

## Nurses' experiences of communicating respect to patients: influences and challenges

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Authors	Clucas, Claudine;Chapman, Hazel M.;Lovell, Andy
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1 **Registered nurses' experiences of communicating respect to patients: influences and**  
2 **challenges**

3

4

**Abstract**

5 *Background:* Respectful care is central to ethical codes of practice and optimal patient care,  
6 but little is known on influences on and challenges in communicating respect.

7 *Research question:* What are the intra- and inter-personal influences on nurses'  
8 communication of respect?

9 *Research design and participants:* Semi-structured interviews with 12 hospital-based United  
10 Kingdom registered nurses were analysed using interpretative phenomenological analysis to  
11 explore their experiences of communicating respect to patients and associated influences.

12 *Ethical considerations:* The study was approved by the Institutional ethics board and National  
13 Health Service Trust.

14 *Findings:* Three interconnected superordinate themes were identified: 'private self: personal  
15 attitudes', 'outward self: showing respect' and 'reputational self: being perceived as  
16 respectful'. Respectful communication involved a complex set of influences, including  
17 attitudes of respect towards patients, needs and goals, beliefs around the nature of respectful  
18 communication, skills and influencing sociocultural factors. A tension between the outward  
19 self as intended and perceived presented challenges for nurses' reputational self as respectful,  
20 with negative implications for patient care.

21 *Discussion:* The study offers an in-depth understanding of intra- and interpersonal influences  
22 on communicating respect, and sheds light on challenges involved, helping provide practical  
23 insights to support respectful care.

24 *Conclusion:* Findings stress the need for improved conceptualisations of respect in healthcare  
25 settings to formally recognise the complex attitudinal and socially constructed nature of  
26 respect and for appropriate professional training to improve its communication.

27

28 **Keywords:** attitudes; codes of ethics; communication; interpretative phenomenological  
29 analysis; nurse-patient relationship; respect

## 30 Introduction

31 Respectful care is central to ethical codes of practice in healthcare systems around the  
32 world<sup>1,2</sup> and needed for optimal patient care. Patient reports and complaints of being  
33 disrespected by healthcare professionals,<sup>3-5</sup> and disparities in experiences of respectful care<sup>6</sup>  
34 suggest this ethical imperative is not being fully achieved. Feeling respected means feeling  
35 worthy or valuable in interactions with others.<sup>7</sup> It is critical for patients' emotional well-being  
36 and good provider-patient relationships<sup>8-11</sup> and associated with adherence to advice, receipt of  
37 optimal preventive care and seeking necessary care<sup>12,13</sup>. Good provider-patient relationships  
38 are necessary for patient-centred medical care, leading to high-quality care and positive  
39 patient outcomes.<sup>14,15</sup>

40 However, little attention has been paid to how respectful care can be achieved in  
41 practice. In particular, little is known on influences on and challenges in communicating  
42 respect, a state of affairs that is complicated by a lack of a unified body of literature on  
43 respect. Respect is often operationalised as a set of behaviours that recognise a person's  
44 worth and value, such as ensuring patient privacy and treating patients as equals,<sup>17</sup> or in  
45 nursing and medical ethics, protecting the patient's autonomy<sup>18</sup>. However, respect also  
46 involves judgements regarding the respect-worthiness of the object of respect and feelings  
47 relating to experiencing the person as valuable; it is an attitude.<sup>16,19-21</sup> Two main bases for  
48 respect have been identified: humanity, which makes people inherently worthy (this form is  
49 referred to as unconditional or recognition respect) and character-related merits and  
50 achievements (conditional or appraisal respect).<sup>16,22</sup> Respect differs from the attitude of  
51 liking, in that it is owed to a person who demonstrates attributes that command recognition  
52 and appreciation, regardless of personal affinities and needs.<sup>21</sup>

53 While unconditional respect features in the nursing literature, with the expectation  
54 that nurses value patients as persons, it is not always clearly distinguished from the

55 Rogerian<sup>23</sup> concept of unconditional positive regard;<sup>1,18,24</sup> it may only imply a basic level of  
56 respect for all people in view of their humanity, as opposed to full acceptance of the person  
57 but research is needed on the topic. Moreover, conditional respect is largely overlooked. Yet,  
58 a small body of research has shown physicians to have less respect for certain types of  
59 patients, such as younger patients, patients not known as well by physicians and patients with  
60 higher body mass index,<sup>18,25</sup> suggesting healthcare providers may have difficulty in  
61 respecting all patients equally. However, it is uncertain if these findings apply to nurses as  
62 well; factors influencing nurses' evaluations of patients' worth and value - attitudes of  
63 respect, as opposed to liking - have not been investigated. There are stronger expectations  
64 that nurses should respect patients than like them and it is possible to value a person you do  
65 not like.<sup>21</sup>

66         It is also uncertain if nurses' attitudes of respect towards patients influence their  
67 behaviours of respect. Only one study examined the relationship between healthcare  
68 professionals' attitudes and behaviours of respect. This quantitative observational study in the  
69 United States (US) showed physicians shared more information and showed more positive  
70 affect to patients whom they respected,<sup>18</sup> however, the direction of the findings was unclear  
71 with patients' behaviour possibly influencing the physicians' behaviour and attitudes, and the  
72 study did not measure physicians' attitudes towards patient-centred or respectful care, or  
73 personal communication goals, which could have confounded the findings.<sup>26</sup> According to  
74 the Theory of Planned Behaviour,<sup>27</sup> strong role expectations and professional obligations  
75 relating to respectful care,<sup>28</sup> and beliefs in the importance of respect, are likely to motivate  
76 respectful behaviour regardless of potentially conflicting personal feelings or beliefs towards  
77 patients. This might be particularly so in nurses for whom being caring and respectful is a  
78 particularly defining aspect of their professional identity globally.<sup>29</sup> It is unknown if attitudes

79 of respect conflict with respectful communication intentions, or how nurses experience and  
80 negotiate these potential differences.

81 An in-depth understanding of intra- and inter-personal influences on nurses'  
82 communication of respect, such as attitudes, needs, as well as beliefs is necessary.<sup>26,30</sup> If  
83 nurses are unclear about what respect is, and how it should be shown, this may lead to  
84 misunderstandings over ethical expectations in practice. Therefore, the present study aimed to  
85 explore registered nurses' experiences of communicating respect to patients in hospital-based  
86 nursing encounters and associated influences in order to clarify intra- and inter-personal  
87 influences on their communication of respect and inform future support for nurses to deliver  
88 respectful and ethical care for positive patient outcomes.

## 89 **Method**

90 Using Interpretative Phenomenological Analysis (IPA), an in-depth exploration and analysis  
91 of individual accounts was utilised to understand the complexity of nurses' lived experiences  
92 of communicating respect to patients and associated influences.<sup>31</sup>

### 93 **Participants and procedure**

94 Twelve registered nurses were recruited from a public hospital in England using purposive  
95 sampling. The inclusion criteria were (a) having nurse registration status and (b) currently  
96 working in a United Kingdom (UK) National Health Service (NHS) hospital. To facilitate  
97 recruitment given the sensitive nature of the research, participants were recruited by Practice  
98 Education Facilitators who provided study information and invited them to attend an  
99 individual meeting with the researcher to discuss the study further if interested in  
100 participating. Twelve participants met with the researcher (HMC) out of 20 nurses  
101 approached (60% positive response rate) and were interviewed individually on-site in a  
102 private room. A sample size of 12 is considered large for IPA given its idiographic nature,  
103 intensive in-depth analysis of each participant's account, and representation of differences

104 and similarities in experiences between participants.<sup>31</sup> Sample characteristics can be found in  
105 Table 1.

106 Insert Table 1

### 107 **Data collection**

108 Face to face semi-structured interviews took place in August 2014 and lasted between 29 and  
109 96 minutes ( $M = 61$  minutes). They were digitally audio-recorded and transcribed verbatim.

110 The interviewing researcher was a Registered Nurse and university nurse educator  
111 and was introduced as such to participants. None knew her beforehand. The interview  
112 schedule asked participants about the importance of respect in their nursing practice, what  
113 respect for patients meant to them, expectations and behaviours of respect in practice, factors  
114 influencing their respect for patients (including challenges and facilitating factors) and what  
115 they believed influenced patients' respect for them, and was used flexibly to allow for  
116 exploration of responses and unanticipated themes. Several of the interview questions had  
117 previously been piloted in student nurses.<sup>28</sup>

### 118 **Ethical considerations**

119 Participants were told the study was interested in their experiences of respect in order to  
120 support nurses in caring respectfully for patients, and were reassured about data  
121 anonymisation and confidentiality and that their participation would not affect their  
122 employment. Participants provided written consent before being interviewed. Participants are  
123 referred to by non-gender specific pseudonyms to protect anonymity. The study was  
124 approved by the University Health and Social Care Ethics Committee (RESCO114-473) and  
125 the NHS trust Research and Development committee.

### 126 **Analysis**

127 IPA is an idiographic method that seeks to make sense of participants who are themselves  
128 trying to make sense of their experiences.<sup>31</sup> We followed the steps and guidelines by Smith et

129 al..<sup>31</sup> Each transcript was analysed in depth one at a time. First, we read the transcript several  
130 times, familiarising ourselves with the content. Second, line-by-line coding was applied  
131 focusing on the participants' experiential concerns and cares. Third, accounts were  
132 interrogated by searching for repetitions, contradictions and any imagery employed. Key  
133 issues or themes were then identified. Two of the authors (CC - a female psychologist and  
134 HMC - a female nurse) each analysed six transcripts and met frequently to discuss their  
135 independent analysis of the transcripts, ensuring the themes were supported by the data,  
136 mindful of their influence in the data analysis process. A third author (AL - a male  
137 sociologist) analysed three of the transcripts; additional themes identified were considered in  
138 relation to the other transcripts. This process ensured rigour and credibility of analysis.<sup>32</sup> The  
139 themes were then clustered into superordinate themes and compared across cases.  
140 Participants were given the opportunity to comment on the analysis (referred to as "member  
141 checking")<sup>32</sup> to provide an additional credibility check. Interviews were carried out when  
142 nurses were under negative public scrutiny,<sup>33</sup> which could have affected participants'  
143 accounts.

## 144 **Results**

145 Table 2 lists the three superordinate themes identified, along with their subthemes,  
146 concerning nurses' experiences of communicating respect to patients and associated intra-  
147 and interpersonal influences at the level of the private, outward and reputational self.

148 **Insert Table 2**

### 149 **Private self: personal attitudes towards patients**

150 All nurses strongly valued respectful care and described respecting patients as an integral part  
151 of the nursing role, yet did not value all patients equally. More respect was experienced  
152 towards patients who were perceived as particularly respect-worthy whilst nurses struggled to  
153 have respect for some "difficult" patients. Specific circumstances sometimes led to powerful

154 unintentional internal attributions and disrespectful attitudes. Attitudes of conditional respect  
155 were therefore evident, even when attitudes of unconditional respect were also described.

156 ***Recognition/unconditional and appraisal/conditional respect as additive.*** Beliefs in  
157 human equality and attitudes of unconditional respect were evident in Kelly and Jules: “*I*  
158 *don’t disrespect anybody. That’s just ‘cause they’ve had a different upbringing. Makes no*  
159 *odds, we’re all equals far as I’m concerned*” (Kelly). However, it was clear that patients’  
160 behaviour also influenced nurses’ respect for them, including for nurses who voiced beliefs in  
161 shared humanity and human worth, such that unconditional and conditional respect were  
162 additive. Indeed, nurses expressed having a particularly high level of respect for patients  
163 showing patience, bravery or a fascinating life history, e.g. older people:

164 “there’s like I say a story behind every person and if you are lucky enough to get a  
165 story and I love listening to them, it’s...that makes you even respect them more I  
166 believe, you know, from my perspective ‘cause you know that they’ve...they’ve  
167 probably had a lot harder life than you” (Kelly).

168 At the same time, the nurses struggled to have respect for “difficult” patients who were rude,  
169 aggressive or demanding but valued empathy. An empathic orientation generally enabled  
170 them to understand that the patient’s behaviour was due to their circumstances, such as their  
171 illness, feeling worried, scared or vulnerable in the hospital environment - an understanding  
172 that developed with nursing experience and maturity – facilitating respect. For instance,  
173 Gabriel and Campbell found the behaviour of some people with dementia offensive, but  
174 could respect them because they felt they were not responsible for it. Jules was able to  
175 withstand disrespectful patients and then understand the reason for their behaviour, taking  
176 comfort in knowing s/he was ‘doing right’ by them.

177 ***Internal attributions and affective reactions.*** Certain situations elicited internal  
178 attributions and negative affective reactions that resulted in disrespectful attitudes towards

179 patients in that the nurse perceived the patient as non-respect-worthy and/or felt little respect  
180 for them. Internal attributions also occasionally triggered a perceived attack to one's worth as  
181 a person, influencing attitudes. An empathetic orientation was not always sufficient and  
182 participants sometimes saw patients' "challenging" behaviour as deliberate, attributing the  
183 behaviour to negative intent or a flaw in character. For instance, Val made negative  
184 assumptions about a patient's character, which s/he later realised, on developing the  
185 relationship, to be incorrect: '*...so I was probably making an assumption just thinking gosh,*  
186 *this woman's a bit of a cold fish*'. Wider societal views of civility, the organisational culture  
187 and nurses' professional status elicited such internal attributions, and powerful negative  
188 affective reactions of anger and frustration, making it difficult to value the patient. For  
189 instance, Rudy felt angry when a young patient refused the only bed they had in a ward with  
190 other elderly and poorly men:

191 ...'I'm not staying next to all these, they're all sheds and they're all dying and he's  
192 smelly in the corner'. (...) when he did come back and (...) he got what he wanted. He  
193 got the bed next door to the younger person. (...) I was so cross that he could say that  
194 openly as he's looking round at these five other gentlemen and not know that...and  
195 think it was OK to do that [...] I...I never thought I'd feel that angry towards anybody  
196 who I didn't know but I did.

197 While the nurse justified her anger at the patient's behaviour by reference to his ageist  
198 remarks, this was reinforced by categorising him as a "demanding patient", possibly due to  
199 his age:

200 ...So I think that sometimes you will get those characters that are used to having things  
201 immediately or used to demanding and it being there and when they're ill sometimes  
202 it's exacerbated (...) there could be some really poorly person erm...in the corner (...)  
203 but you've got somebody here demanding your attention because you're over there

204 (...) Most people can see what's happening and very often you find it's the young  
205 ones.... (Rudy).

206 A view that younger less seriously ill patients are demanding and disrespectful appeared to be  
207 encouraged by Rudy personally valuing self-effacing behaviour when others are in greater  
208 need as a sign of respect and a belief this has become lost in the younger generation. Rudy  
209 explained that she was from an '*era where respect was respect*' and people would wait  
210 patiently when someone was in greater need. At the time, Rudy struggled to see that the  
211 patient's behaviour was due to fear of dying and vulnerability as later explained by the  
212 patient's girlfriend.

213 Perceptions of the patient's behaviour as lacking consideration for others, as misusing  
214 the healthcare system, or as undermining, underpinned disrespectful attitudes and were  
215 exacerbated by other patient stereotypes. Some participants felt frustrated or angry by  
216 patients with addictions or with no signs of physical illness, perceived as attention-seeking:

217 ...there is nothing physically wrong with them, you know that they come in just for the  
218 attention and it's difficult, it's difficult to spread your time between someone who's  
219 really poorly and needs you and someone that's just there abusing the system... (Sam).

220 Val felt frustrated by '*tricky*' patients who come in and ask nurses '*lots of loaded questions*'  
221 to then second guess them, never satisfied with the answers, yet never asking the doctor their  
222 questions. Val perceived these patients as having '*a real agenda*': '*I think over the years you*  
223 *can spot these people quite easily and they...they literally...what they're trying to do is just to*  
224 *try and catch you out (...) trip you up*'. Val and Campbell felt that patients valued doctors  
225 more than nurses: '*...when I was trying to help him (...) that wasn't good enough and when*  
226 *the consultant came round he was as nice as pie to him (laughs) which is always annoying*  
227 *(...)*' (Campbell). Glenn also felt there was no respect for nurses. The view that patients  
228 sometimes lack respect for nurses as professionals could also explain why Gabriel struggled

229 to respect a patient who was abrupt and asking her/him for tissues she could easily reach,  
 230 without being able to articulate the source of his/her frustration:

231 ...I wasn't rude, you know, I would say that I was cool. (...) there's a lot of frustration  
 232 and (...) I'm not very good at being able to step back a little bit from that  
 233 (...)...it's...it's not tangible enough to...for you to be able to deal with it. (...) I did  
 234 feel there was like a bit of a...a power er...thing going on...

235 Nurses found it particularly difficult to respect verbally abusive patients whose extremely  
 236 rude and aggressive behaviour made them feel vulnerable. The inability to see an obvious  
 237 reason for the patient's verbally abusive behaviour (such as dementia or an infection), the  
 238 patient being repeatedly rude, or the perception that the aggressive behaviour was under the  
 239 patient's control further culminated in resentment and a need to stand up for themselves as  
 240 persons deserving of respect: '*...you can't think of a good reason why they're like that and  
 241 you think well, why are they being rude to me (...) It's like, you know, hang on, I'm a person  
 242 as well so it...it...it works both ways (...)*' (Charlie).

### 243 **Outward self: showing respect**

244 Nurses endeavoured to show respect to patients, however this could be either a warmer or a  
 245 more detached/surface response depending on their attitudes of respect. A competing  
 246 psychological need for authenticity/internal congruence and proficiency in communication  
 247 skills played an important role in influencing the form of communication.

### 248 ***Showing warmth and support versus surface respect: minimising dissonance.***

249 Showing respect followed naturally from deep concern or respect for patients, and took the  
 250 form of extra care in making sure the patient's needs were met:

251 ...you couldn't help but respect him...you couldn't help ...do your best in that situation  
 252 and make sure that erm...that his needs and he knows that you are listening to him (...)  
 253 (Gabriel).

254 When such an attitude of respect for patients was not present, nurses still showed respect:

255 I can't imagine anybody being rude to a patient. You might think it sometimes (laughs)  
 256 and count to ten in your head but I would never ever be rude to someone at all, [...]  
 257 perhaps it's just not in my nature but I've just been taught that [...] you don't do things  
 258 like that (Campbell).

259 Normative/role expectations and positive attitudes towards the behaviour of showing respect  
 260 motivated respectful behaviour in the absence of a respectful attitude towards the patient.

261 However, in such situations, showing respect often took the form of not showing disrespect  
 262 by not being rude, yet 'cool' (Gabriel). Similarly, Campbell explains: '*I didn't get into*  
 263 *conversation...I've come to do your IV antibiotics is that ok?, and that was it, I decided that*  
 264 *the least I said to him was probably the best...*'. Sam felt distressed caring for someone  
 265 having a late termination of pregnancy, a situation s/he was unprepared for and went against  
 266 his/her beliefs and talked about supporting this patient without "*having to be false*", possibly  
 267 allowing her/him to minimise emotional dissonance between feelings and behaviour:

268 I spoke to her, just like she was a normal person and (...) it wasn't about she was  
 269 having a termination, it was about we're gonna get your pain under control and...(...)  
 270 explaining things to her and...holding her hand, little simple things, you know, sitting  
 271 with her while she was scared. It...it's not...it doesn't take much, it really doesn't.  
 272 You don't have to bend over backwards and be false to someone.

273 ***Proficiency in respect as a communication skill.*** The nurses appeared to vary in their  
 274 ability to keep a respectful front. There were indications that this was not easy, with the risk  
 275 that negative feelings slip through: '*I do...feel like having a little weep inside but I would*  
 276 *never let them know, hopefully*' (Val). Val and Sam found it particularly hard when the  
 277 patient was aggressive or when they were under work pressures but Campbell described  
 278 effective self-presentation strategies:

279 ...it's hard sometimes [to respect a patient] if you get people that are really rude to you  
280 but I think you've just got to rise above that (...) so you probably just better stay calm  
281 (laughs) and go along with some of the things they want, you know, it is difficult but...  
282 I think I do it quite well...

283 Campbell was aware that instances of "subtle" disrespect could occur where the nurse is '*not*  
284 *rude but a bit sharp to a patient*' but saw these as isolated instances or else they would be  
285 noted.

### 286 **The reputational self: being perceived as respectful**

287 Nurses described challenges in being perceived as respectful because of differences in how  
288 behaviour was perceived or interpreted. Such challenges, coupled with the need for a positive  
289 professional reputation/identity, negatively impacted on respectful communication.

290 *Tension between the outward self as intended and perceived.* Despite nurses' strong  
291 investment in their professional roles and in giving patients the best care they could give, half  
292 of the participants explained they or other nurses could be perceived as disrespectful when  
293 not intending to be or aware of being disrespectful, which presented a challenge to gaining  
294 respect. Two of these pointed out a tension between nurses' behaviour and patients' or  
295 relatives' experiences of it:

296 ...people's perceptions are all different erm...and (...) you can say something to  
297 someone in a certain way and somebody is gonna...can turn it round and...and make  
298 it in to something else (...) So something's been done but they've sort of seen it in a  
299 different way and you know, people's interpretations can be different (Charlie).

300 This tension was linked to insufficient awareness of the patient's perspective and/or different  
301 beliefs in what it means to show respect. Non-verbal behaviours also appeared to play an  
302 important role, although nurses endorsed different beliefs on the need for genuineness for  
303 communicating respect. Some nurses attributed the tension to insufficient awareness of the

304 patient's perspective: *'if you're kind of a happy jokey person and said "right come on let's all*  
305 *get out of bed" some people would be fine whereas other people can't take it...'* (Campbell).  
306 Kelly explained that nurses are likely to endorse different beliefs about what it means to be  
307 respectful based on their upbringing/values, past experiences and the care environment since  
308 this is not formally taught. For instance, Campbell explained that when she trained as a nurse,  
309 respecting patients did not involve respecting their autonomy since patients were not involved  
310 in their care. Alex and Charlie stressed that a lack of appreciation of generation differences in  
311 expressions of respect could lead to coming across as disrespectful, for instance younger  
312 nurses being informal when first addressing the elderly.

313 Campbell also explained that you had to be careful about your choice of words and  
314 the manner in which you talk: *'it's interesting listening to the nurses speaking to other*  
315 *patients (laughs) you might think oh I don't think that sounded very good ...'* Similarly, Alex  
316 who often dealt with patient concerns explained that patients pick up on nurses' disrespectful  
317 non-verbal communication such as facial expressions. Some nurses may not be aware of this  
318 or could struggle to control their non-verbal behaviours when endeavouring to show a non-  
319 genuine professional respectful front. Three participants, including Campbell and Val,  
320 believed you could be respectful without feeling respectful and respect could take the form of  
321 a more genuine or more superficial response depending on the patient's behaviour and the  
322 emotions elicited in the nurse: *'...there are some patients that you really absolutely adore*  
323 *and there are other patients that you...put up with but you still respect them but it's a*  
324 *different sort of erm...feeling'* (Riley). In contrast, Jules believed congruence between what  
325 you say and the manner in which you say it was necessary to show respect.

326 ***Impact of reputational self on respectful communication.*** The perception that  
327 behaviour could be interpreted as disrespectful despite one's intentions sometimes led nurses  
328 to use strategies to protect their professional reputation. For instance, Charlie explained the

329 need to carefully document care, taking time away from patient care: '*...if you have a*  
330 *conversation with somebody make sure it's documented (...)* nowadays it's just everything's  
331 *gotta be in black and white because...sometimes it's somebody's word against*  
332 *some...somebody else's (...)*'. Three participants also explained that experiencing a positive  
333 professional identity and happiness in the job were important for respectful care: '*...if you're*  
334 *happy within your job and within your role I think it's easy to be respectful to people. I think*  
335 *if you're unhappy I think you just don't be bothered...*' (Sam).

### 336 **Discussion**

337 The study identified three interconnected superordinate themes relating to nurses'  
338 experiences of communicating respect to patients and associated intra- and interpersonal  
339 influences at the level of the private, outward and reputational self. Despite respect being an  
340 important element of patient-centred and ethical care, to our knowledge this is the first  
341 qualitative study to provide an in-depth understanding of healthcare professionals'  
342 experiences of communicating respect. The findings provide important theoretical insights  
343 into the process of respectful communication and influencing factors, and shed light on  
344 challenges involved, helping inform interventions to promote respectful care.

345 Communicating respect was complex and challenging. Relating the findings to key  
346 components of the broad communication framework of Feldman-Stewart et al.<sup>26</sup>, which  
347 integrates several classical and healthcare communication frameworks, influences on  
348 respectful communication emerging from each of the three themes can be broadly categorised  
349 into a set of needs/goals, beliefs and emotions, skills, external sociocultural factors and a  
350 distinction between conveyed and received messages. See Figure 1. Framework components  
351 were often interrelated; for instance, respectful attitudes and beliefs about the nature of  
352 communication facilitated genuineness in communication and reception of the message as  
353 respectful.

354 Insert Figure 1

355 In the healthcare literature, respect is often equated with unconditional valuing of  
356 patients as persons.<sup>1</sup> Indeed, it can be given on the basis of one's humanity.<sup>16</sup> However,  
357 whilst some nurses displayed attitudes of unconditional respect, endorsing beliefs in human  
358 worth, respect was mostly conditional. Moreover, nurses displaying unconditional respect  
359 also held stronger feelings of appreciation for patients perceived to have admirable qualities  
360 of overcoming hardship, bravery and patience, showing unconditional and conditional respect  
361 to be additive. Promoting unconditional respect could therefore still result in disparities in  
362 respect experiences, highlighting the need to pay more attention to patients' qualities that  
363 attract (dis)respect.

364 Nurses struggled to have respect for patients who were rude, demanding,  
365 confrontational, or asked difficult questions. Interestingly, these characteristics have  
366 previously been associated with the "difficult" or "unpopular" patient,<sup>34</sup> but it appeared to be  
367 more specifically the perceived lack of consideration for other patients in greater need and  
368 their taking nurses away from patients in "real" need, or a view that the patients undervalued  
369 the nurse, that led to disrespectful attitudes towards them, as opposed to other aspects. Not all  
370 "difficult" patients attracted disrespect, with an empathic orientation often facilitating respect  
371 towards them. However, this was not always sufficient; wider societal views of civility,<sup>35</sup>  
372 nurses' lower professional status<sup>36</sup> and the organisational culture with a focus on medical  
373 rather than psychological aspects of care<sup>37</sup> led to powerful unintentional internal attribution  
374 processes resulting in the patient being perceived as deliberately undermining or lacking  
375 consideration for other patients or the healthcare system more broadly. In line with attribution  
376 theory,<sup>38</sup> internal attributions were associated with negative affective reactions of anger and  
377 frustration that were difficult to control.

378           When nurses did not feel respect towards patients, they were not rude, yet adopted a  
379 more detached and distant interpersonal approach. Similarly, Beach et al.<sup>18</sup> found American  
380 physicians to be less affectively positive towards patients whom they respected less, but our  
381 study shows this was evident even when positive intentions to communicate respect were  
382 held. Disrespectful attitudes resulting from feeling undervalued were accompanied by  
383 resentment, as well as a desire to affirm one's worth. Thus, despite positive intentions to  
384 communicate respect, this psychological need, as well as that of being internally congruent to  
385 maintain a sense of oneself as authentic rather than "fake", presented barriers to  
386 communicating respect. These findings emphasise the need to assist nurses with questioning  
387 the origins of their internal attributions and disrespectful attitudes, possibly in workshops  
388 and/or clinical supervision.

389           Nurses' beliefs regarding the nature of respectful communication were also  
390 problematic. Nurses did not necessarily perceive a polite but more detached approach to care  
391 as disrespectful, and some believed they could communicate respect in the absence of a  
392 respectful attitude towards the patient. Adopting such beliefs may be an important way to  
393 negotiate the conflict between personal attitudes and ideals of care, and might be encouraged  
394 by a paucity of literature discussing attitudes in conjunction with behaviours of respect and  
395 legitimised by the prescription of emotional detachment in some settings such as palliative  
396 care.<sup>39</sup> However, behaviours of care and warmth have been shown to make an important  
397 contribution to respectful communication from the patient's perspective and to explain  
398 sociodemographic disparities in experiences of respectful care.<sup>6</sup> Second, nurses' accounts  
399 suggested that genuine respect is likely to facilitate its communication. Indeed, showing  
400 respect was described as a challenging communication skill, with a concern of negative  
401 feelings slipping through, and indications that patients might be picking up on non-intended  
402 non-respectful non-verbal communication. Third, beliefs in needed congruence between

403 verbal and non-verbal behaviour to communicate respect may facilitate respectful attitudes. A  
404 nurse who endorsed such beliefs adopted a different strategy; of “withstanding” disrespectful  
405 behaviour in order to understand the reason behind the behaviour, allowing for the future  
406 development of a respectful attitude towards such patients. The study underscores the need to  
407 more formally recognise respect as a complex attitudinal construct, with attitudinal influences  
408 on behaviour and success of communication, to reduce the risk that the concept of respect  
409 becomes open to different interpretations.

410         The study also underscores the need for more formal discussions on the socially  
411 constructed nature of respect<sup>22</sup> to be included in pre-registration and continuing development  
412 programmes in health and social care, as well as greater partnership with patients to  
413 understand their needs and expectations in relation to respect. Nurses’ beliefs on what it  
414 means to show respect were based on their upbringing and social environment, with  
415 differences extending beyond culture,<sup>40</sup> which presented challenges to being perceived as  
416 respectful. In turn, the fear of patient complaints and the need to maintain a positive  
417 professional reputation led to adopting strategies that took time away from patient care,  
418 potentially threatening respectful communication, whilst the ability to maintain a role identity  
419 as a good and respectful nurse supported respectful communication intentions through  
420 happiness within and commitment to the nursing role.<sup>41,42</sup> These findings highlight the  
421 potentially circular nature of difficulties in communicating respect, which could increase  
422 threats to professional reputation and further hinder respectful communication.

423         A study limitation was that nurses were all from one hospital in the UK but several  
424 influencing factors, such as professional and ethical pressures to be respectful, some of the  
425 patient stereotypes and the perception of nursing as a lower status profession apply to  
426 healthcare delivery and systems in other countries as well, including the US, Singapore and  
427 Sweden.<sup>2,43,37,44</sup> Therefore, similar challenges in communicating respect might also be found

428 elsewhere. Nurses provided rich data, enabling important insights, yet the professional  
429 necessity to show respect and sensitivity of the research topic might have restricted full  
430 disclosure or reflection on certain experiences of care. The interviews were carried out not  
431 long after the Francis report was released in England, which negatively impacted on public  
432 perceptions of nurses, and could have influenced some of the findings relating to the  
433 reputational self in particular. However the high number of written complaints against nurses  
434 in 2017-2018<sup>45</sup> show that similar challenges relating to critical patient attitudes are still very  
435 much alive today. Moreover, the discourse around respect and high quality care has become  
436 more “pronounced” in recent years with a renewed commitment to improve quality of care in  
437 the UK<sup>46</sup> and other countries such as the US<sup>47</sup>. This further underscores the need to more  
438 deeply understand influences on respectful communication and the utility of the present  
439 findings.

440         To conclude, this study has deepened our understanding of intra- and inter-personal  
441 influences on the communication of respect. In addition, it identified several challenges to  
442 communicating respect that can be quite clearly understood within the framework developed,  
443 including the additive nature of unconditional and conditional respect, the influence of  
444 conditional attitudes of respect towards patients situated within a larger sociocultural context,  
445 competing psychological and professional needs/goals and differing understandings of  
446 respect. The overriding cultural and professional expectation for health practitioners to show  
447 equal respect to all patients, irrespective of situation, behaviour and socio-cultural demands is  
448 hard to achieve in the reality of the clinical setting. The study advocates the need to more  
449 formally recognise the complex attitudinal and socially constructed nature of respect and  
450 urges education providers and organisations to more robustly prepare and support  
451 practitioners to develop respectful attitudes, in order to improve their communication of  
452 respect. To this end, it offers useful insight into the antecedents of respectful attitudes.

453 *Table 1: Sample characteristics*

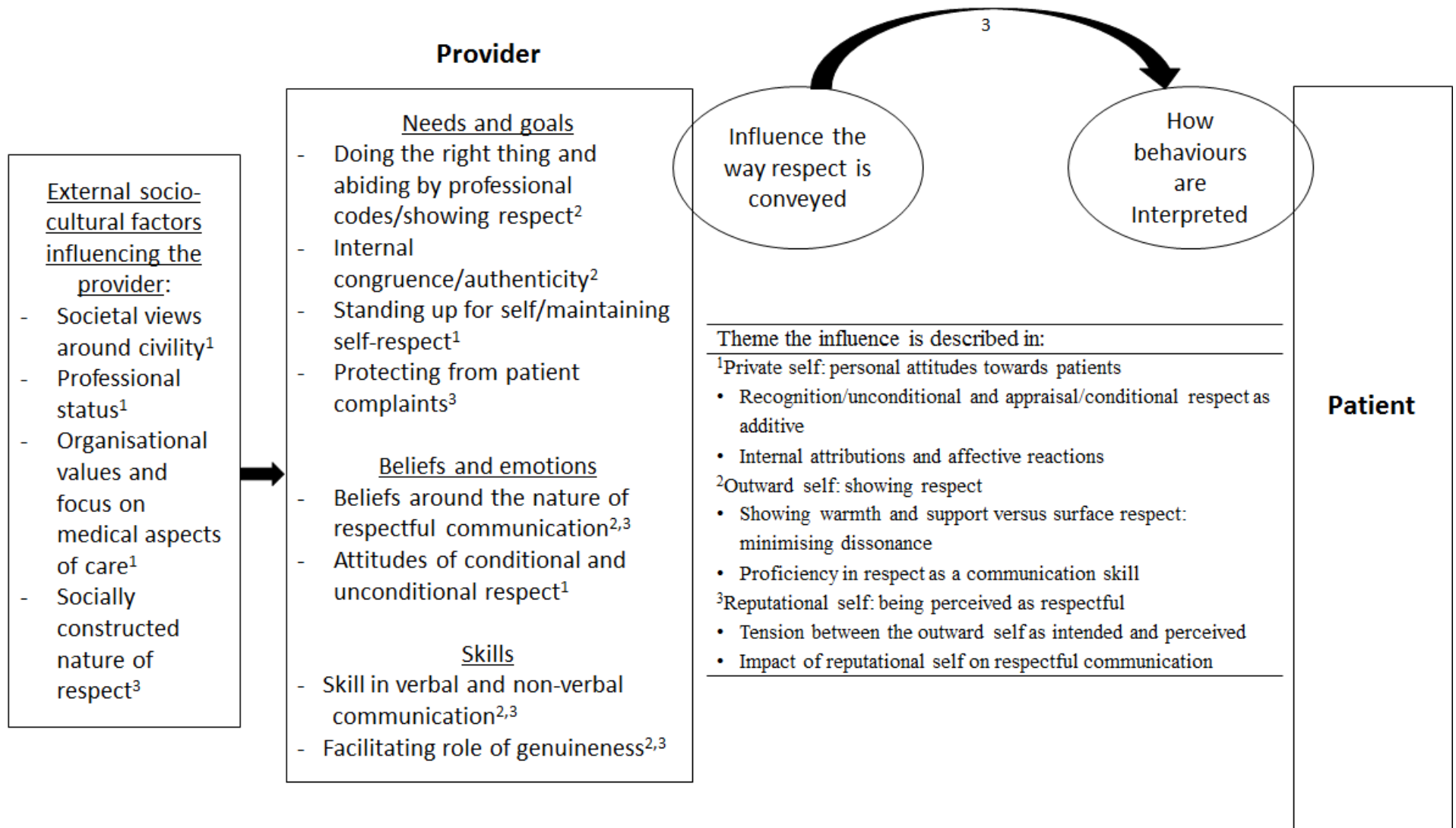
<b>Characteristic</b>	<b>Sample</b>
Gender	11 females, 1 male
Age	30-59 years ( <i>Mean</i> = 46)
Time practising as Registered nurse	4-34 years ( <i>Mean</i> = 14.29)
Area of work	4 elderly ward, 2 breast care unit, 2 intensive/critical care, 1 stroke unit, 1 planned surgery, 1 pre-assessment clinic, 1 medical ward.

454

455 *Table 2: Themes and subthemes*

<b>Theme</b>	<b>Subthemes</b>
	<p data-bbox="564 331 1378 434">Recognition/unconditional and appraisal/conditional respect as additive</p> <p data-bbox="564 479 1118 512">Internal attributions and affective reactions</p> <p data-bbox="564 557 1246 660">Showing warmth and support versus surface respect: minimising dissonance</p> <p data-bbox="564 705 1174 739">Proficiency in respect as a communication skill</p> <p data-bbox="564 784 1342 817">Tension between the outward self as intended and perceived</p> <p data-bbox="564 862 1142 896">Impact of reputational self on respectful care</p>

456



457

458 *Figure 1.* Framework of influences on communicating respect from nurses to their patients.

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## References

461

462 1. Department of Health. *The NHS Constitution*, 2015. Crown Copyright: London.

463 2. International Council for Nurses. *Code of ethics for nurses*, 2012. ICN, Geneva.

464 3. Abdelrahman W, Abdelmageed A. Understanding patient complaints. *BMJ Careers*,

465 [http://careers.bmj.com/careers/advice/Understanding\\_patient\\_complaints](http://careers.bmj.com/careers/advice/Understanding_patient_complaints) (2017,

466 accessed 23 June 2018)

467 4. Chadwick A. A dignified approach to improving the patient experience: promoting

468 privacy, dignity and respect through collaborative training. *Nurse Educ Pract* 2012;

469 12:187–191. doi: 10.1016/j.nepr.2011.12.006

470 5. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic

471 review and coding taxonomy. *BMJ Quality Saf* 2014; 23: 678-689. doi:10.1136/bmjqs-

472 2013-002437

473 6. Clucas C. Cancer patients' respect experiences in relation to perceived communication

474 behaviours from hospital staff: analysis of the 2012-2013 National Cancer Patient

475 Experience Survey. *Support Care Cancer* 2016; 24(4): 1719-28. doi:10.1007/s00520-

476 015-2973-5

477 7. Parse RR. Feeling respected-a parse method study. *Nurs Sci Q* 2006; 19: 52-6. doi:

478 10.1177/0894318405283553

479 8. Clucas C, St Claire, L. The effect of feeling respected and the patient role on patient

480 outcomes. *Appl Psychol Health Well Being* 2010; 2(3): 298 – 322. doi:10.1111/j.1758-

481 0854.2010.01036.x

482 9. McCabe C. Nurse-patient communication: an exploration of patients' experiences. *J Clin*

483 *Nurs* 2004; 13(1): 41-9. doi: 10.1111/j.1365-2702.2004.00817.x

- 484 10. Staniszewska SH, Henderson L. Patients' evaluations of the quality of care: influencing  
485 factors and the importance of engagement. *J Adv Nurs* 2005; 49(5): 530-537.  
486 doi:10.1111/j.1365-2648.2004.03326.x
- 487 11. Thorne S, Oliffe JL, Stajduhar KI, et al. Poor communication in cancer care: patient  
488 perspectives on what it is and what to do about it. *Cancer Nurs* 2013; 36: 445-453.  
489 doi:10.1097/ncc.0b013e31827eeda4
- 490 12. Beach MC, Sugarman J, Johnson RL, et al. Do patients treated with dignity report higher  
491 satisfaction, adherence and receipt of preventive care? *Ann Fam Med* 2005; 3(4): 331-  
492 338. doi:10.1370/afm.328
- 493 13. Blanchard J, Lurie N. Respect: Patients' reports of disrespect in the health care setting  
494 and its impact on care. *The Journal of Family Practice* 2004; 53: 721-730.
- 495 14. Street RL, Makoul G, Arora NK. et al. How does communication heal? Pathways linking  
496 clinician-patient communication to health outcomes. *Patient Educ Couns* 2009; 74(3):  
497 295-301. doi: 10.1016/j.pec.2008.11.015
- 498 15. Yu J, Kirk M. Measurement of empathy in nursing research: systematic review. *J Adv*  
499 *Nurs* 2008; 64(5): 440-454. doi:10.1111/j.1365-2648.2008.04831.x
- 500 16. Lalljee M, Laham SM, Tam T. Unconditional respect for persons: A social psychological  
501 analysis. *Gruppendynamik und Organisationsberatung* 2007; 38(4): 451-464.  
502 doi:10.1007/s11612-007-0037-0
- 503 17. Care Quality Commission. Guidance for providers on meeting the regulations,  
504 [https://www.cqc.org.uk/sites/default/files/20150324\\_guidance\\_providers\\_meeting\\_regu-](https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf)  
505 [lations\\_01.pdf](https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf) (2015, accessed 3 August 2018).
- 506 18. Beach MC, Roter DL, Wang N, et al. Are physicians' attitudes of respect accurately  
507 perceived by patients and associated with more positive communication behaviors?  
508 *Patient Educ Couns* 2006; 62(3): 347-354. doi:10.1016/j.pec.2006.06.004

- 509 19. Frei JR, Shaver PR. Respect in close relationships: Prototype definition, self-report  
510 assessment and initial correlates. *Pers Relatsh* 2002; 9(2): 121-139. doi: 10.1111/1475-  
511 6811.00008
- 512 20. Hendrick S, Hendrick C. Measuring Respect in Close Relationships. *J Soc Pers Relat*  
513 2006; 23(6): 881-899. doi: 10.1177/0265407506070471
- 514 21. Van Quaquebeke N, Eckloff T. Defining respectful leadership: What it is, how it can be  
515 measured, and another glimpse at what it is related to. *J Bus Ethics* 2010; 91(3): 343-358.  
516 Doi: 10.1007/s10551-009-0087-z
- 517 22. Grover SL. Unraveling respect in organization studies. *Hum Relat* 2014; 67(1): 27-51.  
518 doi: 10.1177/0018726713484944.
- 519 23. Rogers C. *On becoming a person: a therapist's view of psychotherapy*. London:  
520 Constable, 1967.
- 521 24. Riley JB. *Communication in nursing*. St Louis: Elsevier Health Sciences, 2015.
- 522 25. Huizinga MM, Cooper LA, Bleich SN, et al. Physician respect for patients with obesity. *J*  
523 *Gen Intern Med* 2009; 24(11): 1236-1239. doi:10.1007/s11606-009-1104-8
- 524 26. Feldman-Stewart D, Brundage MD, Tishelman C et al. A conceptual framework for  
525 patient–professional communication: an application to the cancer  
526 context. *Psychooncology* 2005; 14(10): 801-809. doi: 10.1002/pon.950
- 527 27. Ajzen I. *Attitudes, personality and behaviour*. 2nd ed. Maidenhead: Open University  
528 Press, 2005.
- 529 28. Chapman H, Clucas C. Student nurses' views on respect towards service users - An  
530 interpretative phenomenological study. *Nurse Educ Today* 2013; 34(3): 474-9.  
531 doi:10.1016/j.nedt.2013.05.012

- 532 29. Hoeve YT, Jansen G, Roodbol P. The nursing profession: public image, self-concept and  
533 professional identity. A discussion paper. *J Adv Nurs* 2014; 70(2): 295-309. doi:  
534 10.1111/jan.12177
- 535 30. Dovidio JF, Fiske ST. Under the radar: how unexamined biases in decision-making  
536 processes in clinical interactions can contribute to health care disparities. *Am J Public*  
537 *Health* 2012; 102(5): 945-952. doi:10.2105/ AJP.2011.300601
- 538 31. Smith JA, Flowers P, Larkin M. *Interpretative phenomenological analysis: theory, method*  
539 *and research*. London: Sage, 2009.
- 540 32. Elliott R, Fischer CT, Rennie DL. Evolving guidelines for the publication of qualitative  
541 research studies in psychology and related fields. *Br J Clin Psychol* 1999; 38(pt 3):  
542 215-29. doi:10.1348/014466599162782
- 543 33. Francis R. The Mid Staffordshire NHS Foundation Trust Public Inquiry. Accessed  
544 10/10/2015 from <http://www.midstaffpublicinquiry.com/report> (2013, accessed 10  
545 October 2015).
- 546 34. Robiner WN, Petrik ML. Managing Difficult Patients: Roles of Psychologists in the Age  
547 of Interdisciplinary Care. *J Clin Psychol Med Settings* 2017; 24: 27-36.  
548 doi:10.1007/s10880-017-9490-2
- 549 35. Eyres H. Civilisation, or just civility? The Slow Lane. *Financial Times*, 15 October 2011,  
550 p. 18.
- 551 36. Royal College of Nursing (RCN). *RCN employment survey*. 2015. London, Labour  
552 Research Department.
- 553 37. Van Boekel LC, Brouwers EP, Van Weeghel J. et al. Stigma among health professionals  
554 towards patients with substance use disorders and its consequences for healthcare  
555 delivery: systematic review. *Drug Alcohol Depend* 2013; 131(1): 23-35. doi:  
556 10.1016/j.drugalcdep.2013.02.018

- 557 38. Weiner B. *Judgments of responsibility: A foundation for a theory of social conduct*. NY:  
558 Guilford Press, 1995.
- 559 39. Funk LM, Peters S, Roger KS. The emotional labor of personal grief in palliative care:  
560 Balancing caring and professional identities. *Qual Health Res* 2017; 27(14): 2211-  
561 2221. doi: 10.1177/1049732317729139.
- 562 40. Mackenzie L, Wallace M. The Communication of respect as a significant dimension of  
563 cross-cultural communication competence. *Cross-Cultural Communication* 2011; 7(3):  
564 10-18. doi:10.3968/j.ccc.1923670020110703.175
- 565 41. Burke PJ, Stets JE. Trust and commitment through self-verification. *Soc Psychol Q* 1999;  
566 62: 347-366. doi: 10.2307/2695833
- 567 42. McCarthy J, Gastmans C. Moral distress: A review of the argument-based nursing ethics  
568 literature. *Nurs Ethics* 2015; 22(1):131-52.
- 569 43. Eriksson U, Svedlund M. Struggling for confirmation—patients’ experiences of  
570 dissatisfaction with hospital care. *J Clin Nurs* 2007; 16(3): 438-446.  
571 doi:10.1111/j.1365-2702.2005.01544.x
- 572 44. Tay LH, Ang E, Hegney D. Nurses’ perceptions of the barriers in effective  
573 communication with inpatient cancer adults in Singapore. *J Clin Nurs* 2012; 21: 2647-  
574 2658. doi:10.1111/j.1365-2702.2011.03977.x
- 575 45. Health and Social Care Information Centre. Data on written complaints in the NHS,  
576 <https://files.digital.nhs.uk/5B/D86467/Data%20on%20Written%20Complaints%20in%20the%20NHS%202017-18%20Report.pdf> (2018, accessed January 14, 2019).
- 578 46. NHS England. Nursing, midwifery and care staff: Leading Change, Adding Value,  
579 <https://www.england.nhs.uk/leadingchange/>(accessed January 18, 2019)
- 580 47. CMS.gov: Centers for Medicare and Medical Services. The Hospital Value-Based  
581 Purchasing (VBP) Program, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient->

582        [Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-](#)  
583        [Purchasing.html](#) (accessed January 26, 2019)

584