

2018

Faculty to faculty incivility in Iowa nursing education programs

Candace Chihak
University of Northern Iowa

Copyright ©2018 Candace Chihak
Follow this and additional works at: <https://scholarworks.uni.edu/etd>

Let us know how access to this document benefits you

Recommended Citation

Chihak, Candace, "Faculty to faculty incivility in Iowa nursing education programs" (2018). *Electronic Theses and Dissertations*. 601.
<https://scholarworks.uni.edu/etd/601>

This Open Access Dissertation is brought to you for free and open access by the Graduate College at UNI ScholarWorks. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Copyright by
CANDACE CHIHAK MSN, RN
2018
All Rights Reserved

FACULTY TO FACULTY INCIVILITY IN
IOWA NURSING EDUCATION PROGRAMS

An Abstract of a Dissertation

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Doctor of Education

Approved:

Dr. Victoria Robinson, Committee Chair

Dr. Patrick Pease,
Interim Dean of the Graduate College

Candace Chihak

University of Northern Iowa

July 2018

ABSTRACT

Uncivil work relationships are common in several professions, including nursing. Experiences of incivility within nursing education have been well described in the relationships between students, students to faculty, and faculty to students, however, there is less empirical evidence on the presence of incivility between nursing faculty.

Purpose: The purpose of this paper is to identify the perception of incivility in faculty-to-faculty relationships in nursing education. Additionally, this paper will look for relationships between nurse educators and their intentions to stay within higher education.

Methods: Nursing faculty from one Midwest state were surveyed utilizing the Workplace Incivility Civility Survey (WICS). Additionally, they were asked about the impact incivility has had on their work performance, personal wellbeing, and intention to persist in nursing education.

Findings: The majority (81.7%) of participants indicated incivility was a problem in nursing education. While several of the uncivil behaviors were experienced or observed by less than half of participants, all 23 uncivil behaviors were experienced and observed 'often' by at least some participants during the previous 12 months. Based on demographic information, the tenured faculty identified experiencing and observing the uncivil behaviors statistically more than the non-tenured faculty. Additionally, faculty teaching in both undergraduate and graduate programs identified being impacted by uncivil behaviors more than those teaching only at the graduate level.

Conclusions: The results of this study suggest that incivility is a problem in nursing education.

FACULTY TO FACULTY INCIVILITY IN
IOWA NURSING EDUCATION PROGRAMS

A Dissertation
Submitted
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

Approved:

Dr. Victoria Robinson, Chair

Dr. Fabio Fontana, Committee Member

Dr. Denise Schares, Committee Member

Dr. Catherine Zeman, Committee Member

Candace Chihak MSN, RN

University of Northern Iowa

July 2018

TABLE OF CONTENTS

LIST OF TABLES	v
LIST OF FIGURES	vi
CHAPTER 1 INTRODUCTION	1
Background of the Problem.....	3
Nursing Shortage	3
Incivility.....	4
The Culture of Nursing Education and Nursing Faculty Incivility	7
Statement of the Problem	8
Purpose of the Study	9
Research Questions	11
Significance of the Study	11
Assumptions, Limitations, and Delimitations	12
CHAPTER 2 REVIEW OF LITERATURE.....	14
Theoretical Framework	14
Oppressed Group Behavior Theory.....	14
Oppressed Group Behavior Theory in Nursing.....	15
Review of Research.....	21
Methodological Traditions	21
Review and Critique of Literature.....	21
Incivility in Higher Education	21
Incivility in Nursing Education	23
CHAPTER 3 METHODOLOGY	27
Research Questions	27
Research Design.....	27
Population and Sample.....	28
Instrumentation.....	29
Data Collection.....	30
Data Analysis	31

Conclusion.....	31
CHAPTER 4 RESEARCH FINDINGS	32
Introduction	32
Findings	32
To what Extent is Faculty-to-Faculty Incivility Perceived to be a Problem in Nursing Education?	35
What is the Perception of Uncivil Faculty-to-Faculty Behaviors?	37
Gender	46
Years Teaching at the Institution.....	46
Title or Rank.....	48
Tenure or Non-Tenure Status	51
Education of Participant	52
Administration or Non-Administration	52
Is there a Difference in Perception between Faculty Working in Different Types of Settings?	53
Is there a Difference in Perception between Faculty Working at Different Levels of Nursing Education?.....	55
Level Taught.....	56
Common Behaviors Experienced or Observed	57
How does the Perception of Incivility Relate to Nursing Faculty’s Intentions to Persist in Nursing Education?.....	57
Gender	58
Years Taught at Institution	59
Title.....	60
Tenure or Non-Tenure.....	60
Highest Education of Participant.....	61
Administration or Non-Administration	61
ADN or BSN Taught	61
DNP or Non-DNP Taught	61
Pre- or Post-Licensure	62

Public or Private	63
Undergraduate or Graduate	63
Highest Level Taught	64
Common Impact Areas	64
Conclusion.....	65
CHAPTER 5 CONCLUSIONS, DISCUSSION, SUGGESTIONS FOR FUTURE RESEARCH.....	68
Summary of Findings	68
Conclusions	69
To what Extent is Faculty-to-Faculty Incivility Perceived to be a Problem in Nursing Education?	69
What is the Perception of Uncivil Faculty-to-Faculty Behaviors?.....	69
Is there a Difference in Perception between Faculty Working in Different Types of Settings?	74
Is there a Difference in Perception between Faculty Working at Different Levels of Nursing Education?	75
How does the Perception of Incivility Relate to Nursing Faculty's Intentions to Persist in Nursing Education?.....	76
Discussion	77
Suggestions for Future Research.....	78
Conclusion.....	79
REFERENCES	81
APPENDIX A: DEMOGRAPHIC INFORMATION AND SURVEY	86
APPENDIX B: CONSENT.....	92

LIST OF TABLES

TABLE	PAGE
1 Participant Demographics	34
2 Behaviors Considered Always or Usually Uncivil by more than 80% of Respondents	39
3 Uncivil Behaviors Experienced Often or Sometimes in previous 12 months by 30% or more of Respondents	42
4 Contributing Factors to Workplace Incivility	44
5 Strategies to Improve Workplace Civility	45
6 Tenured or Non-Tenured Significant Experienced/Observed	51
7 Administration or Non-Administration Significant Experienced/Observed.....	54
8 Behaviors Commonly Experienced/Observed by Multiple Groups	58
9 Frequency of Agreement with Impact Statements.....	59
10 Tenured or Non-Tenured Impact Areas	60
11 Impact Statements Common to Multiple Groups	64
12 Reasons for Avoiding Dealing with Incivility	65

LIST OF FIGURES

FIGURE	PAGE
2 Extent of Problem	36
2 Level of Civility	37
3 Are Behaviors Uncivil	38
4 Frequency of Behaviors Experienced	41
5 Frequency of Behaviors Observed.....	43

CHAPTER 1

INTRODUCTION

Violence and incivility have become part of the fabric of everyday life in America. Over 70% of respondents in the 2014 *Civility in America* survey agreed that incivility is resulting in more violence across the country (KRC Research, 2014, p. 11). Incivility within the workplace includes negative work environments experienced by the nursing profession (Thompson, 2015). The American Nurses Association (ANA; 2015b) published a position statement on *Incivility, Bullying, and Workplace Violence* in response to this phenomenon, calling for nurses and employers to create an environment of respect and civility. Clark (2009, p. 194) defined incivility as “rude or disruptive behaviors which often result in psychological or physiological distress for the people involved – and if left unaddressed, may progress into threatening situations.” Incivility within nursing has been identified in various healthcare settings, starting as early as in nursing educational programs.

One common feature of all nurses is a nursing education program. The experiences in nursing education can contribute to the culture of the nursing profession. A culture of incivility within nursing education can translate into new nurses continuing the culture of incivility they have learned into the nursing profession. Nursing faculty are one of the first intraprofessional groups that nursing students will learn from and observe. The culture role-modeled between nursing faculty can set the stage for the culture that nursing students will come to accept as normal behavior within their chosen profession.

A culture of incivility in the nursing education setting can set the tone for incivility within the practice of nursing (Clark, 2017). There is a plethora of research indicating the presence of a culture of incivility within the profession (Baltimore, 2006; De Villers & Cohn, 2017; Meires, 2018; Ward-Smith, 2018; Wilson, 2016), not limited to the long-established adage that ‘nurses eat their young.’ De Villers and Cohn (2017) completed a literature review on nursing incivility and identified ten research studies which all concluded that incivility was a problem within nursing practice. Therefore, an understanding of the perception of professionalism and civility present between nursing faculty is the first step to understanding and addressing the ongoing concern and the resulting consequences of incivility within the nursing profession.

Consequences of an uncivil environment within both nursing practice and nursing education include nursing burn-out, poor health consequences for the nurse, and turnover in the profession (Deery, Walsh, & Guest, 2011). The nursing profession is repeatedly, and currently, facing a nursing shortage (Glazer & Alexandre, 2008; Hinshaw, 2008; Lafer, 2005). Identifying factors that contribute to this nursing shortage has the potential to positively influence and improve the shortage. One perspective to address this nursing shortage is to address the culture of incivility within nursing education, which may impact the shortage of nursing faculty available to prepare new nurses and impact the overall nursing shortage by continuing to contribute to a negative culture which fosters a continual turnover within the profession. The first step to addressing incivility in the profession is to recognize its presence in order to implement possible solutions. The

purpose of this study is to provide a description of the perception of faculty to faculty incivility in the nursing education programs within one Midwest state.

Background of the Problem

Nursing Shortage

According to the Bureau of Labor and Statistics (2015) nursing occupations are expected to increase by 16% over the next decade, being one of the top occupations to show employment growth through 2024. The American Association of Colleges of Nursing (AACN; 2017) has projected a shortage of nurses to fulfill the increased need for nurses within the healthcare industry. There has been much dialog on the shortage of nurses within the United States, however, according to Lafer (2005), the demand for nurses is not a shortage of qualified personnel, but a shortage of qualified personnel willing to continue working within health care.

The nature of nursing can easily lead to emotional exhaustion, with nursing burnout a prime example of nurses not working in needed areas. Lafer (2005, p. 36) observed that “the stress, danger, exhaustion, and frustration that have become built into the normal daily routine of hospital nurses constitute [the] single biggest factor driving nurses out of the industry.” Incivility within the profession can compound this sense of emotional exhaustion and contribute to the unavailability of nurses to fill the healthcare needs of the nation. Erickson and Grove (2007) found that nurses who bury or cover-up their emotions instead of expressing them are more prone to burnout. Incivility contributes to nurses leaving the profession and the nursing shortage contributes to safety concerns with patients (Hinshaw, 2008). Conditions that contribute to the nursing

shortage are nurses who leave the profession and limitations in educating the number of new nurses needed, mainly due to limited number of nursing faculty to provide education (Glazer & Alexandre, 2008). AACN (2017) noted, in the 2016-2017 academic year, U.S. nursing schools did not have the capacity to meet the education needs for 64,067 qualified nursing student applicants due to limited number of faculty, as well as, limits in clinical sites, classroom space, preceptors, and budgets.

Incivility

Incivility is an ubiquitous aspect of life. The news and social media illustrate a plethora of incivility and a majority of Americans perceive a problem with the level of civility in the United States (KCR Research, 2014) with over 60% of the population indicating that incivility has reached ‘crisis’ proportions. Stanley, Martin, Michel, Welton and Nemeth (2007) found that 46% of respondents reported incivility to be “somewhat serious” to “very serious” in their work area and up to 65% reported frequent incidences of uncivil behaviors. Namie, Christensen, and Phillips (2014) surveyed 1000 U.S. adults and found that over one-fourth (27%) have experienced bullying in the workplace, while 21% have witnessed workplace bullying and 72% were aware of workplace bullying.

Zapf, Escartin, Einarsen, Hoel, and Varita (2011) identified characteristics of bullying as a victim who is harassed, offended, teased, badgered, and insulted, and perceives that they have no recourse to address. Additionally, they identified forms of bullying as verbal or physical attacks, however, bullying could also be more subtle, for example excluding or isolating someone from their peer group (Zapf et al., 2011). Similarly, Clark (2013, p 14) identified a continuum of incivility ranging from

“distracting, annoying and irritating behaviors to aggressive and potentially violent behaviors.” Examples from the lower intensity end of the spectrum include actions such as nonverbal behaviors of eye rolling to bullying or taunting and finally on the other end of the continuum physical violence and tragedy (Clark, 2013, p 14). Within nursing literature, the terms lateral or horizontal violence or incivility are used to describe the encounters along this continuum, which show similarities to the bullying behaviors described by Zapf et al. (2011). Throughout this text the term ‘incivility’ will be used to describe phenomena across the continuum. The nursing profession, while being known for its compassionate care to others, is not immune to this ubiquitous culture of incivility. The consequences of incivility in nursing, however, can impact more than the individual nurse.

Incivility within the nursing profession can impact patients. Roche, Diers, Dufield, and Catling-Paull (2010) found correlation between the incivility and adverse health events for patients, such as patient falls, medications administered late, and medication errors. Purpora and Blegan (2012) found a correlation between incidences of incivility and a decrease in peer communication. An environment of incivility can lead to fear of communicating concerns or expressing emotions; ineffective communications have been associated with medical errors and placing patient safety in jeopardy (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012; Purpora & Blegan, 2012; Stanley, Dulaney, & Nemeth 2014). Nurses, who do not communicate with their colleagues, for any reason, including fear of humiliation or irritation and annoyance with coworkers, may be less likely to seek clarification of medical orders or seek assistance when needed.

According to the American Organization of Nurse Executives (AONE; 2014) “workplace violence is an increasingly recognized safety issue in the health care community.”

Research has connected incivility to the potential for medical errors (Dehue, Bolman, Völlink, & Pouwelse 2012; Demir & Rodwell, 2012; Stanley et al., 2014), however this is just one area of consequence to the profession.

Researchers have found physical consequences for those experiencing incivility to include weight loss, fatigue, headaches, hypertension and even angina (McKenna, Smith, Poole, & Coverdale, 2003). Rucker (2008) associated incivility in the workplace with stress related illnesses such as headaches, irritability, and nausea. Ongoing physical symptoms and unrelieved stress can lead to nurses leaving their position or even leaving the profession entirely. While these physical consequences can result in nurses leaving the profession, these are not the only consequences of incivility.

McKenna et al. (2003), in a study of 584 nurses, found psychological consequences of incivility to include fear, anxiety, sadness, depression, frustration, mistrust and nervousness. Researchers also identified factors associated with incivility in the workplace including stress related symptoms: irritability, anxiety, depression and Post Traumatic Stress Disorder (Rucker, 2008; Rodríguez- Muñoz, Moreno-Jimenez, Sanz Vergel, & Garrosa Hernandez, 2010). Self-doubt, including low self-esteem and feeling devalued, inadequate, or embarrassed have also been associated with workplace incivility (Bostian-Peters, 2014).

The consequences of incivility impact the profession of nursing through low job satisfaction (Demir & Rodwell, 2012; Woodrow & Guest, 2012); increased absenteeism

(McKenna et al., 2003); depression and stress (Bostian-Peters, 2014; Demir & Rodwell, 2012; McKenna et al., 2003); and burnout and turnover (Bostian-Peters, 2014; Deery et al., 2011; Dellasega, Volpe, Edmonson, & Hopkins 2014; Demir & Rodwell, 2012; Farrell, Bobrowski, & Bobrowski, 2006; McKenna et al., 2003; Woodrow & Guest, 2012). Deery et al. (2011), found that nurses who experienced incivility from both managers and coworkers were over 11 times more likely to leave a position.

The Culture of Nursing Education and Nursing Faculty Incivility

The culture of nursing begins when nursing students launch their formal education. A norm of incivility within the nursing education program can contribute to nursing students carrying these learned behaviors into the field. Clark (2013) correlates the environment of civility with success of the student in their future practice of nursing. Research has found a culture of incivility between nursing students, students and faculty, and between nursing faculty. Lim and Bernstein (2014) indicated civility is a learned behavior. The relationship between nursing faculty is one of the first intraprofessional relationships that nursing students observe, making the civility between faculty an early example of how nurses should engage with each other.

The culture demonstrated between nursing faculty provides an early lesson to nursing students. As quoted by Maya Angelou “people will forget what you said, people will forget what you did, but people will never forget how you made them feel” (Clark, 2013, p. 92). Nursing students who witness incivility between faculty members may be more likely to feel that this is an acceptable behavior in the profession, regardless of what they are taught about acting professionally (Condon, 2015). Lim and Bernstein (2014)

and Condon (2015) noted role-modeling as critical to creating a culture of civility within the future nursing work force. Condon (2015) concluded nursing students being socialized to a culture of incivility may result in a norm from which the nursing profession may not be able to escape.

Nursing faculty must create a culture of civility within nursing education. This culture of civility needs to include relationships between students, students and faculty, and possibly most importantly between faculty themselves. The culture established during a nurse's education has the potential to influence the broader culture within the profession, therefore the culture needs to be strategically and specifically incorporated into the curriculum. Nursing education must establish a norm of civility, starting with role-modeling a culture of civility between nursing faculty.

Statement of the Problem

Incivility within nursing education can normalize an uncivil environment, which students may then take into their professional practice. Incivility within the nursing profession contributes to employee burn-out and nurses leaving the profession. Incivility within nursing education contributes to the problem of retaining high quality nursing faculty to educate the next generation of nurses. This shortage of nursing faculty compounds the problem of the national nursing shortage. A clear picture of civility within nursing education is the first step to addressing the larger concern of the nursing shortage. One starting point is to gain a clearer understanding of the perception of incivility between nursing faculty members. Clark (2013) illustrated the concern over a low level of incivility when she compared incivility to a cancerous tumor, which will

grow and spread. Clark (2013), in a discussion on the magnitude of incivility, relates a scenario in which a doctor responds to a patient who has recently completed a series of tests telling them not to worry because there are only a few malignant cells. Similarly, Dellasega et al. (2014) state that the negative behavior of only one nurse can alter the culture within the broader unit. Condon (2015, p 24) indicated that not addressing incivility would not result in the poor behavior stopping, and may in fact result in the behavior escalating. Any level of incivility impacts the profession and needs to be identified in order to appropriately address the issue, even a very few negative employees can have a great impact on the organization and the profession. As stated in the ANA Positions Statement, *Incivility, Bullying, and Workplace Violence* (2015b), it is vital to identify and acknowledge the presence of negative actions in an effort to eliminate the behaviors.

Purpose of the Study

The purpose of this study is to describe the perception of faculty to faculty incivility within nursing education programs in one Midwest state. This includes an assessment of any differences between the perceptions of incivility within different types of nursing programs: community college, private non-profit four-year, public four-year, and private for-profit programs. Nursing education programs prepare students to take the National Council Licensure Examination (NCLEX) to become a registered nurse (RN). These nursing education programs are available to students through two-year or four-year programs. However, all RN programs, whether two-year or four-year program, are preparing the students for the same high stakes examination and the same professional

role. The length of the program, however, could potentially contribute to the stress level of students and faculty resulting in different cultural norms being experienced. Faculty working in different levels of nursing education: practical nursing, associate degree registered nurse, baccalaureate, and graduate nursing programs could experience varying levels of stress. Different degree program characteristics could create a variance in the impact on the culture of the educational environment. Students in RN to BSN or Master's level programs without a clinical practice component, such as MSN in health advocacy, leadership, administration, education, or informatics, are not required to complete a high stakes examination at the end of the program, which could result in a different stress level for students and faculty. Again, this could result in a difference in the culture of the educational environment. Program characteristics that will be investigated include types of college, length of program, type of program and presence of high stakes examinations.

Finally, this assessment will attempt to identify any relationship between incivility and actions of the nurse educators. The survey will assess for a link between the workplace culture for nurse educators and their job satisfaction or potential to be absent from work. The survey will assess for any connection between the culture and the nurse educator's intention to stay within higher education. Each of these factors can contribute to the ability of educational programs to educate the number of new nursing students needed for the profession.

Research Questions

The following questions will be researched.

- 1 To what extent is faculty-to-faculty incivility perceived to be a problem in nursing education within one Midwest state?
 - a. What is the perception of uncivil faculty-to-faculty behaviors?
 - b. Is there a difference in perception between faculty working in different types of settings: two-year versus four-year programs?
 - c. Is there a difference in perception between faculty working at different levels of nursing education: practical nursing (LPN/LVN), associate degree registered nurse (ADN), baccalaureate nursing (BSN), masters (MSN, ARNP) and doctoral (DNP, PhD)?
- 2 How does the perception of incivility relate to nursing faculty's intentions to persist in nursing education?

Significance of the Study

While there are many examples of studies that discuss incivility within nursing education, the main focus has typically been to view uncivil behaviors from nursing students to faculty, faculty to nursing students, or between nursing students. There is minimal literature that describes the perception of incivility between nursing faculty members. The culture role-modeled by faculty to faculty incivility, will provide a new lens within which to consider the phenomena of incivility within the profession.

Assumptions, Limitations, and Delimitations

Limitations of the study will be the generalization of the findings to faculty in other states, sampling bias, possible low response rate, and lack of interventions to address the issue.

The assessment describes the current perception of incivility within one geographic area. Perceptions may change at any given time, under a variety of different circumstances. The instrument has previously been used to assess the perception of nursing faculty in one Northeastern state and in one national study of nurses from a variety of locations across the nation; the assessment of the perception of faculty in a Midwestern state will add to the overall knowledge in this area.

The purposive convenience sample could lead to bias, faculty who have experienced incivility may be more apt to respond, providing them an opportunity to express their frustrations. There is equal possibility that faculty may choose not to air their grievances and may minimize the incivility they have experienced to preserve the reputation of the nursing profession as being a caring, compassionate profession. While this can lead to inaccurate sense of the degree to which incivility is present, even a single incidence can lead to other instances within that group or can spread through nursing students mimicking this behavior as a norm within the profession.

While nurse educators are often supportive of nursing research, there is the possibility for a low response rate. The heavy workload of nursing educators and a sense of not having enough time to complete another task, may impact the response rate. Faculty are being surveyed early in the spring semester in an effort to contact them before

the busyness of the semester begins. Additionally, response rate may also be low related to blocked email addresses. Responses were not received from any faculty at a few colleges, calling to question if any of the faculty received the electronic request from Qualtrics. Four colleges, for a total of 70 nurse educators were not able to be reached through the Qualtrics email, therefore, an email was sent to faculty email addresses with the anonymous link to the survey. This generated 27 additional responses, while the remaining 43 may have chosen not to participate, or may not have received the email invitation either.

While this study intends to describe the perception of incivility in nursing education, it does not include interventions to address the phenomena. Interventions would be the next logical step to addressing incivility, and positively impacting the profession of nursing and the nursing shortage.

CHAPTER 2

REVIEW OF LITERATURE

Theoretical Framework

Oppressed Group Behavior Theory

The phenomena of the culture of incivility within the nursing profession has been viewed through the lens of Oppressed Group Behavior Theory (OGBT). Paulo Freire (1972) introduced the theory based on observations of South Americans who were controlled by Europeans and the impact of the control and oppression on the group. Characteristics within the oppressed group included: assimilation, marginalization, self-hatred, low self-esteem, submissive-aggressive syndrome, and horizontal violence (Matheson & Bobay, 2007). Freire (1972) explained that the root cause of oppression was related to the learned value system that the non-dominated group is inferior to the dominating culture. This belief is established through the dominant culture establishing their own value and belief system as the accepted norm for all, creating situations where the oppressed group begins to hate their own attributes, accepting that their differences are inferior and not of value. This ongoing belief of inferiority contributes to a feeling of powerlessness and a lack of cultural pride, which results in low self-esteem and low respect for themselves and others within their shared group. Members of the oppressed group find the only way to break free from their oppressed state is to assimilate, however through their assimilation to the dominant culture they become oppressors themselves. An additional feature of the oppressed group behavior is the tendency toward inward aggression and violence, related to fear and low self-esteem. The oppressed group

members are unable to express their feelings or frustration toward their oppressor, so often their aggression is expressed toward their own group (Freire, 1972).

Oppressed Group Behavior Theory in Nursing

Dubrosky (2013) related the OGBT to the nursing population, identifying how nursing fit into the different categorizations of Young's Five Faces of Oppression which included: exploitation, marginalization, cultural imperialism, powerlessness, and violence. Matheson and Bobay (2007) also identified similarities between OGBT and the nursing profession in a literature review. The five general characteristics identified within this literature review included: assimilation, marginalization, self-hatred and low self-esteem, submissive-aggressive syndrome, and horizontal violence. Characteristics of oppressed groups are compared to characteristics of nurses as a whole.

Exploitation is defined as to unfairly use someone/something for the benefit of another. Exploitation was correlated to the physician-nurse relationship, which originated with nurses being trained by physicians to assist physicians and follow physician orders. Nurses have always been expected to assimilate into the medical model. The medical model focuses on diagnosis, treatment and cure for illness, while the nursing model focuses on a patient-centered holistic care of the individual and family. Nurses are the day-to-day eyes and ears for the healthcare team, they monitor for changes and report findings to physicians in an effort to support the medical model. However, nursing is also about looking beyond the current diagnosis to address the long-term, holistic needs of each patient; assisting individuals in basic cares when they are unable to perform the tasks for themselves; and aiding them in regaining the skills needed as their health

condition changes. The profession of nursing, although it has grown through nursing-centered research and maintains a different yet parallel focus to medicine, continues to be expected to operate within the medical paradigm. The ‘invisibility of nursing work’ is noted as not being relevant or as valued as medicine: it is considered at best secondary to the medical model (Dubrosky, 2013). This leads to the nursing profession being marginalized, considered secondary to the medical field, resulting in self-hatred and low self-esteem.

Marginalization is correlated in the concept of nurse managers being unable to change the imbalance of power, even from management positions (Dubrosky, 2013). Physicians or administration are typically the decision makers in filling leadership positions, resulting therefore in selecting the nurses that will uphold the institution’s decisions rather than to push for decisions that promote nurses or the profession. Marginalization is also related to the concept of “silencing of self,” in which nurses do not advocate for themselves, sacrificing their own needs for the good of the patient or out of a need to maintain peace (DeMarco, Roberts, Norris, & McCurry, 2008). Silencing of self has been related to feelings of marginalization and minimizing self-worth, including self-hatred and low self-esteem.

Powerlessness was related to the nurse’s inability to develop and practice to their full capabilities (Dubrosky, 2013). This can be related to nurses being required to work within the nursing scope of practice which is controlled by legislation or within institutional policy and practice dictated by physicians or administration. Scope of practice, controlled by state legislation, determines what nurses are allowed to do

according to the law. This is especially relevant in advanced practice nursing, where many states do not extend the scope of practice to the full scope of knowledge and skills for which advanced practice nurses are educated.

Cultural imperialism is defined as the dominant group's culture and norms becoming the culture/norm of the oppressed group (Dubrosky, 2013). This again results from the profession of nursing primarily practicing within the domain of the medical model and is related to assimilation. Roberts (1983) noted that the oppressed group loses its own identity, conforming to the cultural norm of the dominant group, therefore losing confidence in their own ability. This results in nurses seeking approval and recognition within the medical system. Seeking professional growth may result in nurses assimilating to the medical model, taking on the values of the medical field, to push themselves up within the hierarchy. This also tends to result in internal conflict, as nurses try to better themselves potentially at the expense of their coworkers or lash out at each other when they feel powerless to express their frustration against the oppressor (Roberts, 1983).

Each of these characteristics, individually, could lead to the oppressed group feeling frustrated and feeling unable to release that frustration. This frustration leads to inward aggression and violence. Inward violence was defined as an internal conflict manifesting as violence or aggression directed at the group, just for being part of that group (Dubrosky, 2013). This violence, unchecked, gains legitimacy and becomes the norm. Violence is noted as a behavior of the oppressed toward others of their own group, also termed lateral violence, as a result of their own powerlessness and frustration resulting from being unable to express themselves toward the dominant group.

Dubrosky (2013) further states that oppressed group behavior is based on the oppressed group displaying characteristics in only one of the previous categories, however, nursing has been shown to fit into all five categories. This leads the author to the conclusion that nursing as a profession is an oppressed group and that there is a need to address these characteristics in an effort to improve the culture within the profession and the extended consequences of the impact on patient safety.

Dubrosky (2013) further cites examples in the literature that identify nursing work as going unnoticed by other groups, especially physicians, administration, and even the general public. Ask the general population what a nurse does and you will find a variety of superficial answers that stem from the idea of carrying out medical orders, with no recognition of the critical nature of nursing assessment or the holistic approach in caring for patients that embodies the nursing profession. Ask nurses and, again, there is a variety of answers, which do not provide a true, encompassing, picture of the profession. Nursing has been known for silence of self, advocating for patients, while not self-promoting the importance of nursing to the overall healthcare industry. DeMarco and Roberts (2003) noted, organizationally imposed powerlessness has resulted in nurses learning to not assert themselves individually or collectively in the workplace.

The nursing profession is often not recognized outside of the hierarchy of the medical profession. This adds to the sense of powerlessness and marginalization (DeMarco & Roberts, 2003). Similar to the findings of Dubrosky (2013), Matheson and Bobay (2007) found that nurses lack or ineffectively use power, lending to physicians and administration being a controlling body over nurses. These concepts were associated

with nursing leaders being unable to address the imbalance of power. While nurses are in midlevel management positions, they are still operating within the medical paradigm and unable to make significant changes to the nursing profession; they must still meet the expectations and demands of administration and physicians. Front-line nurses are expected to follow the procedures and rules of the dominant culture, medicine, typically without any inclusion into the decision-making process. Through these different attributes an environment of coping through lashing out at those who are not dominant over the group- their fellow nurses- has become the norm (Demarco, & Roberts, 2003; Dubrosky, 2013; Fletcher, 2006; Matheson & Bobay, 2007; Roberts, 1983; Roberts, Demarco, & Griffin, 2009).

DeMarco et al. (2008) assessed nurses utilizing the Silencing the Self Scale (STSS) and the Nurse Workplace Scale (NWS). The STSS is grounded in concepts of judging one's self by the standards and values of others, putting other's needs first, suppressing one's self to avoid conflict, and remaining within prescribed gender roles. The NWS measures oppressed group behaviors. Their conclusion was that through not expressing one's needs and always putting other's needs first, self-worth and self-esteem are minimalized, which has been linked to OBGT. Putting other's needs first and not speaking up for themselves are common characteristics within nursing (DeMarco & Roberts, 2003).

Frye, in Dybrosky (2013) compared oppression to a birdcage, in which one looks at the individual wires so closely as to miss the concept that the bird is in fact trapped by the combined wires which comprise the birdcage. Comparably the profession of nursing

is trapped, as the bird, with many outside forces as the wires of their cage. These wires, or constraints, have included the medical paradigm, employer policy and procedure, legislation and scope of practice, and expectations of the public related to media images of the profession. Each of these dictates how a nurse is allowed to perform within their state, according to individual state boards of nursing, and according to individual employers' policies and procedures.

Nurse educators may find additional wires on their cages to include the need to prepare students for high stakes testing such as the NCLEX; to meet the nursing needs in a wide variety of healthcare/community settings and employer expectations; and to be able to continually grow and adjust as healthcare continues to grow and change. Each of these can dictate what must be included within nursing education, and can result in an overload of knowledge needing to be covered in a finite amount of time. Additionally, nurse educators must continually strive to meet and maintain accreditations standards. The cumulative knowledge bases needed for nursing, also requires nursing faculty to work collaboratively across content areas, to ensure students are well prepared. Faculty not effectively collaborating can result in students receiving duplicative information at the risk of not having enough time for new content or receiving conflicting information resulting in confusion. These additional constraints can further create feelings of oppression, powerlessness, or marginalization among nursing faculty, resulting in lateral violence or faculty to faculty incivility.

Review of Research

Methodological Traditions

The methodologies previously used to assess perceptions of incivility in nursing education have been qualitative, quantitative, and mixed methods. While there is a variety of data related to incivility from student to faculty, and student to student, and even some from faculty to student, the research considering the interaction between faculty and faculty is minimal. Most research in the area of nursing faculty incivility has been conducted by very few researchers. An assessment tool has been developed to assess the degree of incivility, including testing for construct validity and reliability, but the instrument has not been extensively utilized for faculty to faculty assessment. A broader understanding of the level of incivility can provide a richer picture to the profession and potentially influence interventions to address civility.

Review and Critique of Literature

Incivility in Higher Education

Hollis (2012) conducted a mixed methods study of 401 staff from four-year colleges and universities along the East Coast. Results included 62% of the participants indicating they had been bullied or witnessed co-workers being bullied within the previous 18 months. The majority of participants were bullied or treated uncivilly by a supervisor or 'vicariously' by a subordinate of the supervisor per the supervisor's biddings. Participants, who identified as being bullied, included those with educational backgrounds ranging from two year degrees to doctorates. The bullies were typically identified as directors (22%) and tenured faculty (14%). Consequences of bullying or

other aspects of incivility, specific to higher education, included disengaged faculty and staff resulting in less effective teaching or meeting student's needs. This has been related to the need to redirect energy to defend against bullying and incivility from coworkers or administration. Hollis (2012) found an average of 3.9 hours were spent avoiding a bully instead of in productive work.

DelliFraine, McClelland, Erwin, and Wang (2014) also used mixed methods to assess bullying in healthcare administration faculty. Utilizing a stratified random selection of faculty working for institutions with membership in Associations of University Programs in Health Administration (AUPHA), they sent the survey to 250 faculty members (20% of US health administration faculty), with 134 faculty responding (53% response rate) and identifying 249 instances of bullying. The results indicated 64% of participants had experienced bullying, with an average of 2.9 instances per person. Most common bullying behaviors (71%) included: gossiping or malicious rumors, belittling remarks, ignoring contributions, or unprofessional comments. Data indicated 25% of incidents were within the previous twelve months, and 49% identified more than six offenders (mobbing). Faculty identified the culture of incivility to be 'moderately severe' (41%), or 'severe' (14%) and most perceived the bully as not intending physical harm, but perceived that the bully did intend emotional harm. The targets of bullying behavior were most commonly at the associate professor level (51%) and typically untenured (73%). No lecturers in this study identified as being targets of bullying, while 34.2% of targets identified as assistant professors and 27.6% as full professors. A

majority of those surveyed reported witnessing bullying episodes (78%), some indicating the instances had been happening for more than a year (58%).

Characteristics of higher education that may contribute to a culture of incivility include the tenure system, the notion of academic freedom, and peer review. Keashly and Neuman (2010) identified unique characteristics of academia that may contribute to the level of civility within higher educational culture. The faculty review process often utilizes subjective criteria related to scholarship and faculty contributions required for promotion and tenure. Additionally, the peer-review process incorporates colleagues evaluating each other. The tenure system, which may empower faculty who have achieved tenure to feel ‘untouchable,’ may result in using the process as a threat to junior faculty. Additionally, junior faculty may be concerned about this potential and not identify problems such as bullying or misconduct of tenured faculty. Keashly and Neuman (2010) also identified ‘competition for scarce resources’ as a source of conflict between faculty. Faculty, who may be competing for the same resources, may be in a position to use their tenure status or rank to put themselves at an advantage for resources by keeping junior faculty down.

Incivility in Nursing Education

Literature supports the idea that there is a shortage of nurses and a shortage of nursing faculty. One reason cited for the shortage is poor retention of nurses related to the environment or a culture of incivility (Hinshaw, 2008). Consequences of incivility include stress, burn-out, depression, PTSD, decreased job satisfaction, increased work absences, and resulting problems with employee retention (Rocker, 2008). Witnessing

incivility can also result in the same consequences (Rocker, 2008). Those witnessing incivility can experience stress and other health consequences as they worry about the potential for themselves to become victims. There are a variety of reasons for the shortage of nursing faculty; retirement and low wages in academic settings have also contributed to nursing faculty shortage (Hinshaw, 2001). However addressing these contributing factors, without also addressing the larger problem of an uncivil culture, will not solve the shortage problem.

While the consequences of workplace incivility are extensively noted, and the degree of incivility within the nursing profession well established, there is limited information on incivility between faculty within nursing education. The American Nurses Association (ANA) has long acknowledged the presence of an atmosphere of incivility within the nursing profession. The sixth provision in the ANA *Code of Ethics* calls for nurses to create a work environment to maintain a culture that promotes safe and high-quality health care (ANA, 2015a). Faculty incivility has been identified as a “grave and growing concern” (Clark & Springer, 2007, p. 14). Clark (2013) has identified a variety of behaviors that contribute to this culture of incivility.

Clark and Springer (2007) identified faculty challenging another faculty member’s “knowledge or credibility” and “taunts and disrespect” as the most common forms of incivility noted between faculty. Clark and Springer (2010) further identified excluding others, not communicating or poor communication skills, gossiping, resisting change, conspiring against each other, and rude nonverbal behaviors as frequently noted faculty uncivil behaviors. Additional acts of incivility of note include “overt acts of

intimidation, including bullying and putdowns, setting others up to fail, exerting superiority and rank over others, and failing to perform one's share of the workload" (Clark & Springer, 2010, p. 322). These observations were reported from both the faculty and the student perspective and included the view that nurse faculty have a responsibility to foster an environment of respect and civility (Clark & Springer, 2010). As students observe faculty behaviors and interactions, they may be prone to develop the feeling that the behavior is considered acceptable (Kuhlenschmidt & Layne, 1999). Condon (2015) predicts long-term consequences to the nursing profession if incivility in nursing education continues to go unaddressed. This phenomenon of incivility growing from nursing education cannot be adequately addressed until there is a clear picture of the issue.

The breadth of information on the degree of incivility within nursing education is limited. While several studies have identified behaviors and consequences associated with workplace incivility, and others have identified the degree of incivility between students, from faculty to students, and even from student to faculty, there has been limited assessment of faculty to faculty incivility. Clark, Olender, Kenski, and Cardoni (2013), assessed 588 faculty from 40 states investigating the degree of faculty incivility and found that 68% of respondents felt the problem of faculty to faculty incivility to be at either a moderate or severe level. Additionally, Clark and Springer (2007) assessed what behaviors were considered by faculty or students to be uncivil. This data was collected from within one public university within northwestern United States, collecting data from 32 faculty and 324 students within this one university. However, there has not been an

assessment of enough nursing faculty in varied geographic locations to provide a clear picture nationwide (Clark & Springer, 2007). More data is needed to provide a broader picture of incivility within nursing education.

CHAPTER 3
METHODOLOGY
Research Questions

The following research questions to be addressed in this study.

- 1 To what extent is faculty-to-faculty incivility perceived to be a problem in nursing education within one Midwest state?
 - a. What is the perception of uncivil faculty-to-faculty behaviors?
 - b. Is there a difference in perception between faculty working in different types of settings: two-year versus four-year programs?
 - c. Is there a difference in perception between faculty working at different levels of nursing education: practical nursing (LPN/LVN), associate degree registered nurse (ADN), baccalaureate nursing (BSN), masters (MSN, ARNP) and doctoral (DNP, PhD)?
- 2 How does the perception of incivility relate to nursing faculty's intentions to persist in nursing education?

Research Design

This comparative, quasi-experimental, quantitative study explored the perception of civility between colleagues in nursing education. Additionally, the study assessed for links between the culture and faculty's work behaviors, psychological well-being, and intention to persist in nursing education.

Population and Sample

A purposive sample was used. The research site included nursing education programs in one Midwest state. A search of the state board of nursing website was used to establish a list of all nursing programs operating within the state, this included only programs that had a face-to-face base within the state, but included programs that offer programming in face-to-face, as well as, an online format. Nursing programs within the state included public four-year, public two-year, private non-profit two-year, private non-profit four-year, and private for-profit four-year programs.

According to the board of nursing annual report for the selected Midwest state, there were fifteen public nursing education programs with associate degree in nursing (ADN) programs; two private, non-profit ADN nursing program; and one for-profit ADN program (Wienberg, 2017). Additionally, there was one public program with a bachelor of science in nursing (BSN) program, and fourteen private, non-profit BSN programs. There were sixteen non-profit RN to BSN nursing programs, one public RN to BSN program, and one for-profit RN to BSN program. Graduate programs in the state accounted for five non-profit private programs, one public program, and one for-profit online program. Faculty working full-time for the colleges were included, according to the annual report that includes 473 full-time nursing faculty (Wienberg, 2017). A total of 474 requests were sent out through Qualtrics, however, 27 of those were identified as 'failed' or 'bounced' by Qualtrics. Additionally, four groups of participants (70 individuals) resulted in no responses, calling to question if any of the respondents successfully received the survey email through Qualtrics. These groups were emailed the

anonymous link to their email address, resulting in an additional 27 surveys being completed. This also means that 43 potentially did not receive the email or survey, resulting in as few as 404 potentially receiving the request to participate. All programs were invited to participate, and included requests for faculty at each level and in each program to participate, through a purposive, convenience sample.

Instrumentation

Data was collected through the use of the Workplace Incivility/Civility Survey (WICS). The WICS instrument was modified from the Incivility in Nursing Education (INE) and Faculty-to-Faculty Incivility Survey (F-FI Survey) developed to assess faculty-to-faculty incivility within nursing education (Clark, 2008; Clark, Barbosa-Leiker, Gill, & Nguyen, 2015). Demographic questions were added to the WICS instrument. Format of the survey was a Likert scale, with response options of ‘always,’ ‘sometimes,’ ‘rarely,’ and ‘never’ used in assessing the faculty’s perception of what they considered uncivil behavior. The frequency with which faculty have experienced or witnessed these behaviors was assessed using a Likert scale of ‘often,’ ‘sometimes,’ ‘rarely,’ and ‘never.’ Permission from the instrument author was acquired to separate the experienced from the witnessed incidences within this survey, the same Likert scale was used for both sets of questions. The WICS instrument was developed through expertise, consultation with content experts, literature review, and pilot testing (Clark et al., 2013). The instrument was tested for reliability using Cronbach’s alpha (Clark et al., 2013).

An additional set of questions was added to the survey to assess for the impact of incivility on faculty intentions to persist in education, job performance, and psychological

wellbeing. These additional questions were adapted from the workplace bullying survey utilized by UMass Amherst's Campus Coalition (Workplace Bullying Survey, 2015). Validity and reliability for these additional questions were not available. Adjustments made to the UMass survey questions included substituting the term 'incivility' for 'bullying' to maintain consistency throughout the survey.

Data Collection

The nursing education programs were approached through their department chairs or program directors to gain access to the faculty. The department chairs were asked to confirm a list of faculty for their program, which was pulled from their website. Department chairs were also asked to share and promote participation in the study with the nursing faculty. Emails were sent to all nursing faculty through Qualtrics to their employee email, with description of the survey and the link to participate. Consent and participation was requested within the directions of the survey and was assumed through participants continuing through the survey. All full-time faculty teaching within the nursing programs were invited to complete the survey electronically. Adjunct clinical faculty were not included within this study, as these adjunct clinical faculty do not typically have decision making positions within the program. Institutional review board (IRB) approval was received from the overseeing doctoral program institution. Additionally, each institution, with participants being invited to participate, was provided the opportunity to complete their own IRB process.

Data Analysis

The data was analyzed to provide a description of the level of faculty to faculty incivility within nursing education, within the state. The data was analyzed using t-tests to assess for differences between groups. The null hypothesis was that there is no significant difference between nursing faculty teaching in different types of institutions in their perception of faculty-to-faculty incivility. The second null hypothesis was that there is no significant difference between nursing faculty teaching in different levels of nursing education in their perception of faculty-to-faculty incivility. ANOVA will be used to analyze the data for differences in age, gender, ethnicity, education level of faculty, type of institution, and level of nursing program. A p-value of <0.05 will indicate statistical significance.

Conclusion

This research is significant to the profession of nursing, as there is currently a shortage of nurses to fill the healthcare needs within the profession. Incivility within the nursing profession has long been acknowledged and studied, and has been identified as contributing to poor nursing retention. Nurse educators are early role models to nursing students, so it would translate that incivility between nursing faculty can impact how nursing students learn to engage with colleagues in the profession. Assessing the presence of incivility is the first step to making positive changes that will decrease incivility within nursing education, and hopefully translate to more civil behavior between future nurses.

CHAPTER 4

RESEARCH FINDINGS

Introduction

This study surveyed nurse educators from across one Midwestern state. The survey was sent out electronically to 474 participants, although 27 were undeliverable. Responses were received from 161 nurse educators, however only 133 participants had complete surveys, which were utilized for statistical analysis. This reflects a 29.7% response rate for complete surveys. Participants were asked to identify a list of 23 behaviors on a civility scale of *always uncivil*, *usually uncivil*, *sometimes uncivil*, and *never uncivil*. Then participants were asked if they had experienced each of the 23 behaviors in the previous 12 months, identifying the frequency as *often*, *sometimes*, *rarely*, or *never*. Third they identified if they had seen the 23 listed behaviors occur between nursing faculty in their organizations, within the previous 12 months, indicating their frequency of observation from *often*, *sometimes*, *rarely*, to *never*. Additional data included the participant's reasons for avoiding dealing with incivility, what they thought contributed to the incivility, strategies they thought would improve civility, and they ranked the level of incivility within their work environment. Finally, the participants were asked if they agreed or disagreed with eight statements related to how work incivility has impacted them.

Findings

The majority of participants identified as female and White/Caucasian, see all demographic data in Table 1. Due to the homogenous sample, no further statistical

analysis was completed on race differences. The length of time the participants had been teaching within their current institution ranged from 2 months to 44 years ($\bar{x} = 9.63$, $sd = 8.72$). The largest group of participants had been teaching with their current institution five years or less (42.9%). Participants included both nurse educators in administrative roles (19.7%), such as dean, department chair, and assistant department chair, and nurse educators in non-administrative positions (80.3%). The nurse educators sampled were from both two-year and four-year colleges, public and private, and for-profit and not-for-profit institutions.

Participants' responses on whether their institution was for-profit or not-for-profit was inconsistent. Participants from the same institution indicated opposing responses on this category. Responses were recoded, based on participant's institutional email address, and those without information on the participants' institution were removed from analysis for this question only. The number of participants from for-profit institutions was too small for statistical comparison.

The participating nurses represented educators teaching across the curriculum, from teaching at the LPN level all the way up to the doctorate level. Most participants taught at more than one nursing level, with a small percentage (4%) teaching in only post-licensure programs such as RN-to-BSN, MSN, or PhD programs and the majority (75%) teaching at levels preparing students for licensure, such as LPN, ADN, BSN, and ARNP. Some participants (21%) taught in both licensure preparation and post-licensure levels. Thirteen participants noted teaching in a DNP program: three of these participants teaching the DNP level only and the other ten teaching DNP in combination with other

Table 1

Participant Demographics

Participant Demographics		N(%)
Gender	Female	128 (96.2%)
	Male	4 (3.0%)
	Transgender	1 (0.08%)
Race	White/Caucasian	131 (98.5%)
	Black/African	1 (0.08%)
	American Indian/Native Alaskan	1 (0.08%)
Years teaching at current Institution	5 years or less	51 (42.9%)
	6-10 years	29 (24.4%)
	11-20 years	27 (22.7%)
	21+ years	12 (10.01%)
Title	Professor	12 (9.1%)
	Assistant Professor	40 (30.3%)
	Senior Lecturer	28 (21.2%)
	Lecturer	26 (19.7%)
	Clinical/Simulation	13 (9.8%)
Tenure Status	Tenured	44 (34.4%)
	Non-Tenured	84 (65.5%)
Administration	Administration	26 (19.7%)
	Non-administration	106 (80.3%)
Type of Institution	ADN program	65 (59.1%)
	BSN program	45 (40.9%)
	Public college/university	79 (63.7%)
	Private college/university	45 (36.3%)
Highest degree earned	BSN	5 (3.8%)
	MSN	75 (56.8%)
	Doctoral	52 (39.4%)

levels. DNP programs within the state can be either post-licensure or preparing nurses for licensure exams, and there was no way to distinguish if each individual participant's DNP program was post-licensure or preparing for licensure. To know if the stress of preparing students for high stakes examinations makes a difference in incivility, the question would have been better phrased 'do you teach in a program that prepares nurses for a national licensure exam, a program that does not prepare for licensure, or both pre- and post-licensure programs.'

To what Extent is Faculty-to-Faculty Incivility Perceived to be a Problem in Nursing Education?

The nurse educators were asked to rate the extent of the problem of incivility within their own work setting using the categories of 'no problem at all' (17.6%), 'mild problem' (42%), 'moderate problem' (19.8%), 'serious problem' (19.8%), or 'don't know' (0.8%). The majority of the participants reported that incivility in their work environment was at least a mild problem (81.7%). The results for the current group of nurse educators show the serious and moderate problem responses were less than previous groups and the mild to no problem were higher, see Figure 1.

The participants were also asked to rank the civility of their work environment on a 100-point scale: zero being no civility at all and 100 being complete civility, see Figure 2. Participants used the whole range of the scale with one nurse ranking their work environment 'completely uncivil' and one nurse ranking their work environment 'completely civil.' Participants (32.5%) ranked their environment in the lower half of the scale, a score of 50 or less, while 67.5% ranked their work environment in the upper half

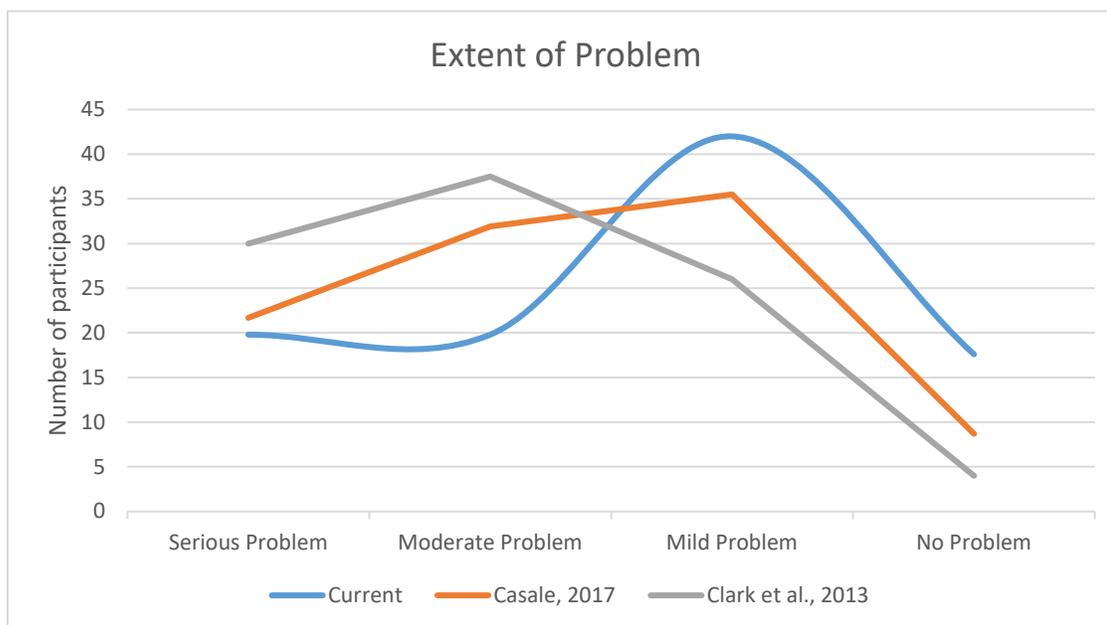


Figure 1. Extent of Problem

of the scale, scores of over 50. The median score for ranking on the 100-point scale was 80. Most of the participants indicated their work environment was mostly civil, while also indicating incivility was a problem within their institution, leading to the question of what level of incivility is considered tolerable or acceptable within nursing education, and when does incivility become a 'problem.' Approximately 61% of the participants felt confident in their ability to address the issue of incivility, while a large proportion of the participants did not feel confident in their ability to handle work environment incivility (minimally confident-31.8% and no confidence- 6.8%).



Figure 2. Level of Civility

What is the Perception of Uncivil Faculty-to-Faculty Behaviors?

The nurse educators were asked to rank a list of 23 behaviors on a civility scale of always uncivil, usually uncivil, sometimes uncivil, and never uncivil. The majority (96.3%) of participants identified each of the behaviors in one of the three levels indicating the behaviors were sometimes, if not always, uncivil, see Figure 3.

The median score for each individual behavior was 1.0, except for 'engaging in secretive meetings' with a median of 2.0. A score of one would indicate the behavior is 'always' uncivil, while the score of two would indicate it is 'usually' uncivil. Less than 10% of participants identified any individual behavior as 'never' uncivil or as a 4.0.

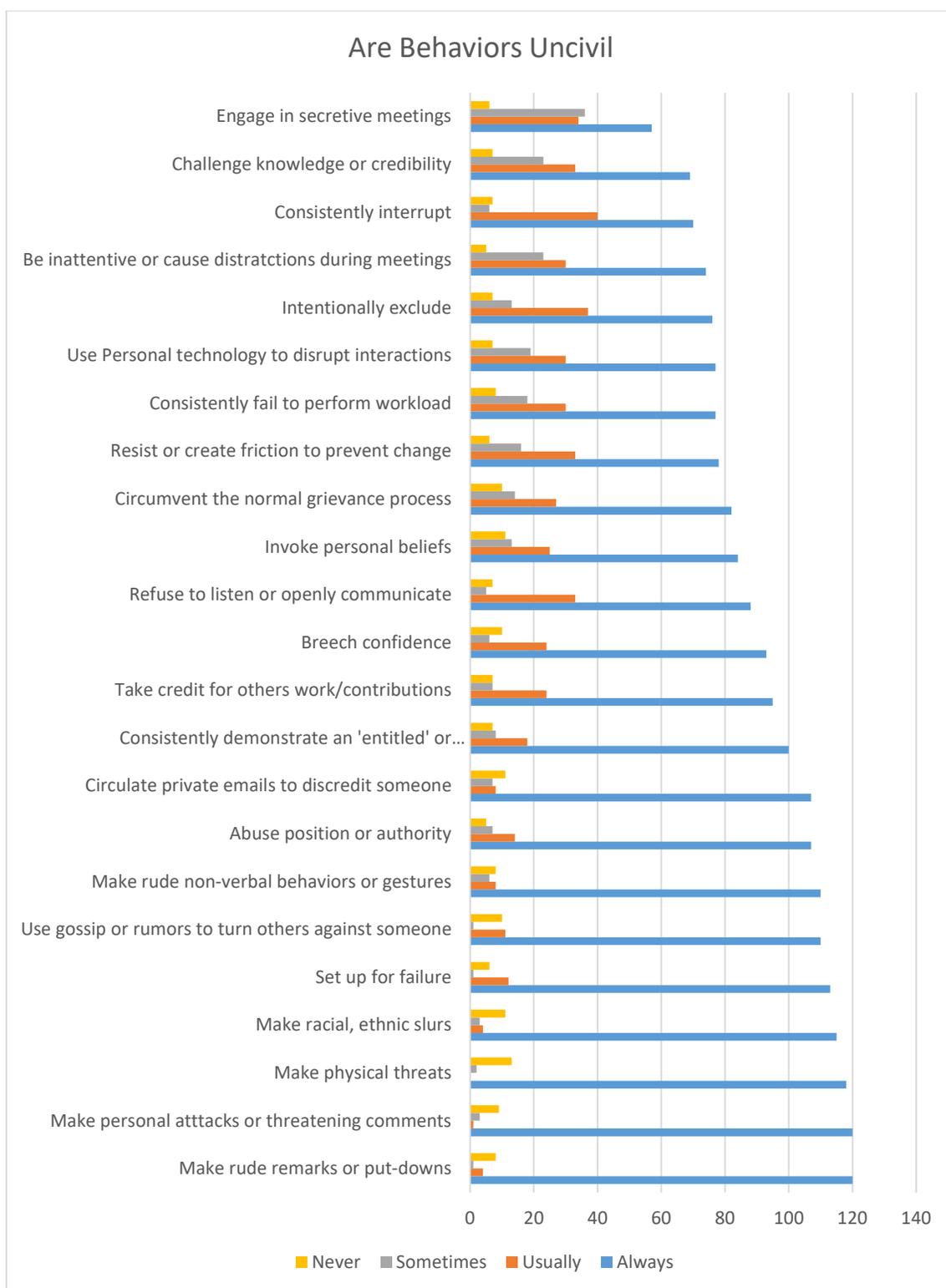


Figure 3. Are Behaviors Uncivil

The behavior identified by the most participants (95.9%) as being uncivil, always, usually or sometimes, was ‘consistently demonstrate an ‘entitled’ or ‘narcissistic’ attitude toward you or a co-worker.’ This ‘entitled or narcissistic’ behavior was not experienced most frequently (61%) nor observed most frequently (68.5%) by participants. The behavior most frequently experienced (83.1%) and most frequently observed (86.8%) by participants was ‘being inattentive or cause distractions during meetings.’ Surprisingly,

Table 2

Behaviors Considered Always or Usually Uncivil by more than 80% of Respondents (N=133)

Behavior	No. (%) of respondents Always or Usually
Setting someone up to fail	125 (94.7%)
Make rude remarks, put-downs, or name-calling	123 (93.2%)
Use gossip or rumors to turn others against you or a co-worker	120 (91.6%)
Refuse to listen or communicate on work issues*	120 (90.9%)
Personal attacks or threatening comments*	120 (90.9%)
Abuses position or authority*	120 (90.9%)
Take credit for work/contributions of others	118 (89.4%)
Make racial, ethnic, sexual, gender, or religious slurs	118 (89.4%)
Make rude non-verbal behaviors or gestures*	117 (89.3%)
Make physical threats*	117 (88.6%)
Consistently demonstrate an ‘entitled’ or ‘narcissistic’ attitude	117 (88.6%)
Breach a confidence	116 (87.9%)
Circulate private emails, without knowledge or permission (to discredit)	114 (86.4%)
Intentionally exclude or leave people out of activities	112 (84.8%)
Resist or create friction to prevent changes from occurring in the workplace	110 (83.3%)
Consistently interrupt	109 (82.6%)
Circumvent the normal grievance process	108 (81.8%)
Invoke personal religious/political values/beliefs to impose a specific outcome	108 (81.8%)
Use personal technology in a way that disrupts and/or interrupts interactions	106 (80.3%)
Consistently fail to perform their share of the workload	106 (80.3%)

* Values vary due to missing responses

'making physical threats' had the lowest percentage (90.2%) of participants agreeing that the behavior was uncivil-always, usually or sometimes. 'Making physical threats' was also the least experienced-always, usually or sometimes- (11.4%) and least observed-always, usually or sometimes- (12.9%) by participants. The range of responses, for each behavior indicating that behavior was uncivil at some level, was 90.2% to 96.2%. The behaviors identified, by over 80% of the participants, as being uncivil are noted in Table 2.

Participants were asked if they had *experienced* each of the behaviors in the previous 12 months, identifying the frequency as *often, sometimes, rarely or never*. The majority (77.3%) of participants identified that they had experienced at least some of the behaviors at some point within the previous 12 months, see Figure 4. Nine of the behaviors were reported as experienced *often* or *sometimes* by over 30% of the respondents are show in Table 3.

Additionally, the participants identified if they had *observed* the listed behaviors occur between nursing faculty in their organizations, within the previous 12 months, indicating their frequency of observation from *often, sometimes, rarely, or never*. The majority (97.7%) indicated they had observed behaviors occurring between their co-workers within the previous 12 months, see Figure 5. Fifteen of the behaviors (65%) were observed *often* or *sometimes* by at least 30% of the respondents are show in Table 3.

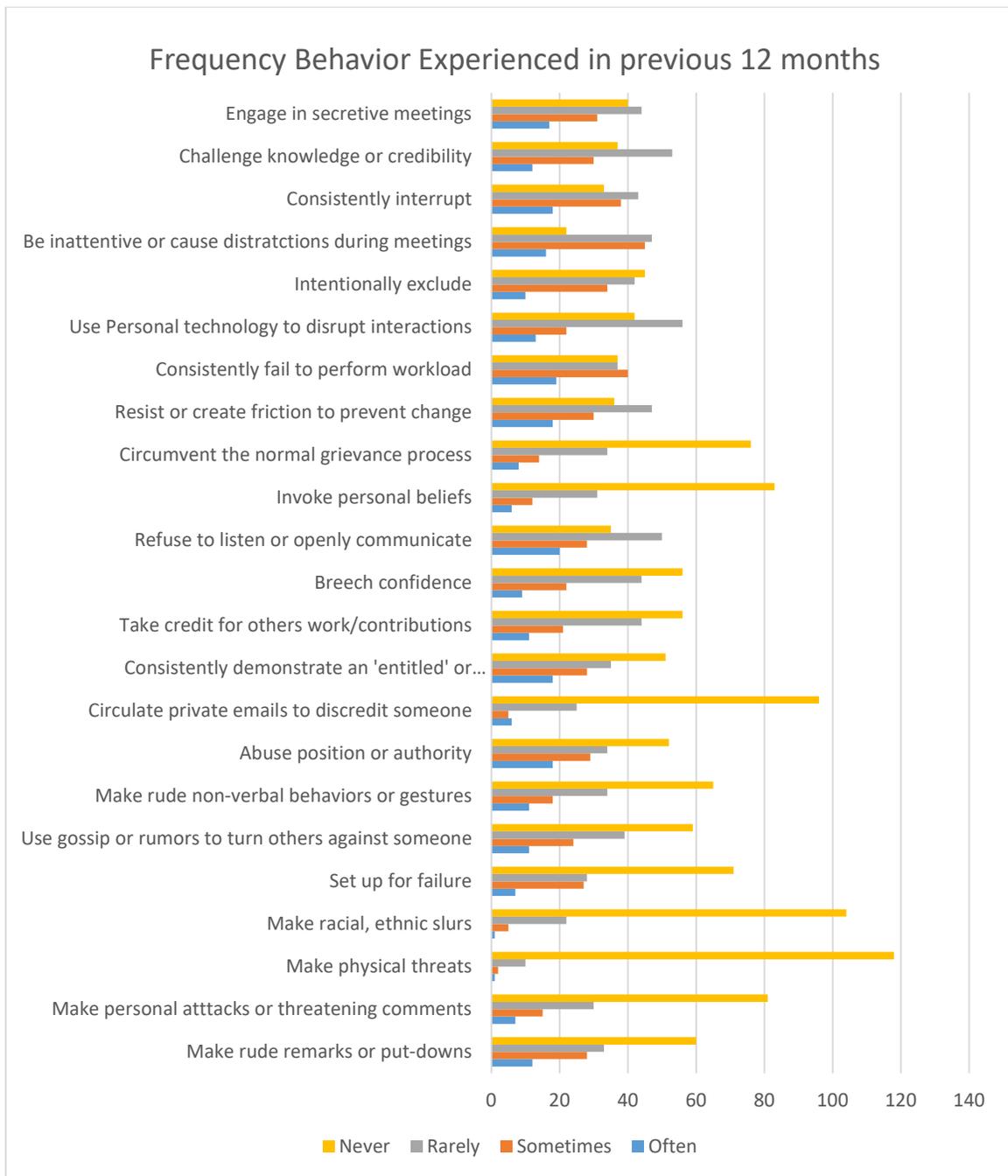


Figure 4. Frequency of Behaviors Experienced

Table 3

Uncivil Behaviors Experienced Often or Sometimes in previous 12 months by 30% or more of Respondents (N=133)

Behaviors	No. (%) of Respondents indicating Often or Sometimes
Be inattentive or cause distractions during meetings	60 (46.5%)
Consistently fail to perform their share of the workload	58 (43.9%)
Consistently interrupt*	55 (42%)
Resist or create friction to prevent changes from occurring in the workplace*	48 (36.9%)
Engage in secretive meetings behind closed doors*	48 (36.6%)
Refuses to listen or openly communicate on work related issues	48 (36.4%)
Consistently demonstrate an 'entitled' or 'narcissistic' attitude *	45 (34.4%)
Intentionally exclude or leave someone out of activities*	44 (33.8%)
Challenge your or a co-worker's knowledge or credibility	42 (32.1%)
Uncivil Behaviors Observed Often or Sometimes in previous 12 months by 30% or more of Respondents (N=133)	
Be inattentive or cause distractions during meetings*	72 (55.8%)
Consistently fail to perform their share of the workload	70 (53%)
Consistently interrupt*	60 (46.2%)
Engage in secretive meetings behind closed doors*	60 (46.2%)
Abuses position or authority*	59 (45%)
Intentionally exclude or leave someone out of activities*	56 (43.1%)
Resist or create frictions to prevent changes from occurring	54 (41.5%)
Refuses to listen or openly communicate on work related issues	52 (39.4%)
Make rude remarks, put-downs, or name-calling*	52 (39.7%)
Consistently demonstrate an 'entitled' or 'narcissistic' attitude	49 (37.7%)
Challenge you or a co-worker's knowledge or credibility*	46 (35.4%)
Setting someone up to fail*	46 (35.1%)
Use personal technology in a way that disrupts and/or interrupts interactions	43 (32.6%)
Use gossip or rumors to turn others against someone*	40 (30.8%)
Breach a confidence*	39 (30%)

* Values vary due to missing responses

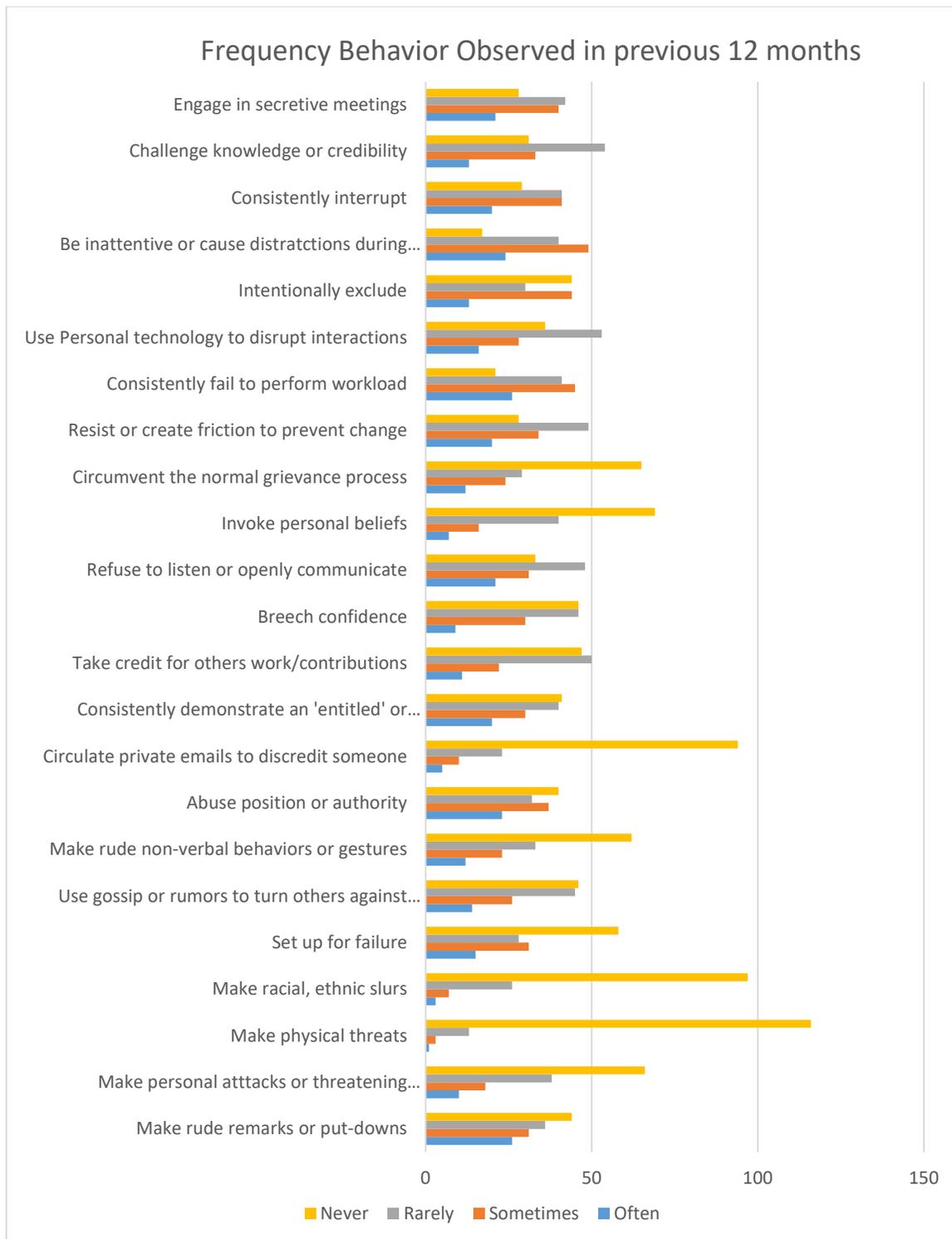


Figure 5. Frequency of Behaviors Observed

While some of the behaviors were never experienced or observed by a number of the participants, all of the behaviors were experienced and observed by some of the participants in the previous 12 months. Additionally, the majority of participants indicated that each of the 23 behaviors was considered uncivil at some level.

The participants were also asked to select what they felt contributed to incivility within the work environment. The top three contributing factors included: stress demanding workloads, and a sense of entitlement and superiority, see Table 4. Other contributing factors identified by participants included the lack of consequences and the behaviors becoming the norm/accepted and not having a clear policy to address workplace incivility.

Table 4

Contributing Factors to Workplace Incivility

Contributing Factors to workplace incivility	Number of participants selecting
Stress	93
Demanding workloads	90
Sense of entitlement and superiority	85
Juggling multiple roles and responsibilities	84
Unclear roles and expectations/imbalance of power	82
Organizational conditions/volatility/stressful	75
Lack of knowledge and skills in managing conflict	70
Inadequate resources (financial, human, informational...)	56
Technology overload/changes	34

Participants also selected the top three strategies they felt would improve workplace civility. Role-modeling professionalism and civility, establishing codes of conduct that define acceptable and unacceptable behaviors, and taking personal responsibility and standing accountable for actions were identified as the top three strategies to improve incivility, see Table 5.

Table 5

Strategies to Improve Workplace Civility

Strategies to improve workplace Civility	Number of participant s selecting
Role-model professionalism and civility	83
Establish codes of conduct that define acceptable and unacceptable behaviors	57
Take personal responsibility and stand accountable for actions	49
Provide training for effective communication and conflict negotiation	37
Integrate civility and collegiality into performance evaluations	34
Implement strategies for stress reduction and self-care	34
Raise awareness, invest in civility/incivility education	30
Reward civility and professionalism	30
and implement comprehensive policies and procedures to address incivility	18
Use empirical tools to measure incivility/civility and address areas of strength/growth	10

Gender

There was minimal diversity of race or gender for this group of participants. Analysis was completed assessing for differences based on gender. Statistically significant differences in mean scores were noted for participants experiencing and observing the behavior ‘engaging in secretive meetings.’ The 126 female participants identifying experiencing ($\bar{x} = 2.79$, $sd = 1.03$) the behavior more frequently than the four male participants ($\bar{x} = 3.0$, $sd = 0.00$), ($t = -2.249$, $df = 125$, $p = 0.026$). Additionally, the female participants ($\bar{x} = 3.82$, $sd = 0.489$) observed physical threats more frequently than male participants ($\bar{x} = 4.0$, $sd = 0.00$), ($t = -0.705$, $df = 129$, $p = 0.00$).

Years Teaching at the Institution

Analysis of variance (ANOVA) was used to analyze differences in perception based on the length of time the participants had been teaching at their current institution. Participants were categorized based on criteria of teaching at the institution five years or less (50), six to ten years (30), 11-20 years (27), or over 20 years (12). Statistically significant differences in the mean scores were noted in three areas for *experiencing* behaviors and four areas for *observing* behaviors.

Resist Changes in the Workplace. There were significant differences in the report of experiencing ‘resist or create friction to prevent changes from occurring in the workplace’ related to how long the nurse educators had been at their current institution ($F_{3, 113} = 3.137$, $p = 0.028$). Tukey post-hoc indicated that nurse educators teaching at their institution 11-20 years ($\bar{x} = 2.3$, $sd = 0.97$) more frequently experienced resistance to

change than nurse educators teaching at their institution 5 years or less ($\bar{x} = 2.96$, $sd = 0.988$, $p = .037$).

Consistently Interrupting. There were significant differences in the report of experiencing ‘consistently interrupting’ considering how long the participant had worked at their current institution ($F_{3, 114} = 2.684$, $p = 0.050$). Tukey post-hoc indicated that nurse educators teaching at their institution 11-20 years ($\bar{x} = 2.3$, $sd = 1.01$) more frequently experienced interrupting behaviors than nurse educators teaching at their institution 5 years or less ($\bar{x} = 2.94$, $sd = 0.967$, $p = 0.039$).

Taking Credit. There were significant differences, based on length of time within their institution, in the report of experiencing ($F_{3, 114} = 2.796$, $p = 0.043$) and observing ($F_{3, 113} = 3.228$, $p = 0.025$) ‘taking credit for work or contributions of others.’ Tukey post-hoc indicated that nurse educators teaching at their institution 11-20 years ($\bar{x} = 2.69$, $sd = 1.12$) experienced others taking credit more frequently than those teaching 5 years or less ($\bar{x} = 3.33$, $sd = 0.864$, $p = 0.03$) and the nurse educators teaching 11-20 years ($\bar{x} = 2.65$, $sd = 1.164$) observed others taking credit more frequently than those teaching 5 years or less ($\bar{x} = 3.28$, $sd = 0.809$, $p = 0.026$).

Use Technology to Disrupt or Interrupt Interactions. There were significant differences reported for observing ‘use technology in a way that disrupts and/or interrupts interactions,’ considering length of time teaching within their current institution, ($F_{3, 115} = 3.308$, $p = 0.023$). Tukey post-hoc indicated participants teaching 21 plus years ($\bar{x} = 2.33$, $sd = 0.887$) more frequently observed disruptive use of technology than those teaching 5 years or less ($\bar{x} = 3.11$, $sd = 0.791$, $p = 0.045$).

Breach of Confidence. Finally, there were significant differences reported for observing ‘breach of confidence’ considering length of time teaching within their current institution ($F_{3, 113} = 4.626, p=0.039$ and $p=0.004$). Tukey post-hoc indicated the participants teaching 11-20 years ($\bar{x} = 2.74, sd = 1.02$) observed ‘breach of confidence’ more frequently than participants teaching 5 or less years ($\bar{x} = 3.3, sd = 0.762, p = 0.039$), and the participants teaching more than 21 years ($\bar{x} = 2.41, sd = 0.514$) observed ‘breach of confidence’ more frequently than participants teaching five years or less ($\bar{x} = 3.3, sd = 0.762, p = 0.010$).

No other statistically significant differences were noted for experiencing or observing any of the 23 behaviors, based on years teaching within their current institution.

Title or Rank

Statistically significant differences were noted in *experiencing* five behaviors and in *observing* four behaviors based on the participants’ faculty rank or title. Most commonly the differences were noted between the ranks of senior lecturer and clinical/simulation faculty.

Consistently Interrupting. There were significant differences, considering title or rank, in the report of experiencing ($F_{3, 113} = 3.281, p = 0.014$) and observing ‘consistently interrupting’ ($F_{4, 112} = 2.992, p = 0.022$). Tukey post-hoc indicated that the 27 senior lecturers ($\bar{x} = 2.14, sd = 1.06$) experienced ‘consistently interrupting’ more frequently than the 26 lecturers ($\bar{x} = 2.88, sd = 0.99, p = 0.048$) and more frequently than the 13 clinical/simulation faculty ($\bar{x} = 3.07, sd = 0.759, p = 0.04$). Additionally, Tukey

post-hoc indicated the senior lecturers ($\bar{x} = 2.10$, $sd = 1.065$) observed ‘consistently interrupting’ more frequently than the lecturers ($\bar{x} = 2.84$, $sd = 0.967$, $p = 0.045$).

Refuse to Listen or Communicate. There were significant differences, considering title or rank, in the report of experiencing ($F_{3, 114} = 4.193$, $p = 0.003$) and observing ($F_{4, 114} = 3.495$, $p = 0.010$) ‘refusing to listen or openly communicate.’ Tukey post-hoc indicated that the 28 senior lecturers ($\bar{x} = 2.32$, $sd = 0.862$) experienced ‘refusing to listen or communicate openly related to work’ more frequently than the 13 clinical/simulation faculty ($\bar{x}=3.61$, $sd=0.506$, $p = 0.001$), additionally the 26 lecturers ($\bar{x} = 2.69$, $sd = 1.08$) experienced this behavior more frequently than the 13 clinical/simulation faculty ($\bar{x} = 3.61$, $sd = 0.506$, $p = 0.043$). Additionally, Tukey post-hoc indicated the senior lectures ($\bar{x} = 2.25$, $sd = 0.844$) more frequently observed ‘refuse to listen or communicate’ than by the clinical/simulation faculty ($\bar{x} = 3.46$, $sd = 0.66$, $p = 0.003$).

Resist changes in the workplace. There were significant differences in the report of experiencing ‘resist or create friction to prevent changes from occurring in the workplace’ considering participant’s rank or title ($F_{3, 112} = 2.899$, $p = 0.025$). Tukey post-hoc indicated that the 27 senior lecturers ($\bar{x} = 2.4$, $sd = 0.971$) experienced ‘resist or create friction to prevent change’ more frequently than the 13 clinical/simulation faculty ($\bar{x} = 3.38$, $sd = 0.767$, $p=0.032$).

Being Inattentive or Causing Distractions during Meetings. There were significant differences in the report of experiencing ‘being inattentive or causing distractions during meetings’ considering participant’s rank or title ($F_{4, 112} = 5.309$, $p = 0.001$) and for observing the behavior ($F_{4, 112} = 3.346$, $p = 0.013$). Tukey post-hoc

indicated the 28 senior lecturers ($\bar{x} = 2.03$, $sd = 0.744$) experienced ‘being inattentive or causing distractions during meetings’ more frequently than the 25 lecturers ($\bar{x} = 2.72$, $sd = 1.10$, $p = 0.032$), more frequently than the 39 assistant professors ($\bar{x} = 2.082$, $sd = 0.72$, $p = 0.003$), and more frequently than the 13 clinical/simulation faculty ($\bar{x} = 3.15$, $sd = 0.800$, $p = 0.001$). Additionally, the 28 senior lecturers ($\bar{x} = 1.89$, $sd = 0.685$) observed ‘being inattentive or causing distractions during meetings’ more frequently than assistant professors ($\bar{x} = 2.53$, $sd = 0.913$, $p = 0.037$), and more frequently than clinical/simulation faculty ($\bar{x} = 2.84$, $sd = 0.688$, $p = 0.018$).

Racial, Ethnic, Sexual, Gender, or Religious Slurs. There were significant differences in the report of observing ‘slurs’ considering participant’s rank or title ($F_{4, 114} = 2.66$, $p = 0.036$) Tukey post-hoc indicated the 26 lecturers ($\bar{x} = 3.26$, $sd = 1.0$) observed ‘slurs’ more frequently than the 40 assistant professors ($\bar{x} = 3.8$, $sd = 0.516$, $p = 0.02$).

Use Personal Technology that Disrupts or Interrupts Interactions. There were significant differences in the report of observing ‘use personal technology in a way that disrupts or interrupts interactions’ considering participant’s rank or title ($F_{4, 114} = 3.313$, $p = 0.013$). Tukey post-hoc indicated the 28 senior lecturers ($\bar{x} = 2.25$, $sd = 0.844$) observed the ‘use of technology to disrupt or interrupt’ more frequently than the 40 assistant professors ($\bar{x} = 3.07$, $sd = 0.764$, $p = 0.010$).

No other statistically significant differences were noted for experiencing or observing any of the 23 behaviors, based on participants rank or title.

Tenure or Non-Tenure Status

Data was analyzed using *t*-tests to assess for differences between the participants who were tenured or non-tenured and their responses to the 23 behaviors. Seven different behaviors were noted to have statistically significant differences in their mean scores, for experiencing the behaviors, and for observing two of the behaviors, see Table 6. The tenured faculty consistently noting more frequent experiences and observation of the uncivil behaviors than the non-tenured faculty.

Table 6

Tenured or Non-Tenured Significant Experienced/Observed

Behavior	Tenured		Non-tenured	
<i>Experienced</i>	<i>N</i>	<i>M(SD)</i>	<i>N</i>	<i>M(SD)</i>
Personal attacks or threatening comments	44	3.13 (1.002)	84	3.5 (0.814)
Rude remarks, put-downs, or name-calling	44	2.68 (1.15)	84	3.29 (0.875)
Resist or create friction to prevent changes	43	2.48 (1.032)	83	2.95 (0.961)
Take credit for work/contributions of others	44	2.79 (1.047)	83	3.3 (0.822)
Challenge knowledge or credibility	44	2.65 (1.01)	84	3.01 (0.843)
Consistently demonstrating an 'entitled' or 'narcissistic' attitude	44	2.613 (1.01)	83	3.07 (1.079)
Rude non-verbal behaviors or gestures	44	2.97 (1.109)	80	3.33 (0.885)
<i>Observed</i>	<i>N</i>	<i>M(SD)</i>	<i>N</i>	<i>M(SD)</i>
Rude remarks, put-downs, or name-calling	44	2.5 (1.1)	83	2.97 (1.02)
Take credit for work/contributions of others	43	2.72 (1.07)	82	3.19 (0.807)

P < 0.05
M of 1 indicates response of 'Often' experiencing/observing the behavior,
M of 4 indicates response of 'Never' experiencing/or observing the behavior

No statistically significant differences were noted in any of the other criteria for *experiencing* or *observing* the behaviors for participants considering their tenure status.

Education of Participant

The data was also analyzed considering the highest level of education the participant had completed. The population of BSN nurse educators (5) was small, compared to the MSN (72) and the doctorate (51) educated participants. Significant differences were noted between the MSN prepared nurse educators and the doctorate prepared nurse educators, with the doctorate prepared nurses more frequently experiencing or observing incivility.

There were significant differences, based on education of participants, in the report of experiencing ($F_{2, 128} = 3.998, p = 0.021$) and observing ($F_{2, 127} = 3.776, p = 0.026$) 'consistently interrupting.' Tukey post-hoc indicated that the doctorate nurse educators ($\bar{x} = 2.4, sd = 1.06$) experienced interrupting more frequently than MSN nurse educators ($\bar{x} = 2.9, sd = 0.921, p = 0.015$). Additionally, the doctorate nurse educators ($\bar{x}=2.3, sd=1.026$) observed 'consistently interrupting' more frequently than the MSN nurse educators ($\bar{x}=2.8, sd=0.952, p = 0.021$).

No statistically significant differences were noted for experiencing or observing any of the other behavior based on the participants highest level of education.

Administration or Non-Administration

Statistically significant differences were noted between nurse educators in administrative roles and those non-administrative roles. The nurses in administrative

roles more frequently experienced and observed uncivil behaviors than the non-administrators in six areas, see Table 7.

No statistically significant differences were noted for experiencing or observing any of the other behavior based on their administrative status.

Is there a Difference in Perception between Faculty Working in Different Types of Settings?

Analysis using *t*-tests were performed to assess for differences in perceptions between faculty working in different types of educational settings, including two- versus four-year nursing programs and public or private institutions. Assessing those working in two-year versus four-year programs was challenging, as some participants teaching in BSN programs, indicated they taught in two-year programs. This could be a result of the participants considering that they teach in an upper division system, where students complete two years of pre-requisites and general education courses, with the final two years covering only nursing courses. The nursing faculty teach only the nursing courses. Therefore, results were recoded according to if the degree earned by the students was a two-year degree (ADN) or a four-year degree (BSN), and only data for which a determination could be made as to which college the participant was from were utilized in this assessment. There were no statistically significant differences noted in experiencing or observing any of the criteria based on whether the participant taught in an ADN or a BSN program. To determine if the length of time, two or four years, to prepare the students for their national licensure examination has an impact on the perception of incivility, the demographic question would have been better phrased 'do you teach

students preparing for their ADN or BSN degree,' as these two degrees are not typically taught within the same institutions.

Table 7

Administration or Non-Administration Significant Experienced/Observed

Behavior	Administration		Non-administration	
	<i>N</i>	<i>M(SD)</i>	<i>N</i>	<i>M(SD)</i>
<i>Experienced</i>				
Personal attacks or threatening comments	26	3.07 (1.055)	106	3.46 (0.83)
Use personal technology in a way that disrupts and/or interrupts interactions	26	2.61 (1.022)	106	3.05 (0.881)
Inattentiveness or causing distractions during meetings	25	2.2 (0.816)	104	2.68 (0.905)
<i>Observed</i>				
Use personal technology in a way that disrupts and/or interrupts interactions	26	2.5 (0.989)	106	2.91 (0.937)
Failure to perform workload	26	2.07 (0.934)	106	2.51 (0.978)
Consistently interrupt	26	2.26 (1.00)	104	2.70 (0.974)
Breach of confidence	25	2.64 (0.994)	105	3.06 (0.901)

$P < 0.05$

M of 1 indicates response of 'Often' experiencing/observing the behavior,

M of 4 indicates response of 'Never' experiencing/or observing the behavior

Comparing educators teaching in public and private institutions, statistically significant differences were noted for observing 'racial, ethnic, sexual, gender, or religious slurs about anyone.' The 45 participants teaching in private institutions ($\bar{x} =$

3.42, $sd = 0.89$) identified observing the behavior more frequently than the 79 participants teaching in public institutions ($\bar{x} = 3.72$, $sd = 0.55$), ($t = 2.039$, $df = 63.688$, $p = 0.046$). No statistically significant differences were found in any of the other 23 behaviors for experiencing or observing, based on teaching in public versus private institutions.

Is there a Difference in Perception between Faculty Working at Different Levels of Nursing Education?

The difference in faculty, based on the level they teach, was difficult to assess as most of the nursing faculty identify teaching at multiple levels. The various levels of nursing education were separated who teach post-licensure, such as RN to BSN, MSN, and PhD. The population that identified teaching in the programs considered post-licensure was very small, compared to those teaching in programs which are licensure preparation. Additionally, the DNP degree has the potential to be either licensure preparation or not, and could not be considered in either pre- or post- licensure group. A nurse can earn a DNP in leadership or education, which would be post-licensure programs, or a nurse can earn a DNP in a clinical focus, which would result in preparing for licensure examination. To determine if preparing students for licensure examination impacted the perception of incivility, this question would have been better phrased by specifically asking if the participants teach in licensure preparation programs, post-licensure programs, or teaching in both types of programs. Data analysis was completed through several different categorizations based on level taught.

Level Taught

DNP or No DNP. Participants were compared based on if they taught in a DNP program, alone or in combination with any other level, or if they did not teach any DNP students. No statistically significant differences were found when comparing participants based on if they taught DNP students or not, for experiencing or observing any of the 23 behaviors.

Pre- or Post- Licensure. Data was analyzed using *ANOVA* for comparison between the 91 teaching pre-licensure, the 4 teaching post-licensure levels, and the 26 teaching in both, with responses from faculty teaching in DNP programs removed from calculations for this analysis only. No statistically significant differences were noted for experiencing or observing in any of the 23 behaviors, based on teaching in pre-licensure, post-licensure, or both types of programs.

Undergraduate or Graduate. This group was also analyzed considering whether the level they taught was in an undergraduate (LPN, ADN, BSN, or RN to BSN) program, in a graduate level (MSN, ARNP, DNP, or PhD) program, or both types of program (undergraduate and graduate). Analysis of variance (*ANOVA*) noted no statistically significant differences in experiencing or observing any of the criteria for the groupings of teaching in the graduate level, undergraduate level or teaching in both levels.

Highest Level Taught. Analysis of variance (ANOVA) procedures were used to determine whether differences existed between participants based on their indicated highest level of students they taught: LPN, ADN, BSN, Masters or Doctorate. There were no other statistically significant differences noted for experiencing or observing any of the criteria based on highest level taught by participants.

Common Behaviors Experienced or Observed

Statistically significant differences were noted across multiple demographic groupings of participants for the uncivil behaviors, including experiencing behaviors of: ‘interrupting,’ ‘inattentiveness or causing distractions during meetings,’ ‘resisting or creating friction to prevent change,’ and ‘taking credit.’ Also noted across groups were observing behaviors of: ‘interrupting,’ ‘taking credit,’ ‘racial, ethnic, sexual, gender, or religious slurs,’ ‘using technology to disrupt,’ and ‘breaching confidence,’ see Table 8.

How does the Perception of Incivility Relate to Nursing Faculty’s Intentions to Persist in Nursing Education?

The participants were asked about impacted of work incivility and their personal wellbeing and work performance. Participants responded to each statement with: ‘strongly agree,’ ‘agree,’ ‘neutral,’ ‘disagree,’ or ‘strongly disagree’ for eight behaviors, see Table 9. When considering the impact of incivility on their work performance over half reported the incivility having a ‘negative impact on their work performance’ (54.3%), being ‘less satisfied with their job’ (59.4%), and the incivility ‘increasing their stress level’ (60.5%). Less than half reported the incivility ‘lowering their self-confidence’ (41.1%), ‘negatively affecting their emotional’ (45.7%) and ‘physical’

Table 8

Behaviors Commonly Experienced/Observed by Multiple groups

Behavior Experienced	Significant findings for the Group					
	Years teaching	Title/Rank	Tenure/Non-tenure	Educ of Participant	Admin/ Non-Admin	Public/Private
Consistently Interrupting	EXP	OBS		EXP/ OBS	OBS	
Inattentiveness or causing distractions during meetings		EXP			EXP	
Use personal technology in a way that disrupts and/or interrupts interactions	OBS	OBS			OBS	
Racial, ethnic, sexual, gender or religious slurs		OBS				OBS
Breach of confidence			OBS		OBS	
Resisting change	EXP	EXP	EXP			
Taking credit	EXP/ OBS	EXP	EXP/ OBS			

P < 0.05
 EXP= statistically significant for Experiencing; OBS=statistically significant for Observing

(31.1%) health. A small portion of the participants (14%) admitted to ‘staying home from work because of the incivility,’ while 45.8% have ‘considered changing their job’ as a result of the uncivil culture. Data was analyzed to assess for significant differences based on demographic characteristics.

Gender

There were no statistically significant differences for any of the eight impact areas, related to gender, for the group of participants.

Table 9

Frequency of Agreement with Impact Statements (N=133)

Incivility at work has.....	No. (%) Respondents indicating <i>Strongly Agree</i> or <i>Agree</i> with statement
Increased my stress level	78 (60.5%)
Resulted in my being less satisfied with my job	76 (59.4%)
Negatively affected my work performance	70 (54.3%)
Resulted in me to consider changing jobs	59 (45.8%)
Negatively affected my emotional health	59 (45.7%)
Lowered my self-confidence	53 (41.1%)
Negatively affected my physical health	40 (31.1%)
Resulted in my staying home from work	18 (14%)

Years Taught at Institution

Considered Changing Jobs. ANOVA was utilized to analyze the length of time teaching at the institution and the impact of incivility on the nurse educators. Statistically significant differences were noted for 'considered changing jobs' based on the length of time teaching within the participant's current institution ($F_{3, 111} = 2.728, p = 0.047$). Tukey post-hoc indicated the nurse educators teaching 6-10 years ($\bar{x} = 2.4, sd = 1.52$) more frequently indicated they had considered changing jobs, as a result of workplace incivility, than the educators teaching over 20 years ($\bar{x} = 4, sd = 1.414, p = 0.037$) at their current institution.

No other statistically significant differences were noted, based on number of years with their current institution, for impacting work.

Title

There were no statistically significant differences for any of the eight impact areas, related to title or rank, for the group of participants.

Tenure or Non-Tenure

Statistically significant differences were found between the tenured nurse educators and the non-tenured nurse educators in the impact categories of ‘lowered self-confidence,’ ‘negatively affecting emotional health,’ ‘negatively affecting physical health,’ and ‘less satisfied with work.’ The tenured faculty more frequently indicating they have been impacted by the incivility within their work environment, than the non-tenured faculty, see Table 10.

Table 10

Tenured or Non-Tenured Impact Areas

Behavior	Tenured		Non-tenured	
Incivility at work has.....	<i>N</i>	<i>M(SD)</i>	<i>N</i>	<i>M(SD)</i>
Lowered my self-confidence	42	2.8 (1.41)	82	3.41 (1.51)
Negatively affected my emotional health	42	2.59 (1.57)	82	3.40 (1.55)
Negatively affected my physical health	42	2.9 (1.64)	82	3.89 (1.44)
Increased my stress levels	42	2.19 (1.43)	82	2.92 (1.61)
I am less satisfied with work because of incivility at work	41	2.24 (1.3)	81	3.01 (1.6)

P < 0.05
M of 1 indicates response of ‘Strongly Agree’ with statement
M of 4 indicates response of ‘Strongly Disagree’ with statement

There were no other statistically significant differences noted for the other impact areas based on participant's tenure status.

Highest Education of Participant

Stayed Home from Work. Statistically significant differences were found based on highest education of participant for the impact area of 'stayed home from work' ($F_{2, 125} = 4.296, p = 0.016$). The 49 doctorate prepared nurse educators ($\bar{x} = 3.81, sd = 1.53$) more frequently agreeing that they had 'stayed home from work' as a result of the uncivil work environment than the 72 master's prepared nurse educators ($\bar{x} = 4.47, sd = 1.02, p = 0.011$).

There were no other statistically significant differences noted for the other impact areas based on participants level of education.

Administration or Non-Administration

There were no statistically significant differences for any of the impact areas, related to whether the participants were in administrative or non-administrative roles.

ADN or BSN Taught

No statistically significant differences were noted for participants, based on teaching in an ADN program versus a BSN program, for any of the eight impact areas.

DNP or Non-DNP Taught

No statistically significant differences were noted for participants, based on teaching in a DNP program or not in a DNP program, for any of the eight impact areas.

Pre- or Post-Licensure

Statistically significant differences were noted in three of the impact areas for those teaching pre-licensure, post-licensure, or both levels. Participants teaching in both pre- and post- licensure levels more frequently agreeing they have been impacted by workplace incivility.

Negative Impact on Emotional Health. There were statistically significant differences in mean scores based on teaching in pre-licensure, post-licensure, or both programs for the impact of incivility ‘negatively affecting emotional health’ ($F_{2, 118} = 3.259, p = 0.042$). Tukey post-hoc indicated that the 26 nurse educators teaching in both pre- and post-licensure programs ($\bar{x} = 2.42, sd = 1.50$) more frequently agreed that workplace incivility had impacted their emotional health than to the 91 nurse educators ($\bar{x} = 3.31, sd = 1.58, p = 0.032$) teaching in only pre-licensure programs.

Lowered Self-Confidence. There were marginally not significant differences in mean scores for these groups in whether incivility had ‘lowered their self-confidence’ ($F_{2, 118} = 3.047, p = 0.051$). Tukey post-hoc indicated that the 26 nurse educators teaching in both pre- and post-licensure programs ($\bar{x} = 2.61, sd = 1.49$) agreed that workplace incivility had lowered their self-confidence more than the 91 pre-licensure nurse educators ($\bar{x} = 3.41, sd = 1.45, p = 0.042$) agreed with the statement.

Stayed Home from Work. There were statistically significant differences in mean scores, based on teaching pre-licensure, post-licensure or both levels, in whether incivility had resulted in the participant ‘staying home from work’ ($F_{2, 118} = 3.76, p = 0.026$). Tukey post-hoc indicated that the 26 nurse educators teaching in both pre- and

post-licensure programs ($\bar{x} = 3.65$, $sd = 1.62$) more frequently indicated they had stayed home from work related to uncivil work environments than the 91 nurse educators teaching only pre-licensure ($\bar{x} = 4.32$, $sd = 1.15$, $p = 0.045$).

There were no other statistically significant differences noted for this group in any of the other impact areas.

Public or Private

No statistically significant differences were noted for participants, based on working in a public or private institution, for any of the eight impact areas.

Undergraduate or Graduate

Stayed Home from Work. Statistically significant differences were noted, based on whether the participants taught in undergraduate only, graduate only, or both undergraduate and graduate programs for civility impacting the participant's decision to stay home from work ($F_{2, 124} = 4.193$, $p = 0.017$). Tukey post-hoc results indicate participants teaching in both the undergraduate and the graduate levels ($\bar{x} = 3.18$, $sd = 1.83$) more frequently agreed that incivility had resulted in them staying home from work than those teaching in either the undergraduate only ($\bar{x} = 4.29$, $sd = 1.17$, $p = 0.016$), or the graduate only ($\bar{x} = 4.41$, $sd = 1.22$, $p = 0.032$) levels.

No statistically significant differences were noted for participants, based on teaching in graduate, undergraduate, or both programs, for any of the other impact areas.

Highest Level Taught

No statistically significant differences were noted for participants, based on highest level of students taught, for any of the eight impact areas.

Common Impact Areas

Statistically significant differences were noted in three impact areas for participants across multiple demographic characteristics: stayed home from work, lowered self-confidence, and negatively affected emotional health, see Table 11.

Table 11

Impact Statements Common to Multiple Groups

Behavior				
Incivility at work has....	<i>Pre-, Post-licensure or both taught</i>	<i>Undergrad, Graduate, or both taught</i>	<i>Tenure/ Non-tenure</i>	<i>Educ of Participant</i>
Lowered my Self-Confidence	yes		yes	
Negatively affected my Emotional health	yes		yes	
Resulted in me staying home from work	yes	yes		yes
P <0.05				

In addition to looking at individual behaviors and participants experiences and observation with those behaviors and the impact of incivility, the participants were also asked reasons they may avoid addressing incivility at work. The top reasons identified were: fear of professional retaliation, fear of personal retaliation, lack of administrative support, and preferring to avoid confrontation or conflict, see Table 12.

Table 12

Reasons for Avoiding Dealing with Incivility

Reasons for avoiding dealing with incivility	Number of participants selecting
Fear of Professional retaliation	55
Fear of Personal retaliation	42
Lack of administrator support	41
Prefer to avoid confrontation or conflict	41
Addressing it makes matters worse	38
Do not have clear policy to address workplace incivility	24
Do not avoid	24
Lack of knowledge and skills	21
Addressing it may lead to poor evaluations	19
It takes too much time and efforts	14
Reluctant to challenge authority or position	13

Conclusion

The participating nurse educators lacked diversity in gender and race. Participants across all demographic characteristics identified the 23 behaviors as uncivil. It is worth noting that *experiences* and *observations* of incivility were noted across the spectrum of time teaching at the institution, tenure status, title or rank, and administrative or non-administrative roles, and in difference in types of colleges. Additionally, all of the 23 behaviors were experienced and observed ‘often’ by at least some of the participants during the previous 12 months. Participants also agreed that the incivility within their

work environment had a negative impact for them. Although the majority of participants rated their work environment as mostly civil, they also identified that incivility was at least a mild problem within their work setting.

Participants in this study identified incivility as being a problem within their work environment as nurse educators, 40.9% considering the problem to be at a moderate to serious level. While most participants identified confidence in their own ability to address workplace incivility, unfortunately their ability to address the incivility appears to be necessary. While the frequency of 'often' *experiencing* or *observing* each of the individual behaviors may not have even reached 50% consistently, each of the behaviors were *experienced* and *observed* within the previous 12 months by some of the participants, including all behaviors 'often' experienced and observed by at least some of the participants. All 23 behaviors were, overwhelmingly, identified as 'always' uncivil, with the exception of 'engaging in secretive meetings' which was identified as 'usually or always' uncivil. It should be considered that if all of the behaviors are 'always' uncivil, then what is the threshold for tolerating the behavior. Is it acceptable for nurse educators to experience or observe the behaviors even at the rarely level? According to Dellasega et al. (2014) and Clark (2013) a high frequency of incivility is not necessary for the incivility to be a problem. Dellasega et al. (2014) state that the negative behavior of only one nurse can alter the culture within the broader unit. Every uncivil encounter does not only have an impact on the nurse educator experiencing the incivility, but impacts other educators and role-models negative behaviors that impact the nursing student and even the broader profession. Lim and Bernstein (2014) identified civility as a behavior that is

learned and therefore needs to be taught, both directly and indirectly through positive role-modeling.

CHAPTER 5

CONCLUSIONS, DISCUSSION, SUGGESTIONS FOR FUTURE RESEARCH

Incivility is a concern across the profession of nursing. ANA published a position statement on *Incivility, Bullying, and Workplace Violence* in response to this phenomenon, calling for nurses and employers to create an environment of respect and civility. Nurse educators are the early role-models to professional nurses; therefore, it is critical to be aware of the culture of civility, or lack thereof, within nursing educational settings and to create a civil environment within nursing education.

Incivility has been related to the shortage of nurses, contributing to nurses leaving the profession. Working upstream, to nursing education, to create and role-model a more civil culture has the potential to positively impact the nursing profession through facilitating change in how new nurses are encultured into the profession and through positively impacting nurse educators to remain within the profession and more specifically within nursing education. First, it is necessary to understand the current culture of nursing education, what is being role-modeled for new nurses, and the impact of incivility on nurse educators.

Summary of Findings

Incivility was identified as a problem, within nursing education, by 82.6% of the survey participants. Three of the 133 participants indicated that all 23 of the behaviors were never uncivil, the remaining 130 participants identifying the 23 behaviors as rarely, if not always, uncivil. Only two of the 133 participants indicated they had never

experienced nor observed any of the 23 behaviors, two additional participants indicated they had not experienced any of the behaviors themselves, but they had observed at least some of the behaviors. One participant had never observed any of the behaviors, but they had experienced at least one behavior 'often.' These were the outliers. Assessing various characteristics of the participants identified that incivility was present across all demographics.

Conclusions

To what Extent is Faculty-to-Faculty Incivility Perceived to be a Problem in Nursing Education?

What is the Perception of Uncivil Faculty-to-Faculty Behaviors?

The majority of the nurse educators participating in the study perceived incivility between nursing faculty to be a problem. Only 17.4% of participants identified to extent of incivility to be 'no problem' within their workplace. While only one participant rated their work place as completely civil, when rating from zero to 100, all behaviors were experienced 'often' by some of the participants. While one nurse, within any organization, may perceive the environment to be completely civil, that does not necessarily mean that others within the same organization have the same perception. The majority of nursing programs within the state were represented by more than one participant in this survey. The culture of incivility is also known to spread, infecting others. Incivility within nursing education is a problem, for the nurse educators and for the nursing students who look to the faculty for how they should behave toward other

nurses. If the goal is to have civility within nursing education, not only for the nurse educators but also for the role-modeling to students, then even rare experiences and observations can be harmful. Although there were seven behaviors ‘never’ experienced and six behaviors never ‘observed’ by over half of the participants, other participants did experience and observe these same behaviors. There were no behaviors that had never been experienced or observed by at least some of the participants. Additionally, there were 11 behaviors that were *experienced* ‘often’ or ‘sometimes’ by over 30% of the participants and 15 behaviors that were *observed* ‘often’ or ‘sometimes’ by at least 30% of participants. Clark et al. (2013) identified 12 behaviors that respondents indicated they had experienced *often* or *sometimes*, ranging from 51 to 70% in their study. Additionally, Casale (2017) identified five behaviors, as most frequently experienced by over 45% of participants. All five of Casale’s most frequently experienced behaviors are also included on the current list behaviors experienced by over 30% of participants. While the frequency of experiencing and observing the behaviors is lower for the current group of participants than for participants in previous studies, it cannot be concluded that the civility is improving, only that the current group has had a different experience.

It may not be realistic to expect complete civility at all times, however 30% experiencing and observing is still high, especially when considering the long-term impact from role-modeling to future nurses. This would also be evident based on the majority (81.7%) of participants indicating incivility was a problem within their nursing education program. The most common behaviors experienced and observed by this group of nurse educators was ‘being inattentive or causing distractions during meetings,’ which

was different than the most common behavior noted in previous studies. Clark and Springer (2007) identified ‘challenging knowledge or credibility’ and ‘taunts and disrespect’ as the most common uncivil behaviors between nursing faculty. Again, the conclusion that can be drawn from this difference is that the groups both experienced incivility, even though the form of incivility was different for the different groups.

The demographic characteristic that found the most, seven behaviors, to have statistically significant differences in mean scores was the characteristic of tenure status. While most might think that the non-tenured faculty would be more at risk for incivility, and other research has found untenured to more frequently experience incivility (DelliFraine et al., 2014), the opposite was noted in this survey. The tenure participants in this survey noted consistently more *experiences* and *observations* of incivility than the non-tenured faculty. Considering OGBT and the common characteristics of tenure, such as peer review and higher expectations, these findings may not be surprising. OGBT has noted that as individuals move up in rank or stature, they are more likely to experience pressure from both sides. This has also been noted within the nursing profession, nurse managers experience pressure from higher administration to perform a certain way and to meet certain expectations which may be in conflict with supporting staff nurses. The expectations in teaching and for scholarship or service may be higher for tenured than for non-tenured faculty. The higher expectation for scholarship may push tenured faculty to conduct or implement research more frequently than non-tenured faculty, this would coincide with the more frequent experience and observation of encountering resistance to change. Through this resistance to change the concepts of challenging knowledge and

credibility would also come into play. Recall that the nature of nursing education is highly intertwined and collaborative while academic freedom is considered a value of higher education. Tenured faculty seeking to utilize evidence-based practice to improve their own teaching environment closely connects to expectations and experiences for other faculty's teaching. Typically, for the most benefit and long-term effect evidence-based practice interventions would be most successful when supported and implemented across a curriculum, encouraging change through the implementation of new evidence-based practices.

Additionally, untenured faculty may experience less strenuous peer-review processes than tenured faculty. While a portion of the untenured review process may be peer-review, a greater portion may still come from administration. The opposite may be accurate for tenured-faculty, including review by a committee of peers, resulting in more potential for tenure and non-tenure peers to influence the long-term professional outcomes for the tenured faculty. These characteristics would also match with the top two contributing factors identified by survey participants, stress and demanding workloads and reasons for avoiding addressing incivility: fear of professional or personal retaliation.

Additionally, statistically significant differences were noted for those in administrative roles, with those in administrative positions more frequently experiencing or observing incivility. The more frequent observations of incivility may be explained by administration being more aware of all of the dynamics within the department. Faculty who wish to address the topic of incivility would likely approach administration for support, this would definitely lead to more awareness of any incivility within the

department. Again, similar to the tenured faculty and in line with OGBT as individuals move up in the ranks they are caught in that middle management position, responding to the powers above and the expectations of the faculty and staff. This would be similar to the struggles, within nursing practice, of nurse managers.

Looking upstream from nursing practice to the nursing education, this assessment looks at the culture being role-modeled to students: future nurses. Continuing that look upstream to consider who is role-modeling the expectations or setting the culture for a nursing education department, it could be considered that those with more seniority, those with higher rank, those with tenure, or those in administrative or leadership roles would set the stage. Yet, these are some of the groups most frequently experiencing the phenomena for this group of participants. This matches the characteristics within OGBT of marginalization, these nurse educators who should be leading being overlooked or their expertise not being considered relevant. The concept of academic freedom may be embraced more by other faculty than the expertise and experience the senior, more experienced, tenured, or administrative faculty bring to the department. The nature of nurses advocating for others, and not for themselves, may also play into this.

Additionally, OGBT identifies powerlessness as a trait of oppressed groups. While these groups, by nature of these characteristics, would appear to be the groups of power within higher education, the peer-review process and academic freedom may leave these group powerless, yet expected to be leaders. Leaving them caught in the middle, on the front line of incivility.

Finally, the concept of cultural imperialism from OGBT, speaks to the leadership's more frequent experience or observation of incivility. Unfortunately, there is a well-established norm, within the nursing profession, of incivility. Nurse educators all come from practice areas and may bring this culture with them into higher education. Nurse educators are first and foremost practicing nurses, they are not extensively educated in the pedagogy of education. While they receive some education, through their master's program, this education brings nurse educators from a variety of levels of expertise into higher education. Nurse educators may rely heavily on what they have experienced in their own education and in practice, into how they engage and perform in higher education. This is the vicious cycle of nursing education: nurse educator's role-model incivility that new nurses take into practice as the norm for the profession, then practicing nurses cycle into higher education, bringing the norm of incivility from practice with them, and the cycle continues.

Is there a Difference in Perception between Faculty Working in Different Types of Settings?

This question is redefined as faculty teaching in ADN (two-year) versus BSN (four-year) programs. The difference between the two programs being the length of time to achieve the same goal of students passing the same national licensure examination. Less time to prepare students could indicate a higher stress level, which could result in higher incivility. The null hypothesis, that there is no difference in the perception of incivility between faculty teaching in ADN versus BSN programs is accepted. Incivility was noted in nurse educators teaching in both ADN and BSN programs. Regardless of

the increased stress of trying to achieve the same goal with less time, there were no significant differences in the experience or observation of incivility, nor in their view on the extent of the problem, for these participants.

Similarly, there were not significant difference between those working in public versus private institutions. And it was not possible to assess for differences between for-profit and not-for-profit institutions due to limited number of for-profit participants responding.

Is there a Difference in Perception between Faculty Working at Different Levels of Nursing Education?

The null hypothesis, that there is no difference in the perception of incivility between faculty teaching at different levels of nursing education is accepted. Incivility was noted in nurse educators teaching at each of the different levels of nursing education, with no statistically significant differences based on the highest level they teach for experience or observation of incivility. When considering those teaching in programs preparing students for licensure exams versus those teaching a combination of licensure preparation and post-graduate differences were noted in several impact areas. One impact area noted to be significantly different was in 'staying home from work.' What was not measured was the impact of 'presentism' or 'disengagement:' being physically present at work, but not putting their usual effort into their work due to the effects of the uncivil environment or due to investing their time into dealing with the incivility.

Significant differences in the impact of incivility were also noted in nurse educators who were teaching at different levels, when considering those teaching in

undergraduate courses, graduate level course, or teaching in both levels. Those teaching in both undergraduate and graduate levels were impacted by the incivility more frequently than those teaching only in graduate levels and undergraduate levels. Similarly, those teaching a combination of pre-licensure and post-licensure were impacted more frequently than those teaching only pre-licensure programs. Those teaching in multiple levels, either based on licensure preparation or on graduate or undergraduate level were more likely to identify the negative impacts of incivility. The combination of teaching in multiple levels could lead to working with more faculty, resulting in more exposure to incivility. Working in two different programs could also lead to faculty who only teach in one program or at one level having a perception that those teaching in both are less engaged or committed to their program, which could result in more negativity toward those teaching in both. Those teaching in both may not be acknowledged as a full member of either group, or be consider an outsider by both groups.

How does the Perception of Incivility Relate to Nursing Faculty's Intentions to Persist in Nursing Education?

Over half of the participants agreed or strongly agreed that incivility affected them in at least some of the impact areas identified. Research has also shown that over time, incivility results in various consequences. Just under half of participants (45.8%) stated they had considered changing jobs because of workplace incivility. While this is not even 50%, it is still relevant, considering the current nursing shortage and the shortage of nursing faculty. One comment on why participants do not take action against

incivility was that it is easier to endure than to try and replace a nurse educator. This also speaks to the shortage of nurse educators. Deery et al. (2011), found that nurses who experienced incivility were over 11 times more likely to leave a position. The long-term consequences of incivility in nursing education includes nurse educators leaving teaching, as well as, the impact of incivility role-modeled to future nurses. Over half of the nurse educators (54.3%) reported that incivility negatively affected their work performance. This could be in the form of not being available to students, due to avoiding negative interactions on campus. It could be a result of 'presentism,' when the faculty may be present and performing but not performing to their highest quality due to dealing with the lowered self-confidence or the physical or emotional symptoms from the incivility. The negative impact on their work can directly impact the learning environment for the students, besides setting the cultural norm for nursing.

Discussion

Mentoring of new nurse educators is one approach used by some institutions to facilitate retention of new faculty. Considering this current data, attention may need to be given to the faculty who have settled into the institution, may be moving up in rank or tenure and may have increased expectations, but lack support to achieve these expectations. This would include faculty who are tenured, been with the institution for 11-20 years, or being in a senior lecturer rank. Each of these demographics would correlate to a faculty who is past being a 'new' employee and therefore may not be receiving the same supports as during their initial years. These faculty may be starting to take on more leadership or higher expectations and have a renewed need support.

Additional support may also be needed by educators who are splitting their time between different groups, such as those teaching in both undergraduate and graduate programs or those teaching in licensure preparation and post-licensure programs. These faculty may be juggling expectations for multiple programs or levels and they may not be considered a full member of either group. Team cohesiveness is important for all members of the team, including those who split their time and part-time or adjunct faculty who may be contributing to the workload.

Finally, differences from current participants perspective and previous research has shown differences in frequency of behaviors being experienced or observed. While it has been suggested in other research to have clear policies related to civility, it may also be worthwhile to conduct periodic internal assessments of the work environment to know what is occurring at the micro level and what needs to be addressed for a group of co-workers to create the most respectful and civil work environment. Generic policies that do not address the concerns of a particular group may be less helpful to the overall goal of increasing the civility within the nursing profession.

Suggestions for Future Research

Future research should include further assessment of incivility across the nation, including assessing for interventions to address the phenomena. More research is needed to determine if incivility is widespread across all areas of the nation and if diversity within faculty or certain geographic areas are more prone to incivility. Also, more research is needed to determine if the added stress of preparing students for licensure examination impacts the stress and therefore incivility within the nursing department.

Considering the low frequency of staying home from work related to incivility, it may be of interest to see if ‘presentism’ or ‘disengagement’ are occurring and the impact these tendencies may have on student pass rates for licensure examination.

Studies in other areas of higher education found a higher percentage of faculty identifying ‘moderate to severe’ level of incivility. DelliFraine et al. (2014) found 55% of the participants in their health administration survey identified the culture as ‘moderate to severe’ level of incivility, while Clark et al. (2013) found 68% of faculty in a nationwide nurse faculty survey identified the incivility to be at a ‘moderate to severe’ level. This current survey included 39.7% respondents identifying the level of civility to be ‘moderate to severe.’ Continued research is needed to determine if this is a result in a shift within nursing education or differences related to other factors.

Conclusion

Incivility is a problem in nursing education within one Midwestern state. While there are differences in the incivility experienced and observed by the current group of nurse educators and previous groups, what is consistent is the continued perception of incivility being a problem in nursing education and the continued experience and observation of incivility between faculty. The differences could be related to different geographic regions, different times of the year, and different groups of individuals or many other factors. The bottom line is that incivility is still present and impacting nursing faculty and future nurses.

Faculty to faculty incivility negatively impacts nurse educators, most notably in lowered self-confidence and emotional health. Incivility also impacts students through

faculty staying home due to incivility and from the environment that future nurses are being encultured into the profession. Incivility within nursing education may go unaddressed out of fear of professional or personal retaliation or due to a lack of administrative support. The nursing profession has a long history of incivility, the ANA has called for employers and nurses to create environments that are respectful and civil, this needs to start from the beginning: with civil nursing education programs. Starting from the top, with respectful and civil relationships between nursing faculty.

REFERENCES

- American Association of Colleges of Nursing (AACN). (2017). *Nursing shortage fact sheet*. Retrieved June 4, 2017 from <http://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Shortage>
- American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursesbooks.org. Retrieved from <http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html>
- American Nurses Association. (2015b). *Position statement on incivility, bullying, and workplace violence*. Retrieved November 4, 2016 from <http://www.nursingworld.org/DocumentVault/Position-Statements/Practice/Position-Statement-on-Incivility-Bullying-and-Workplace-Violence.pdf>
- American Organization of Nurse Executives. (2014). *Mitigating violence in the workplace*. Retrieved November 4, 2016 from <http://www.aone.org/resources/mitigating-workplace-violence.pdf>
- Baltimore, J. J. (2006). Fact or fiction?. *Nursing Management*, 37(5), 28-36.
- Bostian-Peters, A. (2014). Faculty to faculty incivility: Experiences of novice nurse faculty in academia. *Journal Of Professional Nursing*, 30(3), 213-227. DOI: 10.1016/j.profnurs.2013.09.007
- Bureau of Labor and Statistics. United States Department of Labor. (2015). *Occupational outlook handbook: Registered Nurse: Job outlook*. Retrieved November 4, 2016 from <http://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-6>
- Casale, K. R. (2017). Exploring nurse faculty incivility and resonant leadership. *Nursing Education Perspectives* (Wolters Kluwer Health), 38(4), 177-181. doi:10.1097/01.NEP.0000000000000171
- Clark, C. (2008). Faculty and student assessment of and experience with incivility in nursing education. *Journal of Nursing Education*, 47(10), 458-465.
- Clark, C. (2009). Faculty field guide for promoting student civility in the classroom. *Nurse Educator*, 34(5), 194-197.
- Clark, C. (2013). *Creating & sustaining civility in nursing education*. Indianapolis, IN: Sigma Theta Tau International.
- Clark, C. (2017). An evidence-based approach to integrate civility, professionalism, and ethical practice into nursing curricula. *Nurse Educator*, 42(3), 120-126.

- Clark, C. M., Barbosa-Leiker, C., Gill, L. M., & Nguyen, D. (2015). Revision and Psychometric Testing of the Incivility in Nursing Education (INE) Survey: Introducing the INE-R. *Journal of Nursing Education, 54*(6), 306-315. doi:10.3928/01484834-20150515-01
- Clark, C., Olender, L., Kenski, D., & Cardoni, C. (2013). Exploring and addressing faculty-to-faculty incivility: A national perspective and literature review. *Journal of Nursing Education, 52*(4), 211-218.
- Clark, C., & Springer, P. (2007). Incivility in nursing education: A descriptive study of definitions and prevalence. *Journal of Nursing Education, 46*(1), 7-14.
- Clark, C., & Springer, P. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education, 49*(6), 319-325. doi:10.3928/01484834-20100224-01
- Condon, B. (2015). Incivility as bullying in nursing education. *Nursing Science Quarterly, 28*(1), 21-26.
- Deery, S., Walsh, J., & Guest, D. (2011). Workplace aggression: The effects of harassment on job burnout and turnover intentions. *Work, Employment & Society, 25*(4), 742-759. doi:10.1177/0950017011419707
- Dehue, F., Bolman, C., Völlink, T., & Pouwelse, M. (2012). Coping with bullying at work and health related problems. *International Journal of Stress Management, 19*(3), 175-197.
- Dellasega, C., Volpe, R. L., Edmonson, C., & Hopkins, M. (2014). An exploration of relational aggression in the nursing workplace. *Journal of Nursing Administration, 44*(4), 212-218. doi:10.1097/NNA.0000000000000052
- DelliFraine, J., McClelland, L., Erwin, C., & Wang, Z. (2014). Bullying in academia: Results of a survey of health administration faculty. *The Journal of Health Administration Education, 31*(2), 147-163.
- DeMarco, R. & Roberts, S. (2003). Negative behaviors in nursing: Looking in the mirror and beyond. *American Journal of Nursing, 103*(3), 113-116.
- DeMarco, R., Roberts, S., Norris, A., & McCurry, M. (2008). The development of the nurse workplace scale: Self-advocating behaviors and beliefs in the professional workplace. *Journal of Professional Nursing, 24*(5), 296-301.

- Demir, D., & Rodwell, J. (2012). Psychosocial antecedents and consequences of workplace aggression for hospital nurses. *Journal of Nursing Scholarship*, 44(4), 376-384. doi:10.1111/j.1547-5069.2012.01472.x
- De Villers, M., & Cohn, T. (2017). Incivility in Nursing Practice. *Nursing Management*, 48. 42-51. 10.1097/01.NUMA.0000522183.31780.76.
- Dubrosky, R. (2013). Iris Young's five faces of oppression applied to nursing. *Nursing Forum*, 48(3), 205-210.
- Erickson, R. & Grove, W. (2007). Why emotions matter: Age, agitation, and burnout among registered nurses. *The Online Journal of Issues in Nursing*.
- Farrell, G., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: Findings from an Australian study. *Journal of Advanced Nursing*, 55(6), 778-787.
- Fletcher, K. (2006). Beyond dualism: Leading out of oppression. *Nursing Forum*, 41(2), 50-59.
- Freire, P. (1972). *Pedagogy of the oppressed*. (Myra Bergman Ramos, Trans., 1968.) New York, NY: Herder.
- Gaffney, D. A., DeMarco, R. F., Hofmeyer, A., Vessey, J. A., & Budin, W. C. (2012). Making things right: Nurses' experiences with workplace bullying--A grounded theory. *Nursing Research & Practice*, 1-10. doi:10.1155/2012/243210
- Glazer, G & Alexandre, C. (2008). Legislative: The nursing shortage: A public health issue for all. *The Online Journal of Issues in Nursing*, 14(1).
- Hinshaw, A. (2001). A continuing challenge: The shortage of educationally prepared nursing faculty. *The Online Journal of Issues in Nursing*, 6(1).
- Hinshaw, A. (2008). Navigating the perfect storm. *Nursing Research*, 57(1), S4-S10.
- Hollis, L. (2012). *Bully in the ivory tower: How aggression & incivility erode American higher education*. Wilmington, DE: L.P. Hollis.
- Keashly, L., & Neuman, J. H. (2010). Faculty experiences with bullying in higher education. *Administrative Theory & Praxis (M.E. Sharpe)*, 32(1), 48-70. doi:10.2753/ATP1084-1806320103
- KRC Research. (2014). *Civility in America*. Retrieved from <https://www.webershandwick.com/uploads/news/files/civility-in-america-2014.pdf>

- Kuhlenschmidt, S. L., & Layne, L. E. (1999). Strategies for Dealing with Difficult Behavior. *New Directions for Teaching and Learning*, 1999(77), 45.
- Lafer, G. (2005). Hospital speedups and the fiction of a nursing shortage. *Labor Studies Journal*, 30(1), 27-46.
- Lim, F. A., & Bernstein, I. (2014). Civility and workplace bullying: Resonance of nightingale's persona and current best practices. *Nursing Forum*, 49(2), 124-129. doi:10.1111/nuf.12068
- Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing*, 23(4), 226-234.
- McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of Registered Nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90-96. doi:10.1046/j.1365-2648.2003.02583.x
- Meires, J. (2018). Workplace incivility. The essentials: Here's what you need to know about bullying in nursing. *Urologic Nursing*, 38(2), 95-98. doi:10.7257/1053-816X.2018.38.2.95
- Namie, G., Christensen, D., & Phillips, D. (2014). *Workplace bullying institute: 2014 WBI U.S. Workplace bullying survey*. Retrieved from <http://www.workplacebullying.org/wbiresearch/wbi-2014-us-survey/>
- Purpora, C., & Blegan, M. (2012). Horizontal violence and the quality and safety of patient care: A conceptual model. *Nursing Research and Practice*, 2012. doi:10.1155/2012/306948.
- Roberts, S. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 21-30.
- Roberts, S., Demarco, R., & Griffin, M. (2009). The effect of oppressed group behaviours on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management*, 17, 288-293.
- Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13-22. doi:10.1111/j.1547-5069.2009.01321.x
- Rocker, C. (2008). Addressing nurse-to-nurse bullying to promote nurse retention. *The Online Journal of Issues in Nursing*, 13(3).
- Rodríguez-Muñoz, A., Moreno-Jiménez, B., Sanz Vergel, A. I., & Garrosa Hernández, E. (2010). Post-traumatic symptoms among victims of workplace bullying:

- Exploring gender differences and shattered assumptions. *Journal of Applied Social Psychology*, 40(10), 2616-2635. doi:10.1111/j.1559-1816.2010.00673.x
- Stanley, K., Dulaney, P., & Nemeth, L. (2014). White paper: Disruptive behaviors in nursing practice and education. *International Society of Psychiatric-Mental Health Nurses (ISPN)*
- Stanley, K., Martin, M., Michel, Y., Welton, J., & Nemeth, L. (2007). Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing*, 28(11), 1247-1265.
- Thompson, R. (2015). *Nurse bullying: Can you guess who is "eating" whom?* Retrieved from <https://www.americansentinel.edu/blog/2015/11/20/nurse-bullying-can-you-guess-who-is-eating-whom/>
- Ward-Smith, P. (2018). Workplace incivility: Perceptions of urologic nurses. *Urologic Nursing*, 38(1), 20-26. doi:10.7257/1053-816X.2018.38.1.20
- Wienberg, K. (2017). *Iowa Board of Nursing Annual Report: July 1, 2016 - June 30, 2017*. Retrieved May 1, 2018 from https://nursing.iowa.gov/sites/default/files/documents/2018/01/2017_annual_report_final_corrected_12_11_2017.pdf
- Wilson, J. L. (2016). An exploration of bullying behaviours in nursing: A review of the literature. *British Journal of Nursing*, 25(6), 303-306.
- Woodrow, C., & Guest, D. E. (2012). Public violence, staff harassment and the wellbeing of nursing staff: An analysis of national survey data. *Health Services Management Research*, 25(1), 24-30. doi:10.1258/hsmr.2011.011019
- Workplace bullying survey. (2015). Retrieved November 11, 2017 from <http://umassmsp.org/sites/umassmsp.org/files/Appendix%20B%20Workplace%20Bullying%20Survey%20Paper.pdf>
- Zapf, D., Escartin, J., Einarsen, S., Hoel, H., & Varita, M. (2011). Empirical findings on prevalence and risk groups of bullying in the workplace. In the workplace in S. Einarsen, H. Hoel, D. Zapf, & C.L> Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (2nd ed., pp. 75-105). Boca Raton, FL: CRC Press.

APPENDIX A:
DEMOGRAPHIC INFORMATION AND SURVEY

For how many years have you worked at your current college/university?	_____years
Are you:	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Transgender <input type="radio"/> Prefer not to answer
What is your race?	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African <input type="radio"/> Hispanic <input type="radio"/> Native Hawaiian <input type="radio"/> White/Caucasian
What is your working title at your college/university (select all that apply)?	<input type="radio"/> Dean <input type="radio"/> Department head/chair <input type="radio"/> Associate department head/chair <input type="radio"/> Professor <input type="radio"/> Associate professor <input type="radio"/> Assistant professor <input type="radio"/> Senior Lecturer <input type="radio"/> Lecturer <input type="radio"/> Other _____
What is your current faculty status?	<input type="radio"/> Tenured faculty <input type="radio"/> Non-tenured faculty
What type of institution do you primarily teach nursing education through?	<input type="radio"/> Four-year college/university <input type="radio"/> Two-year college
	<input type="radio"/> For-profit college/university <input type="radio"/> Non-for-profit college/university
	<input type="radio"/> Public college/university <input type="radio"/> Private college/university
What is your highest level of education:	<input type="radio"/> Bachelor's degree <input type="radio"/> Master's degree <input type="radio"/> Other _____ <input type="radio"/> Doctorate degree
What levels of nursing education do you teach (select all that apply)	<input type="radio"/> LPN <input type="radio"/> ADN <input type="radio"/> BSN <input type="radio"/> RN-BSN <input type="radio"/> MSN <input type="radio"/> ARNP <input type="radio"/> DNP <input type="radio"/> PhD

Listed below are some behaviors that may be considered uncivil. Please indicate whether you consider this behavior to be uncivil and whether the behavior has happened to you or someone you know within the past 12 months.

9. Is it uncivil for someone to...	10. How often have you <i>experienced</i> this in the past 12 months?				11. How often have you <i>seen</i> this in the past 12 months?							
	Always	Usually	Sometimes	Never	Often	Sometimes	Rarely	Never	Often	Sometimes	Rarely	Never
A. Set someone (you or a co-worker) up to fail alone or in concert with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Abuse position or authority (e.g. make unreasonable or unfair demands, assign inequitable workload)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Make rude remarks, put-downs, or name-calling (when done to you or a co-worker)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Consistently fail to perform his or her share of the workload	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Consistently interrupt you or a co-worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Engage in secretive meetings behind closed doors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Invoke personal religious or political values or beliefs to impose a specific outcome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Intentionally exclude or leave you or a co-worker out of activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I. Make personal attacks or threatening comments (verbal comments, e-mail, telephone, etc. toward you or a co-worker)	<input type="radio"/>											
J. Make physical threats (toward you or a co-worker)	<input type="radio"/>											
K. Make racial, ethnic, sexual, gender, or religious slurs about anyone	<input type="radio"/>											
L. Refuse to listen or openly communicate on work related issues	<input type="radio"/>											
M. Resist or create friction to prevent changes from occurring in the workplace	<input type="radio"/>											
N. Take credit for work/contributions of others (yours or a co-worker)	<input type="radio"/>											
O. Use gossip or rumors to turn others against you or a co-worker	<input type="radio"/>											
P. Use personal technology (cell phones, hand-held devices, etc.) in a way that disrupts and/or interrupts interactions	<input type="radio"/>											

Q. Be inattentive or cause distractions during meetings	<input type="radio"/>											
R. Breach a confidence (share personal information about you or a co-worker made in confidence)	<input type="radio"/>											
S. Challenge your or a co-worker's knowledge or credibility	<input type="radio"/>											
T. Circulate private e-mails, without knowledge or permission (to discredit you or a co-worker)	<input type="radio"/>											
U. Circumvent the normal grievance process (e.g. going above someone's head or failing to follow procedures to resolve conflict)	<input type="radio"/>											
V. Consistently demonstrate an "entitled" or "narcissistic attitude" toward you or a co-worker	<input type="radio"/>											
W. Make rude non-verbal behaviors or gestures (toward you or a co-worker)	<input type="radio"/>											
12. To what extent do you think incivility is a problem in your workplace? <input type="radio"/> No problem at all <input type="radio"/> Moderate problem <input type="radio"/> Mild problem <input type="radio"/> Serious problem <input type="radio"/> I don't know/can't answer												

<p>13. Please indicate the level of confidence you have in addressing workplace incivility</p> <p> <input type="radio"/> High level of confidence <input type="radio"/> Minimal level of confidence <input type="radio"/> Moderate level of confidence <input type="radio"/> No confidence at all </p>													
<p>14. If you avoid dealing with workplace incivility, what keeps you from addressing it? (Check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> Lack of knowledge and skills</td> <td><input type="checkbox"/> Lack of administrator support</td> </tr> <tr> <td><input type="checkbox"/> Fear of professional retaliation</td> <td><input type="checkbox"/> Addressing it makes matters worse</td> </tr> <tr> <td><input type="checkbox"/> Fear of personal retaliation</td> <td><input type="checkbox"/> Reluctant to challenge authority or position</td> </tr> <tr> <td><input type="checkbox"/> It takes too much time and effort</td> <td><input type="checkbox"/> Prefer to avoid confrontation or conflict</td> </tr> <tr> <td><input type="checkbox"/> Do not have a clear policy to address workplace incivility</td> <td><input type="checkbox"/> Do not avoid</td> </tr> <tr> <td><input type="checkbox"/> Addressing it may lead to poor evaluations</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>		<input type="checkbox"/> Lack of knowledge and skills	<input type="checkbox"/> Lack of administrator support	<input type="checkbox"/> Fear of professional retaliation	<input type="checkbox"/> Addressing it makes matters worse	<input type="checkbox"/> Fear of personal retaliation	<input type="checkbox"/> Reluctant to challenge authority or position	<input type="checkbox"/> It takes too much time and effort	<input type="checkbox"/> Prefer to avoid confrontation or conflict	<input type="checkbox"/> Do not have a clear policy to address workplace incivility	<input type="checkbox"/> Do not avoid	<input type="checkbox"/> Addressing it may lead to poor evaluations	<input type="checkbox"/> Other _____
<input type="checkbox"/> Lack of knowledge and skills	<input type="checkbox"/> Lack of administrator support												
<input type="checkbox"/> Fear of professional retaliation	<input type="checkbox"/> Addressing it makes matters worse												
<input type="checkbox"/> Fear of personal retaliation	<input type="checkbox"/> Reluctant to challenge authority or position												
<input type="checkbox"/> It takes too much time and effort	<input type="checkbox"/> Prefer to avoid confrontation or conflict												
<input type="checkbox"/> Do not have a clear policy to address workplace incivility	<input type="checkbox"/> Do not avoid												
<input type="checkbox"/> Addressing it may lead to poor evaluations	<input type="checkbox"/> Other _____												
<p>15. In your opinion, which factors contribute to workplace incivility? (Check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> Stress</td> <td><input type="checkbox"/> Technology overload/changes</td> </tr> <tr> <td><input type="checkbox"/> Organizational conditions/ volatility/stressful</td> <td><input type="checkbox"/> Juggling multiple roles and responsibilities</td> </tr> <tr> <td><input type="checkbox"/> Unclear roles and expectations and imbalance of power</td> <td><input type="checkbox"/> Inadequate resources (financial, human, informational, etc)</td> </tr> <tr> <td><input type="checkbox"/> Sense of entitlement and superiority</td> <td><input type="checkbox"/> Lack of knowledge and skills in managing conflict</td> </tr> <tr> <td><input type="checkbox"/> Demanding workloads</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>		<input type="checkbox"/> Stress	<input type="checkbox"/> Technology overload/changes	<input type="checkbox"/> Organizational conditions/ volatility/stressful	<input type="checkbox"/> Juggling multiple roles and responsibilities	<input type="checkbox"/> Unclear roles and expectations and imbalance of power	<input type="checkbox"/> Inadequate resources (financial, human, informational, etc)	<input type="checkbox"/> Sense of entitlement and superiority	<input type="checkbox"/> Lack of knowledge and skills in managing conflict	<input type="checkbox"/> Demanding workloads	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Stress	<input type="checkbox"/> Technology overload/changes												
<input type="checkbox"/> Organizational conditions/ volatility/stressful	<input type="checkbox"/> Juggling multiple roles and responsibilities												
<input type="checkbox"/> Unclear roles and expectations and imbalance of power	<input type="checkbox"/> Inadequate resources (financial, human, informational, etc)												
<input type="checkbox"/> Sense of entitlement and superiority	<input type="checkbox"/> Lack of knowledge and skills in managing conflict												
<input type="checkbox"/> Demanding workloads	<input type="checkbox"/> Other _____												
<p>16. Using a scale from 0-100, how do you rate the level of CIVILITY in your workplace?</p> <p>_____ Civility Level (Scale from 0-100) (0 is absence of civility, 100 is completely civil)</p>													
<p>17. What top 3 strategies do you suggest for improving the level of CIVILITY in your workplace?</p> <p> <input type="radio"/> Use empirical tools (surveys, etc.) to measure incivility/civility and address areas of strength/growth <input type="radio"/> Establish codes of conduct that define acceptable and unacceptable behaviors <input type="radio"/> Role-model professionalism and civility <input type="radio"/> Raise awareness, invest in civility/incivility education Integrate civility and collegiality into performance evaluations <input type="radio"/> Provide training for effective communication and conflict negotiation <input type="radio"/> Develop and implement comprehensive policies and procedures to address incivility <input type="radio"/> Reward civility and professionalism <input type="radio"/> Implement strategies for stress reduction and self-care <input type="radio"/> Take personal responsibility and stand accountable for actions <input type="radio"/> Other _____ </p>													

18. The following description is an example of an uncivil encounter you have experienced in your workplace within the past 12 months (fill in the blank)...

19. The most effective way to promote or address workplace civility is to (fill in the blank)...

20. Please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree		Strongly Agree	Agree	Disagree	Strongly Disagree
A. Incivility at work has negatively affected my work performance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	E. Incivility at work has negatively affected my emotional health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Incivility at work has lowered my self-confidence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	F. Incivility at work has negatively affected my physical health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. I am less satisfied with my job because of incivility at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	G. I have considered changing my job because of workplace incivility.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. I have stayed home from work because of incivility.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	H. Incivility at work has increased my stress level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

APPENDIX B:

CONSENT

Greetings. I am a doctoral student through the University of Northern Iowa Educational Leadership program conducting research for my dissertation. The purpose of this research is to gain a broader understanding of the presence of incivility in nursing education programs across the state. Increased awareness of a culture of incivility within nursing education can bring the conversation of nursing educational culture to the forefront to potentially address negative cultures and create an expectation of a positive culture.

You are invited to participate in a survey for research on the perception of incivility in nursing education. The purpose of this research is for dissertation and publication. The survey should take approximately ten to fifteen minutes. Participants will answer questions related to basic demographic information and their perception of incivility in nursing education programs.

All information from this survey will be kept confidential. Institution identification will be coded through a numbering system, and data analyzed by type of institution (all two-year versus all four-year programs) and by type of program (ADN, BSN, graduate nursing programs) to protect identification of individuals. Raw data will be available to the principle investigator and the dissertation committee for analysis. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data transmitted electronically. Data will be kept for five years.

Risk to participants includes potential emotional discomfort at reliving unpleasant experiences of incivility, invasion of privacy, and potential stress that conversations, within the department, related to a culture of civility may create an uncomfortable atmosphere. Participants are encouraged to seek counsel from their local mental health professionals if distress results from participation. While there is no direct benefit to participants, the results of the research are intended to identify if a culture of incivility within nursing education is present so that interventions can be implemented to address the issue to potential increase the presence of a culture of civility within nursing educational programs.

There is no compensation for participation. Your participation in this survey is voluntary and you may choose to leave the survey at any point. Consent will be given by participants selecting to open the survey link and proceed through the survey.

Questions about the research study can be addressed to the principle investigator: Candace Chihak UNI doctoral student at [REDACTED] or faculty advisor Dr. Victoria Robinson at victoria.robinson@uni.edu. Questions related to research participant's rights can be directed to UNI IRB Administrator at anita.gordon@uni.edu or 319-273-6148.

Thank you for participating in this research study. To proceed with the survey please click on the link below: _____

Candace Chihak RN, MSN

University of Northern Iowa Ed.D. doctoral candidate