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The Impact of Nurses' Religiosity on their Willingness to Relinquish Relational Control in Conversations with Patients about End-of-life Care

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Introduction

- Relational control studies of conversations between patients and medical providers have found that patients ultimately have better health outcomes and satisfaction if they are allowed to have some control of the conversation with their provider.
- But physicians and nurses often struggle to give patients that control and patients are not always willing to try to claim control from their medical providers.
- Nurses may struggle with giving patients control because they often have to be purposeful and focused in their conversations with patients. However, discussions about certain topics such as end-of-life care may bring up personal religious values, both for the nurse and for the patient.
- The study investigates how religious beliefs may influence how nurses relinquish and retain control in conversations with patients.

Relational Control Theory

- The study is grounded in relational control theory, which suggests that conversation partners give and claim control of the conversation by how they behave during the interaction.
- Relational control assumes that all messages in a conversation communicate both a piece of information and something about the nature of the relationship between the two conversation partners.

  For example:
  - If a conversation partner responds to a question with another question, that partner may be trying to claim control of the conversation by redirecting it.
  - If a conversation partner only speaks in response to the other partner and makes no effort to initiate a direction in the conversation, he or she is giving control to the partner.
- The dimension of control is defined by Millar and Rogers as "establishing the right to define, direct and, delimit the actions of the dyad at the current moment" (1987, p.120).
  - Control must be continually negotiated in changing conditions.
  - Control can be measured by redundancy, dominance and power

Approach to Measuring Relational Control

Relational Control Variables (from Burgoon and Hale)
• I attempt to persuade the patient.
• I do not attempt to influence the patient.
• I try to control the interaction.
• I do not try to win the patient's favor.
• I have the upper hand in the conversation.
• I want to stick to the main purpose of the interaction.
• I am very work-oriented.
• I am more interested in working on the task at hand than having a social conversation.
Additional Relational Control Variables (by author)
• I would want a patient to interrupt if I suggested a treatment contrary to his or her religious beliefs
• I would not feel comfortable discussing religious topics unless the patient brought it up first

Methods

Participants/ Demographics

The participants were all graduate students in the College of Nursing at a Catholic Midwestern university. Participants were recruited through an introductory letter and an e-mail with a link to the survey.

Data Collection

An online census survey was administered to nursing graduate students at a Midwestern university.

The survey included items to measure:
- Relational control, as measured by the subscales of dominance and task orientation in Burgoon and Hale's scale of relational communication;
- Clinician empathy, as operationalized by the Jefferson scale of clinician empathy;
- Intrinsic and extrinsic religiosity, the degree to which religious views are held for deep personal reasons or social reasons, as measured by the Maltby and Lewis scale, designed for religious and non-religious samples.

Data were analyzed using one-way ANOVAs and multiple logistic regression

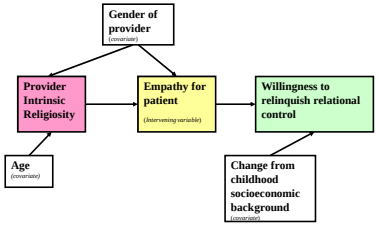
Research Questions

RQ1: Does the nurse's religiosity impact his or her willingness to relinquish relational control in conversations with patients about end-of-life care?

The hypothesized relationship between the variables can be seen in the model below. Individual hypotheses are listed in the results section.

RQ2: What is the relationship of the control variables age, gender and socioeconomic status to religiosity, empathy and willingness to relinquish relational control?

Hypothesized Model



Results

Description of participants

	No. responding	(%)
Gender		
Male	6	5.2
Female	98	85.2
No response	11	9.6
Age		
23-29	35	30.4
30-39	30	26.1
40-49	23	20.0
50-59	16	13.9
No response	11	9.6
Reported Religious Affiliation		
Catholic	53	46.1
Protestant	14	12.2
Christian – Other	27	23.5
Buddhist	1	0.8
Latter-Day Saints	1	0.8
Agnostic	2	1.7
Reported "None"	6	5.2
No Response	11	9.6
Year of Nursing Experience		
More than 10 years	38	33.0
7-10 years	14	12.2
4-6 years	7	6.1
1-3 years	21	18.3
Less than one year	24	20.0
No response	9	7.8

Hypothesis 1

Nurses who are high in intrinsic religiosity will display more empathy toward patients

Not Upheld

- There was no statistically significant difference in empathy between those who were higher and those who were lower in intrinsic religiosity.

Hypothesis 2

Nurses who are high in empathy will be more willing to relinquish relational control in conversations with patients about end-of-life care

Upheld in part

- There was a statistically significant difference between those higher and lower in empathy in the two additional relational control variables.
  - "I would want a patient to interrupt if I suggested a treatment contrary to his or her religious beliefs"
    - $F_{7,101}=2.257$, p<.05
  - "I would not feel comfortable discussing religious topics unless the patient brought it up first,"
    - $F_{7,101}=3.733$, p<.001
- There was no statistical difference between those higher and lower in empathy and relational control as measured by the Burgoon and Hale relational control variables.

Hypothesis 3

Nurses who are high in intrinsic religiosity will exhibit more willingness to relinquish relational control in conversations with patients about end-of-life care.

Upheld in part

- There was a statistically significant difference between those higher and lower in intrinsic religiosity one of the relational control variables.

	I would want a patient to interrupt…
Control Variables	
RN Experience	-.232d
R^2 *change*	.033
Religiosity	
Intrinsic	.295b
Extrinsic	.032
R^2 *change*	.081a
ANOVA	$F_{5,103}=2.630$, p<.05

a: p<.05 c: p<.001 b: p<.01 d: p<.05, one-way

- ANOVA for "Discussing religion" was $F_{5,103}=1.244$, p=.294
- There was no statistical difference between those higher and lower in intrinsic religiosity and relational control as measured by the Burgoon and Hale relational control variables.

Hypothesis 4

When empathy is introduced as an intervening variable, the relationship between intrinsic religiosity and willingness to relinquish relational control will be decreased.

Not Upheld

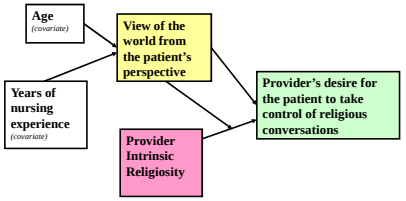
- Because it was hypothesized that those who were higher in intrinsic religiosity would be higher in empathy, it was hypothesized that when empathy was factored in to the relationship between religiosity and relational control, the impact of religiosity would be diminished.
- In fact, religiosity had a slight enhancing effect the impact of religiosity on willingness to relinquish relational control, as seen in the table below.

	I would want a patient to interrupt…
Control Variables	
RN Experience	-.233d
R^2 *change*	.003
Empathy	
R^2 *change*	.103a
Religiosity	
Intrinsic	.326c
Extrinsic	.035
R^2 *change*	.095b
ANOVA	$F_{9,99}=3.292$, p=.002

a: p<.05 c: p<.001 b: p<.01 d: p<.05, one-way

- When empathy was added to the analysis, the effect of intrinsic religiosity and willingness to relinquish control increased slightly.
- ANOVA for "Discussing religion" was $F_{9,99}=3.716$, p<.001

Revised Model



I revised the original model to show the demonstrated relationship between empathy, intrinsic religiosity and willingness to relinquish relational control. The covariates of age and nursing experience, which had a significant effect on empathy, were also included.

Conclusions & Implications

Survey results

- Both higher intrinsic religiosity and higher levels of empathy positively affected the respondents' willingness to give control to patients in certain contexts.
- Empathy was not an intervening variable, as hypothesized, but rather slightly accentuated the impact of intrinsic religiosity on willingness to give the patient control.

Suggestions for clinical practice

- Relational control in medical contexts is not as simple as teaching nurses to give patients control, but is a matter of teaching the benefits of patient participation and recognizing when it is appropriate to let patients take control.
- The effect of empathy on willingness to give the patient control demonstrates the importance of empathy in a clinical setting and helps make the case for empathy training for both nurses and physicians.
- The effect of intrinsic religiosity does not mean that employers should start encouraging nurses to be religious, rather, it demonstrates that there is no reason to fear a nurse's religious beliefs.
- A nurse's religious beliefs can enhance the clinical experience without the nurse trying to impose his or her beliefs on the patient as the nurse works to make sure the patient's religious beliefs are upheld.

Future research

- Future studies of relational control in medical contexts should make use of variables that pose clinical scenarios of giving and taking control, rather than existing variables which do not account for a respondent's professional persona.

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