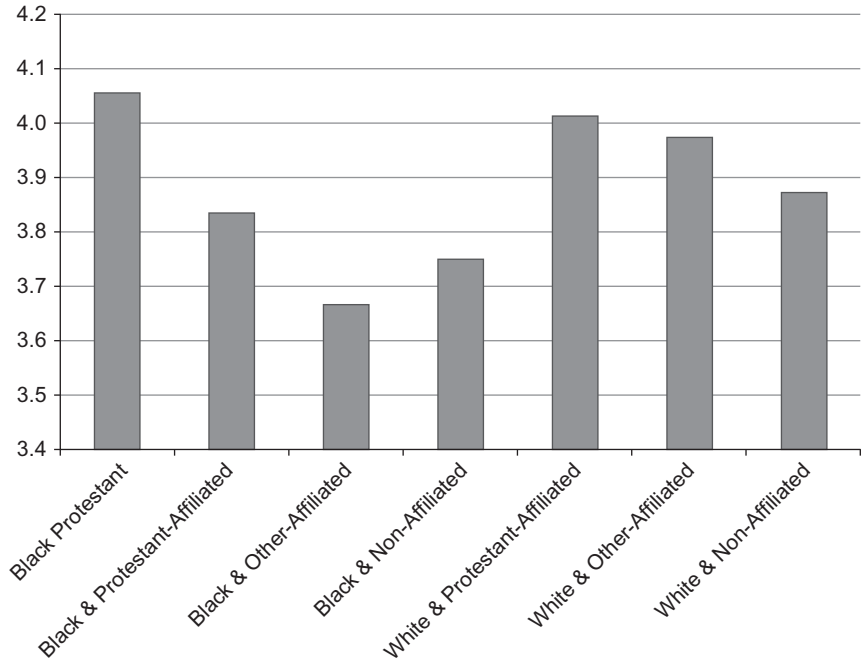

Fig. 1. Physician Trust by Race and Religious Affiliation, $N = 2{,}209$.

models in Table 3 is black respondents who are classified as Black Protestants. The black coefficient in Model 1 of Table 3 indicates that blacks who are not Black Protestant exhibit less trust than blacks who are Black Protestant ($b = -0.250$; $p = 0.004$). As such, Hypothesis 2 is confirmed.

Moreover, the simplified RELTRAD religious affiliation coefficients in Model 1 of Table 3 indicate that Black Protestants exhibit more trust than respondents of any race or of any other religious affiliations ($F[3,2204] = 4.49$; $p = 0.004$). Specifically, Black Protestants are more trusting than persons who are affiliated with other Protestant groups ($b = -0.280$; $p = 0.011$), persons who are affiliated with other faiths ($b = -0.291$; $p = 0.010$), and persons who are non-affiliated ($b = -0.397$; $p = 0.001$). These findings hold when controlling for religious differences in sociodemographic characteristics (Table 3, Model 2). Black Protestants are more trusting of physicians than other religious groups even when individual characteristics are considered.

Models 3 and 4 of Table 3 employ an intersectional typology of ethno-religious affiliations to more explicitly examine Black Protestant's levels of

Table 3. Weighted Linear Regression for the Effect of Ethnoreligious Affiliation on Physician Trust, $N = 2{,}209$.

	Model 1	Model 2	Model 3	Model 4
Racial group membership (ref. White)				
Black	−0.25**	−0.25**		
	(0.09)	(0.09)		
Religious affiliation: simplified RELTRAD (ref. Black Protestant)				
Protestant-affiliated	−0.28*	−0.26*		
	(0.11)	(0.11)		
Other-affiliated	−0.29**	−0.26*		
	(0.11)	(0.11)		
Non-affiliated	−0.40***	−0.26*		
	(0.11)	(0.11)		
Ethnoreligious affiliation (ref. Black Protestant)				
Black and Protestant-affiliated			−0.22	−0.20
			(0.14)	(0.14)
Black and other-affiliated			−0.46**	−0.38*
			(0.17)	(0.16)
Black and non-affiliated			−0.32	−0.22
			(0.18)	(0.17)
White and Protestant-affiliated			−0.04	−0.02
			(0.07)	(0.07)
White and other-affiliated			−0.03	0.01
			(0.08)	(0.08)
White and non-affiliated			−0.16	−0.01
			(0.08)	(0.09)
Controls		Included		Included
Constant	4.27***	4.31***	4.02***	4.07***
	(0.11)	(0.19)	(0.07)	(0.16)
Observations	2,209	2,209	2,209	2,209

Source: 2002 and 2006 General Social Survey.

Notes: Unstandardized beta coefficients shown; standard errors in parentheses. Reference category for religious affiliation and ethnoreligious affiliation is Black Protestant. Models with controls include adjustments for subjective class identification, worker status, household size, parental status, female gender, age of respondent, Southern regional location, parental nativity, years of education, civic participation, political party identification, and religious service attendance.

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$ (two-tailed test).

physician trust in relation to race-specific religious (i.e., ethnoreligious) groups. The main coefficient for black racial group status is interacted with the four-category simplified RELTRAD designation variable. Model 3 reveals that blacks who are affiliated with non-Protestant places of worship are significantly less trusting of physicians than blacks who attend Black Protestant churches ($b = -0.462$; $p = 0.007$). Moreover, supplemental tests for the joint

significance of ethnoreligious groups (available upon request) indicates that Black Protestants hold distinct views of personal physicians than other ethnoreligious groups (F[6,2202] = 2.86; p = 0.009), other black ethnoreligious groups (F[3,2202] = 3.35; p = 0.018), and other-affiliated persons (F[2,2209] = 3.85; p = 0.0213). The negative value of the beta coefficients in Model 3 suggests that Black Protestants are more trusting of personal physicians than white ethnoreligious groups. Still, while Black Protestants have higher levels of trust in personal physicians than whites on average, the difference between Black Protestants and whites is not statistically significant (F[3,2202] = 2.06; p = 0.1039). Hypothesis 3 is not confirmed: Black Protestants hold similar views towards physicians as do whites.

Model 4 of Table 3, which includes covariates for pertinent sociodemographic factors, show similar patterns. Differences in levels of physician trust between Black Protestants and other black respondents are partly attenuated once sociodemographic factors are considered (F[3, 2186] = 2.46; p = 0.061). Supplemental analysis (available upon request) indicates that the sociodemographic factors responsible for the attenuation of the distinction between Black Protestants and other black ethnoreligious groups are a combination of political factors and religious service attendance. Holding all else constant, differences in physician trust between Black Protestants and other-affiliated black respondents remain statistically significant, (b = −0.384; p = 0.016). Hypothesis 2 is partly supported.

Meanwhile, Hypothesis 3 is not supported. Although Model 3 of Table 3 indicates that blacks who attend Black Protestant churches are slightly more likely to trust physicians than whites who are not affiliated (b = −0.155; p = 0.059), Black Protestants are not more likely to trust physicians than whites who are affiliated with Protestant or non-Protestant organizations. These findings indicate that there are more similarities between Black Protestants and whites in regards to physician trust (though they may be referencing different physicians) than between Black Protestants and non-Protestant blacks. Altogether, the results show that blacks who attend Black Protestant churches trust differently than blacks who do not attend black Protestant churches.

DISCUSSION

This chapter examined the role of religious affiliation in attenuating racial differences in physician trust. We found that Black Protestants are more

trusting of physicians than other ethnoreligious groups. Our findings have implications for highlighting how the public health intervention model can be more successful – that is, by working through the safe spaces of Black Protestant churches. We argue that public health and health services researchers will be more effective at breaking down black distrust by working through churches and other faith-based organizations.

Black distrust in physicians must be recognized as rooted in a distinct racialized history characterized by institutional and individual acts of discrimination that can be traced back to American slavery and Jim Crow and linked to the current sociohistorical ramifications of being racially marginalized in America. Gamble's conceptualization of collective memories (Gamble, 1997) identifies how the very fabric of institutionalized social relationships are shaped by American race relations that systemically produce racialized spaces of disadvantage and opportunity (Feagin, 2006). As a social condition, race shapes the formation and maintenance of relationships (Link & Phelan, 1995; Williams & Collins, 1995), thereby serving as a key axis by which affective bonds develop that facilitate the extension of trust in the behaviors of institutional actors.

Black Protestant churches are effective at reducing racial differences in trust because these sites already have trust embedded in the makings of the social institution. Since the 1700s, churches have been one of the few places where blacks can find refuge (Frazier, 1964). Black pastors are community trustees (Levin, 1986) who in many ways have "a symbolic key to the Black community" (Ray, 2014). The literature on health and religion shows that Black Protestant churches serve not only as intervention sites but also as hubs that increase healthcare utilization by connecting church members with trustworthy practitioners who will show a high level of care and concern for their health and the health of their loved ones (Blank, Mahmood, Fox, & Guterbock, 2002; DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Levin, 1984, Ray, 2014; Young & Stewart, 2006). Black Protestant churches can be found in all areas throughout the country regardless of racial composition, whether this is rural Indiana or the plains of Kansas. As some of the first owned and fully operated black establishments, Black Protestant churches are not only places of faith, but also places of safety, leadership, and trust for a host of black communities (Lincoln, 1974; Lincoln & Mamiya, 1990; Ray, 2014; Taylor et al., 2004).

Methodologically, we go beyond simply identifying the unique contributions race and religion to variations in physician trust. Instead, we describe physician trust levels by ethnoreligiosity – a two dimensional social condition that reflects an individual's concurrent positionality within a racialized

society divided by religious groupings. From this perspective, we do not seek to decompose the "race gap" per se. Rather, we sort the population by levels of physician trust in ways that capture the unique intersections of race and religion. Similar approaches have been taken by Idler and Kasl (1997) in their decision to bifurcate Protestants by race. Yet, the formulization of a Black Protestant category by Steensland et al. (2000) allows us to take a further step by dividing other religious groupings by ethnoraciality. Moreover, our racialization of religious groupings occurs within the context of the analytical model rather than in the context of the research design. In these ways, our interactional approach to race and religion represents a fundamental reconsideration of traditional categorization methods in studies of race and religion.

Admittedly, our analysis does not reflect the multi-ethnic environment of the United States. Past research employing the GSS has found it difficult to untangle the effect of race from that of ethnicity because of small sample sizes. Still, Latinos have been found to have lower levels of trust than whites (Stepanikova, Mollborn, Cook, Thom, & Kramer, 2006) and qualitatively different perspectives on social attitudes (Hunt, 2007). Also, our analysis relies on a shortened version of the Trust in Physician scale (Anderson & Dedrick, 1990). Black Protestant effects are unable to be evaluated with the longer version of the Trust in Physician scale, which was only asked in the 1998 GSS, due to small sample sizes. As such, this study provides preliminary evidence that blacks affiliated with Black Protestant churches exhibit higher levels of physician trust than other ethnoreligious groups.

Future research would benefit from understanding the similarities and points of departure in ethnoreligious determinants of trusting attitudes among and between Latinos and Asians as compared to blacks and whites. Future research would also benefit from examining ethnoreligious differences in physician trust using a broader range of items to determine trust in physicians. Further, exploring intraracial diversity in the correlates of trust will provide a more nuanced understanding of how historic and contemporary forces interweave to produce unique collective memories across and within racial and ethnic groups.

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