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Deconstructing student perception of incivility in the nursing education triad

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DECONSTRUCTING STUDENT PERCEPTIONS OF INCIVILITY IN THE NURSING EDUCATION TRIAD

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DEDICATION

This work is dedicated to my late mother. It was her dream that I finish my doctoral studies. My mother attended college for one year during the depression. Her father offered to give her the family home if she would quit and come back to the small town where they resided. Times were difficult and she obeyed her father. As a result, she willed both of her daughters to get an education. My father's roots were poor – his father was a bricklayer and his mother a housewife. No one in my father's family had ever gone to college. Yet, he supported my mother wholeheartedly. After I graduated from high school, my mother shipped me off to the state university. Even though I would call home weekly begging to quit and come home, my mother persevered. She would not hear of it, but told me to stick it out and I would be glad.

My father quit school in the eighth grade to help support his family. Calling him had no effect either. He would say the same thing my mother did. Five years after beginning college, I graduated with two degrees – one in education and one in nursing. Both my parents were extremely proud and both wanted me to continue school. After I completed my master's degree, my mother encouraged me to continue and complete my doctorate. Though this was always my desire, life got in the way. I only wish she were here with me to help me celebrate the end of this journey. Thus, it is with both sadness and joy that I dedicate this work to her.

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We can rejoice, too, when we run into problems and trials,
for we know that they are good for us – they help us learn to endure. Romans 5:3

Though late in my life, this journey began as a result of my mother's encouragement and belief that nothing was impossible. She gave me roots, wings, and a joy of learning. This journey is complete as a result of help from many sources. First, my faith in God gave me the courage and strength to continue when I wanted to quit. I thank Dr. Kim MacGregor for all her help and encouragement, I am grateful for our time together and the sharing of our lives. I am indebted to all the members of my committee – Dr. Charles Teddlie, Dr. Eugene Kennedy, Dr. Roland Mitchell, and Dr. William Bankston for their help, suggestions, and encouragement. Dr. Teddlie encouraged me to explore the heart and soul of nursing education. Dr. Kennedy introduced me to the exciting world of measurement and provided plenty of smiles, encouragement, and thoughtful suggestions. Dr. Mitchell was willing to step in at the last minute and I am appreciative he was willing to do so. Dr. Bankston provided a sociological perspective which was greatly needed to complete this work. Thank you one and all.

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love, support, and listening ear. Thank you also, Gene, Mike, and Cody, for loving us and keeping us grounded. I love you all so much.

To my friend Melanie, I am glad we traveled this journey together. You challenge me to become a better scholar and more importantly, a better person. Having you by my side has made this sojourn a great deal more fun and definitely less threatening. Thank you for your continual encouragement and support.

I work with a most talented group of women and men who not only have supported me, but have continually encouraged me. They have provided me with support, help, and most importantly laughter. Thank you for being there and for being such a special group.

Nursing Education

Teaching, a journey,
Student, teacher together
Knowledge discovered.

The mountain is high.
Ebb, flow, forward, back building
The journey is shared.

Nursing education:
Faculty, students, nurses,
All interacting.

Working together,
Discovering new knowledge,
The nursing triad.

Beck, 2009

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ABSTRACT

This triangulated mixed methods study examines the construct of incivility in nursing higher education within the southeastern United States. A modification of the Incivility in Nursing Education (INE) survey (Clark, 2007) was administered to determine behaviors students identify as uncivil within the various contexts of the associate degree nursing educational environment – classroom and clinical area and among the nursing education triad – students, faculty, and nurses.

Ten factors were isolated as a result of exploratory factor analysis. There was a statistically significant difference between beginning and graduating students' perceptions regarding one factor, Abuse of Faculty Position. Beginning students described this factor as faculty showing favoritism and "not caring." Graduating students described this factor as faculty being rigid and acting superior. There was a statistically significant difference between where beginning and graduating students perceived incivility occurred most frequently. Beginning students identified the classroom and graduating students identified the clinical area as venues where incivility appeared the most.

Analysis of students' open ended responses revealed differences in the uncivil behaviors found in the classroom and on the clinical unit. Themes emerging included the severity of consequences, harassment, and perpetrators. The consequences of incivility on the clinical unit had the potential to be more severe; there was more opportunity for harassment on the clinical unit where nurses, faculty, patients, peers, and staff were potential perpetrators.

A comparison of programs with high and low levels of incivility was conducted through a content analysis of documents related to school mission, curricula, conduct codes, and faculty and by analyzing the open-ended responses on the INE. Findings revealed that programs with high perceived levels of incivility had extensive conduct codes with no student representation on appeals committees, required students to attend nursing classes during the summer, and had an environment which tolerated incivility with consequences focusing on punishment. Programs with low perceived levels of incivility had student representation on appeals committees, did not require attendance

during the summer, and focused on dialoguing with those involved in uncivil behavior.

Implications for nursing educators are discussed and suggestions for future research are identified.

CHAPTER 1. INTRODUCTION

It is better to be patient than powerful;
it is better to have self-control than to conquer a city. Proverbs 17:32

During the last two decades, much has been written on violence in both the workplace and on university campuses. Anderson and Pearson (1999) introduced the concept of incivility in the workplace, defining it as "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect" (p. 455); thus, differentiating this concept from other forms of deviant behavior that occur. By defining incivility as deviant behavior, Anderson and Pearson (1999) place this concept on a continuum where one end is incivility and the other is violence. Specific behaviors defined as workplace violence include aggressive acts such as killing, raping, or physically harming a coworker or superior, while uncivil behavior includes thoughtless, unethical behavior such as obscene comments, sarcasm, favoritism, scapegoating, or sabotage (Anderson & Pearson, 1999; Griffin, 2004; Hutton, 2006). To further describe the concept of incivility, Anderson and Pearson (1999) devised the incivility spiral, a new construct to serve as a framework for assessing uncivil behavior in the workplace, and proposed interventions to prevent behavior from escalating.

Within the academy, researchers were addressing issues of incivility in the classroom, though not always labeling these behaviors as uncivil. By the mid 1990s, researchers were identifying uncivil classroom behaviors and discussing their effect on teaching and learning (Boice, 1996). These researchers agreed that incivility is a violation of behavioral norms, but cautioned that norms are socially constructed and as such vary from venue to venue (Moffat, 2001; Boice, 1996).

Boice (1996), Lashley and de Meneses (2001), Thomas (2003), Nilson and Jackson (2004), and Clark and Springer (2007a) describe behaviors by both students and faculty that are acts of incivility. Student behaviors include coming late for class, talking during class, cheating, and openly insulting the faculty (Boice, 1996; Buckley, Wiese, & Harvey, 1998; Lashley & de Meneses,

2001; Thomas, 2003; Nilson & Jackson, 2004; Clark & Springer, 2007a, 2007b). Incivility on the part of the faculty includes such behaviors as making negative comments to students, expressing disinterest in class material and the students, canceling class without notice, and coming late or unprepared for class (Boice, 1996; Braxton, Bayer, Noseworthy, 2002, 2004; Clark & Springer, 2007a, 2007b).

Within the discipline of nursing, incivility has been studied largely within the workplace. Hutton's (2006) meta-analysis on incivility in academe uncovered one article dealing with uncivil behaviors among nursing faculty and students. Luparell (2007) believes that incivility in nursing classrooms is a problem and is increasing. She cites three articles that address this issue and draws the conclusion that there is a paucity of research on incivility in nursing education (Luparell, 2007). Clark and Springer (2007a) agree with Luparell (2007) and point out that incivility in nursing education is increasing as a result of the cultural shift in American society where incivility is tolerated.

Kenny (2007) discusses the implications of unethical behavior for nurses who are bound to adhere to a professional code of ethics that charge them to protect the public's health and act morally with integrity. Kleinman (2006) echoes these sentiments and describes nursing as "infused with a deep foundation of core values and emphasizes strict professional standards" (p. 72). She describes standards as guiding principles that define what is acceptable and values as guiding principles that elucidate important beliefs (Kleinman, 2006). The nursing profession must follow the ethical standards and values defined by the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association, 2001) and *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 1998). Additionally, each state board of nursing defines the scope of practice for the registered nurse. Inherent within the scope of practice are these same standards and values (National Council of State Boards of Nursing, 2006).

As part of the educational process, student nurses are socialized into the professional role of registered nurse (Cohen, 1981). This requires the student to acquire not only the knowledge and skills necessary to function as registered nurses, but also the values, beliefs, and norms of the nursing profession (Cohen, 1981). With today's fast-paced world that is fraught with challenges, nursing students must be able to make ethical decisions in their private lives, the classroom, and the clinical practice arena. As registered nurses, they will be faced with staffing shortages, complex health needs, and ethical dilemmas, situations which will require them to make ethical decisions (Clark & Springer, 2007b). The goal of the socialization process is to instill within the novice nurse the ethical values set forth in the Code of Ethics (ANA, 2001).

Incivility in nursing practice is described in the literature as "eating their young," horizontal violence, lateral violence, bullying, and aggression (Griffin, 2004; Farrell, 1997, 2001; Leiper, 2005; Felblinger, 2008; Dellasega, 2009). These researchers describe behaviors such as gossiping, withholding information, criticizing co-workers, and bickering as incivility (Griffin, 2004; Farrell, 1997, 2001; Leiper, 2005; Felblinger, 2008; Dellasega, 2009). One author suggests that nursing education should prepare their students for violent acts such as arson, sexual harassment, and threats of harm in the workplace (Waitere, 1998; Dellasega, 2009). Hutton (2006) states that incivility in the workplace, if left to escalate, can result in violence and cost over 4 billion dollars a year through burnout, therapeutic errors, patient harm, and death (Shirey, 2005; Luparell, 2007; Baxter & Boblin, 2007).

The literature on incivility in nursing discusses the fact that today's students are different than those attending nursing school prior to 1990 (Clark & Springer, 2007a; Thomas, 2003; Lashley & de Meneses, 2001; Kupperschmidt, 2006; Skiba & Barton, 2006; Lower, 2007). Today's students were reared in an era when children were protected and coddled; perceiving nursing as an occupation not a calling, and caring more about their grade than acquiring knowledge (Kupperschmidt, 2006; Lower, 2007). Conflicts arise when these values clash with nursing faculty,

primarily baby boomers, who believe that nursing is a calling and embrace the beliefs and values associated with the profession (Kupperschmidt, 2006). Boomers have a strong sense of professional identity with a strong work ethic, adopting some of the values of their predecessors (Kupperschmidt, 2006). Today's nursing educational system was devised primarily by nursing educators born prior to 1944 and the beliefs, values, and curriculum tend to reflect this (Kupperschmidt, 2006). This system was designed to teach a very different type of student. The average age of today's nursing faculty is 45.2 years and 48 percent of these nurse educators are over the age of 55 (Kupperschmidt, 2006). Yet the students cross generations; thus, this diverse age span creates tension as values, beliefs, and attitudes differ (Kupperschmidt, 2006; Skiba & Barton, 2006; Walker et al., 2006). It is understandable that these tensions would cause misperceptions about behaviors perceived as uncivil and makes salient the investigation of incivility in nursing education from the student's point of view, particularly since the focus of most studies has been from the faculty perspective (Clark & Springer, 2007a).

A number of theories are used to explain the occurrence of incivility including anomie, social disorganization, social exchange, oppression, and gender theory (Bray & Del Favero, 2004; Farrell, 2001). Anomie emerged from the work of Durkheim and Merton as a theory to explain deviance (Cohen, 1965; Olsen, 1965). While both describe anomie as referring to social order; each perceives this theory somewhat differently. Merton views anomie as chronic while Durkheim views anomie as acute (Scott & Turner, 1965). Since the primary unit of study in this research is the individual, anomie theory which refers to social order, does not seem like a good fit.

Shaw and McKay's social disorganization theory addresses factors that lead to disruption in the disorganization of communities which lead to deviant behavior (Sampson & Groves, 1989). Again, this theory is not appropriate for this research study since this study's unit of study is the student. Both oppression and gender theory have a place in nursing research. As a result of the Nightingale model of nursing education, nursing has become a primarily feminine profession with a

patriarchal hierarchy (Wilson, 2006). To frame this research within gender theory would be difficult since this research is situated within the discipline of nursing where the overwhelming majority of nurses are female. One could view this study though the lens of oppression theory; however, the power relationship within the nursing education triad (faculty and student, nurse and student, or faculty and nurse) would become a critical focus within the study. This power relationship should be examined in future studies on incivility.

As a result of the growing culture of consumerism in higher education (Delucchi & Korgen, 2002), social exchange theory was deemed the most appropriate frame for this research. In social exchange theory, learning is seen as an exchange of knowledge (Emerson, 1976). Reinforcement, resources, rewards, and costs are the salient concepts in this process (Emerson, 1976). Within the classroom, the approach the faculty member uses when communicating with the students can either reinforce or diminish learning (Bray & Del Favero, 2004). Students also reinforce faculty by their conduct and response to learning. In social exchange vernacular, the faculty is a resource for the student, rewards are grades, and costs are time and energy (Bray & Del Favero, 2004). From a faculty perspective, student response to learning can serve as a resource; rewards are positive student evaluations, while the cost is poor student evaluations (Bray & Del Favero, 2004). If one perceives the student as the consumer of knowledge, this theory is particularly relevant. Clark and Springer (2007a) found that students feel they can act as they wish, being as disrespectful and "rude as they want because they are paying customers" and have a sense of entitlement (p. 96). These students desire a very different relationship with the university. "They prefer relationships like those they already enjoy with their bank, their telephone company, and their supermarket" (Levine & Cureton, 1998, p. 5).

As a nursing educator with nearly thirty years of experience, I have observed changes in student attitude and institutional culture over the last two decades with acts of uncivil behavior increasing. This is supported by the findings of Public Agenda's research report on the status of

rudeness in America (Farkas, Johnson, Duffett, & Collins, 2002). These researchers found that Americans believe that rudeness is increasing due in part to a "declining sense of community, offensive and amoral entertainment media, and an overall rise in selfishness and callousness" (p.6) and the fact that rudeness begets rudeness.

The literature is now reporting that within nursing education there are four decades of faculty members and students with differing beliefs, values, and ethics. Lashley and de Meneses (2001) found that incivility in both the traditional classroom and the clinical arena have increased over the previous five years. For example, the nursing literature suggests that between 15% and 20% of nursing students have falsified patient records by recording treatments, medications, or observations that they did not administer (Langone, 2007; Baxter & Boblin, 2007). Incivility in the clinical setting is not often discovered unless there is a negative patient outcome, the most severe being the patient's death (Baxter & Boblin, 2007). With a national nursing shortage of both practicing nurses and nursing faculty, it seems prudent to explore the depth of this problem and the factors contributing to it.

Previous research by Clark and Springer (2007a, 2007b), Clark (2006), Clark (2008a, 2008b, 2008c, 2008d), Clark and Carnosso (2008), Lashley and de Meneses (2001), Langone (2007) has not addressed differences in incivility related to educational environments – traditional classroom and clinical area; nor did their research focus on associate degree students and their perception of incivility. Since one outcome of nursing education is to socialize student nurses into the profession of nursing, one can hypothesize that values and beliefs change as a result of this education (Leners, Roehrs, & Piccone, 2006; Schank, Weis, & Ancona, 1996). If values and believes change, does perception of incivility change as a result of nursing education?

To date the preponderance of the research on incivility in nursing education focuses on baccalaureate prepared nurses. A search of EBSCO databases using the key words nursing education, incivility, and associate degree resulted in no citations. By removing "associate degree"

from the search parameters, twenty-two citations were found. Only one of these studies addresses associate degree nurses and this study compared baccalaureate nurses with those educated at the associate degree level (Lashley & de Meneses, 2001). Lashley and de Meneses (2001) found no significant difference in the reporting of incivility between program types with the exception of bringing infants to class which occurred more frequently in baccalaureate programs.

1.1 Problem Statement

To address this gap in the literature, this study will focus on associate degree nursing students and their perception of incivility within the context of nursing education – traditional classroom or clinical area. Additionally, student perception of incivility at the beginning of the nursing program and prior to graduation will be examined. The context of this study is nursing higher education in the southeastern United States and for purposes of this study, incivility will be defined as violating the behavioral norms of the nursing profession and the nursing classroom – traditional classroom and the clinical unit.

To guide this study, the following research questions are posited:

1. What behaviors in the learning environment do associate degree nursing students perceive as incivility at the beginning and at the end of their associate degree in nursing education?
2. What are the differences in the perception of incivility by students in the various contexts of the associate degree nursing educational environment – classroom and clinical area?
3. What are the differences between programs with high and low perceived levels of incivility?

1.2 Limitations

Limitations to this study include the fact that the study was conducted only in the southeastern United States. Students in this region were impacted by Hurricane Katrina and this

may have affected their perception of incivility. The aftermath of Katrina was horrific as people were herded into the Superdome and the New Orleans Convention Center with no food or running water. There was no security and frontier law was the norm. Living through this experience may have desensitized individuals to occurrences of incivility.

The fact that nursing is composed primarily of Caucasian females is also a limitation as minorities and men are underrepresented. Sample size is also a limitation as well as the fact that only students at schools who admitted a spring and fall cohort were sampled. It has not been empirically determined whether schools with fall and spring nursing admission cohorts differ in any significant manner from schools admitting only once per year.

CHAPTER 2. LITERATURE REVIEW

The literature review focuses on concepts salient to this study: social exchange theory, the construct of incivility, nursing as a profession, socialization into the profession of nursing, the culture of nursing, institutional culture, and the construct of student as a consumer of higher education.

2.1 Social Exchange Theory

Exchange theory is a method of describing social behavior in terms of acts exchanged between two or more people that result in costs or rewards (Homans, 1961). Meeker (1971) considers the basic assumption in exchange theory to be that "human social behavior can be logically derived or predicted from premises held by the" individual "whose behavior is being predicted" (p. 485). These premises include (1) the individual's values, (2) the perception of the various behaviors available to the individual, (3) perceived consequences of the behaviors, and (4) social norms dictating a prescription for behavior (Meeker, 1971). Meeker (1971) defines values as nonvoluntary and behavior as voluntary or within the control of the individual and points out that people choose things or behavior they value more than they choose things they do not value. Exchange theory posits that an individual's behavior maximizes values which can be both positive (rewards) or negative (costs) (Meeker, 1971). Within a behavioral act is a fundamental tension between avoiding costs and adhering to the social norms (rewards) (Meeker, 1971). Where values are individual, norms by definition are not (Morris, 1956). Norms are generally accepted behaviors or beliefs and social norms are those behaviors or beliefs that are socially accepted and enforced (Morris, 1956; Meeker, 1971; Mills & Mills, 2000).

Social Exchange theory emerged through the work of George Homans, John Thibaut, Harold Kelly, and Peter Blau (Emerson, 1976). George Homans' essay describing behavior in a social context as exchange was one of the earliest writings on exchange theory (Emerson, 1990). Homans described social exchange as an activity involving at least a dyad where rewards and costs

were exchanged (Blau, 1964). According to social exchange theory, individuals are faced with choices which involve costs (time, energy, money) and rewards (products, services, benefits) (Blau, 1964; Emerson, 1990). This activity becomes reciprocal as individuals are motivated by need to continue receiving these rewards or benefits from the exchange (Blau, 1964). Blau (1964) differentiates social exchange from economic exchange by pointing out that an economic exchange requires a formal contract defining the obligations of the exchange. Whereas a social exchange involves an exchange with an expectation of future returns which are unspecified (Blau, 1964). This exchange leads to mutual feelings of trust, gratitude, and interdependence where economic exchange does not (Blau, 1964). For example, one does not feel obligated nor necessarily trust the dealer from whom a car is purchased and the dealer does not feel gratitude toward the buyer, though the dealer may feel some sense of obligation toward the buyer.

Emerson (1990) discusses the attributes of social exchange theory and describes the conceptual unit as the exchange relationship or the transactions between the same people or group over time. This relationship over time allows for commitment, trust, and obligation to emerge while the relationship develops into one of mutual dependence (Emerson, 1990). This serial relationship distinguishes social exchange from economic exchange (Emerson, 1990). As a nascent theory, research on social exchange theory primarily dealt with dyads. The theory was then expanded to include groups, networks, and emotions (Emerson, 1990; Lawler & Thye, 1999).

2.1.1 Emotions in Social Exchange

Lawler and Thye (1999) examined the role emotions play in social exchange – in deciding what to exchange and how much of it to exchange. Inherent within this act are two phenomena: self-interest and interdependence (Lawler & Thye, 1999). Works on social exchange prior to this one, alluded to emotion within the exchange process, but did not theorize or examine emotions to any degree (Lawler & Thye, 1999). One only has to observe the interaction between two lovers, a mother and child, or even two friends to see that emotions play a role in these interactions.

Emotions can not be separated from either reward or costs. They are a part of the exchange process and can affect both the process and the outcome of the exchange (Lawler & Thye, 1999).

Psychologists have attempted to categorize and define fundamental emotions and determine whether some are categorically different from others and as a result two models have emerged (Lawler & Thye, 1999). One model portrays emotions along continua of pleasure-displeasure and high arousal-low arousal while the other model depicts emotions as discrete events with unique properties (Lawler & Thye, 1999). These fundamental distinct emotions include fear, anger, frustration, sadness, joy, and pleasure. For example, even though fear and anger are both negative emotions, fear may lead one to flight while anger may lead one to fight (Lawler & Thye, 1999). For purposes of their analysis, Lawler and Thye (1999) define emotion as a "short-lived positive or negative evaluative state that has neurological and cognitive elements" (p. 219). Emotions are internal and the individual does not always have control over them (Lawler & Thye, 1999). The literature on incivility describes the emotions felt by all involved (Clark, 2008a, 2008b, 2008c, 2008d; Rowe & Sherlock, 2005; Luparell, 2008; Heinrich, 2007; Erickson & Grove, 2007).

Lawler (2001) posits "an affect theory of social exchange" (p. 321) to explain the role of emotions within the social unit of exchange. He expands the theoretical domain from the dyad in which each person has something the other one desires to networks and includes the emotional component of the exchange. Successful exchanges result in positive emotions and unsuccessful exchanges result in negative emotions (Lawler, 2001). Secondly, by its very nature, social exchange is a joint activity but the intensity of the emotions vary depending on how the individuals perceive their joint activity, their relationship, and their commitment to the group or dyad (Lawler, 2001). Lawler (2001) explains that within networks, dyads are connected so that an exchange within one dyad will affect the network or an exchange within other dyads in the same network.

Lawler's (2001) affect theory has five fundamental assumptions: (1) the exchange produces global emotions ranging from positive to negative, (2) these emotions are internal stimuli, (3)

individuals seek to avoid negative stimuli and incur positive stimuli, (4) the global emotions trigger cognitive efforts to understand their cause resulting in specific emotions, and (5) individuals explain and interpret their global feelings in relationship to the group or network by connecting feelings to experience. An essential component of the affect theory is the belief that global emotions are responses to stimuli and therefore, not under the control of the individual experiencing them (Lawler, 2001). These global emotions evoke a cognitive response that results in the formation of more specific and object focused emotions (Lawler, 2001). Foundational to this theory is the assumption that positive emotions increase commitment to the group and negative emotions decrease commitment (Lawler, 2001). For example, when individuals remain in the group despite better alternatives, the group membership has value for this individual (Lawler, 2001).

Saavedra and Van Dyne (1999) explored the emotional investment of work groups through a social exchange frame. They defined emotional investment as composed of loyalty to the group, caring for its members, and commitment to the group as a whole (Saavedra & Van Dyne, 1999). This study posits that groups that are emotionally invested will survive assuming that during the process of exchange, individuals evaluate personal rewards in relation to costs. Thus, if rewards exceed costs, the exchange is continued (Saavedra & Van Dyne, 1999). These researchers build on Rusbult's (1983) study of dyads and define rewards as behavioral attributes that are enjoyable or beneficial and costs as those that are irritating or annoying hypothesizing that rewards will illicit stronger emotional investment (Saavedra & Van Dyne, 1999). Saavedra and Van Dyne (1999) believe that as emotional investment increases, the focus of the exchange changes from one where there is mutuality to one where the group strives to meet members' needs.

Saavedra and Van Dyne (1999) studied 28 work groups of 134 undergraduate management students, 60% of which were male. These groups were newly formed and consisted of individuals who had not worked together, thus controlling for previous emotional involvement. Tasks and time were controlled by providing frequent sessions of 60 minutes and one 90 minute session allowing

for social relationships to develop. To facilitate resource exchange among group members, specific tasks were required. Initially, members had to determine "the talents, skills, background, and experience of" each individual in the group (Saavedra & Van Dyne, 1999, p. 113). Member roles were determined based on this information. Groups were required to answer questions throughout the semester, prepare a report, and complete a group project based on job redesign. To reinforce group exchange, 65% of the course grade was based on group work (Saavedra & Van Dyne, 1999). After completing nine weeks of group work, members were asked to complete a survey assessing cost and reward of working together in the group. Ten days later, group members completed a second survey which included items related to emotional investment (Saavedra & Van Dyne, 1999).

Two hypotheses were tested at the group level – (1) both costs and rewards will predict the amount of emotional investment and (2) "rewards will have a positive effect and costs a negative effect on emotional investment" (Saavedra & Van Dyne, 1999, p. 117). A factor analysis using Varimax rotation was conducted to determine distinct factors. Three emerged accounting "for 66% of the variance – emotional investment, rewards, and costs" (Saavedra & Van Dyne, 1999, p. 115). Additionally, descriptive statistics and Cronbach's alpha were run on the three factors and group performance. Results indicated that group members agreed most on their assessment of personal rewards (Saavedra & Van Dyne, 1999). Hypotheses were tested using hierarchical regression analysis which supported the second hypothesis, but indicated that only rewards predicted emotional investment (Saavedra & Van Dyne, 1999). These findings support Lawler and Thye (1999) in that emotions are inherent in social interactions and affect relationships and may bias information processing or diminish cognitive capacity.

2.2 Construct of Incivility

Certainly emotions are a fundamental part of uncivil behavior. In 2002, Public Agenda published a report on rudeness in America (Farkas et al., 2002). They found that 78% of Americans felt that rudeness was increasing; only 24% of Americans felt that most people have good manners,

and only 20% of high school students treat their teachers with respect (Farkas et al., 2002). If indeed emotions diminish cognitive capacity, this has tremendous implications for learning. Shirey (2007) points out that as rudeness, stress, and anger increase in society; these emotions also enter the college classroom.

Boice (1996) suggests that though incivility in the higher education classroom happens, it has received little attention. He proposes four views on why this has occurred: the academy perceives that incivilities will be interpreted as a result of lack of skill, faculty feel little can be done to eradicate incivility, faculty do not engage the students, and little research has been conducted on the topic (Boice, 1996). The costs of allowing incivility to proliferate "include discomfort, danger, and derailed learning" (Boice, 1996, p. 459). Both students and faculty described "classroom terrorists" whose unpredictable behavior made the classroom uncomfortable, if not intolerable (Boice, 1996).

Yet, what is incivility? The literature differs on how incivility is defined and though definitions vary, those involved believe they can recognize incivility when it happens. Anderson and Pearson, (1999) define incivility as "low-intensity deviant behavior with ambiguous intent to harm the target" (p. 455). Incivility violates organizational norms and is interactive (Anderson & Pearson, 1999). Boice (1996) echoes this stating that the majority of researchers studying incivility in the classroom assume that both faculty and students contribute to the occurrences of incivility.

Lashley and de Meneses (2001) surveyed nursing administrators at 611 nursing programs throughout the United States to determine the degree of incivility occurring in nursing education. Three behaviors were identified as disruptive by all respondents: "student inattention in class, student absence from class, and student lateness to class" (Lashley & de Meneses, 2001, p. 82). They found that verbal abuse, rudeness, and cheating occurred most often in public institutions and large programs with over 200 students (Lashley & de Meneses, 2001). These researchers report that respondents felt that the quality of student work in the classroom and the clinical area had

diminished within the last five years (Lashley & de Meneses, 2001). Behaviors cited included having a chair thrown at faculty, fighting on patient care units, and charting nursing care that was not completed. Lashley and de Meneses (2001) conclude that nursing faculty "have not come to grips with the new types of students entering nursing programs" (p. 86). They propose a national forum to discuss the issue of incivility in nursing classrooms.

Clark and Springer (2007a) explored both faculty and student perceptions of incivility in nursing education. They surveyed the population of nursing students and faculty at a public university in the northwestern United States. These researchers used the Incivility in Nursing Education (INE) survey which was developed by Clark (2006) and designed to measure perceptions of incivility in nursing education (Clark & Springer, 2007a). Student behaviors most often described as uncivil were

> cheating on examinations or quizzes; using cell phones or pagers during class; holding distracting conversations; making sarcastic remarks or gestures; sleeping in class; using computers for purposes not related to the class; demanding make-up examinations, extensions, or other favors; making disapproving groans; dominating class discussion; and refusing to answer direct questions (Clark & Springer, 2007a, p. 10).

Uncivil faculty behaviors included being distant, belittling students, refusing to answer questions or meet with students outside of class, ignoring classroom disruptions, expressing disinterest in the subject, speaking too quickly or unintelligibly, and canceling class at the last minute (Clark & Springer, 2007a, 2007b). Clark and Springer (2007a) identify possible causes including a high stress environment with high stakes testing, faculty arrogance, competitiveness, and students who either are not really interested in nursing or who are unclear about expectations.

Luparell (2007) utilized the critical incident technique to identify nursing faculty's perception of incivility by their students. She used a semi-structured interview of 21 faculty members attending a conference on incivility to glean "36 critical incidents of incivility" (p. 16).

Luparell (2007) uses the analogy of a battle to describe these incidents and states that incivility in the nursing classroom has a negative effect on the educational process and the faculty. She suggests using a debriefing process to assist faculty in reconciling these instances since each faculty member experienced an emotional reaction to recounting the experience. Luparell (2007) points out that the consequence of these encounters is severe and taking efforts to diminish incivility is critical. She believes that "the well-being of faculty, nursing education, and even the profession may be at stake" (Luparell, 2007, p.19).

Within the discipline of nursing, the context of the classroom includes not only the traditional classroom, but the skills' laboratory and the clinical environment. Although no empirical studies have established this connection, a number of researchers have suggested this relationship between classroom behavior and clinical behavior (Lewenson, Truglio-Londrigan, & Singleton, 2005; Kenny, 2007; Kolanko, Clark, Heinrich, Olive, Serembus, & Sifford, 2006; Langone, 2007; Lashley & de Meneses, 2001; Luparell, 2004; Baxter & Boblin, 2007; Clark, 2008a). Kolanko et al. (2006) discuss incivility in nursing practice as well as nursing classrooms. These nurses suggest interventions to diminish incivility and discuss the role faculty play in inciting these acts (Kolanko et al., 2006). They maintain that "workers in the health care industry are the largest population to experience Type II violence" or bullying (Kolanko et al., 2006, p. 39). Randle (2003) found that practices in nursing contribute to the occurrence of Type II violence. Students were bullied, saw nurses bullying patients and each other, and then bullied others (Randle, 2003).

Rowe and Sherlock (2005) studied stress and verbal abuse among nurses. They point out that previous research had focused on patients, families, and health care workers as the source of verbal abuse. The purpose of their study was to determine if nurses verbally abuse other nurses. Rowe and Sherlock (2005) surveyed 213 nurses and 96.4% of the respondents reported that they had been verbally abused. These abusers included patients (79%), attending physicians (74%), other nurses (75%), and patients' family members (68%) (Rowe & Sherlock, 2005). Seventy

percent of the respondents stated that these episodes lasted a "few hours" (Rowe & Sherlock, 2005, p. 245). The most distressing finding was that nurses were the most frequent source of verbal abuse to other nurses. The most frequent types of verbal abuse included "anger, judging and criticizing, and condescension" (Rowe & Sherlock, 2005, p. 246). An encouraging finding emerging was that the majority of the responding nurses used positive coping skills to address the behavior. These nurses dealt directly with the perpetrator; however they still felt angry, frustrated, and hurt (Rowe & Sherlock, 2005). Rowe and Sherlock (2005) conclude that "verbal abuse is a very real problem for the health care industry. The problem is deep seated and has existed for many years. Nurses have become a significant source of verbal aggression, a position formerly held by doctors" (Rowe & Sherlock, 2005, p. 247). Implications include high nurse turnover, decreased continuity of care, poor patient outcomes, and increased cost to hospitals (Rowe & Sherlock, 2005).

Luparell (2008) discusses the impact incivility has on both faculty and students. Faculty report both emotional and physical consequences including loss of sleep, loss of confidence, and a desire to quit teaching (Luparell, 2007). Students report feeling traumatized, stressed, powerless, and a belief that faculty are attempting to "weed them out" (Luparell, 2008, p. 44). When this happens, it is a violation of the ANA Code of Ethics (ANA, 2001) and reflects a lack of dignity and value for the other person (Luparell, 2008). This behavior is inconsistent with the precepts of nursing. Benner (1994), in describing nursing, declares that "caring sets up the possibility for cure" and "the science and practice of health care workers lose their ethical and epistemologic moorings without an ethic of care and responsibility as a guide" (p. 44).

Contributing to this increase in incivility is the market mentality of nursing students. Today's student sees him/herself as the consumer with power over the faculty (Delucchi & Korgen, 2002; Potts, 2005). They believe that their tuition pays the faculty's salary, so these students are in essence the boss (Kolanko et al., 2006). This behavior and entitlement carries over into the clinical arena (Kolanko et al., 2006) where nursing supervisors complain that new graduates are demanding,

unwilling to work the less desirable shifts, and over-confident (Baltimore, 2006). Rau-Foster (2004) cites stress, difficult working conditions, and unresolved conflict as contributing to the increase of incivility in the clinical environment where outsiders are often excluded. Students as well as new graduates are "outsiders" and the group evaluates these newcomers for evidence of common values and beliefs (Rau-Foster, 2004). Until these "outsiders" are accepted into the group, they may experience uncivil behavior from group members (Rau-Foster, 2004).

2.3 Nursing as a Profession

Historically, only men served as nurses since caring for the poor and sick was not work fit for a lady. Nursing as a male profession ended when Florence Nightingale returned from the Crimean War and reestablished nursing as a woman's occupation (Evans, 2004; Wilson, 2006). Nightingale established a paternal style of nursing which existed until the late twentieth century. In the paternalistic style of nursing, the father role was assumed by physicians, the role of child assumed by patients, and the nurse assumed the mother role (Evans, 2004). This belief that nursing was an extension of the female mother role was instrumental in establishing nursing as a woman's occupation which was not only unskilled, but undervalued (Evans, 2004).

In the late 1800s, Florence Nightingale opened a nursing school for women between 25 and 35 years of age. These women lived at the hospital and learned nursing by working under the supervision of physicians (Wilson, 2006). This model of nursing education became known as the Nightingale model and was replicated by schools of nursing in England, the United States, and Canada (Wilson, 2006). Prior to this, nursing education followed an apprenticeship model that socialized the apprentice into the role of the nurse (Wilson, 2006). It was not until nursing education migrated into higher education that this Nightingale model began to change. Young (1996) explains this movement from hospital to higher education as a paradigm shift from a medical model of nursing education to a more holistic caring model. Williams and Taliaferro (2001) agree

and deem that nursing education will be different in the future as the health care industry and society evolve and change.

Initially, nurse educators in higher education thought that nursing knowledge was acquired through classroom instruction with clinical experiences offering a venue in which to apply this knowledge (Young, 1996). It wasn't until the 1960s with the expansion of community college systems, that associate degree education in nursing began replacing diploma or hospital-based nursing education (Pendergast, 2000). This trend has continued due in part to the shortage of practicing nurses, the emphasis on the professional values, and the desire to produce nurses who would function in an ever changing health care environment (Mahaffey, 2002). With the curriculum revolution and initiation of dialogue about evidenced-based teaching, there began a "growing belief that nursing is grounded in both knowledge and experience" (Young, 1996, p. 191); thus, supporting the need for both classroom instruction and clinical experience.

2.4 Socialization into the Nursing Profession

Secrest, Norwood, and Keatley (2003) point out that in any profession, the development of a professional identity is crucial. Within nursing education, students are preparing to enter the health care environment within various health care settings. These students often identify with the professionals in these various settings adopting the values and beliefs espoused in the health care system. These values and beliefs may be counter to those endorsed by the profession itself or the academic institution where the student is educated (Secrest et al., 2003). Cohen's (1981) seminal work exploring nursing's quest for an identity began by investigating how student nurses internalized professional values and norms. Cohen (1981) defines professional socialization as the process by which one acquires the skills and knowledge needed to fulfill the professional role while integrating the profession's values and norms into one's own self-concept. This process is accomplished through professional training and education. There are four goals of the socialization

process: 1) learning facts and theories inherent in the profession, 2) internalizing the culture, 3) discovering a professional role, and 4) integrating this role into one's sense of self (Cohen, 1981).

Professional socialization as defined by du Toit (1995) expands this socialization process by providing for mentoring "novice practitioners into the profession to become successful professional practitioners" (p. 164). Implicit within a professional identity are the values and norms of the professional group (Cohen, 1981; du Toit, 1995; Howkins & Ewens, 1999). As the individual adopts the group's values and norms, the concept of self also changes until the individual is socialized into the profession or group (du Toit, 1995). Within the profession of nursing, the socialized individual develops an identity as "the nurse." Secrest et al. (2003) believe that this socialization process begins upon admission to nursing school.

When examining the development of nursing identity in two schools of nursing in Australia, du Toit (2003) used the Professional Socialization Scale (PSS) to survey students in their first and third year of the nursing program. The PSS has 54 questions designed on a seven-point Likert scale. Of the 300 questionnaires distributed 58% (173) were returned and utilized in the study (du Toit, 2003). Of the 173 participants, 88.4% scored above the midpoint on the Professional Socialization Scale and based on the responses, a verbal picture of the ideal type of nurse emerged (du Toit, 2003). This nurse exhibits a service calling and views caring for others as important (du Toit, 2003). The ideal nurse demonstrates supervisory skills, collaborates with members of the health care team, uses critical decision-making, and exhibits a commitment to the profession of nursing (du Toit, 2003).

Leners et al. (2006) examined the development of professional values in nursing students as they progress through the educational process. These researchers suggest that as the health care environment changes, nurses will be faced with moral and ethical issues that require use of professional values to guide and shape these decisions (Leners et al., 2006). These professional values guide, motivate, and shape nursing behavior (Leners et al., 2006). The values for

professional nursing are identified and defined in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998) and are foundational for nursing practice guiding interactions with clients, colleagues, other professions, and the public (Leners et al., 2006). These values are "internalized through professional socialization – the process of learning or understanding the 'nature of being' a nurse" (Leners et al., 2006, p. 505). Nursing values are influenced by education and affect client care (Schank et al., 1996; Schank & Weis, 2001; Leners et al., 2006). Core professional values outlined by the AACN include altruism, integrity, autonomy, human dignity, and social justice (AACN, 1998). AACN (1998) defines altruism as concern for the well-being of others, integrity as congruence with a code of ethics and a standard of care, autonomy as self-discipline, human dignity as an appreciation for the uniqueness and worth of individuals, and social justice as upholding legal and moral principles.

Using the Nursing Professional Values Scale (NPVS), Leners et al. (2006) surveyed four cohorts of nursing students at a large research-intensive institution in the western United States. Ninety-eight percent completed the pretest during the first week of class their first semester in school and 87% completed the post-test during the last week of class their senior semester. These researchers found that professional values did change significantly throughout the course of the nursing program (Leners et al., 2006). It is important to remember that although these students entered the nursing program with some values already in place, the educational experience influenced their values. Leners et al. (2006) point out that research is needed to explore how the nursing educational experience facilitates value development.

How can these same students engage in uncivil behavior? Did they fail to embrace the professional values of the nurse? Kenny (2007) thinks that students engaging in unethical behavior lack the values and standards required by the nursing profession and are likely to continue to behave unethically in their nursing practice. She assumes that behavior in the classroom has the potential to translate to behavior at the bedside (Kenny, 2007).

Randle (2003) used grounded theory as a framework to support this premise. She found that the "process of becoming a nurse was a distressing and psychologically damaging one" (Randle, 2003, p. 397). The students interviewed expressed feelings of diminished self-esteem, lack of control, and powerlessness. Yet, these same students adopted the same behaviors they saw in the nurses as they became socialized into the profession. du Toit (1995) found that the majority of the nursing students she studied conformed to the professional norms so that their nursing identity subsumed their personal identity.

Within the majority of professions – medicine, law, physical therapy, and dentistry, socialization begins at the masters or doctorate level of education when students are admitted into these programs. In nursing, socialization into the profession begins the first day of nursing school (Secrest et al., 2003). These students may be as young as 18 years old when this begins. At 18 years of age, most individuals are still forming their adult identity. Perry (1999) studied the intellectual and ethical development of college students and how they viewed knowledge, the process of learning, and their understanding of their world. He also examined the challenges collegiate study presents to the student. Perry (1999) found that the majority of students enter college with dualistic thinking (position 2) where the teacher is right and knows everything about the subject. In this stage of intellectual development, the individual can not think for oneself. The ability to think for oneself does not appear until position 4 and the majority of students reach this position by graduation (Perry, 1999). If students don't begin to think for themselves until they graduate from college, this has implications for socialization into the nursing profession.

2.5 The Culture of Nursing

The nursing profession as it exists today in the United States has its roots in the Nightingale model (Cohen, 1981). While Florence Nightingale rejected the feminine mores of the Victorian era when she went to Scutari during the Crimean War, she encouraged a health care system that produced nurses who were subordinate to physicians (Cohen, 1981). In this way, Nightingale added

an additional submissive role to the already subservient female role (Cohen, 1981). Nursing education in America is patterned after the Nightingale model where schools of nursing were housed in hospitals and their purpose was to provide staff for the supporting hospital (Cohen, 1981). As a result of this history, the educational structure within the profession of nursing supports this culture of submission as does the health care system (Cohen, 1981).

Defining the culture of nursing has proven difficult (Suominen, Kovasin, & Ketola, 1997). In a general sense, nursing culture refers to the knowledge, values, and beliefs that are passed from one generation of nurses to the next (Suominen et al., 1997). The culture of nursing has distinctive features – rituals such as shift report, pinning, and assigning new nurses the worst shifts; a common language; and common dress (Suominen et al., 1997). Historically, the culture has been defined by gender. Initially males were the only nurses, but after Nightingale created a school of nursing, the body of nursing became distinctly feminine and as a result some nurses are calling for a name change because the name nursing and nurses is "so female-oriented" (Suominen et al., 1997, p. 188).

One can not discuss the nursing culture without addressing the issue of power. In every interaction and circumstance in nursing, there is power intertwined (Suominen et al., 1997). When nurses interact with physicians, the physicians exert their power. When the nurse interacts with the patient, the nurse may exert his/her power. In the workplace, be it hospital, a clinic, or a community agency, there is a hierarchy of power. Suominen et al. (1997) believe that nursing culture in its most austere form is a matter of professional power where the task of each generation of nurses is to transfer this power structure to the next generation (Suominen et al., 1997).

Historically, nurses are seen as subordinate and powerless in the health care system (Freshwater, 2000). The "good nurse" is one who is compassionate, caring, and obedient; again, this contributes to the perception of the nurse as female and powerless (Randle, 2003). Freire (2003) describes how oppressed groups tend to behave the way their oppressors do because their

thinking becomes distorted. Unconsciously, the oppressed identify with their oppressors and thus become oppressors themselves (Freire, 2003). Roberts (1983) suggests that coercive and rigid behavior is typical in oppressed groups. Therefore, these nurses feel that they lack power except over those who are helpless such as patients and students. Randle (2003) believes this is a characteristic of horizontal violence where oppressive/uncivil behaviors move horizontally between group members (Freire, 2003).

Randle's (2003) study suggests that not only should nursing scrutinize the manner in which nursing students are socialized, but the context of the health care system should also be examined. In a context where nurses perceive themselves as powerless, bullying and horizontal violence is rife (Randle, 2003). It is within these types of environments where the "good nurse" is one who is compassionate, caring, and subservient (Randle, 2003). Freshwater (2000) agrees stating that nurses are historically an oppressed group who are viewed as powerless and subordinate in the health care system.

Meissner (1986) asks, "are we eating our young?" She believes that this begins with nurse educators who focus on judging students instead of supporting them (Meissner, 1986). This behavior is perpetuated by staff nurse colleagues of the new graduate. Rowe and Sherlock (2005) believe that burn-out contributes to the propagation of abuse. They studied 213 nurses in the Philadelphia area who reported that "the most frequent source of abuse was nurses" with staff nurses being the most frequent source (Rowe & Sherlock, 2005, p. 242).

Clark (2006) found that nursing faculty behavior is positively correlated to treatment they received as students. Thus, if faculty members were treated badly during their own nursing education, they tend to treat their students in the same manner. Heinrich (2007) found that often nursing faculty members are targets of the uncivil behaviors of their administrators. She maintains that this results in feelings of powerlessness which causes the individual to "act out" to make up for their lack of control (Heinrich, 2007).

Adams (2007) discusses nursing culture as part of the environment in which nurses practice. Nursing culture and its environment is informed by the history of nursing (Adams, 2007). For example, historically nursing has a strong military tie. This is the foundation for the discipline, loyalty, and obedience required in the profession (Adams, 2007). Discipline because the work is difficult and directed by the physician; loyalty and obedience to one's institution, profession, and superiors (Adams, 2007).

Florence Nightingale embedded within the history of nursing the construct of the virtuous woman, the good nurse, or the angel of mercy (Adams, 2007). By the 1990s, society had changed as had nursing. Nurses were no longer willing to be the "handmaidens" of the physician (Adams, 2007, p. 5). The idea of nursing serving as patient advocate arose and nursing moved from diploma or hospital-based education into the realm of higher education (Adams, 2007). These changes have forged the way for nursing to shift from a hierarchical, ritualistic profession to a more autonomous one; though Adams (2007) cautions that this has been and still is a slow process.

2.6 Institutional Culture

Culture as described in the literature is viewed through many lens. Merriam-Webster's Online Dictionary defines culture as a set of shared values, attitudes, and practices that characterizes an institution, organization, or discipline. Kuh and Whitt (1988) describe institutional culture as "the collective, mutually supporting patterns of norms, values, practices, beliefs, and assumptions that guide the behavior of individuals and groups" (p. 12). They deem that culture provides "a frame of reference within which to interpret the meaning of events and actions on and off campus" (Kuh & Whitt, 1988, p. 13). Toma, Dubrow, and Hartley (2005) relate culture to the emotions of the organization; therefore, the organizational culture serves to convey organization identity, define authority, and facilitate commitment. Strong institutional cultures promote commitment and pride among its members and these institutions tend to function more effectively (Toma et al., 2005).

The literature supports the concept that institutional cultures vary across types of institutions with values differing within each type (Toma et al., 2005; Birnbaum, 1988; Bensimon, Neumann, & Birnbaum, 1989; Bolman & Deal, 2003). For example, in an institution of higher education that functions as a collegium, power is shared and individuals interact as equals (Bensimon et al., 1989). The culture of these institutions is one where there are strong community ties, an emphasis on shared power, consensus, and mutual respect (Birnbaum, 1988). In these institutions the group's goals are valued above individual goals (Bensimon et al., 1989). Collegial institutions tend to be small institutions where members interact face-to-face and share a strong coherent culture (Birnbaum, 1988). Institutional norms are pervasive and congruent (Birnbaum, 1988).

In an institution functioning as a bureaucracy, the president is seen as the locus of power whose primary function is to allocate resources (Bensimon et al., 1989). These institutions tend to be somewhat larger and emphasize rationality, expertise, and performance (Bensimon et al., 1989; Birnbaum, 1988). The hallmark of the bureaucracy is the organizational chart indicating the power structure (Birnbaum, 1988; Bensimon et al., 1989). The culture of bureaucracies is one of hierarchy and inefficiency where norms are enforced through rationality and structure (Bensimon et al., 1989; Birnbaum, 1988).

Universities and colleges that function as a political system focus on setting and achieving goals. These institutions tend to be large, regional public universities governed by a board of regents where conflict is the norm and their leaders function as mediators (Bensimon et al., 1989; Birnbaum, 1988). The culture of these institutions not only allows, but expects conflict. A symbol of political institutions is the power bloc with serves to impede productivity (Bensimon et al., 1989). The political process and structure of these institutions tend to protect the institution from disruption and the sphere of influence varies depending on the issue and the group attached to it (Birnbaum, 1988). Therefore, institutional norms tend to be group focused not institutionally focused (Birnbaum, 1988).

Anarchical institutions tend to be large research-intensive universities. These institutions are composed of coalitions that tend to be department or discipline focused (Birnbaum, 1988). Decision-making in these institutions is done through resolution, flight, or oversight and "neither coordination … nor control are practiced (Birnbaum, 1988, p. 153). The culture of anarchical institutions allows individuals to function autonomously and groups to respond to their specific interests or market influences (Birnbaum, 1988).

The cybernetic university system is a combination of the four other types and in this system, performance is continually assessed through feedback loops. These institutions have monitors that assess the performance of their department and they tend to run themselves (Bensimon et al., 1989). These institutions have two types of control systems – explicit controls and implicit controls (Birnbaum, 1988). Explicit controls are the rules and regulations of the institution and its structure. Implicit controls are social controls imposed by group members (Birnbaum, 1988). Since cybernetic institutions are composed of subsystems which function through feedback loops, culture tends to be stable until a problem occurs; however, each subsystem responds to a limited set of stimuli since these feedback loops are system focused (Birnbaum, 1988).

Additionally, each health care environment has a unique culture. Student nurses have to function in the culture of their learning environment on campus and in the culture of the health care setting. Within health care, there is "a history of tolerance and indifference to intimidating and disruptive behaviors" (The Joint Commission, 2008, ¶ 5). Institutions that allow this type of behavior indirectly sanction it. As a result, The Joint Commission issued new guidelines for healthcare institutions. Effective January 1, 2009, accredited institutions must have a code of conduct and a process for addressing disruptive behaviors (The Joint Commission, 2008).

Schneider, Bowen, Ehrhart, and Holcombe (2000) discuss the climate of service in organizations noting that the role of the leader and leadership style had an effect on the organizational climate. Issues regarding relationships and attitudes have been central to the study of

climate in organizations particularly when evaluating consumer and employee satisfaction (Schneider et al., 2000). Lee (2007) examined departmental culture within higher education. She maintains that departments have their own distinct culture which functions as a subculture within the university. As a result, departments differ with regard to rewards, interactions among faculty and students, pedagogy, and curricular requirements (Lee, 2007). Within the nursing educational context, there is a fundamental distrust between students and faculty (Luparell, 2008). The "silent and seemingly sullen students in our classrooms are not brain-dead: they are full of fear" (Palmer, 1998, p. 44). This silence is the silence of the marginalized. Today's young people are marginalized in society (Palmer, 1998) and nursing is marginalized within the health care system (Randle, 2003). Freire (2003) describes how those who are oppressed tend to become like their oppressors. This contradiction between oppressor and the oppressed can translate into nursing education with the faculty becoming the oppressor and the student the oppressed. Freire (2003) calls this banking education and provides insight as to why this contradiction occurs. The

> teacher teaches and the students are taught; …the teacher knows everything and the students know nothing; …the teacher confuses the authority of knowledge with his or her own professional authority, which she and he sets in opposition to the freedom of the students (Freire, 2003, p. 73).

This type of educational process diminishes critical thinking and creativity (Freire, 2003) – two essentials of expert nursing practice (Benner, 2001). Freire (2003) believes that to separate the individual from their own decision-making, depersonalizes and objectifies the individual. This in turn continues the process of marginalizing the individual and diminishing their ability to problem-solve and think critically (Freire, 2003).

New graduates are in the early stages of developing the skill set of the expert nurse. Historically, these new graduates would have an extensive orientation process to prepare them for practice. As a result of the nursing shortage, this orientation has gotten shorter and shorter (Fero,

Witsberger, Wesmiller, Zullo, & Hoffman, 2008). Coinciding with the nursing shortage is the increase in complexity of the health care system. Concern for patient safety is increasing as a result of the high rates of error and injury occurring in the health care system (Fero et al., 2008). Fero et al. (2008) state that "patient safety can be directly affected by the critical thinking ability of the nurse" (p. 140). For example, nurses must be able to prioritize their actions, anticipate physician orders, perform independent nursing actions, and recognize subtle changes in patient conditions. These actions require critical thinking (Fero et al., 2008). If nursing students continue to be educated in an environment that stifles critical thinking, patient safety errors are likely to continue to increase.

Distrust in the classroom, also affects the faculty. It causes them to disconnect from their students (Palmer, 1998). Research shows that this disconnection from faculty diminishes the educational experience for students leading to decreased involvement with their educational process (Tinto, 1997; Kuh & Hu, 2001; Hu & Kuh, 2002; Umbach & Wawrzynski, 2004). This in turn affects their learning. Tinto (1997) stated, "Contact with the faculty inside and outside the classroom serves directly to shape learning and persistence…" (p. 617), thus contact with faculty both inside and outside the classroom is important.

Within higher education, students are becoming increasingly less engaged (Hu & Kuh, 2002) and in part this is due to the belief that the purpose of higher education is merely economic – students care about getting a job, not learning (Delucchi & Korgen, 2002). This orientation toward consumerism conflicts with the purpose of higher education which is to educate citizens for a democratic society (Chickering, 2003). A consumer orientation also conflicts with effective pedagogy by investing the authority in the student and not the professor (Delucchi & Korgen, 2002).

2.7 Student as Consumer

Delucchi and Korgen (2002) describe a culture of disengagement on college campuses as a result of the belief that the purpose of a college education is economic and assume this is in part due to the marketplace. Higher education has become another consumer marketplace where students have authority in the role of customers who want to be served in ways they find pleasing (Delucchi & Korgen, 2002). In this environment, students are more interested in grades than in learning reasoning that if they are paying for an education, they are entitled to "As" and a degree (Delucchi & Korgen, 2002). The prevailing value in the consumer climate is one of obtaining high grades for minimal effort, expecting to be entertained and not challenged (Delucchi & Korgen, 2002). Zemsky (1993) explained, "Students today want technical knowledge, useful knowledge, labor-related knowledge in convenient, digestible packages" (p. 17).

Potts (2005) discusses the impact of student consumerism on higher education, stating that consumerism destroys higher education from within. If the student is seen as the consumer and the consumer is always right, this will erode the educational process. Trout (1997) notes that consumers should not have to work hard to buy something and when they do, this increases student complaints. If the goal of higher education is to impart knowledge or to educate, then if higher education functions in the realm of consumerism, the product becomes satisfaction and not knowledge (Potts, 2005). This consumer model of education allows the student to focus on succeeding or graduating and not on inquiry, honesty, and the pursuit of knowledge (Potts, 2005). Under this model, low standards and cheating are easier to justify, because both would assist the student in achieving his/her purpose; thus corrupting both the student and the institution (Potts, 2005).

Delucchi and Smith (1997) describe the environment in colleges and universities as one where knowledge can be scrutinized and debated, where Socratic exchange is the norm. However, this is antithetical to the belief that the "customer is always right" (Delucchi & Smith, 1997, p. 337).

Freire (2003) believed that, “Through dialogue, the teacher of the students and the students of the teacher cease to exist and a new term emerges: teacher-student with student-teachers” (p. 80). “They become jointly responsible for a process in which all grow” (Freire, 2003, p. 80). Instead of a process where all grow, the consumer mentality erodes academe as the academy and the student are at cross purposes.

Love (2008) explains that in the current economic climate, higher education is being re-conceptualized into a business model where “knowledge comes in packages and we [faculty] are the retailers” (p. 16). In this environment, students are the consumers and the university is the “responsive service provider” (Love, 2008, p. 17). This shift has reconfigured the power structure within higher education. Today’s students are more career oriented, yet academically disadvantaged (Levine & Cureton, 1998). They want a different type of relationship with the university, one that focuses on service, convenience, quality, and cost; one like they have with their bank (Levine & Cureton, 1998). This supports Potts’ (2005), Delucchi and Smith’s (1997), and Zemsky’s (1993) impression of student as consumer of higher education.

The literature supports the use of the social exchange theory as a frame for incivility. Emerson (1976) suggests that instead of a theory, social exchange is a “frame of reference that takes the movement of valued things through social processes...” (p. 349). Certainly education and nursing are social activities. One goal of nursing education is to socialize the student into the culture of nursing (Leners et al., 2006). As part of this process, students are expected to embrace the professional values and beliefs of the discipline of nursing. One of these values – autonomy or the right to self-determination, has been slowly embraced as a result of nursing’s paternalistic history (Adams, 2007). Yet, autonomy is necessary for nurses to function in today’s health care environment. Birnbaum (1988) points out that culture tends to be stable until there is a problem or crisis. Incivility in nursing is definitely a problem. If culture consists of those values and beliefs that are passed from nurse to nurse, then incivility may cause a cultural change (Suominen et al.,

1997). Indeed, students who perceive education as a commodity to be purchased are the antithesis of the core nursing values. As Luparell (2007) asserts, incivility in nursing has consequences for the well-being of patients, students, faculty, and the profession itself.

CHAPTER 3. MATERIALS AND METHODS

This chapter addresses the study's research design, survey instrument, population and sampling methods, and procedures for data collection.

3.1 Research Design

A triangulated, mixed methods design provides a framework for this study (Creswell & Clark, 2007). This design allows the researcher to gather data quantitatively to illustrate the research problem and qualitatively to illuminate the quantitative data (Creswell, 2008). By utilizing this design, the disadvantages of single methodologies are neutralized. For example, by collecting data through Likert scale items and open-ended questions, the researcher uses multiple methods and triangulates data collection (Teddlie & Tashakkori, 2003).

This non-experimental study used a cross-sectional survey design to administer a modified version of the Incivility in Nursing Education (INE) survey developed by Clark (2006, 2007, 2008a; Clark, Farnsworth, & Landrum, 2009). In this type of design, data are collected at one point in time in order to measure current attitudes, beliefs, or practices (Creswell, 2008). Data were collected during the spring 2008 semester from 10 nursing programs and during fall 2008 from an additional ten nursing programs. Advantages to using survey research are that it is economical and the research can be conducted in a short amount of time over a diverse geographical area (Creswell, 2008). Additionally, survey research allows the researcher to maintain anonymity of responses. Rea and Parker (1997) point out that surveys provide "an opportunity to reveal the characteristics of institutions and communities by studying individuals who represent these entities in a relatively unbiased and scientifically rigorous manner" (p. 5).

3.2 Instrument

The INE (Clark, 2007) contains 131 items divided into three sections. The first section contains five demographic questions, section two includes student and faculty disruptive and threatening behaviors (122 items), and section three consists of four open-ended questions which

were used to collect qualitative data. Open-ended responses allow the participant to create their own response without interviewer bias (Creswell, 2008).

The INE survey was developed by Clark (2008a) to allow both faculty and students to use the same tool, to explore the frequency of uncivil behavior, and to allow for open-ended comments. Clark (2008a) modified three existing tools that were not nursing specific, the Defining Classroom Incivility survey (Indiana University Center for Survey Research, 2000), the Student Classroom Incivility Measure (Hanson, 2000), and the Student Classroom Incivility Measure-Faculty (Hanson, 2000). The Defining Classroom Incivility survey was designed for faculty to evaluate student incivility and though this tool was pretested, it lacked adequate reliability and validity (Indiana University Center for Survey Research, 2000; Clark, 2008a, Clark et al., 2009).

Hanson's (2000) Student Classroom Incivility Measure (SCIM) and Student Classroom Incivility Measure - Faculty (SCIM-F) used both quantitative and qualitative measures to evaluate student and faculty perceptions of student incivility (Hanson, 2000; Clark et al., 2009). These tools had three parts. Part A asked students to rate the frequency of uncivil behavior they previously engaged in while in the classroom (Hanson, 2000; Clark et al., 2009). Cronbach's alpha for this part was 0.86 (Hanson, 2000; Clark et al., 2009). Parts B and C used a four-point Likert scale to determine the extent students' perceived student and faculty incivility occurred in the classroom. Cronbach's alpha for parts B and C was 0.84 for each (Hanson, 2000; Clark et al., 2009). Hanson's (2000) SCIM–F contains items similar to those on the SCIM; however, items were worded differently. Cronbach's alpha for the SCIM–F was 0.67 (Hanson, 2000; Clark et al., 2009).

After the nascent items on the INE were obtained from the Defining Classroom Incivility Survey (Indiana University Center for Survey Research, 2000), the SCIM (Hanson, 2000), and the SCIM–F (Hanson, 2000), "a panel of experts reviewed the items to further establish content validity" (Clark et al., 2009, p. 8). This 17 member panel was composed of six nursing and non-nursing faculty members, 10 students, and a statistician. As a result of this review, several items

and the format of the INE were revised (Clark et al., 2009). Findings from Clark's 2006 phenomenological study were used to further refine the INE (Clark et al., 2009).

Clark's INE survey measures both faculty and student perceptions of uncivil student and faculty behaviors and the frequency of the behaviors (Clark, 2008a). The tool also elicits suggestions for preventing these behaviors and for intervening to stop them. Clark revised the survey in 2007 adding a definition of incivility and categorizing behaviors as disruptive or threatening. In the original survey, the disruptive behaviors were identified as uncivil and the threatening behaviors were termed beyond uncivil (Clark & Springer, 2007a). Clark changed these terms to clarify the terminology (Cynthia Clark, personal communication, September 24, 2007).

Clark's (2007) revised survey is divided into three sections. Section I contains five demographic questions. Section II is divided into two subsections – behaviors that are potentially disruptive and those that are potentially threatening. There are 15 student behaviors that are identified as disruptive, 20 faculty behaviors that are identified as disruptive, 13 student behaviors that are identified as threatening, and 13 faculty behaviors that are identified as threatening. Participants are asked to determine the degree to which they perceive the behaviors as disruptive or threatening, rating their answers as always, usually, sometimes, and never (Clark & Springer, 2007a; Clark, 2007; Clark et al., 2009). Respondents then determine if these behaviors have happened to them in the past 12 months. Section III consists of four open-ended questions that ask students and faculty to identify factors contributing to incivility and solutions to the problem (Clark & Springer, 2007a; Clark, 2007; Clark, 2008a; Clark et al., 2009). Prior to use, permission to use the INE was obtained from Clark (Cynthia Clark, personal communication, September 24, 2007). Clark's (2007) modified INE survey can be obtained by contacting Dr. Cynthia Clark at cclark@boisestate.edu.

To date, no study has examined clinical behaviors that students consider uncivil. Clinical behaviors encompass any behavior by the student nurse, nurse faculty, or clinical agency nurse

occurring in the clinical area. The original survey by Clark (2006) surveyed both students and faculty members and as a result needed to be modified for surveying students at the beginning and the end of their nursing program. The survey modification also allowed the researcher to explore perceptions of incivility in traditional classrooms and the clinical arena.

Additionally, the researcher modified Clark's 2007 survey to include behaviors students could encounter in the clinical arena. Student and faculty behaviors were adapted to reflect student and faculty behavior directed at nurses and patients. For example, Clark's (2007) survey asks if one considers "taunting or showing disrespect to students" as threatening (p. 5). The researcher added a statement asking if one considers taunting or showing disrespect to nurses as threatening. Additional items were added based on current literature (Gastmans, 1998, 1999; Andrews, 2008; Texas Board of Nursing, 2008; The Joint Commission, 2008). Three behaviors were added to the disruptive behaviors and nine behaviors were added to the list of threatening behaviors. The researcher also adapted student and faculty behaviors to identify 16 disruptive nurse behaviors and 20 threatening nurse behaviors. One open-ended question assessing incivility in the clinical area was added to the end of the tool. To determine if students perceived there to be more incivility on the clinical unit or in the traditional classroom, the researcher added a question to the end of the survey which asked the participant to check the venue where students perceive that the most incivility occurs. Similar to the original survey by Clark (2006), the quantitative items in the modified survey use a Likert scale with a range of responses that include always, usually, sometimes, and never. The Likert scale is used to indicate whether the student perceives the behavior as either disruptive or threatening and to determine the frequency of the behavior within the past 12 months. The researcher's modification of the INE survey is included in Appendix A.

3.3 Sampling Procedures

The South is recognized as a specific cultural region and subculture of the United States (Griffin, 2006; Carlton, 2001) and by sampling schools in this region, the researcher controls for

regional differences. Because the schools in this area are accredited by the SACS-COC, the accreditation standards for the institution in which the school of nursing is situated are the same. While there are a variety of nursing programs within the schools of nursing, this study focuses on associate degree nursing programs. Table 3.3.1 illustrates the numbers of programs in each of the eleven southern region states by category – urban, rural, secular, religious, spring and fall admits.

Table 3.3.1: Numbers of ASN Programs per Category by State

State	# ADN Programs	# Urban N (%)	# Rural N (%)	# Secular N (%)	# Religious N (%)	# with Spring & Fall Admissions N (%)
Alabama	21	9 (43%)	12 (57%)	20 (95%)	1 (5%)	9 (43%)
Florida	23	13 (57%)	10 (43%)	22 (96%)	1 (4%)	13 (57%)
Georgia	17	8 (47%)	9 (53%)	17 (100%)	0 (0%)	6 (35%)
Kentucky	15	4 (27%)	11 (73%)	15 (100%)	0 (0%)	7 (41%)
Louisiana	8	5 (62%)	3 (38%)	7 (88%)	1 (12%)	7 (88%)
Mississippi	16	3 (19%)	13 (81%)	16 (100%)	0 (0%)	7 (44%)
N. Carolina	13	7 (54%)	6 (46%)	10 (77%)	3 (23%)	3 (23%)
S. Carolina	12	7 (58%)	5 (42%)	12 (100%)	0 (0%)	8 (67%)
Tennessee	13	8 (62%)	5 (38%)	11 (85%)	2 (15%)	5 (38%)
Texas	44	28 (64%)	16 (36%)	41 (93%)	3 (7%)	24 (55%)
Virginia	17	7 (41%)	10 (59%)	17 (100%)	0 (0%)	4 (24%)
Total	**199**	**99 (50%)**	**100 (50%)**	**188 (94%)**	**11 (6%)**	**93 (47%)**

Schools were identified as urban or rural and secular or religious to assist the researcher in answering the research question, "In what ways are programs with high perceived levels of incivility different from those with low perceived levels of incivility?" Dowd (2004) found that colleges in urban areas have fewer resources than those in towns and rural areas. Student revenues in rural colleges "are estimated to have per student revenues 13-18% greater than colleges in large cities" (Dowd, 2004). Spaights and Farrell (1986) use Klotsche's (1966) definition and define the urban university as one that is "located in and serving an urban community" (p. 356). These researchers point out that urban universities serve a higher percentage of minority and older students from educationally and economically disadvantaged backgrounds (Spaights & Farrell, 1986). These schools face the same challenges as cities face – increased crime, crowding, poverty,

and lack of educational resources (Glazer, 1999). Hagedorn (2004) found that students in urban community colleges often disrupt the flow of their education by utilizing "stopout – the temporary cessation of enrollment" (p. 24). This behavior contributes to attrition and lower grades (Hagedorn, 2004). Additionally, the new 2005 Carnegie's Basic Classifications provide classifications for colleges offering an associate degree using the "suffix *serving*" (Hagedorn, 2004, p. 6). Community colleges are now classified as rural-serving, suburban-serving, and urban-serving "reflecting the reality that nearly all public community colleges are place-based institutions, with geographic service delivery areas defined by state statute, regulation, or custom" (Hagedorn, 2004, p. 6). There is no empirical evidence to date supporting the effect this has on incivility.

Religious schools exhibit a commitment to the "holistic nurturing of students – body, mind, and spirit" (Hatch, 2005, ¶ 13). Watson (1985) stresses the importance of caring as a construct in nursing. The construct of care "is transmitted by the culture of the profession as a unique way of coping with its environment" (Watson, 1985, p. 8). She defines a caring environment as one where each individual can develop to his/her full potential (Watson, 1985). If religious schools do nurture the holistic student, then it logically follows that within this environment one would develop to his/her full potential and exhibit care leading to diminished occurrences of incivility.

Initially, the target population was identified as National League for Nursing Accrediting Commission (NLNAC) accredited associate degree programs situated in institutions that are accredited by the Southern Association of Colleges and Schools – Commission on Colleges (SACS-COC). According to the NLNAC Web site (2008), there are199 accredited associate degree programs of nursing in the southeastern SACS-COC region of the United States and 11 of these programs are religiously based. In order to obtain a perception of students at the beginning and end of their educational experience, the sample is limited to schools who admit students in the spring and fall semesters. Nursing programs admitting students once per year would have either beginning students or graduating students in any given semester while schools admitting in both the spring and

fall would have both beginning and graduating students enrolled every semester. Ninety-three, or approximately 47%, of these schools admit a class of nursing students in the spring and fall semesters. Since one purpose of the nursing educational process is to socialize the student into the mores and norms of nursing, it is hoped that graduating students would be less tolerant and more aware of incivility (Leners et al., 2006).

Associate degree programs in South Carolina were eliminated from the population because these students were participating in a training program through the state's Area Health Education Consortium (AHEC) as a result of The Joint Commission's initiative that addresses disruptive and inappropriate behavior in healthcare facilities (The Joint Commission, 2008). This decreased the population of associate degree programs in the SACS-COC accreditation region admitting a spring and fall cohort to 85 (N = 85). Table 3.3.2 represents the sampling scheme.

Table 3.3.2: Sampling Scheme

Steps	Date	Sampling Methodology
1.	February 2008	Target population identified.
2.	March and April 2008	An invitation was sent to all Deans and Directors within the target population asking them to participate in the research project.
3.	April 2008	Paper surveys or Web links were sent to participating programs.
4.	April 2008	All non-responding programs were sent an e-mail link to the online survey requesting their participation.
5.	September and October 2008	An invitation was sent to all Deans and Directors who had not previously responded asking them to participate in the research project.
6.	March 2009	Participating programs divided into the upper quartile and the lower quartile.
7.	April 2009	Six programs representing those with the highest and lowest perceived levels of incivility were identified.

The total number of programs participating was 20 (n = 20) or 24% of the total population of programs providing a sample with a confidence level of 95%, $\alpha = .05$, power = .90, and an effect size of 1.25σ (Hinkle, Wiersma, & Jurs, 2003). A total of 863 students responded. Of those responses, 111 surveys were eliminated because students completed less than 80% of the survey. Therefore, 752 student responses (n = 752) or an average of 37.6 responses per program were

analyzed. If each program averages 40 beginning students and 30 graduating students per program, the population would be approximately 6,000 students (N = 6,000). To reach a confidence level of 95% and a precision level of ± 5%, a total sample of 375 is needed (Israel, 1992). Therefore, the total sample of students is adequate. Fowler (2002) cautions that when there are subgroups within the population, the sample size must provide a "minimally adequate sample" of the smallest subgroup (p. 36). Within each participating program, a stratified purposeful sample of beginning and graduating nursing students was surveyed. Thus, the smallest subgroup within this population is the group containing the graduating students. Attrition in nursing programs ranges from 20% to 41% (Ehrenfeld, Rotenberg, Sharon, & Bergman, 1997; Ehrenfeld & Tabak, 2000). Estimating that if 40 students were admitted per program and 30 students graduated per program, the attrition rate assumed is 25%. Thus, the population of the subgroup of graduating students would be 2,550. This would require a sample of 188 graduating students allowing a confidence interval of 95%, alpha of .05, and a precision of ± 7% (Israel, 1992). There are 212 graduating students who completed surveys; therefore, the sample is adequate for both beginning and graduating students.

3.4 Data Collection Procedures

Prior to beginning the study, Institutional Review Board (IRB) approval was obtained (see Appendix B). The study was conducted during the spring and fall 2008 semesters. Programs were identified by accessing the NLNAC Web site during the spring 2008. A spreadsheet with the information was constructed and a number was assigned to each school to ensure confidentiality. Throughout the data collection and analysis process, respondents were identified only by number. Survey data were collected during the spring and fall semesters of 2008 using a modification of the Incivility in Nursing Education (INE) survey (Clark & Springer, 2007a; Clark et al., 2009).

During the spring 2008 semester, an e-mail was sent to the Deans and Directors of each of the 85 programs in the population soliciting participation (see Appendix C). This initial e-mail gave a short explanation of the research project, asked if they were willing to participate, and if they

agreed to identify an introductory and a terminal course cohort of students to be surveyed. Additionally, these Deans and Directors were asked which format their students would prefer – accessing a Web link or paper and pencil. Two weeks later, a follow-up e-mail was sent (Appendix D) and a letter was sent through the US postal service to those Deans and Directors who had not previously responded (Appendix E). Initially, 31 programs agreed to participate, nine choosing to use paper surveys. Copies of the surveys were sent to these nine programs in April 2008. Included in the packet of surveys was a cover letter explaining the study and why responding was important (Appendix F), a copy of the study abstract (Appendix G), directions for completing the survey (Appendix H), as well as return postage and return labels. Attached to each survey was a consent letter to the student requesting their participation (Appendix I).

At the end of two weeks, a follow-up e-mail was sent reminding the participants to return the completed surveys (Appendix J). Two weeks later, another follow-up e-mail was sent to the participating programs encouraging them to participate and to return the surveys (Appendix K). Four weeks after the initial mailing, all Deans and Directors who had agreed to participate, but had not returned surveys were contacted by phone. Of the nine programs agreeing to participate using paper survey, five programs returned surveys. Fowler (2002) believes that the most important difference between a good return rate and a poor one is repeated contact with those who have not responded. Dillman (2007) suggests five elements that contribute to a high survey response rate by mail. These are: 1) a respondent friendly survey, 2) five contacts by first class mail, 3) return stamped envelopes, 4) personalizing the correspondence, and 5) financial reward. Dillman (2007) states that contact by a different method the fifth time improves response rate.

Each of the 22 programs choosing to use Survey Monkey© was sent a link to the survey with instructions during April 2008 (Appendix L, Appendix M). Due to government regulations, the researcher does not have access to student e-mail accounts; therefore, Deans or Directors had to send the e-mails to the participating students. Attached to the e-mail was a cover letter explaining

the study and why responding was important as well as a consent letter to the student requesting their participation. Deans and Directors agreed to post the link in their course management system or to send an e-mail to their beginning and graduating students with the link to the survey embedded and the consent letter attached. Of these 22 programs, students in five programs participated.

All Deans and Directors who had not responded to the initial request for participation were contacted again in the middle of April 2008 both by phone and by e-mail (Appendix N). Each Dean or Director was sent an e-mail link to the survey in Survey Monkey© and were asked to provide their beginning and graduating students the URL. This did not elicit additional responses. Therefore, students in a total of 10 programs completed surveys (paper or Web) during spring 2008. Appendix O contains a table depicting the demographics of the sample of programs returning surveys during spring 2008.

Due to the small number of programs responding during spring 2008, a follow-up request for participation was extended during fall 2008 to all nonparticipating nursing programs in the population. The same procedure utilized during the spring 2008 was followed during the fall 2008. Additionally, Presidents of the schools' Student Nurses Association (SNA) were contacted by correspondence in an effort to reach more students (Appendix P). As a result, 12 additional programs agreed to participate. The same procedure used during the spring 2008 was followed during the fall 2008. However, only ten of these programs had students respond bringing the total of participating programs to 20 or 24% of the population. IRB approval was required and obtained from three of these schools (see Appendix Q). Three of these programs completed surveys online through Survey Monkey© and seven completed paper surveys. Appendix R contains a table illustrating the sample of programs participating during fall 2008.

Approximately two-thirds of the students completing surveys were beginning students (72.3%) and one-third (27.7%) were graduating students. These students ranged in age from 19

years old to 53 years old with approximately one third of the participants in the 21 to 24 years old age group. Table 3.4.1 depicts the age demographics of the sample.

Table 3.4.1: Age Demographics of the Sample in Percentages (n = 745)

Age	18-20	21-24	25-29	30-34	35-39	40-44	45-49	≥ 50
Percentage	7%	30%	19%	19%	14%	8%	3%	< 1%
# Students	n=52	n=223	n=142	n=141	n=104	n=59	n=22	n=2

As the ethnic make-up of the United States becomes increasingly more diverse, the nursing profession is attempting to recruit a more diverse student body (Uyehara, Magnussen, Itano, & Zhang, 2007). The gendered composition of the sample includes a higher percentage of males (13.2%) than reflected in the current population of nurses in the United States where only 5.8% of the registered nurses are male (U.S. Department of Health and Human Services, 2006). The ethnicity of the sample is more diverse than that of the population of nurses in the United States (U.S. Department of Health and Human Services, 2006) with a higher percentage of African Americans (12.9% compared to 4.2% in the population of nurses), Hispanics (4.3% compared to 1.7% in the population of nurses), Native Americans (1.5% compared to 0.3% in the population of nurses), and multi-racial students (3.0% compared to 1.4% in the population of nurses). Students selecting the "Other" category identified themselves as multi-racial. Eight participants did not indicate gender or ethnicity. Table 3.4.2 illustrates the gender demographics and Table 3.4.3 depicts the ethnic composition of the sample.

Table 3.4.2: Gender Demographics of the Sample in Percentages (n = 747)

Beginning Male	**Graduating Male**	**Total Male**	**Beginning Female**	**Graduating Female**	**Total Female**	**Sample Total**
65	33	98	458	191	649	747
66.3% of total male	33.7% of total male	13.1% of sample	70.6% of total female	29.4% of total female	86.9% of sample	100%

Table 3.4.3: Ethnic Composition of the Sample in Percentages (n = 747)

Ethnicity	**African American**	**Asian**	**Caucasian**	**Native American**	**Pacific Islander**	**Hispanic**	**Other**	**Total**
Beginning Students	75	10	388	6	1	25	18	523
Graduating Students	11	4	189	5	2	7	6	224
Total	**86**	**14**	**577**	**11**	**3**	**32**	**24**	**747**

Table 3.4.4 illustrates the final sample.

Table 3.4.4: Total Sample of Participating Programs (n = 20)

State	**# ADN Programs**	**Urban N (%)**	**Rural N (%)**	**Secular N (%)**	**Religious N (%)**	**Beginning Students N (%)**	**Graduating Students N (%)**
Alabama	4	1 (33%)	3 (67%)	4 (100%)	0 (0%)	65 (61%)	42 (39%)
Florida	2	2 (100%)	0 (0%)	2 (100%)	0 (0%)	59 (93%)	4 (7%)
Georgia	1	1 (100%)	0 (0%)	1 (100%)	0 (0%)	52 (63%)	31 (37%)
Kentucky	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Louisiana	5	2 (40%)	3 (60%)	4 (80%)	1 (20%)	188 (70%)	80 (30%)
Mississippi	2	0 (0%)	2 (100%)	2 (100%)	0 (0%)	126 (82%)	28 (18%)
N. Carolina	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tennessee	1	1 (100%)	0 (0%)	0 (0%)	1 (100%)	12 (52%)	11 (48%)
Texas	3	3 (100%)	0 (0%)	2 (67%)	1 (33%)	9 (39%)	14 (61%)
Virginia	2	1 (50%)	1 (50%)	2 (100%)	0 (0%)	29 (94%)	2 (6%)
Total	**20**	**11 (55%)**	**9 (45%)**	**17 (85%)**	**3 (15%)**	**540 (72%)**	**212 (28%)**

After identifying programs with the highest and lowest perceived levels of incivility, Deans and Directors of these programs were contacted via phone to determine how to contact students for interview. The purpose of the interview was to gain insight into their perceptions of their nursing educational environment. Students were solicited by their Dean or Director who asked the student

to e-mail the researcher if they were interested in participating in the interview. Students were offered a $15 gift card for *i*tunes as an incentive to participate. Initially, four Deans agreed to solicit students. However, they were unable to get students to agree to be interviewed. Therefore, qualitative data was gathered only from the open-ended questions on the modified INE survey.

3.5 Validity and Trustworthiness

Since data were collected via survey across different contexts and using two strata of students, the researcher feels that triangulation of data collection increased internal validity of the quantitative data (Gall, Gall, & Borg, 2003). Content validity was compelling since the INE survey has been field tested on similar samples, evaluated by experts, and has Cronbach's alphas ranging from .808 to .955 (Clark et al., 2009). External validity is believed to be valid for like settings in the southeastern United States. Additionally, sample size was adequate and representative of the target population. However, further research should explore whether the findings can be generalized across the country as well as exploring the effect type of institution and program has on nursing incivility.

Lincoln and Guba (1985) suggest four criteria for trustworthiness of qualitative data: credibility, dependability, confirmability, and transferability. The data is dependable and credible. Data was collected over person, place, and time. For example, the survey was administered to over 750 students and the majority completed the qualitative portion. The survey was administered to students in 20 different associate degree nursing programs throughout the southeastern United States. Additionally, the survey was administered to both beginning and graduating cohorts during the spring and fall 2008 semesters. The findings are believed to be transferable to like settings and groups.

CHAPTER 4. RESULTS

This study employed a triangulated, mixed methods design to answer the following research questions:

1. What behaviors in the learning environment do associate degree nursing students perceive as incivility at the beginning and at the end of their associate degree program?
2. What are the differences in the perception of incivility by students in the various contexts of the associate degree nursing educational environment – classroom and clinical area?
3. What are the differences between programs with high and low perceived levels of incivility?

This chapter presents a synthesis of the research results beginning with an overview of the data analysis. Results are organized by research question.

The INE survey was administered by paper and through Survey Monkey©. Paper surveys were collected on Scannable paper and therefore, upon receipt were scanned into a database which was then inputted into Statistical Package for the Social Sciences (SPSS), Version 14.0 for the purpose of performing the statistical analyses. Surveys completed online using Survey Monkey© were downloaded into Excel and then uploaded into SPSS. These files were merged into one file and data were cleaned to ensure that errors did not occur due to keystroke or delinquent mistakes by study respondents.

Exploratory factor analysis using the principal components approach (Harris, 1985; Sheskin, 2004) was applied to determine the presence of underlying patterns of meaning for behaviors on the modified INE. Data were split into six files by INE category and subcategory: 1) student disruptive behaviors, 2) student threatening behaviors, 3) faculty disruptive behaviors, 4) faculty threatening behaviors, 5) nurse disruptive behaviors, and 6) nurse threatening behaviors. Bartlett's test of

sphericity and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy were used to evaluate the strength of the linear association among the items in each of the six correlation matrixes. Additionally, diagonals of the anti-image correlation matrix were over .8 for each of the six sets of items, supporting the inclusion of each behavior in the factor analysis. The communalities were ≥ .469 for each item in the six sets of items, further confirming that each behavior shared some common variance with the other behaviors. For example, communalities for student disruptive behaviors ranged from .469 to .729 while communalities for nurse threatening behaviors ranged from .792 to .970. Appendix S contains communalities for each of the six sets of items. Thus, factor analysis was deemed appropriate and conducted on each section of behaviors in the modified INE. Individual factor analyses were run on student disruptive behaviors, student threatening behaviors, faculty disruptive behaviors, faculty threatening behaviors, nurse disruptive behaviors, and nurse threatening behaviors for a total of 6 factor analyses. The following six sections present the results of each of these factors. Included in each section is a vignette that illustrates the factor. The open-ended questions on the INE provide the data for the vignettes.

4.1 Student Disruptive Behavior

Principle component analysis of student disruptive behaviors extracted a total of 3 factors from the 18 items listed under student disruptive behaviors. Bartlett's test of sphericity was significant ($X^2 = 7052.273$, $p = .000$), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.933), an index that compares the magnitude of the observed correlations with the magnitude of the partial correlation coefficients, was excellent, according to Kaiser's criteria (Pett, Lackey, & Sullivan, 2003). A scree test was used to verify that a final factor solution of three factors was appropriate (Harris, 1985; Sheskin, 2004). Components with initial eigenvalues of 1.0 or higher (range = 1.271 – 8.306) accounted for 61.6% of the variance. Varimax orthogonal rotation was then used to maximize the loadings of each student disruptive behavior on one factor. From this rotation, three patterns of student disruptive behavior emerged: avoidance,

student disregard for others, and integrity compromised. These three factors exhibit Cronbach's coefficient alpha (α) scores ranging from .416 to .767. The Cronbach's coefficient alpha is used to assess the internal consistency of a set of variables. Specifically, it represents the proportion of total variance on a given scale that can be attributed to a common source (Pett et al., 2003). It also provides a means for estimating the internal consistency of items that are scored as continuous variables such as a Likert scale (Creswell, 2008).

4.1.1 Avoidance

The factor termed Avoidance is comprised of six items reflecting student disruptive behaviors from the modified INE (Table 4.1.1.1). The behaviors with the highest loadings on this factor are "cutting class," "leaving class early," "arriving late for class," "and being unprepared for class." Avoidance is defined as limiting engagement with course content, course materials, or course activities. To further illustrate this factor, a fictional vignette derived from the open-ended responses on the INE is provided.

Table 4.1.1.1: Factor Loadings of Specific Student Behaviors on the Factor Avoidance

Modified INE Item	**Loading**
Students….	
Cutting class	.764
Leaving class early	.747
Arriving late for class	.746
Being unprepared for class	.732
Using a computer during class for purposes not related to the class	.480
Using cell phones or pagers during class	.416

Note: Percent of explained variance = 46.146; Cronbach's alpha = .859.

- Case: Avoidance

Sally Martin applied to nursing school because her mother told her she needed to get a job with a future and nursing could provide that for her. Sally hated the sight of blood, didn't like dealing with sick people, and wanted to work in the fashion industry. She tried explaining this to her parents, but they merely responded that she would be glad she completed nursing school; after all, her aunt was a nurse and was able to provide for her six children after their father died. Sally

complied, entered nursing school, and hated every minute of it. She skipped class as much as was allowed, was never really prepared, often shopped over the internet in class, and either came late or left early. Sally did only enough to get by and eke out a passing grade. When asked by her classmates why she even came to nursing school, she replied, "I had to get my parents off my back. Maybe once I graduate, I can save enough money to go to school and major in something that I'm interested in. I am just putting in my time."

4.1.2 Student Disregard for Others

The second factor identified under student disruptive behaviors, student disregard for others, is comprised of seven items as illustrated in Table 4.1.2.1. Student disregard for others consists of behaviors that disrespect other students, faculty, nurses, or patients and discount the needs or desires of other people.

Table 4.1.2.1: Factor Loadings of Specific Student Behaviors on the Factor Student Disregard for Others

Modified INE Item	Loading
Students….	
Making disapproving groans	.767
Making sarcastic remarks or gestures	.764
Acting bored or apathetic	.715
Holding conversations that distract you or other students	.593
Sleeping in class	.592
Refusing to answer direct questions	.583
Not paying attention in class	.571

Note: Percent of explained variance = 8.377; Cronbach's alpha = .871.

To further illustrate this factor, a fictional vignette is provided.

- Case: Student Disregard for Others

Chase Appleton applied to nursing school because he wants to be a nurse anesthetist. This would afford him a comfortable lifestyle, autonomy, and he wouldn't have to put up with the politics on the clinical units. He had no interest in nor did he intend to be a bedside nurse. Nursing school was a hoop to jump through on his way to graduate school. Chase was intelligent and a solitary learner, so he spent his days in class sleeping or talking to his friends. When he did happen

to listen to the instructor, he often had a comment about what was said. For example, after one test when the faculty member explained the correct answer, Chase commented, "You have got to be kidding! No one would ever do that!"

4.1.3 Integrity Compromised

The third factor identified under student disruptive behaviors, integrity compromised, is comprised of six items as illustrated in Table 4.1.3.1. Integrity compromised is composed of behaviors where the ethics of nursing were breached.

Table 4.1.3.1: Factor Loadings of Specific Student Behaviors on the Factor Integrity Compromised

Modified INE Item	**Loading**
Students….	
Charting nursing care not performed	.781
Not admitting an error made in patient care	.733
Being unprepared for the clinical experience	.725
Demanding make-up exams, extensions, grade changes, or special favors	.621
Creating tension by dominating class discussion	.583
Using cell phones or pagers during class	.416

Note: Percent of explained variance = 7.062; Cronbach's alpha = .821.

One behavior, "using cell phones or pagers during class," loaded equally on Factor 1 and Factor 3 with a loading of .416. The researcher felt this item was more consistent with the definition of Factor 1 and therefore, eliminated it from Factor 3. To further illustrate this factor, a fictional vignette is provided.

- Case: Integrity Compromised

Joi Jones was a third semester nursing student attending clinical on a busy surgical unit. This was her first day with three patients and she felt totally disorganized. She had been counseled by her instructor the previous two weeks for being unprepared to care for her patients and one of those weeks she had been sent off the unit to go practice her skills in the skills lab. Joi was cautioned that the next time she was unprepared, she would receive a clinical unsatisfactory and a clinical failure for the day. After assessing all of her patients, she had to give her 9 am medications and was behind again. Two of her patients had orders for vital signs every two hours and these

were also due at 9 am. To catch up, Joi made the decision to give the meds and chart the vital signs but not to take them again. She knew if she didn't get this done on time, she would receive a failure for the day.

4.2 Student Threatening Behavior

Principle component analysis of student threatening behaviors extracted a total of 22 factors. Bartlett's test of sphericity was significant (X^2 = 33858.404, p = .000), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.964) was excellent according to Kaiser's criteria (Pett et al., 2003). A scree test was used to verify that a final factor solution of two factors was appropriate (Harris, 1985; Sheskin, 2004). Components with initial eigenvalues of 1.0 or higher (range = 1.449 – 17.817) accounted for 87.6% of the variance. Varimax orthogonal rotation was then used to maximize the loadings of each student threatening behavior on one factor. From this rotation, two patterns of student threatening behavior emerged: aggressive antagonism and uncongenial actions. These two factors exhibit Cronbach's coefficient alpha (α) scores ranging from .655 to .891.

4.2.1 Aggressive Antagonism

The factor termed Aggressive Antagonism is comprised of 16 student threatening behaviors from the modified INE (Table 4.2.1.1). The behaviors with the highest loadings on this factor are "making threats of physical harm against faculty" and "making threats of physical harm against other students." Aggressive antagonism is defined as dominating others in a hostile fashion. To further illustrate this factor, a fictional vignette is provided.

- Case: Aggressive Antagonism

Mindy Jacobs entered nursing school as a way to escape poverty. She had to defend herself throughout her childhood against gangs, peers, and her father. When other students asked for help in the clinical area, Mindy always disappeared. When confronted, she threatened to "beat them up" and at times sent e-mails stating the same sentiments. After failing her first test, she screamed at the

instructor stating, “You’ll be sorry, you bitch!” As Mindy left the room, she punched a hole in the wall.

Table 4.2.1.1: Factor Loadings of Specific Student Behaviors on the Factor Aggressive Antagonism

Modified INE Item	Loading
Students….	
Making threats of physical harm against faculty	.891
Making threats of physical harm against other students	.891
Neglecting patients in the clinical area	.875
Damaging property	.873
Making vulgar comments directed at patients	.866
Making harassing comments (racial, ethnic, gender) directed at patients	.865
Making vulgar comments directed at nurses	.856
Making vulgar comments directed at faculty	.852
Making statements about having access to weapons	.847
Making harassing comments (racial, ethnic, gender) directed at nurses	.841
Charting patient care not completed	.837
Making harassing comments (racial, ethnic, gender) directed at faculty	.830
Making vulgar comments directed at other students	.825
Sending inappropriate e-mails to faculty	.819
Sending inappropriate e-mails to other students	.766
Making harassing comments (racial, ethnic, gender) directed at other students	.655

Note: Percent of explained variance = 80.985; Cronbach’s alpha = .991.

4.2.2 Uncongenial Actions

The second factor identified under student threatening behaviors, uncongenial actions, is comprised of six behaviors as illustrated in Table 4.2.2.1. Uncongenial actions consist of behaviors that unsympathetic or disagreeable and unbecoming of a nurse. To further illustrate this factor, a fictional vignette is provided.

Table 4.2.2.1: Factor Loadings of Specific Student Behaviors on the Factor Uncongenial Actions

Modified INE Item	Loading
Students….	
Challenging faculty knowledge or credibility	.828
Challenging the nurse’s knowledge or credibility	.828
Taunting or showing disrespect to faculty	.823
Taunting or showing disrespect to nurses	.813
Taunting or showing disrespect to other students	.800
Taunting or showing disrespect to patients	.720

Note: Percent of explained variance = 6.588; Cronbach’s alpha = .956.

- Case: Uncongenial Actions

Brittany McCall has worked as a paramedic for 10 years when she decided to attend nursing school. Her patient had a physician's order to insert an IV. Prior to entering the patient's room for the procedure, Brittany's instructor asked her to describe what she was going to do. When the instructor tried to correct Brittany, she replied, "You don't know what you are doing, I'm going to ask the nurse." The patient's nurse agreed with the instructor and Brittany stated, "Neither one of you are right. I've been doing this for over 10 years, and that is not how to do it."

4.3 Faculty Disruptive Behavior

Principle component analysis of faculty disruptive behaviors extracted a total of 23 factors. Bartlett's test of sphericity was significant (X^2 = 20391.307, p = .000), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.980) was excellent according to Kaiser's criteria (Pett et al., 2003). A scree test was used to verify that a final factor solution of two factors was appropriate (Harris, 1985; Sheskin, 2004). Components with initial eigenvalues of 1.0 or higher (range = 1.220 – 16.479) accounted for 77% of the variance. Varimax orthogonal rotation was then used to maximize the loadings of each faculty disruptive behavior on one factor. From this rotation, two patterns of faculty disruptive behavior emerged: abuse of position and faculty disregard for others. These two factors exhibit Cronbach's coefficient alpha (α) scores ranging from .640 to .852.

4.3.1 Abuse of Position

The factor termed Abuse of Position is comprised of 13 faculty disruptive behaviors from the modified INE (Table 4.3.1.1). The behaviors with the highest loadings on this factor are "making rude gestures or behaviors toward others" and "making condescending remarks or put downs." Abuse of position is defined as improper use of power in the faculty role. To further illustrate this factor, a fictional vignette is provided.

Table 4.3.1.1: Factor Loadings of Specific Faculty Behaviors on the Factor Abuse of Position

Modified INE Item	Loading
Faculty….	
Making rude gestures or behaviors toward others	.852
Making condescending remarks or put downs	.845
Being unavailable on the patient care unit	.832
Exerting superiority or rank over others	.826
Being distant and cold toward others	.815
Threatening to fail student for not complying to faculty's demands	.807
Refusing or reluctant to answer questions	.804
Being unavailable outside of class	.797
Being unavailable for practice in the skills laboratory	.793
Ignoring disruptive student behavior	.789
Subjective grading	.747
Taking over for the student when providing patient care	.709
Punishing the entire class for one student's misbehavior	.682

Note: Percent of explained variance = 71.647; Cronbach's alpha = 981.

- Case: Abuse of Position

Regina Wilburn was the epitome of the "nurse." She still wore a white dress uniform and clinic nursing shoes. Only recently had she agreed to quit wearing her nursing cap after one hostile patient yanked it off her head. Regina felt she was personally responsible for maintaining the ideals of the profession. Regina taught the foundations of nursing course which was the first clinical course. She had high standards and could not tolerate anything less. When her students had difficulty performing skills on the clinical unit, Regina was by their side ready to take over to demonstrate to the student the correct way to perform the procedure. After completing the procedure, she would tell the student, "If you want to be a nurse, you had better learn how to perform this skill. If this happens again, I will fail you."

4.3.2 Faculty Disregard for Others

The second factor identified under faculty disruptive behaviors, faculty disregard for others, is comprised of 10 behaviors as illustrated in Table 4.3.2.1. Faculty disregard for others consists of behaviors that disrespect other students, faculty, nurses, or patients and discount the needs or desires of other people.

Table 4.3.2.1: Factor Loadings of Specific Faculty Behaviors on the Factor Faculty Disregard for Others

Modified INE Item	Loading
Faculty….	
Arriving late for scheduled activities	.793
Leaving scheduled activities early	.778
Being unprepared for scheduled activities	.757
Canceling scheduled activities without warning	.742
Not allowing open discussion	.713
Ineffective teaching style/method	.668
Refusing to allow make-up exams, extensions, or grade changes	.654
Deviating from the course syllabus, changing assignments or test dates	.653
Making statements about being disinterested in the subject matter	.643
Being inflexible, rigid, and authoritarian	.640

Note: Percent of explained variance = 5.303; Cronbach's alpha = .951.

- Case: Faculty Disregard for Others

Frank had been a nursing faculty member for the past 30 years. He was well respected, published prolifically, and brought millions of federal dollars to the college. At this point in his career, he was more interested in writing than in teaching often making this known to his students. Frank was habitually late to class and usually dismissed class 45 minutes to an hour early telling the students that they could "just read their text." As the semester progressed, if time became an issue, Frank would adjust the syllabus to accommodate for the fact that the class was behind schedule. On more than one occasion, the students found a note on the classroom door notifying them that class had been cancelled.

4.4 Faculty Threatening Behavior

Principle component analysis of faculty threatening behaviors extracted a total of 22 factors. Bartlett's test of sphericity was significant (X^2 = 42016.397, p = .000), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.967) was excellent according to Kaiser's criteria (Pett et al., 2003). A scree test was used to verify that a final factor solution of one factor was appropriate (Harris, 1985; Sheskin, 2004). A component with initial eigenvalues of higher than 1.0 (19.788) accounted for 89.9% of the variance. The pattern of faculty threatening

behavior was titled aggressive actions. This factor exhibits Cronbach's coefficient alpha (α) scores ranging from .855 to .979.

4.4.1 Aggressive Actions

The factor termed Aggressive Actions is comprised of the 22 faculty threatening behaviors from the modified INE (Table 4.4.1.1). The behaviors with the highest loadings on this factor are "making vulgar comments directed at faculty" and "making vulgar comments directed at nurses." Aggressive actions are defined as performing dominating or hostile actions. To further illustrate this factor, a fictional vignette is provided.

- Case: Aggressive Actions

Thelma Williams worked as a nurse for 15 years before she became a faculty member. During that time, she held several administrative positions. Thelma believed in the Nightingale model of nursing where nurses were "the handmaiden of the physician" where nurses were female and physicians were male. During her classes, Thelma would often make remarks about nursing being a female field and men who chose nursing must have homosexual leanings. At times, she would ask male students how they expected to provide a caring environment for their patients when that was beyond the scope of what a male could do. Thelma often sent the minority and male students off the unit to practice in the skills lab telling the majority students that she couldn't allow "those" students to make mistakes with her patients.

4.5 Nurse Disruptive Behavior

Principle component analysis of nurse disruptive behaviors extracted a total of 16 factors. Bartlett's test of sphericity was significant (X^2 = 19470.899, p = .000), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.978) was excellent according to Kaiser's criteria (Pett et al., 2003). A scree test was used to verify that a final factor solution of one factor was appropriate (Harris, 1985; Sheskin, 2004). A component with initial eigenvalues of higher than 1.0 (13.632) accounted for 85.2% of the variance. The pattern of nurse disruptive

behavior was titled nurse disregard for others. This factor exhibits Cronbach's coefficient alpha (α) scores ranging from .816 to .956.

Table 4.4.1.1: Factor Loadings of Specific Faculty Behaviors on the Factor Aggressive Actions

Modified INE Item	**Loading**
Faculty….	
Making vulgar comments directed at faculty	.979
Making vulgar comments directed at nurses	.979
Making harassing comments (racial, ethnic, gender) directed at nurses	.978
Making harassing comments (racial, ethnic, gender) directed at faculty	.977
Making vulgar comments directed at patients	.976
Making harassing comments (racial, ethnic, gender) directed at patients	.973
Making vulgar comments directed at students	.973
Making harassing comments (racial, ethnic, gender) directed at students	.969
Making threats of physical harm against faculty	.969
Making threats of physical harm against students	.965
Taunting or showing disrespect to patients	.962
Damaging property	.957
Sending inappropriate e-mails to students	.954
Sending inappropriate e-mails to faculty	.950
Taunting or showing disrespect to nurses	.950
Taunting or showing disrespect to students	.943
Taunting or showing disrespect to faculty	.938
Making statements about having access to weapons	.937
Neglecting patients in the clinical area	.905
Charting patient care not completed	.900
Challenging faculty knowledge or credibility	.861
Challenging the nurse's knowledge or credibility	.855

Note: Percent of explained variance = 89.946; Cronbach's alpha = .995.

4.5.1 Nurse Disregard for Others

The only factor identified under nurse disruptive behaviors, nurse disregard for others, is comprised of 16 behaviors as illustrated in Table 4.5.1.1. Nurse disregard for others consists of behaviors that disrespect other students, faculty, nurses, or patients and discount the needs or desires of other people.

Table 4.5.1.1: Factor Loadings of Specific Nurse Behaviors on the Factor Nurse Disregard for Others

Modified INE Item	Loading
Nurses….	
Refusing or reluctant to answer questions	.956
Making condescending remarks or put downs	.954
Making rude gestures or behaviors toward others	.952
Making statements about being disinterested in the working with students	.949
Being unavailable on the patient care unit	.948
Being cold and distant toward others	.943
Ineffective teaching style/method	.938
Being inflexible, rigid, and authoritarian	.934
Threatening to fail student for not complying to the nurse's demands	.933
Exerting superiority or rank over others	.930
Being unprepared for patient care	.928
Subjective grading of students	.914
Taking over for the student when providing patient care	.901
Refusing to allow students to perform patient care	.893
Arriving late for work	.867
Leaving work early	.816

Note: Percent of explained variance = 85.203; Cronbach's alpha = .988.

- Case: Nurse Disregard for Others

Tracy Dundee is a nurse on a busy medical unit that often had student nurses assigned. The students arrived at 6:45 am after staff arrived at 6:30 am. One particular group of students wore pink uniforms and as they arrived, Tracy commented, "Oh great – here comes the pink plague again!" The students were devastated and asked that they not be assigned to Tracy's patients.

4.6 Nurse Threatening Behavior

Principle component analysis of nurse threatening behaviors extracted a total of 20 factors. Bartlett's test of sphericity was significant (X^2 = 40307.999, p = .000), which indicated that the correlation matrix was not an identity matrix. The KMO statistic (.971) was excellent according to Kaiser's criteria (Pett et al., 2003). A scree test was used to verify that a final factor solution of one factor was appropriate (Harris, 1985; Sheskin, 2004). A component with initial eigenvalues of higher than 1.0 (18.660) accounted for 93.3% of the variance. The pattern of nurse threatening

behavior was titled aggressive actions. This factor exhibits Cronbach's coefficient alpha (α) scores ranging from .890 to .985.

4.6.1 Aggressive Actions

The factor termed Aggressive Actions is comprised of the 20 nurse threatening behaviors from the modified INE (Table 4.6.1.1). The behaviors with the highest loadings on this factor are "making vulgar comments directed at nurses" and "making vulgar comments directed at patients." Aggressive actions are defined as performing dominating or hostile actions. To further illustrate this factor, a fictional vignette is provided.

Table 4.6.1.1: Factor Loadings of Specific Nurse Behaviors on the Factor Aggressive Actions

Modified INE Item	**Loading**
Nurses….	
Making vulgar comments directed at other nurses	.985
Making vulgar comments directed at patients	.983
Making vulgar comments directed at faculty	.983
Making harassing comments (racial, ethnic, gender) directed at faculty	.983
Making harassing comments (racial, ethnic, gender) directed at patients	.982
Making harassing comments (racial, ethnic, gender) directed at other nurses	.982
Making vulgar comments directed at students	.980
Making harassing comments (racial, ethnic, gender) directed at students	.979
Making threats of physical harm against faculty	.977
Making threats of physical harm against students	.975
Taunting or showing disrespect to faculty	.970
Taunting or showing disrespect to other nurses	.969
Damaging property	.969
Taunting or showing disrespect to students	.968
Taunting or showing disrespect to patients	.967
Neglecting patients in the clinical area	.965
Charting patient care not completed	.948
Making statements about having access to weapons	.946
Challenging faculty knowledge or credibility	.911
Challenging other nurse's knowledge or credibility	.890

Note: Percent of explained variance = 93.301, Cronbach's alpha = .996.

- Case: Aggressive Actions

Shelby Blake is a nurse in a busy emergency room. One Saturday evening, the emergency room was full and there were only a few hospital beds vacant. Several student nurses were assisting in the emergency room. As one large woman was wheeled in on a stretcher, Shelby commented,

"Here comes another frequent flyer. She is addicted to drugs, food, and sex, but not necessarily in that order." Shelby told the patient, "You don't need emergency treatment, you need a man, a diet, and a fix and you'll be alright."

4.7 Beginning and Graduating Student Differences in Perception of Uncivil Behavior

To answer research question number one (What behaviors in the learning environment do associate degree nursing students perceive as incivility at the beginning and at the end of their associate degree program?), the files were split into beginning and graduating students. Initially descriptive statistics including mean, standard deviation, and variance were obtained for all 121 Likert items on the INE and for each factor. Means for each factor were compared between the two groups of students using independent *t*-tests. Independent *t*-tests were utilized since the beginning and graduating students were independent samples and could not be matched (Sheskin, 2004). Of the 121 behaviors included on the modified INE, 40 are student behaviors, 45 are faculty behaviors, and 36 are nurse behaviors. Student, faculty, and nurse behaviors are subdivided into disruptive and threatening behaviors.

4.7.1 Student Disruptive Behavior

Six items loaded on Factor 1, seven items loaded on Factor 2, and six items loaded on Factor 3. However, one of these items also loaded on Factor 1. The item, "using cell phones or pagers during class" is conceptually closer to Factor 1, so it was placed with it (Pett et al., 2003). There was no significant difference in beginning and graduating student perception among the three factors as a whole. Table 4.7.1.1 illustrates this result.

Table 4.7.1.1: Student Perception of Disruptive Student Behavior Factors

Factor	**Mean**		***t***	***p***
	Beginning	**Graduating**		
1. Avoidance	2.43	2.30	1.5435	0.1231
2. Student Disregard for Others	2.48	2.56	1.0133	0.3113
3. Integrity Compromised	2.77	2.77	0.000	1.000

Responses from beginning and graduating students to the open-ended questions on the INE were also examined related to student disruptive behavior. Beginning students described disruptive behaviors such as sleeping in class, "blurting out comments regarding the content of subject at hand," texting on their cell phones, coming to class late or unprepared, dominating discussions, talking to other students during class and "helping others cheat." Graduating students provided similar comments, but also stated that students chart patient care that wasn't completed, and coming to clinical unprepared.

4.7.2 Student Threatening Behavior

Two factors emerged from the analysis on items categorized as student threatening behavior. Sixteen items loaded on Factor 1 and six items loaded on Factor 2. There was no statistically significant difference between the means for beginning and graduating students on the two factors of student threatening behavior. Table 4.7.2.1 identifies these results.

Table 4.7.2.1: Student Perception of Threatening Student Behavior Factors

Factor	**Mean**		***t***	***p***
	Beginning	**Graduating**		
1. Aggressive Antagonism	3.25	3.27	0.2218	0.8246
2. Uncongenial Actions	2.93	2.98	0.5563	0.5782

Beginning students' short answer comments related to student threatening behaviors included students making negative comments or jokes about patients, making rude comments, and voicing negative opinions of others. Graduating students added "students tend to feed off of each other and gang up on the faculty."

4.7.3 Faculty Disruptive Behavior

Beginning and graduating students did not agree on which faculty behaviors identified as disruptive on the modified INE were uncivil. Thirteen of the 23 items loaded on Factor 1 and the remaining 10 items loaded on Factor 2. There was a statistically significant difference between beginning and graduating student perception of the Factor 1 (Abuse of Position), but not of Factor 2 (Faculty Disregard for Others). Table 4.7.3.1 illustrates these results.

Table 4.7.3.1: Student Perception of Disruptive Faculty Behavior Factors

Factor	Mean		*t*	*p*
	Beginning	**Graduating**		
1. Abuse of Position	3.07	3.35	3.0445	0.0024
2. Faculty Disregard for Others	2.84	2.92	0.8725	0.3832

Beginning students describe faculty disruptive behaviors as treating adult students as teens, showing favoritism, being unfriendly, being lenient, and "not caring." These students also stated that faculty fought and argued among themselves and failed to address unacceptable classroom behavior. Graduating students described faculty as being rigid, acting superior, and taking it personally when a student asks for clarification during test review.

4.7.4 Faculty Threatening Behavior

All 22 faculty behaviors identified as threatening on the modified INE loaded on one factor (Aggressive Actions). There was no statistically significant difference between beginning and graduating student perception of these behaviors individually or between the students' perception of the factors ($t = 0.4323$, $p = 0.6657$).

Beginning students describe faculty threatening behaviors such as making "cutting remarks," "being rude and unkind," and "being condescending." Graduating students describe faculty as "being mean to students."

4.7.5 Nurse Disruptive Behavior

All of the 16 disruptive nurse behaviors listed on the modified INE loaded on one factor (Nurse Disregard for Others). There was no statistically significant difference between beginning and graduating student perception of Factor 1 ($t = 0.6946$, $p = 0.4875$).

Beginning students described few nurse disruptive behaviors. They did state that some nurses did not want to work with students or spend time helping students. Graduating students described nurses who charted patient care that they did not perform or rushing and ignoring students.

4.7.6 Nurse Threatening Behavior

The modified INE listed 20 behaviors for nurses categorized as threatening. All 20 behaviors loaded on one factor (Aggressive Actions). There was no statistically significant difference between beginning and graduating student perception of the factor ($t = 0.2227$, $p = 0.8238$).

Nurse threatening behaviors were described by both beginning and graduating students as "being rude," "challenging faculty's knowledge or ability to care for patients," "neglecting patients," and making comments that disrespect students and patients.

4.8 Differences in Incivility in Traditional Classrooms and the Clinical Area

To answer research question number two (What are the differences in the perception of incivility by students in the various contexts of the associate degree nursing educational environment – classroom and clinical area?), questions number 10, 11, and 17 of the scale items on the modified INE and the open-ended items on the modified INE were examined.

Question 11 on the modified INE asks, "To what extent do you think incivility in the nursing academic environment is a problem?" Students answering this question could choose one of four choices: 1) no problem at all, 2) moderate problem, 3) serious problem, and 4) I don't know/can't answer. More beginning students felt that incivility in the nursing academic environment is not a problem; however, more beginning students also chose I don't know/can't answer. An independent *t*-test revealed no statistically significant difference between responses by beginning students and those by graduating students ($t = 0.9903$, $p = .322$). Both the majority of beginning and graduating students felt that incivility in the nursing education environment was a moderate to serious problem. Table 4.8.1 provides the results related to question 11.

Table 4.8.1: Extent of Student Perception of Incivility in the Nursing Academic Environment by Percentage

Question	**Response Percentage**		
To what extent do you think incivility in the nursing academic environment is a problem?	Beginning Students	Graduating Students	Total Students
No problem at all	23.9% (n = 117)	18.7% (n = 39)	21.3% (n = 156)
Moderate problem	43.1% (n = 211)	55.0% (n = 115)	49.0% (n = 326)
Serious problem	14.9% (n = 73)	15.3% (n = 32)	15.1% (n = 105)
I don't know/can't answer	18.2% (n = 89)	11.0% (n = 23)	14.6% (n = 112)
Total	100.0% (n = 490)	100.0% (n = 209)	100.0% (n = 699)

Question 12 on the modified INE asks, "Based on your experiences or perceptions, do you think that students or faculty are more likely to engage in uncivil behavior in the nursing academic environment?" Students answering have a choice of six responses: 1) faculty members are much more likely, 2) faculty members are a little more likely, 3) about equal, 4) students are a little more likely, 5) students are much more likely, and 6) don't know. The answer to this question will provide some insight into students' perceptions of causes of incivility. Only 9.2% of the students felt faculty members were more likely to engage in uncivil behavior, while 39.4% of the students thought that students were more likely. Approximately one fourth of the students (25.3%) thought both were equally likely and one fourth (26.0%) didn't know. Table 4.8.2 illustrates the results for this question.

Question 17 on the modified INE asks, "In your opinion, where are uncivil behaviors the most prevalent?" Students answering the survey can check either "traditional classroom" or "clinical unit." The majority of respondents (57.5%) felt that there was more incivility in the traditional classroom. Interestingly, the majority of graduating students felt more incivility occurs on the clinical unit and the majority of beginning students felt more incivility occurs in the traditional classroom. An independent *t*-test revealed a statistically significant difference between

the responses of beginning and graduating students for this question (t = 3.2425, p = .001). Table 4.8.3 illustrates the results related to question 17.

Table 4.8.2: Student Perception that Incivility in the Nursing Academic Environment is a Problem by Percentage

Question	**Response Percentage**		
Based on your experiences or perceptions, do you think that students or faculty are more likely to engage in uncivil behavior in the nursing academic environment?	Beginning Students	Graduating Students	Total Students
Faculty members are much more likely.	2.1% (n = 10)	4.3% (n = 9)	2.7% (n = 19)
Faculty members are a little more likely.	5.6% (n = 27)	8.7% (n = 18)	6.5% (n = 45)
About equal.	24.5% (n = 118)	27.4% (n = 57)	25.3% (n = 175)
Students are a little more likely.	25.8% (n = 124)	29.8% (n = 62)	27.0% (n = 186)
Students are much more likely.	12.9% (n = 62)	11.5% (n = 24)	12.4% (n = 86)
Don't know.	29.1% (n = 140)	18.3% (n = 38)	26.0% (n = 178)
Total	100.0% (n = 481)	100.0% (n = 208)	100.0% (n = 689)

Table 4.8.3: Student Perception of where Incivility Occurs Most Frequently

Question	**Response Percentage**		
In your opinion, where are uncivil behaviors the most prevalent?	% Beginning Students	% Graduating Students	Total Students
Traditional classroom	62.4% (n = 260)	46.7% (n = 85)	57.6% (n = 345)
Clinical Unit	37.6% (n = 157)	53.3% (n = 97)	42.4% (n = 254)
Total	100.0% (n = 417)	100.0% (n = 182)	100.0% (n = 599)

Obvious differences in incivility in the traditional classroom and incivility on the clinical unit include the fact that uncivil behaviors on the clinical unit can involve nurses and patients as well as students and faculty. Therefore, the potential for harm is greater because two vulnerable populations are involved – patients and students (Longo, 2007; Shirey, 2007; Kerfoot, 2008). In addition, incivility on the clinical unit has legal ramifications (Suplee, Lachman, Siebert, & Anselmi, 2008; The Joint Commission, 2008). Charting patient care that was not done is a violation

of nursing ethics and falls under the category of falsifying patient records (Hilbert, 1985). This is against the nurse practice act and could result in untoward effects upon the patient as well as legal action against the nurse (Louisiana State Board of Nursing, 2004). Langone (2007) cites the 2003 Gallup poll as rating nursing as the "most honest of 23 professions and the one with the highest ethical standards" and believes that because of this high level of trust as well as the ethical standards associated with the profession, "nurses have a responsibility to conduct themselves in a manner that warrants this degree of public trust" (p. 45).

To further illuminate research question number two (What are the differences in the perception of incivility by students in the various contexts of the associate degree nursing educational environment – classroom and clinical area?), the responses to the open-ended question on the modified INE, "What are the differences in the uncivil behaviors seen in the traditional classroom and on the clinical unit?" were examined. Responses were entered into Atlas.ti by site and identified by student level. Using a constant comparative approach, transcripts of the answers were read and reread several times in order to gain an awareness of the content, feelings, and tone (Gall et al., 2003). Responses were then sorted into categories which were formulated into broader themes. These themes were compared to Clark's (2008a) themes that emerged from her study of 289 nursing faculty members in 41 states. The two factors relating to student incivility that emerged in Clark's (2008a) study were stress and an attitude of entitlement. Students identified three themes related to stress: 1) burnout, 2) competition, and 3) need to cheat. These themes were primarily related to students' feelings that their nursing programs were "extremely competitive and rigorous" (Clark, 2008a, p. E41). Students identified four themes related to an attitude of entitlement. These included: 1) lack of personal responsibility, 2) having a consumer mentality, 3) feeling that they were owed an education, and 4) making excuses for not being successful (Clark, 2008a).

Two factors emerged from Clark's (2008a) study related to faculty incivility. These were "stress" and an "attitude of superiority" (Clark, 2008a, p. E43). Four themes emerged related to faculty stress. These themes were identified by faculty and included: 1) burnout; 2) lack of qualified faculty; 3) effects of juggling work, family, and school; and 4) exposure to incivility (Clark, 2008a). Three themes were identified by students that related to faculty air of superiority. These were: 1) exercising power over the students, 2) threatening to dismiss or fail students, and 3) a lack of appreciation for students' previous life experiences (Clark, 2008a). Though labeled differently, these themes were congruent with themes emerging in this study.

Responding to the differences in uncivil behavior in the traditional classroom and on the clinical unit, one theme that emerged was severity of consequences. For example, one student stated, "In the classroom, it just includes other students and faculty. At the clinical site an actual patient is involved and at risk….Someone may die." Another student added, "Clinical behavior can result in patient harm….Patients' lives are on the line." Other students echoed this theme with one student stating, "Incivility in the classroom is less harmful usually than in clinical."

A second theme that surfaced was harassment. One student explained, "At clinical there is more opportunity for ridicule or avoiding students who need help. Clinical grades are more subjective." Another student expressed stronger sentiments,

> Others [clinical experiences] feel like I have been thrown into a pool of barracudas. It tends to be influenced by management. If management has a negative attitude, there is a trickle down effect, and the unit tends to be negative and destructive…

The literature discusses nurses "eating their young" (Meissner, 1986). One student supported this finding and stated, "There are so many more uncivil behaviors exhibited in the clinical situation because that is where the staff nurses are. The staff nurses tend to be much more intimidating that the clinical educators." Another student supported this by stating,

> I do feel that nurses on the unit could be nicer to the students. The nurses on the unit (not

faculty) are usually the ones who present the biggest challenge to nursing students by treating them as less, by acting superior, and by forgetting that they were once students also.

Other students identified similar feelings. A student commented, "…the floor nurses at my clinical site were for the most part, great, but some of them displayed attitudes that transmitted that we were just another herd of students." Another student commented, "I got to do a cath with my nurse. She yelled that I was taking too long and then just took over the procedure."

Other students described the differences in terms of the perpetrators. One student commented, "There is more student uncivil behavior towards the faculty in the classroom and more nurse uncivil behavior towards the student in the clinical setting." Another student stated,

> …in the classroom [the uncivil behavior] is disagreement between students about what should be done in a hypothetical situation. In the clinical unit, the uncivil behavior is nurses ignoring students and patients. Many times they appear to be burned out.

4.9 Differences in Programs with High and Low Perceived Levels of Incivility

To answer research question number three, "What are the differences between programs with high and low perceived levels of incivility?" results for student, faculty, and nurse behaviors experienced or seen in the past 12 months were examined. Initially, data was split into sites. Means for each category of behavior occurrence were determined. For example, a mean for each item occurrence at each site was obtained. Then six grand means for occurrence of student disruptive behavior, student threatening behavior, faculty disruptive behavior, faculty threatening behavior, nurse disruptive behavior, and nurse threatening behavior were hand calculated for each participating site. However, of the 20 participating schools, three programs had less than five students responding. These programs were eliminated for the purpose of answering research question number three. Therefore, the sample of programs utilized to answer research question

number three was 17. Table 4.9.1 illustrates the sample of programs used to answer research question number three.

Table 4.9.1: Sample of Programs with more than Five Students Responding

State	Program	Urban	Rural	Secular	Religious	# Students
Alabama	2		X	X		69
Alabama	17		X	X		6
Alabama	14		X	X		22
Florida	15		X	X		9
Florida	11	X		X		9
Georgia	9	X		X		82
Louisiana	7		X	X		42
Louisiana	8	X			X	78
Louisiana	12		X	X		22
Louisiana	16	X		X		104
Mississippi	3		X	X		58
Mississippi	4		X	X		95
Tennessee	10	X			X	23
Texas	5	X			X	18
Texas	6	X		X		73
Virginia	1	X		X		17
Virginia	13		X	X		14
Totals		**8**	**9**	**14**	**3**	**741**

To determine which of these programs had the highest and lowest levels of student perceived incivility, the six grand means were examined. These means represented 1) student perception of the occurrence of disruptive student behavior, 2) student perception of the occurrence of threatening student behavior, 3) student perception of the occurrence of disruptive faculty behavior, 4) student perception of the occurrence of threatening faculty behavior, 5) student perception of the occurrence of disruptive nurse behavior, and 6) student perception of the occurrence of threatening nurse behavior. Programs with the largest grand mean and the smallest grand mean for each category were identified. These means were then summed to determine programs with the highest and lowest means for perceived levels of incivility. Table 4.9.2 illustrates the grand mean for each behavior occurrence category by program.

Table 4.9.2: Grand Means of Student Perception of Occurrence of Incivility by Site for All Modified INE Survey Categories

	Student Grand Mean		Faculty Grand Mean		Nurse Grand Mean	
Site	**Disruptive**	**Threatening**	**Disruptive**	**Threatening**	**Disruptive**	**Threatening**
1	2.084	1.178	1.222	1.01	1.367	1.089
2	1.94	1.138	1.45	1.178	1.501	1.668
3	1.787	1.302	1.273	1.145	1.446	1.303
4	2.746	1.320	1.487	1.177	1.405	1.244
5	2.278	1.670	1.533	1.193	2.100	1.61
6	2.344	1.145	2.548	1.264	1.60	1.050
7	2.298	1.399	1.552	1.345	1.658	1.403
8	2.119	1.278	1.696	1.165	1.605	1.286
9	1.995	1.277	1.410	1.075	1.502	1.193
10	1.83	1.236	1.342	1.162	1.473	1.355
11	2.702	1.188	1.365	1.081	1.283	1.129
12	1.851	1.246	1.379	1.021	1.368	1.145
13	1.839	1.285	1.093	1.022	2.043	1.454
14	2.204	2.196	1.79	1.500	1.602	1.06
15	2.112	1.324	1.493	1.025	1.756	1.142
16	1.991	1.307	1.552	1.174	1.602	1.06
17	1.902	1.212	1.444	1.085	1.181	1.103

It is interesting that at site 7, students' perception of incivility was among the four highest in all categories. The three programs with the highest levels of perceived incivility had the highest level in one of the six categories. For example, site 5 had the highest perceived level of nurse disruptive behavior occurrence, site 6 had the highest perceived level of faculty disruptive behavior occurrence, and site 14 had the highest level of student threatening behavior occurrence and the highest perceived level of faculty threatening behavior occurrence. All three sites with the lowest perceived levels of incivility occurrence had mean scores in the lower half of the scores. However, no one site emerged as the most or the least uncivil in all categories. Therefore, the means were summed to determine which programs had the highest and the lowest student perceived levels of incivility across the six categories. Table 4.9.3 depicts the sum of the means for each site.

Table 4.9.3: Sum of Means Depicted in Table 4.9.2 by Site

Site	Mean	SD
1	7.95	.348
2	8.875	.466
3	8.256	.689
4	9.379	.570
5	13.384	.759
6	9.951	.390
7	9.655	.664
8	9.149	.603
9	8.452	.566
10	8.398	.641
11	8.748	.419
12	8.01	.537
13	8.736	.420
14	10.352	.697
15	8.852	.558
16	8.686	.679
17	7.927	.455

In addition to identifying the program, the researcher identified whether the program resided in a secular or religious institution and if the institution was located in a rural or urban locale. There were three programs identified as having the highest levels of incivility as perceived by the students and three programs were identified as having the lowest perceived levels of incivility. Table 4.9.4 illustrates this data.

Table 4.9.4: Programs with the Highest and Lowest Perceived Levels of Incivility

Program	Mean Sum	Rural	Urban	Religious	Secular
5.	13.384	X		X	
14.	10.352	X			X
6.	9.951		X		X
12.	8.01		X		X
1.	7.95		X		X
17.	7.927	X			X

A content analysis of key documents related to institutional mission statements, institutional goals, faculty and student handbooks, institutional values, and program Web sites was conducted. All documents were obtained from the respective institutional Web site and evaluated for content. Initially, *a priori* codes were identified from the literature and included admission policy; conduct

codes; faculty number, gender, and workload; and institutional commitment to the surrounding community (Morphew & Hartley, 2006; Scott, 2006; Abelman & Dalessandro, 2008; Adams, 2008; Meacham, 2008). For example, mission statements, values, and goals were examined to determine if the institution valued its commitment to education, if there was a link to industry, and if there was a commitment to civic engagement. Student and faculty handbooks were examined to determine the presence of conduct codes, faculty workload, and curriculum. Behavior codes were analyzed for the presence of legal terminology, the extent of the code, the methods for appeal, and student representation on appeals and grievance committees. Faculty workloads were scrutinized to determine length of contract, credit hour/course load per faculty per semester, and whether a tenure track was available. A preliminary review of the key documents identified the following emergent codes: student stress, faculty/nurse stress, and lack of respect for others. These codes are consistent with Clark's (2008a) themes. Table 4.9.5 illustrates the *a priori* codes, emergent codes, and Clark's (2008a) themes.

The three institutions with low perceived levels of incivility have institutional missions that are directed at improving the quality of life for the surrounding area (civic engagement) and meeting the educational needs of the people living in the area (commitment to education). For example, one institution states that their mission is "committed to the professional and cultural growth of each student….[and] strives to provide an educational environment that promotes development and learning…." and the college "utilizes a participative management structure." Another institution with low perceived levels of incivility has an open-door admission policy and its mission includes a statement that includes "providing a dynamic learning environment that will change people's lives and enrich our community." While the third institution with low perceived levels of incivility engages in efforts to "benefit industry and to enhance economic development and cultural growth in this region and beyond."

All three programs with low perceived levels of incivility have an explicit student conduct code and one of the programs discusses state law pertaining to nursing licensure on its Web site. The program with the lowest level of perceived incivility publishes a student bill of rights explaining that the student has a right to an "open interchange of knowledge and philosophies" where "student grades will not be influenced by opinions expressed in the classroom or outside the classroom." At all three institutions, there is student representation on appeals and grievance committees and the primary faculty responsibility is teaching.

All three of the programs with low perceived incivility are small with less than 20 faculty members. Two of the three programs had male faculty members. Workloads at all three were similar with only one of the programs having a tenure track and this was the only program situated in a university.

The three programs with the lowest perceived levels of incivility are all part of a larger public educational system, two of them are part of state-wide community college systems and one is part of a state-wide university system. As a result, many of their policies are state-wide policies as opposed to specific institutional policies. All three of these nursing programs are full-time, highly competitive, six semester programs. Two of the programs are 72 credits and one is 67 credits. All three discuss the faculty's commitment to student success in the program's mission or philosophy.

The programs with high perceived levels of incivility were also relatively small programs with less than 20 faculty members and again, two of the three programs had male faculty members. All three programs with high perceived levels of incivility had mission statements that addressed meeting the educational needs of the surrounding communities. Two of the three programs with high perceived levels of incivility required 72 credits to graduate and one required 66 credits. None of the parent institutions have tenure tracks for faculty. All three nursing programs have competitive admissions, require attendance during a summer semester, and have no student representation on appeals or grievance committees.

It is interesting that one of the schools with the highest perceived level of incivility is religiously affiliated. This particular institution has a very extensive discipline code including the ability to suspend a student for failing to honor a summons to an administrative conference and this institution has an appeals process that has five levels. Lau (2004) points out that codes of conduct in faith-based institutions are often more extensive than ones in secular institutions and this is due in part to *the in loco parentis* philosophy at faith-based institutions.

The researcher also analyzed the student responses to the open-ended questions on the modified INE from these six schools. Answers to the open-ended questions were entered into Atlas.ti by site and identified by student level – beginning or graduating. Using a constant comparative approach, transcripts of the answers were read and reread several times in order to gain an awareness of the content, feelings, and tone (Gall et al., 2003). Responses were then sorted into categories which were formulated into broader codes. As a result, the following emergent codes were identified: student stress, student air of entitlement, faculty/nurse air of superiority, faculty/nurse stress, the norm of violence, lack of trust between students and faculty, and lack of respect for others. These codes were compared to Clark's (2008a) themes that emerged from her study of 289 nursing faculty members in 41 states. All codes (*a priori* and emergent) were defined. Table 4.9.5 illustrates the *a priori* codes, emergent codes, and Clark's (2008a) themes.

Table 4.9.5: Codes Relevant to Programs with High and Low Perceived Incivility Occurrences

A Priori	**Emergent**	**Clark's (2008a)**
Admission policy	Student Stress	Stress (student)
Behavior Codes	Student Air of Entitlement	Attitude of Student Entitlement
Faculty Number	Faculty/Nurse Air of Superiority	Faculty Attitude of Superiority
Faculty Gender	Faculty/Nurse Stress	Stress (faculty)
Faculty Workload	Norm of Violence	
Commitment to Surrounding Communities	Lack of Trust between Students and Faculty	
	Lack of Respect for Others	

4.9.1 Reasons for Incivility

At schools with high perceived levels of incivility, when asked why students and faculty contribute to incivility, students responded that the behavior is tolerated; people are insecure, immature, tired, stressed, uncooperative, have a "poor upbringing," lack respect for others, and lack communication skills.

- Stress

The increased stress of nursing was a prevalent theme that emerged. One student at a program with a high perceived level of incivility commented "a nursing program is way more demanding than any traditional class that I have ever been in so the students are under a lot more pressure and have a lot more stress." Other students attending programs with high perceived levels of incivility remarked, "Students are under a lot of stress and cannot openly communicate with instructors" and "…students assume that they always need to be in offense mode [sic] and are under a lot of stress."

- Lack of Respect

Students at programs with high perceived levels of incivility identified a lack of respect for individuals, the rules, and the differences in people as contributing to incivility. One student commented, "I believe that some students lack respect for the rules. They just don't want to follow direction." Another student stated that, "They just don't care." Faculty talks over people so they can be heard and delegate "job duties they feel they are too good for." They don't respect "others thoughts or feelings." Yet another student added, "Faculty do [sic] not respect students as mature, responsible individuals."

- Faculty/Nurse Attitude of Superiority

One student attending a program with high perceived levels of incivility described her faculty as having a "mightier-than-thou attitude" while another student stated that her faculty had "attitudes of superiority." Yet another student stated, "I have experienced that the 'adage' is true.

Nurses (including faculty at large) 'eat their young.'" Students also believed that faculty were socialized to the "norm of horizontal violence and hazing of students" and "they [faculty] think they need to almost 'haze' nursing students with harsh treatment as a part of their formal education since that was how they [faculty] were treated when they went to school 20 years ago." Another student described her faculty as "acting like a big shot," refusing to be kind or see the reasoning behind the other's actions. "Faculty seem [sic] to have no regard for students as individuals."

- The Norm of Violence

Students in programs with a low perceived level of incivility offered similar answers to the question; however, they tended to equate incivility with the discipline of nursing stating it is "the personality type of a 'nurse.' It is competitive to get into the program and takes a dedicated/driven person to complete [the program]." Another student attending a program with low perceived levels of incivility stated, "I think it is like a waterfall effect and when the people (instructors, nurses) are teaching us, we learn that it is then okay to do." Another student attending a program with low perceived levels of incivility commented, "I believe its ignorance. I don't believe that most mature individuals act with incivility. I don't think they realize the effects of the words coming out of their mouths." One respondent compared incivility to ethical behavior stating, [they act that way because they have a] "lack of knowledge and [lack of] moral behavior."

4.9.2 Ways of Being Uncivil

When asked how do students and faculty contribute to incivility, students at programs with high perceived levels of incivility described behaviors such as gossiping, cheating, not caring, being judgmental, and being disrespectful. Themes emerging included entitlement, air of superiority, and the norm of violence.

- Student Entitlement

One student attending a program with high perceived levels of incivility gave this example, one day a student got written up for being late to clinical 2 times. It was my med pass day

> and she spent about an hour in the hallway of the patient care area arguing with our instructor about it. It was disturbing the patients and a few even asked us to close the doors for them.

Another student described the behaviors as "not …doing what is best for the group." One student gave the following example: They [the students]

> gossip and huddle around the desk and don't take care of their patients. They chart skills, like bed baths, that haven't been done. They don't do appropriate complete head to toe physical assessments. They also tend to form clichés and isolate other members of the team.

Students at programs with low perceived levels of incivility described the uncivil behaviors as disrespectful. For example, when asked how students and faculty contributed to incivility, one student attending a program with low perceived levels of incivility commented, "by disrespecting each other and being impatient. Not thinking about other's feelings and not putting their heart into their work/studies." Behaviors students described were texting during class, talking on cell phones during class, side conversations, and dominating discussions.

- An Air of Superiority

A student attending a program with high perceived levels of incivility in her final course explained an incident that happened during her first semester. She described her faculty member this way.

> I did really bad on a test and went to talk to one of the instructors as was mandated by the syllabus. I told her I did bad [sic] on the test and the syllabus said we had to talk to an instructor if we failed a test. The whole time I was trying to talk to her she was texting on her cell phone. She never even looked at me….She made it sound like I was a greedy person looking for an easy out. I didn't ask for special treatment. The only reason I went to talk to her was because it was mandated. I knew where the weakness was and why I did bad

[sic] on the test, she never even asked me about that….Why should I even have to talk to them if they don't care?

Another student stated, "Faculty contribute by being condescending and sometimes mean towards students." Yet another student at a program with high perceived levels of incivility described faculty this way, "…rude and condescending and acting like they know the answers to the world's problems."

- The Norm of Violence [Faculty and Nurse]

A student attending a program with a high perceived level of incivility referred to the cycle of negativity by stating, "They [faculty] are drawn in by negativity maybe from within themselves or influence from others and continue the cycle by being negative toward others." Students at programs with high perceived levels of incivility also described faculty as "fighting and arguing amongst themselves" and "belittling student's lack of knowledge and showing impatience…." This "makes the instructor unapproachable."

Another student attending a program with high perceived levels of incivility described an ongoing clinical situation stating, "The nurses on that floor would hide the dynamaps so we couldn't get our vital signs done on time. It was terrible especially since the instructor knew this was going on and did nothing to stop it."

Students at programs with low perceived levels of incivility tended to equate the behaviors to a lack of respect. One student observed, "Faculty show disrespect towards students and each other." Another student attending a program with low perceived levels of incivility commented, [they allow] "the pressures to build to a point where a blowup is inevitable. We need to remember that nothing is insurmountable unless we allow it to be, and we all need someone or something to help us vent frustrations." Table 4.9.2.1 illustrates the characteristics of programs with high perceived levels of incivility and those with low perceived levels of incivility.

Table 4.9.2.1: Characteristics of Programs with High and Low Perceived Levels of Incivility

Category	High	Low
Institutional Mission	Commitment to education	Commitment to education and civic engagement
Code of Conduct	Extensive codes with no student representation on appeals or grievance committees	Codes varied in length and depth, student representation on appeals and grievance committees
Nursing Curriculum	Nursing classes required during summer	No nursing classes required during summer
Faculty	9, 10.5, or 12 month contracts, 12-15 hour workloads, no tenure track	9, 10.5, or 12 month contracts, 12-15 hour workloads, tenure track at one institution
Ways of Being Uncivil	Active disruptive behaviors that tend to interrupt the class such as gossiping, dominating class discussions, not taking care of patients, faculty and nurses ignoring students in the clinical area.	Passive disruptive behaviors that are more annoying such as texting or using the computer for non-class purposes during class, being impatient, "not putting their heart into their work," disrespecting others.
Reasons for Being Uncivil	Environment tolerates incivility because nursing is stressful, students don't respect the rules, and nurses "eat their young."	Individuals lack of knowledge of how to act because that is the personality type of the nurse, they were reared poorly, or they lack moral values.
Suggested Consequences for Being Uncivil	Focus on punishment.	Focus on dialogue.

4.9.3 Addressing Incivility

When asked how incivility should be addressed, students at schools with high perceived levels of incivility were more punitive. These students felt offenders should be punished.

- The Norm of Violence [Faculty]

One student maintained, "Our program has a 'policy' where they write students up for certain activities and if you get written up 2 x's for the same offense then you fail the semester. I think incivility should be one of these offenses." Another respondent stated, "Laying out exact 'punishments' for behavior." One student chastised faculty by stating, "Faculty at my school should start by showing respect for each other and not trash-talking other faculty members."

Students in programs with low perceived levels of incivility expressed sentiments similar to those expressed by students in programs with high perceived levels of incivility. For example, "There should be a zero tolerance for it [incivility] with penalty being termination of employment of the guilty faculty or expulsion from school for the student." Another student gave a similar response, "Should be addressed with reprimand for first offense and understanding that another offense will result in termination."

- Showing Respect

However, the majority of responses from students in programs with low perceived levels of incivility felt violations should be handled one-to-one. As one student stated, "First address the problem directly verbally. If it doesn't work, do it again. If still persists, take action…." Another student replied, "They should be warned. Then they should be written up if they continue to do things that are uncivil." Students also felt that they should politely address faculty when a faculty member was uncivil. For example, one student from a school with low perceived levels of incivility said, "Politely bring it up to the instructor at the end of class." This requires that the student-faculty relationship be based on trust and this maybe a characteristic of the student-faculty relationship in programs where there is a low perceived level of incivility.

Other students felt that incivility should be openly discussed and ways to avoid or prevent incivility should be taught. For example, students stated "teach what is not acceptable," "teach ways to prevent," and "talk as a group…and solve it as a team." These students felt it should be addressed as soon as it happens and "teachers should do more about incivility."

Another student at a school with a low perceived level of incivility addressed the behavior of the nurses stating,

> I'm really not sure what can be done since many of the behaviors are from the staff nurses. Students realize that the staff nurses are doing their jobs and cannot be available to answer lots of questions, but it would be nice if the staff nurses would foster an attitude of

helpfulness or at least acceptance of student nurses on their unit because we are helping to take care of their patients.

- Lack of Trust

A student in a program with high perceived levels of incivility remarked, "I feel it is the responsibility of the institution to address those instructors who are rude and condescending to students." This student demonstrates a lack of trust in his/her faculty by putting all the responsibility for addressing the behavior on the institution.

One self-identified male student stated, "I find it interesting, in nursing it's all about the treatment/caring for your patient but some instructors forget they lead by example on how they treat the students." Another student responded, "Recognize that it is real: faculty feel [sic] that if they had to 'pay their dues' students should have to also….And most of all, as a faculty, don't perpetuate. Good luck with that." These comments illustrate the hopelessness of these students that the problem will be addressed and eliminated.

Interestingly, several students suggest that mediators be used to handle incivility. For example, "[incivility should be addressed] in a secluded meeting with witnesses and mediators" and "by having the parties involved speak either alone or with a mediator." One student suggested, "Have a mediator to see what the problem is." Another student addressed incivility in terms of student rights noting, "Students need to know they have rights, that being belittling [sic], putdowns, harassment, and discrimination are not allowed."

Several students discussed addressing incivility with the nurses. One suggested, "A more cooperative relationship needs to develop. Getting the nurses more involved in the academic setting so they get to know the students more as people would help. Nurses tend to ignore students and don't like to deal with them unless they have to." Another student echoed these sentiments stating, "Nurses and students need to work together more to see that both sides are just people. There needs to be more holism in nursing. We teach it in class when dealing with our patients but we don't

practice it ourselves when dealing with other people." One student commented, "It [incivility] really makes me rethink my choice of nursing. Do other professions treat each other this bad or is it just nurses?"

4.10 Summary

Data gathered from the participants in this study support previous research. Associate degree nursing students believe there is a moderate problem with incivility in nursing education. The majority of these students feel that students are more likely to engage in uncivil behavior, though one fourth felt students and faculty were equally likely.

Ten factors were isolated as a result of exploratory factor analysis. There was a statistical difference between beginning and graduating students on one of these factors. This factor (*Abuse of Position*) appeared under Faculty Disruptive Behaviors. Beginning students described this factor as faculty showing favoritism, being unfriendly, "not caring," and arguing among themselves. Graduating students described this factor as faculty being rigid, acting superior, and taking questions about test items personally. There was a statistically significant difference between where beginning and graduating students felt incivility occurred the most. Beginning students identified the classroom and graduating students identified the clinical area as the venues where incivility appeared the most.

Students identified differences in the uncivil behaviors found in the classroom and on the clinical unit. Themes emerging included the severity of consequences, harassment, and perpetrators. The consequences of incivility on the clinical unit had the potential to be more severe; there was also more opportunity for harassment on the clinical unit. Perpetrators on the clinical unit included nurses, faculty, patients, peers, and staff.

The third research question asked about the differences between schools with high perceived levels of incivility and those with low perceived levels of incivility. The three schools identified as having the highest perceived level of incivility had extensive codes of conduct as well as honor

codes. One school required students to sign an honor code pledge and had as a program objective "to demonstrate ethical behavior in the classroom."

The three schools with the lowest levels of perceived incivility also had codes of conduct, but none had honor policies. Additionally, these schools tended to use more positive wording in their codes of conduct with one school having a Student Excellence Committee, one having a Student Success Center, and the third having participative management. All three had student representation with more than a single student on their appeals committee.

CHAPTER 5. DISCUSSION

Clearly, the literature and the participants in this study assert that incivility in nursing education in both the traditional classroom and the clinical area is a problem. In a profession that professes to care for individuals, the significance of this finding seems obvious.

5.1 Conclusions

There was no difference in perception of student disruptive behavior between the beginning and graduating students. The three factors extracted from student disruptive behavior included Avoidance, Student Disregard for Others, and Integrity Compromised. The fact that there was no statistically significant difference between beginning and graduating students could be related to the fact that students have completed a minimum of 12.5 years of schooling prior to being admitted to a nursing program. With the highly competitive nature of the nursing admission process, these students would have focused on making "As" and achieving a high grade point average. Hilbert (1985) state that pressure to get good grades influences cheating behavior. Unfortunately, the behaviors extracted in these three factors are behaviors that I believe students see throughout their educational experience. I don't believe they begin in nursing school; therefore, all students are familiar with student behaviors and the process of attending nursing school would not impact their knowledge or opinion of these behaviors.

Two factors were extracted from student threatening behavior – Aggressive Antagonism and Uncongenial Actions. Again, there was no statistically significant difference between beginning and graduating students. If socialization to nursing school begins the first day, the fact that the nursing school experience does not impact student opinion related to student threatening behaviors is also understandable. Nursing students are on the clinical unit with nurses having various degrees of experience as well as other students and at times students who are in their final semester of school. This would make beginning students more aware of these threatening behaviors. Additionally, many programs have a big sister/brother – little sister/brother program where

beginning students are paired with upper classmen in a mentorship. This would also inform beginning students. The presence of the Student Nurses Association also mixed all levels of students in an effort to mentor the beginning students. Therefore, beginning students are not isolated and would have knowledge of some of the experiences of the upper class student.

Abuse of Position and Faculty Disregard for Others are the two factors extracted from Faculty Disruptive Behavior. Though there was no statistical difference between beginning and graduating students with regard to Faculty Disregard for Others, there was a statistically significant difference between the beginning and graduating students for Abuse of Position with graduating students identifying this as more of a problem. The behaviors included in the factor Faculty Disregard for Others are ones students could experience at all levels of the educational process, where behaviors loading on Abuse of Position may only become apparent over time. Additionally, faculty members teaching in the first semester tend to be ones who have a great deal of patience and they tend to nurture the students. Also, students may become more aware of faculty behavior after becoming socialized into the nursing educational process.

One factor was extracted for each of the following: Faculty Threatening Behavior, Nurse Disruptive Behavior, and Nurse Threatening Behavior. There was no statistically significant difference between the beginning and graduating students on any of these factors. This could be related to the fact that associate degree students have not interacted enough with the faculty or nurses to identify nuances in their behavior.

To determine the difference in student perception of incivility in the traditional classroom and the clinical unit, the researcher evaluated whether students perceived incivility as a problem in the nursing academic environment. Though there was no statistically significant difference between beginning and graduating students, approximately 64% of the respondents felt incivility was a moderate to severe problem. Approximately 39% of the students felt that students were more likely to engage in uncivil behavior in the nursing academic environment. Though the majority of

students felt that incivility occurred most often in the traditional classroom, there was a statistically significant difference between beginning and graduating students regarding where uncivil behaviors occurred the most with graduating students identifying the clinical unit as the venue where incivility occurred most often. This finding could be related to the fact that graduating students have spent more time on different clinical units. Nursing literature (Roberts, 1983; Freshwater, 2000; Griffin, 2004) describes nurses as oppressed and as such they experience feelings of powerlessness. As a result, they may act in an aggressive manner, particularly toward each other (Randle, 2003; Griffin, 2004; Dellasega, 2009).

To further illuminate differences in incivility in the various contexts of associate degree nursing education, the answers to the open-ended questions on the modified INE survey were analyzed. Emergent themes included student, faculty, and nurse stress; student entitlement, faculty/nurse air of superiority; and student, faculty, and nurse disrespect for others. Students specifically identified harassment as a theme, but harassment is a form of disrespect for others. Students also described the effect of incivility on the clinical unit versus the traditional classroom, citing the severity of consequences on the clinical unit where patients could die.

The third research question asked what were the differences in programs where students perceived high levels of incivility and those where students perceived low levels of incivility. At programs with high perceived levels of incivility, students described other students and faculty as not caring and not respecting others. These students described faculty and nurses as acting superior and identified a "norm of violence" believing that incivility was modeled so students, faculty, and nurses began to accept this behavior as the norm. Students referenced faculty "mightier than thou attitudes" and the feeling that faculty were perpetuating "genocide when it comes to dealing with our young nurses" (Meissner, 1986, p. 52). Students at programs with a low perceived level of incivility tended to describe the reasons for incivility as ignorance or poor "upbringing."

These comments suggest that students in nursing school are fearful. Palmer (1985) points out that "from grade school on, education is a fearful enterprise" and "educational institutions are full of divisive structures" (p. 36). This fear can interfere with the educational process and may cause some students, faculty, and nurses to act in an uncivil manner (Palmer, 1985; Luparell, 2008; Clark, 2008c). One student described this fear as "personal insecurity" stating that this causes the student to "cut down and degrade others." Palmer (1985) believes this fear plays a role in the disconnection and distrust between the students and their faculty and plays a role in separating emotions from intellect. The result of this separation is lack of passion for learning. This paradox limits the possibilities of the classroom. Fear causes a disconnect between teacher and student, teaching and learning, and eventually between patient and nurse. The emergence of fear as a theme supports previous research (Clark, 2008a, 2008b, 2008c, 2008d; Luparell, 2003, 2008; Shirey, 2007) and give credence to framing this study within social exchange theory.

Erik Erikson describes the first stage of development as "Trust versus Mistrust." Erikson believes that one must master this before progressing through the next developmental stage. Palmer (1985) has described the educational process as one full of fear. It is therefore reasonable to assert that students begin each class in the "Trust versus Mistrust" stage of development. Carter (1998) notes that "trust (along with generosity) is at the heart of civility…[and] cynicism is the enemy of civility" (p. 67). Cynicism implies an underlying distrust of others. Students in this study describe this lack of trust in a number of ways – insecurity, lack of professionalism, ineffective coping skills, being rude and stubborn, and a lack of caring. McCabe, Trevino, and Butterfied (1999) determined that when faculty members do not address incivility in the classroom, it erodes the student-faculty relationship therefore, eroding trust.

Respondents frequently cited immaturity as a reason for incivility. Hernandez and Fisher (2001) postulated that today's students lack social graces because they grew up in a technologically complex world where they were isolated from adults. This limited their exposure to adult decision-

making and allowed them to see themselves as part of the adult world. The result is a lack of social graces. The internet and television, in particular, provide society with information about any topic imaginable. Nordstrom, Bartels, and Bucy (2009) believe that current students have developed their view of the world from peers rather than from adults. This has contributed to differences of opinion as to what constitutes appropriate behavior. Nordstrom et al. (2009) found that the strongest predictor of classroom behaviors was not seeing anything inappropriate with the behavior. If today's students have developed their own set of values which conflict with those of nursing faculty, one can see why there are increased incidents of incivility in the classroom. Dellasega (2009) refers to behavior this as relational aggression.

A common theme appearing in the answers to the open-ended questions at both schools with high and low levels of incivility was that faculty should address incivility when it happens. One student stated, "Sometimes you report to your instructor something you feel should not be occurring and you don't know if they are addressing what you tell them." Students recognize that the faculty member is in charge of the classroom and the clinical experience and though some students were willing to address uncivil situations, the majority felt that it was the faculty member's responsibility. One student commented "Faculty sets the tone for what kind of behaviors are allowed and/or endured…."

Faculty need to be aware of their influence on student development. As Luparell (2008) points out, "behaviors signify values" and when one acts in an uncivil manner it "reflects a lack of value for the dignity of others" (p. 44). This is a violation of the ANA Code of Ethics (ANA, 2001), which asserts that "the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual…." (p. 4). The Code of Ethics (ANA, 2001) extends this statement to encounters with colleagues and students by prohibiting "…any and all prejudicial actions, any form of harassment or threatening behavior, or disregard for the effect of one's actions on others" (p. 9). Previous research indicates that faculty

can impact the learning environment either positively or negatively, thus impacting student learning (Kuh, 1995; Pascarella & Terenzini, 2005; Palmer, 1985). Green (2008) discovered that nursing faculty felt that when a faculty member demeans other faculty or nurses, this negatively impacts learning and should be addressed by administration. Helm (2006) stresses the importance of role modeling for teaching behavioral expectations. She believes these behaviors should be constantly modeled from the beginning of the educational process (Helm, 2006). Meissner (1986) warns that nursing education focuses on "*judging* students rather than assisting and supporting them" (p. 52, italics in the original) and rather than modeling civility, nurse educators are the first offenders in committing incivility.

Students describe typical faculty behavior as "overly critical," "loves to correct you," and "arrogant." To stop this cycle of violence, faculty and nursing staff need to role model desirable behavior. Sadly, one student commented that there should be zero tolerance for incivility, "but that will not happen with the nursing shortage. I have found that having an instructor is more important than incivility."

Ways of being uncivil at programs with high perceived levels of incivility tended to have an effect on other people. Behaviors included monopolizing class or clinical, ignoring patients and students, charting patient care that wasn't done, being condescending, and faculty "fighting and arguing among themselves" [sic]. At programs where students perceived a low level of incivility, uncivil behaviors tended to affect the individual with less impact on the group. For example, texting in class, skipping class, and "not putting their hearts into their work/studies." Behaviors described by students at programs with low perceived levels of incivility were primarily categorized as disrespect for others.

Students at programs with high perceived levels of incivility felt incivility should be punished and the institution was responsible for the punishment. For example, students should be dismissed or expelled and faculty should be terminated. At programs with a low perceived level of

incivility, students described handling incivility one-to-one through dialogue. Some students suggested using mediators and one suggested getting the staff nurses more involved in the educational process so they could "get to know students as people."

In today's economic and educational climate, students are primarily interested in obtaining an education which prepares them for employment (Levin, 2005). This desire contributes to a consumer mentality on the part of the student (Delucchi & Korgen, 2002; Potts, 2005; Zemsky, 1993) and supports viewing education through the lens of social exchange theory. Students as consumers exchange tuition for knowledge. Therefore, students believe they are entitled to a degree. This belief contributes to the disconnect between student and faculty (Delucchi & Korgen, 2002); therefore, impacting the learning environment. One student commented that "students may think the teachers are gonna baby them" which would indicate a consumer mentality by demanding "customer service" (Love, 2008).

One student, when asked why students and faculty contribute to incivility, commented, "Students are failing. We pay way too much to fail." Luparell (2003) points out that previous generations viewed failure as an opportunity, where students today see it as a barrier to a goal. She views this in the context of entitlement citing Newton's (2002) suggestion that students have unrealistic expectations about the amount of effort it will take to achieve their goal of becoming a registered nurse.

Much has been written about colleges and universities as market driven instead of mission driven. Anctil (2008) points out that students in higher education today are the consumers as well as the product and what the student wants may not be the best for the product. A sampling of mission statements of the institutions in this study illustrates this market mentality. For example, local community college "provides access to education that develops individuals for employment and career advancement…and builds a skilled workforce that contributes to regional economic development." Another institution's mission states that its efforts are "based upon the economic

and social needs of the College service area." A third institution's mission states "through its programs and services, and partnerships with industry, the College supports the economic growth of the community and the region." If the mission describes a college's basic purpose, then today's institutions of higher education have moved from serving the public good to serving the marketplace (Kezar, Chambers, & Burkhardt, 2005). This shift in institutional purpose and values has implications for the learning environment which may impact civility in the classroom.

Additionally, the emergence of student entitlement as a theme in this study supports the use of social exchange theory as the theoretical base of this study; however, using only social exchange theory is superficial and limiting. The results were much broader and support the use of critical theory as well. There is evidence that students feel entitled to an education, feeling that they have paid for the degree and therefore, faculty work for them. However, this theory does not explain all of the findings. The factors, *abuse of position* and *aggressive actions*, support framing the study within critical theory. Critical theory examines power relationships through an emancipatory lens while analyzing social and cultural influences (Pinar, Reynolds, Slattery, & Taubman, 2002).

5.2 Implications for Practice

This study confirms that incivility in nursing education is a problem that needs to be rectified. Forni (2002) avows that "many acts of violence have their origin in acts of incivility" (p. 67) and student nurses are vulnerable to this violence (Di Martino, 2003). Research has suggested a number of methods for addressing uncivil behavior. However, this information remains limited. As a result of this study, three specific implications for practice were identified. These implications are explained below.

- Clarify and Teach the Ethics of Nursing

Nordstrom et al. (2009) suggest that reframing uncivil behaviors as problematic is a powerful way to establish the norm of civility. They describe the reframing as helping students to develop "subjective norms" (Nordstrom et al., 2009, ¶ 24). By allowing students to define the rules

of the classroom and the consequences for not following the rules, students take ownership of the rules. Even if the student doesn't care what the instructor thinks, he/she may care what his/her peers think (Nordstrom et al., 2009). The first day of my associate degree nursing class with 54 students, I elicited student input in determining the class rules. These rules were typed and distributed at the beginning of the next class period. Students signed and returned a copy to me and kept a copy of the rules to refer to throughout the semester. I found that these students policed themselves. For example, the students decided that eating in class was disruptive and therefore, not allowed. When one student began eating chips, her peers reminded her that it wasn't allowed and she stopped. Also, instead of talking to each other and asking for clarification, students raised their hands to ask questions. This worked so well, that I will do it again.

Nordstrom et al. (2009) found that the second highest predictor of uncivil behavior was a consumer orientation to education. They suggest setting performance standards emphasizing knowledge instead of grades (Nordstrom et al., 2009). This is challenging in prelicensure nursing programs where students must pass the National Council Licensing Examination for Registered Nurses (NCLEX-RN) to practice nursing. The NCLEX-RN is a multiple choice test and nursing faculty feel an obligation to prepare students to pass this exam. As a result, most nursing faculty members use multiple choice exams as their method of classroom evaluation. I propose allowing students to determine what method will be used to evaluate them. Faculty could still give multiple choice exams using them as learning tools instead of evaluation methods. I tried this in an undergraduate research class of 30 students. Students were given the guideline that they had to include a paper in the class assignments. These students decided that their grade would be based on participation (25%) and a minimum of a 20-page literature review (75%). The student could turn in drafts of the literature review throughout the semester for input and suggestions. This worked extremely well. At times, students would approach me and ask if they could do extra credit activities. I would remind them that they were the ones who decided what methods would be used

to determine their grade. Each student who was reminded of this replied, “Oh, yow, I forgot.” Allowing student input into their evaluation method may also diminish their sense of entitlement to a passing grade.

Greater emphasis needs to be placed on teaching and modeling the nursing ethics. The old adage “children learn what you do, not what you say” is true. Luparell (2008) points out that behavior indicates values. One can tell students that they care, but if they continue to miss their appointments with students, text or answer their phone during student meetings, and demean students, this speaks volumes and will erode the student-faculty relationship. As one student participating in the study stated, “Why do they make us meet with them if they don’t help and don’t care.”

Unfortunately, “violence is so common among workers in contact with people in distress that it is often considered an inevitable part of the job” (Di Martino, 2003). Whitley, Jacobson, and Gawrys (1996) maintain that violence is so prevalent in the health care sector that nurse educators are obligated to prepare their students to deal with this violence. Bailey (2007) agrees.

- Enhance Nursing Student Socialization into the Profession

Bond (2009) suggests that “students are not prepared to handle the realities of nursing, in part because they are not fully socialized into the profession” (p. 136). If today’s students are reared in isolation from adult decision-making, one facet of socialization into the profession needs to be conflict resolution. The literature is replete with studies on workplace violence and incivility in the health care environment. It seems prudent to provide new nurses and nursing students a better method of resolving disagreements. I suggest that nursing schools include conflict resolution in their curriculum and that nursing faculty and administration model these behaviors. Incivility will prevail if that is all that is modeled or known. Conflict resolution strategies should be introduced in the first nursing course.

- Link Academic Integrity to Clinical Practice

Unfortunately, research supports that not all nurses adhere to the ANA Code of Ethics. Newspapers report incidences of nurses who abuse their patients or patients who don't receive adequate nursing care (Andrews, 2008). Andrews (2008, p. 21) asks "When did nurses start to need training to see that abusing patients is wrong?" She suggests that the reason this happens is that other nurses allow it. Does this begin in nursing school when other faculty members allow one faculty member to bully students or to not address uncivil behavior? More studies need to be done examining the relationship between incivility in nursing school and incivility in clinical practice. Andrews (2008) believes that nurses are afraid to address patient abuse. Is this a result of fear developed during nursing school?

Whitley et al. (1996) assert that the safety of nurses and nursing students is of critical concern to the profession. Dellasega (2009) discusses nurse-on-nurse bullying citing that from 18% to 44% of nurses have experienced bullying from their peers and Felblinger (2008) cites Sofield and Salmond (2003) stating that verbal abuse is common in the health care environment with from 80% to 90% of health care providers experiencing this abuse. Baltimore (2006) believes that the root of this uncivil behavior is found in the hierarchical structure of academia and healthcare with nursing education serving as the "initial breeding ground" (p. 30). She asserts that nursing faculty often thrives on their feelings of superiority when controlling students and junior faculty and that some institutions adhere to the philosophy that suffering equates learning and therefore they set unrealistic course expectations (Baltimore, 2006). Green's (2008) study substantiated this finding. Nurse educators need to remember that aggression breeds aggression and that new nurses carry these behaviors over into the healthcare environment where they thrive (Baltimore, 2006).

5.3 Recommendations for Future Research

To date, the research on incivility has provoked as many questions as answers. Seven areas for further exploration are identified.

5.3.1 The Connection between Incivility and Learning

There is evidence to support that incivility interferes with learning. What do students learn when incivility is ignored? Does ignoring uncivil behavior condone it? Is faculty in essence teaching students to cheat by ignoring cheating? The millennials view working together as the norm and they value collaboration (Skiba & Barton, 2006). Is it possible that when these millennial students collaborate on an assignment that they do not perceive this as cheating? The generational differences in perception of cheating should be explored. Research questions that need to be addressed include, how do the various generations define academic incivility? Do some assignments lend themselves to cheating more than others? Do students cheat more when the assignment is perceived as "busy work?" Do retention, progression, and nonprogression policies influence cheating? What attributes in the learning environment impede incivility? Is there a relationship between incivility and NCLEX-RN pass rates?

5.3.2 Strategies for Combating Incivility

Though research has begun to address strategies for combating incivility, there is a need to explore additional methodologies for addressing incivility. By further understanding the connection between learning and incivility, different strategies can be undertaken. Research questions to be studied include, what specific strategies work in associate degree nursing? Do these strategies transfer to the clinical environment? Are there specific strategies that work best in the clinical environment? Does the culture of the program impact the prevalence of incivility and strategies for combating incivility? Does the culture of the clinical environment impact the prevalence of incivility and strategies for combating incivility? Do different strategies for combating incivility work better with specific generations?

5.3.3 The Relationship between Admission Criteria and Incivility

There have been numerous studies addressing the relationship between admission criteria and success in nursing school (Ehrenfield & Tabak, 2000; Sayles, Shelton, & Powell, 2003;

Newton, Smith, & Moore, 2007; Uyehara et al., 2007; Gilmore, 2008; Pryjmachuk, Easton, & Littlewood, 2009) suggesting the use of interviews, standardized tests, and grade point average, but none addressing the relationship between admission criteria and incivility. Findings from this study support that the competitiveness of nursing and admission to nursing programs increases the incidence of incivility. Is this a generalizable finding? Is this true for programs where admission is not competitive? Specific research questions to be addressed include, does competitiveness increase the incidence of incivility in nursing programs? Does this competitive attitude follow the student to the clinical area? Is there more incivility in programs with competitive admissions? Does interviewing applicants to nursing programs decrease the amount of incivility seen?

5.3.4 The Role of Gender, Diversity, and Power in Incivility

The role of gender on incivility in the workplace has been explored on a limited basis. Dellasega (2009) found that men tend to express their aggression physically while women tend to express their aggression through "humiliation, betrayal of trust, and exclusion" (p. 53). To date the role of gender and diversity on incivility in nursing education has not been examined. This is understandable since nursing is primarily a Caucasian female profession. The role of power on incivility has been explored in the clinical environment, but addressed in a limited manner in nursing education. Research questions to be addressed related to gender, diversity, and power include, what impact does gender have on incivility in nursing education? Is there a relationship between male faculty members and the level of incivility in nursing education? What impact does diversity have on incivility? Does power play a role in incivility in the nursing education environment? What is the role of faculty superiority and student entitlement on incivility in nursing education?

5.3.5 The Impact of Student Development on Incivility

Immaturity emerged as a theme in this study, yet the role of student development on incivility in nursing education has not been addressed. This relationship needs to be examined.

Perry (1999) describes student development as a continuum beginning with duality and moving toward developing commitments. Perry (1999) describes the final three positions on his continuum as those where ethical development occurs. He believes most students enter college in a dualistic developmental stage and move to relativism by graduation; therefore, not achieving commitment until after graduation. Since over half of the students in this study are older than the traditional college graduate, it is conceivable that these respondents may have referred to their younger peers. Thus, it is important to examine the relationship between student development and incivility. For example, does a course on nursing ethics enhance cognitive development and decrease incivility in the nursing education environment? Does awareness of student cognitive level affect the perception of incivility in the nursing education environment? What role do emotions play in the occurrence of uncivil behavior? What role does the nursing educational process play in value development?

5.3.6 The Role of Trust and Stress in Uncivil Student-Faculty Relationships

Stress as well as a lack of trust between students and faculty emerged as themes in the current study. Certainly stress affects students, faculty, and nurses and individual reactions to stress vary greatly. Though some researchers have addressed the impact of stress in the nursing environment, little has been written about the role of trust in the nursing education environment. Bond (2009) discusses the need for trust in connected student-faculty relationships suggesting that if trust is lacking, students may feel powerless and develop feelings of low self-esteem. In these relationships, students focus on the faculty member and not on learning (Bond, 2009). If Palmer (1998) is correct and educational institutions evoke fear in their students, then faculty must make a conscious effort to establish a trusting classroom and clinical environment. Carter (1998) deconstructs the construct of civility into two parts – generosity and trust. He believes that civility depends on trusting others even when there is risk involved (Carter, 1998). The role of stress and trust in the nursing education environment needs to be explored more fully. For example, what faculty behaviors increase the student-faculty connection? What faculty behaviors facilitate trust

development in nursing students? Students today have more stressors and emotional issues than their predecessors (Levine & Cureton, 1998). Research related to the role these emotional issues play in the occurrence of incivility should be explored.

5.3.7 The Effect Nursing Faculty has on Student Ethics and Integrity

Most of the research on incivility in nursing education has focused on the effect of student incivility on nursing faculty. Few studies have addressed the effect nursing faculty have on student ethics and integrity particularly related to role modeling ethical behavior. The role of appropriate conflict resolution on student, faculty, and nurse incivility should be explored as well as the impact of faculty workload on incivility.

5.4 Summary

This dissertation extends the previous research conducted by Clark (2006) on incivility in nursing education by determining what behaviors associate degree nursing students perceive as uncivil in both the traditional classroom and the clinical area. The results of this study expand the understanding of incivility and the role that students, faculty, and nurses play. If violence in health care constitutes almost one fourth of all violence occurring in the workplace and if student nurses have the greatest risk of experiencing this violence (Di Martino, 2003), it is imperative that nursing education begins to address incivility. Students, faculty, nurses, patients, and the profession deserve nothing less.

REFERENCES

Abelman, R., & Dalessandro, A. (2008). The institutional vision of community colleges. *Community College Review, 35*(4), 306-335.

Adams, J. M. (2008). Who cares about the mission? Creating and leading through a meaningful mission statement. *University Business, 11*(3), 27-28.

Adams, V. (2007). Laughing it off: Uncovering the everyday work experience of nurses. *International Journal of Qualitative Methods, 6*(1), Article 1. Retrieved September 30, 2007, from http://www.ualberta.ca/~iiqm/backissues/6_1/adams.pdf

American Association of Colleges of Nursing (AACN). (1998). *The essentials of baccalaureate education for professional nursing practice.* Washington, D.C.: author.

American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretive statements*. Washington, D.C.: American Nurses Publishing.

Anctil, E. J. (2008). Market driven versus mission driven. *ASHE Higher Education Report, 34*(2), 1-8.

Anderson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review, 24*(3), 452-471.

Andrews, J. (2008). Travesty of trust. *Nursing Standard, 23*(7), 20-21.

Bailey, A. (2007). Abuse – a day in the life of a student nurse. *British Journal of Nursing, 16*(10), 573.

Baltimore, J. J. (2006). Nurse collegiality: Fact or fiction? *Nursing Management, 37*(5), 28-36.

Baxter, P. E., & Boblin, S. L. (2007). The moral development of baccalaureate nursing students: Understanding unethical behavior in classroom and clinical settings. *Journal of Nursing Education, 46*(1), 20-27.

Benner, P. (1994). Caring as a way of knowing and not knowing. In S. S. Phillips & P. Benner (Eds.), *The crisis of care: Affirming and restoring caring practices in the helping professions* (pp. 42-62), Washington, D. C., Georgetown University Press.

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice Hall Health.

Bensimon, E. M., Neumann, A., & Birnbaum, R. (1989). *Making sense of administrative leadership: The "L" word in higher education*. ASHE-ERIC Higher Education Report No. 1. Washington, DC: School of Education and Human Development, The George Washington University.

Birnbaum, R. (1988). *How colleges work: The cybernetics of academic organization and leadership*. San Francisco: Jossey-Bass.

Blau, P. M. (1964). *Exchange and power in social life*. New York: Wiley.

Boice, B. (1996). Classroom incivilities. *Research in Higher Education, 37*(4), 453-486.

Bolman, L. G., & Deal, T. E. (2003). *Reframing organizations: Artistry, choice, and leadership* (3rd ed.). San Francisco: Jossey-Bass.

Bond, M. E. (2009). Exposing shame and its effect on clinical nursing education. *Journal of Nursing Education, 48*(3), 132-140.

Bray, N. J., & Del Favero, M. (2004). Sociological explanations for faculty and student classroom incivilities. *New Directions for Teaching and Learning*, 99, 9-19.

Braxton, J. M., Bayer, A. E., & Noseworthy, J. A. (2002). Students as tenuous agents of social control of professional misconduct. *Peabody Journal of Education, 77*(3), 101-124.

Braxton, J. M., Bayer, A. E., & Noseworthy, J. A. (2004). The influence of teaching norm violations on the welfare of students as clients of college teaching. *New Directions for Teaching and Learning*, 99, 41-46.

Buckley, M. R., Wiese, D. S., & Harvey, M. G. (1998). An investigation into the dimensions of unethical behavior. *Journal of Education for Business, 73*(5), 284-290.

Carlton, D. L. (2001). Rethinking southern history. *Southern Cultures, 7*(1), 38-49.

Carter, S. L. (1998). *Civility: Manners, morals, and the etiquette of democracy*. New York: Harper-Collins Publishers.

Chickering, A. W. (2003). Reclaiming our soul: Democracy and higher education. *Change, 35*(1), 39-44.

Clark, C. (2008a). The dance of incivility in nursing education as described by nursing faculty and students. *Advances in Nursing Science, 31*(4), E37-E54.

Clark, C. (2008b). Faculty and student assessment of experience with incivility in nursing education. *Journal of Nursing Education, 47*(10), 458-465.

Clark, C. (2008c). Student perspectives on faculty incivility in nursing education: An application of the concept of rankism. *Nursing Outlook, 56*(1), 4-8.

Clark, C. (2008d). Student voices on faculty incivility in nursing education: A conceptual model. *Nursing Education Perspectives, 29*(5), 284-289.

Clark, C. M. (2006). Incivility in nursing education: student perceptions of uncivil faculty behavior in the academic environment. University of Idaho, 2006. *Dissertation Abstracts International*. AAT 3216197.

Clark, C. M. (2007). *Incivility in nursing education survey*. Boise, ID: Author.

Clark, C. M., & Carnosso, J. (2008). Civility: A concept analysis. *The Journal of Theory Construction & Testing, 12*(1), 11-15.

Clark, C. M., Farnsworth, J., & Landrum, R. E. (2009). Development and description of the Incivility in Nursing Education (INE) survey. *The Journal of Theory Construction & Testing, 13*(1), 7-15.

Clark, C. M., & Springer, P. J. (2007a). Incivility in nursing education: A descriptive study of definitions and prevalence. *Journal of Nursing Education, 46*(1), 7-14.

Clark, C. M., & Springer, P. J. (2007b). Thoughts on incivility: Student and faculty perceptions of uncivil behavior in nursing education. *Nursing Education Perspectives, 28*(2), 93-97.

Cohen, A. K. (1965). The sociology of the deviant act: Anomie theory and beyond. *American Sociological Review, 30*(1), 5-14.

Cohen, H. A. (1981). *The nurse's quest for a professional identity*. Menlo Park, CA: Addison-Wesley Publishing Co.

Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Pearson, Merrill, Prentice Hall.

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications, Inc.

Culture. (2008). In *Merriam-Webster's online dictionary*. Retrieved October 30, 2008, from http://www.m-w.com/dictionary/culture

Dellasega, C. A. (2009). Bullying among nurses: Relational aggression is one form of workplace bullying. What can nurses do about it? *American Journal of Nursing, 109*(1), 52-58.

Delucchi, M., & Korgen, K. (2002). "We're the customer – we pay the tuition": Student consumerism among undergraduate sociology majors. *Teaching Sociology, 30*, 100-107.

Delucchi, M. & Smith, W. L. (1997). A postmodern explanation of student consumerism in higher education. *Teaching Sociology, 25*(4), 322-327.

Dillman, D. A. (2007). *Mail and internet surveys: The tailored design method* (2nd ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Di Martino, V. (2003). *Relationship of work stress and workplace violence in the health sector.* Geneva: Joint Programme on Workplace Violence in the Health Sector.

Dowd, A. C. (2004). Community college revenue disparities: What accounts for an urban college deficit? *The Urban Review, 36*(4), 251-270.

du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing, 21*, 164-171.

Ehrenfeld, M., Rotenberg, A., Sharon, R., & Bergman, R. (1997). Reasons for student attrition on nursing courses: A study. *Nursing Standard, 11*(23), 34-38.

Ehrenfeld, M., & Tabak, N. (2000). Value of admission interviews in selecting of undergraduate nursing students. *Journal of Nursing Management, 8*(2), 101-106.

Emerson, R. M. (1976). Social exchange theory. *Annual Review of Sociology, 2*(1), 334-362.

Emerson, R. M. (1990). Social exchange theory. *Social Psychology*, *53*(1), 30-65.

Erickson, R. J., & Grove, W. J. C. (2007). Why emotions matter: Age, agitation, and burnout among registered nurses. *The Online Journal of Issues in Nursing, 13*(1). Retrieved September 23, 2009 from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol13/

Evans, J. (2004). Men nurses: A historical and feminist perspective. *Journal of Advanced Nursing, 47*(3), 321-328.

Farkas, S., Johnson, J., Duffett, A., & Collins, K. (2002). *Aggravating circumstances: A status report on rudeness in America*. New York: Public Agenda.

Farrell, G. A. (1997). Aggression in clinical settings: Nurses' views. *Journal of Advanced Nursing, 25*, 501-508.

Farrell, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing, 35*(1), 26-33.

Felblinger, D. M. (2008). Incivility and bulling in the workplace and nurses' shame responses. *JOGNN, 37*(2), 234-241.

Fero, L. J., Witsberger, C. M., Wesmiller, S. W., Zullo, T. G., & Hoffman, L. A. (2008). Critical thinking ability of new graduate and experienced nurses. *Journal of Advanced Nursing, 65*(1), 139-148.

Forni, P. M. (2002). *Choosing civility: The twenty-five rules of considerate conduct*. New York: St. Martin's Griffin.

Fowler, F. J., Jr. (2002). *Survey research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications , Inc.

Freire, P. (2003). *Pedagogy of the oppressed* (30th ed.). New York: Continuum.

Freshwater, D. (2000). Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing, 32*, 481-484.

Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: An introduction* (7th ed.). Boston: Allyn and Bacon.

Gastmans, C. (1998). Challenges to nursing values in a changing nursing environment. *Nursing Ethics, 5*(3), 236-245.

Gastmans, C. (1999). Care as a moral attitude in nursing. *Nursing Ethics, 6*(3), 214-223.

Gilmore, M. (2008). Predictors of success in associate degree nursing programs. *Teaching & Learning in Nursing, 3*(4), 121-124.

Glazer, N. (1999, December 3). The dilemma of higher education in the inner city. *Chronicle of Higher Education, 46*(15), B4-B5.

Green, M. H. (2008). *Academic impropriety: Violations of normative teaching behaviors as identified by nursing educators* (Unpublished doctoral dissertation). Louisiana State University, Baton Rouge, Louisiana.

Griffin, L. J. (2006). The American south and the self. *Southern Cultures, 12*(3), 6-28.

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing, 35*(6), 257-263.

Hagedorn, L. S. (2004). The role of urban community colleges in educating diverse populations. *New Directions for Community Colleges, 2004*(127), 21-34.

Hanson, M. F. (2000). Classroom incivility: Management practices in large lecture course (Doctoral dissertation, South Dakota State University, 2000). *Dissertation Abstracts International, 61*, 2618.

Harris, R. J. (1985). *A primer of multivariate statistics* (2nd ed.). Orlando, FL: Academic Press, Inc.

Hatch, N. O. (2005, May 6). Intellectual and moral purpose still meet at Catholic universities. *Chronicle of Higher Education, 51*(35), B16-B17.

Heinrich, K. T. (2007). Joy stealing: 10 mean games faculty play and how to stop the gaming. *Nurse Educator, 32*(1), 34-38.

Helm, C. M. (2006). Teacher dispositions as predictors of good teaching. *Clearing House, 79*(3), 117-118.

Hernandez, T. J., & Fister, D. L. (2001). Dealing with disruptive and emotional college students. *Journal of College Counseling, 4*, 49-62.

Hilbert, G. A. (1985). Involvement of nursing students in unethical classroom and clinical behaviors. *Journal of Professional Nursing, 1*(4), 230-234.

Hinkle, D. E., Wiersma, W., & Jurs, S. G. (2003). *Applied statistics for the behavioral sciences*. Boston: Houghton Mifflin Company.

Homans, G. C. (1961). *Social behavior: Its elementary forms*. New York: Harcourt, Brace, and World.

Howkins, E. J., & Ewens, A. (1999). How students experience professional socialization. *International Journal of Nursing Studies, 36*(1), 41-49.

Hu, S., & Kuh, G. D. (2002). Being (dis)engaged in educationally purposeful activities: The influence of student and institutional characteristics. *Research in Higher Education, 43*(5), 555-575.

Hutton, S. A. (2006). Workplace incivility: State of science. *Journal of Nursing Administration, 36*(1), 22-28.

Indiana University Center for Survey Research. (2000). *Preliminary report: A survey on academic incivility at Indiana University*. Bloomington, IN: author.

Israel, G. D. (1992). *Determining sample size*. Retrieved from http:// edis.ifas.ufl.edu/PD006

Kenny, D. (2007). Student plagiarism and professional practice. *Nurse Education Today, 27*, 14-18.

Kerfoot, K. M. (2008). On leadership: Leadership, civility, and the 'no jerks' rule. *Urologic Nursing, 28*(2), 149-150.

Kezar, A., Chambers, T., & Burkhardt, J. (2005). *Higher education for the public good*. San Francisco: Joseey-Bass.

Kleinman, C. S. (2006). Ethical drift: When good people do bad things. *JONA's Healthcare Law, Ethics, and Regulation, 8*(3), 72-76.

Kolanko, K. M., Clark, C., Heinrich, K. T., Olive, D., Serembus, J. F., & Sifford, K. S. (2006). Academic dishonesty, bullying, incivility, and violence: Difficult challenges facing nursing education. *Nursing Education Perspectives, 27*(1), 34-43.

Kuh, G. D. (1995). The other curriculum: Out-of-class experiences associated with student learning and personal development. *The Journal of Higher Education, 66*(2), 123-155.

Kuh, G. D., & Hu, S. (2001). The effects of student-faculty interaction in the 1990s. *The Review of Higher Education, 24*(3), 309-332.

Kuh, G. D., & Whitt, E. J. (1988). *The invisible tapestry: Culture in American colleges and universities*. ASHE-ERIC Higher Education Report No. 1. Washington, DC: Association for the Study of Higher Education.

Kupperschmidt, B. R. (2006). Addressing multigenerational conflict: Mutual respect and carefronting as strategy. *OJIN: The Online Journal of Issues in Nursing, 11*(2), Manuscript 3. Retrieved September 9, 2007 from http://nursingworld.org/ojin

Langone, M. (2007). Promoting integrity among nursing students. *Journal of Nursing Education, 46*(1), 45-47.

Lashley, F. R., & de Meneses, M. (2001). Student civility in nursing programs: A national survey. *Journal of Professional Nursing, 17*(2), 81-86.

Lau, B. A. (2004). Reasons for student behavior codes: A qualitative study at two Christian liberal arts institutions. *NASPA Journal, 42*(4), 549-564.

Lawler, E. J. (2001). An affect theory of social exchange. *American Journal of Sociology, 107*(2), 321-352.

Lawler, E. J., & Thye, S. R. (1999). Bringing emotions into social exchange theory. *Annual Review of Sociology, 25*, 217-244.

Lee, J. J. (2007). The shaping of the departmental culture: Measuring the relative influences of the institution and discipline. *Journal of Higher Education Policy and Management, 29*(1), 41-55.

Leiper, J. (2005). Nurse against nurse: How to stop horizontal violence. *Nursing 2005, 35*(3), 44-45.

Leners, D. W., Roehrs, C., & Piccone, A. V. (2006). Tracking the development of professional values in undergraduate nursing students. *Journal of Nursing Education, 45*(12), 504-511.

Levin, J. S. (2005). The business culture of the community college: Students as consumers; Students as commodities. *New Directions for Higher Education, 129,* 11-26.

Levine, A., & Cureton, J. S. (1998). What we know about today's college students. *About Campus, 3*(2), 4-9.

Lewenson, S. B., Truglio-Londrigan, M., & Singleton, J. (2005). Practice what you teach: A case study of ethical conduct in the academic setting. *Journal of Professional Nursing, 21*(2), 89-96.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing, 21*(3), 177-178.

Louisiana State Board of Nursing (LSBN). (2004). *Law governing the practice of nursing* (Louisiana Revised Statutes 37:911 et seq. as re-enacted and amended). Retrieved August 15, 2009 from http://www.lsbn.state.la.us/documents/npa/npafull.pdf

Love, K. (2008). Higher education, pedagogy and the 'customerisation' of teaching and learning. *Journal of Philosophy of Education, 42*(1), 15-34.

Lower, J. (2007). Generation Y. *American Nurse Today, 2*(8), 26-29.

Luparell, S. (2003). Critical incidents of incivility by nursing students: How uncivil encounters with students affect nursing faculty. University of Nebraska – Lincoln, 2003. *Dissertation Abstracts International*. AAT 3116540.

Luparell, S. (2004). Faculty encounters with uncivil nursing students: An overview. *Journal of Professional Nursing, 20*(1), 59-67.

Luparell, S. (2007). The effects of student incivility on nursing faculty. *Journal of Nursing Education, 46*(1), 15-19.

Luparell, S. (2008). Incivility in nursing education: Let's put an end to it. *Imprint, 55*(3), 42-46.

Mahaffey, E. H. (2002). The relevance of associate degree nursing education: Past, present, future. *Online Journal of Issues in Nursing, 7*(2), Manuscript 2. Retrieved September 9, 2007 from http://www.nursingworld.org/ojin

McCabe, D. L., Trevino, L. K., & Butterfield, K. D. (1999). Academic integrity in honor code and non-honor code environments: A qualitative investigation. *The Journal of Higher Education, 70*(2), 211-234.

Meacham, J. (2008). What's the use of a mission statement? *Academe, 94*(1), 21-24.

Meeker, B. F. (1971). Decisions and exchange. *American Sociological Review, 36*(3), 485-495.

Meissner, J. E. (1986). Nurses are we eating our young? *Nursing*, 51-53.

Mills, J. C. H., & Mills, A. J. (2000). Rules, sensemaking, formative contexts, and discourse in the gendering of organizational culture. In N. M. Ashkanasy, C. P. M. Wilderom, & M. F. Peterson (Eds.), *Handbook of organizational culture and climate* (pp. 55-70). Thousand Oaks, CA: Sage.

Moffat, R. C. L. (2001). Incivility as a barometer of societal decay. *Florida Philosophical Review, 1*(1). Retrieved September 17, 2007 from http://www.cah.ucf.edu/philosophy/fpr/journals/volume1/issue1/moffat.html

Morphew, C. C., & Hartley, M. (2006). Mission statements: A thematic analysis of rhetoric across institutional type. *The Journal of Higher Education, 77*(3), 456-471.

Morris, R. T. (1956). A typology of norms. *American Sociological Review, 21*(5), 610-613.

National Council of State Boards of Nursing (NCSBN). (2006). *Mission & Values.* Retrieved November 18, 2006, from https://www.ncsbn.org/182.htm

Newton, S. E., Smith, L. H., & Moore, G. (2007). Baccalaureate nursing program admission policies: Promoting success or facilitating failure? *Journal of Nursing Education, 46*(10), 439-444.

Nilson, L. B., & Jackson, N. S. (2004, June). *Combating classroom misconduct (incivility) with bills of rights.* Paper presented at the meeting of the International Consortium for Educational Development, Ottawa, Ontario, Canada.

Nordstrom, C. R., Bartels, L. K., & Bucy, J. (2009). Predicting and curbing classroom incivility in higher education. *College Student Journal, 43*(1), 74-85.

Olsen, M. E. (1965). Durkheim's two concepts of Anomie. *The Sociological Quarterly, 6*(1), 37-44.

Palmer, P. J. (1998). *The courage to teach: Exploring the inner landscape of a teacher's life*. San Francisco: Jossey-Bass Publishers.

Pascarella, E., & Terenzini, P. (2005). *How college affects students: A third decade of research* (Vol. 2). San Francisco: Jossey-Bass Publishers.

Pendergast, L. R. (2000). *The history of Our Lady of the Lake College, 1923-2000: A study in organizational change.* Unpublished doctoral dissertation, Louisiana State University, Baton Rouge.

Perry, W. G. (1999). *Forms of ethical and intellectual development in the college years: A scheme*. San Francisco: Jossey-Bass.

Pett, M. A., Lackey, N. R., & Sullivan, J. J. (2003). *Making sense of factor analysis: The use of factor analysis for instrument development in health care research*. Thousand Oaks, CA: Sage Publishing.

Pinar, W. F., Reynolds, W. M., Slattery, P., & Taubman, P. M. (2002). *Understanding curriculum: An introduction to the study of historical and contemporary curriculum discourses*. New York: Peter Lang.

Potts, M. (2005). The consumerist subversion of education. *Academic Questions, 18*(3), 54-64.

Pryjmachuk, S., Easton, K., & Littlewood, A. (2009). Nurse education: Factors associated with attrition. *Journal of Advanced Nursing, 65*(1), 149-160.

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43*(4), 395-401.

Rau-Foster, M. (2004). Workplace civility and staff retention. *Nephrology Nursing Journal, 31*(6), 702.

Rea, L. M., & Parker, R. A. (1997). *Designing and conducting survey research: A comprehensive guide* (2nd ed.). San Francisco: Jossey-Bass.

Roberts, S. J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science, 5*(4), 21-30.

Rowe, M. M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: Do burned out nurses eat their young? *Journal of Nursing Management, 13,* 242-248.

Rusbult, C. E. (1983). A longitudinal test of the investment model: The development (and deterioration) of satisfaction and commitment in heterosexual involvements. *Journal of Personality and Social Psychology, 45*(1), 101-117.

Saavedra, R., & Van Dyne, L. (1999). Social exchange and emotional investment in work groups. *Motivation and Emotion, 23*(2), 105-123.

Sampson, R. J., & Groves, W. B. (1989). Community structure and crime: Testing social disorganization theory. *The American Journal of Sociology, 94*(4), 772-802.

Sayles, S., Shelton, D., & Powell, H. (2003). Predictors of success in nursing education. *The ABNF Journal, 14*(6), 116-120.

Schank, M. J., & Weis, D. (2001). Service and education share responsibility for nurses' value development. *Journal for Nurses in Staff Development, 17*(5), 226-233.

Schank, M. J., Weis, D., & Ancona, J. (1996). Reflecting professional values in the philosophy of nursing. *JONA, 26*(7/8), 55-60.

Schneider, B., Bowen, D. E., Ehrhart, M. G., & Holcombe, K. M. (2000). The climate for service: Evolution of a construct. In N. M. Ashkanasy, C. P. M. Wilderom, & M. F. Peterson (Eds.), *Handbook of organizational culture and climate* (pp. 21-36). Thousand Oaks, CA: Sage.

Scott, J. C. (2006). The mission of the university: Medieval to postmodern transformation. *The Journal of Higher Education, 77*(1), 1-39.

Scott, M. B., & Turner, R. (1965). Weber and the Anomic theory of deviance. *The Sociological Quarterly, 6*(3), 233-240.

Secrest, J. A., Norwood, B. R., & Keatley, V. M. (2003). "I was actually a nurse": The meaning of professionalism for baccalaureate nursing students. *Journal of Nursing Education, 42*(2), 77-82.

Sheskin, D. J. (2004). *Handbook of parametric and nonparametric statistical procedures* (3rd ed.). Boca Raton, FL: Chapman & Hall/CRC Press.

Shirey, M. R. (2005). Ethical climate in nursing practice. *Journal of Nursing Administration's Healthcare Law, Ethics, and Regulation, 7*(2), 59-67.

Shirey, M. R. (2007). An evidence-based solution for minimizing stress and anger in nursing students. *Journal of Nursing Education, 46*(12), 568-571.

Skiba, D. J., & Barton, A. J. (2006). Adapting your teaching to accommodate the net generation of learners. *OJIN: The Online Journal of Issues in Nursing, 11*(2), Manuscript 4. Retrieved September 9, 2007 from http://nursingworld.org/ojin

Spaights, E., & Farrell, W. C. (1986). The enigma of the urban university. *Education, 106*(4), 356-361.

Suominen, T., Kovasin, M., & Ketola, O. (1997). Nursing culture – some viewpoints. *Journal of Advanced Nursing, 25*, 186-190.

Suplee, P. D., Lachman, V. D., Siebert, B., & Anselmi, K. K. (2008). Managing nursing student incivility in the classroom, clinical setting, and on-line. *Journal of Nursing Law, 12*(2), 68-77.

Teddlie, C., & Tashakkori, A. (2003). Major issues and controversies in the use of mixed methods in the social and behavioral sciences. In A. Tashakkori, & C. Teddlie (Eds). *Handbook of mixed methods in social and behavioral research.* Thousand Oaks, CA: Sage Puhlications.

Texas Board of Nursing. (2008). When does a nurse's duty to a patient begin? Texas Board of *Nursing Bulletin, 39*(4), 7, 9.

The Joint Commission. (2008, July 9). *Sentinel event alert, 40*. Retrieved August, 22, 2008, from http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm

Thomas, S. P. (2003). Handling anger in the teacher-student relationship. *Nursing Education Perspectives, 24*(1), 17-24.

Tinto, V. (1997). Classrooms as communities: Exploring the educational character of student persistence. *The Journal of Higher Education, 68*(8), 599-623.

Toma, J. D., Dubrow, G., & Hartley, M. (Eds.). (2005). Understanding institutional culture. *ASHE Higher Education Report, 31*(152), 39-54.

Trout, P. A. (1997). Disengaged students and the decline of academic standards. *Academic Questions, 10*(2), 50.

Umbach, P. D., & Wawrzynski, M. R. (2004, June). *Faculty do matter: The role of college faculty in student learning and engagement.* Paper presented at the forum of the Association for Institutional Research, Boston, MA. Retrieved September 9, 2004, from http://www.iub.edu/~nsse/pdf/research_papers/faculty_do_matter.pdf

U.S. Department of Health and Human Services. (2006). *The registered nurse population: Findings from the March 2004 national sample survey of registered nurses* (BHP Publication No. 00217). Rockville, MD: Author.

Uyehara, J., Magnussen, L., Itano, J., & Zhang, S. (2007). Facilitating program and NCLEX-RN success in a generic BSN program. *Nursing Forum, 42*(1), 31-38.

Waitere, R. (1998). Coping with horizontal violence. *Kai Tiaki Nursing New Zealand, 4*(2), 24.

Walker, J. T., Martin, T., White, J., Elliott, R., Norwood, A., Mangum, C., et al. (2006). Generational (age) differences in nursing students' preferences for teaching methods. *Journal of Nursing Education, 45*(9), 371-374.

Watson, J. (1985). *Nursing: The philosophy and science of caring*. Niwot, CO: University Press of Colorado.

Whitley, G. G., Jacobson, G. A., & Gawrys, M. T. (1996). The impact of violence in the health care setting upon nursing education. *Journal of Nursing Education, 35*(5), 211-218.

Williams, G. B., & Taliaferro, D. H. (2001). From Nightingale to beyond 2000: Philosophical issues related to nursing education. *International Journal for Human Caring, 5*(2), 15-20.

Wilson, B. (2006). History lesson: Men in nursing. *Men in Nursing, 1*(2), 32-44.

Young, C. E. (1996). Statewide articulation plan for nursing education: A study of change. *N & HC: Perspecitves on Community, 17*(4), 190-195.

Zemsky, R. (1993). Consumer markets & higher education. *Liberal Education, 79*(3), 14-17.

APPENDIX A

MODIFIED INCIVILITY IN NURSING EDUCATION SURVEY

Incivility is a concern in the nursing academic environment and is defined as disruptive, rude, discourteous, or threatening speech or action. The nursing academic environment is defined as any location associated with the provision or delivery of nursing education, whether on or off campus including the "live" or virtual classroom or clinical setting (Clark, 2005, 2007).

1. Please indicate your status at your college/university.

   □ Beginning nursing student □ Graduating nursing student

2. Please indicate your gender.

   □ Male □ Female

3. In what year were you born?
   □□□□

4. Your ethnic/racial background is

   □ Black, African American
   □ Asian
   □ Caucasian (white)
   □ Native American
   □ Pacific Islander
   □ Spanish/Hispanic/Latino/Mexican
   □ Other_____

5. Please indicate whether your college/university is

   □ Secular □ Religious □ Rural □ Urban/Suburban

6. Listed below are some **STUDENT** behaviors you may have experienced or seen in the nursing academic environment. Please indicate the level of "disruption" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior disruptive?				**How often have you experienced or seen this behavior in the past 12 months?**			
Students…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Acting bored or apathetic								
Making disapproving groans								
Making sarcastic remarks or gestures								
Sleeping in class								
Not paying attention in class								

	Do you consider this behavior disruptive?				How often have you experienced or seen this behavior in the past 12 months?			
Students…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Holding conversations that distract you or other students								
Refusing to answer direct questions								
Using a computer during class for purposes not related to the class								
Using cell phones or pagers during class								
Arriving late for class								
Leaving class early								
Cutting class								
Being unprepared for class								
Creating tension by dominating class discussion								
Demanding make-up exams, extensions, grade changes, or other special favors								
Charting nursing care not performed								
Being unprepared for the clinical experience								
Not admitting an error made in patient care								

7. Listed below are some **STUDENT** behaviors that you may consider **threatening**. Please indicate the level of "threat" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Students…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Taunting or showing disrespect to other students								
Taunting or								

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Students…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
showing disrespect to faculty								
Taunting or showing disrespect to nurses								
Taunting or showing disrespect to patients								
Challenging faculty knowledge or credibility								
Challenging the nurse's knowledge or credibility								
Making harassing comments (racial, ethnic, gender) directed at students								
Making harassing comments (racial, ethnic, gender) directed at faculty								
Making harassing comments (racial, ethnic, gender) directed at nurses								
Making harassing comments (racial, ethnic, gender) directed at patients								
Making vulgar comments directed at other students								
Making vulgar comments directed at faculty								
Making vulgar comments directed at nurses								
Making vulgar comments directed at patients								
Sending inappropriate e-mails to other students								
Sending inappropriate e-								

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Students…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
mails to faculty								
Making threats of physical harm against other students								
Making threats of physical harm against faculty								
Damaging property								
Making statements about having access to weapons								
Neglecting patients in the clinical area								
Charting patient care not completed								

8. Listed below are some **FACULTY** behaviors you may have experienced or seen in the nursing academic environment. Please indicate the level of "disruption" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior disruptive?				How often have you experienced or seen this behavior in the past 12 months?			
Faculty…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Arriving late for schedule activities								
Leaving schedule activities early								
Being unprepared for scheduled activities								
Not allowing open discussion								
Refusing to allow make-up exams, extensions, or grade changes								
Ineffective teaching style/methods								
Deviating from the course syllabus, changing assignments or test dates								
Being inflexible, rigid, and								

	Do you consider this behavior disruptive?				How often have you experienced or seen this behavior in the past 12 months?			
Faculty…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
authoritarian								
Punishing the entire class for one student's misbehavior								
Making statements about being disinterested in the subject matter								
Being distant and cold towards others								
Refusing or reluctant to answer questions								
Subjective grading								
Making condescending remarks or put downs								
Exerting superiority or rank over others								
Threatening to fail student for not complying to faculty's demands								
Making rude gestures or behaviors toward others								
Ignoring disruptive student behavior								
Being unavailable outside of class								
Being unavailable on the patient care unit								
Being unavailable for practice in the skills laboratory								
Taking over for the student when providing patient care								

9. Listed below are some **FACULTY** behaviors that may be considered **threatening**. Please indicate the level of "threat" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior threatening?				**How often have you experienced or seen this behavior in the past 12 months?**			
Faculty	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Taunting or showing disrespect to students								
Taunting or showing disrespect to other faculty								
Taunting or showing disrespect to nurses								
Taunting or showing disrespect to patients								
Challenging faculty knowledge or credibility								
Challenging the nurse's knowledge or credibility								
Making harassing comments (racial, ethnic, gender) directed at students								
Making harassing comments (racial, ethnic, gender) directed at faculty								
Making harassing comments (racial, ethnic, gender) directed at nurses								
Making harassing comments (racial, ethnic, gender) directed at patients								
Making vulgar comments directed at students								
Making vulgar comments directed at faculty								
Making vulgar comments directed at nurses								
Making vulgar comments directed								

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Faculty	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
at patients								
Sending inappropriate e-mails to students								
Sending inappropriate e-mails to faculty								
Making threats of physical harm against students								
Making threats of physical harm against faculty								
Damaging property								
Making statements about having access to weapons								
Neglecting patients in the clinical area								
Charting patient care not completed								

10. Listed below are some behaviors by **NURSES** you may have experienced or seen in the nursing academic environment. Please indicate the level of "disruption" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior disruptive?				How often have you experienced or seen this behavior in the past 12 months?			
Nurses…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Arriving late for work								
Leaving work early								
Being unprepared for patient care								
Refusing to allow students to perform patient care								
Ineffective teaching style/methods								
Being inflexible, rigid, and authoritarian								
Making statements about being								

	Do you consider this behavior disruptive?				How often have you experienced or seen this behavior in the past 12 months?			
Nurses…	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
disinterested in working with students								
Being distant and cold towards others								
Refusing or reluctant to answer questions								
Subjective grading								
Making condescending remarks or put downs								
Exerting superiority or rank over others								
Threatening to fail student for not complying to the nurse's demands								
Making rude gestures or behaviors toward others								
Being unavailable on the patient care unit								
Taking over for the student when providing patient care								

11. Listed below are some behaviors by **NURSES** that may be considered **threatening**. Please indicate the level of "threat" **and** how often each behavior occurred over the last 12 months.

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Nurses	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Taunting or showing disrespect to students								
Taunting or showing disrespect to faculty								
Taunting or showing disrespect to other nurses								

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Nurses	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Taunting or showing disrespect to patients								
Challenging faculty knowledge or credibility								
Challenging other nurse's knowledge or credibility								
Making harassing comments (racial, ethnic, gender) directed at students								
Making harassing comments (racial, ethnic, gender) directed at faculty								
Making harassing comments (racial, ethnic, gender) directed at nurses								
Making harassing comments (racial, ethnic, gender) directed at patients								
Making vulgar comments directed at students								
Making vulgar comments directed at faculty								
Making vulgar comments directed at nurses								
Making vulgar comments directed at patients								
Making threats of physical harm against students								
Making threats of physical harm against faculty								
Damaging property								
Making statements about having access to weapons								

	Do you consider this behavior threatening?				How often have you experienced or seen this behavior in the past 12 months?			
Nurses	**Never**	**Sometimes**	**Usually**	**Always**	**Never**	**Sometimes**	**Usually**	**Always**
Neglecting patients in the clinical area								
Charting patient care not completed								

11. To what extent do you think incivility in the nursing academic environment is a problem?

□ No problem at all
□ Moderate problem
□ Serious problem
□ I don't know/can't answer

12. Based on your experiences or perceptions, do you think that students or faculty are more likely to engage in uncivil behavior in the nursing academic environment?

□ Faculty members are much more likely
□ Faculty members are a little more likely
□ About equal
□ Students are a little more likely
□ Students are much more likely
□ Don't know

13. In your opinion, **WHY** do students and/or faculty contribute to incivility within the academic environment?

14. In your opinion, **HOW** do students and/or faculty contribute to incivility within the academic environment?

15. Please describe how students, faculty, and the university/college should address incivility in the academic environment?

16. What are the differences in the uncivil behaviors seen in the traditional classroom, skills laboratory, and the clinical unit?

17. In your opinion, which of the three learning environments are uncivil behaviors the most prevalent?

□ Traditional classroom
□ Skills laboratory
□ Clinical unit

INE used with permission from Dr. Cynthia Clark, Associate Professor, Boise State University, Department of Nursing, 1910 University Drive, Boise, ID 83725
e-mail: cclark@boisestate.edu

INSTITUTIONAL REVIEW BOARD APPROVAL

Application for Exen

Unless qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/projects using living humans as subjects, or samples or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption.

nal Review Board
rt Mathews, Chair
203 B-1 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.6792
irb@lsu.edu | lsu.edu/irb

- Applicant, Please fill out the application in its entirety and include the completed application as well as parts A-E, listed below, when submitting to the IRB. Once the application is completed, please submit two copies of the completed application to the IRB Office or to a member of the Human Subjects Screening Committee. Members of this committee can be found at http://www.lsu.edu/irb/screeningmembers.shtml
- A Complete Application Includes All of the Following:
  (A) Two copies of this completed form and two copies of parts B thru E.
  (B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1 & 2)
  (C) Copies of all instruments to be used.
  - If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.

  (D) The consent form that you will use in the study (see part 3 for more information.)
  (E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB.
  Training link: (http://cme.cancer.gov/clinicaltrials/learning/humanparticipant-protections.asp.)

1) **Principal Investigator:** Jennifer Beck **Rank:** Doctoral Candidate **Student*? Y/N** Yes

Dept.: ETPP **Ph:** [redacted] **E-mail:** jbeck9@lsu.edu

2) **Co Investigator(s):** please include department, rank and e-mail for each
* If student, please identify and name supervising professor in this space

Dr. S. Kim MacCrate
Associate Professor
smaccrat@lsu.edu

3) **Project Title:** Incivility in Nursing [redacted]

4) **LSU Proposal?(yes or no)** Yes/No **If Yes, LSU Proposal Number** [redacted]

Also, if YES, either ☒ **This application completely matches the scope of work in the grant**

OR

○ **More IRB Applications will be filed later**

5) **Subject pool** (e.g. Psychology Students) [redacted]
- Circle any **"vulnerable populations" to be used**: (children <18; the mentally impaired, pregnant women, the aged, other). Projects with incarcerated persons cannot be exempted.

6) **PI Signature** Jennifer Beck **** Date** 3/11/08 (no per signatures)

****I certify my responses are accurate and complete.** If the project scope or design is later changed I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted. I also understand that it is my responsibility to maintain copies of all consent forms at LSU for three years after completion of the study. If I leave LSU before that time the consent forms should be preserved in the Departmental Office.

*****Effective August 1, 2007, all Exemptions will expire three years from date of approval, unless a continuation report, found on our website, is filed prior to expiration date*****

Study Exempted By:
Dr. Robert C. Mathews, Chairman
Institutional Review Board
Louisiana State University
203 B-1 David Boyd Hall
225-578-8692 | www.lsu.edu/irb
Exemption Expires: 3-11-2011

[redacted]

Consent Form for Non-Clinical Study

1. Study Title: Incivility in Nursing Education

2. Performance Site: Louisiana State University and Agricultural and Mechanical College

3. Investigators: The following investigators are available for questions about this study:
Jennifer Beck, Doctoral Candidate, ETPP, 225-235-4120
Dr. Kim MacGregor, Associate Professor, 225-578-2150

4. Purpose of the Study: The purpose of this study is to determine associate degree nursing students' perception of incivility in the classroom and clinical area and to examine if differences in perception exist between students in their first clinical course and those in their last clinical course.

5. Subject Inclusion: Associate degree nursing students in the first clinical course of their nursing program and those in the last clinical course of their nursing program.

6. Number of Subjects: 3000

7. Study Procedures: This study will be conducted in two phases. In the first phase, subjects will spend about 20 to 25 minutes completing the modified Incivility in Nursing Survey (Clark, 2007). In the second phase, subjects will participate in a focus group interview which will last approximately 60 to 75 minutes.

8. Benefits: Subjects will receive a $10 gift card for participating in the focus group.

9. Risks: There are no risks for participants. The surveys will be anonymous and focus group participants will be identified by an assigned number, not by name or institution.

10. Right to Refuse: Subjects may choose not to participate without penalty.

11. Privacy: Results of the study may be published, but no names or identifying information will be included in the publication. Any subject information obtained will remain confidential.

12. Signatures:

This study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or concerns, I can contact Robert C. Mathews, Institutional Review Board, (225) 578-8692, irb@lsu.edu, http://www.lsu.edu/irb. Return of the survey will be considered my consent to participate.

APPENDIX C

INITIAL E-MAIL TO DEANS AND DIRECTORS

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Friday, February 22, 2008 11:31 AM
To: Beverly H. Gulledge
Subject: Student Incivility Study

Dear Ms. Gulledge:

I am a doctoral student at Louisiana State University completing my dissertation on incivility in nursing education. The focus of my dissertation is to determine if there are differences in students' perception of incivility in the classroom and the clinical setting. My study will determine if differences of perception occur between the beginning of an associate degree nursing program and graduation. This study was approved on March 11, 2008 by the Louisiana State University Institutional Review Board.

I am soliciting your program's participation in this research. If you agree, I would like to survey students in their first clinical course and those in their last clinical course. I can administer the survey via the Web or by paper and pencil and would like your input as to which method would garner the largest response. If you are willing to participate, please identify the appropriate courses and number of students in each course by return e-mail. If you have any questions, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you in advance for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX D

FOLLOW-UP E-MAIL TO DEANS AND DIRECTORS

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Friday, February 29, 2008 10:37 AM
To: Beverly H. Gulledge
Subject: Student Incivility Study

Dear Ms. Gulledge:

On February 22, I e-mailed you requesting your program's participation in my research study on incivility in nursing education. The focus of my dissertation is to determine if there are differences in students' perception of incivility in the classroom and the clinical setting. My study will determine if differences of perception occur between the beginning of an associate degree nursing program and graduation. This study was approved on March 11, 2008 by the Louisiana State University Institutional Review Board.

I am again soliciting your program's participation in this research. If you agree, I would like to survey students in their first clinical course and those in their last clinical course. I can administer the survey via the Web or by paper and pencil and would like your input as to which method would garner the largest response. If you are willing to participate, please identify the appropriate courses and number of students in each course by return e-mail. If you have any questions, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you in advance for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX E

CONSENT LETTER TO DEANS AND DIRECTORS

Dear Dean or Director:

I am a graduate student conducting a study on incivility in nursing education under the direction of Dr. Kim MacGregor at Louisiana State University in Baton Rouge, LA. I am requesting your participation, which will involve having your first semester nursing students and graduating students complete the modified Incivility in Nursing Education (INE) survey. The modified INE lists behaviors that you would rate on a Likert scale and takes approximately 25 to 30 minutes to complete.

I am requesting your permission for the participation of a criterion selected group of students attending your nursing program. The study will involve completing the survey during this spring semester. I have included a packet explaining the study and that participation in this research is voluntary. I have also explained that though the study may be published, the surveys are anonymous.

If you have any questions concerning this study, please contact me at 225-768-1787 or e-mail at jbeck@ololcollege.edu. You may contact my major professor, Dr. Kim MacGregor at 225-578-2150 or e-mail at smacgre@lsu.edu. Thank you in advance for your consideration.

Sincerely,

Jennifer Beck

Jennifer Beck, PhD(c), RN

Educational Theory, Policy, and Practice Graduate Student

APPENDIX F

COVER LETTER TO DEANS AND DIRECTORS

April 3, 2008

Dear Ms. O'Donnell:

I have included 125 copies of the modified Incivility in Nursing Education survey (Clark, 2007), to be given to your beginning and graduating students. Please have them use a # 2 pencil to complete the survey which should take approximately 25-30 minutes. I have included my abstract explaining the study, directions for completing the survey, and a letter for each participant that explains that this research is voluntary and though the results of this study may be published, the responses are anonymous.

This study was approved on March 11, 2008 by the Louisiana State University Institutional Review Board. If you have any questions concerning this study, please contact me at 225-768-1787 or e-mail at jbeck@ololcollege.edu or Dr. Kim MacGregor at 225-578-2150 or e-mail at smacgre@lsu.edu. If you have questions about your rights or concerns, you may contact Dr. Robert Mathews, IRB, (225) 578-8692, irb@lsu.edu, http://www.lsu.edu/irb. Return of the survey will be considered your consent to participate.

Sincerely,

Jennifer Beck

Jennifer Beck, PhD(c), RN

Educational Theory, Policy, and Practice Graduate Student

APPENDIX G

ABSTRACT SENT TO DEANS AND DIRECTORS

This triangulated mixed methods study examines the construct of incivility in nursing higher education in the southeastern United States. To date, the overwhelming majority of studies examining incivility do so from the faculty perspective; therefore, this study seeks to explore incivility from the perspective of the student. Nursing is a practice discipline where workplace incivility has long been identified. Research posits that behavior during the educational process transfers to the workplace. The purpose of this study is to determine associate degree nursing students' perception of incivility in the classroom and clinical area and to examine if differences in perception exist between students in their first clinical course and those in their last clinical course. To guide this study, the following research questions are posited:

1. What behaviors in the learning environment do associate degree nursing students perceive as incivility at the beginning and at the end of their associate degree in nursing education?
2. What are the differences in the perception of incivility by students in the various contexts of the associate degree nursing educational environment – classroom and clinical area?
3. What are the differences between programs with high and low perceived levels of incivility?

This study will be conducted in two phases. In the first phase, subjects will spend about 25 to 30 minutes completing the modified Incivility in Nursing Survey (Clark, 2007)[1]. In the second phase, selected subjects will participate in phone interviews which will last approximately 30 minutes.

[1]Clark, C. M. (2007). *Incivility in nursing education survey*. Boise, ID: Author.

APPENDIX H

DIRECTIONS FOR COMPLETING THE MODIFIED INCIVILITY IN NURSING EDUCATION SURVEY

1. Please have the students use a # 2 pencil to complete this survey.

2. The survey is 9 pages in length and should take about 25-30 minutes to complete. Please complete all pages.

3. Please return the completed surveys to me using the provided labels, stamps, and the boxes in which the surveys were sent.

Thank you very much for your help and participation.

APPENDIX I

CONSENT LETTER TO STUDENT NURSES

Dear Student Nurse,

I am a graduate student conducting a study on incivility in nursing education under the direction of Dr. Kim MacGregor at Louisiana State University in Baton Rouge, LA. This letter is written to request your participation in my research study which will involve completing one survey – the modified Incivility in Nursing Education (INE) survey. The modified INE lists behaviors that you would rate on a Likert scale and takes approximately 25 to 30 minutes to complete. Your participation in this study is voluntary and if you choose not to participate, there are no consequences. Though the results of this study may be published, your responses will be anonymous.

If you have any questions concerning this study, please contact me at 225-768-1787 or e-mail at jbeck@ololcollege.edu. You may contact my major professor, Dr. Kim MacGregor at 225-578-2150 or e-mail at smacgre@lsu.edu. Return of the survey will be considered your consent to participate.

Sincerely,

Jennifer Beck, PhD(c), RN

Educational Theory, Policy, and Practice Graduate Student

APPENDIX J

E-MAIL TO DEANS AND DIRECTORS REQUESTING RETURN OF SURVEYS

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Friday, March 21, 2008 1:51 PM
To: Dayna Davidson
Subject: Student Incivility Study

Dear Ms. Davidson:

On March 1, I sent you 120 copies of the modified Incivility in Nursing Education survey by Clark (2007) to provide your beginning and graduating students an opportunity to participate in my research study on incivility in nursing education. I am writing to encourage your program's participation in this research. Research to date supports that incivility is a problem in nursing education and this study adds to the body of knowledge by surveying associate degree students. Therefore, it is important to have input from as many programs as possible. I would appreciate it if you would survey your students and return the surveys by April 12, 2008. If you have any questions or I can assist you in any way, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you in advance for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX K

E-MAIL TO DEANS AND DIRECTORS ENCOURAGING PARTICIPATION

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Monday, March 10, 2008 10:17 AM
To: Alice Nied
Subject: Student Incivility Study

Dear Ms. Nied:

On February 29, I e-mailed you requesting your program's participation in my research study on incivility in nursing education. The focus of my dissertation is to determine if there are differences in students' perception of incivility in the classroom and the clinical setting. I am writing to encourage your program's participation in this research. Research to date supports that incivility is a problem in nursing education and this study adds to the body of knowledge by surveying associate degree students. Therefore, it is important to have input from as many programs as possible.

I encourage you to have your program's participate in this research. If you agree, I would like to survey students in their first clinical course and those in their last clinical course. I can administer the survey via the Web for student convenience. If you have any questions, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you in advance for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX L

E-MAIL CONTAINING LINK TO SURVEY MONKEY©

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Monday, March 10, 2008 11:50 AM
To: Jose Martinez
Subject: Student Incivility Study

Dear Ms. Martinez:

I have attached the link to the survey created in Survey Monkey© (https://www.surveymonkey.com/s.aspx?sm=26AFTDRtKJmJ87gH2LBMlw_3d_3d), an abstract of the study, a copy of the instructions for completing the survey, and a letter to the students. Please have your students click the link to complete the survey in Survey Monkey©. If you have any questions, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX M

DIRECTIONS FOR COMPLETING THE MODIFIED INCIVILITY IN NURSING EDUCATION SURVEY ON THE WEB

1. Left click on the link to the survey created in Survey Monkey©.
https://www.surveymonkey.com/s.aspx?sm=4Uw_2fDZ8yknv7hDZrZcYTlg_3d_3d

2. The survey is 3 pages in length and should take about 25 to 30 minutes to complete. Please complete all pages.

3. When you finish the survey, left click on the "Done" button. The results will be saved and the window will close.

Thank you very much for your participation.

APPENDIX N

E-MAIL TO NONPARTICIPATING PROGRAMS CONTAINING LINK TO SURVEY MONKEY©

From: Beck, Jennifer [mailto:JBeck@ololcollege.edu]
Sent: Tuesday, April 01, 2008 11:50 AM
To: Ann Blankenship
Subject: Student Incivility Study

Dear Ms. Blankenship:

I am a doctoral student at Louisiana State University completing my dissertation on incivility in nursing education. The focus of my dissertation is to determine if there are differences in students' perception of incivility in the classroom and the clinical setting. My study will determine if differences of perception occur between the beginning of an associate degree nursing program and graduation.

I am soliciting your school's participation in this research. If you agree, I would like to survey students in their first clinical course and those in their last clinical course. I have attached the link to the survey created in Survey Monkey© (https://www.surveymonkey.com/s.aspx?sm=qHcT5AwlvyRCEH0vqR1aNw_3d_3d), an abstract of the study, a letter to you, and a letter to the students. If you are willing to have your students participate, please have them complete the survey in Survey Monkey©. If you have any questions, do not hesitate to contact me at jbeck@ololcollege.edu or by phone at 225-768-1787 (work) or 225-235-4120 (cell).

Thank you in advance for your participation,
Jennifer Beck
Doctoral Candidate

APPENDIX O

TABLE DEPICTING DEMOGRAPHICS FOR PROGRAMS PARTICIPATING SPRING 2008

Table O: Spring 2008 Programs Participating in the Study (n = 10)

State	**# ADN Programs**	**# Urban N (%)**	**# Rural N (%)**	**# Secular N (%)**	**# Religious N (%)**	**# Beginning Students N (%)**	**# Graduating Students N (%)**
Alabama	2	1 (50%)	1 (50%)	2 (100%)	0 (0%)	46 (58%)	33 (42%)
Florida	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Georgia	1	1 (100%)	0 (0%)	1 (100%)	0 (0%)	52 (63%)	31 (37%)
Kentucky	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Louisiana	1	1 (100%)	0 (0%)	0 (0%)	1 (100%)	42 (54%)	36 (46%)
Mississippi	1	0 (0%)	1 (100%)	1 (100%)	0 (0%)	50 (85%)	9 (15%)
N. Carolina	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tennessee	1	1 (100%)	0 (0%)	0 (0%)	1 (100%)	12 (52%)	11 (48%)
Texas	3	3 (100%)	0 (0%)	2 (67%)	1 (33%)	9 (39%)	14 (61%)
Virginia	1	1 (100%)	0 (0%)	1 (100%)	0 (0%)	12 (86%)	2 (14%)
Total	**10**	**8 (80%)**	**2 (20%)**	**7 (70%)**	**3 (30%)**	**223 (62%)**	**136 (38%)**

APPENDIX P

LETTER TO STUDENT NURSES ASSOCIATION PRESIDENTS

17634 Beckfield Avenue
Baton Rouge, LA 70817
October 26, 2008

President, Student Nurses Association
Amarillo College
Nursing Division
P.O. Box 447
Amarillo, TX 79178-0001

Dear SNA President:

I am a graduate student conducting a study on incivility in nursing education under the direction of Dr. Kim MacGregor at Louisiana State University in Baton Rouge, LA. I am requesting your participation, which will involve having first semester nursing students and graduating students complete the modified Incivility in Nursing Education (INE) survey. The INE lists behaviors that you would rate on a Likert scale and takes approximately 25-30 minutes to complete. I have included my abstract explaining the study and that participation in this research is voluntary. Also included is a copy of the survey and I have also explained that though the study may be published, the surveys are anonymous.

The survey may be completed on paper or on the Web. If you are willing to participate, I will either send you copies of the survey with return postage or a Web link to the survey. The study has been approved by the IRB at Louisiana State University. If you have any questions concerning this study, please contact me at 225-768-1787 or e-mail at jbeck@ololcollege.edu. You may contact my major professor, Dr. Kim MacGregor at 225-578-2150 or e-mail at smacgre@lsu.edu. Thank you in advance for your consideration.

Sincerely,

Jennifer Beck, PhD(c), RN
Educational Theory, Policy, and Practice Graduate Student

Enclosures: Abstract
INE survey

APPENDIX Q

INSTITUTIONAL REVIEW BOARD APPROVAL FROM PARTICIPATING SCHOOLS

MEMORANDUM

TO: Dr. Jennifer Beck, Louisiana State University

FROM: Barbara Talbot, University Research

SUBJECT: HUMAN USE COMMITTEE REVIEW

DATE: December 16, 2008

In order to facilitate your project, an EXPEDITED REVIEW has been done for your proposed study entitled:

"Incivility in Nursing Education"

 # HUC-617

The proposed study's revised procedures were found to provide reasonable and adequate safeguards against possible risks involving human subjects. The information to be collected may be personal in nature or implication. Therefore, diligent care needs to be taken to protect the privacy of the participants and to assure that the data are kept confidential. Informed consent is a critical part of the research process. The subjects must be informed that their participation is voluntary. It is important that consent materials be presented in a language understandable to every participant. If you have participants in your study whose first language is not English, be sure that informed consent materials are adequately explained or translated. Since your reviewed project appears to do no damage to the participants, the Human Use Committee grants approval of the involvement of human subjects as outlined.

Projects should be renewed annually. ***This approval was finalized on December 8, 2008 and this project will need to receive a continuation review by the IRB if the project, including data analysis, continues beyond December 8, 2009***. Any discrepancies in procedure or changes that have been made including approved changes should be noted in the review application. Projects involving NIH funds require annual education training to be documented. For more information regarding this, contact the Office of University Research.

You are requested to maintain written records of your procedures, data collected, and subjects involved. These records will need to be available upon request during the conduct of the study and retained by the university for three years after the conclusion of the study. If changes occur in recruiting of subjects, informed consent process or in your research protocol, or if unanticipated problems should arise it is the Researchers responsibility to notify the Office of Research or IRB in writing. The project should be discontinued until modifications can be reviewed and approved.

If you have any questions, please contact Dr. Mary Livingston at 257-4315.

Version 03/01/08

VALENCIA COMMUNITY COLLEGE
Human Research Protection (HRP) Institutional Review Board (IRB)

IRB Determination Form

Title of Research Protocol: Incivility in Nursing Education

Principal Investigator (PI): Jennifer Beck

Date Received by IRB Chair: 12/04/08

IRB Number: 09-014

Based on the IRB Protocol Initial Submission Form (or, as appropriate, the IRB Continuing Review/Termination Form or the IRB Addendum/Modification Form) submitted by the Principal Investigator and for the project identified above, the following determination has been made by the Valencia IRB:

☒ The research is exempt from IRB review. Exemption category: 2

☐ The research is eligible for expedited review and has been approved.

☐ The research is eligible for expedited review but requires modifications and re-submission before approval can be given.

☐ The research is subject to full review and will be discussed at the next IRB meeting, currently scheduled for _____.
(date)

☐ The research has been subjected to full review and has been approved.

☐ The research has been subjected to full review and has been disapproved.

Period of Approval: 12/04/08 to 12/20/08
(cannot be retroactive)

Exemption from Valencia IRB review does not exempt the PI or Co-PI from compliance with all applicable institutional, Federal, State, and local rules, regulations, policies, and procedures.

Although the IRB has determined that this application is exempt from IRB review, the Principal Investigator is encouraged to read, understand, and apply the attached Investigator Responsibilities document, which is required of Principal Investigators whose research protocols are approved under the Valencia IRB full or expedited review process.

If you have any remaining questions about Valencia's IRB process, contact the IRB Chair at irb@valenciacc.edu .

Signature of IRB Chair or Designated Representative — 12/04/08 Date

C: IRB File, IRB Members, PI Supervisor/Administrator

November 24, 2008

Dear Nursing Student,

I am a graduate student conducting a study on incivility in nursing education under the direction of Dr. Kim MacGregor at Louisiana State University in Baton Rouge, LA. This letter is written to request your participation in my research study which will involve completing one survey – the modified Incivility in Nursing Education (INE) survey. The INE lists behaviors that you would rate on a Likert scale and takes approximately 25-30 minutes to complete. Your participation in this study is voluntary and if you choose not to participate, there are no consequences. Though the results of this study may be published, your responses will be anonymous.

This study was approved on March 11, 2008 by the Louisiana State University Institutional Review Board. If you have any questions concerning this study, please contact me at 225-768-1787 or e-mail at jbeck@ololcollege.edu or Dr. Kim MacGregor at 225-578-2150 or e-mail at smacgre@lsu.edu. If you have questions about your rights or concerns, you may contact Dr. Robert Mathews, IRB, (225) 578-8692, irb@lsu.edu, http://www.lsu.edu/irb. Return of the survey will be considered your consent to participate.

Sincerely,

Jennifer Beck

Jennifer Beck, PhD(c), RN

Educational Theory, Policy, and Practice Graduate Student

VALENCIA IRB:
Application # 09-014
Determination Exempt 2
Period 12/04/08 to 12/20/08

APPENDIX R

TABLE DEPICTING DEMOGRAPHICS FOR PROGRAMS PARTICIPATING FALL 2008

Table R: Fall 2008 Programs Participating (n = 10)

State	# ADN Programs	Urban N (%)	Rural N (%)	Secular N (%)	Religious N (%)	Beginning Students N (%)	Graduating Students N (%)
Alabama	2	0 (0%)	2 (100%)	2 (100%)	0 (0%)	19 (68%)	9 (32%)
Florida	2	1 (50%)	1 (50%)	2 (100%)	0 (0%)	59 (94%)	4 (6%)
Georgia	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Kentucky	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Louisiana	4	2 (50%)	2 (50%)	4 (100%)	0 (0%)	146 (77%)	44 (23%)
Mississippi	1	0 (0%)	1 (100%)	1 (100%)	0 (0%)	76 (80%)	19 (20%)
North Carolina	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tennessee	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Texas	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Virginia	1	0 (0%)	1 (100%)	1 (100%)	0 (0%)	17 (100%)	0 (0%)
Total	**10**	**3 (30%)**	**7 (70%)**	**10 (100%)**	**0 (0%)**	**317 (81%)**	**76 (19%)**

APPENDIX S

COMMUNALITIES FOR EACH FACTOR ANALYSIS

Table S.1: Communalities for Student Disruptive Behaviors

Item	Initial	Extraction
Acting bored or apathetic	1.000	.629
Making disapproving groans	1.000	.723
Making sarcastic remarks or gestures	1.000	.729
Sleeping in class	1.000	.592
Not paying attention in class	1.000	.635
Holding conversations that distract you or other students	1.000	.573
Refusing to answer direct questions	1.000	.510
Using a computer during class for purposes not related to the class	1.000	.501
Using cell phones or pagers during class	1.000	.469
Arriving late for class	1.000	.661
Leaving class early	1.000	.687
Cutting class	1.000	.630
Being unprepared for class	1.000	.665
Creating tension by dominating class discussion	1.000	.547
Demanding make-up exams, extensions, grade changes, or other special favors	1.000	.578
Charting nursing care not performed	1.000	.686
Being unprepared for the clinical experience	1.000	.728
Not admitting an error made in patient care	1.000	.544

Table S.2: Communalities for Student Threatening Behaviors

Item	Initial	Extraction
Taunting or showing disrespect to other students	1.000	.816
Taunting or showing disrespect to faculty	1.000	.875
Taunting or showing disrespect to nurses	1.000	.883
Taunting or showing disrespect to patients	1.000	.850
Challenging faculty knowledge or credibility	1.000	.759
Challenging the nurse's knowledge or credibility	1.000	.792
Making harassing comments (racial, ethnic, gender) directed at other students	1.000	.835
Making harassing comments (racial, ethnic, gender) directed at faculty	1.000	.907
Making harassing comments (racial, ethnic, gender) directed at nurses	1.000	.925
Making harassing comments (racial, ethnic, gender) directed at patients	1.000	.935
Making vulgar comments directed at other students	1.000	.882
Making vulgar comments directed at faculty	1.000	.924
Making vulgar comments directed at nurses	1.000	.935
Making vulgar comments directed at patients	1.000	.932
Sending inappropriate e-mails to other students	1.000	.778
Sending inappropriate e-mails to faculty	1.000	.862
Making threats of physical harm against other students	1.000	.942
Making threats of physical harm against faculty	1.000	.939
Damaging property	1.000	.907
Making statements about having access to weapons	1.000	.851
Neglecting patients in the clinical area	1.000	.899
Charting patient care not completed	1.000	.838

Table S.3: Communalities for Faculty Disruptive Behavior

Item	Initial	Extraction
Arriving late for scheduled activities	1.000	.743
Leaving scheduled activities early	1.000	.652
Canceling scheduled activities without warning	1.000	.777
Being unprepared for scheduled activities	1.000	.834
Not allowing open discussion	1.000	.708
Refusing to allow make-up exams, extensions, or grade changes	1.000	.541
Ineffective teaching style/methods	1.000	.744
Deviating from the course syllabus, changing assignments or test dates	1.000	.637
Being inflexible, rigid, and authoritarian	1.000	.693
Punishing the entire class for one student's misbehavior	1.000	.798
Making statements about being disinterested in the subject matter	1.000	.759
Being distant and cold towards others	1.000	.839
Refusing or reluctant to answer questions	1.000	.863
Subjective grading	1.000	.735
Making condescending remarks or put downs	1.000	.878
Exerting superiority or rank over others	1.000	.837
Threatening to fail student for not complying to faculty demands	1.000	.790
Making rude gestures or behaviors toward others	1.000	.890
Ignoring disruptive student behavior	1.000	.806
Being unavailable outside of class	1.000	.799
Being unavailable on the patient care unit	1.000	.872
Being unavailable for practice in the skills laboratory	1.000	.807
Taking over for the student when providing patient care	1.000	.697

Table S.4: Communalities for Faculty Threatening Behavior

Item	Initial	Extraction
Taunting or showing disrespect to students	1.000	.889
Taunting or showing disrespect to other faculty	1.000	.879
Taunting or showing disrespect to nurses	1.000	.903
Taunting or showing disrespect to patients	1.000	.925
Challenging faculty knowledge or credibility	1.000	.741
Challenging the nurse's knowledge or credibility	1.000	.731
Making harassing comments (racial, ethnic, gender) directed at students	1.000	.939
Making harassing comments (racial, ethnic, gender) directed at other faculty	1.000	.955
Making harassing comments (racial, ethnic, gender) directed at nurses	1.000	.956
Making harassing comments (racial, ethnic, gender) directed at patients	1.000	.948
Making vulgar comments directed at students	1.000	.946
Making vulgar comments directed at other faculty	1.000	.959
Making vulgar comments directed at nurses	1.000	.959
Making vulgar comments directed at patients	1.000	.953
Sending inappropriate e-mails to students	1.000	.911
Sending inappropriate e-mails to other faculty	1.000	.903
Making threats of physical harm against students	1.000	.931
Making threats of physical harm against other faculty	1.000	.939
Damaging property	1.000	.916
Making statements about having access to weapons	1.000	.878
Neglecting patients in the clinical area	1.000	.819
Charting patient care not completed	1.000	.810

Table S.5: Communalities for Nurse Disruptive Behavior

Item	Initial	Extraction
Arriving late for work	1.000	.752
Leaving work early	1.000	.666
Being unprepared for patient care	1.000	.861
Refusing to allow students to perform patient care	1.000	.798
Ineffective teaching style/methods	1.000	.880
Being inflexible, rigid, and authoritarian	1.000	.872
Making statements about being disinterested in working with students	1.000	.901
Being distant and cold toward others	1.000	.889
Refusing or reluctant to answer questions	1.000	.915
Subjective grading of students	1.000	.835
Making condescending remarks or put downs	1.000	.910
Exerting superiority or rank over others	1.000	.864
Threatening to fail student for not complying to the nurse's demands	1.000	.871
Making rude gestures or behaviors toward others	1.000	.907
Being unavailable on the patient care unit	1.000	.899
Taking over for the student when providing care	1.000	.811

Table S.6: Communalities for Nurse Threatening Behavior

Item	Initial	Extraction
Taunting or showing disrespect to students	1.000	.937
Taunting or showing disrespect to faculty	1.000	.941
Taunting or showing disrespect to other nurses	1.000	.940
Taunting or showing disrespect to patients	1.000	.936
Challenging faculty knowledge or credibility	1.000	.831
Challenging other nurse's knowledge or credibility	1.000	.792
Making harassing comments (racial, ethnic, gender) directed at students	1.000	.957
Making harassing comments (racial, ethnic, gender) directed at faculty	1.000	.966
Making harassing comments (racial, ethnic, gender) directed at other nurses	1.000	.964
Making harassing comments (racial, ethnic, gender) directed at patients	1.000	.965
Making vulgar comments directed at students	1.000	.961
Making vulgar comments directed at faculty	1.000	.966
Making vulgar comments directed at other nurses	1.000	.970
Making vulgar comments directed at patients	1.000	.966
Making threats of physical harm against students	1.000	.950
Making threats of physical harm against other faculty	1.000	.955
Damaging property	1.000	.938
Making statements about having access to weapons	1.000	.894
Neglecting patients in the clinical area	1.000	.931
Charting patient care not completed	1.000	.900

VITA

Jennifer Wibbenmeyer Beck is a registered nurse who currently serves as Associate Dean of the School of Nursing at Our Lady of the Lake College in Baton Rouge, Louisiana. She completed her basic nursing preparation in 1972 at the University of Missouri – Columbia where she earned a Bachelor of Science degree in nursing and education. Beck completed her Master of Science degree in 1975 at California State University – Los Angeles with an emphasis on nursing administration and adult health. In her 37 years as a registered nurse, she has worked as a staff nurse in medical-surgical nursing, critical care, and emergency care and taught in licensed practical nursing, diploma nursing, associate degree nursing, baccalaureate nursing, and master's nursing programs in American Samoa, California, and Louisiana. Prior to being appointed Associate Dean, Beck served as Level II Coordinator, RN-BSN Program Director, and ASN Program Director at Our Lady of the Lake College.

Beck is a member of the National League for Nursing; Association of Women's Health, Obstetric, and Neonatal Nursing; Phi Kappa Phi Honor Society; Louisiana Organization for Associate Degree Nursing; and the American Educational Research Association. She has one daughter, Meredith; a son-in-law, Tommy; a grandson, Nate; a granddaughter, Abby; and two pugs, Baxter and Tex.