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Exploring Incivility among Nursing and Health Science Students: A Descriptive Study

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EXPLORING INCIVILITY AMONG

NURSING AND HEALTH SCIENCE STUDENTS:

A DESCRIPTIVE STUDY

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy in Nursing Education

Nova Southeastern University

Diane Louise Smith
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NOVA SOUTHEASTERN UNIVERSITY
HEALTH PROFESSIONS DIVISION
RON AND KATHY ASSAF COLLEGE OF NURSING

This dissertation, written by Diane L. Smith under direction of her Dissertation Committee, and approved by all of its members, has been presented and accepted in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY IN NURSING EDUCATION

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Abstract

Incivility has infiltrated our institutions of higher learning as well as the world of nursing. All too familiar in nursing is the phrase "eating their young," which aptly describes how nurses treat other nurses, even though they should be nurturing and caring professionals. The investigator explored nursing and health science students' perceptions of student and faculty uncivil behaviors within the academic environment, seeking the levels and frequency of the problem. Bandura's social learning theory presents a sound theoretical framework for this dissertation. The research methodology consisted of a quantitative descriptive approach. The Incivility in Higher Education-Revised (IHE-R) Survey was used to compare nursing and health science student perceptions of the level and frequency of student and faculty incivility. Descriptive statistics and independent *t* tests were used to compare the different student perceptions. The study results indicated that perceptions of student behavioral levels were between *somewhat* and *moderately* uncivil. Student perceptions of faculty behavioral levels were found to be more *moderate*. Review of the frequency levels reflected students' frequencies to be *never* as compared with faculty, which indicated a frequency of *sometimes*. These results indicated that students perceived incivility to not be problematic within their individual programs, although it found faculty behavior levels were more uncivil even when similar behaviors were demonstrated by students. In general, these results were atypical than other results as incivility is found to be a rising problem. Further study is needed to confirm these results.

Keywords: incivility, horizontal violence, bullying, lateral violence

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Chapter One

Introduction

Incivility and other dysfunctional behaviors have risen to the top of national and world news reports as of late. All too often, the public receives news about the horrific displays of incivility and intolerance, such as the mass shootings taken place in Orlando, Florida, 2016 or previously in Columbine, Colorado, with the high school disaster of 1999. School campuses, encompassing elementary to college level institutions, endure such shootings, which resulted in horrendous human suffering, injury, and even death. According to Misawa and Rowland (2015), these behaviors are social issues that negatively affect individuals and society. Andersson and Pearson (1999) claimed incivility represents nonfunctional and immoral implications for society overall. These mass violence acts displayed on school campuses show the intolerances for others and their beliefs. There is an obvious lack of civility as it is evident in every aspect of society and epitomizes an epidemic that threatens our interpersonal relations (Dilenschneider, 2013).

Certainly, these examples of incivility are extreme but open the door for further exploration of the less severe instances. According to Porath, Gerbasi, and Schorch (2015), incivility represents a negative interpersonal social exchange that further fosters insensitive behaviors. In addition, incivility shows a general lack of regard or respect for others.

Academia is not exempt from incivility or other forms of disruptive behaviors. In fact, incivility is common in many academic settings (Fogg, 2008; Keim & McDermott, 2010). However, acknowledgement of incivility within academia rarely becomes the topic of conversation (Goldberg, Beitz, Wieland, & Levine, 2013). Keashly and Neuman (2010) claimed that academics pay little attention to incivility and bullying within their institutions, even though research has demonstrated workplace aggression over the past two decades. Hence, the focus of this nonexperimental quantitative study is to determine the level and frequency of student and faculty incivility as perceived by nursing students in comparison to other health science students. For the purpose of this dissertation, the definition of incivility is "rude or disruptive behaviors which often result in psychological or physiological distress for the people involved, and if left unaddressed, may progress into threatening situations" (Clark, 2009, p. 194).

Incivility Descriptors

To be civil means to balance and contain personal desires, especially when they are in conflict with another (Twale & DeLuca, 2008). To act in a civil manner requires respect, restraint, and responsibility with demonstration of manners, etiquette, and behaviors toward others (Hughes, 2011). Civility requires honesty, self-control, fairness, and the ability to treat others as one wishes to be treated. Uncivil behaviors deserve responsiveness, as they can be precursors to more violent and aggressive acts against others (Clark, 2008a; Hunt & Marini, 2012).

Clark (2013b) explained incivility as rude or disruptive behaviors that often result in psychological or physiological distress for the people involved (such as the targets,

offenders, bystanders, peers, stakeholders, and even organizations). Peters (2015)

described incivility as a deliberate and discourteous approach toward others that creates

self-doubt and lowers one's self esteem. Griffin and Clark (2014) believe incivility to be

generally a one-on-one experience and perceive it to be less threatening than bullying or

mobbing. Although incivility tends to be a form of intimidation, it can be devastating for

those affected. By not addressing incidents of incivility, it potentially leads to the

worsening of situations, resulting in possible injury, whether temporary or permanent

(Griffin & Clark, 2014).

Conflicting Terminologies

The phenomenon of incivility is frequently synonymous with horizontal and

lateral violence, bullying, mobbing, and relational aggression, but the designation itself is

dependent on the severity of the behaviors involved (Clark, 2013b). Cortina (2008) also

describes this phenomenon as the modern-day discrimination. Incivility originates as a

mistreatment of others.   Clark (2013a) stated that how one recognizes and responds to

the uncivil behavior will affect the intensity of the influence on the individual. In fact,

Andersson and Pearson (1999) alluded to the premise that incivility is the precursor to the

future exchange of intimidating and bullying actions. Civility tends to be a subjective

concept, which makes its study very arduous (McKay, Arnold, Fratzl, & Thomas, 2008).

There are various terms and phrases in the literature to describe these behaviors.

The terms for incivility, bullying, horizontal violence, and so forth tend to overlap and

are frequently used to describe such behaviors (Clark & Springer, 2007a; Cortina, 2008;

Embree & White, 2010; Gallo, 2012; Hutchinson & Hurley, 2013; Johnson, 2009;

Sheridan-Leo, 2008; Stanley, Martin, Michel, Welton, & Nementh, 2007). *Nurses eating*

their young is an expression used to depict uncivil behaviors (Baker, 2012; Bartholomew, 2006). Scapegoating, backstabbing, belittling, criticizing, undermining, withholding information, isolation, raising eyebrows, rolling eyes, infighting, broken confidences, intimidation, and other overt and covert behaviors are some of the behaviors demonstrated (Hutchinson & Hurley, 2013; Lally, 2009; Longo & Sherman, 2007).

A terminology problem exists due to the multiplicity of words or phrases used to describe this behavior. Opinions vary in description of the phenomenon (Keashly & Neuman, 2012). Because so many terms attempt to label this dysfunctional behavior, measurement becomes difficult (Dentith, Wright, & Coryell, 2015). The nursing profession tends to use two terms for such behaviors: incivility and horizontal or lateral violence. The term of incivility is common usage among nurses according to Clark and Ahten (2011), Clark and Springer (2007b), Condon (2015), and Luparell (2011). The other terms used for these behaviors include horizontal or vertical violence (Dumont, Meisinger, Whitacre, & Corbin, 2012; Embree & White, 2010; Griffin & Clark, 2014; Longo & Sherman, 2007; Sheridan-Leos, 2008; Stanley et al., 2007). Additionally, dysfunctional behaviors displayed within the workplace in general tend toward the bullying label (Namie & Namie, 2015; Nielsen & Einarsen, 2012). Academic environments use bullying as the term of choice as well (DelliFraine, McClelland, Erwin & Wang, 2014; Keashly & Neuman, 2010; McKay et al., 2008; Piotrowski & King, 2016). Consequently, the full extent of the problem is still relatively unknown and requires further study (Johnson, 2009). Appendix B contains a brief sampling of the various terms, definitions, and sources.

Statistical Evidence of Incivility

Weber Shandwick and Powell Tate collaborated with Keystone Research Center (KRC) to survey American's attitudes regarding civility and incivility experiences in America ("Civility in America," 2013). The original survey began in 2010 and continues to provide yearly statistics. In the latest version of "Civility in America" (2016), the author posited that 95% of Americans believe civility to be a problem in general. The online poll included 1,005 adults 18 years and older from January 7 to 14, 2016, and indicated 70% of the respondents believed incivility to be at crisis levels in this country, which was up from 65% in 2014 ("Civility in America," 2016). Eighty-one percent of survey respondents believed uncivil behavior was leading to the increase in violence ("Civility in America," 2013). On average, Americans encounter incivility 17 times during the course of one week or more than two times per day ("Civility in America," 2013). In addition, 35% of the United States workforce reports bully-like behaviors at work (Namee & Namee, 2013). For nursing, 70% of survey respondents reported incivility and bullying at work (Vessey, DeMarco, Gaffney, & Budin, 2009). These survey results demonstrated incivility and these dysfunctional behaviors to be problematic and an ongoing issue that warrants further in-depth study.

Incivility in Various Settings

Health care and higher education environments often show signs of the presence of incivility among its workforce. Workers and students spend many hours in these environments giving of themselves while caring for the sick and injured in addition to the learning of their disciplines. People within these areas have a responsibility to promote teamwork, safety, and patient-centered care as a model for the health care experience.

Unfortunately, these qualities are not always evident. This section presents incivility among these various settings and populations, specifically the workplace, academic environment, students, faculty, nursing practice, nursing academia, and other health science education.

Incivility Related to Workplace

Andersson and Pearson (1999) defined workplace incivility as a low-intensity deviant behavior with ambiguous intent to harm a target, which violates normal behaviors of respect and courtesy. Several examples of workplace incivility include interrupting colleagues when speaking, addressing others in an inappropriate manner or making jokes, and/or remarks at another's expense (Miner & Cortina, 2016). It can be relatively mild in nature but has been shown to exert a powerful negative effect on employees (Sliter, Withrow, & Jex, 2014). Miner and Cortina (2016) contended there is a clear link between workplace incivility and detrimental outcomes. There also exists a negative consequence for those who witness such incivility to others and presents that other employees experience harm by working under such conditions (Porath, Macinnis, & Folkes, 2010).

Workplace incivility can have a spiraling effect (Blau & Andersson, 2005; Fox & Stallworth, 2003; Pearson, Andersson, & Porath, 2000). The spiraling effect concept defines how civility can potentially escalate into more intense behaviors (Andersson & Pearson, 1999). Clark (2013a) asserted that these unchecked behaviors may progress to threatening situations or violence. There is a belief that incivility is a precursor to more serious behaviors and negative consequences (Pearson & Porath, 2005; Torkelson, Holm, Backstrom, & Schad, 2016). Subsequently, the risk of progression into more serious

forms of aggressive behavior (such as those behaviors with an intention to harm) exists (Torkelson et al., 2016).

Incivility Related to Academic Environments

Academia has unique opportunities for individuals to engage in discussion with differences of opinion to further knowledge and expand current thinking. According to Clark (2008a), the norm for behavior in higher education is one of mutual respect in the teaching-learning environment. Uncivil behaviors violate the assumed practice of respectful interactions, which enhance the learning process within higher education environments (Knepp, 2012). However, the nature, structure, and perspective of academia often work against this ideal, becoming an environment of incivility and bullying (Klein & Lester, 2013).

Uncivil behavior within academia is a serious issue. Whether it involves student to student, student to faculty, or faculty to faculty, the issues remain the same. Knepp (2012) described incivility as a reciprocal process, which involves students and faculty. Both factions can contribute to the uncivil atmosphere of the classroom, leading to disruption of the learning environment (Knepp, 2012). These behaviors can lead to emotional concerns, such as loss of self-esteem; feelings of isolation, depression worthlessness, shame, and powerlessness; and problems with health disorders, extreme stress, and physical symptoms (Dentith et al., 2015; Luparell, 2011).

To understand the phenomenon of incivility within academia, it is important to identify the behaviors and the levels of incivility displayed. Uncivil behaviors demonstrated by faculty and students can infringe on the mutual respect expected within the teaching-learning environment (Clark, 2008a). Student behaviors can range from

sleeping in class and acting bored to stalking and intimidation of professors. Whereas, faculty uncivil behaviors can be expressed as coming to class late and unprepared or making unreasonable demands for students to meet (Knepp, 2012). The learning environment may be compromised because of student and faculty incivility. If these behaviors are not addressed, the campus atmosphere can be seen as accepting of incivility and perpetuation of the problem exists (Knepp, 2012).

In addition, the frequencies of the uncivil occurrences are vital for a better comprehension of the phenomenon. There have been several studies about academic incivility, and the frequency rate varies widely between 18% to 68% (Keashly & Neuman, 2010; Kinman & Jones, 2004; Lewis, 1999; Raskauskas, 2006).

These rates appear high when compared with the general population. For example, the general population incivility/bullying rate within Scandinavian countries ranges from 2% to 5%, and for the United Kingdom, it is 10% to 20%, and in the United States, the range is 10% to 14%, (Keashly & Jagatic, 2011; Rayner & Cooper, 2006). These comparisons indicate a high prevalence of academic incivility versus the number within the general population. Therefore, further research is needed in the academic area for a better understanding of the phenomenon.

According to Fogg (2008) and Raineri, Frear, and Edmonds (2011), those who use disruptive behaviors, such as incivility or bullying, often lack self-confidence or a sense of adequacy. To compensate for one's shortcomings, one engages in these behaviors to divert from oneself. Motivation for such behaviors can sometimes be due to prejudices related to race, age, or gender, but not always (Dentith et al., 2015). Prospective targets usually display attributes such as confidence, kindness, competence,

and optimism, and these qualities make the proposed target a significant threat to the perpetrator (Dentith et al., 2015).

Incivility Related to Students

According to Connelly (2009), incivility commonly breaks down into two groups: less serious and more serious behaviors. Some less serious examples of student uncivil behaviors are (a) sleeping in class, (b) acting bored or disinterested, (c) dominating class discussions, (d) not taking notes during lecture, or (e) challenging the instructor's knowledge or credibility (Connelly, 2009). Examples of more serious uncivil behaviors are (a) not paying attention in class, (b) cheating or other academic integrity violations, (c) intimidation, (d) using a cell phone during class, (e) student conversations distracting instructor and/or other students, or (f) sending inappropriate emails to the instructor (Connelly, 2009). Knepp (2012) presented another category for consideration, such as the most serious uncivil behaviors, which occur when students threaten others with violence.

Many hypothesize as to the reasons for these behaviors within academia. Alberts, Hazen, and Theobald (2010) believed that many students in the United States (US) were not challenged academically prior to their college experience, therefore, making their perceptions of college work misleading. In addition, today's college students present unique challenges due to indulgent parenting, tolerant school environments, and instant gratification practices (Alberts et al., 2010). Nordstrom, Bartels, and Bucy (2009) claimed that students exhibit a sense of entitlement, believing they are making an effort in class and need appropriate rewards for their work. Some students feel attendance in class is enough to earn high grades (Knepp, 2012).

Burke, Karl, Peluchette, and Evans (2014) identified several factors that have contributed to student incivility. Situational factors, such as timing during the academic year, student evaluations of faculty, faculty behavior, the increase use of technology in classrooms, narcissism, consumerism, and student attitudinal gaps, contribute to student uncivil behaviors (Burke et al., 2014). McKinne and Martin (2010) cited different student expectations of the classroom as compared with those of faculty members, and these expectations contribute standards, but not seen as such by all. The various generations represented in higher education may have different values, and these differences can be a source of conflict.

According to Clark, Nguyen, and Barbosa-Leiker (2014), stressors, (such as assignments, deadlines, examinations, challenging curricula, demanding coursework, high-stakes testing, and coping with clinical experiences) contribute to (a) burnout from demanding workloads; (b) family, school, and work demands; (c) competition in high stakes environments; and (d) student stress as previously noted. Kassem, Elsayed, and Elsayed (2015) concluded that nursing students lacked the skills to deal with the stress and uncivil behaviors, such as verbal abuse, and, therefore, perceived themselves as powerless to change those behaviors.

Incivility Related to Faculty

Some researchers expressed academic freedom and tenure as a contributing factor for these behaviors to flourish within higher education (Dentith et al., 2015; Fogg, 2008; Keashly, 2015). According to Keashly (2015), the presence of tenure has protection from retaliations for any controversial opinions. Because the academic environment fosters academic freedom, faculty members are encouraged to explore ideas and broaden

knowledge and experiences, even if it is controversial in nature (Keashly, 2015).

Academic freedom is used for disagreement, criticism, and debate along with his/her

investigation. These practices become central to the faculty members practice and their

focus of tenure as the desired status (Keashly, 2015).   Faculty-to-faculty incivility among

those who overlap academic and health care practice (due to his/her professional practice

as clinical faculty) remains concerning as well because these faculty members must meet

institution benchmarks, such as tenure and promotion, along with maintaining his/her

professional certification and/or licensure (Wright & Hill, 2015).

Twale and DeLuca (2008) contended that tenure is enabling incivility and

bullying because of the competitive nature within the environment. DelliFraine et al.

(2014) studied health care management faculty and found 51% of bullied experiences

were directed to participants of the assistant professor rank, and 73% of experiences

occurred while targeted individuals were untenured (*n* = 134). The notion of collegiality

has encouraged discourse and debate, but issues arise when the line of incivility is

crossed. Taylor (2013) also stated that a person's interpretation defines incivility in

addition to the behaviors deemed appropriate by the profession itself. Keashly and

Neuman (2010) suggested that academia is a vulnerable environment for aggression and

uncivil behaviors because of the long-standing relationships among faculty due to

attainment of tenure. Achievement of tenure has the protection and the perception of

little risk for those who engage in these dysfunctional behaviors (Keashly, 2015).

There is an incidence for faculty-to-faculty incivility, but not addressed as it

should be (Cassell, 2011; Keashly & Neuman, 2010; McKay et al., 2008). Cassell (2011)

reported those persons predominantly affected by the incivility to be in the caring and/or

support professions, such as nursing, health sciences, and so forth. These factors support further research for faculty-to-faculty incivility specifically and this intended study.

Incivility Related to Nursing Practice

Incivility affects the nursing profession, too. Stagg and Sheridan (2010) contended that considerable evidence of incivility, bullying, and violence exist within many nursing workplaces. A sense of the actual incidence and prevalence of these behaviors among nurses in the workplace is difficult because it is often unrecognized and underreported (Becher & Visovsky, 2012). Unfortunately, it is quite common to hear the phrase *nurses eat their young* (Baker, 2012; Bartholomew, 2006; Meissner, 1986; Sauer, 2012). In fact, since Meissner (1986) coined the phrase, little has changed except for the names of these behaviors. As noted previously, many terms represent the behaviors, especially within the nursing discipline. These terms include incivility, horizontal violence, lateral violence, relational aggression, or bullying (Clark, 2013b; Dellasega, 2009; Griffin & Clark, 2014; Longo & Sherman, 2007; Mitchell, Ahmed, & Szabo, 2014; Purpora & Blegen, 2012; Woelfle & McCaffrey, 2007). There remain some variances to each of the terms specific meanings, but in essence, all express the negative behaviors experienced within the nursing world.

Nursing workplaces may be quite vulnerable to incivility because of varying patient acuity, fluctuation in staffing ratios, constant changes within the health care environment itself, lack of normal shifts for work, different types of staff interactions, and constant interruptions in the flow of the nurses' day (Hunt & Marini, 2012). Nurses and patients can suffer due to an uncivil work place. These behaviors potentially threaten the quality of patient care delivered (Etienne, 2014; Hutchinson & Jackson, 2013;

Purpora, Blegen, & Stotts, 2015). Fears of incivility can also interfere with the nurses'
communication skills and create a difficult transmission of vital information among the
health care team members (Purpora & Blegen, 2012).

Longo, Dean, Norris, Wexner, and Kent (2011) suggested generational
differences directly affect the workplace communication and collaboration due to the lack
of workplace contributions. Four-generational levels exist within the current workforce
and increase the risk for conflict, especially because of the differing values and work
ethics within each generation (Longo et al., 2011). Challenges exist for today's nurses
particularly with advancing technologies and the increasing levels of patient acuity.
These workplace generational differences can create a lack of understanding, potentially
increase stress and possibly contribute to further incivility (Mitchell et al., 2014).

The American Nurses Association (ANA, 2015) considers uncivil behavior,
bullying, and violence in the workplace to be serious issues. No federal standards
currently exist, but several states have enacted legislation and/or regulations for
workplace violence protection (ANA, 2015). The development of a position statement
against incivility, bullying, and workplace violence by the ANA is a step toward
awareness of the severity of the issue and requires all nurses to create an environment of
civility, kindness, respect, and dignity (ANA, 2015). In addition, The Joint Commission
(2008) announced a sentinel event alert for intimidating and disruptive behaviors within
health care organizations. Together with these and other organizations, the problem of
incivility is becoming more apparent.

Incivility Related to Nursing Education

Incivility continues to appear in the literature and in the workplace for a variety of disciplines, which includes nursing (Bartlett & Bartlett, 2011). Nursing education faculty members are not immune to incivility within academia either. Incivility takes on several forms within academia (Luparell, 2011). It can be in various arrangements, such as students to faculty, student to student, faculty to faculty, faculty to administrators, or administrators to faculty.

According to Clark (2008b), academic incivility is becoming a more common and distressing problem within nursing education. Faculty members are reporting more problematic student behaviors with the level of student incivility in nursing education increasing (Clark & Springer 2007a). Incivility can negatively influence students, ranging from classroom interruptions to horrific acts of violence. Students subjected to faculty incivility described feelings of hopelessness, helplessness, and of being emotionally traumatized (Clark, 2008b). Clark (2008b) reported students felt powerless and afraid of the repercussions due to speaking out. Schaeffer (2013) believed these dysfunctional behaviors interfere with student-faculty relationships along with a disruption in student learning and their continuing desire to learn.

Nursing faculty members are susceptible to student incivility as well. Clark and Springer (2007b) reported students made disparaging groans, sarcastic remarks or gestures, lacked attention during class, cheated on examinations, used cell phones, or dominated the class conversations. Frequency and intensity of student incivility increased to name calling, yelling at faculty, and engaging in physical contact.

According to Clark and Springer (2007b), some uncivil nursing faculty behaviors toward students consisted of making condescending remarks, acting arrogant and superior, and criticizing students in front of peers. Clark and Springer (2010) believed that academic incivility negatively affects teaching and learning and is becoming more common and certainly distressing within nursing education. Years of tolerance for these behaviors have led to perpetuation of a cycle of violence passed from one generation of nurses to another (Longo & Sherman, 2007). Clark (2013a) perceives incivility as a continuum. Figure 1 depicts this phenomenon. Role modeling professional behaviors is the expectation for all faculty members, and it is not to perpetuate the cycle of incivility, bullying, and horizontal violence (Gallo, 2012). The reality that incivility and other dysfunctional behaviors do exist within nursing academia is quite disturbing.
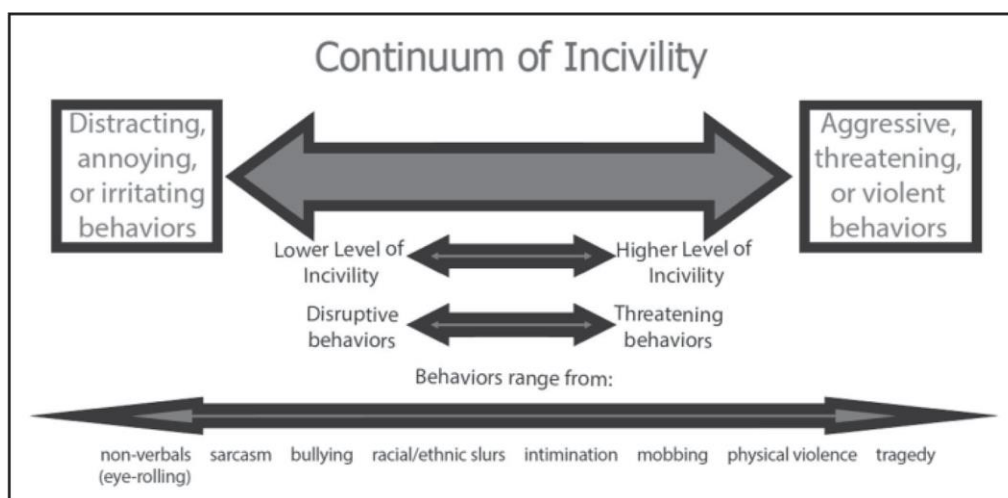
Figure 1. Clark's continuum of incivility. Adapted from *Creating and sustaining civility in nursing education* (p. 14), by C. M. Clark, 2013a, Indianapolis, IN: Sigma Theta Tau International. Copyright 2013 by Sigma Theta Tau International.

Randle (2003) believed that incivility and bullying behaviors were commonplace when becoming a nurse. Palumbo (2018) indicated there is research to suggest that nursing students and registered nurses beginning practice were the most vulnerable and

likely to become victims to uncivil behaviors. Thomas and Burk (2009) indicated that students endured unwelcome or ignored behaviors from staff nurses while on the unit. Others experienced belittlement, falsely blamed for events, or even being humiliated in front of their peers. The most frequent uncivil behavior was the devaluing of the students' efforts (Clarke, Kane, Rajacich, & Lafreniere, 2012).

Incivility and bullying as part of the normal behaviors within nursing educational experiences would encourage a future culture of incivility, which is far from the desired result (Condon, 2015). Incivility during student socialization may further affect learning and performance (Clark, 2008a; Luparell, 2004,). Because of the students' exposure to these behaviors in the clinical and academic settings, there exists a potential for students to perceive these as normal within health care and nursing (Luparell, 2011).

Graduate nurses can be especially vulnerable to incivility in the workplace (McKenna, Smith, Poole, & Coverdale, 2003; Roberts, DeMarco, & Griffin, 2009). This behavior was found across various clinical setting with new graduates with most of the behaviors as covert and subtle (McKenna et al., 2009). In addition, there is a correlation between incivility and graduate nurse burnout leading to the belief that incivility helps precipitate burnout and burnout may initiate incivility (Laschinger, Finegan, & Wilk, 2009).

Incivility can significantly affect our nursing students, ranging from classroom interruptions to horrific acts of violence. Faculty members may also suffer emotional and physical tolls. Nurse educators confronted by these behaviors report a loss of enthusiasm and motivation for their work (DalPezzo & Jett, 2010). According to DalPezzo and Jett (2010), decreased morale affects the quality of life and the nursing profession. If a

situation of decreased morale and loss of enthusiasm continue, a toxic work environment develops into to job dissatisfaction along with psychological and physical stress (DalPezzo & Jett, 2010). Lack of passion by nurse educators can negatively influence the future of nursing education and our graduates.

Nurse educators need to become exemplary role models for their students and not introduce or further perpetuate the cycle of these behaviors in health care environments. Nurse educators also have a responsibility to develop curricula that educate and encourage discussion by students about these behaviors (Walrafen, Brewer, & Mulvenon, 2012). Nurse educators can provide information related to professional behaviors, in addition to helping develop new directives, policies, and guidelines for a safe academic environment (Edwards & O'Connell, 2007).

Incivility Related to Other Health Sciences Education

Incivility exists among other health science educational programs as well, but the literature remains sparse. Behaviors considered uncivil by male and female dental students included (a) eating in the clinic area, (b) drinking in the clinic area, (c) demanding special treatment, (d) being unprepared for clinic experience, and (e) arriving late to the clinic (Ballard, Hagan, Townsend, Ballard, & Armbruster, 2015). Surprisingly, there was stronger agreement among female dental students than the male students for the following uncivil behaviors: (a) challenging authority in class, (b) making offensive remarks, (c) dominating discussion, (d) sleeping in class, (e) challenging instructor's knowledge and credibility, and (f) cheating to be uncivil (Ballard et al., 2015).

Knapp et al. (2014) suggested bullying is also evident in pharmacy clinical education, but there were no data related to its prevalence. The components of the identified behaviors from faculty to students included humiliation, excessive criticism, and offensive behaviors (Knapp et al. 2014). There were no studies evident, which focused on the classroom aspect for these pharmacy students, so these data may be overreported or underreported. Additionally, physical therapy students identified bullying within their clinical experiences. According to Whiteside, Stubbs, and Soundy, (2013), the bullying incidents surrounded the high stress environment and the lack of support from the instructor. In radiology, Johnson and Trad (2014) found 71% of radiation therapists have been bullied. Specific proof of incivility within other health science majors was not evident.

Problem Statement

Incivility in the workplace is inappropriate, demeaning, and unwarranted. Academic incivility can be equally detrimental to students and faculty whether acknowledged as a witness or a personal experience. Students tend to learn behaviors from the faculty role modeling process, which enhances student growth and development within his/her discipline. Faculty and administrators must demonstrate impeccable professional behaviors, so all others can emulate these activities as they all become part of a team, whether health care or workplace. The focus of this dissertation is on nursing and other health science (HS) students specifically.

Purpose of the Study

This investigator explored whether nursing students (independent variable) perceived uncivil behavior (dependent variable), whether experienced or witnessed

within their academic environment, differently than how health science (HS) students (the independent variable) perceived these behaviors. This investigator found there to be no difference in the level or frequency of student incivility as perceived by nursing and HS students. However, this investigator did find there to be a difference in the level of faculty incivility, but there was no difference found in the frequency as perceived by nursing and other HS students.

It is important to know the level and frequency of incivility to measure the breadth and depth of the problem within nursing and heath science academic environments. Because nursing and HS students ultimately become health care providers, interprofessional collaboration and teamwork becomes vital for effective patient care. Interprofessional education intentionally is used to prepare students for collaborative practice with other professions to develop working relationships that involve negotiation and other advanced communication skills to provide effective health care (Gestadt & Hibbert, 2013; Wright & Hill, 2015). Wiencek, Lavandero, and Berlinger (2016) considered interprofessional work foundational to health care delivery. This investigator also explored if incivility is unique to nursing or if other HS disciplines have the same issues related to incivility, which could potentially affect interprofessional practice. In addition, this dissertation could be used to enlighten faculty about the behaviors nursing and HS students consider as uncivil, so students are better prepared to work together.

Research Questions and Hypotheses

Based on a review of literature, these questions guided this dissertation and subsequent analysis of the data.

Research Question and Hypothesis 1

  Research Question 1. Is there a difference in nursing and health science students' self-reported levels for student incivility behaviors over the past 12 months?

  Research Hypothesis 1. There is no difference in the self-reported levels of nursing and health science students for student incivility behaviors over the past 12 months.

Research Question and Hypothesis 2

  Research Question 2. Is there a difference in the self-reported frequency rate of student incivility experienced or witnessed by nursing and HS students over the past 12 months?

  Research Hypothesis 2. There is no difference in the self-reported frequency rate among nursing and HS students who experienced or witnessed incidents of student incivility over the past 12 months.

Research Question and Hypothesis 3

  Research Question 3. Is there a difference in nursing and HS student's self-reported levels for faculty incivility behaviors over the past 12 months?

  Research Hypothesis 3. There is no difference in nursing and health science student's self-reported levels for faculty incivility behaviors over the past 12 months.

Research Question and Hypothesis 4

  Research Question 4. Is there a difference in the self-reported frequency rate of faculty incivility experienced or witnessed by nursing and HS students over the past 12 months?

Research Hypothesis 4. There are no differences in the self-reported frequency rate for faculty uncivil behaviors experienced or witnessed by nursing and HS students within the past 12 months.

Significance of the Study

This investigator provided information about student perceptions of student and faculty incivility and in order to better prepare students to work in the health care industry. The areas of significance considered were nursing education, practice, and research, in addition to public policy.

Nursing Education

With increased cognizance of student incivility, nursing faculty members are in a position to acknowledge its existence and use techniques to decrease and/or stop student incivility within academia. Nurse faculty will need to have a greater awareness of uncivil behaviors and, subsequently, intervene when the uncivil behaviors appear. The cycle of incivility inadvertently learned while in nursing education programs can be broken with appropriate instruction and training for students and faculty. In addition, identification of uncivil behaviors and the factors that contribute to student incivility can all help to further a student's educational experience and stay connected to the learning process. Tantleff-Dunn, Dunn, and Gokee (2002) stated that conflicts between faculty and students are sometimes seen as coercive or authoritarian, which can cause students to disengage from their education.

Teamwork and interprofessional collaboration remain essential for effective patient care and management (Lerner, Magrane, & Friedman, 2009). Unfortunately, teamwork does not transpire without specific education and training about how to work

together and understand other health care providers' roles/responsibilities (Lerner et al.,

2009). The differences in the various health care providers' education can produce

obstacles for interprofessional collaboration. Hall (2005) suggested different professional

cultures continue to impede interprofessional collaboration. Throughout each program of

study, professional behaviors and civility are in need of reinforcement. Nursing and

other health care professionals must provide educational opportunities for their students

to discover the uniqueness of each profession, the foundations of interprofessional

collaboration, effective communication, and conflict management (Price, Doucet, &

McGillis-Hall, 2014).

Incivility can negatively influence nursing students, ranging from classroom

interruptions to horrific acts of violence. Certainly, incivility is a concern and may be

contributing to student stress overall (Clark, 2008a, 2013a). Nursing students experience

significant stressors while in school for many reasons. Students may not have the correct

coping mechanisms to deal with stress and incivility. Students need to learn various

coping skills, stress reduction techniques, and overall positive self-efficacy. Awareness

of the stressors students face is used for growth and assistance from educators.

Students frequently avoided faculty who made negative comments about others.

They also felt disrespected when faculty ignored or failed to answer their questions.

Clinical appraisals can be subjective, and for fear of retaliation, students avoid interaction

with uncivil instructors (Altmiller, 2012). These negative perceptions by students can

cause serious implications for faculty members and their teaching in the future. This

specific study was used to increase the knowledge of the frequency of uncivil behaviors

and shed some light on the students' perception on the level of civility within academia.

Nursing Practice

It is important to remember that nurses play a vital role in health care and have a responsibility to help promote a healthy work environment (Johnson, Phanhtharath, & Jackson, 2010). Unfortunately, uncivil behaviors continue to be a concern in the practice arena as well. The presence of incivility among nurses relates to possible threats to the quality of patient care and potentially poor patient outcomes (Hutchinson & Jackson, 2013). In addition, patient safety concerns arise from a reduced patient safety culture, which link to high medication error rates, increased work injuries, and reluctance to report errors (Chiang & Pepper, 2006; Clarke, Sloane, & Aiken, 2002; Hofmann & Mark, 2006).

The scope of the incivility issue affects the health care systems as well as the patient outcomes (Stagg & Sheridan, 2010). Uncivil practice environments lead to decreased teamwork and poor morale. Team communication is at a greater risk within uncivil areas. Poor interprofessional communication increases the potential for errors, affecting patient care outcomes (Kohn, Corrigan, & Donaldson, 2000). The World Health Organization (WHO, 2010) recognized the need for interprofessional education as essential for all health care professionals. All health care providers need to understand the benefit of interprofessional teams functioning well because of knowing each other's roles/responsibilities, and they are able to be respectful in order to value others;' contributions to patient outcomes. (Lapkin, Levett-Jones, & Gilligan, 2013). Uncivil work environments contribute to ineffective delivery of patient care and potential stress among all health care professionals (American Association of Critical Care Nurses [AACN], 2015).

Workplace burnout and intent to leave can also negatively affect the workforce (Jimenez, Dunkl, & Peißl, 2015; Longo, 2007). Job satisfaction and organizational commitment decrease when an uncivil work place exists (D'Ambra & Andrews, 2013). According to D'Ambra and Andrews (2013), incivility within the work environment becomes a source of discontent for which new graduate nurses are vulnerable. When incivility contributes to high levels of turnover, especially with new graduate nurses, the organizational costs rise due to constant orientation and patient care suffers due to less than optimal staffing.

The development of reporting systems for health care organizations needs to occur to encourage new graduates and all health care providers to identify uncivil behaviors without the fear of retaliation or poor performance evaluations. The culture of the organization must be one of support and non-tolerance for incivility. Nursing students are generally more vulnerable to uncivil workplaces because they are often younger, have less clinical and life experience, have fewer coping skills, and have no authority in their current position (Abd El Rahman, 2014; Dellasega, 2009).

The focus of this research was used to explore the frequency of the various behaviors of incivility either experienced or witnessed by nursing with HS students. This investigator categorized the amount of incivility within health care programs that are used to teach the professional role expectations through modeling of faculty members, staff members, and possibly other students. The frequency of student incivility noted among nursing and HS programs was categorized as *rarely* and *never* (on a scale of *often, sometimes, rarely*, and *never*). The frequency of faculty incivility noted among nursing and HS students was categorized as *never* (on the same scale noted above). Pertinent

data were provided about the extent of incivility as well as the level of incivility among

nursing and HS students. With this information, strategies for prevention of uncivil

behaviors within academia can provide strategies to enhance excellent role modeling for

students and practitioners of nursing programs as well as safer patient care and healthier

work environments.

Nursing Research

According to Clark and Springer (2007b), the frequency and intensity of incivility

among students has increased to include verbal abuse, yelling at fellow students and

faculty, and potential physical contact. In addition, Hollis (2012) found increasing rates

of workplace incivility and bullying within higher education after surveying multiple

colleges and universities. This investigator sought to provide better transparency into the

academic incivility issue. Researchers must be able to determine the frequency and level

of uncivil behaviors that exist within academic environment. With an improved image of

the problem, predictors of academic incivility, researchers can focus on developing

improved methods to address and prevent further episodes of these disruptive behaviors.

It is vital for researchers to follow incidents of workplace incivility to lessen and improve

work environments for all professions.

It is also vital to view this issue through the students' perspective to gain a better

understanding of the dynamics of incivility. Students can bring a unique perspective to

uncivil behaviors and their reactions to it. Altmiller (2012) found that students believe

incivility is justified if they perceive incivility directed toward them and that it validates

subsequent student incivility. These views present opportunities for researchers to

develop various strategies, methods, and tools to help students navigate uncivil behaviors.

Public Policy

According to The Joint Commission (2008), failure to address workplace incivility through formal avenues is indirectly promoting it. Yamanda (2007) identified four public policy goals to help mitigate workplace bullying: prevention, resolution, compensation and assistance, and deterrence. These strategies are certainly useful with uncivil workplace behaviors as noted by the description of the behaviors used: false accusations, hostile glares, intimidating nonverbal behaviors, put-downs, harsh criticism, and the silent treatment. Lawmakers need to propose and enact formal legislation related to these behaviors due to the many ethical and legal implications. The goal of this dissertation was to highlight the magnitude of the problem and provide substantial evidence for policymakers to take appropriate action in the form of legislation.

Philosophical Underpinnings

A post-positivism approach is the basis for this quantitative research. Within the post-positivist paradigm, there is a continued belief in reality and the desire to understand (which originates from the positivist paradigm). In addition, the post-positivist paradigm also recognizes the impossibility of total objectivity (Polit & Beck, 2012). The aim of post-positivism is to produce objective and generalizable knowledge, but the reality of knowing with certainty is not conceivable. Instead, the focus is on a probability approach with supporting evidence for the ways of knowing (Polit & Beck, 2012). Deductive reasoning is used to generate predictions that are then tested. Usually the procedures are orderly, systematic, and controlled to acquire information. Because objectivity is valued, avoidance of personal beliefs and biases is vital as contamination of the study must be prevented (Polit & Beck, 2012).

Theoretical Framework

As developed by Bandura (1977), the social learning theory is a classic work that provided a sound theoretical framework for this descriptive, quantitative study. The theory presents how one learns various behaviors, attitudes, and values from others through observation, modeling, and imitation of others. Bandura, Ross, and Ross (1961) conducted experiments with children who watched an adult model act aggressively toward a Bobo doll. The children's behavior was measured after seeing the model rewarded, punished, or experienced no consequence for aggression toward the doll. These experiments were demonstrations of Bandura's social learning theory, depicting that people learn through observing, imitating, and modeling. In addition, learning by reward or punishment became evident as well as watching someone else receiving a reward or punishment (Bandura et al., 1961).

Bandura's Social Learning Theory

The social learning theory presents observation and modeling of behaviors, attitudes, and emotional reactions of others (Merriam, Caffarella, & Baumgartner, 2007). Bandura (1977) believed learned behaviors result from direct observation or vicariously through others. When one learns by observation, the learner acquires behaviors without trial and error (Bandura, 1977). Individuals learn within a social situation by observation; imitation; and the modeling of various attitudes, experiences, exhibited behaviors, and consequences of such situations (Bandura, 1977).

Constructs. The major concepts within the social learning theory are the following: (a) cognitive, (b) environmental, and (c) behavioral. Bandura believed in *reciprocal determinism* in which there is an exchange between the cognitive, behavioral,

and environmental factors for which a human's behavior occurs, which means that an individual's behavior influences and is influenced by social and personal characteristics. The environmental aspect influences the intensity and frequency of the behaviors. The behavior itself can influence the environment as well (Bandura, 1977). Refer to Figure 1 for a visual representation of the theory.

The cognitive concept relates to knowledge, expectation, and attitudes within a social perspective. A person learns through thought and reasoning of his/her experiences, and these experiences may determine future actions (Bandura, 1977). Self-efficacy is a person's confidence about his/her ability to execute certain behaviors that lead to an outcome and considered to be a core construct of the social learning theory (Glanz, Rimer, & Viswanath, 2015). Bandura (1977) posited a person's self-efficacy formation is through four sources: (a) previous mastery experiences, (b) vicarious experiences, (c) social persuasions, and (d) emotional arousals. Previous experience assists a person to develop behavioral skills, beliefs, and a mental image of his/her own level of self-efficacy. Positive outcomes increase self-efficacy as negative outcomes lower it. According to Glanz et al. (2015), current behavior and a mastery of that behavior predicts future behavior, for example, a person is trying to cease alcohol addiction. Active learning strategies that coach behaviors and require accountability are steps in this process and frequently assist this person toward cessation of alcoholic consumption. As mastery of the new behavior increases so does self-efficacy and, therefore, a subsequent increase toward the healthier behaviors related to alcohol consumption.

The environmental influences are physical and social factors within an individual's environment that affect a person's behavior (Glanz et al., 2015). These

factors are outside the person, such as environmental norms, the influence on others, and ability to change one's environment. The environment presents opportunities for social support. Observational learning occurs when a person learns new information through observing the behaviors and consequences of the behavior of others (Glanz et al., 2015). Mentoring and role modeling are forms of observational learning. Bandura (1977) contends that learners tend to acquire their behaviors through a modeling process rather than through a stimulus-response association. Observational learning would not occur without the cognitive process. Therefore, humans must think about the behaviors first before modeling can occur (Bandura, 1977). Internalization of the learning then comes from various cues or responses in addition to the actual presence and amount of reinforcement following the response (Twale & DeLuca, 2008).

The four necessary conditions that drive the modeling process are (a) attention, (b) retention, (c) motor reproduction, and (d) reinforcement and motivation (Bandura, 1977). During the attention process, the learner needs to be intent to acquire new knowledge and stay focused on the potential learning activity. If the learner is lacking in attention, no learning will occur. The retention processes require memory of the modeled behavior either through verbal or visual means. Bandura (1977) believed there cannot be modeling of behaviors unless the person has recall of such behavior through some symbolic form and, therefore, maintained within the permanent memory. Within the motor reproduction process, a duplication of learned behaviors becomes best with practice. The amount of modeled learning demonstrated via behaviors depends on the persons skills of the behavior (Bandura, 1977). Bandura (1977) considered reinforcement as facilitative rather than a necessary condition. The reinforcement and

motivation for learned behaviors are dependent on positive incentives, such as past reinforcement, promised reinforcement, or vicarious reinforcement. Negative motivators for learned behaviors can be past punishments, promised punishments or threats, and vicarious punishments. When adverse or unfavorable reinforcements are present, non-exhibited learned behaviors are occurring (Bandura, 1977). According to Bandura (1977), modeling of behaviors increases when the person improves his/her skills in selective observation along with memory encoding, coordination of sensorimotor systems, his/her personal ideology, and his/her ability to foresee the consequences for the exhibited behavior (Bandura, 1977).

Additionally, other environmental influences on behavior, such as social support, normative beliefs, and barriers/opportunities, are pertinent factors that affect a person's behavior. Social support is the support received from a person's social network that includes informational, instrumental, and emotional support for the exhibited behavioral changes. Cultural norms are reflecting the socially acceptable behaviors within an organization and are playing a vital role in the prevalence of a behavior (Glanz et al., 2015). Barriers/opportunities are characteristics of the social and physical environment that makes behaviors harder or easier to perform. By increasing a person's opportunities or removing his/her impediments, changes will occur to behaviors (Glanz et al., 2015).

Behavioral concepts are related to the mastery of skills to perform specific behaviors, specific practices, and intentions along with reinforcement and punishment factors. Bandura (1977) believed humans process the information received and reflect about the behavior along with its potential consequences. Glanz et al. (2015) considered these behaviors to be either health enhancing or health compromising. Behaviors for the

improvement in health or those leading to poor health are significant behavioral factors within the social learning theory. Behavioral skills reflect the person's abilities to perform a behavior successfully. One's intentions serve as incentives and guides to future behaviors. Reinforcement and punishment can increase or decrease behaviors (Glanz et al., 2015).

  Aberrant behaviors. Twale and DeLuca (2008) posited that social circumstances determine individual behavior patterns, even aggressive behaviors. Bandura (1973) also claimed that aggressive actions tend to occur at a certain time in certain places toward certain individuals in response to forms of provocation. In addition, people tend to follow the performance cues of those with social power and/or status within an organization. When aggressive responses resemble either approved or unpunished offences, the likelihood of continuation of the behavior becomes more probable (Bandura, 1973). Therefore, the perpetuation of negative behaviors, such as incivility, continues. Erroneously, these behaviors become suitable and the incivility cycle remains.

  Aggression and other manifestations of human behavior, such as power struggles, paternalism, feminism, and competition in the workplace, are relative to incivility behaviors as well (Twale & DeLuca, 2008). According to Walrafen et al. (2012), individuals tend to emulate the behaviors of group members as a way of seeking acceptance of that group. Bandura's social learning theory also has significant relevance to adult learning within his/her environment with behaviors swaying others (Smith, 2014).

Theory application and relevance. The social learning theory is used to support the development of suitable behaviors for students through observational learning and role modeling. Lemos (2007) suggested that civil behavior is learned behavior and becomes more complex as society changes. Bandura (1977) considered modeling influential when establishing behavior. All students need support and guidance relative to the various responsibilities of the professional role they are seeking. Within the learning period, students gain knowledge of the college, health care institutional values, ethical principles, and cultural norms of the profession within that organization. According to Messersmith (2008), this learning is truly a socialization process in which individuals learn from those around them through listening and observation. This learning incorporates the language and technology of the profession and internalization of the profession's values and norms with integration of the behaviors into one's identity and life role (Waugaman & Lohrer, 2000). Socialization opportunities within the nursing school are used to enhance knowledge of the professional nurse's role and encourage career development through to lifelong learning. Observational learning and role modeling is used to enable the student to assimilate to the professional role with grace, ease, and confidence in his/her knowledge and skills.

Socialization and learning of civil behaviors begin upon entry into a nursing program and continues throughout their working years. Students learn their role as that of a professional nurse and change their personal values and beliefs. Maben, Latter, and Clark (2006) showed that theory and task education only for students leads to undesirable results. The combination of role modeling, interaction with other nurses, and internalization of knowledge and norms can help students fulfill their professional

demeanor. Keeling and Templeman (2013) stated that observation in the clinical environment of both positive and negative role models is powerful for student nurses in their professional development.

While using the social learning theory to explain student incivility, the behavioral influences include (a) the ability needed to perform the behavior, (b) the intent to add or modify behaviors if needed, (c) the existence of reinforcement or punishment for the behaviors, and (d) individual communication skills. The personal and cognitive influences include (a) knowledge of civil behaviors and expected outcomes within academia, (b) the collegial expectation for students, (c) the ability of the student to actively participate in learning activities, and (d) the ability of the group (either nursing or other HS students) to work toward the achievement of the desired outcomes. The environmental influences include (a) existence of observational learning, (b) normative beliefs of the group, (c) perception of social support, and (d) existence of barriers and opportunities. Based on this theory, the environment (academia) and the personal/cognitive factors of the student influence the resulting behaviors (civil or uncivil) in a reciprocating manner with each factor affecting the other.   Refer to Figure 2 for a depiction of incivility and the triage relationship of Bandura's social learning theory.

UNCIVIL BEHAVIORS

Expressing disinterest, boredom or apathy toward coursework; making rude gestures or nonverbal behaviors toward others; sleeping or not attentive; late arrival to class; using electronic devices for unrelated

PERSONAL AND COGNITIVE

PHYSICAL AND SOCIAL ENVIRONMENT

Autonomy; self-confidence; self-image; self-efficacy; jealousy; competition & comparison with others; personal ideologies;

Higher education; clinical areas; gender, cultures, school workload, pressure to continue in school from family; areas of clinical practice;

Figure 2. The triadic relationship of Bandura's social learning theory as it relates to student incivility. Diagram adapted from (https://wildcatpsychology.files.wordpress.com/2016/03/reciprocal-determinism-diagram.jpg)

Theoretical Assumptions

The assumptions of the social learning theory are as follows:

1. Observation, direct experience, and outcomes influence human thought, affect,

   and behavior.

2. Humans are able to self-regulate their behavior by selection and organization of his/her cognitive processes using attention, memory, rehearsal, motivation, and reinforcements.

3. The reciprocal interaction between cognition, behavioral, and environmental factors explain human behavior.

Definition of Terms

The following terms were used throughout the study and include the definitions follow to clarify the constructs.

Health science student. Also known as allied health, health science students are students who learn a variety of health care occupations. For this dissertation, the HS student participated in one of the following programs dental hygiene, occupational therapy assistant, physical therapy assistant, imaging technology, paramedic, physician assistant, or surgical technology, which are two-year associate degree or four-year baccalaureate degree-seeking programs.

Nursing student. A nursing student is an individual who is currently participating in a nursing program. For this dissertation, the nursing student was participating in any pre-licensure nursing major (practical nurse [PN] with an associate degree, registered nurse [RN] two-year associate degree-seeking, or RN four-year baccalaureate-seeking program).

Theoretical Definition

The theoretical definition of incivility includes Bandura's social learning theory. Reciprocal determinism is foundational and presents the development of incivility

through observational learning, self-efficacy, knowledge of appropriate behaviors, various barriers and opportunities, skills, intentions, and reinforcement and punishments.

Operational Definition

Incivility is based on the student's ability to identify or experience behaviors that are disruptive, disturbing, belittling, condescending, undermining, intimidating or threatening, and ambiguous uncivil behaviors (Peters, 2015). Incivility must have been experienced or seen within the last 12 months. Measurement of incivility was with the Clark Instrument (IHE-R), which is used to quantify the students' perceived frequency of uncivil behaviors and level of incivility for each identified behavior.

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Chapter Summary

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This chapter presented the problem of incivility and described its current situation, areas of existence, its targets and perpetrators, and, explicitly, the problem of faculty and student incivility. Incivility today exists within our schools, workplaces, and private and public sectors. No corner of society remains exempt from its negative effects. Nursing itself has a history of incivility as the coined phrase stated: nurses eat their young. Academic environments, once considered the ivory tower and the elite, still have the problematic behaviors of incivility within its walls.

Chapter 1 also has alluded to the different terminologies used to describe the disruptive behaviors. Similarities and differences are noted; hence, a clear description of incivility was used to identify the areas for this dissertation. Clark (2009) defined incivility as "rude or disruptive behaviors which often result in psychological or physiological distress for the people involved, and if left unaddressed, may progress into threatening situations (p. 194).

An overview of the social learning theory represents the theoretical framework for this dissertation. Forethought and a personal sense of control have regulated the behaviors exhibited (Glanz et al., 2015). Cognitive/social, behavioral, and environmental factors along with the principles of reciprocal determinism help influence and form civil versus uncivil behaviors. The premise that learning of various behaviors, attitudes, and values transpire through observation, modeling, and imitation of others was reinforced with the theory.

The students' perception of the level of student and faculty incivility among nursing and HS students was the problem and purpose for this dissertation. This investigator quantified and compared the students' perceptions of the frequency of student and faculty incivility observed within the academic environment over the past 12 months. The information gained from this dissertation contributed to our knowledge of incivility within the academic environment.

Chapter Two

Literature Review

The level and frequency of student and faculty incivility exhibited according to the perceptions of nursing and HS students was the focus of this dissertation. Additionally, the types of uncivil behaviors experienced or witnessed by nursing and other HS students were investigated.

The purpose of this chapter is to explore the literature pertaining to incivility within higher education, particularly among nursing and health science students. Synthesis and analysis of the literature follow throughout this chapter. This review also summarizes the topic of incivility as it related to nursing education, workplace, and higher education, and the investigator identified the gaps within the literature. Incivility within higher education is a growing concern that affects the education itself, the students' development of professionalism, faculty collegiality, and teamwork among all other health care providers with its unintended effect on the patient as shown in the literature.

To explore incivility among nursing and HS students, the following key search words were used horizontal violence, bullying, lateral violence, incivility, mobbing, nursing education, nursing students, health science, and allied health. EBSCO databases used for this search included the Cumulative Index to Nursing and Allied Health (CINAHL) complete, ProQuest nursing and Allied Health, MedLine, ProQuest Central, and Education and Resource Center (ERIC). Historical and current literature were

searched. The majority of the findings have represented the last 10 years as it is important to understand the historical literature and the current ideas related to incivility.

There was an abundance of empirical research on workplace incivility and within the nursing profession itself. The literature related to nursing incivility included practice situations; workplace; and academia involving students, faculty, and administration. There has been more research evident recently on academic incivility as many researchers have brought the issue to light. Previously, academic incivility was not discussed even though it existed (Twale & DeLuca, 2008). The current gap in the literature involves a dearth of research associated with incivility and health science students. In the following section, the issues related incivility through documented resources pertaining to the workplace, higher education, nursing practice, nursing academia, and health science and nursing students are substantiated.

Incivility and the Workplace

There is considerable evidence related to incivility, bullying, and disruptive behaviors and their existence within the workplace (Andersson & Pearson, 1999; Namie & Namie, 2014; Pearson & Porath, 2009). While many workplace factors found in the literature do not relate well to student incivility, there are some associated factors, such as personality traits, existence of a power situation, and personal effects on the individual. Low intensity uncivil behaviors usually characterize workplace incivility (Andersson & Pearson, 1999). In addition, the behaviors displayed can be subtle and sometimes difficult to detect. Despite the lower intensity, incivility represents a precursor to more serious aggression and negative consequences (Torkelson et al., 2016).

Antecedents

There are many sources for the antecedents of incivility and bullying within the workplace (Bartlett, Bartlett, & Reio, 2008; Carroll & Lauzier, 2014; Torkelson et al., 2016). Some organizational pressures, such as downsizing, work force restructuring, mergers, poor leadership, new technologies, compressed deadlines, and work overload, all contribute as potential causes for workplace incivility (Salin, 2003; Torkelson et al., 2016). Torkelson et al. (2016) identified the several positive antecedents to workplace incivility, such as a demanding job within a high-stress environment, organizational change, and job insecurity. Their quantitative research examined a Swedish municipality of employees through a questionnaire. A direct relationship was found to exist between being uncivil and organizational factors as noted above ($n = 512$). These antecedents deal primarily with workplace issues and lack direct relations with student issues, but these pressures negatively affect the staff, which in turn can affect student acceptance within the area.

Personality. Bartlett et al. (2008) stated that personality is a motivator for incivility. Type A personalities, individuals with traits of aggression, hostility, power, and ego are all traits that can motivate incivility (Cortina, Magley, Williams, & Langout, 2001; Salin, 2003). In contrast, individual characteristics, such as dependence, instability, introversion, and conscientiousness, can affect perceptions of power differences and subsequently lessen the risks of the target being able to retaliate (Coyne, Seigne, & Randall, 2000). These behaviors manifest among students as well as workers.

Additional triggers identified in the literature can include the abilities (such as leaders who are less competent or lack knowledge), environment, and demographics. As

certain behaviors can act as potential triggers, there are also actions (such as response to rage, fear, anger and lack of communication) that enable uncivil behaviors (Bartlett et al., 2008). Samnani and Singh (2012) suggested that weak leadership is less likely to intervene when incivility occurs; therefore, an aggressor perceives the risk of punishment as less because of the lower risk of being held responsible for the disruptive behaviors. Unfortunately, these aggressors would be more likely to engage in disruptive behaviors (Salin, 2003). In addition, power imbalances can create conditions conducive to incivility and bullying in the workplace (Salin, 2003).

Sliter et al. (2014) examined whether personality characteristics were predictive of perceptions of incivility. Undergraduate students ($n = 708$) from a large Midwestern university were exposed to vignettes describing behaviors that could be perceived as uncivil. Participants completed an online survey and then rated perceived rudeness through incivility vignettes. After the vignettes, participants filled out personality items along with their demographics. A 22-item incivility vignette scale specifically developed for this dissertation assessed perceptions of incivility. The results indicated that agreeableness, emotional stability, and openness were negatively related to perceptions of incivility. However, positive effect (indicate a predisposition to experience positive emotions, such as enthusiasm, activeness, and alertness) and trait anger (the tendency for individuals to perceive situations as threatening and, therefore, become angry) were positively related to incivility. Sliter et al. (2014) suggested that personality might influence whether a person assesses incivility, if at all. For example, some individuals may go into the workplace with a predisposition to label other employee's behaviors as uncivil (i.e., positive effect and trait anger employees). Sliter et al. (2014) concluded that

there might be implications, such as personality testing and trait anger assessment, for future employee selection and development.

Power. There has been significant research presenting evidence to support power and social status relationship to the presence of incivility (Estes & Wang, 2008). Uncivil behaviors produce an unequal power situation, for which a victim feels subjected to humiliation and embarrassment (Lim, Cortina, & Magley, 2008). Pearson and Porath (2005) determined that those with additional power tend to have more ways of being uncivil and that the target has less legitimate power than the perpetrator. Doshy and Wang (2014) found that a person's higher position within an organization is a deterrent for experiencing incivility. Power relations and power struggle within organizations tend to intensify incivility (Callahan, 2011; Doshy & Wang, 2014). Cortina et al. (2001) argued that incivility becomes a method for exerting power. According to Callahan (2011), those in power rarely experience incivility and are often the perpetrator.

Doshy and Wang (2014) confirmed that supervisors often use their power to mistreat the study participants. They implemented a qualitative research design with purposive sampling. The focus of the participant criteria was on the individual having experienced incivility in the workplace. Data collection via interviews continued until data saturation was attained ($n = 11$). The results showed that an unequal power structure between the victim and perpetrator was the primary cause of workplace incivility (Doshy & Wang, 2014).

Power situations can exist in academia between students and faculty as well. Clark (2008b) conducted a phenomenological study in which students were subjected to uncivil behaviors from faculty. Clark (2008b) applied Robert Fuller's concept of rankism

that indicates an abuse of power and a position used to disadvantage another individual. Delegation as a distribution of power as a manner to prevent situations in which one authority holds all the power is suggested by Clark's work (Schaeffer, 2013).

Consequences

There is noteworthy evidence as to the influence of incivility related to the work environment. Job satisfaction, commitment to one's workplace, motivation, morale, low confidence, and self-efficacy are all attitudes that relate to consequences of workplace incivility (Andersson & Pearson, 1999; Blau & Andersson, 2005; Cortina et al., 2001; Estes & Wang, 2008; Martin & Hine, 2005; Pearson, Andersson, & Porath, 2000, 2005; Pearson & Porath, 2005; Salin, 2003). In addition, Cortina (2008) suggested that incivility is a form of discrimination because incivility sometimes represents covert displays of gender and racial bias in the workplace.

Personal effects on individual level. There has been significant research presenting the personal effects of incivility on the individual (Einarsen & Mikkelsen, 2003; Hoel, Einarsen, & Cooper, 2003; Simon, Stark, & DeMarco, 2011). Incivility presents negative consequences in relation to a victim's mental and physical health (Lim et al., 2008). Victims often suffer psychological effects caused by the perpetrators uncivil actions and words. Many victims experience anxiety, depression, insomnia, reduced self-esteem, stress, phobias, and digestive and musculoskeletal disturbances (Estes & Wang, 2008; Lim, Cortina, & Magley, 2008). Targets also suffered from weight gain, post-traumatic stress, and hypertension (Hollis, 2015). Uncivil behaviors can cause individuals to feel uncomfortable, unhappy, and dissatisfied with their work environment and further provoke stress, which could eventually lead into chronic stress

(Lim et al., 2008). Others experience a loss of their individual creativity and focus (Doshy & Wand, 2014).

In a longitudinal study, Finne, Knardahl, and Lau (2011) found that bullying at work caused mental distress and that mental distress lead to bullying. Finne et al. measured factors, such as individual characteristics, mental distress (measured with the Hopkins Symptom Checklist [HSCL-10]), self-reported workplace bullying (measured with a single item from the General Nordic Questionnaire for Psychological and Social Factors at Work [QPSNordic]) and job demands and job control (assessed by QPSNordic; Finne et al., 2011).

Doshy and Wang (2014) conducted qualitative research to understand workplace incivility and the individual's coping strategies. A purposive sampling strategy was used with a criterion for participant selection in that the participants must have experienced incivility at work during their career. The final sample size consisted of 11 participants in which data saturation was achieved. Interviews were conducted using six, semi-structured, open-ended questions. The study findings resulted in four themes: (a) position and personality, (b) negative attributes of the perpetrator, (c) effect on the victim, and (d) organizations' willful blindness. Participant comments showed the adverse effects of the incivility on their mental, emotional, and physical well-being. Coping strategies varied among the participants and were indicated by responses such as frustration, annoyance, kept emotions to self or openly crying, and feelings of being uncomfortable and unsafe (Doshy & Wang, 2014).

Incivility and Higher Education

There has been limited empirical research about incivility, specifically related to the higher education setting. Most of these behaviors are referred to as bullying, and there is a significant amount of literature in which emphasis is on bullying. Because the behaviors of incivility and bullying overlap, exploration of both is indicated. Throughout the history of higher education, incivility exists, even though the pretense is to the contrary (Hollis (2012). The designation of the *Ivory Tower*, ingeniously named by Hollis, refers to higher education with all of its pomp, traditions, hierarchy, and elite professoriates (2012). Hollis conducted a mixed methodological study, which included faculty and administrators from 175 four-year American colleges and universities. The participants ($n = 401$) completed a 35-question survey with the results indicating almost 62% of the respondents confirmed being bullied or witnessed bullying within the last 18 months. Surprisingly, the results of 62% were significantly higher than the 37% of reported workplace bullying by Namie and Namie (2009). These findings indicated that bullying occurs at a higher rate in higher education than the workplace and is more pervasive than in the general population (Hollis, 2012).

Higher education institutions are not immune to incivility. Some people may not agree that eye rolling or making remarks at another's expense as uncivil and refuse to confront the issue. Fogg (2008) believed some academics prefer to remain connected to their books as opposed to interacting with associates who present with uncivil behaviors, thereby avoiding any conflict. Incivility is perceived as a lower intensity behavior and, therefore, less significant than other forms of harassment (Cassell, 2011). However, students, faculty, and administrators do subject their academic counterparts to acts of

incivility. Those uncivil behaviors range from rudeness, intimidation, humiliation, suppression, and even exclusion. Even though the academic culture produces some nuances, general workplace incivility literature can come into play here as well.

Academic Culture

With academic culture**,** some specific challenges are created for civility within itself. Its composition revolves around teaching, service, and scholarship. Scholarship, an integral aspect of academe, shares its consideration with discovery, integration, application, and teaching (Boyer, 1990). Academic freedom is another aspect that distinguishes higher education from other workplaces as exploration and broadening of knowledge and experiences are encouraged (Keashly, 2015). Because of this liberty, faculty members are granted freedom in their research, publication, and teaching. Autonomy remains an integral component of academic freedom due to the need for independence of thought and action and immunity from influence of others (Keashly & Neuman, 2010). In addition, shared governance assures that perceptions and understanding is in alliance with the institution.

Tenure, an academic distinction also presents a form of protection and a sense of entitlement (Keashly, 2015; Keashly & Neuman, 2010). Tenure is a practice within academic institutions that offers job security until retirement age to faculty members, which is earned after a period of time, experience, and fulfilment of specified criteria. Salin (2003) posited that those faculty members, who believe tenure protects them from disciplinary action, may engage in uncivil or bullying behaviors. Along with the assumed protection under tenure, faculty may perceive engagement in discourse and debate while using an aggressive opposing view or even a personal attack as refuge under

the academic freedom premise (Taylor, 2013). The American Association of University

Professors (AAUP, n.d.) denounces such incivility and insists on condemnation of these

acts with dismissal if adequate cause is determined.

Tenure can be competitive in nature. In a Finnish study of university employees,

Bjorkqvist, Osterman, and Hjelt-Back (1994) identified several reasons for perceived

targeting by bullies: envy, competition for positions, competition for status, and the

aggressor being insecure about them. Taylor (2012) supported this competitive nature of

tenure-track faculty members, especially when esteemed institutions are obtainable. At a

Midwestern research university, Taylor (2013) sought feedback from faculty experiences

and perceptions as bullied targets and/or witnesses and the chance of responding with

disruptive behaviors in response to the workplace. In addition, the Taylor provided some

insight into tenure status as related to workplace experiences. The Negative Acts

Questionnaire-Revised (NAQ-R) was the survey tool used. Analysis of the results

indicated that tenure status showed a noteworthy variation in the faculty members'

experience of being targeted (Taylor, 2013). Being a target may be a consideration for

the likelihood of leaving an institution as well as the tenure status significantly adds to

the likelihood of exiting. Therefore, the lower the tenure status, the greater likelihood the

faculty member will exit the institution (Taylor, 2013).

Hierarchical structure. A hierarchical structure exists within institutions of

higher education, which usually entail a president, provost, assistant vice presidents,

deans, chairpersons, and faculty members for various majors. Westhues (2004) described

higher education as the perfect climate for uncivil behaviors because of its organizational

factors, such as high job security, subjective performance evaluations, and conflicting

goals. Taylor (2013) affirmed that large hierarchical institutions contribute to the increasing rates of incivility and bullying. Raineri et al. (2011) studied business and economic faculty from colleges and universities in the northeast and central areas of the US. These results showed a significant increase in the likelihood of bullying tendencies with increased hierarchy with senior faculty members being most often the perpetrator (51.7%). Hollis (2015) questioned its respondents about the organizational level of the perpetrator. Study findings indicated the following percentages and positions: directors at 40%, tenured faculty at 26.29%, dean at 21.12%, and vice president or provost at 20.26%. Hollis (2015) also indicated lower percentages for assistant directors, assistant deans, assistant provost, and president. Raineri et al. (2011) demonstrated rank and its influence on disruptive behaviors. In addition, the Cooper and Snell (2003) supported previous research related to bullying behaviors that thrive in power imbalance situations.

Prevalence within academia.   The current literature for adult incivility and bullying is extensive, but studies about academic adult bullying and related incivility are sparse (DelliFraine et al., 2014; Goldberg et al., 2013; Piotrowski & King, 2016). Because of the limited empirical literature, the actual frequency of academic incivility becomes difficult to quantify. Keashly and Neuman (2008) studied one university using an online questionnaire related to the definition and a behavioral checklist that occurred over the prior 12 months. The results indicated 68% of the survey participants experienced some form of aggression while 46% reported some experience with bullying or as a witnessed ($n = 1,185$; Keashly & Neuman, 2008).

McKay et al. (2008) created a survey tool used for their study and sent it to faculty members, instructors/lecturers, and librarians from a mid-sized Canadian

university. Their online survey measured the influence of academic bullying on its participants by asking about separate experiences rather than experiences grouped together. This approach allowed for a better understanding about the frequency and the characteristic of the experiences. The instrument included 53 questions with eight of them open-ended questions, and the remainder used yes/no, multiple choice, or Likert scale. The results indicated that 53% of the participants experienced bullying with 32% expressing serious involvement ($n = 100$). In addition, 21% of the respondents asserted the behaviors have been ongoing for 5 years with 16% indicating it was currently occurring as well. A majority of the respondents also claimed experiencing five or more separate encounters over a five-year reporting period. Although the percentages appear high, the response rate was 12% out of a pool of 820 possible participants. The researchers suggested interpretation of the numbers rather than the estimated percentage (McKay et al., 2008).

Kakumba, Wamala, and Wanyama (2014) studied the existing work relations of staff and the prevalence of different aspects of incivility and bullying at Makerere University. A mixed methods research approach was used with the study through a questionnaire and key informant interviews. The findings showed 53.3% of the respondents experienced incivility/bullying ($n = 102$) predominately by undermining or disrespectful behaviors. However, the behaviors labeled as inactions by these researchers skewed the overall percentage, making the amount of incivility higher than reported (Kakumba et al., 2014). The inaction behaviors, such as ignoring others; giving the silent treatment; and withholding feedback, praise, or information, were clearly uncivil behaviors, according to the definition used in this proposal.

In another significant study regarding the prevalence of incivility/bullying within higher education, Hollis (2015) surveyed participants from 175 four-year institutions and found 62% of higher education administrators had either experienced or witnessed bullying within the 18 months prior to the study ($n = 401$). This investigator specifically examined various departments within higher education, such as athletics, academic affairs, student affairs, human resources, admissions, financial aid, information technology, and the executive ranks.

Incivility and Nursing Practice

There is a plethora of literature on nursing and incivility. Many of the same themes are evident here as with workplace incivility, but nursing has additional implications related to the quality of patient care and the risk of poor health outcomes. This section presents the prevalence within nursing practice, the personal influence on nurses, and the effect on graduate nurses and patient care implications.

Prevalence within Nursing

The literature continues to be saturated with evidence of the incivility within and across all health professionals, especially with the evidence that supports nursing as having the greatest problem intraprofessionally, because of its prevalence and influence on those affected (Randle, 2003; Woelfle & McCaffrey, 2007). However, the exact amount of incivility within nursing practice remains unidentified due to the difficult tracking of events related to the inconsistent definition and methods for measurement. While the particular frequency is undetermined, many agree incivility is a significant issue facing the nursing profession (Lowenstein, 2013). The exhibited behaviors are inappropriate and unprofessional and are widespread across the nursing workforce

(Mitchell et al., 2014; Vessey, DeMarco, & DiFazio, 2010). Others suggest that these behaviors continue to be a global problem as well (Griffin, 2004; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Johnson & Rea, 2009; McKenna et al., 2003; Purpora, Cooper, & Sharifi, 2015; Randle, 2003; Sa & Fleming, 2008; Simons, 2008; Stanley et al., 2007).

Quine (2001) conducted a study in the United Kingdom consisting of health care workers and found that 44% of the nurses ($n = 396$) reported experiencing bullying within the overall group ($n = 778$). Equally important, McKenna et al. (2003) surveyed new graduate nurses to determine the prevalence of various types of disruptive behaviors experienced by nurses in their first year of practice. The results showed 41% ($n = 70$ of 170) of the respondents experienced rude, abusive, or humiliating comments (McKenna et al., 2003). In another study conducted in Taiwan, Pai and Lee (2011) found that 51.4% ($n = 268$ out of 521) nurses experienced verbal abuse with 29.8% ($n = 155$ out of 521) being victims of bullying (Pai & Lee, 2011). Certainly, these statistics demonstrate a significant problem with incivility along with other disruptive behaviors and causes great concern for the nursing workforce.

Nursing is at a high risk for workplace violence with 80% of nurses experiencing uncivil behaviors at some time in their career (Lewis, 2006). Etienne (2014) conducted a descriptive study using a convenience sample from the Pacific Northwest state professional nurses' association. The NAQ-R served as the tool with the results yielding 48% of respondents ($n = 95$) confirmed being bullied in the workplace during the previous 6 months. The most common negative act identified were *being ignored or excluded* and *having opinions and views ignored* (Etienne, 2014).

Personal Impact on Nurses

The literature is robust in this area. The personal effect on nurses is the same as other incivility victims. Nurse victims suffer from anxiety, feelings of isolation, helplessness, and dejection. In addition, nurse victims experience psychosomatic symptoms and physical illness with an increased use of sick time (Lee, Bernstein, Lee, & Nokes, 2014; McKenna et al., 2003; Murray, 2009; Stokowski, 2010; Yildirim & Yildirim, 2007). Corney (2008) conducted a phenomenological study on how it feels to be bullied. Stress, fear, and guilt were the significant aspects identified. Stress caused sleeplessness, which further affected daily life. Physically feeling ill due to nausea, along with tachycardia, dry mouth, and an inability to speak reflected one of the participant's experiences. The physical ramifications led the victim to question their ability to function as a professional and lack self-confidence while decreasing self-esteem (Corney, 2008; Einarsen & Mikkelsen, 2003).

Impact on graduate nurses. There is support in the literature that many new graduates experience disruptive behaviors in their clinical settings and even within their first year of practice. New graduates are often the targets of incivility because they are at the lower end of the unit hierarchy (Evans, Boxer, & Sanber, 2008; McKenna et al., 2003; Stanley et al., 2007). McKenna et al. (2003) surveyed New Zealand graduate nurses and found that 41 out of 551 respondents mentioned reduced confidence and self-esteem after these experiences. Others identified psychological effects, such as fear, sadness, depression, frustration, mistrust, and anxiety ($n = 33$ out of 551). A small portion of the respondents identified physical consequences, such as weight loss, fatigue, headaches, and rare occurrences of hypertension and angina. Others expressed

disillusionment with the nursing profession and considered leaving (Johnson & Rea, 2009; Laschinger et al., 2009; McKenna et al., 2003; Roberts et al., 2009; Simons, 2008; Vogelpohl, Rice, Edwards, & Bork, 2013).

Simons (2008) conducted a survey using the NAQ-R instrument on new nurse graduates in Massachusetts. The results indicated that 31% of the respondents (n= 511) reported being bullied. Bullying is a significant factor in their intent to leave the organization (Johnson & Rea, 2009; Simons, 2008; Vessey, et al., 2010). Vogelpohl et al. (2013) conducted a quantitative study to determine the respondents' intent to leave nursing after experiencing disruptive behaviors. The researchers also used the NAQ-R instrument to survey new graduates from five nursing schools in Northwestern Ohio. These results indicated that 29.5% of the respondents ($n = 135$) considered leaving the nursing profession. According to these researchers and others, about a third of new graduates who experienced bullying do intend to leave their current position (Johnson & Rae, 2009; Laschinger, Grau, Finegan, & Wilk, 2010; McKenna et al., 2003).

Patient Care Influence

When nursing staff are under pressure, they are least likely to perform at their best, resulting in poor patient practice (Woelfle & McCaffrey, 2007). Patient safety is always paramount when managing patients. The Institute of Medicine (IOM; 2003) emphasized the need for honest communication and collaborative teamwork to create this culture of safety to reduce patient risks. Negative patient safety cultures contribute to high medication error rates (Hofmann & Mark, 2006) as well as a reluctance to report errors (Chiang & Pepper, 2006). Rosenstein and O'Daniel (2008) reported that 67% of respondents ($n = 4530$) believed that adverse events, such as errors, patient safety threats,

effects quality of patient care, and patient mortality, occur due to disruptive behaviors. Roche, Diers, Duffield, and Catling-Paul (2010) also concluded there is a positive correlation between workplace incivility and patient falls, medication delays, and medication errors. Riskin et al. (2015) added that thinking abilities after incivility negatively affects the individual's performance and critical thinking. Workplace incivility or other disruptive behaviors influence several factors, which relate to errors and negatively affect patient outcomes (Laschinger, 2014; Longo & Sherman, 2007; McNamara, 2012; Mitchell et al., 2014; Warner, Sommers, Zappa, & Thornlow, 2016).

Disruptive behaviors, such as incivility and bullying, have been associated with poor clinical outcomes (Longo & Hain, 2014). Farrell, Bobrowski, and Bobrowski (2006) studied workplace aggression among Australian nurses with two thirds of the respondents admitting they made patient care errors because they were upset over a prior incident of aggression. The respondents ($n = 2407$) experienced high levels of verbal and physical abuse in the four-weeks prior to the administration of the survey. The nurses expressed frustration and distress because of their inability to provide appropriate care to meet their patient needs.

Purpora et al. (2015) surveyed a random sample nurses from California ($n = 175$) to test their hypothesis that horizontal violence is inversely related to quality of care, and it is positively related to errors and adverse events. They developed their quality of care scale after two items from the Nurse-Related Quality of Care survey (Aiken, Clarke, & Sloan, 2002) and a third item after the, Hospital Survey on Patient Safety Culture (Agency for Health Care Research and Quality, 2004). A paper and online survey was used for the data collection method. Purpora et al. (2015) used the resulting data analysis

to support the hypothesis that as horizontal violence increases, the quality of care decreased, and errors and adverse events increase.

Incivility and Nursing Education

As noted abundantly in the literature, forms of disruptive behaviors, such as incivility and bullying, are real problems within nursing education (Clark Olender, Kenski, & Cardoni, 2013; Heinrich, 2006, 2007; Kolanko et al., 2006; Meissner, 1986; Sheridan-Leos, 2008). Luparell (2011) suggested that workplace incivility spills into academia through nursing's clinical sources. The workplace incivility issues with nursing itself as a discipline has been addressed in the literature, providing rich enlightening research about the incivility problems within academia. There is growth in the nursing research, especially in areas among students and faculty (Clark, 2006; Clark Farnsworth, & Landrum, 2009; Clark & Springer, 2007a; Luparell, 2004), within the faculty ranks (Clark, 2013b; Clark et al., 2013; Edwards & O'Connell, 2007; Goldberg et al., 2013; Heinrich, 2007) as well as individual students (Clark, 2008a, 2008c; Cooper, Walker, Winters, et al., 2009; Robertson, 2012).

Luparell (2011) posited that it is unknown where the propensity for incivility begins. Some researchers point to the nurses eating their young cliché with nursing school being a nurse's first exposure to the phenomenon (Baker, 2012; Condon, 2015; Dinmohammadi, Peyrovi, & Mehrdad, 2013; Meissner, 1986). Bartholomew (2006) believed incivility to be more cyclical in nature, stemming from the subordinate beginnings of the profession itself. Nightingale and the actual culture of her era may have played a role in incivility. Lim and Bernstein (2014) suggested that class

differences contributed to perceptions of incivility as Nightingale supervised her staff, using the mistress-servant relationship, with her as the mistress.

Students

There is much research on students and incivility in the literature. According to Longo and Sherman (2007), nursing students suffer in the fallout with incivility. In addition, students who experience or witness incivility may undergo psychological distress, negativity toward learning, or even question their decision to become nurses (Birks, Budden, Park, Simes, & Bagley, 2014; Curtis, Bowen, & Reid, 2007). Clarke et al. (2012) considered nursing students to be at particular risk due to their limited authority and experience. The extent of incivility experienced or witnessed by students remains unclear (Smith, Gillespie, Brown, & Grubb, 2016).

Clinical practice experiences. An area of great concern exists for students while participating in their clinical practice experiences. Thomas and Burk (2009) reviewed narratives from junior level Bachelor of Science in Nursing (BSN) students ($n = 221$). Their analysis showed that student nurse anger was provoked far more frequently while at clinic because of their perceptions of unfair and unjust treatment. Hospital staff nurses were most often the perpetrators, using behaviors, such as condescending language and an overbearing presence with rude, sarcastic, disrespectful, patronizing, and degrading remarks. The students felt unwanted, ignored, unfairly blamed, or publicly humiliated (Kern, Montgomery, Mossey, & Bailey, 2014; Thomas & Burk, 2009). Curtis et al. (2007) investigated second- and third-year nursing students' experiences ($n = 152$) with horizontal violence via a questionnaire. Curtis et al. recognized several themes, such as humiliation and lack of respect, powerlessness, and being invisible. More importantly,

51% of these respondents indicated their experience would influence future career and/or employment choices. Other researchers found nursing students to be excluded or dismissively treated (Anthony & Yastik, 2011; Clarke et al., 2012; Hutchinson Vickers, Wilkes, & Jackson, 2010; Smith et al., 2016).

Clarke et al. (2012) conducted a descriptive quantitative study to determine the types, frequencies, and sources of bullying behaviors encountered by nursing students from the United Kingdom (UK) during their clinical experiences. Of the survey respondents ($n = 674$), 88.72% reported experiencing at least one act of bullying. According to the respondent's year of study, 97.1% of fourth-year students ($n = 69$), 94% of third-year students ($n = 141$), 92.4% of second-year students ($n = 231$), and 77.23% of first-year students ($n = 156$) reported experiencing at least one bullying act. The behaviors experienced by these respondents varied between undervaluing their efforts, negative remarks about becoming a nurse, being treated with hostility, being excluded or ignored, and being unjustly criticized (Clarke et al., 2012). Participants identified clinical instructors as the most frequent source for undervaluing efforts, placing pressure to produce work, setting impossible expectations, and unjustly criticizing. Participants also identified staff nurses as expressing negative comments about becoming a nurse, ignoring or excluding them, belittling or undermining student work, or withholding necessary information (Clarke et al., 2012). These results are similar to Abd El Rahman's (2014) descriptive study in which the most frequently reported negative behaviors were negative remarks and undervalued efforts.

Smith et al. (2016) conducted a qualitative study from multiple sites. Eight focus groups occurred across four pre-selected college campuses. One to two researchers led

each focus group with an interview guide to assure the same questions. Respondents

described their personal experiences of bullying while being a nursing student in the

clinical setting. Six themes emerged from the focus groups: being ignored, avoided, or

isolated; witnessing non-verbal behaviors; experiencing negative interactions; being

denied an opportunity to learn; being hazed; and being intimidated (Smith et al., 2016).

Student perceptions. Because of the existence of academic incivility, a review

of the students' perspective may be important. There are several researchers who

explored the students' perspective of incivility (Abd El-Azeem Ibrahim & Qalawa, 2016;

Altmiller, 2012; Clark, 2008c; Clark et al., 2014; Keeling & Templeman, 2013).

Altmiller (2012) conducted an exploratory study to research the students' perception of

incivility. Student recruitment ($n = 24$) was affected from one state and three private

universities, located within a major metropolitan area in the Mid-Atlantic states.

Researchers used a focus group approach to gather the data. With the analysis of the data,

the researchers identified several themes for behaviors that students found to be uncivil:

unprofessional behaviors, poor communication techniques, power gradient between

student and faculty, inequality, loss of control, stressful clinical environments,

authoritative failure, difficult peer behaviors, and students' views of faculty perceptions

(Altmiller, 2012).

Clark et al. (2014) explored the student perceptions of relationships between

stress, coping, and academic civility during a three-year longitudinal mixed method

study. The respondents ($n = 68$) were a cohort of prelicensure nursing students with data

collected in 2010, 2011, and 2012.   Civility levels over the three-year study period

indicated an overall decrease across sophomore, junior, and senior level students with the

Bonferroni post hoc tests showed a significant decrease from sophomore to senior year.

Academic incivility and stress can be circular in nature in that increased incivility

leads to stress and increased stress can potentially increase incivility (Clark, 2008a).

Clark (2008a) explored the student and faculty perceptions of incivility in nursing

education as the *dance* of incivility. Clark utilized a mixed-method design, involving

nursing faculty members ($n = 194$) and students ($n = 306$). The Incivility in Nursing

Education (INE) survey was the instrument for the study. Both groups perceived many

of the student uncivil behaviors in the same way (Clark et al., 2009). For the qualitative

portion of the study, the faculty and student respondents perceived two factors that

contribute to student incivility: stress and an attitude of entitlement (Clark, 2008d). Yet

again, stress can play a role in academic incivility.

Incivility and Health Science Students

The amount of research related to incivility and health science students is

extremely limited. There are some researchers who examined how student experiences

of mistreatment to others trigger distress (which indicates they are aware of the correct

way to act, but feel unable to do so; Neumann et al., 2011). In a cross-sectional online

study, Monrouxe, Rees, Dennis, and Wells (2015) examined professional dilemmas and

subsequent distress from negative workplace behaviors (along with patient dignity and

safety, and consent for student learning). The study included medical ($n = 2397$), nursing

($n = 756$), physical therapy ($n = 201$), pharmacy ($n = 268$), and dental students ($n = 174$)

from the UK. Results indicated that 80.4% of female and 71.5% of male medical

students and 83.3% of female and 47.8% male other health care students indicated being

victims of abuse. A total of 57.2% of female and 47.8% of male medical students and 49.6% of female and 37.8% of male other health care students indicated witnessing the abuse of colleagues. The most common professional dilemmas encountered from this dissertation's results indicated student abuse along with patient dignity and safety concerns (Monrouxe et al., 2015).

In a qualitative study, Hakojarvi, Salminen, and Suhonen (2014) explored the bullying experiences of Finnish health care students ($n = 41$). The target population included second- and third-year students from two Finnish universities of applied sciences who were studying biomedical laboratory science (3 out of 41 or 7%), emergency care nursing (1 out of 41 or 2%), midwifery (10 out of 41 or 24%), physical therapy (none participated), radiography (none participated), nursing (17 out of 41 or 41%), dental hygiene (2 out of 41 or 5%), public health nursing (6 out of 41 or 14%), and occupational therapy (2 out of 41 or 5%). A questionnaire was used to collect the data. The respondents experienced verbal and non-verbal bullying, such as being shouted at, being humiliated in front of staff or patients, no guidance, and social exclusion. The results indicated that bullying occurred during clinical experiences with the perpetrators as health care professionals from several health care occupations (Hakojarvi et al., 2014).

Rosenstein and O'Daniel (2006) suggested that health care professionals are more likely to experience bullying than in other industries due to the demands and pace of the work and emphasis on performance. Johnson and Trad (2014) studied the dynamics of how the bully executed his/her behavior within the radiation department. Radiation therapists completed a survey that focused on bullying prevalence, demographics, workplace environment, and effects on personal health. Results showed that workplace

bullying was present in their either current workplace or previous radiation therapy department ($n = 194$). Participants (71%) answered yes to having been a victim of bullying and 94% indicated they witnessed others bullied within the workplace. The behaviors of bullying displayed were humiliation, abuse of authority, destruction of workplace relationships, verbal shouting, and interference with work (Johnson & Thad, 2014).

Ballard et al. (2015) examined dental students, perceptions of incivility between faculty and students in addition to perceptions in different courses of study and different years of study. A survey was used for the data collection instrument and included classroom and clinical settings. Results showed significant differences in the perceived uncivil behaviors between dental faculty ($n = 103$) and students ($n = 173$) as well as among dental students (dental, dental hygiene, and dental technology). Significant differences in perception of uncivil behavior were found between faculty and students as well as male and female respondents. These results differed from the similar survey conducted by Rowland and Srisukho (Ballard et al., 2015).

Rowland and Srisukho (2009) also compared dental student and faculty members' perceptions of classroom incivility. They used a survey tool as well, but it was distributed through paper-pencil and Web-based means. Their results showed that among the faculty respondents ($n = 68$), there were no statistically significant differences among response according to gender. Student respondents ($n = 127$) did show statistically significant differences in perceptions of uncivil behaviors between males and females (Rowland & Srisukho, 2009). According to Ballard et al. (2015), the differences between the two studies may be due to the smaller percentage of female faculty respondents in

their study (female respondents 30% and male respondents 70%) as compared with the Rowland and Srisukho study (female respondents 41% and male respondents 59%).

Gaps in the Literature

There is some growth in the overall literature related to incivility within academia. However, there continues to be insufficient research about the various health science (or allied health) student body and their experiences with incivility. The prevalence of the issue continues to elude us. The focus of further research needs to be on the experiences of these students along with the level and frequency of uncivil behaviors. In addition, the mechanism for perpetuation should be explored as well. Are students learning or modeling these uncivil behaviors from exposures while in school? Does nursing have the most prevalent occurrences with incivility, or is it just more prevalent in high stress areas? Does nursing as a discipline have a greater propensity toward incivility as compared with other health care providers? If so, why and how do we influence nursing education to prevent further instances? This investigator examined the experiences and determined the level and frequency of student and faculty incivility as perceived by nursing and health science students. This dissertation was able to add to the body of literature in an area not covered by others. This newfound body of knowledge certainly has contributed to the education of nursing and health science students. The information could be used to address how these students are taught and help faculty lessen the stressors experienced during clinical education.

The development of effective teamwork and interprofessional collaboration is a contributor to a safe and productive workplace and professional growth as well as essential for positive patient outcomes rendered by any health care provider.

Chapter Summary

In this chapter, the current literature was reviewed as related to incivility within academia and specifically nursing and other health science professionals. Incivility in various settings, such as the workplace, higher education, and nursing specifically was explored. In a small segment of this chapter, the investigator delved into the heath science literature as it related to student experiences with incivility but found little in that area, and it certainly warrants further study. Much of the literature was used to describe the behaviors in detail along with the effects on its victim.

In the workplace incivility literature, there was substantial information found as antecedents and consequences to incivility were reviewed. Researchers used higher education resources for an adequate analysis of the academic culture, hierarchal structure, and prevalence. There was extensive nursing literature for the existence of incivility, prevalence, and its influence on victims and patient care. Nursing education continues to grow as a significant resource for information concerning students, their perceptions, and clinical experiences. Nursing faculty incivility was also explored, but this investigator did not review that subset because the concentration of this dissertation was on students. There was substantial evidence in the nursing literature as to the effect of incivility on nursing as a profession as well as nursing education.

The lack of HS student resources that were related to incivility is noteworthy. There is a severe dearth of literature related to other professions' incivility experiences. There was not a clear differentiation among other disciplines or health care providers associated with prevalence or extent of incivility in the literature. The investigator sought the evidence on the level and prevalence of incivility among nursing and other health

science disciplines. In addition, perhaps this dissertation could be used to explore the possibility of incivility being more prevalent in nursing as compared with other health care providers.

Chapter Three

Methods

The purpose of this dissertation was to explore the level and frequency of student and faculty incivility as perceived by nursing and health science students. A quantitative approach was used for the dissertation in which the following information was sought: the level of student and faculty incivility as perceived by nursing and health science students over the last 12 months and comparison of the frequency of student and faculty incivility perceived by nursing and HS students. The quantitative methodology was used to provide numerical data to aid in the assessment of the magnitude of incivility among the selected population.

Research Design

The investigator employed a quantitative non-experimental approach to describe and document the level of student and faculty uncivil acts as perceived by nursing and HS students. In addition, the investigator compared the levels and frequencies of student and faculty incivility as perceived by nursing and HS students. Because this research topic involves human experiences and emotions, a nonexperimental approach is useful as the variables cannot ethically be manipulated (Polit & Beck, 2012). This dissertation used a cross-sectional, single point data collection design.

The Incivility in Higher Education-Revised survey (Clark, 2007; Clark, Barbosa-Leiker, Money-Gill, & Nguyen, 2015) was used to measure the frequency of student and faculty incivility witnessed or experienced. By using a survey, the level, frequency,

characteristics, attitudes, and behaviors of the selected population were allowed to be generalized (Creswell, 2014). The survey approach is a convenient method for data collection due to the rapid turnover of the data collection and a cost-effective method overall. Surveys are used for the collection of a large amount of data over a larger population. In addition, the survey approach was used to test the proposed theory in relation to the cognitive, environmental, and behavioral concepts. This approach has statistical procedures to assess the results (Creswell, 2014). Surveys have better objectivity with little to none observer subjectivity (Polit & Beck, 2012). This investigator preferred the survey method for all the advantages stated.

One usual concern of the survey method is the inflexible design, especially after data collection has begun. For this dissertation, it is not a concern because the single point data collection was used. Neither questions nor the methods of administration were changed after commencement of the survey. At times, the survey method is not ideal for controversial issues as there may be inappropriateness of the questions. According to Polit and Beck (2012), the validity may be in question due to the standardized question and inability to further explain or question. Surveys can also limit to the respondents' willingness to self-disclose on the topic itself. For this particular study, the survey was the preferable method due to the advantages indicated above.

Research Assumptions

Research assumptions are truths based on logic and/or custom and without proof (Polit & Beck, 2012). For this dissertation, this investigator assumed the following:

- The respondents were able to read and understand the nature of the questions.

- The respondents answered truthfully about their incivility experiences.

- The survey instrument addressed the population of interest, measured the stated questions, and had data pertinent to the study.

- The survey instrument had a sample of uncivil behaviors experienced by students within higher education.

- Incivility was perceived by each of the respondents to be as unwarranted and stressful.

Setting

The setting involved one college within the northeastern region of the United States. This particular college is a public institution whose emphasis is on applied technology education that offers over 100 different career educational programs. The college is renowned for its hands-on technology education with state-of-the-art laboratory facilities. Credentials offered by the college include numerous baccalaureate and associate degrees along with certificates, minors, and other non-degree options. College enrollment is approximately 5,500 to 6,500 students annually.

The college divides its educational programs among six academic schools. The School of Health Sciences has various health careers. These career choices include applied health studies, dental hygiene (DH), emergency medical services (EMS), exercise science specialist (EXS), health information technology (HIT), nursing, occupational therapy (OTA), physician assistant (PA), physical therapy assistant (PTA), radiography (RAD), and surgical technology (ST). The School of Health Sciences specifically has a student population of 1,541 students with nursing being the largest program with 406 students (Pennsylvania College of Technology, 2016).

The nursing program itself has a variety of educational options for the students: associate degrees for the practical nursing (PN) and/or registered nursing (RN) majors, traditional BSN, RN completion pathway to the BSN, and PN to RN advanced placement major. All nursing majors are state-board approved and accredited by the Accrediting Commission for Education in Nursing (ACEN). The other HS majors possess accreditation from their specific accrediting agencies as well. The college offers associate and bachelor's degree options for each of these majors.

Selection of this college for the study was deliberate for a variety of reasons. First, the college had the various nursing and HS majors needed for study. Second, the student population was substantial enough to attain the desired sample size needed. Third, the same institution offered consistency for the participants regarding the academic environment, philosophy of the institution, and faculty training for incivility. Fourth, this investigator had direct access to the faculty and administrators in HS, which permitted the investigator to discuss the benefits of the study without any undue coercion on the students. Having this investigator explain the study may have indirectly provided a better response rate. Finally, this investigator had access to the institutions resources, such as email and research staff if needed.

Sampling Plan

The target population for this dissertation was nursing and health science students. The sampling plan included one academic institution from a region in the northeastern United States that offered nursing and health science majors at the baccalaureate and associate degree level.

The health science majors considered for this dissertation included the following:

- Dental hygiene.

- Exercise science specialist.

- Emergency medical services (paramedic).

- Occupational therapy assistant.

- Physician assistant.

- Physical therapy assistant.

- Radiography technologist.

- Surgical technologist.

The sampling design for this population was single stage as this investigator contacted the administrators from the various majors to seek their approval for student participation. The dean and administrators were the initial contact after receiving institutional review board (IRB) approval.

Sampling Strategy

A non-probability sampling strategy was used for this dissertation because this method provided samples based on the judgment of the investigator and not did not involve random selection. For this dissertation, a very specific sample was required to assess the perceptions of incivility among nursing and HS majors, and a probability sampling was not feasible or practical based on the desired population. Nursing and other disciplines use non-probability sampling frequently because it is not always feasible, economical, timely, or ethical (Polit & Beck, 2012; Talbot, 1995; Trochim & Donnelly, 2008). In practice, it is difficult to obtain a true random sample; therefore, the non-probability sampling approach is used (Portney & Watkins, 2009).

A convenience sampling method was employed for this survey. Convenience samples are affordable, easy, and readily available (Etikan, Musa, & Alkassim, 2016). The desired population for this dissertation was accessible to this investigator with the assumption the target population was homogeneous. Participation was strictly voluntary.

Eligibility Criteria

Individuals eligible to be participants for this dissertation were of any age, ethnic/racial background, sexual orientation, and had the ability to speak English.

Inclusion criteria.

- Must be a student in either in nursing or specified HS majors (DH, EMS, OTA, PA, PTA, RAD, or ST).

- Must have participated in at least one clinical experience.

- Current enrollment as a student in the college selected for this dissertation.

- Associate and baccalaureate program enrollment.

- Must be an on-campus, face-to-face student.

Exclusion criteria.

- Enrolled in a certificate program.

- Students enrolled in totally online programs.

Determination of Sample Size

Power analysis. G* power3 test was run to determine the sample size, indicating 210. Each group (nursing and HS) was at least 105 participants. A medium effect size, along with α error probability of 0.05 was selected for this dissertation. A medium effect size was selected because nursing studies tend to have modest effects, and the variables tend to correlate modestly (Polit & Beck, 2012). The alpha level reflects the Type I error

rate, which is the probability of rejecting the null hypothesis when it is actually true. A common practice is to set it at the 0.05 level (Warner, 2013). See Appendix C for details.

Protection of Human Subjects

Approval from Nova Southeastern University's IRB approval was sought and obtained prior to the implementation of the study. In addition, IRB approval from the study institution was sought prior to execution. This investigator acquired written permission for the Dean of Health Sciences (see Appendix D). A letter of introduction was given to the Dean of Health Sciences (see Appendix E) and respective directors of the HS majors (see Appendix F). The letter included the name of the investigator, the purpose of the study, and confidentiality measures. An investigator handling the survey assured the data results to remain anonymous and confidential. Data were reported as aggregate data pertaining to nursing versus HS students.

Risks and benefits of participation. Risks can potentially involve physical, psychological, social, and economic factors. For this dissertation, the possible risks for participation were minimal. Minimal risk indicates that are no greater risks than those ordinarily encountered in daily life (Polit & Beck, 2012). There was the possibility of psychological or emotional distress because the respondent introspectively may have recalled any incidences of incivility. Respondents might have felt personal discomfort as prior experiences could elicit feelings of stress, pain, anxiety, or embarrassment. Another risk could be the loss of time, approximately 15 to 20 minutes for completion of this survey.

Potential benefits for respondents included a sense of comfort by being able to convey any prior incidents of incivility and the realization of its existence. In addition,

respondents may have felt satisfaction as the information provides his/her perceptions of incivility experiences, which contributed to help others.

Data integrity. Various database preparations were used to assure data integrity. According to Trochim and Donnelly (2008), data integrity involves the proper logging of the data into the computer, the checking of the data for accuracy, transforming the data for any missing values or item reversals, and developing/documenting in a codebook that described the data and indicated where and how it can be accessed. All data for this dissertation was hand entered into the Statistical Package for the Social Science (SPSS) software by this investigator. All original data (such as completed surveys and researcher notes) will be retained in the investigator's home office for 3 years similar to the computer files under locked conditions.

To assure accuracy of the recorded data, they were double checked by using a 25% random recheck of all the entered data. Data were authenticated by error checking and validation routines established by the investigator. Initial data screening included the legibility of the respondents' survey and checking for completion of all questions and relevant information, such as date and time. All steps taken when recording the data were documented and omissions or holes in the data were indicated with a code of 99 for quantitative items and 66 for qualitative items. The investigator wanted to quickly distinguish the quantitative versus qualitative items that were omitted.

Data storage. All data were stored separately from any identifiers used in the study. Hard copies of the data remain in a locked file cabinet within this investigator's home for 3 years, after which time, they will be shredded. Any computer-based data were password protected within the investigator's home. In addition, data were backed-

up to an alternate location (external hard-drive click-free). The external hard drive was stored in the investigators' home office.   Computer files and any computer storage, such as thumb drives, will be destroyed at the same time as the hard-copy data files. The investigator has the sole access and is the keeper of the data.

Recruitment

This investigator recruited nursing and HS students to participate in this dissertation. The methods used included communication with each program director or department head seeking permission to enter classes to discuss the study. Guidance from the directors/department heads was sought for the best classes for involvement to assure participants meet the eligibility criteria. After consultation with the program administrators, a Participant Letter for Anonymous Surveys was distributed to introduce the survey and its goals to potential participants (see Appendix G for letter). All students were encouraged to participate.

This investigator attended each designated classroom in person and discussed the survey, the reasons for such, and any potential risks and benefits for participation. The investigator reinforced that participation was confidential, strictly voluntary, all present had the right to refuse to participate, non-participants were not penalized in any manner, not to include any personal identifiers on survey sheet, and submission of completed survey implied consent to participate. After the mini presentation for nursing students, this investigator left the room and had a survey administrator (SA; a colleague faculty member who does not teach in nursing) distribute the survey and reinforced as needed any of the information the investigator previously stated. The Participant Letter for Anonymous Surveys was used to waive the usual documentation of informed consent as

consent to participate was presumed by the returned survey. The survey administrator collected the surveys and placed them into a sealed manila envelope, labeled with the specific class only, and placed into the designated secure box within the investigator's office. Unused surveys were returned directly to the investigator in a secure manila envelope. The procedure for health science students were similar to nursing students, except this investigator distributed and collected the surveys directly. There was no need for the SA with health science students as this investigator had no authority over this population.

<div align="center">**Instrumentation**</div>

Name of Instrument

The instrument chosen for this dissertation was the Incivility in Higher Education-Revised as developed by Clark (2007). The original instrument began as the Incivility in Nursing Education (INE) survey and later revised to INE-R in 2015 (Boise State University, 2017; Wagner, 2014). The IHE-R is the same instrument as the INE-R, with the survey reflecting higher education in general instead of being nursing-specific (Wagner, 2014). The IHE-R measures the differences in perceptions of academic incivility among the various disciplines within higher education.

This investigator sought nursing and HS student perceptions of the level of student and faculty incivility for the behaviors listed. In addition, the investigator sought input regarding the frequency of student and faculty uncivil behaviors either experienced or witnessed within the last 12 months, who (student or faculty member) is more likely to engage in uncivil behaviors, and suggestions for strategies to improve the level of civility within higher education.

The IHE-R survey consisted of three sections. It started with clarifying definitions of the terms incivility and academic environment as described by Clark. Section I contained demographic informational items. With the demographic area, the investigator was able to customize the items needed to fit the specific institution and study parameters (Clark, 2007). Section II was divided into two subsections. The first subsection included 24 quantitative items related to student behaviors that the respondent may have experienced or witnessed in the academic environment. Respondents needed to rate the level of incivility for each behavior. In addition, each respondent rated the frequency of each behavior over the past 12 months. The second subsection included 24 quantitative items but related to faculty behaviors experienced or witnessed by nursing or HS students in the academic area. Student survey respondents needed to rate the level of incivility for each faculty behavior and express the frequency of each behavior over the past 12 months. Student and faculty behaviors were unique from each other. Respondents also needed to consider the extent of incivility within their program. Based on experiences or perceptions, respondents also needed to select who was more likely to engage in uncivil behaviors within their program.

Section III of the survey was used to solicit answers to four qualitative questions. Within this section, the respondent provided an example of an uncivil encounter in higher education within the past 12 months. Other open-ended questions were used to solicit the respondents' opinion on the cause for the behaviors, the most significant consequence of the incivility, and the most effective method to promote academic civility. Section III was qualitative in nature and was not evaluated within the realm of this dissertation. The

licensing agreement granted use of the IHE-R survey by Dr. C. Clark in January 2017. A copy of the licensing agreement is located in Appendix H.

The demographic section included gender, current age, ethnic/racial background, length of time at the designated college, length of time in his/her major of choice, current academic major, and the degree the student was seeking. Demographic data from the nursing and HS students were used to describe the sample.

Validity. Content validity involves the degree to which the instrument measures the constructs being investigated (Polit & Beck, 2012). To establish construct validity for this instrument, the investigator performed exploratory factor analysis. INE-R/IHE-R was pilot tested and resulted in favorable ease of administration and completion, content validity, readability, and logical flow.

Face validity was addressed through expert review of the tool and constructs. Content validity signifies that the instrument is measuring the intended construct, which in this case was incivility. A panel of experts comprised of six nursing and non-nursing professors, 10 nursing students, and one statistician reviewed and found the items highly reflective of academic incivility (Clark et al., 2009). This instrument was specifically designed for student and faculty input regarding incivility within higher education.

To assure rigor and validity for this dissertation, a homogenous sample was needed, which controlled for any confounding variables. For this dissertation, only nursing and those designated HS students enrolled in the identified college were addressed. In addition, the appropriate sample size was calculated through G*power 3, a computer-based program.

Reliability. Reliability is the degree of consistency or dependability with which

an instrument measures the desired concept (Polit & Beck, 2012).   An instrument can be

internally consistent to the extent that its items measure the same trait. Inter-item

reliability coefficients were calculated for each of the factors identified during the

exploratory factor analysis. Cronbach's alpha is a widely used method for evaluating

internal consistency that assesses the degree to which responses are consistent across a

set of multiple measures of the same construct (Warner, 2013). For the IHE-R (also

known as the INE-R), the Cronbach alpha coefficients were used. The reliability

coefficient analysis indicated adequate levels of reliability (Clark et al., 2009). The

normal range of values is between 0.00 and +1.00 and higher values reflect higher

internal consistency. According to Polit and Beck (2012), reliability coefficients above

0.80 are desirable. The Cronbach's alpha measurement on the INE yielded a score

ranging from 0.808 to 0.889 for student behavior, indicating good inter-item reliability.

The faculty behavior Cronbach alpha coefficient score ranged from 0.918 to 0.955,

indicating very good inter-item reliability (Clark et al., 2009). After revision of the

original instrument, the revised tool (INE-R) showed a Cronbach's alpha of greater than

or equal to 0.96 for student behaviors and greater than or equal to 0.98 for faculty

behaviors (Clark et al., 2014). In addition, Cronbach's alpha was estimated for each

factor and total score. *P* values (two-tailed) of less than or equal to .05 were used to

indicate significance of factor loadings and factor correlations, using SPSS software for

reliability analysis (Clark et al., 2014).

Scoring. The demographic data were used to compare student groups to

determine the role of demographic factors on the perceptions of incivility among HS and

nursing students.   The level of measurement for these data is nominal as these data were used for labeling and identification purposes.

There are 24 student and 24 faculty behaviors listed among the quantitative items. These behaviors were rated for both the level of incivility and the frequency. The responses were scored according to a four-point Likert Scale for every item and ranged from 1 (*not uncivil*) to 4 (*highly uncivil*). The same behavioral statements were used to measure the frequency in which students experienced faculty uncivil behaviors within the past 12 months, using a similar Likert Scale of 1 to 4 (with 1 being *never* and 4 being *often*). There were several items at the end of the instrument, which included different scales and open-ended questions.

 Analysis of the data indicated if there were any differences between two groups (nursing and HS students) as it related to level and frequency of student and faculty incivility. The level of measurement that it produced is ordinal, meaning that the order of the number is the most important rather than the actual number assigned. The four qualitative fill-in-the-blank items were not scored or analyzed within this dissertation. No considerations were given to the written responses from the various respondents as this survey was seeking quantitative data only with no specific names to be identified. Instructions were provided prior to the distribution of the survey to all potential participants. This instrument was evaluated using a mixed methodology, but this dissertation was purely quantitative in nature.

General Statistical Strategy

The overall objective was to evaluate student perceptions of incivility. Strategies to compare the two independent groups (nursing and HS students) were used. The

comparison of the mean scores indicated if the groups (nursing and HS students) were statistically different. All responses to the survey were entered and analyzed using SPSS software version 24 for Windows.

Data Cleaning

The data was cleaned and screened for errors, specifically accuracy, missing data, normality, and outliers. Frequencies for each variable were assessed. Checks were completed through the SPSS program. For categorical variables (i.e., gender, education level), the minimum and maximum values were reviewed to assure the numbers were within the appropriate range (Pallant, 2016). For continuous variables (i.e., age), minimum and maximum values again were reviewed in addition to the mean and standard deviation. When/if any error was found, the data were corrected. After correction of the errors, a rerun of the program for the frequencies occurred to help double check the data (Pallant, 2016). All errors and changes to the data file were documented into a logbook as indicated earlier to assure integrity.

Missing data were detected by a visual review and by running the SPSS descriptives. If missing data were found, a thorough review was used to determine if it were random or a pattern. Exclude cases pairwise option within SPSS was be implemented for any missing data.

Outliers are values that are well above or well below the other scores (Pallant, 2016). Outliers can potentially remain, be omitted or modified within the data set, depending on the results and sample size (Warner, 2013). The results were reported with and without the outlier to judge the influence of the outlier itself. If the outlier significantly changed the results, transformation of the outlier became the option.

Descriptives

Descriptive statistics were used for summarized data for the demographics for this dissertation (Warner, 2013). These statistics included the mean, frequencies, standard deviation, skewness, and kurtosis. Additional techniques, such as frequency histograms and box plot, had graphic distribution information for analysis. Being that the sample was one of convenience, the nature of the sample limited the generalizability of the results (Warner, 2013).

Reliability Testing

The Cronbach's alpha score was assessed after the data on both the student and faculty behaviors were entered into the SPSS software. Acceptable results were zero to one (Pallant, 2016). If the Cronbach alpha fell below 0.7, items within the instrument were not measuring the same constructs. A Pearson's correlation coefficient was calculated to measure the strength of the items. The correlation coefficient can range from -1 to 1 (Pallant, 2016). If an item is determined to be poorly correlated (items less than 0.3), removal of that item may be necessary. After removal of that item, calculation of another Cronbach's alpha coefficient is prudent.

Hypothesis Testing

The next section describes the specific statistical tests with rationale for testing each hypothesis.

Research Question and Hypothesis

Research Question 1. Is there a difference in nursing and health science students' self-reported levels for student incivility behaviors over the past 12 months?

Research Hypothesis 1. There is no difference in the self-reported levels of nursing and health science students for student incivility behaviors over the past 12 months.

The investigator applied the two-sample independent *t*-test for this question. The independent *t*-test had statistical information needed for analyzing the differences between two means of two different groups of people (Pallant, 2016). For this dissertation, the two groups studied were nursing and HS students.

The *t*-test was ideal because it was used to compare the mean scores of two different groups of respondents. The goal of this dissertation was to determine whether there was a statistical significance in the perceptions of levels and frequencies of student incivility, according to nursing and HS students. The dependent variables were measured at interval levels, using a continuous scale. Although Likert scales are ordinal, Clark et al. (2014) considered them interval because this instrument was based on the Continuum of Incivility (see Figure 1), and pilot testing found that the response categories were able to cover the continuum of responses; therefore, the Clark et al. chose to view the scale as interval. To follow the authors lead, this investigator also considered the responses as interval for purposes of this instrument and study. In addition, each measurement was independent of others and not influenced by other measurements. Homogeneity of the population was evaluated by the Levine test to determine the *F* ratio (Warner, 2013).

Research Question 2. Is there a difference in the self-reported frequency rate of student incivility experienced or witnessed by nursing and HS students over the past 12 months?

Research Hypothesis 2. There is no difference in the self-reported frequency rate among nursing and HS students who experienced or witnessed incidents of student incivility over the past 12 months. A *t*-test was used to test this hypothesis.

Research Question 3. Is there a difference in nursing and HS students self-reported levels for faculty incivility behaviors over the past 12 months?

Research Hypothesis 3. There is no difference in nursing and health science student's self-reported levels for faculty incivility behaviors over the past 12 months. The statistical test used was the independent *t*-test.

Research Question 4. Is there a difference in the self-reported frequency rate of faculty incivility experienced or witnessed by nursing and HS students over the past 12 months?

Research Hypothesis 4. There are no differences in the self-reported frequency rate for faculty uncivil behaviors experienced or witnessed by nursing and HS students within the past 12 months. A *t*-test was used to test Hypothesis 4.

Limitations

There were several limitations noted for this dissertation. Self-reporting relied on honesty and the ability to process the events, so this limitation may have affected the responses. In addition, rating scales on this survey may have left room for personal interpretation. Furthermore, the respondents' personal circumstances for the day of the survey may have affected the responses as well. Other limitations included the geographic location as it was limited to the northeastern United States and that only one institution was selected for the study. The sample population, limited to nursing and HS students only, may have restricted any generalization of the findings to other populations.

Threats to Internal Validity

Threats to the internal validity pose problems for the researcher to make conclusions (Creswell, 2014). Selection may threaten internal validity as the participants for this dissertation were limited to nursing or HS students, were voluntary, and self-reported the responses.

Threats to External Validity

Threats to the external validity of this dissertation included the interaction of setting and treatment. Because the setting was limited to one area and one institution, generalizability was restricted. The culture of the specified area or the institution itself may have contributed to any confounding variables. Researchers cannot generalize to individuals in other settings (Creswell, 2014).

<div align="center">

Chapter Summary

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Chapter 3 introduced the methodology and approach for which the investigator followed. This investigator used a quantitative approach to seek the level and frequency of student and faculty incivility occurrences as perceived by nursing and health science students over the last 12 months. In addition, a comparison of the level and frequency of student and faculty uncivil behaviors as perceived by nursing and HS students was used.

The Incivility in Higher Education-Revised survey by Clark (2007; Clark et al., 2015) was the instrument of choice. By using this survey, this investigator examined the frequency, characteristics, and attitudes of nursing and HS students related to uncivil behaviors. In addition, the investigator sought input regarding the extent of incivility within the programs, who (student or faculty member) was more likely to engage in

uncivil behaviors, and suggestions for strategies to improve the level of civility within higher education.

The setting was in the northeastern region of the United States at a specific college. A convenience sampling occurred with a sought-out sample size of 210 (105 for each independent variable). The population of interest was limited to students from nursing, dental hygiene, exercise science specialist, emergency medical services (paramedic), occupational therapy assistant, physician assistant, physical therapy assistant, radiography technologist, and surgical technologist.

The data was cleaned/screened for errors accuracy, and normality.   Statistical tests used included descriptive statistics, such as mean, frequency, standard deviation, skewness, kurtosis, histogram, box plot, the independent t-test, and Cronbach's alpha. This numerical data was used in the assessment of the magnitude of incivility among the selected population.

Chapter Four

Results

The purpose of this dissertation was to explore incivility among nursing and health science students within an academic environment. Student perceptions of the frequency and intensity of uncivil occurrences over the last 12 months were measured and compared for nursing and health science student responses. The focus of this dissertation was on nursing and HS students who had a minimum of one clinical experience within their major of choice and were enrolled at the associate or baccalaureate degree level in the selected college.

Data collection began immediately after IRB approval from Nova Southeastern University and the designated college. A quantitative, non-experimental approach was employed for this dissertation, using a non-probability sampling strategy as well as a convenience sampling methodology. Permissions from the school dean and program directors were obtained prior to data collection. This investigator visited each classroom requesting student participation in the survey. A brief overview of the study, benefits, possible consequences, and a participation letter were reported to each class prior to distribution of the instrument. Any nursing class approached included the assistance from a survey administrator to minimize any possible impression of coercion because this investigator works in the department. The survey administrator distributed and collected the instruments after this investigator introduced the study and exited the room.

One program was eliminated from the study due to failure to meet inclusion criteria. When seeking permission to attend an exercise science classroom, it was discovered that the students had not participated in any clinical experiences at that point within their program. Because participation in a clinical experience was part of the criteria, this group of exercise science majors were not eligible to participate and, therefore, excluded from this dissertation.

Data Cleaning

The data were manually entered and coded into the SPSS version 24 program for Windows. The data were then visually and programmatically screened for accuracy, validity, completeness, and cleaned for errors. Due to the large sample size, a 25% verification of all data by visual and manual means ensued. The SPSS program was also used to check for errors with each test completed. All calculated sums were manually and computer run, resulting in no errors noted.

Significant errors were noted during the Cronbach alpha calculations of the student level variables due to using "99" as the code for any unanswered responses. All entries of 99 were changed to the code of minus one (-1) to fulfill the entry. The overall amount of completed surveys numbered 370 with 15 surveys missing significant student/faculty frequencies level responses as they appeared blank. In addition, there were seven other surveys with an occasional missed entry. All data were analyzed, using the exclude case pairwise option. This method was used for the cases to be included for the analysis for which the data were available.

One significant outlier was noted within the civility level variable. One respondent entered -43, creating an outlier, and thereby skewing the results. This entry was changed to zero to fit more in line with other responses.

Descriptives

Description of the Sample

Three hundred ninety-seven students were approached to participate in this dissertation by completing the IHE-R survey, using paper-and-pen method. The total number of surveys returned were 385, yielding a response rate of 97%. The return of the surveys was as follows: 233 nursing students and 152 health science students. Students were approached at the end of their respective classes with some students declining to participate in the survey due to an expressed lack of time or overall interest in the study.

Demographic data for the study sample is available in Table 1 and includes the variables of gender, age, race, semesters in program, academic program, and degree sought. Most of the respondents were female (83.4%) with 16.4% male respondents. The participant ages ranged from 67% in the 18- to 25-year-old category, 15.1% in the 26- to 30-year-old category, 10.1% in the 31- to 35-year-old category, 4.9 % in the 36-to 40-year old category, and 2.9% in the 41 and over year-old category. The majority of respondents were identified as Caucasian at 88.8% with a parallel distribution between the other ethnicities, ranging between 0.8% to 3.4%. This ethnic variable remains consistent with the relative lack of diversity within the student body and faculty at the college itself. Most respondents were at the sophomore level (48.1%) with an equitable distribution among the other semesters of the programs (ranging from 15.1% to 21.5%). The academic programs consisted primarily of nursing students at 60.5% and other health

science students at 39.5%. Baccalaureate degree seeking students at 54% compared

similarly to the associate degree seeking students at 45.2%. Table 2 presents an in-depth

analysis of responding nursing students with Table 3 having a description of health

science student respondents as well the itemization of specific health science programs.

Table 1

Demographic Characteristics of the Sample

Variable	Category	*n*	%
Gender	Male	63	16.4
	Female	321	83.4
Age	18-25	258	67
	26-30	58	15.1
	31-35	39	10.1
	36-40	19	4.9
	41-over	9	2.9
Race	Black or African-American	9	2.3
	Asian	5	1.3
	Caucasian (White)	342	88.8
	Hispanic (not-Latino)	3	.8
	Latino	13	3.4
	Others	13	3.4
Semesters in program	1-2 semesters	58	15.1
	3-4 semesters	185	48.1
	5-6 semesters	59	15.3
	7-12 semesters	83	21.5
Academic program	Nursing	233	60.5
	Health Science	152	39.5
Degree sought	Associate	174	45.2
	Baccalaureate	208	54.0
	Other	3	.8

Note: n = 385

Table 2

Demographic Characteristics of Nursing Student Sample

Variable	Category	*n*	%
Gender	Male	35	15.02
	Female	197	84.55
Age	18-25	141	60.52
	26-30	40	17.17
	31-35	34	14.6
	36-40	11	4.72
	41-45	3	1.29
	46-50	2	.86
	51-55	2	.86
Race	Black or African-American	7	3.04
	Asian	2	.87
	Caucasian (White)	207	90
	Hispanic (not-Latino)	3	1.30
	Latino	8	3.47
	Others	4	1.74
Semesters in program	1-2 semesters	52	22.32
	3-4 semesters	76	32.62
	5-6 semesters	33	14.16
	7-8 semesters	60	25.75
	9-10 semesters	9	3.86
	11-12 semesters	3	1.29
Degree sought	Associate	111	47.64
	Baccalaureate	121	51.93
	Other	1	.43

Note: n = 233

Table 3

Demographic Characteristics of Health Science Students Sample

Variable	Category	*n*	%
<u>Gender</u>	Male	28	18.42
	Female	124	81.58
<u>Age</u>	18-25	117	78
	26-30	18	12
	31-35	5	3.33
	36-40	8	5.33
	41-45	1	.67
	46-50	1	.67
	51-55	0	0
<u>Race</u>	Black or African-American	2	1.33
	Asian	3	2
	Caucasian (White)	135	90
	Hispanic (not-Latino)	0	0
	Latino	5	3.33
	Others	5	3.33
<u>Semesters in program</u>	1-2 semesters	6	3.95
	3-4 semesters	109	71.71
	5-6 semesters	26	17.11
	7-8 semesters	7	4.61
	9-10 semesters	4	2.63
	11-12 semesters	0	0

Variable	Category	*n*	%
<u>Academic program</u>	Dental hygiene	35	23.0
	Occupational therapy assistant	28	18.4
	Paramedic	14	9.2
	Physical therapy assistant	15	9.8
	Physician assistant	28	18.4
	Radiology technology	20	13.1
	Surgical technology	12	7.9
Degree Sought	Associate	63	41.45
	Baccalaureate	87	57.24
	Other	2	1.32

Note: n = 152

Responses to the Measurements

Additional data specifically related to this dissertation indicated how the groups (student or faculty) responded to the survey. Nursing student respondents indicated that 14 of the 23 listed behaviors were *highly uncivil*. Those behaviors were as follows: (a) making rude gestures or nonverbal behaviors toward others; (b) sleeping or not paying attention in class; (c) being distant and cold toward others; (d) holding side conversations that distract you or others; (e) cheating on exams or quizzes; (f) making condescending or rude remarks toward others; (g) demanding makeup exams, extensions, or other special favors; (h) ignoring, failing to address or encouraging disruptive behaviors; (i) demanding a passing grade when a passing grade has not been earned; (j) making discriminating comments toward others; (k) using profanity directed toward others; (l) threats of physical harm against others; (m) property damage; and (n) making threatening statements about weapons.

Health science student respondents indicated that 12 out of the 23 listed behaviors were *highly uncivil*. Those behaviors were as follows: (a) being distant and cold toward others; (b) creating tension by dominating class discussion; (c) cheating on exams or quizzes; (d) holding side conversations that distract you or others; (e) making condescending or rude remarks toward others; (f) ignoring, failing to address, or encouraging disruptive behaviors by classmates; (g) demanding a passing grade when a passing grade has not been earned; (h) making discriminating comments directed toward others; (i) using profanity directed toward others; (j) threats of physical harm against others; (k) property damage; and (l) making threatening statements about weapons. Table 4 illustrates and has a comparison of the highly uncivil behaviors identified by nursing and health science respondents in a table format for ease of readability and to note any of the similarities and differences. All of the nursing student respondent behaviors are the same as the health science respondents with three additional behaviors.

Table 4

Comparison of Level of Student Highly Uncivil Behaviors

Behaviors	Nursing Students	Health Science Students
Making rude gestures or nonverbal behaviors toward others (eye-rolling, finger pointing, etc.)	X	
Sleeping or not paying attention in class	X	
Being distant and cold toward others	X	X
Holding side bar conversations	X	X
Cheating on exams or quizzes	X	X
Making condescending remarks	X	X
Demanding make-up exams, extensions, or other special favors	X	
Ignoring disruptive behaviors by classmates	X	X
Demanding a passing grade when a passing grade is not earned	X	X
Making discriminating comments	X	X
Using profanity directed toward others	X	X
Making physical threats against others	X	X
Property damage	X	X
Making threatening statements about weapons	X	X

Additional data results indicated the nursing student respondent's perceptions of student behavioral frequency. Nursing student respondents indicated that none of the behaviors were perceived as *often*. Nursing students did acknowledge that three of the 23 listed behaviors were *sometimes* exhibited. Those behaviors were as follows: (a) expressing disinterest, boredom, or apathy about course content or subject matter; (b)

using a computer, phone, or other media devices during class, meetings, or activities for

unrelated purposes; and (c) holding side conversations that distract you or others.

Health science student respondents indicated that one out of the 23 listed

behaviors were *often* exhibited (i.e., using a computer, phone, or other media devices

during class, meetings, or activities for unrelated purposes). In addition, health science

respondents indicated that four out of the 23 behaviors were *sometimes* exhibited. Those

behaviors listed were as follows: (a) expressing disinterest, boredom, or apathy about

course content or subject matter, (b) making rude gestures or nonverbal behaviors toward

others, (c) sleeping or not paying attention in class, and (d) holding side conversations

that distract you or others. Table 5 presents this comparison in table format for ease of

readability.

Table 5
Comparison of Frequencies of Student Uncivil Behaviors

Behaviors	Nursing Students	Health Science Students
Expressing disinterest, boredom, or apathy about course content or subject matter	S	S
Making rude gestures or nonverbal behaviors toward others (eye-rolling, finger pointing, etc.)		S
Sleeping or not paying attention in class		S
Holding side bar conversations	S	S
Using computer, phone, or other media devices during class, meetings, activities for unrelated purposes	S	O

Note: S = Sometimes. O = Often.

Further study findings indicated that nursing student respondent's perceptions of

faculty behavioral levels indicated that 23 of the 24 listed behaviors were *highly uncivil*.

All survey behaviors were noted to be *highly uncivil*, except for ineffective or inefficient

teaching methods, which was rated as *somewhat uncivil*. Health science student

respondents indicated that 22 out of the 24 listed behaviors were *highly uncivil*.

Similarly, all survey behaviors were noted to be highly uncivil, except for two behaviors,

which were rated as moderately uncivil by health science respondents (i.e., expressing

disinterest, boredom, apathy about course content or subject matter, and ineffective or

inefficient teaching methods).

Interestingly, both respondent student groups agreed that faculty behaviors ranked

highly uncivil, whereas similar student behaviors were quantifiably lower with numbers

of 14 out of 23 and 12 out of 23 behaviors. Table 6 presents the comparison of nursing

and health science respondent's perception of faculty uncivil behaviors.

Table 6
Comparison of Levels of Faculty Uncivil Behaviors

Behaviors	Nursing Students	Health Science Students
Expressing disinterest, boredom or apathy about course content or subject matter		M
Ineffective or inefficient teaching methods	M	M
Leaving class or other scheduled activities early		M & H

Note: M = Moderately uncivil. H = Highly uncivil.

Finally, nursing student respondent's perceptions of faculty behavioral frequency

disclosed that none of the behaviors were perceived as *often*. Nursing student

respondents did acknowledge that two of the 24 listed behaviors were *rarely* exhibited

(i.e., ineffective or inefficient teaching methods and allowing side conversations by

students that distract others). Furthermore, health science student respondents indicated

that one out of the 24 listed behaviors was *sometimes* exhibited (i.e., ineffective or inefficient teaching methods), and another indicated that one out of 24 behaviors were *rarely* exhibited (arriving late for class or other scheduled activities). Both nursing and health science respondents agreed that 22 out of 24 behaviors were *never* exhibited.

Table 7 is used to compare the frequency of faculty uncivil behaviors as identified by nursing and health science respondents that were designated differently from *never*. Upon review of the faculty behavioral frequencies, the data showed that both nursing and health science respondents found 22 of the 24 behaviors to be *never* exhibited, although the specific behaviors vary among the groups.

Table 7
Comparison of Frequencies of Faculty Uncivil Behaviors

Behaviors	Nursing Students	Health Science Students
Ineffective or inefficient teaching methods	R	S
Arriving late for class or other scheduled activities		R
Allowing side conversations by students that distract others	R	

Note: R = Rarely. S= Sometimes.

Additional data were retrieved from the survey that presented the students' perspective of incivility within their programs, although these data did not directly indicate the research questions posed. Overall, the respondent students found incivility to be either a *mild problem* within their programs, yielding 46% or *not a problem* at 39.7%. Interestingly, nursing respondents acknowledged that incivility to be more of a *mild problem* ($n = 233$ at 50.4% for their group) than health science respondents who declared incivility to *not be a problem* ($n = 152$ at 40.8% for their group).

For the survey question related to who, either students or faculty, would tend to engage in uncivil behaviors, both nursing and health science respondents asserted that students were a *little more likely to engage* (42.4%) and *much more likely to engage* in uncivil behaviors (29.7%). Student respondents agreed that faculty members were less likely to engage in uncivil behaviors as suggested by the other ratings (*faculty members are much more likely* at 2.1% and *faculty members are a little more likely* at 6.6%).

Another survey question was used to evaluate strategies for improving the level of civility as perceived by the respondent groups. Both groups asserted the top three strategies to be the following: (a) taking responsibility and accountability for actions (56.5%), (b) to role-model professionalism and civility (49.5%), and (c) to implement strategies for stress reduction and self-care (42.1%).

Statistical Measurements

The respondent groups were divided for ease of analysis as follows: (a) level of student, (b) frequency of student, (c) level of faculty, and (d) frequency of faculty. Table 8 presents the number, mean, and standard deviation (SD) within each of the four variables and two groups.

Table 8
T-Test Group Statistics

Overall Incivility	Program	N	Mean	Std. Deviation	Std. Error Mean
Level of student	Nursing	233	2.9351	.75955	.04976
	Health sciences	152	2.8522	.83906	.06806
Frequency of student	Nursing	231	1.9049	.42139	.02773
	Health sciences	151	1.9505	.55217	.04493
Level of faculty	Nursing	224	3.1449	.86485	.05779
	Health sciences	151	3.0485	.91841	.07474
Frequency of faculty	Nursing	220	1.4396	.33704	.02272
	Health sciences	150	1.6469	.50939	.04159

Reliability Testing

Cronbach alpha was used to test the reliability of the INE-R instrument scale for this dissertation sample. Each group was analyzed individually to assure internal consistency. *P* values (two-tailed) of less than or equal to .05 were used to indicate significance of factor loadings and factor correlations, using SPSS version 24. The Cronbach alpha results for each group was as follows: (a) student levels of behaviors = .968, (b) student frequency of behaviors = .922, (c) faculty level of behaviors = .981, and (d) faculty frequency of behaviors = .918. Table 9 presents individual group Cronbach alpha testing for reliability.

Table 9

Reliability Testing for Variables within IHE-R

	Cronbach Alpha	Number of Variables	Number of Cases Reviewed	Number of Cases Excluded
Student level	.968	23	348	37
Student frequencies	.922	23	332	53
Faculty level	.981	24	360	25
Faculty frequencies	.918	24	353	32

Table 10 presents the reliability testing results from this dissertation to that of

Clark et al. (2014) who conducted the original studies. Student behaviors demonstrated

by Clark et al. showed a Cronbach alpha of greater than or equal to .96, whereas

Cronbach alpha ranged between .922 to .968 in the dissertation study. Faculty behaviors

demonstrated by Clark et al. showed a Cronbach alpha of greater than or equal to .98,

whereas the Cronbach alpha in the dissertation study ranged between .918 to .981.

Table 10

Comparison of Cronbach Alpha Reliability Testing of Variables

	This dissertation	Clark et al. (2014)
Student behaviors	.922- 0.968	$\geq .96$
Faculty frequencies	.918- 0.981	$\geq .98$

Hypothesis Testing

The assumption of homogeneity was tested by determining the mean, 5% trimmed

mean, skewness, and kurtosis for nursing and health science students for each variable

group (the overall level of student incivility, the frequency of student incivility, the

overall level of faculty incivility, and the frequency of faculty incivility). In addition,

Kolmogorov-Simirnov test for normality was calculated along with a histogram and Q-Q

plot diagrams for each respective group. Depictions of histograms and Q-Q plots are shown after each respective hypothesis.

According to Pallant (2016), the significance value of greater than .05 indicates normality. The level of .000 would suggest a violation of normality, which seems to be very common in larger samples (Pallant, 2016). According to the calculated results, all groups except for student frequencies had a suggestion of a violation of normality. The Q-Q plots for all of the groups showed a relative level of normalcy with student frequencies showing the most expected level of normalcy. With large sample sizes (over 30+), techniques for testing tend to be robust enough to not cause major problems in analysis (Pallant, 2016). Homogeneity for this dissertation was therefore assumed due to the relative sameness of the mean and trimmed mean scores, the reasonably normally distributed histograms, and the reasonably straight line for the Q-Q plots. Table 11 shows the tests for normality in chart form.

Table 11
Tests for Normality

	Mean	5% trimmed mean	Skewness	Kurtosis	Kolmogorov-Smirnov		
					Statistic	df	Sig.
Student level							
Nursing	2.9351	2.9824	-1.093	.170	.158	233	.000
Health science	2.8522	2.8939	-.906	-.246	.137	152	.000
Student frequencies							
Nursing	1.9049	1.9010	.169	-.402	.058	231	.060
Health Science	1.9505	1.9297	.160	.319	.055	151	.200
Faculty level							
Nursing	3.1449	3.2155	-1.424	.940	.180	224	.000
Health Science	3.0485	3.1094	.163	.324	.190	151	.000
Faculty frequencies							
Nursing	1.4396	1.4218	.776	.278	.101	220	.000
Health science	1.6469	1.5994	.164	.327	.110	150	.000

Research Question and Hypothesis 1

Research Question 1 was used to analyze any differences in self-reported levels of student incivility as perceived by nursing and health science students. Research Hypothesis 1 stated there are no differences in the self-reported levels of nursing and health science students for student incivility behaviors over the past 12 months. The histograms and Q-Q plots for level of student incivility as perceived by nursing and HS students are shown in Figures 3 to 6. The histograms and Q-Q plots both indicate negative skewness for both nursing and health science student groups. An independent sample *t*-test was conducted to compare the student perceptions of the level of student incivility among nursing and health science students. The results showed no significant difference in scores for nursing students ($M = 2.9351$, $SD = .75955$) and health science students ($M = 2.8522$, $SD = .83906$); $t (383) = 1.004$, $p = .316$ [two-tailed]). The magnitude of the differences in the means (mean difference = .08289) with a 95% CI

[-.07944, .24522] showed a small effect (Cohen's $d = 0.104$). The Levene's test for

equality of variances showed $F = 1.829$ with a significance of .177 (significance value for

Levene's $> .05$); therefore, equal variances were assumed. Table 12 presents the results

leading to the following conclusion. There are no significant differences between nursing

and health science student perceptions related to the level of student incivility.

Therefore, the investigator failed to reject Hypothesis 1.

Table 12
Hypothesis 1 Statistics

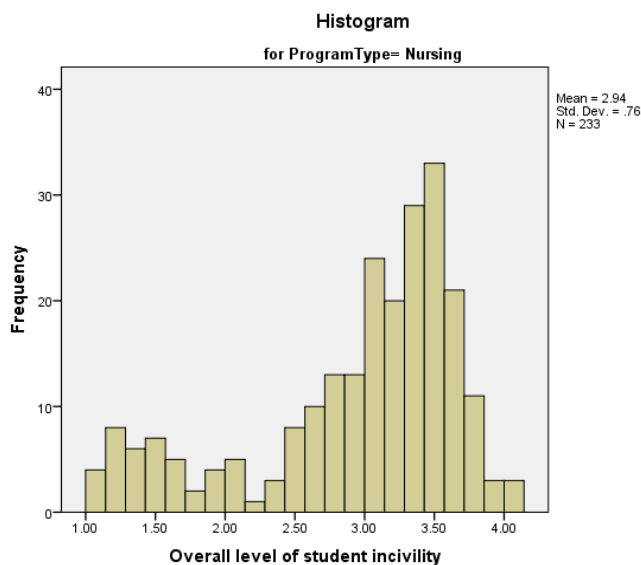| Overall Incivility	*t*-test	*P two-tailed*	df	Mean Diff	CI 95%	Levene's test	Sig level	Cohen's *d*
Level of Student Behaviors	1.004	.316	383	.08289	-.07944-.24522	1.829	.177	.104

Figure 3. Histogram of overall level of student incivility as perceived by nursing students.
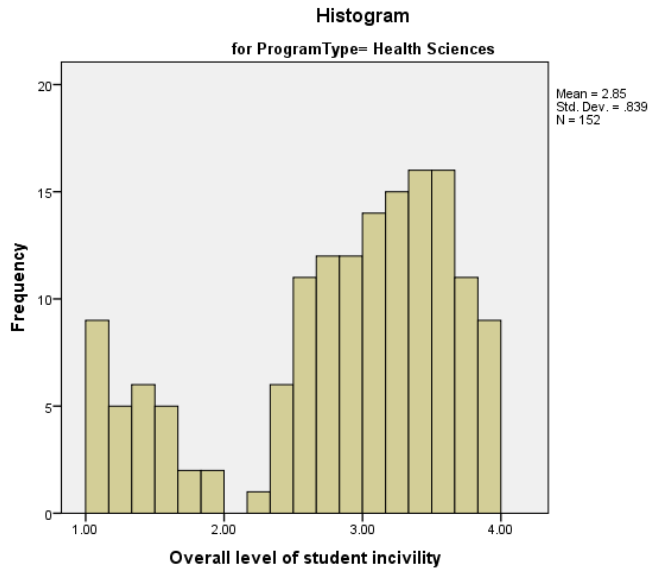
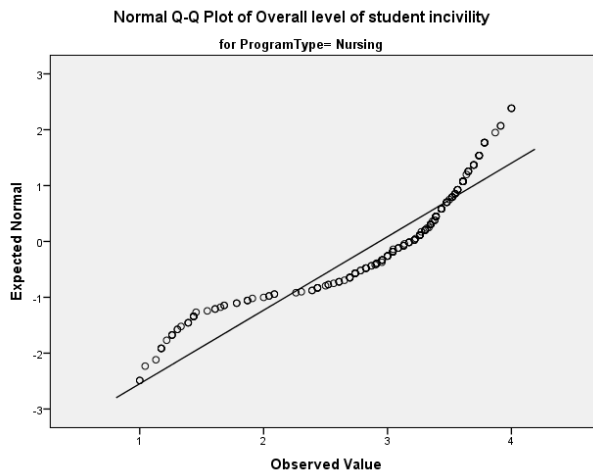*Figure 4*. Histogram of overall level of student incivility as perceived by HS students.

Figure 5. Q-Q plot for overall level of student incivility as perceived by nursing students.
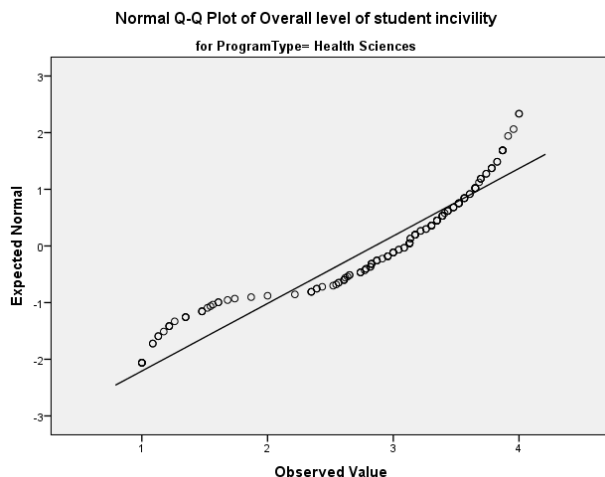
Normal Q-Q Plot of Overall level of student incivility
for ProgramType= Health Sciences

Figure 6. Q-Q plot for overall level of student incivility as perceived by HS students.

Research Question and Hypothesis 2

Research Question 2 was used to analyze any differences in the frequency of student incivility as perceived by nursing and health science students. Research Hypothesis 2 states there is no difference in the self-reported frequency rate among nursing and HS students who experienced or witnessed incidents of student incivility over the past 12 months. The histograms and Q-Q plots for frequency of student incivility as perceived by nursing and HS students are shown in Figures 7 to 10. The Q-Q plots show a fairly normal distribution with both student group histograms showing a slightly positive distribution. An independent sample *t*-test was conducted to compare the student perceptions of the frequencies of student incivility among nursing and health science students. The results showed no significant difference in scores for nursing students ($M = 1.9049$, $SD = .42139$) and health science students ($M = 1.9505$, $SD = .55217$), $t(261.255) = -.864$, $p = .388$ [two-tailed]). The magnitude of the differences in the means (mean difference = -.04563) with a 95% CI [-.14384, .05258] showed a small effect (Cohen's $d = 0.093$). The Levene's test for equality of variances showed $F = 7.606$

with a significance of .006; therefore, equal variances were not assumed (significance

value for Levene's <.05). Table 13 presents the results leading to the following

conclusion. There are no significant differences between nursing and health science

student perceptions related to the frequency of student incivility. Therefore, the

investigator failed to reject Hypothesis 2.

Table 13
Hypothesis 2 Statistics

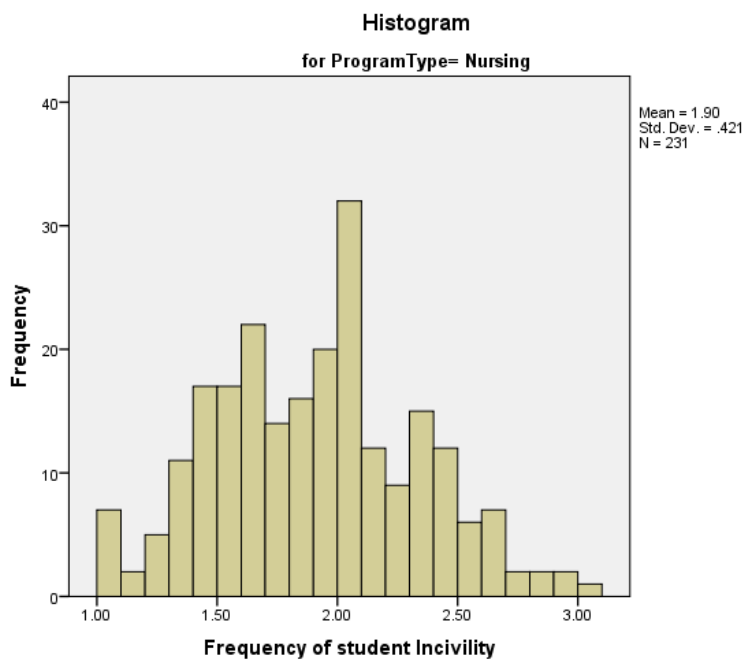| Overall incivility	*t*-test	*P* two-tailed	df	Mean Diff	CI 95%	Levene's test	Sig level	Cohen's *d*
Frequency of student behaviors	-.864	.388	380	-.04563	-.14384 – .05258	7.606	.006	.093

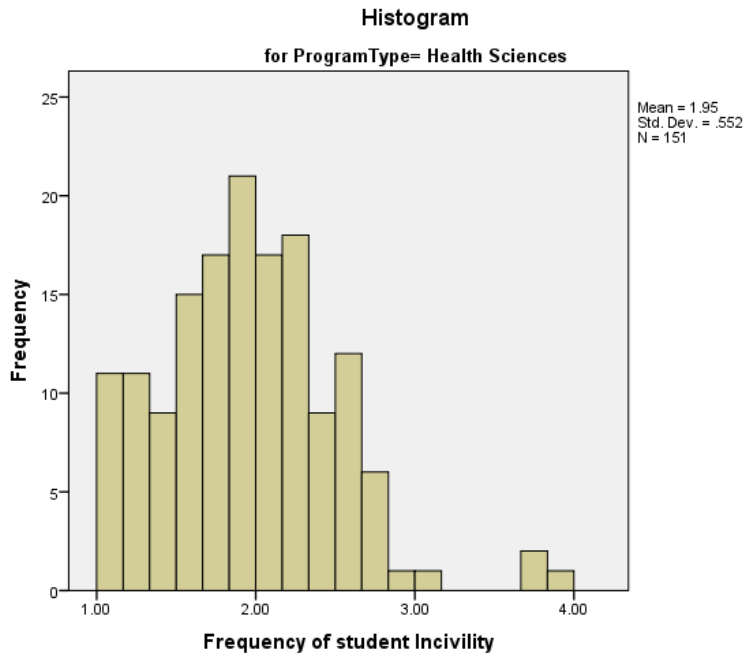*Figure 7.* Histogram of overall frequency of student incivility as perceived by nursing students.

Figure 8. Histogram of overall frequency of student incivility as perceived by HS students.

Figure 9. Q-Q plot of overall frequency of student incivility as perceived by nursing students.

Figure 10. Q-Q plot of overall frequency of student incivility as perceived by HS students.

Research Question and Hypothesis 3

Research Question 3 was used to analyze any differences in levels of faculty incivility as perceived by nursing and health science students. Research Hypothesis 3 states there is no difference in nursing and health science students' levels of faculty incivility behaviors over the past 12 months. The histograms and Q-Q plots for level of faculty incivility as perceived by nursing and HS students are shown in Figures 11 to 14. The histograms and Q-Q plots both indicate a greater negative skewness for both nursing and health science student groups than noted in student levels of incivility. An independent sample *t*-test was conducted to compare the student perceptions of the level of faculty incivility perceived by nursing and health science students. The results showed a significant difference in scores for nursing students ($M = 3.1449$, $SD = .86485$) and health science students ($M = 3.0485$, $SD = .91841$), $t(368) = -4.374$, $p = .000$ [two-tailed). The Levene's test for equality of variances showed $F = 12.105$ with a significance of .001(significance value for Levene's $< .05$); therefore, equal variances were not assumed.

The magnitude of the differences in the means (mean difference = -.20729) with a 95%

CI [-.29381, -.12076] showed a medium effect (Cohen's d = 0.479973). Table 14

presents results leading to the following conclusion. There are significant differences

between nursing and health science student perceptions related to the level of faculty

incivility.   Therefore, for Hypothesis 3, the investigator rejected the null in favor of the

alternative.

Table 14
Hypothesis 3 Statistics

Overall incivility	t-test	P two-tailed	df	Mean Diff	CI 95%	Levene's test	Sig level	Cohen's d
Level of faculty behaviors	-4.374	.000	368	-.20729	-.29381 – -.12076	12.105	.001	.47997
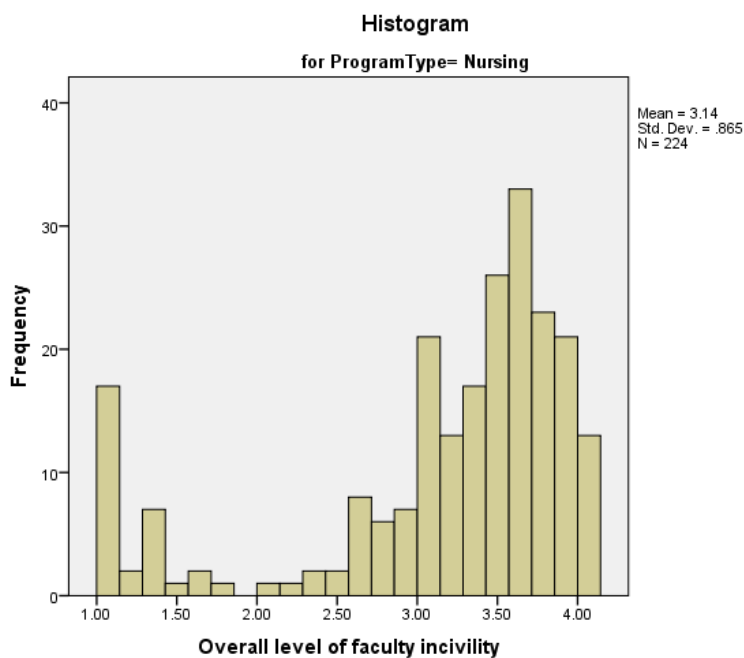
Figure 11. Histogram of overall level of faculty incivility as perceived by nursing
students.

Figure 12. Histogram of overall level of faculty incivility as perceived by HS students.

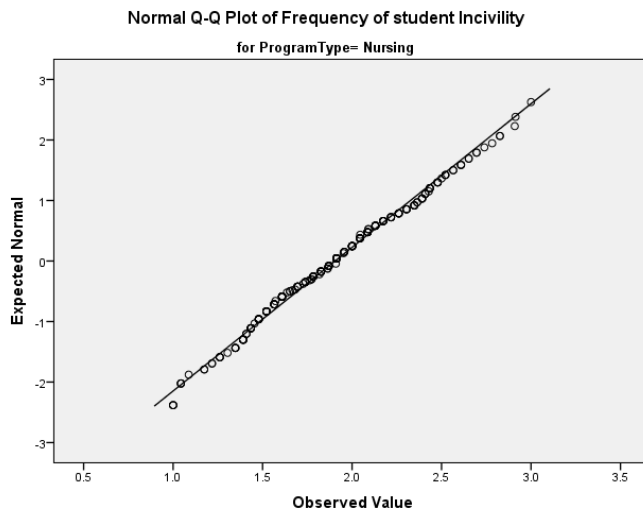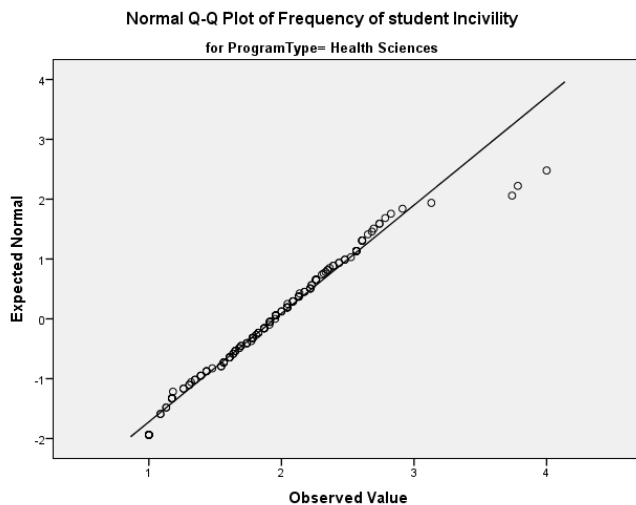*Figure 13*. Q-Q plot of overall level of faculty incivility as perceived by nursing students.

Figure 14. Q-Q plot of overall level of faculty incivility as perceived by nursing students.

Research Question and Hypothesis 4

Research Question 4 was used to analyze any differences in frequency of faculty incivility as perceived by nursing and health science students. Research Hypothesis 4 states there are no differences in the perceived frequency rate for faculty uncivil behaviors experienced or witnessed by nursing and HS students within the past 12 months. The histograms and Q-Q plots for frequency of faculty incivility as perceived by nursing and HS students are shown in Figures 15 to 18. The Q-Q plots show a fairly normal distribution with both faculty group histograms showing a slightly positive distribution, similar to the student group. An independent sample *t*-test was conducted to compare the student perceptions of the level of student incivility among nursing and health science students. The results showed no significant difference in scores for nursing students ($M = 1.4396$, $SD = .33704$) and health science students ($M = 1.6469$, $SD = .50939$), $t (373) = 1.033$, $p = .302$ [two-tailed]). The magnitude of the differences in the means (mean difference $= .09647$) with a 95% CI [-.08713, .28008] showed a small effect (Cohen's $d = 0.108$). The Levene's test for equality of variances showed $F = 1.611$

with a significance of .205 (significance value for Levene's >.05); therefore, equal

variances were assumed. Table 15 presents results leading to the following conclusion.

There are no significant differences between nursing and health science student

perceptions related to the frequency of faculty incivility.   Therefore, for Hypothesis 4,

the investigator failed to reject the null.

Table 15
Hypothesis 4 Statistics

| Overall incivility	*t*-test	*P* two-tailed	df	Mean Diff	CI 95%	Levene's test	Sig level	Cohen's *d*
Frequency of faculty behaviors	1.033	.302	373	.09647	-.08713- .28008	1.611	.205	.108
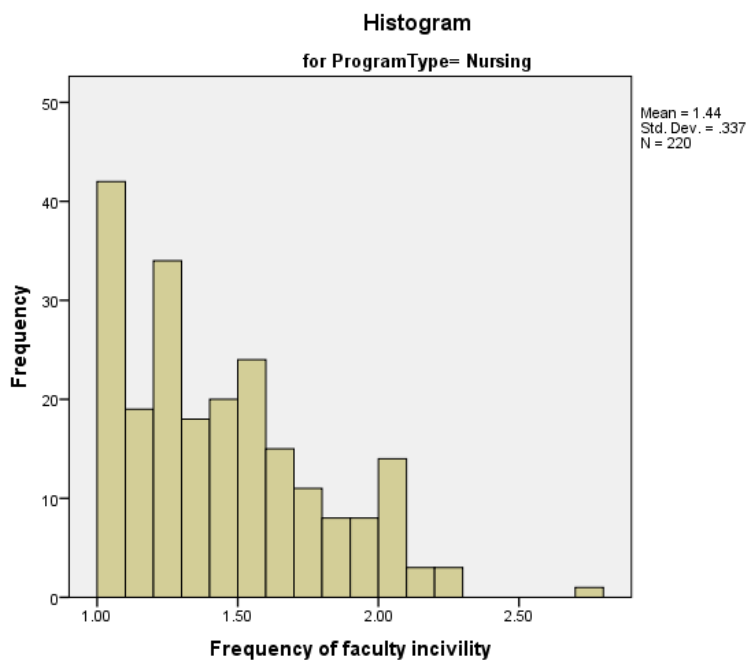
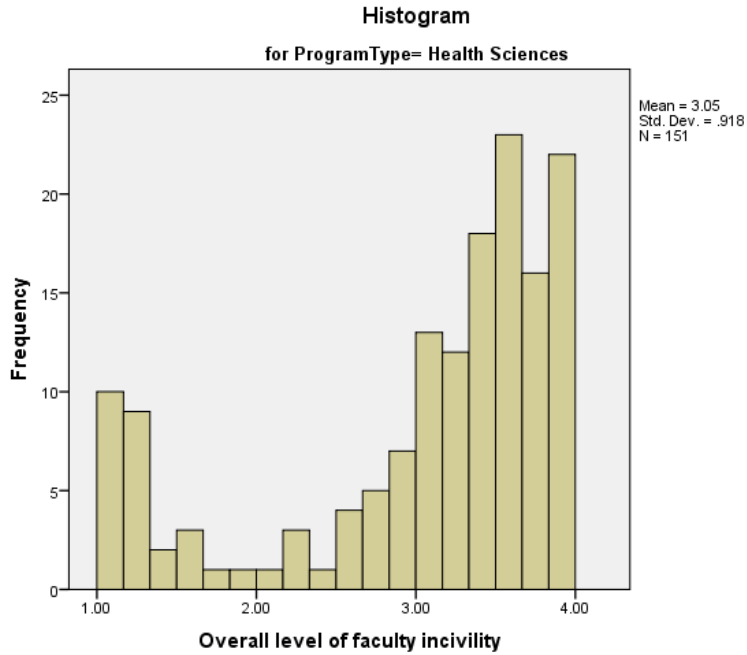*Figure 15*. Histogram of overall frequency of faculty incivility as perceived by nursing students.
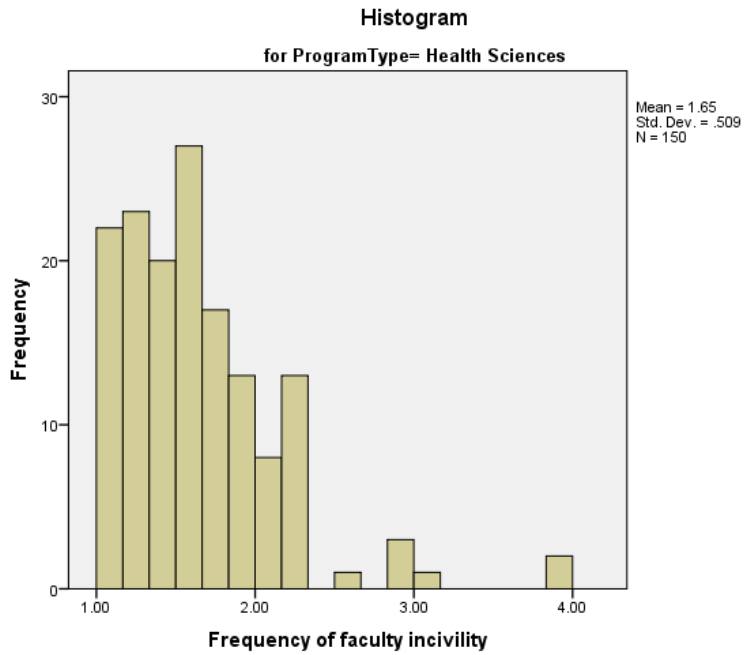
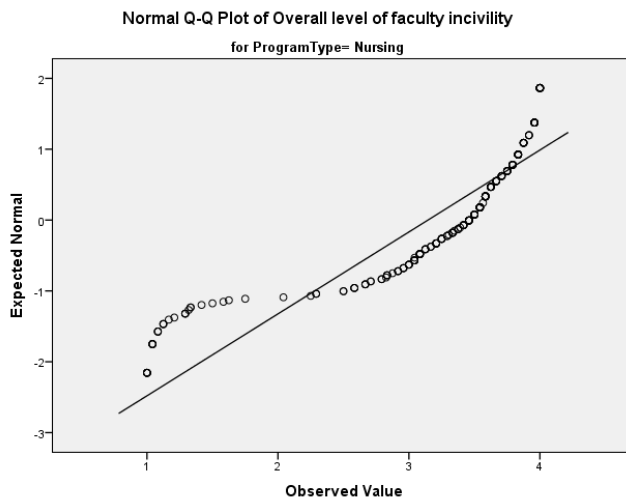*Figure 16.* Histogram of overall level of faculty incivility as perceived by HS students.

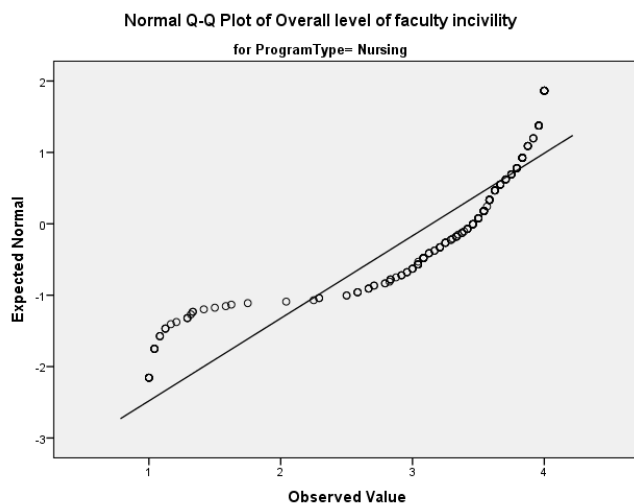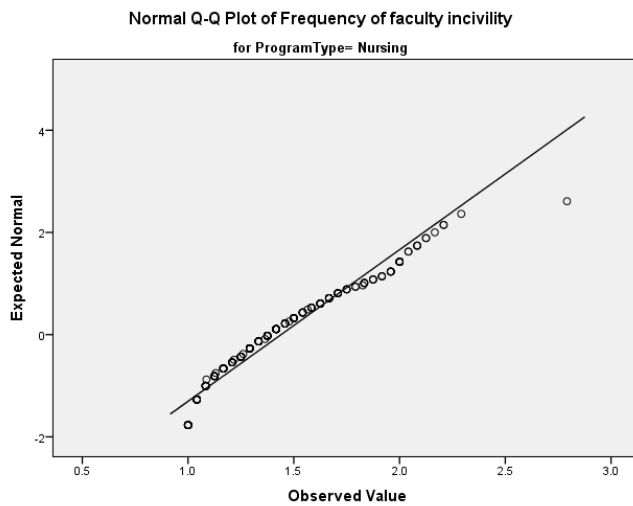*Figure 17.* Q-Q plot of overall frequency of faculty incivility as perceived by nursing students.
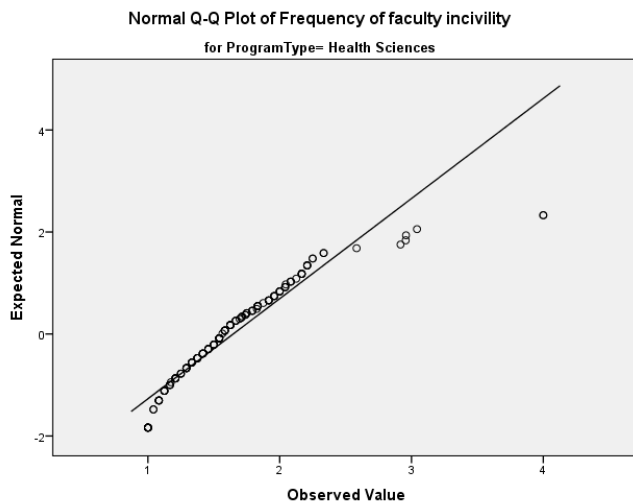
Figure 18. Q-Q plot of overall frequency of faculty incivility as perceived by HS students.

Chapter Summary

The data and initial analysis for this dissertation were presented within this chapter. Demographic data were displayed in tables differentiating the sample as a whole as well as reflective of each group. Descriptive statistics from student and faculty behaviors related to level and frequency of incivility were displayed in table format for convenience and ease of readability. The research questions and hypotheses were analyzed with resulting statistical tests shown. For all hypotheses, the investigator failed to reject the null, except for the faculty level of incivility in which the null was rejected in favor of the alternative. Differences between nursing and health science students were shown throughout the result area.

Chapter Five

Discussion and Summary

The purpose of this dissertation was to quantify and compare the students'

perceptions of the level and frequency of incivility among nursing and HS students

within an academic environment over the past 12 months. Bandura's social learning

theory was used as the theoretical framework for this dissertation under the premise that

learning of behaviors, attitudes, and values are developed through observation, modeling,

and imitation of others. According to the Bandura (1977), modeling becomes influential

when establishing behaviors. Career-specific behaviors are learned as part of the

professional phase of nursing and health science programs, especially when socializing

into the profession itself. This learning encompasses the ethics, language, values, and

norms of the profession to become an integral part of the student's future identity.

Positive and negative role models can become powerful determinants in professional role

development (Keeling & Templeman, 2013). When using the social learning theory to

explain incivility, behavioral, personal/cognitive, and environmental influences become

evident. As noted throughout this dissertation, the students' perceptions indicated the

ability of others to perform the uncivil behaviors as well as the existence of reinforcement

or punishment for uncivil behaviors and varying communication skills. The study results

also indicated personal and/or cognitive influences as noted by the participants

acknowledgment of uncivil behaviors, the collegial expectation for students and faculty,

and the ability to learn and participate toward their desired outcomes. The environmental influences became evident through the normative beliefs of the participant groups as well as the existence of barriers and opportunities, such as student workload, pressure to succeed in program, and areas of clinical practice. Each factor affects other factors in a reciprocating manner consistent with the triage relationship of Bandura's theory.

The study findings have supported the theoretical framework related to role modeling and observation for the development of professional behaviors as confirmed by the participants ability to differentiate civil from uncivil behaviors. In addition, participants clearly identified various levels of incivility and the frequency of such. Teaching of values, attitudes, and behaviors result from the observation and role modeling from their professions teachers and preceptors. According to Keeling and Templeman (2013), the purpose of observation in clinical practice has allowed students the opportunity to learn from other mistakes and also identify positive role models who demonstrate autonomy and internal setting of professional standards. Practice professions, such as nursing and other health science careers, rely on such methods to teach students the physical, emotional, and psychomotor skills relevant to their profession (Ziefle, 2018).

Summary of the Findings

Interestingly, the participants perceptions of student uncivil behaviors were found to be similar in the levels. Nursing students found the following to be highly uncivil behaviors: rude gestures or nonverbal behaviors toward others; sleeping or not paying attention in class; being distant and cold toward others; holding side conversations that caused distractions; cheating on exams or quizzes; expressing condescending or rude

remarks toward others; demanding of makeup exams, extensions, or other special favors; ignoring, failing to address, or encouraging disruptive behaviors; demanding a passing grade when a passing grade was not earned; the making of discriminating comments toward others; the use of profanity directed toward others; threats of physical harm against others; property damage; and making threatening statements about weapons. HS students identified these similar behaviors as highly uncivil except for rude gestures, sleeping in class, or the demanding of passing grades.

Regarding the frequency of student uncivil behaviors, participants were again similar in their responses. Nursing student participants found no behaviors to be ranked as *often* but did indicate there were three behaviors (expressing boredom, using electronic devices in class, and holding side bar conversations) ranked as *sometimes*. HS participants indicated that one behavior (using electronic device) was *often*, and four behaviors (expressing disinterest, making rude gestures, sleeping in class, and holding side bar conversations) were ranked as *sometimes*. It is noted that the behaviors are again similarly identified between the nursing and HS participants.

Nursing student participants indicated that faculty levels of behavior yielded 23 highly uncivil behaviors while HS participants determined 22 uncivil behaviors. The behaviors are similar in nature between the two participant groups. Ironically, the relatively similar behaviors between student and faculty yielded statistically significant differences with student behaviors being less uncivil while faculty behaviors were highly uncivil. This discrepancy may be due to perceived professional ideal of the faculty member versus that of a student. The behavioral expectations for faculty may be perceived greater than of one who is learning.

In addition, this discrepancy may be due to feelings of increased stress among the student population. According to Ziefle (2018), the differences in generational values and expectations can vary between students and faculty and may influence the level of stress within the learning environment. The generational values for the student group may be unique as compared with that of established nursing values (Ziefle, 2018). Cultural norms in the United States show that students have a sense of entitlement and prefer a more casual learning environment (Kopp & Finney, 2013). According to Kopp and Finney, (2013), students who were noncompliant in expected behaviors were significantly higher in entitlement than those students who exhibited professional behaviors. Clark (2008d) noted that her study showed a perception that an attitude of entitlement was heightened by a consumerism mentality, which further influenced the potential for incivility. Aul (2017) contended that students feeling entitled contributes to uncivil behaviors and may be due to generational differences. The role of faculty may be perceived more as a friend and advisor than that of an authority figure. So, as faculty exhibit any of the unwanted behaviors, it is perceived as *highly uncivil* because of the revered professional behaviors expected of faculty.

For the faculty behavioral frequencies, it was found to be either *none* or *rarely* as indicated by nursing participants or as *rarely* or *sometimes* by HS participants. It has been noted that the frequency for either displays of student or faculty uncivil behaviors have been very low within the institution of study.

When reviewing the calculated means for each level and frequency, the results were consistent with the other statistical findings noted. In addition, the student level of uncivil behaviors was found to be between *somewhat* and *moderately* uncivil. Faculty

levels of uncivil behaviors were found to be more *moderate*. Review of the frequency levels reflected students' frequencies to be *never* to *rarely* as compared with faculty that indicated a frequency of *sometimes*. Overall, the student perceptions of faculty levels and frequencies were greater than that of the students' level and frequencies. Again, the justification for the findings may relate back to behavioral standards expected of faculty as an authority figure compared with that of the student role.

<div align="center">**Integration of the Findings with Previous Literature**</div>

Some of the results from this current dissertation were supported by the literature. The results were divided into student levels and frequency of incivility as well as faculty levels and frequency of incivility for ease of comparison.

Level of Student Incivility

There is abundant research about the existence of incivility within nursing education, but minimal research exists related to the perceptions of uncivil behaviors among nursing programs (Aul, 2017). Altmiller (2012) explored the phenomenon of incivility in nursing education from undergraduate nursing students and educators' perceptions. The results indicated that nursing students perceived many of the same behaviors as faculty did in relation to incivility. Several themes emerged relating to unprofessional behaviors, poor communication techniques, power gradients, inequality, stressful clinical environment, authority failure, and difficult peer behaviors. They showed similar areas of agreement between student and faculty perceptions (Altmiller, 2012). Similar behaviors of students and faculty as uncivil as perceived by the nursing and health science participants were confirmed with the dissertation study.

Aul (2017) studied incivility in pre-licensure nursing programs and differentiated between diploma, associate, and bachelor's degree students. The more frequent uncivil behaviors noted in diploma programs were identified as acting bored or apathetic, making disapproving groans, making sarcastic remarks, holding distracting conversations, cell phone use during class, and arriving late. The more frequent uncivil behaviors noted in associate degree programs were similar to the diploma programs with acting bored or apathetic, making disapproving groans as well as sarcastic remarks, and arriving late. Bachelor's degree program behaviors added to the list with not paying attention, using computers and cell phones in class, and dominating class discussions. Aul (2017) noted significant differences ($p < .05$) in the student perceptions for these behaviors between the program types. BSN students found making sarcastic remarks was more disruptive than found by diploma students. In addition, BSN students found distracting conversations more disruptive than associate degree students (ADN). Cheating on exams or quizzes was perceived to be more disruptive for the BSN and diploma students (Aul, 2017). In general, the findings were congruent with the nursing and HS participant responses from this dissertation study when identifying the highly uncivil behaviors. Cheating on exams, sarcastic remarks, and distracting conversations were found to be highly uncivil in both studies. In this dissertation study, there was no differentiation between academic levels of the participants related to specific behaviors, which may be of interest for future study.

Clark and Springer (2007) identified similar uncivil behaviors to be disruptive, such as disrupting others in class by talking, making negative remarks, leaving early, and using cell phones during class. Clark (2008d) identified four major themes related to

uncivil student behaviors: (a) display of disruptive behaviors during class and clinical (such as misuse of cell phones and computers; (b) engaging in side conversations and dominating class, making rude remarks and using sarcasm; (c) pressuring faculty to meet student demands; and (d) speaking negatively about other students, faculty, or the nursing program. These results are also reflected in this dissertation study as nursing and HS students found expressing disinterest, boredom or apathy, rude gestures, holding side conversations, and using computers and phones to be *sometimes* or *often*. The survey participants concurred that holding side conversations; making condescending remarks; demanding make-up exams, extensions, or other special favors; and making discriminating comments were *highly uncivil*. Both nursing and HS student groups agreed in these areas except for HS students who ranked demands on faculty (such as make-up exams, extensions, or special favors) as *moderately uncivil*.

Ballard et al. (2015) found that using a cell phone in class or texting during clinic were uncivil behaviors. Along with those results from the study, dental students considered eating in clinic, making offensive remarks, being unprepared for clinic, arriving late for clinic, and cheating to be comparably uncivil classroom behaviors. According to Rowland and Srisukho (2009), most dental faculty found sleeping in class uncivil. In addition, both dental faculty and students agreed that demanding special treatment, making offensive remarks, prolonged chatting in class, and cheating constituted uncivil behaviors. These findings are similar to those of this dissertation study as nursing and HS participants also found cheating and the making of offensive remarks to be highly uncivil. Areas of divergence were noted to be the following: cell phone usage was found to be somewhat *uncivil* by nursing participants and *moderately*

uncivil by HS participants, unpreparedness for class was found to be *moderately* uncivil by nursing participants and *somewhat* uncivil by HS participants, and arriving late to class was found to be *moderately* uncivil by nursing participants and *somewhat* uncivil by HS participants.

Frequency of Student Incivility

Clark and Springer (2007) found from their pilot study that 70% of nursing students and faculty viewed academic incivility as a moderate to serious problem. Both groups reported similar behaviors as uncivil. In addition, Clark (2007) reinforced her findings that academic incivility was perceived as a *moderate* to *serious problem*. Cooper, Walker, Askew, Robinson, and McNair (2011) found incivility as a pervasive problem. In addition, Abd El Rahman (2014) found that over 87% of the student nurses reported experiencing bullying behaviors, such as negative remarks and undervalued efforts.

This investigator found that student respondents found incivility to be either a *mild problem* within their programs or *not a problem*. Nursing respondents claimed incivility to be a *mild problem* as compared with HS respondents who declared incivility to *not be a problem*. Overall, this investigator did not find student incivility to a problem at the selected college of study and diverged from other studies. This finding may be linked to a limitation of this dissertation. The geographic area studied is isolated and has a small-town atmosphere. This area tends to not be influenced by bigger city attitudes and norms. In addition, the diversity of the area tends to be minimal. People from the area tend to be very ethnocentric with little exchange or acceptance of other ideas. This

backwards atmosphere may have contributed to the lack of uncivil behaviors among the student population studied.

Faculty Level of Incivility

Clark (2007, 2008d) found that student perceptions of faculty included five major uncivil behaviors, including (a) intimidating and bullying students; (b) using inept teaching skills and poor classroom management techniques; (c) making demeaning, belittling comments or gestures toward students; (d) labeling and gossiping about students; and (e) showing favoritism, inconsistency, and bias toward students. The most common theme was noted to be intimidating and bullying students. Masoumpoor, Borhani, Abbaszadeh, and Rassouli (2017) identified three themes, namely disruptive behaviors affecting the communication, the ethical climate, and the learning climate, which converge with Clark's results.

Muliira, Natarajan, and van der Colff (2017) identified faculty uncivil behaviors as arriving late for scheduled activities, leaving scheduled activities early, canceling scheduled activities without warning, ineffective teaching styles and methods, and subjective grading. In addition, Holtz, Rawl, and Drauker (2018) conducted a qualitative study that indicated six ways students perceive faculty to be uncivil: (a) judging or labeling students, (b) impeding student progress, (c) picking on students, (d) putting students on the spot, (d) withholding instruction, and (e) forcing students into no-win situations. Dellifraine et al. (2014) reported common uncivil behaviors by faculty to be sarcastic remarks, gossiping about others, eye-rolling, and chastising others for poor performance.

This investigator found that HS students perceived faculty uncivil behaviors to be *moderately uncivil* and *highly uncivil*, such as expressing disinterest, boredom, apathy about course content or subject matter, ineffective or inefficient teaching methods, and leaving class or other scheduled activities early. Nursing students indicated with their perceptions that ineffective or inefficient teaching methods to be *moderately uncivil,* and there were no other faculty behaviors identified. Similarity between Clark's (2008d) results and this dissertation is directed toward the teaching methods of faculty. Additionally, similarity in noted by Muliira et al. (2017) indicated leaving early or cancelling of prescheduled events to be uncivil. There was no correlation from the dissertation results to those found by Holtz et al. (2018) or Dellifraine et al. (2014) and, therefore, diverged from the dissertation findings. This investigator found faculty incivility behaviors to be rated as highly uncivil by both nursing and HS participants. Perhaps this disparity is due to faculty being held to a higher standard than that of student with different generations involved. Generational differences may play a role as to which students believe faculty behaviors should be exhibited. Ziefle (2018) investigated the differences in experiences of two generations of nursing faculty. Ziefle found that Generation X nursing faculty reported experiencing more incivility than that of baby boomer nursing faculty. Ziefle (2018) attributed the difference to the unique generational values of each group compared with nursing values.

Faculty Frequency of Incivility

Dellifraine et al. (2014) reported that faculty witnessed bullying behaviors during their academic career and that these behaviors lasted longer than 1 year. In addition, they found that 2.4% of instructors initiated uncivil behaviors: 12% by assistant professors,

24.9 % by associate professors, 43% by full professors, and 17% by deans or associate deans.

Results from this dissertation study showed a low incidence of uncivil behaviors exhibited by faculty. Overall, nursing student participants noted frequencies of faculty uncivil behaviors to be *rarely* in the following categories: ineffective or inefficient teaching methods and allowing side conversations. HS participants identified *rare* occurrence in the category of arriving late for class or other scheduled activities and *sometimes* for ineffective or inefficient teaching methods. Muliira et al. (2017) and this investigator found nursing faculty academic incivility to be low.

Implications of the Findings

This dissertation presented important information related to nursing and HS student perceptions of student and faculty uncivil behaviors, the level of those behaviors, and the frequency of uncivil behaviors. It also presented evidence about HS students and their perceptions about uncivil behaviors because the current literature was severely lacking in that area.

This investigator was surprised by the study outcome as it was expected to verify that more uncivil behaviors were experienced and exhibited among nursing students than HS students. This result was not the case or apparent from the findings. The biggest revelation from this dissertation was that both student groups found faculty behaviors to be moderately uncivil, even though similar behaviors among student groups were not determined to be to the same level. The implications of these results are provided within the various arenas, such as nursing education, practice, research, and public policy.

Implications for Nursing Education

With a greater awareness for incivility, students and faculty can implement the standards expected by each profession. Students have a responsibility to uphold professional standards to which they are committed and educated. According to Keeling and Templeman (2013), students perceive vulnerability, symbolic representation, role modeling, discontent, and identity development as elements required for professionalism.

Being able to observe, model, and emulate other behaviors within their desired disciplines is used for students to have the ability to formulate their own image of professionalism while incorporating proficiency, expertise, and competence to become that symbolic display of the profession itself. Students must be made aware of their increasing responsibility and connection to the people for which they care. Students from all careers must embrace the obligation to conduct themselves in an ethical, professional manner (Clark & Springer, 2007). Educational sessions are needed for students to identify incivility and formulate/practice methods to mitigate the behaviors. Students would benefit from learning strategies to confront the uncivil behavior and the person displaying it as well as discussing the issue with the offender and to proceed with an appropriate course of action. Simulation could be a notable event to practice within a safe environment for future encounters.

Any uncivil behaviors acquired during educational preparation for a profession must be converted into exemplary ones through appropriate instruction, modeling, mentoring, and positive reinforcement. Civility must be a conscious choice and not a whim at that moment in time. In her work, Allari (2016) related civility to the choice theories of Glasser (1998) in which all behavior is purposeful, can be altered, and humans

have ultimate control of their behavior. For changes to occur, faculty members must own up to their unintended contribution to the incivility. According to Edwards and O'Connell (2007), nurse educators must accept that there is a need to change and alter their practice. Faculty has a responsibility to exemplify professional behaviors as well as expect civility throughout the learning experience. Any incidents of incivility must be addressed immediately and tactfully, so students can learn the expectations and be held accountable for their behaviors. Faculty can use debriefing techniques post events to improve student awareness and ways to handle uncivil behaviors.

Teamwork and interprofessional practice is essential for all health care disciplines. According to McComb and Hebdon (2013), teamwork becomes the fabric for the delivery of quality patient care within health care organizations. Learning to work alongside other health care providers is not innate process and must be nurtured to be successful. Lerner et al. (2009) believed that teamwork does not inherently work by placing people together in the same environment. Teamwork and interprofessional practice takes respect for one another's role within the health care setting as well as knowledge of each member's contribution to the care of an individual. Along with respect comes civility in which communication and trust can build. Logan (2016) identified communication, trust, and leadership as essential components for effective teamwork and practice. Education about the importance of teamwork and how it is obtained are needed for all health care practitioners to build their competence. Interprofessional events that occur while in school become effective and meaningful experiences for all involved. Nurse educators and other HS educators need to plan such events as well as require student participation, so all disciplines can work together to

improve patient outcomes. Researchers have found that interprofessional teams are

worthwhile approaches and better replacement to the current health care structure

(Purcell, Zamora, Tighe, Li, Douraghi, & Seal, 2017).

With the findings from this dissertation, this investigator suggests faculty need to

address uncivil behaviors in the classroom. Use of cell phones during class, distracting

side-bar conversations, expressions of disinterest, or boredom show poor management

over the classroom environment. Faculty need to use alternative teaching methods to

engage students to lessen displays of uncivil behaviors. Clear guidelines must be

established for classroom behaviors, documented in the course syllabus and standard

upheld consistently.

Implications for Nursing Practice

Patient safety is always a priority in health care and the responsibility for all

health care workers (IOM, 2003). A healthy work environment is essential for the nurses

themselves as well as the patients they care for. Uncivil behaviors within this

environment can contribute to the making of errors, delays in care, conflict amongst

workers, and miscommunication with other professionals (Rosenstein & O'Daniel, 2008).

Quality patient care becomes essential for good patient care outcomes. There is no room

for uncivil behaviors when caring for others. Nursing practice is demanding mentally,

physically, and emotionally. Any personal reserves one may have are drained by

incivility, leaving room for exhaustion, brain fatigue, and the potential for errors.

Gaining confidence in handling uncivil behaviors is needed to be successful in the

nursing role. Graduates need extra care and mentoring when starting their new roles.

Internships or preceptorships can be helpful for the new nurses to adapt to the

environment and learn how to navigate uncivil behaviors.

Nurse managers must also be aware of any unhealthy climates within their institutions and extinguish negative behaviors before they progress to uncivil or bully-like situations. Nurses that experience incivility experience great anguish and contemplate leaving their job or nursing itself. Workplace burnout and the departure of qualified staff further stresses the unit, other nurses, staff, and patients, especially due to less than optimal staffing. These environments can lead to decreased teamwork and poor morale. Nurse leaders can be pivotal in identification, prevention, and management of uncivil behaviors within the health care environment (Hoffman & Chunta, 2015). Strong leadership, zero tolerance of bad behavior, and a true picture of the institutions culture are critical to correct incivility.

In addition to zero tolerance, orientation programs for nurses must be inclusive of expected professional expectations, the great need for competent practice, and the continuous practice of civil behaviors. Orientations for new employees tend to be time consuming and financially costly, but extremely necessary to keep qualified staff. Avoidance of nursing turnover in health care institutions can help prevent unsafe patient care as well. Proper socialization of new graduates to the environment will also help the new member of the staff to feel welcome.

Negative interpersonal interactions on the nursing units can affect patient safety. There can be failures to report patient care errors as well as communication breakdowns that threaten patient safety. According to Hutchinson and Jackson (2013), the presence of incivility among nurses threatens the quality of patient care and potentially affects patient care outcomes. Impaired clinical judgment is a possible consequence from

uncivil behaviors. Other symptoms, such as headaches, poor sleep, and intestinal issues can lead to heightened anxiety, stress, and irritability (Clark, 2013a). All of these negative effects can lead to increase patient care errors related to patient safety, increased incidence of falls, delayed medication administration, and other medication administration errors (Roche et al. 2010). Improved reporting systems related to patient care errors and behavioral issues must be implemented within health care institutions. Nurses must feel that they can report incidents of incivility without repercussions or retribution. The organizational culture must be one of zero tolerance for uncivil behaviors and one of support toward safe competent patient care.

Implications for Nursing Research

Researchers must persist in exploration of the various aspects of incivility. There continues to be evidence of incivility in various workplaces and society in general. More investigation must be conducted in relation to behaviors for all health care workers and society itself. Because of the lack of research related to other HS professions, this investigator began the process. The belief that incivility only exists in nursing is no longer true. This investigator explored incivility among other HS programs and found the perceptions of several uncivil behaviors to be *sometimes* and *often* displayed. Ideally, the behaviors should be *never* seen.

Further research is still needed to concentrate on strategies to extinguish and prevent uncivil behaviors. Certainly, with today's unacceptable behaviors increasing, better methods for detecting issues before they become a problem would be beneficial. Nurses play an important role in educating the public in a variety of situations. Research about how nurses can influence today's youth could help mitigate some of the explosions

of incivility currently displayed.

It is also important to continue research in areas surrounding students' perceptions of faculty behaviors. From the findings of the dissertation, students found faculty behaviors more uncivil than similar behaviors exhibited by students. By understanding the phenomenon surrounding these findings researchers may understand incivility overall.

Experience from conducting this dissertation has opened the door to many conversations with this investigator's students. Many have inquired about how the study was progressing and the indications of the data. Several students have felt comfortable approaching this investigator regarding their experiences with uncivil behaviors. Student awareness of the incivility issues has increased and has prompted a few students to come forward and disclose the incidents currently occurring.

As with all research, the information gleaned must be shared. Dissemination of this research and all research is necessary to provide answers to questions that remain. Dissemination can be in the form of writing for a journal, providing a poster presentation at national nurse and academic meetings, or presenting in front of interested parties.

Implications for Public Policy

Policies for uncivil behaviors need to begin at the top. The top could be representative of the government, or it could be an academic institution. Either way, policies need to be developed for a variety of situations. Colleges and universities need to have policies related to uncivil behaviors and the ramifications for exhibiting such behaviors. Nursing education departments and health care institutions also need to clarify the expected behaviors. Professional organizations, such as the ANA, should

continue to push for policies about the ethical, moral, and legal responsibilities of health care workers (National Council of State Boards of Nursing [NCSBN], 2018).   According to NCSBN (2018), some states have introduced new bills proposing punishment for harming a nurse. To date, Florida and Hawaii have such legislation pending. There needs to be zero tolerance for incivility of any kind.

Limitations

Several limitations have been identified in this dissertation. The limitations are convenience survey, geographic location, lack of randomization, self-reporting, and lack of understanding of survey answer choices.

This investigator used a convenience sample of students from one college. The college was chosen because of the convenience to this investigator who had access to the students and administrators of the college. Further study of other nursing and HS students would allow for greater strength in the findings and diversity of the population.

Another limitation was related to the convenience sample in that one geographic area was explored. The study took place in one state in the northeastern United States, and the results may not be generalizable to other geographic areas. Exploration and study in other geographic locations is recommended to avoid this limitation.

There was a lack of randomization as the participants self-decided to participate or not. In addition, self-reporting is a limitation. Self-reporting is used frequently for surveys but depends on the honesty of the participants. This lack of randomization in itself could cause a limitation.

Another limitation noted was that participants frequently questioned the meaning of one of the survey responses, such as not uncivil. Most students were confused about

the meaning of these words and sought clarity from the investigator or survey administrator. They found it to be a double negative and confusing when attempting to respond to specific behaviors. This negatively worded response could have led to an incorrect response due to double negative confusion of the true meaning.

Chapter Summary

The purpose of this dissertation was to determine nursing and HS students' perceptions of student and faculty uncivil behaviors, especially related to the level and frequency. Results indicated that there were no significant differences between nursing and HS student perceptions of the level of uncivil behaviors. Ironically, both student groups determined faculty behavioral levels to be significantly different from student behavioral levels. In addition, there were no significant differences in the students' perception of frequency of uncivil behaviors of students or faculty.

This chapter summarized the meaning of the results, future implications in nursing education, nursing practice, nursing research, public policy, and study limitations. It is suggested that future research include the HS student population because there is a lack currently available. Research related to why faculty uncivil behaviors were found to more uncivil than student behaviors of a similar nature would be of interest.

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Appendix A

Institutional Review Board Permission

MEMORANDUM

To:	**Diane L Smith**
From:	**Jo Ann Kleier, Ph.D., Ed.D.,**
	Center Representative, Institutional Review Board
Date:	**October 14, 2017**
Re:	**IRB #: 2017-601; Title, "Exploring incivility among nursing and health science students: A descriptive study."**

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt Category 2)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

1)   CONSENT: If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.

2)   ADVERSE EVENTS/UNANTICIPATED PROBLEMS: The principal investigator is required to notify the IRB chair and me (954-262-5369 and Jo Ann Kleier, Ph.D., Ed.D., respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.

3)   AMENDMENTS: Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc: Lynne Bryant, EdD
         Vanessa Johnson

Appendix B

Sampling of Definitions and Sources

Behavioral Name	Definition	Sources
Bullying	"Repeated, offensive, abusive, intimidating or insulting behaviors; abuse of power; or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence"	Vessey, DeMarco, Gaffney, & Budin, 2009, pp. 299-300.
	"Repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. It is abusive conduct that is threatening, humiliating, or intimidating, or work interference such as sabotage, which prevents work from getting done, or verbal abuse"	Namie & Namie, 2015
	"all those repeated actions and practices that are directed to one or more workers, which are unwanted by the victim, which may be done deliberately or unconsciously, but clearly cause humiliation, offence, and distress, and that may interfere with job performance and /or unpleasant working environment"	Einarsen, 1999, p. 17.
Incivility	"One or more rude, discourteous, or disrespectful actions that may or may not have a negative intent"	ANA, 2016
	"Low intensity deviant behavior with ambiguous intent to harm the target in violation of workplace norms; lack of regard for others"	Andersson & Pearson, 1999, p. 457.
	"rude or disruptive behaviors which often result in psychological or physiological distress for the people involved, and if left unaddressed, may progress into threatening situations"	Clark, 2009, p. 194.
	Publicly belittling or finding weakness in others; workplace culture reinforces the behavior; power perception	Twale & DeLuca, 2008
Horizontal Violence	"Characterized by such behaviors as gossiping, criticism, innuendo, scapegoating, undermining, intimidation, passive aggression, withholding	Baltimore, 2006, p. 30.

	information, insubordination, bullying, verbal & physical aggression"	
	"An act of aggression, either overt or covert, that is perpetrated by one colleague toward another in the form of verbal, emotional, and physical abuse"	Longo & Sherman, 2007, p. 35.
	"Manifested through overt & covert behaviors such as withholding pertinent information, criticism, & failure to respect confidences & covert behaviors such as eyebrow raising, snide remarks, & turning away"	Griffin, 2004, p. 258.
Lateral violence	Aggressive behaviors between individuals at the same level within the hierarchy	Stanley, 2010, p. 10
Mobbing	"Continuing conflict where the victim is subjected to 2 or more negative incidents weekly for at least 6 months"	Lehman,1996, p. 168
	"Antagonistic behaviors with unethical communication directed systematically at one individual by one or more individuals in the workplace".	Yildirim, Yildirim, & Timucin, 2007, p. 447.
Vertical violence	Aggressive behaviors between individuals at different levels of the hierarchy, directed downwards or upwards	Stanley, 2010, p 10.

Appendix C

G Power

t tests – Means: Difference between two independent means (two groups)

Analysis:	A priori: Compute required sample size		
Input:	Tail(s)	=	Two
	Effect size d	=	0.5
	α err prob	=	0.05
	Power (1–β err prob)	=	0.95
	Allocation ratio N2/N1	=	1
Output:	Noncentrality parameter δ	=	3.6228442
	Critical t	=	1.9714347
	Df	=	208
	Sample size group 1	=	105
	Sample size group 2	=	105
	Total sample size	=	210
	Actual power	=	0.9501287

Appendix D

School of Health Sciences

To: Diane Smith, PhD candidate, Nova Southeastern University

From: Dr. Edward A. Henninger, Dean of the School of Health Sciences

CC: Recipient names

Date: October 2, 2017

Re: Approval to conduct dissertation study among nursing and health sciences' students

---

After reviewing your research design to use survey response data from a selected sample of our nursing and health science students, I provide my support and approval to conduct this incivility in higher education study pending IRB approval.

Regards,

Dr. Edward A. Henninger

Dean of the School of Health Sciences

Appendix E

Letter to Dean

Date:

To the Dean of Health Sciences,

My name is Diane L. Smith, a doctoral candidate at Nova Southeastern University, Fort Lauderdale, Florida. I am writing to seek your support and approval to conduct a study with your health science students as part of my dissertation work.

My study uses the Incivility in Higher Education–Revised Survey, designed by Dr. Cynthia Clark and adapted from her Incivility in Nursing Education Survey. This survey will measure the level and frequency of student and faculty incivility as perceived by nursing and health sciences (HS) students.

The study will focus on several objectives: (a) to determine the level of student incivility occurrences as perceived by nursing and HS students, (b) to determine the frequency of student incivility as perceived by nursing and HS students, (c) to determine the level of faculty incivility as perceived by nursing and other HS students, and (d) to determine the frequency of faculty incivility as perceived by nursing and HS students. In addition, this study seeks to identify the extent of incivility within the students' program of study. This study will use Bandura's social learning theory as a framework for this study as it involves observation and modeling of behaviors.

I am seeking students who are in either in nursing or specified HS majors (DH, EMS, OTA, PA, PTA, RAD, or ST), will have participated in at least one clinical experience, are currently enrolled as a student in this College, are seeking an associate or baccalaureate degree and are an on-campus, face to face student.

I will have Institutional Review Board approval from Nova Southeastern University in addition to your College.

Thank you for consideration of this request.

Diane L. Smith, PhD candidate, MSN, RN

Appendix F

Letter to Program Directors

Date:

To the Director of the XXXX Program,

My name is Diane L. Smith, a doctoral candidate at Nova Southeastern University, Fort Lauderdale, Florida. I am writing to seek your support and approval to conduct a study with your in-program students as part of my dissertation work.

My study uses the *Incivility in Higher Education–Revised Survey*, designed by Dr. Cynthia Clark and adapted from her *Incivility in Nursing Education Survey*. This survey will measure the level and frequency of student and faculty incivility according to perceptions of nursing and health sciences (HS) students.

The study will focus on several objectives: (a) to determine the level of student incivility as perceived by nursing and HS students, (b) to determine the frequency of student incivility occurrences as perceived by nursing and HS students, (c) to determine the level of faculty incivility as perceived by nursing and other HS students, and (d) to determine the frequency of faculty incivility as perceived by nursing and HS students. In addition, this study seeks to identify the extent of incivility within the students' program of study. This study will use Bandura's social learning theory as a framework for this study as it involves observation and modeling of behaviors.

I am seeking students who are in either in nursing or specified HS majors (DH, EMS, OTA, PA, PTA, RAD, or ST), will have participated in at least one clinical experience, are currently enrolled as a student at this College, are seeking an associate or baccalaureate degree and are an on-campus, face to face student.

I will have Institutional Review Board approval from Nova Southeastern University, in addition to this College. I have also received approval from the Dean of Health Sciences.

Thank you for consideration of this request.

Diane L. Smith, PhD candidate, MSN, RN

Appendix G

Participant Letter

Participant Letter for Anonymous Surveys
NSU Consent to be in a Research Study Entitled
Exploring Incivility among Nursing and Health Science Students:
A Descriptive Study

<u>Who is doing this research study?</u>

This person doing this study is Diane L. Smith, PhD candidate, MSN, RN with Nova Southeastern University, College of Nursing. They will be helped by Dr. Lynne Bryant, EdD, RN, Dissertation Chairperson.

<u>Why are you asking me to be in this research study?</u>

You are being asked to take part in this research study because you are of any age, ethnic/racial background, sexual orientation, and have the ability to speak English. You are also being asked to take part in this study because you

- Are a student in either in nursing or specified health science majors (DH, EMS, OTA, PA, PTA, RAD, or ST)
- Have participated in at least one clinical experience
- Are currently enrolled as a student in the college selected for this study
- Enrolled in an associate and baccalaureate program
- And are an on-campus, face to face student.

<u>Why is this research being done?</u>

The purpose of this study is to determine the level and frequency of student and faculty incivility as perceived by nursing and health science students within a higher education setting.

<u>What will I be doing if I agree to be in this research study?</u>

You will be taking a one-time, anonymous survey. The survey will take approximately 10 to 20 minutes to complete.

<u>Are there possible risks and discomforts to me?</u>
This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

<u>What happens if I do not want to be in this research study?</u>

You can decide not to participate in this research, and it will not be held against you. You can exit the survey at any time.

Will it cost me anything? Will I get paid for being in the study?

There is no cost for participation in this study. Participation is voluntary, and no payment will be provided.

How will you keep my information private?

Your responses are anonymous. Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law. All data will be stored separately from any identifiers used in the study. Hard copies of the data will remain in a locked file cabinet within this researcher's home for 3 years, after which will be shredded. Computer files and any computer storage such as thumb drives will be destroyed at the same time as the hard copy data files. The researcher remains the sole access and keeper of the data. Results of the study in the dissertation or potential publications or presentations will only be reported in a manner that will not jeopardize the participants' privacy. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any granting agencies (if applicable).

Who can I talk to about the study?

If you have questions, you can contact Diane L. Smith at 570 772 8172 or dsmith@mynsu.nova.edu who will be readily available during and after normal work hours. In addition, Dr. Lynne Bryant, Dissertation Chairperson, can be reached at 954 262 1797 or lb933@nova.edu.

If you have questions about the study but want to talk to someone else who is not a part of the study, you can call the Nova Southeastern University Institutional Review Board (IRB) at (954) 262-5369 or toll free at 1-866-499-0790 or email at IRB@nova.edu.

Do you understand and do you want to be in the study?

If you have read the above information and voluntarily wish to participate in this research study, please complete the distributed survey to the best of your ability and submit the finalized survey to the survey administrator in the classroom.

Appendix H

Licensing Agreement for IHE-R

COPYRIGHT LICENSE AGREEMENT

This License Agreement (the "License") is made and entered into this 12th day of January 2017, by and between Boise State University, hereinafter referred to as the "Licensor" and Diane L. Smith, hereinafter referred to as the "Licensee."

WHEREAS, the Licensor owns certain rights, title and interests in the Incivility in Higher Education Revised (IHE-R) Survey, hereafter called the "Licensed Works," and

WHEREAS, the Licensor desires to grant a license to the Licensee and Licensee desires to accept the grant of such license pursuant to the terms and provisions of this License Agreement for the purposes of permitting Licensee to use the Licensed Works for non-commercial purposes as outlined herein;

NOW THEREFORE, in consideration of the payment of the License fee and the other mutual promises and benefits contained herein, the parties hereto agree as follows:

> 1. <u>Grant of License.</u> The Licensor hereby grants to Licensee, its employees, agents and contractors, a limited, non-transferrable, non-exclusive license under Licensor's copyrights to use the Licensed Works to assess the level of incivility in the following environments: single site, single use at Nova Southeastern University in Fort Lauderdale, Florida.

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        effect to choice of law and conflicts of law. Licensor and
        Licensee agree not to designate a particular governing law.

12.   Default. Any failure of either party to perform in accordance with the terms of this Agreement shall constitute a breach of the agreement. In the event of a material breach by Licensee, Licensor may, upon written notice to Licensee, declare this License Agreement terminated and may seek such other and further relief as may be provided by law, including, but not limited to, a temporary or permanent injunction against Licensee's

continued use of the Licensed Works, actual and/or statutory damages, costs of suit, and reasonable attorney fees incurred by Licensor as a result of the breach, plus interest on all amounts from the date of the breach until paid in full, at the highest rate permitted by law.

13. Complete Agreement. This License supersedes any and all prior written or oral Licenses and there are no covenants, conditions or agreements between the parties except as set forth herein. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent innovation, renewal, addition, deletion or other amendment hereto shall have any force or effect unless embodied in a written contract executed and approved by both parties.

In witness whereof, the parties hereto have executed this License on the day and year first above written.

Licensee:

By: _Diane L. Smith_
Diane L. Smith

Date: 1/13/17

Licensor:

By: _Katy Ritter_
Katy Ritter, Director, Office of
Technology Transfer

Date: 1/13/17