The Impact of Doctor Care on COVID-19 Distrust: Results from a Random National Sample

By

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Abstract

The COVID-19 vaccine is known to be the most effective means of fighting the global pandemic; however, many people are hesitant to trust the vaccine. This study examines how one's perception of how much their doctor cares about their overall health and well-being is correlated with their distrust of the COVID-19 vaccine. We analyze data from the sixth wave of the Baylor Religion Survey, which is a random national sample collected early in 2021. We use bivariate analysis and multivariate ordinary least squares regressions to test our hypotheses. We find a strong correlation between believing one's doctor cares about their overall health and vaccine trust. The results emphasize the role that doctors have in generating institutional trust in the COVID-19 vaccine, and these findings speak to the overall importance doctors play in fostering institutional trust in the medical industry. Doctors have served as the medical frontline workers throughout the COVID-19 pandemic, and our findings demonstrate how they also serve on the front lines of combatting misinformation about the vaccine.

Keywords: Vaccine Distrust, Doctor Care, COVID-19

Introduction

The surging outbreak of the COVID-19 virus upended life for most of the nation as many modified their daily routines to curb its spread. Social distancing, mask wearing, and sheltering at home became commonplace in this global battle. However, the vaccine is known as the most effective means to combat the coronavirus (Evans and Jewell 2021). Despite the effectiveness of the vaccine, many throughout the nation remain skeptical about receiving it. Much work has been devoted to understanding why some individuals are more distrusting of the COVID-19 vaccine than others (Bajaj and Stanford 2021; Cowan et al. 2021; Finney Rutten et al. 2021). However, little research has explored the relationship between doctor-patient relationships and vaccine distrust.

We contribute to this gap in the literature by examining how one's perception of how much their doctor cares about their overall health and well-being correlates with one's distrust of the COVID-19 vaccine.

To address this question, we analyze data from the sixth wave of the Baylor Religion Survey, a random national sample collected in early 2021. We employ multivariate OLS regressions and demonstrate a strong *correlation between believing one's doctor cares about their overall health and vaccine trust.*

Physician Empathy and Patient Satisfaction

A patient's perception of their physician's empathy is known to significantly influence satisfaction with the quality of medical care that their physician provides (Derksen et al. 2013; Hojat et al. 2010; Kim et al. 2004; Pollak et al. 2011). Studies point to the empathetic communication skills that a physician employs in their interactions with patients as dictating the degree to which their patients perceive them as being caring. Hojat and their co-researchers (2010) found that physicians that opt to suggest preventative care measures (colonoscopies, mammograms, PSA) over more invasive tests and treatments are more likely to

be perceived as empathetic by their patients. These researchers contend this correlation is likely due to the perception that one's physician does genuinely care about and is invested in the future state of their health (Hojat et al. 2010). Kim and colleagues (2004) interviewed outpatients at a large university in Korea and found a similar pattern in South Korea. Their study demonstrates that a doctor-patient partnership, which is when the patient views their physician as a partner in their health, has a strong positive effect on increasing patient satisfaction. Additionally, they find comparable results with perceived affective empathy, which are behaviors displayed by the physician that indicate that they understand the patients' feelings and emotions. Keeping this in mind, the authors claim that hospitals with more empathetic physicians have an advantage over hospitals with less empathetic physicians due to the differing levels of patient satisfaction (Kim et al. 2004). Another mechanism leading to increased perceived physician empathy is the usage of more reflective statements and/or praise while interacting with patients, as patients report feeling higher autonomy support and that their physicians are truly trying to understand their perspectives in their care. Pollak and colleagues (2011) describe how, when physicians make more reflective statements rather than asking questions, they allow patients to direct the flow of conversation more. This in turn allows for patients to feel more comfortable and in control of the conversation and their overall care, thus leading to increased patient satisfaction (Pollak et al. 2011).

Physician Empathy, Patient Compliance, and Successful Clinical Outcomes

Derksen and colleagues (2013) find a direct positive relationship between physician empathy and the strengthening of patient enablement. Specifically, physician empathy acts to decrease patient anxiety and distress and thereby delivers better clinical outcomes when employed. More empathy within the patient-physician relationship allows for greater understanding and trust, which creates an environment in which the patient feels more comfortable sharing personal information pertinent to their health. As a result, this increased physician empathy leads to a better alignment between patients' particular needs and the treatment options offered by their physicians. Consequently, there are more accurate diagnoses as well as increased patient compliance and adherence to physicians' medical advice reported (Derksen et al. 2013). This study also

expands upon the findings of Kim et al. (2004), where the researchers find increased physician empathy toward their patient is correlated with increased compliance with the physician's recommendations and better overall patient health. Their data show that a physician's empathetic communication skills significantly influence patient compliance, and that the effective use of empathetic communication skills by physicians may be one of the leading methods in improving patient compliance. The authors argue that, in turn, this increased patient compliance will also show improvements in patient health outcomes (Kim et al. 2004).

Medical Institutional Distrust and Patient Care

One's level of trust towards the medical institution has a clear effect on their level of trust with their physician and surrounding the patient-physician relationship. Sullivan (2020) employs a meta-analysis to show how many patients, regardless of race or ethnicity, find that their mistrust of the medical institution impacts their ability to receive proper healthcare. For example, those who perceive pharmaceutical companies untrustworthy and purely motivated by profit are less likely to trust the influenza vaccine (Jamison et al. 2019).

Moreover, Blacks are significantly more likely to express distrust in the government and doubt the government's motives. Consequently, when explaining their distrust in the influenza vaccine, Blacks are more likely to express deep-seated distrust in the motives of the American government (Jamison et al. 2019). Distrust of the United States medical institution within minority populations may be rooted in distrust of the government, as described by Jamison et al. (2019) through their analysis of narratives from both Black and white individuals primarily from Maryland and the Washington D.C. area revolving around institutional trust and the influenza vaccine. It appears that distrust in institutions is a significant reason for distrust in the influenza vaccine, with marked differences in race. In the study, most participants of all races expressed distrust of pharmaceutical companies, which were perceived as clearly motivated by profit, however trust in government varied between races. Blacks were significantly more likely. This distrust may be rooted in medical abuses that have occurred throughout history and have been directed towards minority populations, with many Blacks expressing concern that these abuses are still occurring in the present day. This has direct implications for the COVID-19 vaccine, which was

funded, promoted, and administered by the American government.

Increased Medical Institutional Trust Means Increased Patient Trust

Trust in an institution can influence trust on an interpersonal level with individuals who are involved in that larger organization. This relationship thus plays into the interpersonal relationship between doctors and patients and the larger medical industrial complex in the United States. The development of distrust in one physician can adversely impact one's trust in other physicians, in the overarching medical profession, and the organizations where the individual physician practices. Thus, distrust in one physician has reverberating effects that impact one's levels of trust elsewhere within the medical profession (Goold 2001). Conversely, physicians also can increase their patient's trust in the medical institution. Implementing ideals of empathy, trustworthiness, and supportiveness are known to build this trust within the patient-physician relationship, as well as minimizing institutional distrust in the medical community (Fredericks et al. 2006).

Doctor Care and COVID-19 Vaccine Distrust

With this background regarding physician empathy and trust within the patient-physician relationship and the greater medical institution, we recognize the importance of the physician's role in molding a relationship with their patient that fosters effective medical care. The strong linkage between physician empathy and patient satisfaction, compliance, and positive clinical outcomes points to how crucial the physician's role is. Further, the positive relationship between trust in one's physician and one's level of trust in the medical institution points to the physician's role even further. Given how someone's view of their primary care physician impacts their trust of the medical institution, it is reasonable to infer that increased trust within the patient-physician relationship will lead to increased trust of the medical institution and the medical recommendations and mandates released by the medical community. Additionally, as we see how greater institutional distrust leads to higher distrust with the flu vaccine, we can assume that we would see a similar pattern with the COVID-19 vaccine. This leads to the following hypothesis: The more one believes their doctor cares about their health and well-being the less likely they are to distrust the COVID-19 vaccine.

Data and Methods

To test this hypothesis, we analyze data from the sixth wave of the Baylor Religion Survey (BRS), which was collected early in 2021. Wave VI of the BRS is a random national sample administered and collected by the Gallup Organization and funded by the John Templeton Foundation and contains a total of 1336 respondents. Given the focus of our paper, it is worth noting that this wave of the BRS was fielded during a unique point of time. Specifically, in January of 2021, the COVID-19 vaccine was recently developed. The vaccine was not widely available, as it was distributed to a limited number of mostly high-risk individuals.

The Dependent Variable

Our dependent variable is COVID-19 vaccine distrust, operationalized by the degree with which an individual believes that a vaccine for COVID-19 should *not* be trusted[1]. Analytically, we employ multivariate OLS regressions to test the correlation between doctor care and distrust of the COVID-19 vaccine. We also ran models using an ordered logit, and the results were consistent with the ones presented. Ultimately, we decided to utilize OLS regression because it constrains the spread of omitted variables better than does an ordered logit analysis (see Allison 1987). Additionally, other studies using the BRS also utilize OLS for five-category dependent variables (see Martinez et al. 2018).

The Independent Variables

Our principal independent variable, doctor care, is operationalized by how much an individual feels their physician cares about their health and well-being[2].

In all models we tested, we include several possibly confounding variables to ensure that the correlation of interest is *not* a spurious byproduct of other demographic factors such as socio-economic status, gender, ever having been infected with COVID, political identification, and religious attendance. We operationalize socioeconomic status using four variables. First, we measure **income** by the respondent's total household income[3]. Additionally, we include three

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[1]Vaccine distrust is coded as 1 = Strongly disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Strongly agree.

[2]Doctor care is coded as 1 = Never, 2 = Hardly ever, 3 = Don't know/Does not apply, 4 = Some of the time, 5 = Most or all of the time.

[3]Income is coded with the following attributes: 1 = $10,000 or less, 2 = $10,001 - $20,000, 3 = $20,001 - $35,000, 4 = $35,001 - $50,000, 5 = $50,001 - $100,000, 6 = $100,001 - $150,000, 7 = $150,001 or more.

binary measures of **education** of the respondent, their mother, and their father[4]. We also include a dummy system to account for the respondent's self-reported ethno-racial identity[5]. Additionally, we utilize several binary variables to control for gender[6], sexuality[7], and place of residence[8]. We also control for whether the respondent had ever been infected with COVID-19[9].

Additionally, given the highly politicized nature of the response to COVID-19 protocols (Bock and Schnabel 2022; Perry et al. 2021; Ruiz and Bell 2021), we account for the respondent's **political identification** using a frequently used seven category ordinal variable[10] that is similar to those employed by others (Martinez et al. 2022; McCarthy et al. 2019). The effects of **religious attendance** on responses to COVID-19 protocols are also well documented (Adler et al. 2021; Corcoran et al. 2022; Smothers et al. 2020), and consequently we control for religious attendance using an eight-point ordinal measure ranging from "never" (1) through "several times a week" (8). We also account for religious tradition using a modified version of the RELTRAD typology developed by Steensland et al. (2000). In addition to the respondent's denominational affiliation, the name of the congregation they attend is also taken into consideration (for more details on this modified RELTRAD typology see Dougherty et al. 2007).

Results

Table 1 presents the descriptive statistics for all variables. The average person in the data set falls between feeling that their doctor cares about their health some of the time or most or all the time, with a mean of 4.087. Additionally, regarding the dependent variable, the average person in the data set falls within the range of

[4]All three measures of education are coded so that 0 = non-college graduate and 1 = college graduate.

[5]Non-Hispanic whites serve as the comparison group in our multivariate model.

[6]Gender is coded so that 0 = female or non-binary and 1 = male.

[7]For sexuality 0 represents gay, lesbian, bi-sexual, or questioning individuals and 1 represents straight individuals.

[8]Place of residence is coded so that 1 = large city and everywhere else is coded as 0.

[9]Those who had ever been infected with COVID-19 are coded as a 1, and everyone else is coded as a 0.

[10]Political identification is coded as 1 = Extremely conservative, 2 = Conservative, 3 = Leaning conservative, 4 = Moderate, 5 = Leaning liberal, 6 = Liberal, 7 = Extremely liberal.

disagreeing and neither agreeing nor disagreeing that the vaccine for COVID-19 should be distrusted, with a mean of 2.038. Furthermore, 17.5% of all respondents have been infected with COVID-19. Politically, we have a relatively moderate sample that slightly leans conservative, with a mean of 3.976, (4 = moderate). Regarding church attendance, the mean for the sample is 2.5, which falls between attending once or twice a year and several times a year. (See Table 1 in the Appendix.)

Table 2 displays a multivariate OLS regression to assess the correlation between doctor care and distrust of the COVID-19 vaccine and account for potentially confounding factors. A significant negative correlation exists between doctor care and vaccine distrust, indicating that the more likely a respondent believes their doctor cares for them, the more they are likely to trust the vaccine. From **Table 2**, it is also worth noting that Blacks are more distrusting of the vaccine than whites; however, no other race significantly differed from whites in their levels of vaccine distrust. (See **Table 2** in the Appendix.)

Figure 1 graphs the regression coefficients and displays this relationship with all other variables mean centered. From **Figure 1**, we can see that those who feel that their doctor never cares about their health and well-being are .44 categories *more likely to distrust* the vaccine than those who indicated that they believe their doctor cares about their health and well-being most of the time.

Similarly, a strong positive correlation exists between having been infected by the COVID-19 virus and distrusting the COVID-19 vaccine. Conversely, a negative correlation exists between two measures of social class, household income and being a college graduate, and distrusting the vaccine. Additionally, Evangelical Protestants are more distrusting of the COVID-19 vaccine than are Mainline Protestants, Black Protestants, Catholics, Jewish individuals, and religious "nones." (See **Figure 1** in the Appendix.)

Discussion and CONCLUSION

From the data analyzed for this study, we can conclude that there is strong positive correlation between doctor care and vaccine trust, meaning that the more one believes that their doctor cares for them, the less likely they are to distrust the COVID-19 vaccine. Though there are several factors within one's life that influence their trust of vaccines such as the vaccine for COVID-19, from this study we gain a greater understanding of how one's trust of and relationship with their physician

affects one's perception of the vaccine.

We find a strong negative correlation between believing one's doctor cares for the overall health and well-being and distrusting the COVID-19 vaccine, but there are some limitations that deserve note. First, this survey was taken just prior to the widespread release of the COVID-19 vaccine. Since that survey, the COVID-19 vaccine has become widely available and we have seen a rise in both pro and anti-vaccine movements across the nation, creating a divide in the country's population. Increased media coverage of this crucial divide has heightened tensions across the nation, leading to the highly politicized nature of vaccine rollout that we have seen over the past year. Thus, it is likely that we would see more polarized results from this study if the study was repeated in the present day. As a result, it would be worth examining if the relationship between one's perception that their physician cares about them and vaccine distrust has been amplified. Additionally, it is possible that the causal direction of our variables is flipped. Given the highly politicized nature of the COVID-19 vaccines, it could be that distrusting the vaccines makes individuals more suspicious of the medical community and their physician rather than the other way around. While this is possible, prior literature suggests that the causal direction works in the direction we proposed. However, the cross-sectional data we analyze limits our ability to rule out the possibility that time ordering is flipped. Future studies would do well to collect longitudinal data to ensure the correct casual direction.

It is essential to understand how important the patient-physician relationship is in influencing trust of the medical institution. Doctors are front line workers especially amid a pandemic as widespread as the current COVID-19 pandemic. Doctors should be aware of the role that they play in influencing the trust of their patients both in the larger medical institution and on a smaller scale surrounding social trust. As we both nationally and globally continue to work towards decreasing infection and death rates and increasing vaccination rates, it is important to keep this relationship in mind and to understand how crucial the patient-physician relationship is in shaping one's trust in the medical institution and the behaviors it recommends, like vaccine usage.

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Appendix: Tables 1& 2 and Figure1

Table 1. Descriptive Statistics

	Mean	Std. Deviation	Minimum	Maximum
Vaccine Distrust	2.038	1.115	1.000	5.000
Doctor Cares	4.087	1.129	1.000	5.000
Non-Hispanic whites	0.620	0.486	0.000	1.000
Black	0.113	0.317	0.000	1.000
Asian	0.043	0.204	0.000	1.000
Other	0.022	0.148	0.000	1.000
Hispanic	0.144	0.351	0.000	1.000
Male	0.454	0.498	0.000	1.000
Heterosexual	0.884	0.320	0.000	1.000
Income	4.577	1.712	1.000	7.000
College Grad	0.499	0.500	0.000	1.000
MA College Grad	0.232	0.423	0.000	1.000
PA College Grad	0.287	0.453	0.000	1.000
Large City	0.249	0.433	0.000	1.000
Had COVID-19	0.175	0.380	0.000	1.000
Politically Liberal	3.976	1.621	1.000	7.000
Church attendance	2.580	2.534	0.000	7.000
Evangelical Protestant	0.248	0.432	0.000	1.000
Mainline Protestant	0.135	0.342	0.000	1.000
Black Protestant	0.078	0.268	0.000	1.000
Catholic	0.248	0.432	0.000	1.000
Jewish	0.024	0.153	0.000	1.000
Religious Other	0.084	0.277	0.000	1.000
Religious None	0.183	0.387	0.000	1.000

Source: Baylor Religion Survey, Wave VI 2021

Table 2. OLS Regression of Vaccine Distrust

	B	Beta
Intercept	4.238***	
Doctor Cares	-0.111***	-0.122
Race[a]		
Black	0.670***	0.181
Asian	-0.136	-0.026
Other	0.169	0.025
Hispanic	0.177	0.053
Male	-0.111	-0.050
Heterosexual	0.040	0.011
Income	-0.139***	-0.205
College Grad	-0.137	-0.062
MA College Grad	-0.106	-0.041
PA College Grad	0.046	0.019
Large City	-0.118	-0.046
Had COVID-19	0.246**	0.082
Politically Liberal	-0.210***	-0.313
Church Attendance	-0.022	-0.050
Religious Tradition[b]		
Mainline Protestant	-0.341**	-0.111
Black Protestant	-0.428*	-0.090
Catholic	-0.364***	-0.144
Jewish	-0.459*	-0.070
Religious Other	-0.177	-0.044
Religious None	-0.317**	-0.116
N		
r-squared		

***$p<.001$, **$p<.01$, *$p<.05$

Source: Baylor Religion Survey, Wave VI 2021

a Contrast Category is White, non-Hispanic.
b Contrast Category is Evangelical Protestant.

Figure 1: Regression Coefficient for Vaccine Distrust by How Much One Perceives Their Doctor Cares for Them