Exploring the Meaning of Respect in Medical Student Education: an Analysis of Student Narratives

Orit Karnieli-Miller, PhD[1,2], Amanda C. Taylor, MS[3], Ann H. Cottingham, MAR, MA[2], Thomas S. Inui, ScM, MD[2,4], T. Robert Vu, MD[2,5], and Richard M. Frankel, PhD[2,4,5]

[1]Department of Community Mental Health, University of Haifa, Haifa, Israel; [2]Indiana University School of Medicine, Indiana University, Indianapolis, IN, USA; [3]Indiana University-Purdue University, Indianapolis, IN, USA; [4]The Regenstrief Institute, Indiana University, Indianapolis, IN, USA; [5]Richard L. Roudebush VA Medical Center, Indianapolis, IN, USA.

BACKGROUND: Respect for others is recognized in the medical literature and society as an essential attribute of the good medical professional. However, the specific meaning of respect varies widely and is underexplored as a lived experience of physicians-in-training.
OBJECTIVE: To describe third-year medical students' narratives of respect and disrespect [(dis)respect] during their internal medicine clerkship.
DESIGN: Qualitative thematic analysis of 152 third-year student narratives that 'taught them something about professionalism,' focusing on (dis)respect.
APPROACH: Immersion/crystallization narrative analysis.
RESULTS: We reviewed 595 professionalism narratives and found that one in four narratives involved (dis) respect. We then found that 2/3 of these narratives were negative (describing instances of disrespect rather than respect). In the other coded categories, the proportion of negative narratives was significantly lower. In order to better understand these results, we analyzed the content of the (dis)respect narratives and identified six primary themes: (1) content and manner of communication (including, appreciating or belittling, being sensitive or blunt and respecting privacy); (2) conduct: behaviors expressing (dis)respect; (3) patient centeredness: honoring others' preferences, decisions and needs; (4) treating others as equals; (5) valuing the other and their experience and/or problem; and (6) nurturing students' learning.
CONCLUSIONS: Focusing on the lived experience of (dis)respect on wards broadens the concept of respect beyond any one type of act, behavior or attitude. Students perceive respect as a way of being that applies in all settings (private and public), with all participants (patients, family members, nurses, colleagues and students) and under all circumstances (valuing others' time, needs, preferences, choices, opinions and privacy). Respect seems to entail responding to a need, while disrespect involves ignoring the need or bluntly violating it.

Received November 15, 2009
Revised May 6, 2010
Accepted July 14, 2010
Published online August 17, 2010

KEY WORDS: medical professional; medical education; respect.
J Gen Intern Med 25(12):1309–14
DOI: 10.1007/s11606-010-1471-1

I was in an Intensive Care Unit and overheard a conversation between a nurse and an attending. She had confronted him because she thought that a patient did not understand his prognosis and needed more information. The attending began to raise his voice and tell her that she needed to let his team take care of its patients, that the patient had, in fact, been told the prognosis, and that she [the nurse] was a "pain in the ass." All of this was said in front of the entire team, nurses and any families that happened to be around. It's ridiculous to talk to anyone else like that, but even worse for someone who is a role model for students and needs to have respect to be able to do his job. I think there's a limit to how far you can go and still say "Oh but he's a great doctor…"

(Third-year medical student "professionalism" narrative)

RESPECT AS A PHYSICIAN QUALITY

Respect for others—patients, colleagues and team members—is recognized in the medical literature and society as an essential attribute of the good medical professional[1,2]. Respect in the medical profession is usually situated in the broader context of professionalism, as a central humanistic value that physicians should hold and apply[3–5]. Different scholars consider respect to consist of socially valued relational/interactional acts of one person toward another[6,7]. In the literature, manifesting 'respect' is related to positive attitudes toward human worth and the dignity of every individual[8–10]; maintaining non-judgmental attitudes toward human diversity and uniqueness among patients[2]; support for patient autonomy (including shared decision-making with patients[10,11] and listening[3]); suitable attention to privileges and codes of conduct[2]; and maintaining privacy and confidentiality[3,12]. Other definitions include respectful interactions with family members and colleagues[2].

In recent years, medical educators have emphasized the need to treat students/learners with respect[13] because it models for learners what is expected of them as physicians in interactions with vulnerable others. There is evidence that students who feel belittled and abused are less able to provide respectful treatment to patients, an influence of the "hidden" or informal curriculum on medical training[14].

A recent literature review called for more empirical research[15] on respect that would clarify ambiguities in the definition and usage of the term[16], expand what little is known about how respectful attitudes translate into situational thoughts and behaviors[1] and better understand how respect is experienced in social relations[17]. The present study attempts to address some of these gaps by focusing on a collection of narratives produced by 3rd year medical students on their internal medicine clerkship. Our goal is to empirically describe the situations, participants[7], and consequences that constitute students' experiences of respect or disrespect [(dis)respect] as a starting point for teaching about 'respect' as a tangible and learnable virtue.

METHODS

Third year students on their medicine rotation at Indiana University School of Medicine (IUSM) are required to contribute at least one HIPAA-compliant narrative about an experience (either positive or negative) that 'taught them something about professionalism.' At the end of each rotation the narratives are de-identified and distributed to these students as the basis for a faculty-facilitated small-group discussion. Once the discussion is completed, the narratives are warehoused until the students graduate (to protect them from any possible reprisals). The IUSM Institutional Review Board (IRB) approved the use of these warehoused narratives for research purposes and for feedback to IUSM faculty and residents after graduation. Our analyses are based on a qualitative examination of 595 consecutive students' de-identified narratives collected from June 2004–May 2006.

Analysis

The narratives were analyzed in two stages. First, the 595 narratives were divided into general categories of professionalism. In a second analysis, those narratives that dealt with respect and disrespect were examined to identify themes at a more granular level.

Overall Professionalism Themes. In the initial phase, three analysts (OKM, AHC and RMF) independently read the same group of 15 randomly selected narratives. Four additional review rounds of 15 narratives each were conducted before the main professionalism themes were agreed upon[18]. These themes included Stern's[19] five professionalism categories (accountability, humanism, altruism, communication and excellence) and two new categories that emerged from the data (leadership and teamwork). This taxonomy was applied to all 595 narratives. No narratives were double coded[20], and all were assigned a single overarching theme. In situations when the coder was unsure, a second coder was consulted and consensus was achieved. All narratives were coded as either positive or negative role modeling /behaviors (see Table 1).

(Dis)respect Themes. From the initial sorting we noted that a high proportion (25%) of all narratives dealt with respect and disrespect, and these had a different distribution from the other professionalism categories. While almost 2/3 of the entire corpus of narratives was judged to be positive and 1/3 negative, the proportions in the category of (dis)respect were reversed—2/3 negative and 1/3 positive. As a result, we decided on a detailed analysis of the respect narratives using immersion/crystallization, a qualitative method that involves multiple readings of the narrative material that allows themes to "emerge" or crystallize from the data[18,21]. We focused on identifying the participants in the narratives (e.g., physician and patient), the setting (patient care/education), the consequences and the foci of the (dis)respect narratives.

RESULTS

Participants

Five major groups of (dis)respectful interactions were identified: physicians' (attending, resident and intern) showing (dis)respect toward patients (55%); physicians' showing (dis)respect toward students (24%); nurses' showing (dis)respect toward students, patients and physicians (7.5%); physicians' showing (dis)respect toward nurses (2.5%); and (dis)respectful interactions among other participants on the health care team (students with other students, interaction among colleagues) (11%).

Setting

More than three-quarters of the (dis)respect narratives occurred in patient care and nearly a quarter (24%) occurred in educational settings. In patient care, most narratives dealt with the ways professionals used (dis)respect in the care process (elaborated below). In education, the focus was on faculty treating students with (dis)respect. The following positive narrative illustrates:

> Whenever discussing history and physical evaluations my staff would do so in an individual manner in a room separate from the rest of the team… I thought this was respectful because he made the effort to give us the attention but did so individually… he showed respect to team members.

The writer comments on the individualized nature of educational feedback given to each student on the team, noting that doing so in private is a characteristic of respectful faculty behavior. Recognizing the importance of maintaining privacy in educational activities may also increase the potential for parallel learning, for example, about maintaining patient privacy at the bedside. The narrative also illustrates how the informal curriculum reinforces positive behaviors.

Table 1. The Distribution of Professionalism Narratives

Themes	Patient care focus		Educational focus		Total
	Positive	Negative	Positive	Negative	
Accountability	30	32	6	9	77
Humanism	155	102	12	27	296
Altruism	24	1	2	1	28
Excellence	14	5	39	9	67
Communication	67	25	2	2	96
Leadership	5	1	6	6	18
Teamwork	-	6	3	4	13
Total	295	172	70	58	595
Percent of total	49.6%	28.9%	11.8%	9.7%	100%

Consequences of Acting (Dis)Respectfully or Witnessing (Dis)Respect

Students described potential or actual effect(s) of (dis)respect on themselves or others. In positive narratives, respectful behavior was described as resulting in better responses to suggested treatment(s), enhanced ability to relate to patients, and increased levels of patient satisfaction and communication: "a small gesture (helping the patient put his shoes on) makes a big difference in how patients see and interact with him."

The potential negative effects of disrespectful actions included: patients' hurt feelings, patients' mistrust and decreased willingness to share information. In addition, witnessing or experiencing disrespect as a student resulted in students' fears of posing questions, decreased motivation to be a part of a team and negative emotions from being present. For example "It embarrassed me to be in my white coat in the room with the poor patient" or "I also felt guilty that I saw this happening and did not stop it."

Narrative Foci

To better understand the kind of (dis)respect situations students pay attention to in their day-to-day experience, we attempted to identify a primary focus for each (dis)respect narrative. There were six primary foci: (1) content and manner of communication; (2) conduct: various behaviors; (3) patient centeredness: honoring or ignoring others' preferences, decisions and needs; (4) treating others as equals or being judgmental; (5) valuing or de-valuing the other person and their experience and/or problem; and (6) nurturing students' learning. We briefly describe each focus with an illustrative quote and interpretation.

1. Content and manner of communication (70 narratives)

   The largest focus included narratives about respectful and disrespectful communication between physicians and patients or colleagues. Some narratives focused on the way professionals talked *to* others, while others described the way professionals talked *about* others. This focus included three categories discussed below.

   1.1. Content: Showing appreciation or belittling others (30 narratives).

   Most of the narratives in this category were negative (27/30), describing situations in which the role model belittled or degraded a patient or colleague in face-to-face communication or behind their back. Students also felt uncomfortable when joking, laughing or disrespectful comments were made about them, fellow trainees, patients or colleagues. For example:

   > An intern that went out of their way to 'warn' the members of our team that a particular… [professional] working with us was 'an idiot'… I thought this was extremely disrespectful to the [professional], who was unaware of any of this.

   The few positive narratives (3) focused on appreciating students' input concerning the manner of communication with patients and spending time on building a mutually trustful relationship with patients.

   1.2 Manner: Being blunt or sensitive (23 narratives)

   This category included being blunt (16 narratives) or sensitive (7 narratives) by not paying or paying attention to the timing and manner of communication. The following illustrates being blunt:

   > I encountered a situation where a physician was very rude, subjective and disrespectful about telling a patient to lose weight. He patted the patient on their stomach and made a vulgar gesture about how much weight the patient needed to lose. I thought in this situation the physician was rude and the patient was hurt by the physician's remarks. This type of behavior is something that I would not incorporate in my patient care.

   Communicating the need for a health behavior change (losing weight) in an insensitive and rude manner is perceived by the writer to have two negative consequences: one for the patient, hurt feelings and one for the student, being disappointed in a role model and not wanting to incorporate the observed behavior into his or her future practice. Perhaps not so obvious is the long-term effect(s) of this kind of observed behavior on trainees' caring for patients who have a high-risk burden and need to change lifestyle behaviors. Knowing what one does not want to incorporate into one's clinical practice is one thing; experienced

repeatedly, it may compromise the student's ability to work with patients on lifestyle changes.

Communicating sensitively included raising topics such as drug abuse or loss of a patient in a humane manner. For example, a narrative described how a patient who tested positive for HIV and was concerned about confidentiality was treated by their role model who, "did a wonderful job of bringing up the possibility of HIV… and explained to the patient that we would never tell anything unless he signed a release."

1.3 Violating or maintaining privacy (17 narratives)

This category included many instances of disrespectful behavior (15/17) in which patient information or modesty were compromised or treated as sacrosanct. A positive example follows:

> I saw my attending close the curtains when interviewing a patient in the Emergency Room. I thought that this was very respectful … and was very impressed by this. This simple action of leading by example was more powerful than any lecture that one could receive on the subject.

The student describes appreciation for the sensitivity of the physician to the physical limitations of the setting and explicitly acknowledges the power of role modeling (informal/hidden curriculum) to affect behavior in a positive direction.

The negative examples in this category focused on violations of patients' privacy, including communicating bad news in a non-private setting, not asking for permission to expose private parts of the patients' body in front of students and discussing patient information in public places.

2. Conduct: various behaviors expressing (dis)respect (23 narratives)

This focus contained seven narratives focusing on respectful behaviors including, maintaining equanimity in challenging situations, acting with kindness, thinking and acting on behalf of patients and family members. Acting disrespectfully (16/23) included situations where the professional fell asleep during rounds, came in late, answered a cell phone during patient visits or wore gloves during a routine lung and heart exam.

3. Patient centeredness: honoring or discounting others' preferences, decisions and needs (21 narratives)

The majority of narratives here (15/21) were positive and focused on addressing patients' information needs and ensuring non-judgmental informed decisions. The following quote illustrates:

> … a patient [with] a difficult case of pneumonia did not want to know her diagnosis if it was lung cancer. She refused to have a CT once she realized that it might let her know. …The doctor knowing the patient would refuse treatment for cancer compromised by asking her if she would be willing to get an X-ray and he would let her know if her pneumonia had resolved without letting her know about the cancer unless she was clear… I believe the doctor did the right thing by allowing the patient to make an informed decision on her case in a situation where our training may want us to make this decision for the patient based on our training.

This narrative describes the student's recognition of ethical dilemmas that may require more than a "textbook" response. The author is impressed by the attending's willingness to act according to the patient's wishes rather out of a legal duty to inform her about test results. Other positive narratives in this category included intentionally, carefully and compassionately eliciting the patient's wishes and preferences.

Disrespectful narratives (7/21) centered on diminishing autonomy and using various linguistic devices to persuade a patient to accepting treatment:

> I have found the code status discussions I've witnessed a little unsettling. My attending regularly poses the question to patients as 'If your heart stops, do you want us to press on your chest, give you shots and put you on a breathing machine, or would you rather die in a comfortable, natural way?' Her tone of voice and choice of words clearly demonstrate which choice she is asking the patient and his family to make. In addition, at times I've not been too sure that the patient truly understands what we're talking about…

This student is concerned about the physician's manner of presentation (choice of words and tone of voice) and its effect on patient understanding and decisions. The student raises a concern about the physician's power to promote her own preferences over the patient's without checking to make sure the patient understood their choices.

4. Treating others as equals (13 narratives)

Respect is being non-judgmental toward patients, colleagues and students (8 narratives). When this is not the case (5), and a person is made fun of, especially when they are unable or incapable of speaking or acting for themselves, it is perceived by students as a lack of respect as illustrated in the following narrative:

> The patient had been given some medications to calm her down and make her relax, so she didn't know what was going on throughout the whole procedure. The attending began the procedure and started commenting on the smell and other things that the patient was doing that she had no control over. I feel that it is unacceptable for comments to be made about patients, even jokingly…

Students are particularly sensitive to the interactional tone in the operating room and in situations where patients are unable to speak or act consciously. The student emphasizes the importance of maintaining a respectful environment at all times.

Most of the positive narratives described treating stigmatized populations in a respectful manner and included an element of surprise, especially when physicians treated marginalized populations in a respectful manner (e.g., prisoners, drug addicts).

> This month our team cared for a patient who was a prisoner in the detention unit. …I was pleased to see that this patient received no different care or treatment, and was treated in a professional manner that all patients deserve… I was somewhat intimidated by the chains shackled around his ankles, but I believe that all patients deserve respect when being cared for, and my team did an excellent job at this.

In this narrative, the non-judgmental behavior of a role model produces surprise, challenges the student's initial expectations, and reinforces their humanistic beliefs.

5. Valuing or de-valuing others' experiences and/or problems (17 narratives)

Respectful narratives (6) focused on hearing and believing patients' explanations and experiences of illness. Most (13/17) took place in the educational setting and involved valuing or de-valuing students' input and personhood. The following illustrates the effect(s) of positive feedback:

> All of the students on the team really get a sense that we are a respected component of the team. Pretty much every day when we are leaving she [our resident] says "Thanks for the help today" and that makes all the difference in the world in terms of motivating us to achieve more and be content in what we are doing.

6. Nurturing students' learning (8 narratives)

Most narratives (6/8) in this focus were about creating a nurturing environment where students felt comfortable, experienced growth, asked questions and could make mistakes. Both disrespectful narratives focused on learning that was hampered by some individual(s), as seen in the following narrative:

> … I was standing outside the door looking at a piece of paper with the room assignment on it. One of the doctors inside the lab area looked at me and said "NO!" So I said "Excuse me?" He repeated himself "No. No med school students!" I told him that the room number was correct and asked if this was the '…' lab. Finally the nurse in the room looked up at me and said "Come on in. Just ignore him honey." …I was pretty disappointed. I feel that so many people take the time each day to educate a student to become a physician. I know that one day I hope to pass my experiences on to the next generation… Apparently this particular doctor did not care to create a good learning environment.

DISCUSSION

Our finding that one out of four student narratives about events that "taught them something about professionalism" was about (dis)respect suggests that students find the topic important, although relatively little scholarly attention has been focused on this concept[22]. Student narratives in our setting point to numerous characteristics of respect already extant in the literature including: autonomy[10,11], maintaining non-judgmental attitudes[2] and maintaining patient privacy[3,12]. At the same time, they broaden the concept beyond any one type of act, behavior or attitude[23]. Respect is regarded as multifaceted[15], experienced by students as a way of being that applies in all settings; crossing power and status hierarchies, but mainly exerted by physicians toward patients and students; and is relevant under all circumstances including valuing others' time, needs, experiences, preferences, choices, opinions and privacy. Students describe respect as more than a rote behavior; rather, they describe it as a deep value that guides behavior[1], even behind closed doors. They notice the way their role models communicate and focus on the importance of relationality[7] in all aspects of care and education.

In their pre-clinical years, students often assume that respect in medicine is based on norms of behavior that are expected in everyday life. When a perceived breach occurs in training, it is both noticeable and reportable[24], precisely because it contrasts with conventional expectations and values. Ironically, this phenomenon may also explain why two themes (treating others as equals and honoring preferences and decisions) contained mainly positive narratives. Based on their own negative expectations about equality and patient-centered care, they were surprised and excited to see how their role models acted in these challenging situations. Beach et al.[10] suggest that respect is a moral imperative that is every patient's right irrespective of personal characteristics. Students' narratives about respect for stigmatized populations indicate their appreciation for how respect comes to "life" in these populations.

In trying to deepen our understanding of respect and disrespect, we observed that students discerned respect in small gestures of apologizing, asking permission, and investing an effort in maintaining the right setting or manner in routine communication and behavior. By contrast, disrespect included not adhering to rules of common courtesy such as being insensitive to or violating others' (patients and students) emotional and physical needs. These behaviors often provoked strong responses, suggesting that students pay particular attention to the details of interaction in which disrespect is embedded.

Concerning this issue, our findings add new information about the perceived consequences of (dis)respect[16]. For example, disrespectful behavior was observed to lead to loss of trust, strong negative emotions and damage to relationships, whereas respectful behavior was seen as leading to increased trust, satisfaction, willingness to share information, adherence to treatment and positive emotion. Perhaps most importantly, the student narratives underscore the important role that both positive and negative role modeling can play in shaping student attitudes and behavior. The fact that students view respect as an important way of being professional suggests that we—as medical educators and role models—have an amazing opportunity to influence the next

generation of physicians by embodying respect in every clinical and educational context and interaction. The 'future health' of our health care system may depend upon our success in this endeavor.

Limitations

The narratives are from a single clerkship at one institution and may not generalize across institutions or clerkship types. All data were derived from a single source, without triangulation between methods or member checks. At the same time, intra- and inter-rater coding accuracy was maintained in both phases of the analysis.

An Educational Action Agenda

Despite the AAMC pledge that teaching faculty "…will not tolerate anyone who manifests disrespect or who expresses biased attitudes towards any student or resident," the student narratives indicate that opportunities for improvement abound. The large number of disrespectful narratives is concerning and suggests that even though they are noticed (by patients, nurses, faculty and certainly by students), they are not always dealt with or officially recognized. Using students' "fresh eyes" and observations as a basis for discussion is a novel way of developing a curriculum based on the "lived experience" of (dis)respect and can serve as a basis for deepening learning, increasing awareness, developing positive ideals, and identifying ways of handling these challenges and building community.

CONCLUSIONS

Our analysis of professionalism narratives suggests that students observe and experience mostly positive role-modeling of professionalism. The one exception is in the area of respect where disrespect among physicians and other medical professionals is frequently noted. Students in our sample perceived respect as a way of being that applies in all settings (private and public), with all participants (patients, family members, nurses, colleagues and students) and under all circumstances (valuing others' time, needs, preferences, choices, opinions and privacy). A deeper understanding of (dis)respect and its manifestations in medical training will facilitate actions that engender this attribute among both students and teachers.

Acknowledgements: *None.*

Funding: *Dr Karnieli-Miller is supported by a grant from Indiana University School of Medicine for studying and writing about professionalism.*

Conflict of Interest: *None disclosed.*

Corresponding Author: *Orit Karnieli-Miller, PhD; Department of Community Mental Health, University of Haifa, Eshcol building, room 1111, Har HaCarmel, Haifa 31905, Israel (e-mail: OritKM@gmail.com).*

REFERENCES

1. **Beach MC, Duggan PS, Cassel CK, Geller G.** What does 'respect' mean? Exploring the moral obligation of health professionals to respect patients. J Gen Intern Med. 2007;22:692–5.
2. **Wilkinson TJ, Wade WB, Knock LD.** A blueprint to assess professionalism: Results of a systematic review. Acad Med. 2009;84:551–8.
3. **Inui TS.** A flag in the wind: educating for professionalism in medicine. Washington: Association of American Medical Colleges; 2003.
4. The Accreditation Council for Graduate Medical Education. Available at: http://www.acgme.org/ Accessed July 17, 2010.
5. **Swick HM.** Toward a normative definition of medical professionalism. Acad Med. 2000;75:612–6.
6. **Emirbayer M.** Manifesto for a relational sociology. Amer J Soc. 1997;103:281–317.
7. **Reich W, Schirmer W,** editors. A theory of respect. Work in progress, a shortened version of this manuscript will be presented in the American Sociological Association conference; 2009 Aug; San Francisco. http://humiliationstudies.org/documents/SchirmerReichATheoryo%20Respect2009.pdf. Accessed July 17, 2010.
8. American Medical Association. Declaration of Professional Responsibility: Medicine's Social Contract with Humanity. 2001. Available at: http://www.ama-assn.org/ama/upload/mm/369/decofprofessional.pdf. Accessed July 17, 2010.
9. **Branch WT.** Teaching respect for patients. Acad Med. 2006;81:463–7.
10. **Beach MC, Roter DL, Wang NY, Duggan PS, Cooper LA.** Are physicians' attitudes of respect accurately perceived by patients and associated with more positive communication behaviors? PEC. 2006;62:347–54.
11. **Gillon R.** Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals". J Med Ethics. 2003;29:307–12.
12. **Ainslie DC.** 'Watching' medicine: do bioethicists respect patients' privacy? Theor Med Bioethics. 2000;21:537–52.
13. Association of American Medical Colleges. Compact Between Teachers and Learners of Medicine. Available at: http://www.med.illinois.edu/depts_programs/ClinicalAffairs/Document/Compact%20Between%20teachers%20and%20Learners%20of%20Medicine.pdf Accessed July 17, 2010.
14. **Baldwin DC Jr, Daugherty SR, Eckenfels EJ.** Student perceptions of mistreatment and harassment during medical school—A survey of ten United States schools. West J Med. 1991;155:140–5.
15. **Langdon SW.** Conceptualizations of respect: Qualitative and quantitative evidence of four (five) themes. The J Psy. 2007;141:469–84.
16. **Spagnoletti CL, Arnold RM.** R-E-S-P-E-C-T: Even more difficult to teach than to define. J Gen Intern Med. 2007;22:707–9.
17. **Sennet R.** Respect: The formation of character in an age of inequality. London: Penguin; 2003.
18. **Meitar D, Karnieli-Miller O, Eidelman S.** Personal difficulties with breaking bad news and their influence on patterns of communication. Acad Med. 2009;84:1582–94.
19. **Stern DM.** Measuring Medical Professionalism. New York: Oxford Press; 2006.
20. **Lieblich A, Tuval-Mashiach R, Zilber T.** Between the whole and its parts, between content and structure. In: **Kasan L, Kromer-Nevo M, eds.** Analyzing qualitative data. Beer-Sheva: Ben Gurion University of the Negev press; 2010:21–43.
21. **Crabtree BF, Miller WL.** Doing Qualitative Research: Research methods for primary care. Thousand Oaks, CA: Sage Publications; 1999:179–94.
22. **Shwalb DW, Shwalb BJ.** Research and theory on respect and disrespect: Catching up with the public and practitioners. New Dir Child Adolesc Dev. 2006;114:1–8.
23. **Wright EB, Holcombe C, Salmon P.** Doctors' communication of trust, care, and respect in breast cancer: Qualitative study. BMJ. 2004;328:864.
24. **Burack JH, Irby DM, Carline JD, Root RK, Larson EB.** Teaching compassion and respect: Attending physicians' responses to problematic behaviors. J Gen Intern Med. 1999;14:49–55.