

The Meaning of Respect: A First Nations Perspective

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Partant du point de vue de cinq informateurs-clés des tribus Cries-Ojibway, on a étudié qualitativement la signification du respect. Les données sont tirées d'entrevues en profondeur faites auprès de membres des Premières Nations au nord du Manitoba. Au cours de ces entrevues, on a mis l'accent sur ce que nos interlocuteurs entendaient par respect et s'ils considéraient être traités avec respect ou non pendant leurs interactions avec le système médical. L'analyse qualitative a établi les caractéristiques du respect et du manque de respect dont ont parlé nos interlocuteurs des Premières Nations dans leurs interactions avec les soignants occidentaux. La notion de respect comprenait les valeurs morales liées à l'égalité, la valeur intrinsèque de la personne, son unicité et sa dignité. Les conclusions ont montré la nécessité pour le personnel infirmier de connaître la situation sociopolitique des clients appartenant aux Premières Nations. Les descriptions préliminaires de ce qui signifie le respect, établies par la présente étude, forment le fondement d'une analyse plus poussée du concept.

A qualitative study was conducted to explore the meaning of respect from the perspective of five Cree-Ojibway key informants. Data were obtained from in-depth interviews conducted in a First Nations community in northern Manitoba. Interviews focused on key informants' understanding of the meaning of respect, and their experiences of being treated with or without respect during clinical interactions. The qualitative analysis identified characteristics of respect and lack of respect that reflected the informants' experiences as First Nations persons interacting with Western health-care providers. The features of respect reflected ethical values related to equality, inherent worth, and the uniqueness and dignity of the individual. Findings highlighted the need for nurses to be cognizant of the sociopolitical context of interactions with First Nations patients. The preliminary descriptions of respect identified in this study provide a foundation for further analysis of the concept.

Although the concept of respect is assumed to be fundamental to nursing practice, little is known about the ways in which nurses convey respect. Even less is known about the experience of receiving respect from the patient's perspective. Understanding patients' perspectives and experiences can provide clues about factors that influence the nature and quality of nursing interactions with them. Since respect is a fundamental component of the caring process, gaining patients' perspectives of what it means to be treated with respect has the potential to significantly affect nursing practice. Additionally, as

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more is learned about the concept of respect, opportunities will develop to apply it in valuable ways in practice, theory development, research, and education.

This qualitative study explored the meaning of respect from the perspective of Cree-Ojibway key informants. The study was intended to provide preliminary descriptions of respect as a foundation for further analysis. For the purpose of the study, respect was analyzed as a concept in the domain of nursing action as identified by Kim (1983). Concepts in this domain address the following question: "Would a variation of this occurrence...taking place between the client and the nurse in any way alter (or should alter) the way the client feels, perceives the world relevant to health, and proceeds to make future moves regarding his or her health state?" (Kim, p. 122). The "occurrence" examined in this study was respect, as conveyed to Cree-Ojibway patients by nurses and physicians during health-care interactions.

The study reported in this paper represented the fieldwork phase of a larger study that addressed a concept analysis of respect using the Hybrid Model of Concept Development (Schwartz-Barcott & Kim, 1993). Fieldwork is a critical component of the concept-analysis process. In this phase, empirical data were collected and analyzed as a way of further defining the key elements of the concept (Schwartz-Barcott & Kim). The findings presented in this paper therefore describe the elements of respect as understood by Cree-Ojibway key informants. The paper begins with a review of the literature addressing the meaning and applications of respect. An overview of the design and methods is provided, followed by a discussion of the findings and concurrent analysis. The paper concludes with a discussion of nursing implications related to respect in the context of cross-cultural interactions between Western nurses and First Nations clients.

Review of the Literature

Respect as an Ethical Principle

Various philosophers have deliberated on the meaning and significance of respect as a primary ethical principle and human value. Immanuel Kant describes respect as a "humanity principle" that recognizes the intrinsic value inherent in all humans and their potential for autonomy (in Milne, 1986, p. 86). Downie and Telfer (1970) describe the primacy of respect as the central moral attitude from which all other moral principles are explained. Rokeach (1979) discusses respect as a human value that addresses human dignity and justice. In literature concerning

human rights, respect is considered the core value, an interrelationship that recognizes the freedom of choice, inherent worth, and essential equality of persons (Howard, 1975; McDougall, Lasswell, & Chen, 1980). In a conceptual analysis of the humanization of health care, Howard refers to dignity and respect as ideological dimensions of humanization.

Respect as a Component of Caring Interactions

In nursing literature, respect is discussed as an ethical concept that addresses the values of human dignity, inherent worth, and uniqueness of persons (Carper, 1979; Eliason, 1993; Gaut, 1983, 1986; Kelly, 1987, 1990, 1991, 1992; Leininger, 1989, 1990; Silva, 1983). The first two values for professional nursing identified in the Canadian Nurses Association *Code of Ethics for Nursing* (1991) are respect for the needs and values of clients and respect for client choice.

Respect is also identified as a fundamental concept in theory development pertaining to caring (Carper, 1979; Fenton, 1987; Forrest, 1989; Gardner & Wheeler, 1981; Gaut, 1983, 1986; Kelly, 1987). By studying professional ethics among nursing students, Kelly (1987, 1990, 1991, 1992) was able to define nursing actions that are indicative of respect and caring. Behavioural demonstrations of respect included (a) the manner in which patients were addressed, (b) sending the patient positive messages early in the interaction, (c) providing privacy for patients, (d) explaining and listening to patients, and (e) letting patients do for themselves. Kelly also identifies respect and caring as two central ethics for nursing, noting that the components of respect relate to three themes: (a) respect for human dignity and the uniqueness of patients, (b) respect for the patient's capacity for self-determination, and (c) acceptance of a patient's values. Moreover, respect is considered a necessary antecedent to caring: "In the absence of respect, caring cannot take place" (1990, p. 72).

Patients' Perceptions of Clinical Interactions

Although Kelly's (1987, 1990, 1991, 1992) studies provide substantive data concerning definitions of respect, the author found no studies in the literature that examine the experience of *being* respected, from the patient's perspective. Related results, however, are provided by studies that examine patients' experiences of clinical interactions. For example, Sherley-Spiers (1989) explores Dakota First Nations' perceptions of clinical encounters with Western health-care providers. Findings

demonstrate that clinical encounters were frequently characterized by discriminatory and racist actions, resulting in experiences of depersonalization and dehumanization for patients. Support and respect for Dakota patients were found to be lacking in patient-provider interactions. Although informants did not define respect, the findings suggest a link between respectful (or disrespectful) treatment and issues related to discrimination and prejudice.

Anthropologist John O'Neil (1989) studied patient dissatisfaction in cross-cultural clinical encounters by analyzing Inuit interpreters' understanding of the nature and quality of clinical interactions between Inuit patients and Western health-care providers. His findings illustrate that clinical communication by Western providers was strongly influenced by paternalism and disregard for cultural or sociopolitical factors affecting interactions, resulting in patient dissatisfaction with clinical experiences.

Chipperfield (1992) undertook a longitudinal quantitative study of the degree of respect shown to elderly persons by other members of the community, as perceived by the elderly respondents. Using a five-point scale, differences in perceived respect among various cultural groups were documented, with native elderly persons providing the lowest ratings at all points in time. Interpretation of the findings was limited, however, since no conceptual or operational definitions of respect were provided.

To summarize, the literature discusses respect as an ethical concept for nursing and a necessary component of caring interactions. Studies that involved aboriginal patients point to a link between discriminatory and paternalistic treatment, and a compromise in the integrity of clinical interactions. No studies were found, however, that examined the meaning of respect from the patient's viewpoint. The study presented in this paper was intended to address this gap in the research literature.

Method

Purpose

The purpose of this qualitative study was to provide descriptions of respect as a phenomenon occurring during clinical interactions from the perspective of Cree-Ojibway key informants.

Research Questions

The research questions addressed in this study were: What is the meaning of respect for Cree-Ojibway clients? In what ways are respect-

ful interactions described? In what ways are interactions that lacked respect described? What, if any, are the implications of respect or lack of respect for clients?

Design

The study used in-depth interviews based on ethnographic interview techniques outlined by Spradley (1979). As a qualitative approach to research, in-depth interviews are intended to provide descriptions of human behaviour and experiences from the perspective of those who have lived them, expressed in their own words (Spradley; Taylor & Bogdan, 1984). The emphasis is on obtaining descriptions that reflect the emic (insider's) perspective, instead of the more traditional objective or etic (outsider's) perspective (Spradley). This method of data collection is particularly useful when there is limited knowledge of the phenomena under study and the researcher is interested in description and meaning.

Procedure

Interviews with key informants were conducted in a Cree-Ojibway community in northern Manitoba during a six-week period. After the purpose of the study had been discussed with informants and informed consent had been obtained, unstructured interviews were held with each informant separately, each lasting from one to three hours. Each informant was interviewed a second time, to clarify and validate data obtained in the first interview. The specific aims of the interviews were to: (a) elicit key informants' understanding of the meaning of respect, (b) obtain examples of "model cases" of respectful interactions and "contrary cases" of interactions lacking respect, (c) discuss cases that most people in the community would agree on, and (d) discuss the implications of respect or lack of respect on the informants' thoughts, feelings, actions, and well-being, based on their personal experiences. The interviews were audiotaped and transcribed verbatim as soon after the interviews as possible.

Data were organized and analyzed using a variation of Schatzman and Strauss's notation system, as recommended by Schwartz-Barcott and Kim (1993). The notation system allowed for concurrent collection and analysis of data, and provided the opportunity for key informants to clarify content and validate the emerging analyses in subsequent interviews. As data analysis proceeded, recurrent patterns of interactions and behaviours indicative of respect and lack of respect were

identified. Parts of the narrative data were then classified into model and contrary cases of respect (Schwartz-Barcott & Kim). Classifying data into model and contrary cases facilitated identification of the characteristics of respect described by key informants.

Selection of Key Informants

Five key informants, four women and one man, were selected by the researcher and invited to participate in the study. Suggestions from other Community Health Nurses who worked in the community for five years or longer were also considered in the selection process. Ages of key informants ranged from 27 to 51. All met the criteria for key informants as identified by Spradley (1979): all were knowledgeable about their community and their culture, were currently active members of the community, and had adequate time to devote to the interview process. Although all key informants were fluent in English, their first language was a Cree dialect.

The researcher had worked as a Community Health Nurse in the community's nursing station intermittently over a four-year period and was known to many of the community members. Association with the community had the advantage of contributing to the "rapport process," an essential step in ethnographic interviewing (Spradley, 1979, p. 78). It also allowed "backstage" access to information to which outsiders are not usually privy (Leininger, 1985, p. 49).

Findings

Findings are presented as characteristics of respect and lack of respect, and reflect both model and contrary cases of respect discussed by informants. Examples from the narrative data accompany the characteristics to guide the reader through the investigator's analytic process (Rosenbaum, 1991).

To determine whether the researcher and the key informants were discussing the same concept, informants were asked to give the Cree interpretation of respect. Informants consistently responded with the same Cree term and related its meaning to interactions between people.

Model Cases

After model cases had been collectively reviewed, six characteristics of respect became apparent.

Capacity to treat people as inherently worthy and equal in principle.

Respect was described as a reciprocal process, one that acknowledges the equality of persons. One informant explained:

This is what respect is: when people treat me the way I am, not like a stereotype. When you experience respect in this way you tend to treat other people better, say, people from other races. It is like this: when I respect someone, they respect me.

According to Howard (1975), the capacity to view people as equal in principle is tied to the notion of inherent worth: the capacity to accept people as worthy of respect regardless of merit, ability, or social status. For the key informants, however, issues of equality and worth were tied to their experiences as First Nations persons. Informants described a link between providers' attitudes toward them as First Nations people and the incidence of respectful clinical interactions.

Acceptance of others. All key informants identified acceptance as a specific component of respect. One informant explained:

One member of our family is of a different religion. He is living common-law with someone. In our religion we don't believe in that. But we have to accept it, to function as a family, even if we don't agree with it. And he has to accept our beliefs too. This is a form of respect, because you respect his choice. You don't judge him for it, even if in our eyes it is wrong.

Acceptance of others is closely tied to the capacity to view others as inherently worthy (Howard, 1975). Throughout the narratives in the study, the values of equal status, inherent worth, and acceptance were identified by informants as essential to respect. These values were also supported by the literature as primary features of respect.

Willingness to listen actively to patients. This characteristic was identified by all key informants as an essential feature of respect. One informant stated:

Listening is an important part of respect. The nurse or doctor shouldn't cut me off. I don't have a lot of problems dealing with doctors or nurses because I can speak for myself; I know what I need. But some people can't speak up, or don't speak up. They end up getting shoved around.

Another informant reported:

The main way we show respect to our elders is by having patience with them, listening, and trying to understand them.

Although listening was considered important, it did not necessarily correspond to the amount of time spent with patients. For example,

one physician well known to the community was often rushed during interactions with clients, yet informants still felt respected. One informant related that Dr. A

still treats people with respect, in his own way. He may only take one minute to be with the patient, but when he does he's really there, he really listens, and he's really serious.

The implications of this point are significant, given today's climate of staff cutbacks and increased patient loads. If, as these informants report, respect can be readily conveyed during brief interactions, it is a worthwhile and justifiable pursuit to foster an attitude of respect during interactions with patients.

Genuine attempts to understand patients and the unique situation of each. Informants also discussed their interpretation of providers' attempts to understand their patients.

The main thing is trying to understand the person. If a nurse wants to respect a person, she would ask a lot of questions if she had time, and if it was really important to the patient she would make time. And it would make the patient feel good. Like with our elders, we respect them by trying to understand them, even if we don't agree with what they are saying.

Respect was also defined as understanding and accepting patients' values, beliefs, and practices:

I'm a person that doesn't plan whether I get pregnant or not. It's part of my religion too. I expect others to understand me – what I know for myself about this, and how I feel. But my attitude about this, and the fact that I have 10 kids, is opposite to the medical way of planning and controlling everything. I know it's hard to understand other people's ways of thinking and beliefs, but I think doctors and nurses should be taught to do that, to try to understand their patients' ways of doing things. That would be respectful, in my opinion.

This example illustrates that respect can be demonstrated by understanding not only the patient's unique situation, but also why patients make the choices they do. If "patients feel that their personal understanding of their problems are heard, respected, and given weight in decisions regarding treatment, then satisfaction with the encounter will occur" (O'Neil, 1989, p. 327).

Attempt to provide adequate explanations. Providing understandable explanations to patients during clinical interactions was seen by the informants as another way of showing respect. This characteristic played a role in determining the patient's ability to make decisions related to health issues.

You can show respect to patients by explaining things. Explaining is very important. For example, some people don't know what medicine they are taking. Some people don't ask either; they just take it.... Especially the old people; they don't ask anything. They want to please the nurse so they just take it. But the nurse knows a lot about medicines...that is why they should explain things.

Providers who offered explanations were seen as creating an opportunity for patients to exercise their autonomy. In this context, providing adequate explanations is tied to issues of shared decision-making, power, and control during health-care interactions (Lazarus, 1988), and as such has ethical implications for patient care.

Sincerity during interactions. Key informants described their ability to sense the sincerity of the provider by observing her or his demeanour, especially on initial contact. Something in the provider's verbal and nonverbal behaviours early in the interaction was quickly interpreted by patients as an indicator of respect. The following statements reflect this point:

When we come into the clinic room, we just watch her; how she is, if she says hello, how she acts I know right away the mood the nurse is in; whether she's in a hurry, or doesn't want to answer questions or tell me anything. I just stop [interacting with her]. What's the use?

Informants reported instances in which the nonverbal messages led patients to entirely avoid interacting with certain providers. Patients in cross-cultural interactions may be particularly sensitive to nonverbal messages, as they tune into nuances and nonverbal cues to facilitate communication (Leininger, 1978). It is imperative, therefore, that nurses and other providers develop an awareness of the attitudes they convey nonverbally, so that seemingly innocuous behaviours are not interpreted in negative ways by patients (O'Neil, 1989).

The six characteristics of respect described above reflect key informants' understanding of what it meant, as First Nations persons, to be treated with respect by Western providers. These characteristics are contrasted in the following section with descriptions of lack of respect discussed by informants as contrary cases.

Contrary Cases

Contrary cases represent interactions that resulted in a lack of respect for the patient. Since the key informants spent a significant amount of time describing their experiences of disrespect, eliciting contrary cases

was a particularly useful way of gaining insight into the meaning of respect.

Lack of respect stemming from discriminatory attitudes. Informants discussed lack of respect in the context of First Nations identity and status in Canada, prejudice, and discrimination. They described discriminatory attitudes as indicative of lack of respect.

I felt that she [the hospital nurse] didn't want to touch me because I was Indian, like she thought I was dirty. Why did she have to tell me to shower before she would examine me? I remember that I felt very hurt and angry. I really wondered why she worked in that hospital, since the patients were mostly native.

Discrimination usually results from viewing others as "lesser persons" and failing to acknowledge the inherent worth of others (Howard, 1975, p. 78). By describing contrary cases that are indicative of discriminatory treatment, informants confirmed that ethnic stereotyping and prejudice toward aboriginal people remain prevalent (Frideres, 1994; Sherley-Spiers, 1989).

Failure to consider the patient's perspective. This negative characteristic was seen by the informants as having serious clinical implications, especially for patients receiving services in southern secondary or tertiary hospitals. Disregard for the patient's perception of the problem could have detrimental clinical implications. An informant explained:

A nurse isn't showing me respect when she won't even let me explain what I already know about myself or how my children are feeling. For example, one time I brought my baby to the [nursing] station and the nurse didn't believe that there was anything wrong. I knew there was something wrong, though.... Well, in the end we ended up having to medivac [evacuate by airplane] my baby. She was all right after all, but it was very annoying, and she could have ended up worse.

Informants acknowledged that cross-cultural interactions create a potential for clinical misunderstanding, but added that it is possible for providers to convey a desire to understand their patients. Moreover, failure to do so could create dangerous clinical situations.

Failure to provide privacy for patients. Respect for human dignity was related, by the informants, to the issue of privacy afforded to patients, especially during procedures requiring bodily exposure. Failure to do so conveyed a sense of disrespect for the patient's sense of modesty, as described in the following case:

My mom came to the nursing station with a respiratory problem and some chest pains and I came with her to interpret. In the clinic the

nurse took her clothes off, just like that.... That is very disrespectful for the elders because they are very self-conscious of their body.... It would have been better to ask her if it was O.K. to undress her with the family present or explain why she had to take her shirt off or something... After, she [her mother] was really quiet. I knew she was hurt. She didn't say much about what happened but I knew she was thinking about it.

In the above scenario, the nurse could have conveyed a sense of respect by asking the patient to choose the manner in which she should be exposed. In this way, she would have conveyed both the intention to protect the elder's sense of dignity and the intention to take her choice into consideration.

Failure to provide adequate explanations. Informants described how interactions became dehumanizing when patients were not offered explanations and information concerning their well-being. One informant related her experience in a southern hospital:

When I went to the specialist eye doctor for the first time...[he] put these drops in my eyes, and pinned my head in this brace for quite a long time. It wasn't that;... It was the way he went about doing it that showed he didn't respect me. He would just mumble everything he said to me, and he wouldn't speak clearly... I never knew what he was going to do next... I remember wanting to leave his office when I saw how he was treating me... And I thought of all the elderly people that get sent to him... and how they especially wouldn't understand what was going on.... After he was finished, I asked him what condition my eyes were in, and all he said was that he would send a report to the nursing station. I felt very uneasy and sort of hurt because he didn't want to tell me anything.

Informants felt that in some cases they were not offered the same degree of information or choice regarding their health care that people from other groups were offered. In this context, failure to provide adequate information or explanations may reflect providers' tendencies to view First Nations patients as "people without options" (Howard, 1975, p. 64). Patients – especially elders – who tended to be relatively complacent with providers' suggestions for treatment were seen as particularly vulnerable.

Negative nonverbal behaviours. Informants explained that nonverbal behaviours can be powerful indicators of respect or lack of respect. The effect of tone of voice on a patient was described by an informant:

When elders come to the clinic, some nurses can be rough or treat the elder like a child. This is very offensive to the family, because they have a high respect for their elders. For example, if an elder doesn't

understand the instruction "take a big breath" in English, the nurse might say it again in a harsh tone of voice. We would never speak to our elders in that way, in that tone of voice.

In such cases, providers can convey a sense of valuing or devaluing their patients through nonverbal messages. Morse, Young, and Swartz (1991) and O'Neil (1989) describe similar findings, noting that attitudes of paternalism or superiority are conveyed to aboriginal patients through body posture and positioning, especially when patients are not English-speaking. The consequences of intonation and other nonverbal behaviours may be far-reaching, if they are perceived as disrespectful, and may jeopardize the efficacy of health-care interactions.

Identifying the characteristics of lack of respect described in contrary cases serves to highlight those characteristics that are distinctive of the model cases (Schwartz-Barcott & Kim, 1993). In the following section, the implications of the findings in relation to nursing practice with First Nations patients are discussed.

Discussion and Nursing Implications

A major function of this study was to validate the significance of respect as a powerful component of clinical interactions between patients and health-care providers. The perspectives of the key informants provide insights into how Cree-Ojibway patients may view clinical interactions with Western providers. The findings also demonstrate ways in which clinical interactions were interpreted by clients in terms of the underlying messages conveyed by providers.

Informants' descriptions frequently related to their experiences as First Nations people interacting with Western providers. Several cases emphasized the need for nurses and other health-care providers to consider the implications of their behaviour in light of historical and current factors influencing interactions with First Nations patients. According to O'Neil (1989), failing to critique clinical interactions in light of their sociopolitical context perpetuates the legacy of colonialism in health care for aboriginal people in Canada. Although the findings are not meant to be generalized to other First Nations groups, they are considered valid for the key informants interviewed, and serve as a stimulus for considering similar factors that affect clinical interactions with other client groups or individuals.

A second major function of the findings was to make explicit what was implicit in the literature concerning respect: that respect is an essential concept for nursing, and that the qualities of respect reflect

ethical concerns. Ethical questions arising from this study relate to the ways in which Cree-Ojibway informants felt they were treated during clinical interactions. Were they treated as persons who were inherently worthy, and equal to others in principle, or were they treated in a discriminatory manner? Were they offered the same amount of information offered to others regarding their health care? Did they receive care in consideration of their unique situation and cultural circumstances? Were they offered an appropriate degree of privacy? Were they treated in ways that reinforce the paternalism and power frequently exercised by health-care providers in the past? Although it was beyond the scope of the study to provide answers, the above questions highlight some ethical concerns raised during analysis of the data.

The characteristics of respect derived from informants' descriptions of respectful interactions suggest that respect has tangible observable indicators that patients can discern in the behaviours of nurses and other health-care providers. As more data are collected about patients' experiences of respect, opportunities to compare meanings and indicators of respect in terms of cultural specificity or universality will arise. The challenge, then, will be to incorporate respectful interactions into nursing practice, consistent with clients' expectations (Egan, 1994).

In summary, the in-depth interviewing approach used in this study fulfilled its intended purpose: the collection of rich descriptive data that reflected the perspectives of key informants (Spradley, 1979). By exploring the meaning of respect from the perspective of Cree-Ojibway informants, the study was able to highlight the value and significance of respectful clinical interactions for this client group. The findings illustrate the need for nurses and other providers to be aware of sociopolitical factors influencing the nature and quality of clinical interactions between First Nations clients and Western health-care providers. As future research examines the significance of respectful interactions, nursing can realize its commitment to the values of status equality, inherent worth, and the dignity of persons.

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