MINORITIES IN NURSING: THE EXPERIENCE OF INCIVILITY IN NURSING EDUCATION

by

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A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Capella University

January 2017

Abstract

The aim of this phenomenological study was to explore the lived experiences of minority nursing students with nursing faculty's incivility. Six students of varied ethnicity participated in the study. The guiding theoretical framework for the study included Roy's adaptation model and Clark's conceptual model for fostering civility in nursing education. Data were collected through semi-structured interviews. Colaizzi's (1978) phenomenological method for qualitative research was used to guide the data analysis of the student's experiences with faculty incivility. Seven themes emerged related to nursing faculty uncivil behaviors including: learning environment, unfair treatment, student faculty relationships, demeaning/belittling, emotional impact, adaptive behaviors, and pressure to conform. Implications of this study indicate faculty can meet the needs of minority students and improve relationships leading to higher success in nursing education by understanding the perceptions of students experiencing incivility. Nurse educators need to be aware of differences in social integration, sociocultural context, and learning among minority nursing students. Future research should focus on faculty perceptions of working with minority nursing students and the issues within nursing education. An additional area for future research should be minority nursing faculty working with diverse student populations.

Dedication

First and foremost, I must dedicate this to my family! My husband, Chris, thank you for your support and patience during this journey, the dining room table is finally paper free and can be used for entertaining again! Thank you for keeping me on track when I wanted to give up.

Second, I dedicate this to my three girls. Taylor, Emily, and Samantha, thank you for understanding when I had to spend hours on the computer in order to fulfill my goals. Thank you for letting me read sentences to you, to see if they "made sense". I hope you have learned that education is important and that you can achieve whatever you set out to do.

Finally, I want to thank my parents for instilling in me, that education is important. Yes, I did become a "professional student", but it was because of the hard work you taught me that I have achieved so much in my life. You have always encouraged me to pursue my educational goals and for that I am forever grateful. My oldest brother, Jimmy, showed me from a very early age that education was important and he achieved so much in his career and inspired me to be the best I can be.

Acknowledgments

First, I would like to acknowledge my family. Thank you to my husband, Chris; my girls, Taylor, Emily, and Samantha. There were many weekends when I could not come to games, movies, or be present in the moment and you all understood. The encouragement, help, love, and support each of you demonstrated throughout this journey can never be repaid.

Next, my dissertation mentor, Dr. Jobeth Pilcher, must be acknowledged. She is an incredible asset to the faculty at Capella University and I am grateful she allowed me to work with her and learn from her. Her gentle guidance and expertise throughout the dissertation phase contributed greatly to my learning and success. Dr. Pilcher is a great role model, nurse educator, and person. Thank you for making me a better student, nurse educator, and person!

My dissertation committee must be acknowledged, Dr. Julia Bronner and Dr. Jason Ward. Thank you for your time, support, and commitment in helping me complete this process. Both of you are an incredible asset to the School of Education at Capella University.

Finally, an acknowledgement for my friends, coworkers, and department chairs for encouraging me to complete this experience. My past colleagues, Linda Chitwood and Jean Heslin, thank you for being mentors both in the classroom and out. My dear friend, Melissa Thomas-Eckroade, we began the journey at Capella together however we did not finish together, you are greatly missed. Anthony Mangiafico, thank you for always encouraging me to complete my degree! Dr. Rose Saunders and Dr. Jane Elliott, thank

you for hiring me in my first nursing education position and showing me that I could do this. Dr. Deborah Ulmer, thank you for believing in me and taking chances on me!

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CHAPTER 1. INTRODUCTION

Despite the advances of healthcare and the nursing shortage, the makeup of the nursing workforce is predominantly Caucasian females (Abrums, Resnick, & Irving, 2010). However, with an increasing nursing shortage and economic crisis within the United States, the demographics of the classroom and the hospital setting is shifting. The diverse nature of the student population attending nursing programs today provides the faculty with challenges in meeting their needs in the academic setting. There are more males and more culturally diverse students attending today than in the past (Ierardi, Fitzgerald, & Holland, 2010).

The rationale for becoming a nurse crosses genders, races, ethnicities, and cultures. People choose to become nurses to care for people and to assist them to work through health issues (Genua, 2005). Minority students attending nursing programs may have to work, take care of family, or be the first-generation college student (Doutrich, Wros, Rosario, & Ruiz, 2005). There are three key variables that prevent minorities from succeeding in higher education: educational preparation, financial barriers, and feelings of what the student is able to accomplish (Mingo, 2008).

In addressing a healthy educational environment, one must examine incivility. Lateral violence, horizontal violence, workplace bullying, whichever term may be used, it all represents the same concept. The World Health Organization (WHO) has defined violence as "the intentional use of physical force or power, threatened or actual, against

oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (WHO, 2002, p. 5). The concept of incivility among nurses has been in the literature for the past twenty-five years (Griffin, 2004). Incivility consists of fighting amongst one another, withholding significant information, scapegoating, criticism, and the disregard of personal privacy and confidential information (Griffin, 2004).

Clark and Springer (2007a) examined incivility in nursing education to include both faculty and students. Faculty and students viewed incivility as a moderate to severe problem. In the study, students described feelings of inadequacy, feeling substandard, and a blow to their confidence with the unfair treatment and the exertion of authority by faculty. Students perceived faculty as holding their future in their hands (Clark, 2008a). In a review of literature by Gallo (2012), research on incivility lacked diversity. Most students participating in the studies were undergraduate Caucasian females. Due to these findings, additional studies are needed to explore the experiences of incivility among minority nursing students.

This chapter includes the background of the study. The chapter will begin by explaining the background of the problem, including the research problem, purpose of the study, and the research question. The chapter also includes the relevance and need for the study. A brief overview of the selected research methodology will follow, concluding with definition of terms, assumptions of the study, and the limitations and delimitations of the study.

Background, Context, and Theoretical Framework

As students enter a nursing program, the expectation is to complete the program. Students do not expect to encounter incivility from nursing faculty which could impede completion of a nursing program. Schaeffer (2013) concluded incivility contributed to psycho-social issues, physiological symptoms, and a major reason for nursing student attrition. Thomas and Burk (2009) found that students had experienced embarrassment, intimidation, and humiliation by their instructors. In the hospital setting, nurses were found to continue the intimidation for novice nurses which led to attrition within their first nursing position (Thomas & Burk, 2009). Staff nurses as well as educators participate in incivility against students and can impact the completion of a nursing program and subsequent job success (Seago & Spetz, 2008). Faculty are also known for allowing incivility to occur with students under their clinical supervision (Magnavita & Heponiemi, 2011). Faculty fail to confront the perpetrator of the incivility or make excuses for the nurse's behaviors (Thomas & Burk, 2009).

In 2008, the NLN (National League for Nursing) identified several areas in nursing education needing to be evaluated or created for educational reform. Two areas needing development are the student/teacher learning partnership and student/teacher experiences in schools of nursing. The NLN prides itself on addressing the needs of nursing education and being a leader in innovation. Acting with other agencies to bring awareness to incivility will lead to better educational practices as well as better patient care and outcomes (NLN, 2008).

Clark and Springer (2007a) examined incivility in nursing education to include both faculty and students; they found that both viewed incivility as a moderate to serious problem. In the study, students described feelings of inadequacy, feeling substandard, and a blow to their confidence with the unfair treatment and the exertion of authority by faculty. Students perceived faculty as holding their future in their hands (Clark, 2008a).

In a study by Clark (2008a), students described their fear of being weeded out, jumping through hoops, playing games, and feeling threatened with failure in the pressure to conform to the often rigid requirements of a nursing program. Students expressed fear and anger regarding these issues but also expressed a willingness to conform to avoid failure or being expelled. Students expressed feelings of anger, being traumatized, powerlessness, and helplessness while experiencing incivility in the academic setting. Students that eventually succeeded in completion of their program had support from family and friends. However having a supportive and nurturing nursing faculty member was a better predictor of success.

Student's clinical experiences are often met with incivility from staff nurses (Thomas & Burk, 2009). This type of incivility is often referred to as vertical violence. Students that participated in this study by Thomas and Burk (2009) shared feelings of being unwanted and ignored by staff nurses when assigned to work with patients under their care. Nurses often dismissed assessment findings of the student nurse as being incorrect and would challenge their knowledge and belittle them in the front of others. Thomas and Burk (2009) also found that critical findings by students were often ignored by staff nurses therefore jeopardizing patient safety. This study also revealed that clinical

faculty did not address the behavior of the staff nurse and at times made excuses for the behavior.

The impact of incivility or lateral violence in nursing can impact patient care and safety (Ditmer, 2010). Novice nurses needing answers or help with patient care may receive unprofessional answers or criticism. The Joint Commission (2008) suggested that the lack of teamwork and ineffective communication of health care workers was responsible for 24% of sentinel events resulting in patient death, injury, or disability. Work environments with incivility are also associated with patient falls and medication errors (Roche, Diers, Duffield, & Catling-Paull, 2010). Late administration of medications and technical skills are also associated with incivility (Roche et al, 2010).

The Joint Commission (2008) and the Occupational Safety and Health Administration (OSHA) (2003) addressed the need for hospitals other organizations to create and maintain a safe working environment. They suggested that health care organizations and nursing leaders have a moral, ethical, and legal obligation to provide a safe workplace. Nursing faculty and hospital staff must learn to recognize and break the cycle of lateral violence in the workplace and educational environment.

As nursing colleagues discuss today's students, they often compare them with themselves (LeDuc & Kotzer, 2009). They may believe the students and new nurses are not committed to the profession and are only in it for the paycheck. In addressing the nursing shortage, academia and health care organizations should address the differences in generations of nurses and capitalize on the differences. In order to maintain an adequate number of qualified nurses to care for the aging population and chronic health

care needs of this population, agencies should capitalize on strengths of individuals and accommodate them in the workplace.

Conceptual Model

The conceptual model created by Clark (2008a) demonstrated the complex nature of incivility in nursing education named incivility in nursing education conceptual model. Clark's model served as a guide for the research study presented here. Clark's conceptual model showed the interactions between faculty and students created high amounts of stress for both parties. High stress is influenced by several factors such as student entitlement, faculty superiority, workloads of students and faculty, technology overload, faculty attempting to balance a keen insight with clinical competence, and a lack of skills in conflict resolution (Clark, 2008a). When stress levels are high and faculty-students interact, the interaction could be intense and cause disruptive or threatening behaviors. Behaviors combined with high levels of stress coupled with ineffective coping could lead to incivility. When incivility escalates and the situations are ignored or avoided the incivility may spiral and create a culture of incivility. In contrast when faculty and students work together to resolve the conflict a safe and more civil learning environment is created. This type of environment presents opportunities for growth and learning on all levels.

Statement of the Problem

The Joint Commission (2008) identified incivility in the hospital as a priority for hospital organizations to address with staff. Addressing incivility may lead to improving patient outcomes and maintaining a workforce. Clark (2011) described incivility as rude,

disruptive, intimidating, and undesirable behavior directed toward someone else. Any action that is considered offensive, intimidating, or hostile that can interfere with the learning environment is incivil in nature (Harris, 2013). In order to improve relationships among nursing, the process of identifying incivility and ways to combat it must start in the academic setting and collaborate with healthcare agencies to work on eliminating it (Luparell, 2011). As nursing programs see an increase in enrollment due to the economy, the diversity of the student population is increasing. Although the diversity of the classroom changed, the faculty have not. Minorities report barriers to success as lack of encouragement by nursing faculty; not having minority faculty role models; and incivility in nursing education (Mingo, 2008). Nursing students may withdraw from nursing programs for a variety of reasons, including poor academic performance, financial issues, and family obligations. However, the unhealthy learning environment may contribute to student dissatisfaction and leaving the nursing program in pursuit of other experiences therefore leading to an unsuccessful fulfillment of their goals in nursing. The problem addressed by this study was the experiences of minority nursing students with faculty incivility.

Purpose of the Study

The purpose of the phenomenological qualitative research study was to examine the experiences of minority nursing students with faculty incivility. Interviews with minority nursing students were conducted to better understand the impact of incivility while enrolled in a nursing program. The study specifically examined the perceptions

minority nursing students have while experiencing faculty incivility and how it impacts their educational experience.

Research Question

How do minority nursing students describe their experiences with faculty incivility?

Rationale, Relevance, and Significance

The next sections discussed are the rationale, relevance, and significance for the study. These sections will provide a description of the need for the study, as well as how the results may impact nursing education and the contributions the findings will make to the field of nursing education. Understanding the perceptions of minority nursing students with faculty incivility can help prepare a healthier learning environment.

Rationale

As nursing programs are seeing an increase in enrollment due to the economy, the diversity of the student population is increasing (Mingo, 2008). There are more minorities including male students attending nursing programs. The research does not address incivility directed at minority students (Marchiondo, Marchiondo, & Lasiter, 2010). Furthering this area of research will build on the body of knowledge regarding faculty incivility as it relates to minority student success and may lead to improved faculty/student relationships, work/school satisfaction, and better patient outcomes (Luparell, 2011).

Relevance

The research study presented included an examination of minority nursing students experience with faculty incivility therefore providing insight to educators on how this may impact success of students. Incivility in nursing education disrupts and interferes with the learning process in the classroom (Altmiller, 2012). Findings from the study will assist nursing educators in working with a diverse student population and provide a better understanding of the experience of incivility from faculty.

As faculty are made aware of incivil actions identified by students in their experiences, faculty need to practice approaches to promote professionalism in the profession. Nurse educators have a responsibility to protect the public and therefore it is vital to hold students accountable and responsible by having high expectations and standards (Altmiller, 2012). However, faculty should also create a positive learning environment in which students do not fear faculty.

Faculty are viewed as role models for students and help advance professional behaviors (Clark & Springer, 2007a). Providing a positive example for students is imperative for the profession (Suplee, Lachman, Siebert, & Anselmi, 2008). Faculty may introduce the American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements (2011) to improve professional behavior and civil treatment of students, colleagues, and staff nurses and therefore promoting civil behaviors within the profession.

When faculty and students form a collaborative relationship in the learning environment they grow both personally and professionally (Poorman, Mastrovich, &

Webb, 2008). Positive experiences promote partnerships for the profession. Faculty may wish to reflect on the role they play in incivility and how they block an inequitable relationship with students. As faculty and students reflect on incivility and their role, engagement in conversations and strategies to promote civility and eliminate incivility can improve the academic environment (Clark, 2008a).

Significance

The research study examined the lived experiences of minority nursing students with faculty incivility. The majority of research available in the literature examines Caucasian female's experiences with faculty incivility. The diversity of the classroom has changed for nursing programs from Caucasian females to more males and other more culturally diverse students (Ierardi, Fitzgerald, & Holland, 2010). As changes in the classroom occur, research should demonstrate the change as well, allowing the educator to make adequate adjustments to assist in a health learning environment. In order to assist nursing faculty in changing the learning environment for minority nursing students, it is important for faculty to understand their lived experience with incivility.

The Joint Commission (2008) identified incivility in the practice setting as a priority for hospitals to address with staff. In order to assist hospitals in addressing the issue, Luparell (2011) suggested academic and healthcare agencies work together to combat the issue and eliminate it. The diversity of the student population is increasing. Minority students report barriers to success as lack of encouragement by nursing faculty; not having minority faculty role models and incivility in nursing education (Mingo, 2008). However, a gap in knowledge existed regarding minority students experience

with incivility. The study will help to fill the gap in knowledge through an examination of lived experiences for minority students with faculty incivility and allow the academic world to better address the issue.

Nature of the Study

A qualitative research method was used in this study. Phenomenology was the research design used to study the perceptions of participants with faculty incivility. Phenomenology uses the description of the lived experiences of a certain phenomenon by participants (Munhall, 2012). The researcher used Colaizzi's (1978) phenomenological method of qualitative research for this study. Colaizzi's method is a seven step method for analyzing qualitative data in order to develop themes.

Using Colaizzi's phenomenological study, the researcher conducted face-to-face, one-on-one interviews with participants. Face-to-face interviews are considered the best method for collecting data due to the quality of the information that is collected (Polit & Beck, 2008). Data collection focused on open-ended interview questions. Participants were asked to describe their lived experiences with faculty incivility and to also describe their responses to the incivility. Interviews were transcribed verbatim. Significant statements were extracted and meanings were created. Meanings were placed into themes. A comprehensive description of the experiences as described by the participants is included.

Once themes and meanings were identified, the researcher met with participants to make sure the essence of the phenomenon was validated. Meeting with participants to gain the participants perspectives on the research results adds to the credibility of the

study (Colaizzi, 1978). The next section defines terms that are beneficial to the study. These terms are necessary to understand what the researcher is describing when a term is utilized within the study.

Definition of Terms

This section will define terms that are being used for this study. These terms are how the researcher defined the key terms related to the study as well as terminology related to the research method of phenomenology.

Academic Nursing Environment

Any academic environment engaged in nursing education, whether on or off campus, including live or virtual classroom and clinical environments (Brady, 2010).

Civility

Authentic response to others requiring presence, engagement, and an intention to seek common ground (Clark & Carnosso, 2008).

Experience

The uniting of body and mind in order to gain meaning (Munhall, 2012).

Incivility

Disregard for others, leading to disrespect, conflict, and stress (Clark, 2012; Emry & Holmes, 2005). Behaviors which are rude and disruptive in nature causing stress and if left unaddressed may progress to a threatening environment (Clark, 2012; Clark, 2009).

Minority Nursing Students

Groups of people that are underrepresented in nursing-specifically men and persons from African American, Hispanic, Asian, American Indian, and Alaskan Native ethnic groups (AACN, 2014).

Phenomenology

The study of the lived experience of the individual (Munhall, 2012).

Undergraduate Nursing Student

Pre-licensure student seeking an Associate's degree in nursing (Clark, 2011).

Assumptions, Limitations, and Delimitations

Research studies contain assumptions, limitations, and delimitations. Identification of personal shortcomings that may impact the study results will be explained. Assumptions are out of the researcher's control, but if not present the study may not be pertinent (Simon, 2011). Limitations are also out of the researcher's control and are the potential weaknesses in the study. Limitations are a restriction on the study that may impact design and results. Delimitations are characteristics which define the boundaries and limit the scope of the study and are within the researcher's control (Simon, 2011).

Assumptions

There were several beliefs and assumptions the researcher possessed at the beginning of the study. Nursing student's accounts of incivility are true. The guided interview questions would aid in answering the research question. The responses to the interview questions are honest in nature. Incivility occurs in nursing education. There are

differences in how minority nursing students perceive incivility from non-minority students. The participants would be willing to share their experiences with a Caucasian female.

Limitations

Transferability and generalizability of the findings from this study are limited since the nursing sample of students only represented students in associate degree nursing programs in one southern state. The participants in this study were volunteers. Participant volunteers may have issues they wish to air and therefore this may impact the type of student that volunteers (Pearcey & Elliott, 2004). The number of participants in a qualitative study may make it difficult to generalize as well (Creswell, 2009).

Delimitations

This study was delimited to students in three nursing schools in one state. The study included only students which are considered a minority. The study included student's perceptions of uncivil behaviors. Faculty perceptions were not included.

Organization of the Remainder of the Study

Chapter 2 will present the theoretical framework for the study and present, analyze, synthesize and critique the appropriate literature related to the problem described in Chapter 1. Chapter 3 will include a description of the research methodology selected to respond to the problem and answer the research questions. Once the data collection and analysis is completed, chapter 4 will present an analysis of the data. The completed dissertation will conclude with chapter 5, which will include a summary of the findings, conclusions drawn from the data presented in chapter 4, implications for practice,

relationship of findings to the literature review, and recommendations for practice and future research.

CHAPTER 2. LITERATURE REVIEW

The purpose of the study was to examine the experiences of minority nursing students with faculty incivility. The review of literature of the conceptual framework will be discussed first. The review of literature addresses civility and incivility in nursing and nursing education, as well as literature examining minorities in nursing. Literature related to phenomenology will be discussed. The conceptual framework, as well as the literature on the methodological research, will also be discussed. The review of literature was conducted using the Cumulative Index for Nursing and Allied Health (CINAHL), OVID, PubMed, Dissertation Abstracts, and Education Resource Information Center (ERIC) databases from 1997-2016. Terms used to conduct the search were *nursing shortage, diversity in nursing*, *civility in nursing*, *incivility in nursing*, *minority experiences in nursing* and *minorities in education*.

Conceptual Framework

The guiding framework for this study included Clark's conceptual model and Roy's adaptation model for fostering civility in nursing education. The two models exhibit the relationships necessary for a nursing student and a faculty. The conceptual models provide a foundation in examining the experiences of minority nursing students with faculty incivility.

Clark's Model for Fostering Civility in Nursing Education

Clark (2008a) developed a conceptual model that demonstrated the complex nature of incivility and civility in nursing education. The center of the model represents faculty and student encounters in nursing education. Within the oval depicts where high levels of stress are encountered by both faculty and students. The stress levels are influenced by several factors, including behaviors and attitudes of student entitlement and faculty superiority, demands of nursing school, busy personal lives, over saturation of content, and lack of knowledge and skills (Clark & Kenaley, 2011). Faculty and students have encounters in high stress times as well as low stress times. When stress levels are high, the encounters can be intense and result in threatening behaviors. The arrow in the middle of the model demonstrates the continuum of faculty –student encounters. The left side of the model indicates what happens when faculty and students are unable to resolve a conflict. In contrast, the right side of the model indicates what happens when faculty and students work together for conflict resolution.

The conceptual model illustrates how the increased levels of faculty and student stress along with the attitudes of student entitlement and faculty superiority contribute to the incivility in nursing education (Clark, 2010). Incivility happens when stress levels between faculty and students are high and conflict resolution does not occur from being missed, avoided, or poorly managed. When opportunities are addressed with effective communication and conflict resolution, a culture of civility emerges (Clark, 2010). When faculty and students work together to resolve issues, civility is enhanced and a learning environment emerges in which safety and mutual respect are present.

Incivility in nursing education is a give and take of uncivil behaviors between students and nursing faculty (Clark & Kenaley, 2011). Clark (2008b) stated "Incivility is like a dance-one dancer leads and the other follows-and sometimes the dancers do both" (p. E37.) Clark's quote demonstrates the inter-relationship between faculty and students with incivility. Clark (2008b, 2013) described the interconnectedness of students and faculty as a dance because of the interactions and engagement required in the relationship. Incivility requires at least two participants; the instigator and the victim (Clark, 2013).

Tower-Siddens' (2014) dissertation utilized Clark's model as a conceptual framework in a qualitative study to better understand the impact of faculty incivility on nursing student's ability to learn. The research study identified high stress of faculty was mismanaged and uncivil behaviors were directed toward students. The students in the study managed the uncivil encounters by adapting to them. Tower-Siddens (2014) determined faculty incivility had a negative impact on student learning. The Tower-Siddens interpersonal adaptive model emerged from the study. The new model depicted the interaction as a constant between faculty and student while allowing the student to adapt to the environment to meet learning needs.

After a detailed search of the literature, Clark's conceptual model was used in her own studies and the dissertation of Tower-Siddens. Clark's conceptual model has been utilized in research to assist in providing an understanding of the interrelatedness of incivility in faculty to students. Clark, Otterness, Allerton, and Black (2010) and Clark, Juan, Allerton, Otterness, Jun, and Wei (2012) conducted a study in China on incivility.

Faculty incivility was found to be the result of social and political changes that caused faculty to focus on student success of tests, entrance exams, and professional licensure exams. The interaction between faculty and students led to mismanagement of situations that directly resulted in incivility. Clark's model provided an appropriate manner on how faculty and students could foster a civil environment.

Roy's Adaptation Model

Roy's adaptation model (RAM) uses four major concepts important to the profession of nursing: *person, health, environment, and nursing* (Parker & Smith, 2010). Roy (2009) defined *person* as a holistic system in constant interaction with the environment. Within this model, the phrase *person* can refer to an individual or a group, which copes with changes (Barone, Roy, & Frederickson, 2008). The *environment* includes stimuli and conditions impacting growth and behavior of the person (Roy, 2009). *Health* refers to becoming whole, which would indicate the person adapting to the environment (Roy & Andrews, 1999). Within Roy's model, *nursing* refers to the science and practice of assisting the person to adapt to the stimuli from the environment to affect the health in a positive manner (Roy, 2009). These four concepts demonstrate a relationship between persons with environmental stimuli and the impact on a person's health status. Roy's framework allowed for a better understanding of minority nursing students (person) perceptions of faculty incivility (stimulus from environment).

There are four adaptive modes described in RAM: physiological, self-concept, role function, and interdependence. Tiedeman (2005) provided a description of each mode. The physiological mode defines the basic human needs. The self-concept mode

includes the mind and personal perceptions. The role function and interdependence modes demonstrate the social aspect that defines social integrity and the balance between dependence and independence.

Roy's adaptation model has provided a methodology and framework in research (Frederickson, 2011). The effectiveness of RAM in a quantitative research study regarding verbal abuse toward nurses in a pediatric setting was explained by Pejic (2005). The RAM utilizes the adaptive modes when stimuli are encountered that produce an effect on behavior. Person is in a constant interaction with environment (Pejic, 2005). The study by Pejic (2005) focused on verbal abuse which is an act of incivility and the usefulness of RAM.

Perrett (2007) explained the need to explore and explain the perceptions of the cognitive subsystem using qualitative research methods. Using qualitative methods allows a better understanding of the phenomena being studied from the perception of the person merging cognitive and adaptive themes (Perrett, 2007). The rich descriptions gathered are invaluable in studying adaptation (Perrett, 2007).

A qualitative study conducted by Gagliardi, Frederickson, and Shanley (2002) examined how people with multiple sclerosis make sense of their lived experiences utilizing the RAM as the framework. Interviews were conducted to collect data from participants. The results indicated the adaptation of the person to the environment. The results indicate that cognitive abilities have an influence on coping ability and the person's perceptions of the adaptive modes have a strong influence over an adaptation to

physical health. This study demonstrates the usefulness of the RAM as a framework in examining the effects of faculty incivility on perceptions of minority nursing students.

Roy (2009) described the goal of the professional nurse of facilitating the optimal well-being (health) of the person, helping the person to adapt effectively to stimuli that produces and optimal level of functioning. The person can reach an optimal level of functioning in learning or nursing practice (Roy & Zhan, 2010). The interconnectedness of concepts in the RAM provide a strong framework for use in the exploration of incivility and student perceptions.

Review of the Research Literature and Methodological Literature

Examining incivility among nurses can assist in addressing a healthy educational or work environment. Lateral violence, horizontal violence, workplace bullying, whichever term may be used, it all represents the same concept. The World Health Organization (WHO) has defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (WHO, 2002, p. 5). Nursing shortage, diversity in health care, healthy work environments, incivility in nursing, incivility in nursing education, and minorities in nursing will be discussed in upcoming sections.

Nursing Shortage

The shortage of nurses in the United States is having a significant impact on the health care system, the quality of care, and patient outcomes (Dotson, Dave, & Cazier,

2012; Goodin, 2003). The nurse to patient ratio is inadequate and compromising patient care (Erlen, 2004). Nurses also report a high rate of burnout, moral distress, and ethical dilemmas forcing them to consider leaving the profession (Erlen, 2004). Nurses have an increased patient load, decreased time to provide quality care, and are less satisfied within their jobs (Goodin, 2003).

By 2025, the nursing shortage in the United States is expected to grow to 260,000 (Buerhaus, Auerbach, & Staiger, 2009). In contrast, Allen (2008) expects the nursing workforce to need over one million nurses by 2020. The numbers will begin to worsen as more Baby-Boomers retire from nursing as well as require care. The Council on Physician and Nurse Supply (Nelson, 2009) stated the need for 30,000 nurses to graduate per year to meet the demands of healthcare.

In order alleviate the nursing shortage; nursing programs need to increase enrollment and retention of diverse populations (Goodin, 2003). Opportunities should meet the needs of students that are not the traditional learner offering more flexible scheduling and meeting the needs of diverse student learners. Nurse educators need to understand the need for diversity in the nursing profession in order to assist in meeting the demands of the diverse patient population.

Diversity in Healthcare

The American Association for Colleges of Nursing (AACN) (1997) stated the population of the United States is diverse and would continue to grow in diversity into the 21st century. Diversity is considered to be ethnicity and race but also includes socio-economic status, gender, age, religion, sexual orientation, and physical disabilities.

Health care organizations are charged with caring for diverse populations within the community they serve. By 2020, thirty-five percent of the population will consist of minorities (Barrow, 2010). The fastest growing minorities are Asian (43.3%), Hispanic (43%), Native Hawaiian/Pacific Islander (35.4%), American Indian/Alaska Native (18.4%), and Black/African American (12.3%), while Caucasians only grew (5.7%) (Hart & Mareno, 2013). In contrast, the workforce of registered nurses classifies themselves as non-Hispanic Caucasian (83.2%) and are predominantly female (90.4%).

The increasing health needs of the population have created a need for new solutions to old issues (Barrow, 2010). Cultural competence is a process that involves nurses having knowledge and skills to work with diverse patient populations (Hart & Mareno, 2013). Health care providers must address the need to go beyond knowing about cultures, and have diverse cultures in the professions to better understand the needs of the diverse patient population (Moadel, Morgan, Fatone, Grennan, Carter, Laruffa, Skummy, & Dutcher, 1999). Nurses should represent the populations in which they serve to assist patients in better outcomes.

Educational institutions are responsible for creating a learning environment which will cultivate diversity within the nursing profession as well as the communities served by the nursing professionals (AACN, 1997). AACN (2001) recognized nursing programs needed to attract more men and minority students. If there is no diversity in the programs there will be no diversity in the workforce. Recruitment efforts, as well as retention, are key to increasing the diverse nursing student population as well as the RN workforce.

Healthy Work Environment

Healthy work environments in nursing can influence patient safety, recruitment and retention of nurses, and promote exemplary clinical practice (Brady, 2010). The American Association of Critical-Care Nurses (AACN) identified six standards for creating and maintaining a healthy work environment: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership (AACN, 2005). The AACN (2005, p. 1) also stated that an unhealthy work environment contributed to medication errors, poor patient care, and conflict among healthcare professionals.

To ensure a healthy work environment the educational institution or hospital organization must guarantee patient safety, enhance staff recruitment and retention, and maintain financial viability. (AACN, 2005, p.1). Healthy work environments foster trust, mutual respect, collaboration, and better communication (Moore, Leahy, Sublett, & Lanig, 2013). Healthy work environments are essential for nurses well-being, successful recruitment and retention of nurses, and safe, effective patient care (Moore, et. al., 2013). If a healthy work environment does not exist, then the financial viability of an organization may be in jeopardy. Since all of these characteristics have implications for the nurse educator, it is important that faculty members and administrators in clinical settings hold conversations to help create healthy work environments. Healthy work environments may have substantial impact on patient outcomes as well as staff retention and satisfaction with the job (Moore, et. al., 2013).

The Nursing Organization Alliance (NOA) (2004) developed nine elements that support a healthy work environment. These elements include cultures of collaboration, communication, accountability; the number of qualified nurses present; leadership that is competent, credible, and visible; shared governance; continued education; recognition of the value of the contributions of nursing; and the recognition of the meaningful contribution that nurses make to practice (NOA, 2004). Creating a culture of collaboration included being respectful of diverse opinions, team oriented, and trusting coworkers. Communication is to be open, clear, and respectful. Everyone is accountable with role expectations clearly defined throughout the organization. The presence of adequate numbers of qualified nurses to provide quality care to meet the patient's needs and being able to balance work and home life are essential to the environment. Leadership should be competent, credible, and visible. Leaders serve as advocates for the nursing profession, support shared governance, and allocate appropriate resources to support nursing. Shared decision-making should be present at all levels of the organization. Nurses should participate in system, organizational, and process decisions. Nurses should have control over their practice. Nurses should have support and/or encouragement to continue their education or earn certificates. Nurses should participate in their professional organizations on the local, state, and national levels. Nurses should be paid for their performance and rewarded for a job well done. Nurses should be able to advance their career and expand the profession. The National League for Nursing (NLN) took these elements and defined a healthy work environment for nursing educators as the framework that enables faculty to provide quality nursing education (NLN, 2005).

Incivility in Nursing

Behaviors that are disruptive among healthcare workers do not support a healthy work environment. The concept of incivility among nurses has been written about for the past 25 years (Griffin, 2004). Incivility consists of fighting amongst one another, withholding significant information, scapegoating, criticism, and the disregard of personal privacy and confidential information (Griffin, 2004). In order to help eliminate incivility among nurses, all involved must understand the reasons behind it, the implications, and the educational tools needed to combat it.

Incivility is inappropriate and unacceptable in the nursing profession and in academia. At times it is hard for people to see that the behavior exhibited is uncivil, as they become used to seeing or hearing the behavior. Types of abuse include: verbal abuse, nonverbal abuse, sexual harassment, passive aggressive behaviors, and bullying (McNamara, 2012).

McNamara (2012) further describes the types of abuse typically perpetrated. Verbal abuse includes yelling, shouting, and raising the voice in a threatening manner. The person could also publically reprimand or criticize the individual. Backstabbing, belittling, spreading rumors is also considered verbal abuse. Nonverbal abuse can include eye-rolling, making faces, invading a person's space in an attempt to intimidate, and excluding someone. Sexual harassment includes sexually inappropriate jokes, vulgar language, unwelcome advances, and even requests for sexual favors. Passive aggressive behaviors are typically subtle but are just as damaging to the profession and work environment. These behaviors include setting someone up for failure, giving someone

the ‘silent treatment’, sabotage, and communicating misinformation. Bullying behaviors can include all that are previously listed but tend to be continuous over time and directed toward groups with less power, such as students.

Incivility creates havoc among relationships of the nurse and morale in the workplace (Harris, 2011). Nurses experiencing incivility often produce lower quality work, less effort and burn out faster than nurses who do not. Incivility is a major cause of workplace stress and frustration. According to Leiter and Maslach (2005) the annual cost of job stress due to incivility is $300 billion. Stress can weaken the immune system, causing wear and tear on the body, spirit, and soul (Harris, 2011).

The impact of incivility or lateral violence in nursing can impact patient care and safety (Ditmer, 2010). Novice nurses needing answers or help with patient care may receive unprofessional answers or criticism. The Joint Commission (2008) attributed a lack of teamwork and ineffective communication for 24% of sentinel events resulting in patient death, injury, or permanent loss of function. Unstable work environments are also associated with patient falls and medication errors (Roche, et al., 2010). Late administration of medications and technical skills are also associated with incivility (Roche et al., 2010).

Not only does nurse on nurse incivility impact the nurse, it also impacts patient care. The correlation between incivility and patient adverse events exists (Roche, et al., 2010). Roche et al., (2010) identified that actual physical violence was associated with patient falls, medication errors, and the late administration of medications. The threats of physical violence were associated with falls and medication errors (Roche et al, 2010). In

an organization where incivility is allowed, the staff will lack initiative to perform their jobs well. The impact on the personal relationship among nurses in the workplace can cause errors, accidents, and poor work performance (Sheridan-Leos, 2008; Woelfle & McCaffrey, 2007). Olender- Russo (2009) showed that nurses that participated in or observed incivility, reported being involved in a medication error where intimidation contributed to the event.

The impact of incivility on the nurse consists of physical symptoms such as weight issues, hypertension, cardiac issues, and bowel problems (Sheridan-Leos, 2008; Olender-Russo, 2009). Job dissatisfaction and psychological distress such as depression, anxiety, and post-traumatic stress are also experienced by nurses experiencing incivility (Sheridan-Leos, 2008; Longo & Sherman, 2007). Laschinger, Finegan, and Wilk (2009) found that workplace incivility can lead to early burnout for newly graduated nurses. Luparell (2011) described incivility as a motivating factor in nurses leaving their employers.

Incivility erodes self-esteem leading nurses feeling vulnerable increasing anxiety, which may then lead to anger and resentment (Harris, 2011). The effects can lead to PTSD (post-traumatic stress disorder). Incivility not only impacts the individual but the workplace as well.

Incivility among nurses impacts recruitment, retention, job satisfaction, and morale (Longo & Sherman, 2007). In a time when there is a nursing shortage that will increase with the aging of the Baby Boomers, this problem needs to be addressed. Nursing is considered a caring profession and not a profession where there is a display of

violence among them. Nursing educators may be able to assist in eliminating the issue of incivility in the nursing profession by addressing it within the educational environment. Incivility is costly to an organization. It can lead to high nurse turnover, recruitment issues, and diminished teamwork by nurses left in the organization (Sheridan-Leos, 2008). If the organization chooses to turn their heads and look the other way, the target becomes a victim of the bully as well as the institution or organization (Olender-Russo, 2009). Incivility occurs because of three reasons: it can happen, it is modeled behavior, it is left unchecked (McNamara, 2012).

Incivility in Nursing Education

As students enter a nursing program, their expectation is to complete the program. Thomas and Burk (2009) found that students had experienced embarrassment, intimidation, and humiliation by their instructors. Students also experienced incivility in the clinical setting by faculty and nursing staff (Thomas & Burk, 2009). The incivility experienced by nursing students both in the classroom and clinical areas can impact the completion of a nursing program and subsequent job success.

Faculty are also known for allowing incivility to occur with students under their clinical supervision (Thomas & Burk, 2009). Faculty fail to confront the perpetrator of the incivility or make excuses for the nurses behaviors (Thomas & Burk, 2009). In becoming a more fair-minded thinker, faculty would want to display intellectual autonomy by demonstrating critical thinking, and not just by accepting others beliefs or opinions (Paul & Elder, 2006, p. 19).

Khadjehturian (2012) pointed out that incivility may be seen in institutions where certain types of behavior are encouraged. The hospital environment is typically very controlled and one either conforms to the culture or moves on. If this is any indication of what could be happening changing a person's behavior may be achievable, changing an entire culture may prove to be more difficult.

Nursing and nursing education have myths or sacred cows that permeate the profession (Hegge & Hallman, 2008). One of those sacred cows is the nurse has control over the patient in the hospital or the nurse educator has control over the student in the classroom. Today's patients, as well as today's learners, are partners in their own health care and education. Students come to the classroom expecting a meaningful connection between the content and their career goals. Academic freedom in colleges and universities allows faculty to teach the way they feel comfortable and is a part of controlling the environment (Hegge & Hallman, 2008). Teaching in a manner which is comfortable for the faculty may not reach all learning styles and prepare the nursing student for practice. Resistance to change in higher education is considered a part of academic freedom (Hegge & Hallman, 2008). In order to change this line of thinking, a way to address this and get the best participation by faculty and staff nurses is the use of intellectual courage and intellectual empathy (Paul & Elder, 2006, p. 10-12). Intellectual courage enables the nursing professional to do the right thing for the people they are working with, such as students or patients. Nursing staff and educators will speak out when there is wrong doing regardless of the situation or personal cost (Glasper, 2012). Intellectual empathy is demonstrating compassionate care based on dignity, respect, and

kindness to all persons (Glasper, 2012). Both nurse educators and nursing staff can utilize intellectual courage and empathy within the work environment.

The statement "nurses eat their young," as well as the actions behind this statement, is perceived as an inevitable piece of nursing education and nursing employment (Lally, 2009, p. 17). The Joint Commission (2008) found incivility in the nursing culture and made recommendations for leadership to address the disruptive and inappropriate behaviors displayed by nurses. Developing a more collegial environment in an educational setting can prove to be a challenge, as faculty typically work in isolation in clinical and the classroom (Brady, 2010). In order to overcome this phenomenon, the nursing leaders must identify this as a serious problem that is not acceptable. In doing so, nursing leaders would form a stronger, more unified profession (Olender-Russo, 2009).

Longo and Sherman (2007) indicated that nurses are a part of an oppressed group (predominantly female) and work under a male dominated system of male physicians, administrators, and nurse managers. "Oppression is the experience of repeated, widespread, systemic injustice" (Deutsch, 2006, p. 10). Oppression which is 'civilized' is more difficult to identify and change (Deutsch, 2006). Deutsch (2006) identified five types of injustices that are present in oppression: distributive, procedural, retributive, moral, and cultural imperialism. Cultural imperialism relates closely to nursing and health care. In health care, cultural imperialism exists when the physician's practices, views, values, and beliefs are the dominant culture and the established norm (Minority Nurse Staff, 2013). Nursing is the other group, viewed as different, invisible, devalued

and objectified by the dominant group. In nursing, oppression leads to lower salaries, hostility from coworkers, and unequal access to advancement in career and education (Minority Nurse Staff, 2013).

Nursing administrators and nurse educators have the responsibility to promote a positive atmosphere and to form teams, in order to maximize the strengths of all (Brady, 2010). Sheridan-Leos (2008), stated that nurses lack autonomy, control over their work environment, and self-esteem. This leads to submissive behaviors that then lead to aggression towards others.

In a research study by Khalil (2009), six levels of violence were identified, psychological violence, vertical violence, horizontal violence, covert violence, overt violence, and physical violence. There were three main factors found to contribute to the violence among nurses, lack of communication, lack of respect, and inadequate anger management training (Khalil, 2009). Nationwide attention was given to incivility in nursing education in 2003 when a disgruntled nursing student in the University of Arizona's nursing program murdered three nursing faculty before turning the gun on himself (Hall, 2004). This example is extreme in nature, however it demonstrates a serious issue.

The NLN (2008) identified several areas in nursing education needing to be evaluated or created for educational reform. Two areas needing development are the student/teacher learning partnership and student and teacher experiences in schools of nursing. Both of these areas of reform support the need for research in faculty to student incivility in nursing programs.

Clark and Springer (2007a) examined incivility in nursing education to include both faculty and students; they found that both viewed incivility as a moderate to serious problem. Students described feelings of inadequacy, feeling substandard, and a blow to their confidence with the unfair treatment and the exertion of authority by faculty. Students perceived faculty as holding their future in their hands (Clark, 2008b).

Clark (2008b) described students' perceptions of being weeded out, jumping through hoops, playing games, and feeling threatened with failure by faculty in the pressure to conform to the often rigid requirements of a nursing program. Students expressed fear and anger regarding the treatment, but also expressed conforming to the demands in order to avoid failure or being expelled. Students expressed feelings of anger, being traumatized, powerlessness, and helplessness while experiencing incivility in the academic setting. Students expressed that support from family and friends was important to their success, however having a supportive and nurturing nursing faculty member was a better predictor of success.

Faculty are not the only people to participate in incivility with student nurses. Staff nurses also demonstrate uncivil behavior toward students in the clinical setting (Thomas & Burk, 2009). This type of incivility is often called vertical violence (Thomas & Burk, 2009). Students assigned to work with patients under staff nurses care shared feelings of being unwanted and ignored by the staff nurse (Thomas & Burk, 2009). Students were often questioned on their assessment techniques and abilities, and staff nurses would dismiss any data collected by the student nurse. Staff nurses would belittle and challenge the knowledge level of student nurses in front of other students, staff, and

patients. Patient safety was also in jeopardy when staff nurses chose to ignore critical findings of the student nurse during care. This study also revealed that clinical faculty who knew of the behavior of the staff nurse did not address the staff nurse and at times made excuses for the uncivil behavior.

The incivility in nursing is not just an American phenomenon. Magnavita and Heponiemi (2011) discussed the experiences of Italian nursing students. Students reported incivility both verbal and physical violence from colleagues, staff, teachers, doctors, and supervisors. Nursing students expressed feelings of humiliation, being wrong, needing to change their behaviors, and the desire for revenge. Nurses in the same study whom experienced incivility or lateral violence expressed a desire to leave the workplace or the profession.

Hospitals and nursing education programs need to create and maintain a safe working environment (The Joint Commission, 2008; Occupational Safety and Health Administration (OSHA) 2003). Providing a safe workplace is a moral, ethical, and legal obligation for health care organizations and nursing leaders. Faculty and staff must learn to recognize incivility and break the cycle in the workplace and educational setting.

Nursing colleagues often compare today's students to a time when they were students (LeDuc & Kotzer, 2009). They may assume current students and new nurses are not committed to the profession and are only in it for the financial gain. In examining ways to address the nursing shortage, academia and health care organizations should address the similarities and differences in the diverse nursing workforce and capitalize on those differences. In order to meet the demands of an aging workforce and a population

of patients with chronic health care needs, organizations should capitalize on strengths of individuals and accommodate them in the workplace.

In addressing incivility within the nursing profession, examination of educational programs and how they address the issue is essential. Faculty members have a dual role in addressing the problem of incivility (Clark & Ahten, 2010). Faculty need to make sure students are able to identify unprofessional behaviors in the workplace and also be a model of professionalism (Clark & Ahten, 2010). Nursing students experiencing incivility in the classroom or clinical setting may see a decrease in academic performance influencing success in finishing a program or passing the NCLEX-RN.

Incivility in the academic setting of nursing programs may spill over into the professional role of the registered nurse and impact patient care, retention, and recruitment of nursing staff (Longo, 2010). The role of a professional nurse is to provide patient care. When a person thinks of a nurse, they often think of a caring and compassionate person. Nurses do care for patients, but often ignore or sacrifice each other for the sake of self. The face of nursing today in the classroom and hospital is one of diversity. In order to work with the current population of nursing students and staff, nursing must tackle the incivility directed at one another to enrich patient care and the role of the professional nurse (Mingo, 2008).

Minorities in Nursing Education

Incivility in society has become more apparent. The use of technology has made personal communications less than personal. Bad behaviors seem to be the "norm" and manners a thing of the past. Rudeness seems to be pervasive costing society and possibly

taking a toll on the world- impacting relationships, the economy, government, and health care (Clark & Springer, 2007b; Levine, 2010; Luparell, 2004). Civility is essential to human existence and can mean the difference between life and death as is the case with nursing and caring for patients (Clark, 2009).

Despite the advances of healthcare and the nursing shortage, the makeup of the nursing workforce is predominantly Caucasian females. However, with an increasing nursing shortage and economic crisis within the United States, the demographics of the classroom and the hospital setting is shifting (Mingo, 2008). More males are entering the nursing field from multicultural backgrounds. There is also an increase in Blacks and Hispanics. With the increase in multi-cultural and international students and nurses entering the healthcare workforce there is a growing concern with nursing education being unable to meet the needs of the diverse learner (Mingo, 2008). The responsibility of the nursing administrator/educator is to promote a positive atmosphere and to form teams, in order to maximize the strengths of all (Brady, 2010).

The hospital and school administration may need to address the roles, barriers, and stereotypes prevalent within the current and future nursing workforce and overcome those obstacles. People choose to become nurses to care for people and to assist them to work through health issues (Genua, 2005). The rationale for becoming a nurse crosses genders, races, ethnicities, and cultures.

When examining the role of the nurse and stereotypes, the media has not been a friend. Nurses are often portrayed as sex objects and taking orders from doctors instead of critically thinking on their own. Males in nursing are often depicted as gay or

effeminate (Genua, 2005). The linguistic diversity of nurses or students from other cultural backgrounds may contribute to failure in school and in the workplace. The difference in cultures from the *norm* of the school environment or hospital organization creates a climate for failure and loss of a valuable nurse within today's shortage (Kayes, 2006).

The educator can create an environment of inclusion for all students involved in the educational experience. Providing an environment of trust and acceptance will provide students of all cultures a place to grow and learn about and from one another. Madeline Leininger's Theory of Culture Care (Leininger & McFarland, 2010) provided care measures that are in harmony with a person's cultural beliefs, practices, and values. Her definition of cultural care diversity referred to the differences in meanings, values, or acceptable modes of care within or between diverse groups of people (Leininger, et al., 2010).

Mingo (2008) stated that there seemed to be three key variables that prevented minorities from succeeding in higher education: educational preparation, financial barriers, and feelings of what the student is able to accomplish. The nursing force in the United States has high percentage of Caucasian females. As black students attend nursing programs, they may encounter faculty who are not aware of the diverse needs of students and understand the cultural differences in students thus missing a critical time in the development of life-long learning (Mingo, 2008). Black students are often expected to conform to the school expectations and put aside their own beliefs and views.

Among the Hispanic culture, the person sitting in the classroom is probably a first-generation college student. They will usually attend smaller colleges or community colleges (Doutrich, et al., 2005). Both of these cultural groups may be looked upon as abandoning families. It is important for the instructor to realize this as part of the culture and to help provide emotional support for Blacks and Hispanics. Both cultural groups may have to work, take care of family, and attend programs in order to meet the expectations set by the culture.

Males in Nursing

The perception of society on nursing is the greatest barrier for men entering nursing (Gheller & Lordly, 2015). Nursing has been defined as women's work, marginalizing men in the profession (Evans, 2004). During the 11th and 12th centuries, military knights performed nursing skills for the sick and wounded (Evans, 2004). Noblemen entered into battle as men of lesser status were in nursing service. The knights noted toward the end of the 11th century that nursing should be done by women since caring for animals and sick persons was better performed by them. Men have had a role in nursing since the beginning; however they faced and still face struggles in the role of a nurse.

Men make up 6% of the nursing workforce, but are four times more likely to leave the profession within the first five years compared to women (Anthony, 2006). Job satisfaction is significantly lower in male nurses also (Anthony, 2006). Roth and Coleman (2008) performed a literature review to better understand barriers men face entering into the nursing profession. Four themes were discovered during their review.

The first theme identified that nursing was viewed as a women's profession, one that is subservient to physicians, mostly men (Roth & Coleman, 2008). The second theme identified that male students did not think that nursing would give them job satisfaction or more opportunities as other professions may. Middle class young men also reported a fear of being labeled as gay or feminine if they were to become a nurse. The third and fourth themes are characteristics of male nurses and barriers in the environment (Roth & Coleman, 2008). Females are able to enter a male dominated profession, however males find entering work that is perceived as appropriate for females is much harder. Males work in less feminine specialties such as critical care, emergency departments, perioperative nursing, and psychiatry. The absence of mentoring and role models was the biggest environmental barrier found (Roth & Coleman, 2008). History lacks male contributions to nursing as well as textbooks using feminine pronouns to describe nurses contributed to the perception.

Attrition among male students is high and ways to improve retention need to be examined (Gheller & Lordly, 2015). As the male student enters the nursing environment, he first encounters predominantly female faculty and female students (Genua, 2005). When entering a course in women's health he may not be able to participate because of the intimate requirements and the patient's unwillingness to have a male taking care of them. A fear of being reported as sexually inappropriate may cause males to feel unwelcome in the clinical setting (Roth & Coleman, 2008). Male students may also be the bread winner for their family and the traditional day programs may not fit into their lifestyle. Alternative classrooms such as evening, weekend, and online programs may

need to be available for male students as well as blacks and Hispanics (Doutrich, et al., 2005; Genua, 2005).

Males experience challenges in the classroom due to teaching styles and educational materials designed for female learners (Gheller & Lordly, 2015). The isolation felt from this can have male nursing students reconsidering the career choice. Research reveals a need for more male faculty to provide more positive learning environments (Stott, 2007). Bell-Scriber (2008) described male nursing students experiencing more meaningful learning experiences from patients rather than female faculty and peers. The men in this study expressed feeling that the female nurses and nursing faculty did not approve of men in nursing. One faculty in the study revealed that men in nursing only want to be nurse anesthetists or physician assistants and therefore should not be in nursing.

Gender bias was also perpetuated in the textbooks utilized in nursing programs (Meadus & Twomey, 2011). Male students expressed feelings of discrimination and being used solely for their ability to lift or move heavy patients or equipment or controlling violent situations. Students also felt singled out more in classrooms due to being the only male in the classroom which they felt hindered their learning experience. Faculty would remember the one males name and therefore call on them when no one else answered a question.

Clarke et al. (2012) found that although males and females had experienced significant bullying (84% of males and 89.2% of females), there was no statistically significant difference. In a study by Foster, Mackie, & Barnett (2004) gender differences

were examined in New Zealand nursing students. The findings indicated that 100% of male nursing students stated they had been bullied during clinical. The majority of the bullies were female (86%), but three male participants reported being bullied by males. This finding correlates with previous studies showing when males bully, they bully other males (Hoel & Cooper, 2000).

African Americans in Nursing

African Americans are not graduating from nursing programs at the rate of the general population (Mingo, 2008). Nursing literature is sparse in regards to minority student's perceptions of the educational experience and success (Dapremont, 2011). Research suggests that interactions with peers and faculty in the nursing academic setting influence success (Dapremont, 2014; Tinto, 1993). Peer interactions include study groups to learn content providing students with feelings on inclusion. Faculty support and early identification of issues has been identified to improve the learning environment and retain African American nursing students (Dapremont, 2011; Beacham, Askew & Williams, 2009). Shelton (2003) stated that faculty mentoring can improve retention and graduation rates for African American students when directing them toward resources and services to support them.

Role stereotypes, economic barriers, lack of mentors, lack of direction from early authority figures, lack of knowledge about the profession of nursing, and other career opportunities are identified as barriers to attending and graduating from nursing programs (Mingo, 2008). Increasing the number of African Americans graduating from nursing

programs will help to improve the health care disparities of patients and provide positive role models for future students (Mingo, 2008).

Students reported experiencing intimidation by faculty, whether Caucasian or African American (Mingo, 2008). The faculty employed in nursing programs provided no support and also demonstrated non-minority favoritism (Mingo, 2008). Faculty often insinuated that African American students would do whatever it took to be successful, including cheat (Mingo, 2008).

Seago and Spetz (2005) conducted a study to examine the success rates of minority nursing students in the community colleges in California. The findings alarmed the researchers and suggested for nursing programs to be successful with first time test takers, the programs would need to reduce or exclude minority students or students would need to change their cultural views in order to be successful. The study went on to suggest that the rigidity of nursing curriculum and faculty were obstacles to success for African American students. African American students may communicate and learn in ways that a predominantly Caucasian faculty do not understand, leading to misunderstandings and confusion. The findings of this study suggested significant racial and ethnic characteristics impacting the success of African American nursing students.

Dapremont (2014) found students that studied in a more diverse group understood concepts better than in other groups. African American students developed a stronger sense of belonging and being part of a community when working in diverse study groups. Students expressed a concern with being able to form groups and wanted assistance from faculty in doing so.

Hispanics in Nursing

Although Hispanics are currently 17% of the population, 3% of registered nurses (RNs) are Hispanic (AACN, 2014). With the underrepresentation of Hispanic nurses in the workforce, the health of the Hispanic population is impacted (Moceri, 2010). Increasing the number of Hispanic RNs will provide culturally congruent care for the Hispanic population (IOM, 2002).

ESL (English as a Second Language) students have difficulty with the coursework as well as clinical (Guhde, 2003). The high level of communication, written and verbal, increases the challenges faced by Hispanic nursing students. Faculty are often unprepared to assist the ESL student in overcoming the obstacles to learning. Faculty report ESL students require more time and effort to learn material essential in nursing programs (Torregosa, Ynalvez, Schiffman, & Morin, 2015). Hispanic students may hesitate to ask for clarification from faculty and nursing staff, therefore exhibiting potentially unsafe behaviors (Torregosa, et al., 2015). Social isolation may interfere with important resources for Hispanic students and can influence academic success.

Hispanic nursing students reported several barriers to attending nursing educational programs and being successful. Barriers included: lack of economic support, lack of support from faculty, lack of mentors, and few positive role models (Moceri, 2010). Discrimination, curriculum that was not flexible, and language barriers were also identified as obstacles within nursing education, (Moceri, 2010). Hispanic students also reported family obligations, work, culturally identified gender roles, and loneliness

contributed to feelings of negativity when involved in an educational program (Moceri, 2010).

Hispanic students perceived academic pressure to assimilate to cultural norms in order to be successful (Moceri, 2010). Students also expressed a concern in progressing in nursing programs due to their ethnicity. Students also described feelings of powerlessness as an individual, however, they felt the benefit when other students supported them. Fear of reprisal prevented students from reporting any injustices experienced at several educational institutions (Moceri, 2010). As more racial/ethnic minority students attend nursing programs, nursing educators will need to create environments that foster success.

Asians in Nursing

Asian students who are ESL, face cultural barriers their peers may not (Scheele, Pruitt, Johnson, & Xu, 2011). The literature is limited on this ethnic group compared to other ESL groups. Faculty are encouraged to pair Asian nursing students with students where English is the primary language, enhancing practice of English and exposure of both students to cultural differences.

Asian students identified three areas of incivility in nursing faculty: poor teaching methods, teaching skills, and faculty incompetence; conflict between faculty and students; faculty exhibiting disrespectful behaviors toward students (Clark, Juan, Allerton, Otterness, Jun, & Wei, 2012). Both students and faculty blamed stress, heavy workloads, poor communication, and a disconnection between faculty and students for

incivility. Asian students and faculty called for more open communication and mutual respect in the classroom and clinical area to improve learning and elimination of barriers.

Addressing the Needs of Minority Nursing Students

As the educator addresses all learners' needs in the classroom they must first get to know the students they are working with (Ditmer, 2010). Creating an environment of open communication and trust will allow the learners and instructor to meet the educational needs required by programs. Allowing students to tell their stories of past educational and life experiences can provide insight into how each learner learns and what barriers to education may be ahead of them. By being proactive, the experience can be a rich one for the educator and learner.

As the nation reaches a critical nursing shortage, educators have a responsibility to promote caring and diversity among nursing students and staff (Longo, 2010). Group differences should be valued and perceived as strength for the nursing profession and healthcare. In order to reach the diverse needs of patients, the diversity nursing workforce needs to expand (Mingo, 2008).

The diverse nature of the student population attending nursing programs today provides the faculty with challenges in meeting their needs in the academic setting (Bond & Cason, 2014). There are more males and more culturally diverse students attending nursing programs today than in the past (Mingo, 2008). Nursing education programs need to promote an environment in which all students are welcome and encouraged to complete the program (Mingo, 2008). Faculty need workshops to better understand cultural differences and to develop a learning environment conducive to learning for all

nursing students (Mingo, 2008). The personal knowledge and experiences of minority nursing students can assist in developing culturally appropriate care for the diverse patient population within the hospitals (Leeman, Goeppinger, Funk, & Roland, 2003).

Review of Methodological Issues

The study described in this manuscript employ a phenomenological qualitative approach to examine minority nursing student's perception of faculty incivility**.** The goal of phenomenology is to produce a description of a phenomenon of an experience to understand it. The phenomenon of interest is a shared experience with the participants of the study (Saunders, 2003).

Phenomenological research aims to capture the lived experiences of the individual (Finlay, 2009). Phenomenological researchers direct attention to people's situation as they live it. Participants share their experience in everyday life as they see it. Researchers uncover meanings within the participants lived time, space, and relationships with self and others (Finlay, 2009). The researcher attempts to be open and to meet the phenomenon with a fresh approach where judgements and theories are temporarily suspended and a connection is made with the experience in the world (Finlay, 2009). Meaning is revealed and reforms understanding and leads to more thoughtful action (Flood, 2010).

A structured approach to the complexity of the analysis of a phenomenological study can often overwhelm the researcher. Colaizzi's method allows for unstructured individual interviews to be performed and thus gathering rich data from lived experiences (Saunders, 2003**).** Phenomenology and interviews are a valid method in data collection;

however there are limitations when using this method (Creswell, 2009). Limitations include filtered information provided by the person being interviewed. Interviews are also conducted in a predetermined area rather than in a natural environment of the participant (Creswell, 2009). The presence of the researcher may also create a bias in the responses from the participant. Some participants may have difficulty expressing their experiences clearly. The researcher must be aware of not leading the interviewee while conducting the interview (Creswell, 2009). They must allow the interviewee to lead the discussion using the open-ended questions presented by the researcher. The interviewer must also be able to focus the interview if the interviewee should go off topic. The interviewer must be able to conduct an interview and communicate effectively (Creswell, 2009). Coding and interpretation of the data may also be an issue that arises with phenomenological research. The researcher must insure that coding of data is performed consistently throughout the data analysis process (Creswell, 2009). The researcher will be the only person coding and analyzing the interviewees transcripts to assist in eliminating this issue.

Synthesis of Research Findings

Previous research has focused on defining civility and incivility as well as methods for increasing civility within the academic setting (Clark 2006; Clark 2011; Luparell, 2011). Academia, hospitals, professional organizations, faculty and students have all identified incivility as a significant issue in nursing education and in the nursing profession (Thomas & Burk, 2009; Clark, 2008b; Longo & Sherman, 2007; Griffin, 2004; WHO, 2002). Numerous studies have demonstrated a connection between

civility/incivility impacting student performance, retention, and satisfaction (Al-Hussami, Saleh, Abdalkader, & Mahadeen, 2011; Cox & Ebbers, 2010). The participants of these studies have predominantly included Caucasian females and have not addressed the diversity of nursing education or the nursing profession (Abrums, et al., 2010; Mingo 2008). The studies have not examined the lived experiences of minority nursing students with faculty incivility.

The increasing nursing shortage along with the increasing diversity of the population of the United States creates an issue for nursing education programs as well as hospitals (Hart & Mareno, 2013; Barrow, 2010; Buerhaus, et al., 2009; Erlen, 2004; Goodin, 2003). In order to provide better care for diverse populations the diversity of the nursing workforce must also improve (Hart & Mareno, 2013; Barrow, 2010). If faculty have a better understanding of how incivility is perceived by minority nursing students perhaps the diversity in nursing programs as well as hospitals can improve (AACN, 2001; AACN, 1997).

Critique of Previous Research

The review of literature provided many areas in which incivility has been addressed. As nursing programs are seeing an increase in enrollment due to the economy, the diversity of the student population is increasing (Ierardi, et al., 2010). There are more minorities including male students attending nursing programs. The majority of the research with student participants has been with Caucasian females. The research does not address incivility directed at minority students (Marchiondo, et al., 2010).

The literature reviewed regarding incivility in nursing, incivility in nursing education, and faculty incivility are methodologically sound. Qualitative studies have demonstrated an understanding of the phenomenon of incivility in nursing education, however due to small sample size are not generalizable (Clark 2008b; Clark & Springer, 2010). Quantitative studies have been utilized to demonstrate the prevalence and significance of incivility in nursing and nursing education (Clark, 2008; Clark & Springer 2007a, 2007b; Laschinger, et al., 2009). The lack of research on minority nursing student's perceptions of faculty incivility is distinct (Gallo, 2012; Ierardi, Fitzgerald, & Holland, 2010). More research is needed in understanding minority and gender differences in experiences and perceptions of faculty incivility (Gallo, 2012).

The limited use of Clark's model in research other than her own creates a weakness in the model. The model was utilized in a prior dissertation and supported prior findings (Tower-Siddens, 2014). The model explains the interconnectedness of faculty and students to produce effective teaching-learning environments throughout the literature.

Chapter 2 Summary

Incivility has a profound impact on nursing education, nursing students, and the nursing profession. Clark's (2008a) conceptual model demonstrates the relationship between faculty and student in nursing academia. Roy's adaptation model and Clark's conceptual model provided the foundation and the frameworks that supported this qualitative study on the perceptions of minority nursing students with faculty incivility. Both models illustrated the interrelatedness of faculty and students as well as how

students adapt to uncivil encounters. While abundant research has addressed incivility in the nursing profession, no studies were located regarding perceptions of minority students with faculty incivility. The study described in this manuscript was aimed at filling this gap in the literature.

CHAPTER 3. METHODOLOGY

This study addressed a gap in the literature regarding the experiences of incivility in nursing education by minority nursing students. The purpose of this study and the research question that guided the study will be reviewed. In this chapter, the study methodology will be described, including the research design, sample and setting, instruments, data collection procedures, analysis plan, and ethical issues related to the study.

Purpose of the Study

The purpose of the phenomenological qualitative research study was to examine the experiences of minority nursing students with faculty incivility. Interviews were conducted to better understand the impact of incivility on minority nursing students while enrolled in a nursing program. The study specifically examined minority nursing student's perceptions while experiencing faculty incivility and how it impacts their educational experience.

Research Question

How do minority nursing students describe their experiences with faculty incivility?

Research Design

Incivility in nursing exists in the practice setting as well as the academic setting. The change in demographics in the nursing classroom has changed from predominantly Caucasian females to minorities including males and other culturally diverse populations (Ierardi, Fitzgerald, & Holland, 2010). Minority students report barriers to success as lack of encouragement by nursing faculty, not having positive role models, and incivility in nursing education (Mingo, 2008).

The prevalence of incivility in nursing academia and in the work environment, can lead to speculation regarding a continuation of the incivil acts toward patients and other health care team members. The Joint Commission (2008) has identified incivility in nursing as playing a role in patient errors and lack of safe patient care. The Quality Safety Education for Nurses (QSEN) (2005) began from the work of the Institute of Medicine. QSEN's overall vision is to prepare future nurses with the knowledge, skills, and attitudes needed to work in health care environments providing safe, quality care. Faculty have a responsibility to abide by the ANA Code of Ethics for Nurses (2011) when teaching future nurses. One of the statements in the code addresses behaviors and interactions with patients and other health care workers.

A qualitative phenomenological study was anticipated to assist in answering the research question by focusing on the lived human experience. Participants were asked to describe their experiences. Responses were captured and explored using a phenomenological approach (Creswell, 2009). Through descriptive techniques, insight into the experience of minority nursing students with incivility is shared in the findings.

The participants were interviewed using a semi-structured interview protocol. Once the interviews were completed, the data was analyzed. During the analysis, themes and patterns emerged and the lived experiences of the individual related to the phenomenon were described.

The goal of phenomenology is to produce a description of a phenomenon of an experience to understand it (Creswell, 2009). The phenomenon of interest is a shared experience with the participants of the study (Saunders, 2003). A structured approach to the complexity of the analysis of a phenomenological study can often overwhelm the researcher. Colaizzi's phenomenological data analysis strategy is a seven step process to assist in interpreting the data (Saunders, 2003). Colaizzi's method allows for unstructured individual interviews to be performed and thus gathering rich data from lived experiences (Saunders, 2003).

Target Population, Sampling Method, and Related Procedures

This section includes a description of the target population, the sampling method is reviewed, and other procedures are identified that were used to complete the study. The target population refers to a group of individuals the researcher can draw on for the study (Schmidt & Brown, 2012, p. 297). The sampling method is the process used to select the participants (Creswell, 2009). The section concludes with a discussion related to related procedures of sample size, setting, and recruitment.

Target Population

The participants were from a population of nursing students attending a community college in the southeastern United States seeking their Associate Degree in

Nursing. These programs are typically two years in length and encourage a diverse student population. Most programs within the associate degree programs have an average of 100 nursing students enrolled.

Participants included all racial/ethnic and both genders to capture a random sample of students. In the academic year, 2013-2014, there were 59% female and 41% male attending the program. In the same year, the ethnicity groups attending were self-identified as 72% Caucasian, 13% African American, and 14% other. As nursing programs are seeing an increase in enrollment due to the economy, the diversity of the student population is increasing (Ierardi, et al., 2010). There were more minorities including male students attending nursing programs (Ierardi, et al., 2010). The majority of the research with student participants has been with Caucasian females. Prior research did not address incivility directed at minority students (Marchiondo, et al., 2010). Male students and students from diverse ethnic and racial groups were included in the sample.

Sampling Method and Sample Size

A qualitative study most often uses purposeful sampling (Lodico, Spaulding, & Voegtle, 2010). Purposeful sampling is useful to select people that provide rich, detailed information regarding the studied experience to answer the research question. Numbers are not as important in qualitative research as it is in quantitative (Lodico, et al, 2010). The sample consisted of participants that have experienced faculty incivility. Creswell (2009) indicated that purposeful selection of participants is key in qualitative studies. A sample size of four to eight was anticipated to provide saturation of the data.

Setting

The research study was conducted at an associate degree nursing program in the Southeastern United States. The data was collected in face-to-face interviews at a mutually agreed upon location. Locations were anticipated to include coffee shops, library resource rooms, and restaurants. The goal was to use locations that were quiet, private, and had minimal distractions. Using locations to minimize distractions, eavesdropping, and accidental interruptions will assist in not influencing the interview (Creswell, 2009).

Recruitment

In order to recruit participants, an e-mail describing the study was sent to nursing students notifying them of the opportunity to participate. The e-mail instructed students to contact the researcher directly if they were interested in participating. Participants were assured of anonymity in all phases of the study. Once the participants made contact, directions for participation, a consent form to participate, and a letter outlining the risks/benefits for the study was sent.

Participants were asked several screening questions to insure they met the criteria for participation.

1. How old are you? (all participants must be 18 or older to be included)
2. Are you a current nursing student?
3. What ethnic group do you place yourself in?
4. Have you experienced incivility with a nursing faculty while enrolled in the nursing education program?

If all questions were answered with a "yes", meetings were arranged on a mutually agreed upon time to conduct the interviews. All participants met face-to-face. The participants were advised of the significance of the study and the importance their stories brought to the body of research in order to keep them involved in the research process.

Instrumentation

Face-to-face interviews were conducted with the participants. In order to accurately report the participant responses, the interviews were audio-taped and later transcribed. This interview method allows the researcher to ask open-ended questions to elicit the opinions and experiences of the participants (Creswell, 2009). The face-to-face interview method allows the researcher to have control of the questions and allows the participant to provide rich descriptions of the phenomenon being studied (Creswell, 2009). The guided interview questions were developed based on a thorough review of the literature and included the following:

1. Tell me about yourself, including personal and professional accomplishments.
2. What made you choose a career in nursing?
3. Please tell me about an experience with a faculty member that you considered to be uncivil in nature.
4. What do you think precipitated the encounter?
5. How did this make you feel during and after the experience?
6. How did you respond to this situation?
7. How did the encounter influence your views of the nursing profession?
8. In what way, if any, do you think your ethnicity influenced the uncivil encounter?

Data Collection

Participants were screened for inclusion in the study. Those meeting the inclusion criteria proceeded to the interview phase. A time which was mutually convenient to meet

was determined. Participants signed the IRB consent and provided written permission for audio-taping of the interview. Face-to-face interviews with the participants were conducted.

Face-to face interviews assisted in gaining a sense of the experience. The interviews were semi-structured to allow a wealth of data to be collected. Interviews were audiotaped and transcribed (Creswell, 2009). Participants were asked to describe their lived experiences with faculty incivility and to also describe their responses to the incivility. Interviews were transcribed verbatim.

Field Test

The process of field testing is important as it provides the opportunity for experts to give recommendations for including, altering, or eliminating questions based on the research (Creswell, 2009). The guided interview questions were developed based on a thorough review of the current literature and were field tested by two experts in the field of incivility in nursing education. Both experts had over twenty years' experience in nursing and academia. Both were nationally recognized speakers on the topic of incivility in nursing and have conducted research on the subject area. Both experts provided feedback on the guided interview questions and suggested slight changes to wording the questions to illicit a response from the participants.

Data Analysis Procedures

Colaizzi's (1978) phenomenological method of qualitative research was used to analyze the data. Saunders (2003) outlined a useful method for utilizing Colaizzi's method by a novice researcher. This outline was utilized in the step-by-step procedure.

1. Read all participant's transcripts in order to obtain thoughts, feelings, and ideas experienced by the participants.
2. Extract significant phrases and statements from the transcripts.
3. Meanings are formulated utilizing statements of participants.
4. Formulate clusters of themes.
5. Themes are summarized and placed into exhaustive descriptions.
6. The exhaustive descriptions are placed into a final statement.
7. The final statement is given to participants for validation.

The data compiled from the interviews was transcribed verbatim. Significant statements from the participants were formulated into codes or meanings. Themes were extracted. The researcher manually formulated the statements into codes or meanings. Once major themes were identified, the data was organized and rich descriptions were constructed (Lodico, et al., 2010). Participants reviewed the findings of the interviews for accuracy and verified the findings as valid according to their stories.

Limitations of the Research Design

Phenomenological research is a valid method of research, however it does pose limitations (Creswell, 2009). The study was limited to associate degree nursing students in Southeastern United States colleges; this limits the ability to generalize the results of the study to the overall population of nursing students. Data was only obtained from six students willing to participate. The low participation does not allow for generalizations to be made to a larger population of minority nursing students. The study also is limited on

the focus of minority nursing student's experience with incivility, however this has been an area lacking in prior research.

Credibility

Polit and Beck (2008) defined credibility as the confidence the researcher has in the data and the interpretation of the data. The guided interview questions were field tested by experts which contribute to credibility. Participants were asked to verify the transcription was correct and that the interpretation of what they said was accurate. These procedures assisted in ensuring credibility. Dependability parallels reliability in quantitative research (Lodico, et al., 2010). A detailed description of the research methods used to collect and interpret the data was provided so the processes can be tracked. The relationship between the researcher and the participants was described in terms of the cultivation of the relationship and how interviews were structured.

Transferability

Transferability is the ability of the researcher to generalize the findings to other groups or situations (Creswell, 2009). Transferability is judged by examining the richness of the descriptions in the study (Lodico, et al., 2010). Rich, thick descriptions of the lived experiences of participants were provided. The rich detail aids in determining if the study results could be witnessed in another setting. Phenomenological studies focus on the lived experiences of participants. The descriptive data and analysis should allow consumers to determine the applicability in transferring meaning to others (Polit & Beck, 2014).

Expected Findings

There are several expected findings based on the literature review and phenomenological methods. The study was focused on the lived experiences of minority nursing students, it was assumed the participants would have similar experiences and descriptions of the experiences. Another expected finding was participants would interpret faculty incivility as stressful, demeaning, belittling, and destructive leading to poor performance in nursing school as suggested by Clark's Conceptual Model (Clark & Springer, 2007b; Clark, 2010).

Ethical Issues

Ethical issues are a concern of researchers during every research study. Researchers must understand the importance of the ethical implications for the study, as well as reducing any ethical issues that may appear. Ethical issues related to this study will be discussed in the following sections.

Conflict of Interest Assessment

No conflicts of interest were present in this study. There were no relationships with the nursing schools even though the researcher is a nurse educator. There were no personal relationships with any of the participants. The research was not funded by any outside resources and there was no financial gain by participants or researcher. Any potential conflicts of interest were addressed through the IRB process through Capella University and the participant's college.

Researcher's Position Statement

The researcher has experienced incivility in nursing as a student, staff member, and faculty. The researcher examined biases and reflected on experiences that were similar to the participants (Lodico, et al., 2010). The researcher listened and viewed the experiences through the participants lived experiences. The detail the participants provided assisted in gaining insight into the lived experience of the participant and alleviated any biases or assumptions from the researcher. Reflexivity allowed for self-reflection by the researcher and to keep preconceived ideas regarding faculty incivility suspended (Clark, 2006; Creswell, 2009; Creswell & Miller, 2000; & Polit & Beck, 2014). The researcher had no relationship with the nursing program or nursing students prior to the research.

Ethical Issues in the Study

Ethical issues are a concern for researchers. The researcher completed the Collaborative Institutional Training Initiative (CITI) as a prerequisite for conducting the study. CITI training focused on maintaining strict adherence to the primary ethical principles as defined by the Belmont Report. The ethical principles include beneficence, respect for human dignity, and justice (Office for Human Research Protection, 2008). These ethical principles protect the participant, human rights, and confidentiality.

Guidelines for the use of human subjects through Capella University and the college in which the study was conducted were strictly adhered to. The purpose of the study, instructions for completion of the survey, risks and benefits of participation, and the option to withdraw from the study were explained to participants. Consent to

participate in the study was obtained, protecting them from harm and ensuring confidentiality (Lodico, et al., 2010). Informed consent was provided electronically with the recruitment information and again when each participant met with the researcher. At the beginning of the meeting with the participants, they were allowed to ask any questions regarding the study and informed consent was discussed. The participants provided signed consent.

Confidentiality is a concern for researchers and research participants. Careful attention was given to maintain confidentiality. Once the audio recording began, the participants name was not used. As the interviews were transcribed, no identifying information was included in the transcription, as each participant was given a number. The study presented minimal to no risk for the participants and received expedited review by Capella IRB.

Chapter 3 Summary

Chapter 3 addressed the research methodology chosen to examine the experiences of minority nursing students with faculty incivility. A qualitative design was used and data was gathered using semi-structured interviews. Data collection was described as well as the sample of participants. Data analysis followed the 7-step process developed by Colaizzi (1978). The study was examined in terms of credibility, dependability and transferability. Ethical issues related to the study were also identified and discussed.

CHAPTER 4. DATA ANALYSIS AND RESULTS

The purpose of Chapter 4 is to provide an analysis of the data to assess nursing student's perceptions of faculty incivility in a community college setting. The study was qualitative and utilized Colaizzi's (1978) phenomenological method for describing the lived experiences of the nursing students. This chapter will provide a description of the sample, research methodology and analysis, findings, and a summary of the chapter.

Description of the Sample

All participants were enrolled in their first or second year in an associate degree nursing program in the Southeastern United States. Each participant was over the age of 18, were currently enrolled in an associate degree nursing program, had experienced faculty incivility during the nursing program, and considered themselves to be a minority ethnic group. Six students met the criteria for participation (over the age of 18, currently enrolled in the nursing program, self-identification as a minority ethnic group, and experience with faculty incivility while enrolled) and were interviewed by the researcher. Demographic information of the participants included age over 18, three African-American female students, one Hispanic female student, and two African-American males. Several participants self-identified their ages during the interview: three disclosed they were in their mid-40s, one as being a grandparent, and one as being older than 50.

Participants are identified in this chapter using P1 for Participant 1 through P6 for Participant 6.

Research Design and Introduction to the Analysis

This study utilized a basic qualitative design method to examine the research question "How do minority nursing students describe their experiences with faculty incivility?" Data collection included open-ended, semi-structured interviews. Analysis was performed using Colaizzi's (1978) 7-step approach. Colaizzi's method provided guidelines for inquiry, coding, analysis, as well as ways to improve trustworthiness and credibility of the study (Clark, 2006; Edward & Welch, 2011). Coding was performed using hand written analysis to organize data and assist in determining the prevalence of codes.

The step-by-step method included:

1. Interviews were recorded using a digital recording method via smart phone. An app called TapeACall was used for the recording. The audio recordings were downloaded and saved to a zip drive for storage. At the time of the interviews, each participant was assigned a number to ensure confidentiality. Verbatim transcription was provided by the researcher. The researcher verified the accuracy of the transcription by listening to the audio tape recording while reading the transcripts. Editing allowed for accuracy and for the researcher to be immersed into the data analysis.
2. Significant statements were extracted that related to the phenomenon of faculty incivility. The researcher underlined significant statements using color coding on

printed transcriptions for all interviews. 120 pages of verbatim transcriptions were analyzed.

3. Meaning was created from significant statements. Statements were examined for the meaning of incivil encounters. The researcher performed a statement-by statement analysis of the transcriptions while asking if each statement provided any information related to faculty incivility. Each significant statement was evaluated for its meaning and coded.
4. Meanings were clustered into themes, seven themes were identified.
5. Exhaustive descriptions from the themes and significant statements were developed. The descriptions for the themes included: learning environment, student-faculty relationship, emotional impact, adaptive behaviors, pressure to conform, unfair treatment, and demeaning/belittling.
6. Individual interviews were summarized in concise paragraphs. The summary of the interview was given to the participant via email with a verification statement within two weeks of the interview.
7. Member checking was implemented. Each participant was given one week to verify the summaries that represented the experiences of the participant. The participant signed the verification statement included with the summary and returned the files via mail. Two participants asked the researcher to meet in order to pick the statements up. At that time, the participants expressed that once they spoke about their experience they felt better.

Steps 1-7 were repeated to ensure accuracy and all significant statements were extracted. All participants returned the verification statement signed.

The following section will include a discussion of the findings of the study. Each theme will be supported by statements from the interviews of the participants.

Summary of the Findings

The study findings will be discussed in this section. Seven themes were identified including learning environment, unfair treatment, student faculty relationships, demeaning/belittling, emotional impact, adaptive behaviors, and pressure to conform. The themes will be discussed with examples from the participant interviews. The discussion of the findings will provide insight in how faculty incivility was experienced by minority nursing students.

Learning Environment

The first theme that emerged was the learning environment. Each participant discussed how the faculty impacted the learning environment through an uncivil act. Each participant expressed faculty's lack of answering questions or clarifying assignments impacting the learning environment. Participants stated lack of faculty response created stress in the learning environment.

P1 identified the difficulty in gaining information on a written assignment. She stated when she approached the faculty to ask for a grading rubric, the response was, "Rubrics are not created for this course. Follow the directions and you will be fine." After following the directions and turning the assignment in, she received a failing grade with no explanation. When seeking further clarification on the grade and not getting a

response, she stated she would not ask for assistance in the future. P1stated, "I didn't feel comfortable asking the faculty for help after that."

P2 experienced conflicting responses from faculty regarding content and assignments as well. P2 asked for clarification on cardiac arrhythmias in class and received the following response from faculty, "Did you read your book? The expectation in this course is that you come prepared to discuss the material." P2 stated, "I never asked another question in class. I went to my classmates instead." She explained further that the faculty was new to teaching and didn't seem to know the content area. P2 expressed the tone of the conversation was condescending.

P3 experienced similar answers from faculty when seeking clarification on a policy regarding facial hair in clinical. P3 stated the policy on facial hair was vague and he wanted to make sure he was following the policy in clinical. One faculty told him, "You are fine. It's the unruly beards that will not work in clinical." When he attended the next clinical he was written up for unprofessional appearance and failing to comply with school policy. He asked the faculty about this and explained that another faculty had told him he was within the policy. The faculty stated "You are in my clinical now, I make the rules." When the clinical rotation ended, his clinical evaluation stated, "P3 has difficulty following policy and adhering to clinical guidelines." P3 went to his adviser to discuss this as he felt it was an unfair statement. P3 was told "Just do what she tells you, she is like that with everyone." P3 stated "I have never been so confused in my life. I didn't understand why I had two different responses."

P4 experienced similar responses when taking an online course. She asked for additional help with a discussion board. The faculty stated, "You are a senior student and should know how to respond to a discussion question by now. Use your resources." P4 stated, "I thought she was one of my resources, that's why I asked her." P4 expressed feeling like an "idiot."

P5 experienced incivility when asking about test materials and what to study. P5 was met with this response, "You need to know everything we just covered over the last several weeks." P5 stated they had just covered material in twelve chapters. He stated, "I was hoping the teacher could narrow it down to what I needed to concentrate on."

The significant statements that indicated an issue with the learning environment was a major experience for the participants with faculty incivility. Unfair treatment of students by faculty was another theme that emerged from interviews. Unfair treatment will be discussed in the next section.

Unfair Treatment

The second most common theme identified was unfair treatment. Unfair treatment was described as lack of teacher preparedness, content area expert, requirements of the course, exclusion by faculty, and grading practices. Interactions with faculty that described unfair treatment were present in each interview.

P6 experienced unfair grading practices related to a care plan. P6 had turned in a care plan after working with a student that received "As" on their plans. P6 received her graded care plan with a "C." P6 stated, "There was not much difference in content or structure in our care plans. I wanted to see if there would be a difference in grading, and

there was." P6 expressed feeling that the faculty did not like her as she did not carry conversations with her or laugh like she did with the other student who received the "A." When P6 addressed the faculty about her grade, the faculty stated, "You are going to have difficulty in creating your care plans because English is not your first language." P6 stated "I am Hispanic but I was born in this country and can speak both Spanish and English."

P5 asked about his hair in clinical according to the requirements of the course. "I have dreads, and knew that I was going to have to wear them up like my female peers, but I really didn't know what to do." P5 asked a faculty and was met with this response, "The policy is to have your hair off of your neck and out of your face. So you will need to figure it out." P5 said he pulled it back into a ponytail and had it off the collar. The faculty sent him home for looking "unprofessional" and told him that he may wish to consider getting a haircut to be successful in the course. P5 stated, "The females in my clinical group were allowed to have their hair the same way I did and were not sent home and given an "unsatisfactory" for the clinical day." P5 changed his hairstyle but stated "I just went through the motions to pass clinical and knew I had to stay off the radar."

P3 expressed difficulty with requirements of the course as well as grading practices in a particular experience. P3 had clinical with an all-female group of nursing students on a medical-surgical floor during his second term. Students were allowed to go on alternative clinical experiences (ACE) off of the unit. P3 described his interaction with the faculty as contradictory. The faculty first told him that he could not go to the ACE because he had not given medications to his patients however after the student

performed his medication pass, the faculty then told him he could not go because of the risk of him having a female patient. P3 asked for clarification and the faculty stated "Look, I am not risking my license for you to go off the unit when you don't know what you are doing." P3 stated "I was the only student that didn't get to have an ACE during the rotation." P3 said it was part of the learning outcomes for the course for students to follow a patient through pre-op, surgery, and post-op. He did not get this experience and received an "unsatisfactory" on his evaluation.

P1 identified a situation where she felt excluded by a faculty member. P1 would see students having lunch with a faculty member. Students and the faculty were laughing and seemed to be sharing stories about their personal lives. P1 approached the table and the laughter and talking stopped. The faculty asked if P1 needed anything and P1 stated, "I was going to join you all for lunch." The faculty told P1 that it was a private conversation and she would speak with her later. P1 stood there looking at the faculty as the faculty stared back and then asked "Is there a problem?" P1 turned and walked away. P1 stated she had never felt so unfairly treated by a faculty. Her peers did not say anything in her defense and never addressed the situation with her.

P4 had an encounter in which the faculty showed lack of teacher preparedness as well as lack of ability in being the content area expert. P4 described a classroom encounter with a new teacher lecturing on fluid and electrolytes. P4 described the lecture as disorganized and confusing. She stayed after class to ask questions and the faculty refused to answer questions because "these are not my office hours." P4 then tried to make an appointment with the faculty during "office hours" and the faculty did not

respond to the requests. P4 stated "I understand faculty are busy, but this was important to me. I needed to understand and it was clear to me, that she did not know what she was doing. It was joked about among faculty that fluid and electrolytes was not an area that anyone wanted to teach and the new teacher was stuck with it."

Unfair treatment was expressed by all participants. Participants expressed discrepancies in lack of teacher preparedness, content area expert, requirements of the course, exclusion by faculty, and grading practices. The relationship between student and faculty was a theme in which participants expressed incivil encounters and will be discussed in the following section.

Student-Faculty Relationships

The theme of student-faculty relationships was described by all participants. The use of authority, fear of retaliation, and unprofessional behaviors were apparent in student encounters. Participants described the use of social media in some of the encounters.

P2 described an encounter with a faculty member that had made some comments in front of her about other faculty and the administration. P2 was then approached by the faculty and was told to not say anything to anyone about their conversation. As the faculty was stating this, P2 felt his hand on her elbow squeezing it. P2 stated "I was not going to tell anyone what we spoke about, but when the faculty approached me, I felt threatened and was hoping they were not going to hold this over my head for the remainder of my program." P2 said she did not breathe a word about the conversation or encounter to anyone until now.

P5 explained that students had a "secret" social media page where students had shared information about tests, quizzes, and anything that may be relevant to a student trying to pass courses. P5 described an encounter with a faculty that had found out about the "secret" site and had come into class asking what people knew about it. Students did not divulge any information in the classroom. P5 was approached by faculty and the faculty stated, "I am disappointed to know that you are involved in this. You know that this type of activity can have you removed from the program." P5 stated "I have no knowledge of the site you are referring to." Before this encounter P5 had a good relationship with this faculty. P5 said that after the encounter he would receive the patient assignments in clinical that were the "worst" cases. He received patients that were combative, abusive, and patients that the nursing staff would tell the nursing faculty, "do not give this patient to a student." P5 said this put a bad taste in his mouth about working with this faculty and was glad to be finished with that course and faculty.

P3 described himself as a "big, black man." P3 said that many times he feared retaliation but at the same time felt that faculty were scared of him. One encounter stands out with P3 as "odd." P3 had an appointment with his nursing adviser and she had another faculty in the office with her while they spoke. At the time, he stated he didn't think anything about it, but then realized that the "white" students had appointments behind closed doors without anyone else in the office with the faculty. P3 stated "After noticing this, I didn't know what to think about the program. I want to be a nurse, and want the faculty to help me get there just like the rest of the students." P3 felt he had good relationships until this event.

Student-faculty relationships seemed altered in these encounters. The participants demonstrated a negative impact from the faculty encounters. Behaviors of faculty during incivil encounters by students are addressed next.

Demeaning/Belittling

Participants described encounters with faculty as demeaning or belittling. The behaviors of faculty were demonstrated one-on-one, in front of peers, and in front of nursing staff in clinical. Participants routinely described themselves after these encounters as "stupid", "dumb", or "idiot."

P6 described an encounter with a nursing staff member in front of a faculty as "belittling." The staff nurse had asked the participant about giving a potassium supplement. The student told the staff nurse about potassium but failed to give the patient's current level. The staff nurse then called the faculty over to let them know. The staff nurse stated "Where did you get this student from?" The participant felt that the nurse was joking and trying to lighten the mood however the faculty stated, "I have no idea how this clinical group was accepted. They are by far the worst group I have ever had." The faculty had little to no expression on her face and the nursing staff stated to me, "I was not being serious with her but apparently she was." P6 said the nursing staff showed remorse for her comment and said she would speak with the faculty to let her know she was trying to help me relax. P6 stated "I still don't know if the faculty was being serious or not, but it sure seemed like she was. I was embarrassed by her comments and wondered who else felt like she did. Was I really that bad as a student? It made me doubt my abilities."

P2 described an encounter while administering medications to a patient with a clinical faculty. P2 was giving Lasix intravenously and had never done it before. P2 and the faculty had gone through the steps prior to administering it. P2 stated "I was so nervous. My hands were shaking, and I could not get the syringe to go into the port." The faculty took the syringe out of P2's hand and stated, "If you can't do this correctly, then I will do it for the patient. I don't have time to wait for you to stop shaking." I had tears in my eyes and the patient grabbed my hand and said "It's okay, you did your best. You will get it next time." The faculty then stated "If there is a next time." The faculty then finished administering the medication and walked out. P2 followed her and asked how to calm down. Faculty stated, "I don't know, but you better get a handle on it, if you want to pass." P2 expressed feeling like a failure and not wanting to pass medications again with the faculty.

The participants described belittling/demeaning incivil encounters with the faculty. The experiences by participants also demonstrated the emotional impact that statements made by faculty had on the participant. Emotional impact is addressed further in the next section.

Emotional Impact

The theme of emotional impact emerged from the experiences of the participants. Stress was spoken about the most and tied to emotions. Fear was also revealed as an emotional feeling during the encounters.

P4 stated she had "cried all the way home" after clinical experiences with multiple faculty. P4 stated "I almost quit because of the stress I was under. Nothing is

worth me feeling like a loser." P4 expressed feeling like some faculty didn't like her and that it was personal and she was being "singled-out."

P1 stated she felt "stressed out" because of last minute changes to assignments and unclear expectations. P1 stated "there seemed to be a miscommunication with faculty that taught in the same course." P1 expressed the workload was overwhelming and at times was "difficult to keep up with". P1 said she turned in assignments just to turn them in and didn't have time to do them but she "feared" failure.

The impact on participant emotions experiencing faculty incivility was demonstrated with increased stress and fear. Stress and fear of passing courses as well as the program were discussed by the participants. Participants expressed behaviors in which they needed to use in order to 'survive' nursing school. Adaptive behaviors implemented by the participants to assist in dealing with the faculty incivility are discussed in the next section.

Adaptive Behaviors

Participants identified strategies to adjust to the incivil faculty encounters. Peer-support, learning strategies, and avoiding encounters were utilized by the participants. All participants identified an adaptive behavior to work with the incivility.

P3 discussed the need for peer help in understanding assignments and studying for tests. He stated "I need my friends to help me when I can't figure things out. I also try to get their opinion on the way I have been treated. I am just trying to get through this a semester at a time. When I'm with my peers, that's what we are all doing."

P4 discussed working with peers as a necessity. P4 stated, "What I have learned, I have taught myself or another student has." She went on to talk about the lack of help from faculty. She described study groups that meet every week, groups that will cook meals, and help with childcare for clinical. She stated "This is my family right now."

All participants expressed the purchase of NCLEX review books as a must for studying and "surviving the faculty tests." P1 stated "The tests created by faculty are horrible, so I have to figure this out. The review book helps."

P6 stated she knew students that would just hide in the bathroom to avoid clinical faculty. She said, "There is one student that is not good in clinical or class and everyone knows it. She will hide in the bathroom most of the clinical day. I don't think the faculty has figured it out, yet." P6 shared that she had thought about quitting the program and coming back after the faculty retired or attend another program.

The theme of adaptive behaviors was presented in this section. Participant behaviors demonstrated the determination to complete the nursing program and become a Registered Nurse despite the incivil encounters. Participants expressed pressure to conform with the "normalcy" of nursing school in order to succeed. The next section will address the pressure participants felt to conform.

Pressure to Conform

Participants described feeling the pressure to conform to the "rigid" and "strict" requirements of a nursing program. All participants believed they were being subjected to unreasonable demands by the faculty. Terms such as "weeding out" and "learn to play

the game" were utilized when attempting to have students comply with the demands of faculty.

P2 stated "We all heard rumors that first semester would "weed out" the weak students." She said this made her even more determined to pass and not let them see her as "weak." Once students got through first semester, it seemed that most faculty would help students get through.

P5 stated "My nursing adviser had warned me that I would need to "play the game" with a few faculty." P5 said he did just that. "I would make ask a lot of questions and act interested. I'm sure others were calling me a kiss ass but I didn't care, I had to pass to take care of my family."

All participants expressed the feeling to comply and conform or face the consequences. Participants wanted to complete the nursing program and achieve their goal of becoming a Registered Nurse. Despite the incivil encounters by participants, each participant remained in the nursing program.

Chapter 4 Summary

Chapter 4 included a description of the data analysis and summary of findings. Six students participated in the study and shared their experiences regarding faculty incivility. Data was collected using interviews. Data analysis included Colaizzi's 7-step approach. Findings included seven themes which emerged from the data collection: learning environment, unfair treatment, student-faculty relationships, demeaning/belittling, emotional impact, adaptive behaviors, and pressure to conform. Chapter 5 will cover the conclusions for the study. The chapter will provide a summary

and discussion of the results with support from the literature. Furthermore, limitations, implications, and recommendations for further research will be discussed.

CHAPTER 5. CONCLUSIONS AND DISCUSSION

The purpose of this basic qualitative study was to examine the experiences of minority nursing students with faculty incivility. The experiences of students were explored using open-ended questions in a semi-structured interview process. Interviews were recorded and transcribed verbatim. Data was analyzed using Colaizzi's (1978) 7-step approach, and seven thematic categories emerged related to the research question. Chapter 5 presents a discussion of the findings and their relationship to Roy's adaptation model (Roy, 2009) and to Clark's conceptual framework (Clark, 2008a). The results will be presented followed by a discussion related to the literature for the research question. The limitations, implications for practice, and recommendations for further research will be addressed. The chapter will end with a conclusion for the research study.

Summary of the Findings

The data was gathered from six participants that attended associate degree nursing programs in the Southeast United States. Participants who met the inclusion criteria were chosen because of their ability to provide insight to the research question: How do minority nursing students describe their experiences with faculty incivility? Participants shared their experiences with faculty incivility and the data analysis revealed seven common themes that helped answer the research question. The themes included (a) learning environment, (b) unfair treatment, (c) student faculty relationships, (d)

demeaning/belittling, (e) emotional impact, (f) adaptive behaviors, and (g) pressure to conform. The discussion of findings that follows presents a more detailed description of the themes that emerged from the data analysis in relation to prior literature and research findings.

Discussion of the Findings in Relation to the Literature

Incivility in nursing education is seen throughout the literature presented in Chapter 2. Giddens (2008) stated nursing education plays a pivotal role in promoting the academic success of racial and ethnic minority students. Hassouneh (2006) suggested that nurse educators pay little attention to ethnic minority students in their teaching practice. Nurse educators are uncertain in what teaching methods maximize educational success among minority nursing students (Hassouneh, 2006). Billings and Kowalski (2008) stated since nursing students are diverse in culture, linguistics, and learning styles, educators must enhance their ability to teach this population effectively.

Many researchers have stated the need for greater diversity in the United States nursing workforce to improve health care access, quality, and outcomes among patients with culturally and ethnically diverse backgrounds (Amaro, Abriam-Yago, & Yoder, 2006; Cooper & Powe, 2004; Evans 2007; Lowe & Archibald, 2009; Yarbrough & Klotz, 2007). These studies suggested that health care outcomes would be improved if patients could relate to the nurse providing the care. The upcoming paragraphs include a discussion of each of the themes that arose during the current study in relation to prior literature. Findings will also be discussed in relation to the theoretical and conceptual

framework for this study which included Roy's adaptation model (RAM) (Roy, 2009) and Clark's model for fostering civility in nursing education (Clark, 2008a).

Learning environment. The learning environment theme emerged as a result from significant statements that illustrated lack of faculty answering questions, lack of faculty clarifying assignments, and overall lack of faculty response. Each participant interpreted discrepancies in the learning environment as faculty incivility. The learning environment is the primary source for educating students and all participants indicated incivil acts perpetrated by faculty. The ability to prepare and teach nursing concepts is a major requirement of a nursing educator.

Clark and Springer (2007b) identified faculty lack of preparedness and lack of clarification as uncivil behaviors that impact the learning environment. Similarly, several participants from the current study discussed the lack of clarification on assignments impacting their ability to complete assignments and to manage the workload of the course. Faculty will utilize the learning environment as a way to coerce students by assigning unrealistic workloads (Clark & Kenaley, 2011). Stork and Hartley (2009) identified changes to assignments as an uncivil act. Clark and Springer (2010) found that academic incivility can disrupt student-faculty relationships, as well as creating problems within the learning environment.

Wallace, Bourke, Tormoehlen, and Poe-Greskamp (2015), found students in clinical were sent mixed messages regarding expectations. The expectations in clinical regarding medication administration and charting were different from what they were taught in the skills lab/classroom and led to miscommunication and possible errors in

care. Students in this study also complained of having to wait for the clinical faculty to respond in order to perform treatments on the assigned patient.

Unfair treatment. Unfair treatment emerged as a theme when participants described lack of teacher preparedness, content area expert, requirements of the course, exclusion by faculty, and grading practices. Each participant described unfair treatment during their interview. In a study by Dapremont (2014), black students described asking for assistance from faculty to study and being told to attend a study group instead of being helped. In the same study, participants stated that reading was assigned but it was not identified as something that would jeopardize their success and later they struggled to learn as the course progressed. Black students did not know how to develop tools to be successful and therefore did not use strategies to assist in success (Dapremont, 2014).

In a study by Sedgwick, Oosterbrook, and Ponomar (2014), participants expressed faculty treated them unfairly when they spoke with an accent. One participant stated that when patients could not pronounce the students name, faculty told the patient to call her 'Asian'. Participants stated they felt invisible when they entered clinical as well (Sedgwick, et al., 2014). Those participants asked for the same welcome from clinical faculty and clinicians that was provided for the Caucasian students.

Student-faculty relationships. The connection between faculty and students is undeniable. Clark (2008a) illustrated the connection, describing it as a dance and emphasized the importance of faculty and students working together. Each participant in this study described the use of authority, fear of retaliation, and unprofessional behaviors when working with faculty and viewed these as incivil acts.

In the classroom, the faculty is the leader and authority figure. The hierarchy of faculty over students can be associated with the imbalance of power between the instigator of incivil acts and the victim (Kolanko, Clark, Heinrich, Oliver, Farley, & Sifford, 2006). White and Fulton (2015) stated that African American students would be sent to others for help rather than the faculty helping them, would be given stricter rules to follow, as well as generally treating them differently than other students.

Fear of retaliation and unprofessional behaviors by faculty affect learning in nursing education. Stork and Hartley (2009) identified intimidation or fear of retaliation as a major theme from victims of incivility. Clark et al. (2012) stated faculty are a primary resource of intimidation and unprofessional behaviors toward students in the learning environment. Participants in the current study discussed unprofessional behaviors by faculty and these behaviors have been identified by other researchers (Clark, 2008a; Clark & Springer, 2007a, 2007b, 2010; Clark & Kenaley, 2011).

The authoritative position together with fear of retaliation and unprofessional behaviors is congruent with prior research that suggested these factors play a role in incivility (Clark, 2008a). All participants expressed a negative impact on their learning abilities when they encountered faculty incivility. The authoritative position of faculty is harmful to student learning, the fear of retaliation and belittling also effect the learning environment (Stork & Hartley, 2009).

Demeaning/belittling. The fourth theme that emerged from the interviews was how faculty belittled or made demeaning comments to the participants. Faculty made comments in private, in front of peers, and in view of nursing staff during clinical

experiences. Participants referred to themselves as "stupid", "dumb", or "idiot" while describing the events of the encounter with faculty. Johnson (2009) described one trait of incivil faculty was making belittling remarks. Clark (2008b) described belittling as making "condescending remarks and putdowns, and exerting superiority and rank over students" (p. 286). Clark and Springer (2007a) viewed belittling as the behavior most associated with faculty incivility.

Wallace, et al., (2015) reported students being belittled in front of patients by their clinical instructor. Students in Wallace et al study also reported being questioned on every action by a particular faculty in front of patients, other students, and staff on a clinical unit. Wallace et al stated these actions are often tolerated in clinical as the faculty feel they are making the student stronger.

Emotional impact. The theme of emotional impact included the emotions of fear and stress. Each participant discussed how faculty incivility induced negative emotions that prevented learning and decreased self-confidence. Clark (2013) described emotional experiences that bullied individuals display. These experiences included feeling "physically sick or emotionally upset before going to work or school", "you are belittled, humiliated, or demeaned", "you are the target of rude remarks, insults ,or putdowns", and "you are deliberately denied information or resources to be successful" (Clark, p. 27). Several authors have discussed fear and stress described by individuals who have experienced incivility (Clark, 2013; Clark, 2012; Hunt & Horsfall, 2010).

African American students were told to "stop being sensitive" to racial comments stated while in the nursing program (White & Fulton, 2015). Students felt fear due to the

perception that faculty had the power to fail them and therefore continued to be silent about the concerns. Remaining silent can add to emotional exhaustion which leads to burnout and negative mental health issues (Babenko-Mould & Lachinger, 2014).

Adaptive behaviors. Adaptive behaviors to faculty incivility included peer-support, learning strategies, and avoiding encounters with faculty. Each participant in the current study described developing peer support including study groups, sharing assignments, and peers explanation of assignments or material. The participants expressed a need to complete the program and reach their goals as the reason behind adapting the behaviors.

Harrison (2012) described the benefits of peer support in stressful encounters. Current participants described participating in peer support as a way to succeed and make up for the lack of learning from the faculty. Timpson and Ellis (2013) discussed study groups as a mechanism for promoting confidence, collegiality, and an increased knowledge of concepts.

All participants in the current study described considering alternative means to complete their degree, but with support from family and friends decided that avoidance of the incivil behaviors was their best option for success. The literature describes avoidance as a passive response to incivil actions (Cassell, 2011; Clark & Kenaley, 2011; DalPezzo & Jett, 2009). Pattern of avoidance does not appear to be adaptive. Current participants described this as a better alternative than subjecting themselves to the uncivil encounters.

Pressure to conform. All participants in the current study described feeling pressured to conform to the requirements of the nursing program and to individual

faculty. Students are often caught between the pressure to conform and success (Newton, 2014). Conforming has been demonstrated as a way to adapt and find their place in the academic setting as well as to position themselves to participate and integrate into the learning environment (Newton, 2014).

In an article by White and Fulton (2015), African American nursing students found that 'fitting in' was costly to relationships outside of the nursing program. The students found that they needed to 'speak white' in order to fit in, but when with their African American family and friends they needed to 'speak black'. It was not identified how many were able to fit in, while others did not.

Roy's Adaptation Model. Roy's adaptation model focuses on a person's response to one's environment and the adaptation that ensues. Adaptation is explained using four modes and correlate with the holistic view of person (Roy, 2009). The modes are interconnected and demonstrate how one mode may affect another. The themes that emerged from the participant interviews demonstrated interconnectedness as well.

The perception of faculty incivility in the current study participants correlated with the four modes of RAM in an effort to adapt to the environment. The physiological mode correlates with the learning environment theme. Incivility as the stimulus impacts the cognitive function of the person (Roy, 2009). The person's ability to adapt to the incivility results in an outcome. The person adapting through learning resources, peer support, and avoidance demonstrates the successful management of the incivility (stimulus). The modes of self-concept, role function, and interdependence are demonstrated in the themes of student-faculty relationships, emotional impact, and

adaptive behaviors. When one mode is influenced by a negative stimulus (unfair treatment and demeaning/belittling) another mode provides the support to produce an adaptive response. RAM was demonstrated in this study with the participants abilities to adapt and manage incivil faculty encounters.

Clark's Model for Fostering Civility in Nursing Education. The model for fostering civility in nursing education illustrates the constant interaction of students and faculty in the learning environment. Clark (2008, 2013) illustrated the intercept of high stress when faculty and student stress coincides. Additionally, the model shows how emotional impact (stress) leads to incivility but does not show that stress is a result of the incivility as this study found. One of the themes that emerged, adaptive behaviors, demonstrates how encounters are managed. The current study participants did not provide information about the change in faculty incivility, the participants did manage the uncivil encounters in such a way that promoted success for them.

Limitations

The findings are limited in that the study was conducted in three ADN programs in the Southeastern United States and may not represent other pre-licensure programs or other geographical areas. Therefore, the findings may not be generalizable to other nursing students, nurse educators, or nursing programs. Further research may be needed to expand the findings to other regions and other types of nursing programs.

Implication of the Findings for Practice

The findings of this study provide the perceptions of minority nursing students in an ADN program. Nurse educators and administrators can utilize the findings to better

meet the needs of minority nursing students, improve relationships with minority students and assist the students in being successful. Nurse educators should be aware of how students learn best and incorporate varied learning tools into academia to meet the needs of diverse students.

Nurse educators should strive to develop cultural competence to better understand and work with minority students in nursing education. Nurse educators need to be aware of differences in social integration, sociocultural context, and learning among minority populations. Nurse educators may also reflect and self-examine personal prejudices and assumptions that can contribute to incivility in nursing education.

Recommendations for Further Research

This research study only included six nursing students in three ADN programs in the Southeastern United States. Thus further research should be conducted in different types of nursing programs, such as BSN, RN to BSN, or MSN programs, and in other geographic locations. Additional research could distinguish nurse educator's perceptions of working with diverse nursing students and the issues in nursing education. Examining minority nursing faculty working with minority nursing students would also add to the body of research to assess the needs of both parties. Zajac (2011) found that minority nursing students considered a barrier to their success was the insufficient number of minority faculty members.

Conclusion

The study was conducted in nursing education to explore the perceptions of minority nursing students with faculty incivility. A qualitative approach to collecting

data was utilized to understand the lived experiences of minority nursing students. Recruitment of participants occurred at three associate degree nursing programs in the Southeastern United States using email invitations. Six students met the criteria for inclusion in the study and were interviewed face-to-face using semi-structured interview questions. Data was analyzed using Colaizzi's method and seven themes emerged. The themes included (a) learning environment, (b) unfair treatment, (c) student faculty relationships, (d) demeaning/belittling, (e) emotional impact, (f) adaptive behaviors, and (g) pressure to conform. Roy's adaptation model and Clark's conceptual model for fostering incivility in nursing education provided the theoretical frameworks for the research study. Limitations and implications of this research were addressed. Areas for future research became apparent during the research process and are included in the recommendations for future research. The negative impact interpreted by minority nursing students experiencing incivility warrants further investigation.

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