

Critical Care Registered Nurses' Perceptions of
Nurse-to-Nurse Incivility and Professional Comportment

by

Kenneth John Oja

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Approved November 2015 by the
Graduate Supervisory Committee:

Pauline Komnenich, Co-Chair
Debra Hagler, Co-Chair
Lesly Kelly, Member

ARIZONA STATE UNIVERSITY

December 2015

ABSTRACT

This cross-sectional descriptive study was designed to examine critical care registered nurses' perceptions of nurse-to-nurse incivility and professional comportment, and the extent to which education, nurses' age, nursing degree, and years of nursing experience is related to their perceptions on these topics. Professional comportment is comprised of nurses' mutual respect, harmony in beliefs and actions, commitment, and collaboration. Yet, it was unknown whether a relationship existed between a civil or uncivil environment in the nursing profession and nurses' professional comportment. Correlational analyses were conducted to explore the relationship between perceptions of nurse-nurse incivility and professional comportment, and the relationships between incivility and professional comportment education and perceptions of nurse-nurse incivility and professional comportment. Multiple linear regression analyses were conducted to identify predictors of perceptions of nurse-nurse incivility and professional comportment. Results indicated statistically significant relationships between perceptions of nurse-nurse incivility and professional comportment, and between professional comportment education and perceptions of professional comportment. Professional comportment education was identified as a statistically significant predictor of increased perceptions of professional comportment. Findings of the current study may assist in establishing more targeted and innovative educational interventions to prevent, or better address, nurse-nurse incivility. Future research should more clearly define professional comportment education, test educational interventions that promote professional comportment in nurses, and further validate the Nurse-Nurse Collaboration Scale as a measure of nurses' professional comportment.

DEDICATION

To my Grandmother, Marie Oja (née Van Hulla), who continuously expresses the importance and value of education.

ACKNOWLEDGMENTS

Thank you, Dr. Komnenich, for serving as my committee chair over the past several years. As much as I may have fought in the beginning, I realize now what you were trying to do in providing your time to mentor me in nursing education research. You have enhanced my perspectives on nursing education, nursing research, and the nursing profession in general and, for that, I will always be thankful. Your knowledge, patience, and persistence throughout this process will always be remembered.

Dr. Hagler, you have been such a source of inspiration and support even before I decided to pursue a doctoral degree in nursing. I will never forget you from my RN to BSN program. You are such an amazing educator, inspiring me to be the same, and you were always there for me as I pursued my master's degree and doctoral studies. It was such a pleasure to be your research assistant, as it provided me with the opportunity to work even more closely with you on a professional and personal level. I will always remember you as the perfect example of an exemplary nurse educator, nurse researcher, and person. Thank you for serving as the co-chair of my committee.

Thank you, Dr. Kelly, for serving as a member of my committee. I latched on to you in the midst of my master's degree program and am so thankful that both you and Dr. Hagler were able to assist me with my master's degree project. After graduating with my master's degree, you continued to provide mentorship and support in grant writing, the research process, statistics, and scholarly publications, so I was honored to have you as part of my committee. Your support and wisdom will not be forgotten. You have been an amazing committee member, mentor in practice, and friend.

I would also like to thank Drs. Karen Johnson, Melanie Brewer, and Katherine Kenny for their support and mentorship in the protocol development and recruitment process of this dissertation. I have learned so much from all of you, and appreciate your time and efforts in assisting me to complete my dissertation study.

Finally, thank you to all of my family and friends who have been on this journey with me. A special thank you to John and my mother, Rose Mary. I would never have come this far without being able to simply talk to any of you about my dissertation process whenever I needed to.

TABLE OF CONTENTS

	Page
LIST OF TABLES	viii
LIST OF FIGURES	ix
CHAPTER	
1 INTRODUCTION	1
Background and Significance	1
Conceptual Framework	2
Purpose Statement and Research Questions	5
2 LITERATURE REVIEW	7
Impact of Workplace Incivility on Employees	7
Impact of Workplace Incivility on Organizations	9
Characteristics of Workplace Incivility Instigators	10
Incivility in the Nursing Profession	12
Nursing Education	12
Nursing Practice	13
The Role of Professional Compartment	14
Summary	16
3 METHODS	18
Design	18
Human Subjects	18
Setting	18
Sample	19

CHAPTER	Page
Measures.....	19
Nursing Incivility Scale.....	19
Nurse-Nurse Collaboration Scale.....	20
Education.....	21
Demographics.....	21
Data Collection.....	21
Data Analysis.....	23
Specific Aim One.....	24
Specific Aims Two and Three.....	24
Specific Aims Four and Five.....	24
Specific Aim Six.....	25
4 RESULTS.....	26
Sample Demographics.....	26
Normality, Skewness, and Kurtosis.....	27
Reliability.....	28
Nurse-Nurse Incivility and Professional Comportment.....	29
Specific Aim One.....	29
Incivility and Professional Comportment Education.....	29
Specific Aim Two.....	29
Specific Aim Three.....	30
Predictors of Nurse-Nurse Incivility and Professional Comportment.....	31
Specific Aim Four.....	31

CHAPTER	Page
Specific Aim Five	32
Effect of Professional Comportment on Nurse-Nurse Incivility	34
Specific Aim Six	34
5 DISCUSSION	36
Nurse-Nurse Incivility and Professional Comportment.....	36
Incivility and Professional Comportment Education	38
Predictors of Nurse-Nurse Incivility and Professional Comportment....	39
Effect of Professional Comportment on Nurse-Nurse Incivility	39
Strengths of the Study	40
Limitations of the Study.....	43
Implications for Future Research	44
Conclusion.....	44
REFERENCES.....	45

LIST OF TABLES

Table		Page
1.	Sample Demographics	27
2.	Normality, Skewness, and Kurtosis of Study Variables	28
3.	Perceptions of Nurse-Nurse Incivility and Professional Comportment	29
4.	Perceptions of Nurse-Nurse Incivility and Education	30
5.	Perceptions of Professional Comportment and Education	31
6.	Predictors of Nurse-Nurse Incivility	31
7.	Variables Predicting Conflict Management	32
8.	Variables Predicting Shared Processes	33
9.	Variables Predicting Professionalism	34
10.	Variables Predicting Nurse-Nurse Incivility	35

LIST OF FIGURES

Figure	Page
1. Conceptual Model of Professional Comportment.....	4

CHAPTER 1

INTRODUCTION

Incivility in the American workplace is increasingly common, described in organizational literature as “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Andersson & Pearson, 1999, p. 457). Uncivil behaviors are offensive, disrespectful, and typically represent an absence of consideration for others. Such behaviors typically include contemptuous remarks, belittling comments, unfriendly looks, and/or ostracism (Andersson & Pearson). Compared to workplace bullying and violence, which usually involve more overt and physically threatening, intimidating, and/or assaultive behaviors (National Institute for Occupational Safety and Health, 2002; Namie & Namie, 2011; Occupational Safety and Health Administration, n.d.), workplace incivility is less obvious and may not appear to be as harmful. However, uncivil behaviors in the workplace are known to have significantly damaging consequences on employees and organizations in a variety of professions, jobs, and workplace settings (Cortina & Magley, 2009).

Background and Significance

The Joint Commission (2008) announced a sentinel event alert about incivility in healthcare professions, stating that uncivil behaviors are disruptive, unprofessional, and should not be tolerated. More recently, the American Nurses Association (2015) released a position statement about incivility, declaring the importance of identifying and implementing interventions to prevent incivility in the nursing profession in order to provide safe environments for both nurses and patients. While nursing professional practice programs and educational interventions to decrease incivility in the nursing

profession are in place (Osatuke, Moore, Ward, Dyrenforth, & Belton, 2009; Krugman, Rudolph, & Nenaber, 2013), uncivil behaviors continue in all areas of the nursing profession. Thus, it is important to clearly identify the influences of incivility among nurses. In the past, the presence of uncivil behaviors among nurses was attributed to nurses being a vulnerable population that was unqualified and disempowered to make their own decisions among a team of more powerful and respected workers, such as physicians (Roberts, 1983; DeMarco & Roberts, 2003). Today, there remains a paucity of research about specific causes of incivility among nurses. Clickner & Shirey (2013) posited that uncivil behaviors in the nursing profession are linked to professional comportment. While Benner (1991) suggested that education for the development of a professional nurse should include a nurse's ethical comportment, described as proficiency in social interactions and the ability to provide support and give respect to others, there is a lack of literature supporting the correlation between nursing incivility and the more recently defined concept of professional comportment. As such, an exploration of the relationship between registered nurses' perceptions of nurse-nurse incivility and professional comportment, and how incivility and professional comportment education relates to their perceptions, can be a powerful means toward developing educational interventions that encourage civility, and prevent incivility, in the nursing profession.

Conceptual Framework

Professional comportment was conceptualized as “a nurse’s professional behavior that integrates value, virtues, and mores through words, actions, presence, and deeds” (Clickner & Shirey, 2013, p. 108). According to Clickner & Shirey, professional comportment consists of four *critical attributes*, which include *mutual respect, harmony*

in beliefs and actions, commitment, and collaboration. Mutual respect includes the respect that nurses exhibit toward their patients, colleagues, and the nursing profession. Harmony in beliefs and actions refers to nurses fostering positive relationships, avoiding needless conflict, and acknowledging the existence of a relationship between nursing care and moral values. Commitment involves a nurse's accountability for patients and colleagues through the expression of human dignity, treating everyone as equals, and preventing human suffering. Collaboration is described as constructive interactions among nurses, especially when exchanging vital information, helping team members, and offering encouraging feedback and support. Possessing the four critical attributes of professional comportment is indicative of a nurse's increased capacity for compassion and human dignity, emotional intelligence, self-awareness, reflection, regulation, and confidence, as well as congruence in values and beliefs. Furthermore, upholding the critical attributes of professional comportment enhance a nurse's ability to use caring and respectful words and positive communication, wear professional attire, exhibit respectful behavior, maintain effective relationships with patients and colleagues, self-regulation, and accountability.

Identifying the four critical attributes of professional comportment in nurses includes assessing their *conflict management, shared processes, and professionalism* (Clickner & Shirey, 2013). Conflict management is defined as a nurse's ability to work together with other nurses in either solving or avoiding conflict (Shortell, Rousseau, Gillies, Devers, & Simons, 1991). Shared processes is defined as a nurse's autonomy, authority, and ability to make decisions, as well as agreement with other nurses about common goals for patient care (Ritter-Teitel, 2001; Sasagara, Miyashita, Kawa, &

Kauzman, 2003). Professionalism refers to a mutual respect among nurses, a willingness for nurses to collaborate with each other, nurses maintaining their clinical competence, more senior nurses providing guidance and mentoring to newer nurses, and the belief that nursing leadership supports collaboration among nurses (Sasagara, Miyashita, Kawa, & Kauzman, 2003; Dougherty & Larson, 2010).

Figure 1 illustrates the conceptual model of professional comportment (Clickner & Shirey, 2013). The authors hypothesize that “in the absence of professional comportment, a culture of incivility, nurse aggression, and compromised patient safety will emerge” (p. 111). However, there is limited nursing research that has examined the relationship between nurse-nurse incivility and professional comportment.

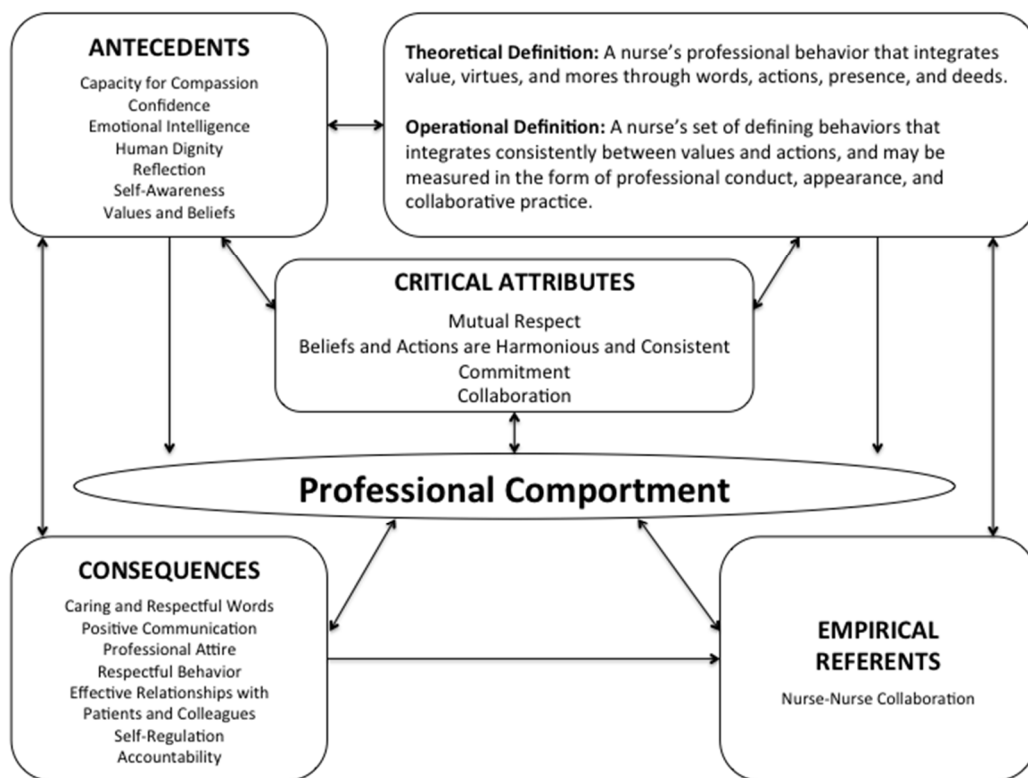


Figure 1. Clickner & Shirey’s (2013) conceptual model of professional comportment.

Purpose Statement and Research Questions

The purpose of this study was to examine the relationship between critical care registered nurses' perceptions of nurse-nurse incivility and professional comportment, and the extent to which education, nurses' age, nursing degree, and years of nursing experience influences their perceptions. Research questions and corresponding specific aims include:

1. What is the relationship between perceptions of nurse-nurse incivility and professional comportment?

Specific aim. Explore the relationship between perceptions of nurse-nurse incivility and professional comportment.

2. What is the relationship between nurses who have had incivility education and their perceptions of nurse-nurse incivility?

Specific aim. Explore the relationship between nurses who have had incivility education and their perceptions of nurse-nurse incivility.

3. What is the relationship between nurses who have had professional comportment education and their perceptions of professional comportment?

Specific aim. Explore the relationship between nurses who have had professional comportment education and their perceptions of professional comportment.

4. To what extent does incivility education, age, nursing degree, and years of nursing experience predict perceptions of nurse-nurse incivility?

Specific aim. Examine incivility education, age, nursing degree, and years of nursing experience as predictors of perceptions of incivility.

5. To what extent does professional comportment education, age, nursing degree, and years of nursing experience predict perceptions of professional comportment?
Specific aim. Examine professional comportment education, age, nursing degree, and years of nursing experience as predictors of perceptions of professional comportment.
6. To what extent do perceptions of professional comportment predict perceptions of nurse-nurse incivility while controlling for incivility and professional comportment education, age, nursing degree, and years of nursing experience?
Specific aim. Examine perceptions of professional comportment as a predictor of perceptions of nurse-nurse incivility while controlling for incivility and professional comportment education, age, nursing degree, and years of nursing experience.

CHAPTER 2

LITERATURE REVIEW

Civility and respect in all relationships are essential components of nursing professionalism (American Association of Colleges of Nursing, 2008; American Nurses Association, 2015), yet the nursing literature indicates that registered nurses, in all areas and roles of nursing education and practice, engage in uncivil behaviors (Clark & Springer, 2007; Clark, 2008; Felblinger, 2008; Wilson, Diedrich, Phelps, & Choi, 2011; Hunt & Marini, 2012; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013). The following review of literature focuses on the impact of workplace incivility on employees and organizations, characteristics of workplace incivility instigators, occurrence of workplace incivility in the nursing profession, and the role of professional comportment in nursing civility/incivility. Implications for identifying the critical attributes specific to professional comportment are discussed, including how such attributes may be related to an environment of civility or incivility in the nursing profession.

Impact of Workplace Incivility on Employees

Employees exposed to uncivil behaviors suffer from a wide range of physical and emotional health issues including decreased confidence and emotional well-being, as well as increased stress, fatigue, and psychological tension (Gardner & Johnson, 2001; Cortina et al. 2002; Sliter, Jex, Wolford, & McInernay, 2010; Bartlett II & Bartlett, 2011; Sliter, 2013; Wilson and Holmvall, 2013). Along with a general decline in overall physical health status, more specific physical effects of workplace incivility included cardiovascular problems, chronic physical health issues, headaches, and an increased body mass index (Kivimaki, Elovainio, & Vahtera, 2000; Simpson & Cohen, 2004;

Moayed, Daraiseh, Shell, & Salem, 2006; Randle, Stevenson, & Grayling, 2007; Johnson, 2009; Bartlett II & Bartlett). Some individuals who experienced workplace incivility reported increased tobacco, alcohol, and other drug use, decreased uninterrupted hours of sleep, and increased use of medications to help induce sleep (Quine, 1999; Vartia, 2001; Namie 2007; Yildiz, 2007; Paice & Smith, 2009). Matthiesen & Einarsen (2004) examined the relationship between workplace incivility and post-traumatic stress disorder (PTSD) noting extremely high levels of symptoms related to post-traumatic stress among administrative and clerical workers who experienced incivility in the workplace. Studies by Yildirim (2009) and Rodriguez-Munoz, Moreno-Jimenez, Vergel, & Hernandez (2010) revealed similar findings, noting that symptoms of PTSD were widespread among targets of workplace incivility. Other psychological health concerns, including clinical depression and thoughts of suicide, have also been reported by targets of workplace incivility (Ayoko, Callan, & Hartel, 2003; Gardner & Johnson; Kivimaki, Elovainio, & Vahtera; Kivimaki, Virtanen, Vartio, Elovainio, & Vahtera, 2003; Namie, 2003).

In relation to an employee's feelings, attitudes, and emotions, workplace incivility has been known to cause workers to feel apprehensive, afraid, depressed, and angry (Quine, 1999, 2001; Ayoko, Callan, & Hartel, 2003; Namie, 2003; Simpson & Cohen, 2004; Yildiz, 2007). In addition, workers exposed to incivility contended with a decreased ability to focus, a lack of motivation, decreased self-confidence, and a sense of helplessness (Gardner & Johnson, 2001; Vartia, 2001; Simpson & Cohen; MacIntosh, 2005; Moayed, Daraiseh, Salem, & Shell, 2006; Yildiz; Yildirim, 2009; Baillien, Neyens, Witte, & Cuyper, 2009). Other effects of workplace incivility included workers being

more prone to irritation, distress, and loneliness (Glaso, Matthiesen, Neilsen, & Einarsen, 2007). Furthermore, some individuals who experienced workplace incivility reported a negative effect on their social relationships beyond the workplace and conveyed feelings of worry, despair, and degradation (Gardner & Johnson; Ayoko, Callan, & Hartel; Yildirim).

Impact of Workplace Incivility on Organizations

When an individual in the workplace is discourteous, impolite, or inconsiderate toward co-workers, there is much more at stake than the impact on the target. In addition to the negative effects of workplace incivility experienced at the individual level, the manner in which employees behave toward each other affects their collaboration, future interactions with co-workers, those who observe the uncivil behaviors and, ultimately, organizations' outcomes (Pearson, Andersson, & Porath, 2000). Typically, health issues resulting from workplace incivility lead to workers taking more time off and incurring increased healthcare costs (Gardner & Johnson 2001; Namie, 2003, Bartlett II & Bartlett, 2011). In addition, over a third of employees who experienced workplace incivility deliberately decreased their productivity. This substandard work and efficiency led to compromised attentiveness and time wasted as a consequence of being troubled by uncivil encounters (Gardner & Johnson; Namie; Yildiz, 2007; Paice & Smith, 2009; Yildirim, 2009; Bartlett II & Bartlett).

Miner & Eischeid (2012) noted that those who observe their co-workers experiencing workplace incivility reported more negative emotionality. Incivility witnessed by co-workers increased their absenteeism, thereby decreasing productivity, since workers who observed uncivil behaviors reported wanting to avoid being exposed

to witnessing future uncivil interactions (Gonthier, 2002). Managers found that appraising employees who had been exposed to workplace incivility was difficult and resulted in unfair evaluations because of employees' job dissatisfaction and inability to handle reproach that resulted from experiencing incivility (Quine, 1999, 2001; Yildiz, 2007; Yildirim, 2009; Bartlett II & Bartlett, 2011). Furthermore, workplace incivility has been shown to affect the outside stakeholders of an organization, such as consumers. For example, targets of workplace incivility may vent their dissatisfaction of their situation to consumers and/or complain to consumers about the incivility (Gonthier).

Characteristics of Workplace Incivility Instigators

In an effort to gain awareness about identifying, understanding, and handling incivility in the workplace, Pearson, Andersson, & Porath (2000) collected data from questionnaires and interviews of more than 700 workers, managers, and professionals from numerous job categories ranging from data entry clerks to senior executives. Respondents characterized individuals in the workplace who encouraged incivility as having a tendency to be rude to co-workers, impolite to subordinates, and/or difficult to get along with. Other characteristics included a propensity to be inconsistent and emotional when faced with difficulty or conflict. Often times, those who instigated incivility in the workplace were typified as "sore losers." As described by one manager, the instigator of incivility "is a total jerk and everyone knows it. You just don't counter his opinion or cross him in any way. If you do, he'll find a way to get even and then some" (p. 128). Instigators of workplace incivility also revel in power (Katrinli, Atabay, Gunay, & Cagarli, 2010). So when an instigator has power or authority, those who reported to that individual were potential targets of workplace incivility (Cortina,

Magley, Williams, & Langhout, 2001). The casual behaviors of instigators may also be linked to incivility in the workplace. As stated by Gonthier (2002), “many people became confused and ultimately concluded that anything goes” (p. 7) as working environments started to become less formal. As such, the typical norms for the respect and concern of others disappeared. In the absence of such traditions, it has become more difficult for employees to distinguish between acceptable and unacceptable workplace behaviors (Pearson, Andersson, & Porath).

Similar research concluded that certain characteristics of workers, such as a history of disrespect, negative affectivity, a tendency for mood swings and unpredictable outbursts of anger, being prone to overly complaining, and the desire to be in control are related to incivility in the workplace (Namie, 2003; Penney & Spector, 2005). Additional characteristics of uncivil individuals include refusing to return phone calls or e-mails, yelling at others, constantly disrupting people, avoiding scheduled appointments, and patronizing co-workers with differing beliefs (Estes & Wang, 2008). Johnson and Indvik (2001) suggested that while such uncivil workplace behaviors are considered to be at the less severe end of the workplace abuse continuum, they have become rampant.

Trudel & Reio (2011) assessed workers’ conflict management styles in relation to workplace incivility using categories of conflict behaviors identified by Blake & Mouton, 1970; Rahim, 1983; Van de Vliert, 1984; & Thomas, 1992. The conflict management styles identified by Trudel & Reio included (a) integrating (collaborating or problem-solving), (b) dominating (competing or forcing), (c) accommodating (obliging), (d) avoiding, and (e) compromising. The dominating style of conflict management was highly correlated with instigating incivility while the integrating conflict style was linked

to decreased levels of instigated uncivil behaviors. Characteristics of the dominating style of conflict management included individuals' high concern for themselves along with a low concern for others. Other behaviors such as making derogatory comments, complaining often, and dismissing the concerns of other workers were characteristic of the dominating style of conflict management. Individuals with an integrating style of conflict management, on the other hand, were often highly concerned for both themselves and the rest of the team, were open to mutually established goals, and were willing to exchange ideas with other members of the team (Trudel & Reio).

According to Einarsen, Hoel, Zapf, & Cooper (2011), the vast majority of research related to workplace incivility has focused on the organizational and individual outcomes of incivility in the workplace. While such research highlights the growing problem of incivility in the workplace, it is also important to further investigate characteristics of instigators' motives and actions. Researchers have established that certain characteristics of workers are significant factors in contributing to workplace incivility (Andersson & Pearson, 1999; Pearson, Andersson, & Porath, 2000; Namie, 2003; Pearson & Porath, 2005; Penney & Spector, 2005; Trudel & Reio, 2011). Still, much of the current literature focuses on the workforce in general, without identifying key worker characteristics that may be specific to a particular profession.

Incivility in the Nursing Profession

Nursing education. Clark (2008) found that nursing students and faculty believe incivility is a mild to severe issue in nursing education, citing student behaviors such as the use of mobile devices while in class, talking out of turn, and/or making derogatory comments. Faculty behaviors included faculty-to-faculty incivility and using rank for

exerting power over students or each other. More threatening student behaviors included stalking, intimidating, or verbally/physically abusing faculty members (Kuhlenschmidt & Layne, 1999). Most concerning is the fact that if uncivil behaviors in nursing education are not addressed, such behaviors may carry over to the practice setting resulting in increased numbers of new graduate nurses who will tolerate, or engage in, uncivil behaviors (Randle, 2003).

Nursing practice. Uncivil behaviors in the nursing practice setting contribute to more errors in patient care, decreased quality of care, increased costs, and a loss of high quality nursing providers and leaders (Clark & Springer, 2010; Laschinger, 2014; Reynolds, Kelly, & Singh-Carlson, 2014). When nurses were asked about their intent to leave their organizations, many nurses cited a desire to leave the current position because of exposure to uncivil behaviors in their work environment (Wilson, Diedrich, Phelps, & Choi, 2011). Additional studies noted similar findings (Spence Laschinger, Leiter, Day, & Gilin, 2009; Leiter, Price, & Spence Laschinger, 2010; Oyeleye, Hanson, O'Connor, & Dunn, 2013).

Acute care settings may be more prone to incivility on account of high stress situations, rapidly changing working environments, demanding and frustrating working conditions, increased number of employees, and constant diverse interactions (Hunt & Marini, 2012). Incivility among nurses in the practice setting is well documented and includes numerous examples of unprofessional actions among nurses from multiple areas and settings of nursing practice, ranging from verbal/non-verbal abuse, backstabbing, and gossiping; to bullying, threatening, and even violent behaviors (Clark & Springer, 2007; Luparell, 2007; Stanley, Dulaney, & Martin, 2007; Woelfle & McCaffrey, 2007; Hunt &

Marini; McNamara, 2012; Ostrofsky, 2012; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013). Other behaviors include spreading rumors, being passive aggressive, sarcastic, or intimidating, putting others down publicly, undermining, or refusing to help co-workers (McNamara). While uncivil behaviors have been known to cross all areas of the nursing profession, the occurrence of uncivil behaviors is even greater in intensive care units, emergency departments, and perioperative settings, most likely due to the higher stress associated with such environments (Bambi, et al., 2014; Nikstaitis & Simko, 2014; Rosenstein & O'Daniel, 2006; Bigony et al., 2009).

The Role of Professional Comportment

Professional comportment is an aspect of nursing practice that is just as significant as the daily duties of a bedside nurse and, as such, should receive similar acknowledgement and opportunity for development (Clickner & Shirey, 2013). In other words, there is more to being a professional nurse than the tasks ascribed for completing the daily bedside nurse functions such as physical assessment and administering medications and treatments. According to Clickner & Shirey, a distinguished demeanor and behaviors related to a healthy well-being define the professionally comported nurse. Moreover, comportment can be described as deportment, in the way that individuals act or present themselves. Roach (2002) incorporated the concept of comportment in The Six Cs of Human Caring and described the importance of being consciously committed, compassionate, competent, and confident as part of professional comportment. According to Roach, comportment, in relation to caring, is an individual's connection, attitude, and peacefulness with themselves and those around them. The ability for an individual to perpetuate agreement between beliefs related to their own self-worth and the worth of

others, and being able to accept how others may act, represents professional comportment (Clickner & Shirey, 2013).

Benner (1991) further described comportment as an important element of nursing ethics, citing nurse characteristics such as the social skills necessary to connect with other individuals in a reverent and concerned fashion. These behaviors may consist of a nurse's verbal communications, goals, and presence. Originally described as part of the foundation for the education and socialization of novice nurses into professional nursing practice, nursing ethical comportment embodies Benner's Novice to Expert theory. Acquiring the expertise, understanding, interpersonal relations, and ability to connect with both patients and other members of the interdisciplinary team expounds nursing ethical comportment (Benner, Sutphen, Leonard, & Day, 2010). A registered nurse who conveys ethical comportment is assertive in professional practice and clinical awareness. The ability to comprehend and relate to others effectively is an example of ethical comportment (Benner et al., 2010). As such, ethical comportment is essential in the establishment and development of the professional registered nurse (Benner et al.). Effective communication and integration into the nursing profession are necessary components in the transition from novice to expert (Benner). Identifying the concept of ethical comportment as important suggests the need to incorporate teaching such characteristics in order to equip registered nurses with the knowledge and skills necessary to belong to a profession (Benner; Benner et al.).

Nursing professional practice programs have become increasingly popular due to their desire to promote professional comportment through encouraging nurse empowerment, healthy nursing work environments, and, ultimately, higher quality patient

outcomes (Krugman, Rudolph, & Nenaber, 2013). Using Benner's (1982) Novice to Expert theory as the foundation, the University of Colorado Hospital (UCH) created the University of Colorado Hospital's Excellence in Clinical Practice, Education, Evidence-based Practice, and Leadership (UEXCEL). Operating continuously for over 22 years, UEXCEL has been shown to develop leadership, autonomy, and empowerment in nursing professional practice resulting in improved patient outcomes. Nursing leaders at UCH have encouraged nurse participation in UEXCEL by allowing for the time, fiscal resources, and support required for the program's success, which has resulted in a more engaged nursing team who are more dedicated to improving patient safety and quality of care (Krugman, Rudolph, & Nenaber). Even though programs like UEXCEL have been in existence for years, and similar professional nursing practice programs are on the rise as more hospitals strive to achieve Magnet status, incivility in nursing remains a problem. Low (2012) found that more than 700 nurses reported to the Maryland Commission on the Crisis in Nursing that incivility in the workplace was one of their top three concerns about the nursing work environment. Despite interventions designed to deter incivility, revamped codes of conduct, development and delivery of education for healthcare workers on the topic of incivility, and extensive research citing the dangers of incivility in the nursing work environment, nurses continue to voice their concerns about the rise of incivility in nursing (Low).

Summary

Workplace incivility has been recognized as a critical and mounting issue in the American workforce that has a markedly unmanageable impact on an organization's employees, consumers, and outcomes. Uncivil behaviors in the workplace negatively

affect the physical and emotional well-being of workers leading to adverse effects on co-workers, consumers, and, ultimately, the organization. In general, uncivil behaviors in the workplace are ambiguous, offensive, and not often viewed as having a serious impact. As such, incivility in the workplace continues to grow in multiple areas of the workforce, including the profession of nursing. Many researchers, in both the organizational and nursing literature, concur that specific types of worker behaviors such as treating others with disrespect, superseding other's decisions, being unwilling to help others, and refusing to collaborate with the team contribute to incivility in the workplace. While interventions for addressing and managing these types of behavior in the general workplace setting have been established, there is a lack of research about specific critical attributes in registered nurses that may be related to an environment of civility/incivility. Clickner & Shirey (2013) described what comprises the behaviors of registered nurses that are related to incivility, thus it is important to further explore, and understand, such characteristics in registered nurses. Nursing leaders in both education and practice need to be more aware of the specific characteristics of nurses that encourage civility in nursing in order to refine today's nursing education and professional practice programs so that they can better address, and prevent, incivility in the nursing profession.

CHAPTER 3

METHODS

Design

A cross-sectional descriptive study was designed using an 85-item electronic survey to explore intensive care unit registered nurses' perceptions of nurse-nurse incivility and professional comportment and whether or not they had ever received any education on the topics of incivility and professional comportment.

Human Subjects

Approval was obtained from the Arizona State University Institutional Review Board (IRB) prior to initiation of the study. Permission to conduct the study was also approved by the participating institutions and their designated IRBs. The research study presented limited risks to the subjects. By completing the survey, participants were giving their consent to participate in the study. Participants were informed that they could withdraw from the study at any time without penalty.

Setting

The sample of registered nurses was drawn from 14 acute care hospitals within three major hospital systems operating in the southwestern United States. The chief nursing officers, nursing directors, and nursing research directors from each hospital agreed to the use of their hospitals as recruitment sites. Participating hospitals were located in inner city, urban, and suburban settings, and ranged in size from 92 to greater than 650 licensed patient care beds. Many of the participating hospitals were highly specialized in certain areas including cancer and stroke care, cardiology, and organ transplant. Some facilities had earned the Magnet designation.

Sample

Registered nurses were invited to participate in the study if they provided full, part-time, or per diem direct patient care in an intensive care unit (ICU) in any of the participating hospitals. Registered nurses working in an ICU were specifically chosen due to the higher incidence of incivility that has been shown to occur among registered nurses in ICU settings (Bambi, et al., 2014; Nikstaitis & Simko, 2014). Registered nurses not employed in an ICU setting, licensed vocational/practical nurses, and graduate nurses without a license were excluded from the research study.

Measures

An 85-item electronic survey was sent via e-mail to all intensive care unit registered nurses at each participating hospital. The survey consisted of (a) an introduction to the study and consent to participate, (b) the Nursing Incivility Scale, (c) the Nurse-Nurse Collaboration Scale, (d) two questions about incivility and professional comportment education, and (e) five demographic questions.

Nursing incivility scale. The Nursing Incivility Scale (NIS) is a 43-item scale developed by Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex (2010) that categorizes nursing incivility by source (General, Nurse, Supervisor, Physician, and Patient). Each source of incivility includes questions from two or more of eight validated subscales: (a) Hostile Climate, (b) Inappropriate Jokes, (c) Inconsiderate Behavior, (d) Gossip/Rumors, (e) Free-Riding, (f) Abusive Supervision, (g) Lack of Respect, and (h) Displaced Frustration. Reliability for the subscales range from a Cronbach's alpha of 0.81 to 0.94 and the subscales demonstrate acceptable convergent and discriminant validity with other variables.

Only survey items from the Nursing Incivility Scale (NIS) that identify participants' perceptions of incivility from other registered nurses (items 10 through 19 on the NIS) were used to create a composite variable representing the overall perception of perceived nurse-nurse incivility on a scale from one to five. Per Guidroz et al. (2010), the NIS allows for source-level scores to be averaged together for an overall score of the level of incivility from any particular source (General, Nurse, Supervisor, Physician, or Patient). A score of one on the nurse-nurse incivility composite variable scale indicates the lowest level of participants' perceived nurse-nurse incivility and a score of five on the scale indicates the highest level. Permission to use the NIS was received from the author (Guidroz et al.)

Nurse-nurse collaboration scale. The Nurse-Nurse Collaboration (NNC) Scale is a 35-item scale developed by Dougherty & Larson (2010) that measures subdomains of nurse-nurse collaboration. Permission to use the NNC scale was received from the author (Dougherty & Larson). Reliability for the subdomains ranges from a Cronbach's alpha of 0.66 to 0.90. The authors found that convergent validity correlations showed minimal shared variance for the subdomains, thus, the NNC scale does not measure an overall concept but, rather, five separate subdomains domains of nurse-nurse collaboration: (a) conflict management, (b) communication, (c) shared processes, (d) coordination, and (e) professionalism. While participants completed the entire NNC scale, only the subdomains of conflict management, shared processes, and professionalism were used for this research as they measure the critical attributes of professional comportment (Clickner & Shirey, 2013).

After reverse scoring items five, six, seven, twelve, thirteen, fourteen, and fifteen from the Nurse-Nurse Collaboration (NNC) Scale, survey responses were used to create three composite variables representing professional comportment on a scale from one to four for each variable (conflict management, items one through seven; shared processes, items 16 through 23; and professionalism, items 29 through 35) (Dougherty & Larson, 2010). A score of one on each of the composite variable scales indicates the lowest level of the perceived variable, while a score of four on each of the variables indicates the highest level.

Education. The participants were asked two single-item questions related to whether they had received education on the topics of incivility or professional comportment. Participants were asked to answer either “yes” or “no” to each question as to whether they had ever received any education on the topics of incivility or professional comportment after being given a definition and examples of education opportunities (e.g. nursing school, in-service, continuing education, etc.).

Demographics. Five questions asked participants’ age (in years), gender (male or female), race/ethnicity (White, Non-Hispanic, Hispanic or Latino, Asian, Black or African American, American Indian or Alaskan Native, I prefer not to answer, or Other), nursing degree (associate degree in nursing, baccalaureate degree in nursing, master’s degree in nursing, PhD in nursing, or DNP), and nursing experience (in years practicing as a registered nurse).

Data Collection

An e-mail communication from the nursing directors at each participating hospital was sent to participants on behalf of the researcher introducing the research study,

describing the inclusion criteria and consent agreement, and providing a link to the electronic survey. The researcher's contact information was included in the e-mail. The electronic survey was available for nurses to complete over a two-week period starting from the time the introductory e-mail and link to the survey were sent to participants. One week after participants received the initial invitation, a follow up e-mail for survey completion was sent. Data collection closed one week after the follow-up e-mail. Due to a minimal number of survey responses, the survey was re-opened for an additional data collection period at each study site with the permission of the sites and as allowed by the IRB classification status. Upon approval from each study site, the study protocol was re-initialized with additional recruitment procedures including more frequent reminder e-mails as well as in-person reminders to nurses on their units. Nurses were reminded the survey had been sent to them before and that they should not complete the survey again if they had previously participated. For those who chose to participate in the survey, completion of the survey was considered consent. Registered nurses were informed that they could withdraw at any time during the research study. If a registered nurse started the survey and then decided not to participate, he/she was able to exit the survey and was not included in the research study. All participants completed the same electronic survey and the survey contained no identifying information.

To encourage participation, all registered nurses who chose to complete the survey were offered an incentive. Participants were informed that their completion of the survey allowed them to be entered into a drawing to receive a \$50.00 gift card and were invited to fill out an optional electronic form after completing the survey that included their e-mail address. Those who chose to participate in the drawing were informed that

their responses would remain confidential with the research team. Participants' e-mail addresses were noted for the drawing of the gift card. At the end of the research study, one name was selected and the recipient was notified by e-mail. The gift card was then mailed to the winning participant. Contact information for the drawing was not linked to the survey responses and, upon sending out the gift card, all contact information was deleted.

Data Analysis

Data analysis included correlational and multiple linear regression analyses. Initially, descriptive statistics of the sample were run including frequencies and distributions, means, standard deviations, and percentiles. Data were then analyzed using the Shapiro-Wilk test to determine normal distribution of nurse-nurse incivility, the three variables representing professional comportment (conflict management, shared processes, and professionalism), incivility and professional comportment education, age, nursing degree, and years of nursing experience. Data were also tested to determine the skewness and kurtosis of the same variables. Reliability tests were performed for the items from the Nursing Incivility Scale (NIS) that represent nurse-nurse incivility (items 10 through 19), and the items from the Nurse-Nurse Collaboration (NNC) Scale that represent professional comportment: conflict management (items one through seven), shared processes (items 16 through 23), and professionalism (items 29 through 35). Even though participants completed the entire NNC scale, only the subdomains of conflict management, shared processes, and professionalism were included in the data analysis as they measure the critical attributes of professional comportment (Clickner & Shirey, 2013).

Specific aim one. A Pearson correlation was used to test the strength and direction of the relationship between registered nurses' perceptions of nurse-nurse incivility and the variables representing professional comportment (conflict management, shared processes, and professionalism). The p value for statistical significance was set at $p < 0.05$.

Specific aims two and three. Point-biserial correlations were used to test the strength and direction of the relationships between (a) registered nurses who have had incivility education and their perceptions of nurse-nurse incivility, and (b) registered nurses who have had professional comportment education and their perceptions of the variables representing professional comportment (conflict management, shared processes, and professionalism). The p value for statistical significance was set at $p < 0.05$.

Specific aims four and five. Multiple linear regression analyses were conducted to examine the effect of registered nurses' incivility and professional comportment education, nurses' age, nursing degree, and years of nursing experience on perceptions of nurse-nurse incivility and professional comportment. Using the composite variable for nurse-nurse incivility as the dependent outcome variable, registered nurses' incivility education, age, nursing degree, and years of experience were simultaneously entered into the model as independent variables to determine their ability to predict the outcome. This process was repeated with the subsequent dependent outcome variables for professional comportment (conflict management, shared processes, and professionalism). Independent variables for all regression models were evaluated with a significance level set at $p < 0.05$.

Specific aim six. Multiple linear regression analysis was conducted to examine the effect of registered nurses' perceptions of professional comportment on perceptions of nurse-nurse incivility while controlling for incivility and professional comportment education, age, nursing degree, and years of nursing experience. Using the composite variable for nurse-nurse incivility as the dependent outcome variable, professional comportment (conflict management, shared processes, and professionalism), incivility and professional comportment education, age, nursing degree, and years of nursing experience were simultaneously entered into the model as independent variables to determine their ability to predict the outcome. Independent variables for all regression models were evaluated with a significance level set at $p < 0.05$.

CHAPTER 4

RESULTS

There were approximately 1,530 critical care registered nurses employed in the intensive care units of the three healthcare systems. Of the 1,530 registered nurses, 322 responded for a response rate of about 21%.

Sample Demographics

Descriptive statistics of the study sample are presented in Table 1. Race was recoded into a dichotomous variable (“White, Non-Hispanic” and “Other”) and nursing degree was recoded into three categories (“Associate’s,” “Bachelor’s,” and “Master’s or Higher”) to avoid having subgroups with fewer than 20 participants. Continuous data are reported with means and standard deviations while frequency statistics are reported for categorical data. A total of 322 registered nurses working in intensive care were recruited. Twenty-one registered nurses began the survey process but completed less than 90% of the survey resulting in their responses being excluded from the study. The final sample for analysis included 301 registered nurses. Over half (85.4%) of the participants were white (n = 240) and female (85.9%, n = 256) with the majority of participants (65.4%) reporting a bachelor’s degree as their highest degree in nursing (n = 191). More than half of the participants reported receiving some type of education on the topics of incivility (54.8%, n = 146) and professional compoartment (59.8%, n = 158).

Table 1

Sample Demographics

	n*	M (SD)	Percent
<i>Age (Years)</i>	284	39.12 (10.53)	
<i>Years as a Registered Nurse</i>	296	12.43 (10.15)	
<i>Nursing Degree</i>	292		
Associate's	74		25.3
Bachelor's	191		65.4
Master's or Higher	27		9.2
<i>Gender</i>	298		
Male	42		14.1
Female	256		85.9
<i>Race</i>	281		
White, Non-Hispanic	240		85.4
Other	41		14.6
<i>Incivility Education</i>	301		
Yes	165		54.8
No	136		45.2
<i>Professional Comportment Education</i>	301		
Yes	180		59.8
No	121		40.2

*Variations in n because of missing data.

Normality, Skewness, and Kurtosis

Results of the Shapiro-Wilk test for normality, as well as skewness and kurtosis statistics for all study variables, are presented in Table 2. Despite the violation of assumption for normality among all variables, and issues with skewness and kurtosis among some variables, histograms of all variables illustrated a relatively normal distribution shape with minimal outliers, suggesting that an assumption of normality for all variables is reasonable.

Table 2

Normality, Skewness, and Kurtosis of Study Variables

	Normality*	Skewness	Kurtosis
Nurse-Nurse Incivility	n	0.144	-0.132
Conflict Management	n	-0.294	0.558
Shared Processes	n	0.012	1.842
Professionalism	n	-0.607	1.663
Incivility Education	n	-0.195	-1.975
Comportment Education	n	-0.402	-1.851
Age	n	0.548	-0.490
Nursing Degree	n	-0.013	-0.110
Years of Nursing Experience	n	1.174	0.756

*N = normal distribution and n = not normal distribution, according to Shapiro and Wilk (1965)

Reliability

The assessment of internal consistency for the items on the Nursing Incivility Scale (NIS) that represent perceptions of nurse-nurse incivility (items 10 through 19) resulted in a Cronbach's alpha of 0.89. The assessment of internal consistency for the items from the Nurse-Nurse Collaboration (NNC) Scale that represent professional comportment (conflict management, items one through seven; shared processes, items 16 through 23; and professionalism, items 29 through 35) produced Cronbach alphas of 0.77 (conflict management), 0.82 (shared processes), and 0.89 (professionalism).

Nurse-Nurse Incivility and Professional Comportment

Specific aim one. Results of the Pearson correlation to test the strength and direction of the relationship between registered nurses' perceptions of nurse-nurse incivility and their perceptions of the variables representing professional comportment (conflict management, shared processes, and professionalism) are reported in Table 3. Three statistically significant relationships were identified: a moderate negative relationship existed between perceptions of nurse-nurse incivility and perceptions of conflict management ($r = -0.523$, $n = 301$, $p < 0.01$), a weak negative correlation was seen between perceptions of nurse-nurse incivility and perceptions of shared processes ($r = -0.352$, $n = 301$, $p < 0.01$), and a moderate negative correlation was shown between perceptions of nurse-nurse incivility and perceptions of professionalism ($r = -0.555$, $n = 301$, $p < 0.01$).

Table 3

Perceptions of Nurse-Nurse Incivility and Professional Comportment

	Conflict Management <i>r</i>	Shared Processes <i>r</i>	Professionalism <i>r</i>
Nurse-Nurse Incivility	-0.523**	-0.352**	-0.555**

** $p < .01$.

Incivility and Professional Comportment Education

Specific aim two. Results of the point-biserial correlation to test the strength and direction of the relationship between registered nurses' perceptions of nurse-nurse incivility and their incivility education are reported in Table 4. There was not a

statistically significant relationship between registered nurses' perceptions of nurse-nurse incivility and incivility education ($rpbi [301] = -0.101, p = 0.079$).

Table 4

Perceptions of Nurse-Nurse Incivility and Education

	Incivility Education <i>rpbi</i>
Nurse-Nurse Incivility	-0.101

Specific aim three. Results of the point-biserial correlation to test the strength and direction of the relationship between registered nurses' perceptions of the variables representing professional comportment (conflict management, shared processes, and professionalism) and their professional comportment education are reported in Table 5. A statistically significant weak positive relationship existed between registered nurses' professional comportment education and their perceptions of the variables representing professional comportment: conflict management ($rpbi [301] = 0.220, p < 0.01$), shared processes ($rpbi [301] = 0.173, p < 0.05$), and professionalism ($rpbi [301] = 0.169, p < 0.05$).

Table 5

Perceptions of Professional Comportment and Education

	Professional Comportment Education <i>rpbi</i>
Conflict Management	0.220**
Shared Processes	0.173*
Professionalism	0.169*

* $p < .05$. ** $p < .01$.

Predictors of Nurse-Nurse Incivility and Professional Comportment

Specific aim four. The multiple linear regression equation predicting perceptions of nurse-nurse incivility was not statistically significant ($F = 1.808$, $p = 0.127$). Thus, registered nurses' incivility education, age, nursing degree, and years of experience did not predict perceptions of nurse-nurse incivility. Results are reported in Table 6.

Table 6

Predictors of Nurse-Nurse Incivility

Variable	Perceptions of Nurse-Nurse Incivility		
	<i>B</i>	<i>SE B</i>	β
Incivility Education	-0.128	0.085	-0.090
Age	0.001	0.007	-0.019
Nursing Degree	0.165	0.075	0.133
Years Nursing Experience	-0.002	0.007	-0.025
R^2		0.026	
F		1.808	

Specific aim five. Results of the multiple linear regression analyses for variables predicting perceptions of professional comportment (conflict management, shared processes, and professionalism) are reported in Tables 6, 7, and 8. A statistically significant regression equation was found for conflict management ($F = 6.583$, $p < 0.01$) with an R^2 of 0.088, with 8.8% of the variance in conflict management accounted for in the equation. Registered nurses' age, nursing degree, and years of nursing experience were not found to be statistically significant predictors of nurses' perceptions of conflict management, however, professional comportment education did statistically significantly predict perceptions of conflict management. Nurses who have had professional comportment education, compared to those who have not, are likely to perceive a 0.254 increase on the conflict management scale when controlling for age, nursing degree, and years of nursing experience. Results are reported in Table 7.

Table 7

Variables Predicting Conflict Management

Variable	Perceptions of Conflict Management		
	<i>B</i>	<i>SE B</i>	β
Comportment Education	0.229	0.052	0.254**
Age	-0.006	0.004	-0.138
Nursing Degree	0.044	0.045	0.057
Years Nursing Experience	-0.001	0.004	-0.012
R^2		0.088	
F		6.583**	

** $p < .01$.

A statistically significant regression equation was found for shared processes ($F = 4.449, p < 0.05$), with an R^2 of 0.061, with 6.1% of the variance in shared processes accounted for in the model. Registered nurses' age, nursing degree, and years of nursing experience were not found to be statistically significant predictors of nurses' perceptions of shared processes, however, professional comportment education did statistically significantly predict perceptions of shared processes. Nurses who have had professional comportment education, compared to those who have not, are likely to perceive a 0.205 increase on the shared processes scale when controlling for age, nursing degree, and years of nursing experience. Results are reported in Table 8.

Table 8

Variables Predicting Shared Processes

Variable	Perceptions of Shared Processes		
	<i>B</i>	<i>SE B</i>	β
Comportment Education	0.172	0.049	0.205*
Age	-0.004	0.004	-0.104
Nursing Degree	0.082	0.043	0.114
Years Nursing Experience	0.002	0.004	0.054
R^2		0.061	
F		4.449*	

* $p < .05$.

A statistically significant regression equation was found for professionalism ($F = 3.554, p < 0.05$), with an R^2 of 0.049, with 4.9% of the variance in professionalism accounted for in the model. Registered nurses' age, nursing degree, and years of nursing experience were not found to be statistically significant predictors of nurses' perceptions

of professionalism, however, professional comportment education did statistically significantly predict perceptions of professionalism. Nurses who have had professional comportment education, compared to those who have not, are likely to perceive a 0.183 increase on the professionalism scale when controlling for age, nursing degree, and years of nursing experience. Results are reported in Table 9.

Table 9

Variables Predicting Professionalism

Variable	Perceptions of Professionalism		
	<i>B</i>	<i>SE B</i>	β
Comportment Education	0.195	0.063	0.183**
Age	-0.007	0.005	-0.141
Nursing Degree	-0.20	0.054	-0.021
Years Nursing Experience	0.000	0.005	0.003
R^2		0.049	
F		3.544**	

** $p < .01$.

Effect of Professional Comportment on Nurse-Nurse Incivility

Specific aim six. A statistically significant regression equation was found for nurse-nurse incivility ($F = 25.102$, $p < 0.01$) with an R^2 of 0.427, with 42.7% of the variance in perceptions of nurse-nurse incivility accounted for in the model. Registered nurses' incivility and professional comportment education, perceptions of shared processes, age, and years of nursing experience were not found to be statistically significant predictors of nurses' perceptions of nurse-nurse incivility. However, nurses' perceptions of conflict management and professionalism, as well as nursing degree, did

statistically significantly predict their perceptions of nurse-nurse incivility. Statistically significant predictors of nurse-nurse incivility included nurses' perceptions of conflict management, professionalism and nursing degree. For each point increase on the conflict management and professionalism scale, nurses reported decreases in their perceptions of nurse-nurse incivility by -0.372 points and -0.365 points, respectively. As nurses move to a higher nursing degree (i.e. from an associate's to bachelor's or bachelors' to master's) their perceptions of nurse-nurse incivility increases by 0.148 points. Results are reported in Table 10.

Table 10

Variables Predicting Nurse-Nurse Incivility

Variable	Perceptions of Nurse-Nurse Incivility		
	<i>B</i>	<i>SE B</i>	β
Conflict Management	-0.596	0.095	-0.372**
Shared Processes	0.018	0.103	0.011
Professionalism	-0.497	0.084	-0.365**
Incivility Education	-0.031	0.077	-0.022
Comportment Education	0.000	0.080	0.000
Age	-0.005	0.005	-0.068
Nursing Degree	0.183	0.059	0.148**
Years Nursing Experience	-0.003	0.006	-0.043
<i>R</i> ²		0.427	
<i>F</i>		25.102**	

***p* < .01.

CHAPTER 5

DISCUSSION

Interpretation of results for each specific aim, taking into account the current literature and addressing the strengths and limitations of the study, are reported in this chapter.

Nurse-Nurse Incivility and Professional Comportment

Specific aim one was focused on exploring the relationship between registered nurses' perceptions of nurse-nurse incivility and professional comportment using the Nursing Incivility Scale (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010) to measure nurse-nurse incivility, and the Nurse-Nurse Collaboration Scale (Dougherty & Larson, 2010) to measure the variables representing professional comportment (conflict management, shared processes, and professionalism). Results suggest a relationship may exist between registered nurses' perceptions of nurse-nurse incivility and perceptions of the variables representing professional comportment. Findings regarding the relationship between perceptions of nurse-nurse incivility and professional comportment may indicate that when registered nurses' perceptions of nurse-nurse incivility are higher, they have lower perceptions of the variables representing professional comportment. In other words, when nurses perceive that they work in an environment where nurses exhibit the behaviors described in the Nursing Incivility Scale (arguing with each other frequently, having violent outburst, screaming, gossiping about co-workers or supervisors, bad-mouthing others, spreading rumors, making little contribution to a project but expecting to receive credit for working on it, claiming credit for others' work, or taking credit for work they did not do), their

perceptions of conflict management, shared processes, and professionalism, as measured by the Nurse-Nurse Collaboration Scale, are decreased. The following paragraphs describe these relationships.

For conflict management, when perceptions of nurse-nurse incivility were high, nurses had decreased perceptions on the Nurse-Nurse Collaboration Scale that (a) all points of view will be carefully considered in arriving at the best possible solution to a problem, (b) nurses will work together to arrive at the best possible solution to a patient care problem, (c) nurses will not settle a dispute until all are satisfied with the decision, (d) everyone contributes from their experience and expertise to produce a high quality solution, (e) when nurses disagree, they will address the issue, (f) nurses will not withdraw from conflict with other nurses, and (g) disagreements between nurses are addressed.

In relation to shared processes, when perceptions of nurse-nurse incivility were high, nurses had decreased perceptions on the Nurse-Nurse Collaboration Scale that they (a) are able to make decisions on their own regarding nursing care, (b) are allowed to make decisions that affect them at work, (c) are involved in making decisions about what happens at work, (d) have a lot to say over what happens for patient care on their unit, (e) agree on goals for patient pain management, (f) agree with patient safety goals for the unit, (g) have the authority to stop a procedure which violates patient safety standards for identification, and (h) have the authority to stop a procedure which violates infection control standards for central line insertions.

As far as professionalism, high perceptions of nurse-nurse incivility were related to decreased perceptions on the Nurse-Nurse Collaboration Scale that (a) there is a

respectful and cordial relationship among nurses, (b) nurses are willing to collaborate with each other, (c) nurses have adequate knowledge of the drugs ordered for patients, (d) nurses have adequate knowledge of the disease processes for patients, (e) nurses have the technical skills necessary to provide safe patient care, (f) nurses with more experience help to mentor and teach less experienced nurses, and (g) nursing leadership supports collaboration.

Incivility and Professional Comportment Education

Specific aims two and three examined the differences in perceptions of nurse-nurse incivility and professional comportment between registered nurses who have had education on incivility and professional comportment and those who have not. There was not a significant relationship between registered nurses' perceptions of nurse-nurse incivility and their nursing incivility education. Conversely, registered nurses' who reported having more education about professional comportment had higher perceptions of the variables representing professional comportment (conflict management, shared processes, and professionalism). Findings regarding the relationship between registered nurses' perceptions of professional comportment and their professional comportment education suggest that when registered nurses' report increased professional comportment education, they have increased perceptions of professional comportment. Thus, it may be important in the development of future educational interventions to focus more on professional development and improving conflict management skills in nurses, as well as gaining support from nursing leaders to help nurses feel more autonomous.

Predictors of Nurse-Nurse Incivility and Professional Comportment

Specific aims four and five examined the effect of incivility and professional comportment education, age, nursing degree, and years of nursing experience on registered nurses' perceptions of nurse-nurse incivility and professional comportment. Registered nurses' incivility education, age, nursing degree, and years of nursing experience were not significant predictors of registered nurses' perceptions of nurse-nurse incivility. Nurses who have had more education on professional comportment were significantly more likely to have increased perceptions of conflict management, shared processes, and professionalism, even when controlling for age, nursing degree, and years of nursing experience. This is an important finding considering the relationship between increased perceptions of conflict management, shared processes, and professionalism and decreased perceptions of nurse-nurse incivility. In other words, if decreased perceptions of nurse-nurse incivility are related to increased perceptions of the variables representing professional comportment, then it may be important to better educate nurses on conflict management, shared processes, and professionalism in order to decrease incivility.

Effect of Professional Comportment on Nurse-Nurse Incivility

Specific aim six examined the effect of professional comportment on nurse-nurse incivility while controlling for registered nurses' incivility and professional comportment education, age, nursing degree, and years of nursing experience. Not all variables of professional comportment predicted registered nurses' perceptions of nurse-nurse incivility. One unexpected variable, nursing degree, was found to be a significant predictor of registered nurses' perceptions of nurse-nurse incivility. While conflict management and professionalism were found to be significant predictors of registered

nurses' perceptions of nurse-nurse incivility when controlling for all other variables, shared processes was not a significant predictor. In addition, when accounting for registered nurses' incivility and professional comportment education, age, years of nursing experience, and their perceptions of the three variables representing professional comportment, nursing degree was found to be a significant predictor of registered nurses' perceptions of nurse-nurse incivility. Findings regarding registered nurses' incivility and professional comportment education, age, nursing degree, and years of nursing experience suggest that when perceptions of conflict management and professionalism are high, there is a decrease in perceptions of nurse-nurse incivility.

Registered nurse's with higher degrees in nursing (moving from associates to bachelors, bachelors to masters, and masters to higher) reported increased perceptions of nurse-nurse incivility. This might suggest that as nurses advance in their education, they are more aware of uncivil behaviors.

Strengths of the Study

The current study revealed several major findings important to the nursing profession. First, there was a significant relationship between registered nurses' perceptions of nurse-nurse incivility and all three variables representing professional comportment (conflict management, shared processes, and professionalism). As registered nurses' perceptions of nurse-nurse incivility increased, their perceptions of conflict management, shared processes, and professionalism decreased. These findings are consistent to previous studies that have confirmed relationships between workplace incivility and dominating styles of conflict management among workers, individuals who have a desire to be in control, and decreased professional behaviors among workers

(Pearson, Andersson, & Porath, 2000; Namie, 2003; Penney & Spector, 2005; Estes & Wang, 2008; Trudel & Reio, 2011).

Secondly, there was a significant relationship between registered nurses' professional comportment education and their perceptions of the variables representing professional comportment. When nurses reported that they had received professional comportment education, as compared to nurses who reported that they had not received professional comportment education, their perceptions of conflict management, shared processes, and professionalism increased. These findings confirm previous research suggesting the need for, and importance of, education about professional behaviors to be part of the socialization of novice nurses in order for them to develop leadership, autonomy, and empowerment in nursing professional practice (Benner, 1991; Benner, Sutphen, Leonard, & Day, 2010; Krugman, Rudolph, & Nenaber, 2013). The lack of a significant relationship between registered nurses' incivility education and their perceptions of nurse-nurse incivility is an important finding to consider when examining current, and developing future, educational interventions to prevent incivility. This finding also raises the questions of whether current interventions for incivility are truly effective and how to increase their effectiveness.

The incidence of incivility in nursing is increased in higher stress areas, such as intensive care units, emergency departments, and perioperative settings (Bambi, et al., 2014; Nikstaitis & Simko, 2014; Rosenstein & O'Daniel, 2006; Bigony et al., 2009). Findings from the current study that critical care registered nurses' perceptions of nurse-nurse incivility are not predicted by their incivility education, age, or years of nursing experience supports the conclusion that incivility crosses multiple areas and settings of

nursing practice (Clark & Springer, 2007; Luparell, 2007; Stanley, Dulaney, & Martin, 2007; Woelfle & McCaffrey, 2007; Hunt & Marini; McNamara, 2012; Ostrofsky, 2012; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013). On the other hand, critical care registered nurses' perceptions of the variables representing professional comportment were significantly predicted by their professional comportment education despite their age, nursing degree, and years of nursing experience. These findings are particularly important to nurse educators and nursing professional development specialists who want to implement educational interventions to help prevent, or better address, incivility among registered nurses in a variety of settings.

Finally, it is important to note that registered nurses' perceptions of conflict management and professionalism, as well as nursing degree, were significant predictors of registered nurses' perceptions of nurse-nurse incivility despite their incivility and professional comportment education, age, and years of nursing experience. Decreased perceptions of conflict management, decreased perceptions of professionalism, and an increase in nursing degree all significantly predicted increased registered nurse perceptions of nurse-nurse incivility. Conflict management and professionalism as significant predictors of nurse-nurse incivility are supported in the current literature (Pearson, Andersson, & Porath, 2000; Namie, 2003; Penney & Spector, 2005; Estes & Wang, 2008; Trudel & Reio, 2011), however, nursing degree as a significant predictor of registered nurses' perceptions of nurse-nurse incivility was an unexpected result of the current study.

Limitations of the Study

While registered nurses' perceptions of nurse-nurse incivility and their perceptions of the variables representing professional comportment (conflict management, shared processes, and professionalism) were defined and measured by valid and reliable tools, the measures related to registered nurses' incivility and professional comportment education could be refined and more clearly defined and measured. Registered nurses' incivility and professional comportment education were simply measured by a "yes" or "no" question as to whether or not participants had ever received any type of education on incivility and professional comportment. There were no opportunities for the participants to describe the type and extent of education they had received on incivility and professional comportment.

There have been no studies to specifically measure professional comportment in nurses. While the Nurse-Nurse Collaboration (NNC) Scale has been used in other studies to measure nurse-nurse collaboration, this is the first study to use the NNC Scale to measure nurses' professional comportment. Further research is needed in the area of measuring professional comportment.

Another limitation of the current study was the low response rate. With a larger sample size, there may have been fewer issues with skewness, as well as an increased support for validity and generalization to other populations. The response rate may have been affected by the sensitivity of the topic of incivility. For example, even though participants were assured anonymity, they may have feared that their responses would be identified and/or revealed to their colleagues and/or supervisors.

Implications for Future Research

Future research on the topics of incivility and professional comportment, and how education on these topics affects nurses' perceptions, might include more defined measures of incivility and professional comportment education. Improving the measures could help nurse educators and nursing professional development specialists in better identifying the most effective types of education on professional comportment.

Additional research might also include an examination of all the subscales from the Nurse-Nurse Collaboration (NNC) Scale to determine if coordination and communication (the subscales not used in the current study) are also related to registered nurses' perceptions of nurse-nurse incivility. This could result in identification of the NNC Scale as a significant tool for measuring professional comportment in nurses.

Conclusion

The transformation to a more civil nursing culture will require diligence and persistence from nursing leaders, especially during a time of nursing workforce shortage (Clark, 2010). This study showed that a nurses' professional comportment may be related to a civil or uncivil environment in nursing and that education about professional comportment is a significant predictor of nurses' perceptions of professional comportment. This important finding has implications for future educational research in developing professional comportment programs for nursing students as well as professional nurses. Following such a line of research can be a powerful means toward developing focused and innovative nursing education to encourage civility and improve patient outcomes.

REFERENCES

- American Association of Colleges of Nursing (2008). The essentials of baccalaureate education for professional nursing practice. Retrieved from <http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf>
- American Nurses Association (2015). Code of ethics with interpretive statements. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/CodeofEthicsForNurses.html>
- American Nurses Association (2015). Incivility, bullying, and workplace violence. Retrieved from <http://www.nursingworld.org/DocumentVault/Position-Statements/Practice/Position-Statement-on-Incivility-Bullying-and-Workplace-Violence.pdf>
- Andersson, L. M. & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *The Academy of Management Review*, 24(3), 452-471.
- Ayoko, O. B., Callan, V. J., & Hartel, C. E. J. (2003). Workplace conflict, bullying, and counterproductive behaviors. *International Journal of Organizational Analysis*, 11, 283-301.
- Baillien, E., Neyens, I., Witte, H. D., & Cuyper, N. D. (2009). A qualitative study on the development of workplace bullying: Towards a three way model. *Journal of Community & Applied Social Psychology*, 19, 1-16.
- Bambi, S., Becattini, G., Giusti, G.D, Mezzetti, A, Guazzini, A., & Lumini, E. (2014). Lateral hostilities among nurses employed in intensive care units, emergency departments, operating rooms, and emergency medical services: A national survey in Italy. *Dimensions of Critical Care Nursing*, 33(06), 347-354.
- Bartlett II, J.E. & Bartlett, M.E. (2011). Workplace bullying: An integrative literature review. *Advances in Developing Human Resources*, 13(1), 69-84.
- Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82, (03), 402-407.
- Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. *Advances in Nursing Science*, 14, 1-21
- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). Educating nurses: A call for radical transformation. San Francisco: Jossey-Bass.
- Bigony, L., Lipke, T.G., Lundberg, A., McGraw, C.A., Pagac, G.L., & Rogers, A. (2009). Lateral violence in the perioperative setting. *AORN Journal*, 89, (04), 688-700.

- Blake, R. R., & Mouton, J. S. (1970). The fifth achievement. *Journal of Applied Behavioral Science*, 6, 413-426.
- Clark, C.M. (2008). Faculty and student assessment of and experience with incivility in nursing education. *Journal of Nursing Education*, 47, (10), 458-465.
- Clark, C.M., & Springer, P.J. (2007). Incivility in nursing education: A descriptive study of definitions and prevalence. *Journal of Nursing Education*, 46, 7-14.
- Clark, C.M. (2010). From incivility to civility: Transforming the culture. *Reflections on Nursing Leadership*, 36(03).
- Clark, C. M. & Springer, P.J. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education*, 49, (06), 319-325.
- Clickner, D.A. & Shirey, M.R. (2013). Professional comportment: The missing element in nursing practice. *Nursing Forum*, 48(02), 106-113.
- Cortina, L. M., Lonsway, K. A., Magley, V. J., Freeman, L. V., Collinsworth, L. L., Hunter, M., & Fitzgerald, L. F. (2002). What's gender got to do with it? Incivility in the federal courts. *Law & Social Inquiry*, 27(2), 235-270.
- Cortina, L. M., Magley, V. J., Williams, J. H., & Langhout, R. D. (2001). Incivility in the workplace: Incidence and impact. *Journal of Occupational Health Psychology*, 6(1), 64-80.
- Cortina, L.M. & Magley, V.J. (2009). Patterns and profiles of response to incivility in the workplace. *Journal of Occupational Health Psychology*, 14(3), 272-288.
- DeMarco, R., & Roberts, S. (2003). Negative behaviors in nursing. *American Journal of Nursing*, 103(3), 113-116.
- Dougherty, M.B. & Larson, E.L. (2010). The nurse-nurse collaboration scale. *Journal of Nursing Administration*, 40(01), 17-25.
- Einarsen, S., Hoel, H., Zapf, D. & Cooper, C. (2011). *Bullying and harassment in the workplace: Developments in theory, research, and practice*. Boca Raton, FL: CRC Press.
- Estes, B. & Wang, J. (2008). Integrative literature review: Workplace incivility: Impacts on individual and organizational performance. *Human Resource Development Review*, 7(2), 218-240.

- Felblinger, D. M. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(2), 234-242.
- Gardner, S., & Johnson, P. R. (2001). The leaner, meaner workplace: Strategies for handling bullies at work. *Employment Relations Today*, 28(2), 23-36.
- Glaso, L., Matthiesen, S. B., Neilsen, M. B., & Einarsen, S. (2007). Do targets of workplace bullying portray a general victim personality profile? *Scandinavian Journal of Psychology*, 48, 313-319.
- Gonthier, G. (2002). *Rude awakenings: Overcoming the civility crisis in the workplace*. Chicago: Dearborn Trade.
- Guidroz, A.M., Burnfield-Geimer, J.L., Clark, O., Schwetschenau, H.M., & Jex, S.M. (2010). The nursing incivility scale: Development and validation of an occupation-specific measure. *Journal of Nursing Measurement*, 18(03), 176-200.
- Hunt, C., & Marini, Z. A. (2012). Incivility in the practice environment: A perspective from clinical nursing teachers. *Nurse Education in Practice*, 12(6), 366-370.
- Johnson, P. & Indvik, J. (2001). Rudeness at work: Impulse over restraint. *Public Personnel Management*, 30, 457-465.
- Johnson, S. L. (2009). International perspectives on workplace bullying among nurses: A review. *International Nursing Review*, 56, 34-40.
- Joint Commission. (2008). Behaviors that undermine a culture of safety. Retrieved from http://www.jointcommission.org/assets/1/18/SEA_40.PDF
- Katrinli, A., Atabay, G., Gunay, G., & Cagarli, B.G. (2010). Nurses' perceptions of individual and political reasons for horizontal peer bullying. *Nursing Ethics*, 17(5), 614-627.
- Kivimaki, M., Elovainio, M., & Vahtera, J. (2000). Workplace bullying and sickness absence in hospital staff. *Occupational and Environmental Medicine*, 57, 656-660.
- Kivimaki, M., Virtanen, M., Vartio, M., Elovainio, M., & Vahtera, J. (2003). Workplace bullying and the risk of cardiovascular disease and depression. *Occupational and Environmental Medicine*, 60, 779-783.
- Krugman, M., Rudolph, M., & Nenaber, A. (2013). Magnet nurses in action: Clinical stars lead a successful professional practice program. *American Nurse Today*, 8(9), 46-50.

- Kuhlenschmidt, S.L. & Layne, L.E. (1999). Strategies for dealing with difficult behavior. In S.M. Richardson (Ed.), *Promoting civility: A teaching challenge* (pp. 45-58). San Francisco: Jossey-Bass.
- Laschinger, H.K.S. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcome. *Journal of Nursing Administration, 44*(5), 284-290.
- Laschinger, H.K., Wong, C., Regan, S., Young-Ritchie, C., & Bushell, P. (2013). Workplace incivility and new graduate nurses' mental health. *Journal of Nursing Administration, 43*(7), 415-421.
- Leiter, M.P., Price, S.L., & Spence Laschinger, H.K. (2010). Generational differences in distress, attitudes and incivility among nurses. *Journal of Nursing Management, 18*, 970-980.
- Low, J.S. (2012). Civility starts with you. *American Nurse Today, 7*(5), 21-22.
- Luparell, S. (2007). The effects of student incivility on nursing faculty. *Journal of Nursing Education, 46*, (01), 15-19.
- MacIntosh, J. (2005). Experiences of workplace bullying in a rural area. *Issues in Mental Health Nursing, 26*, 893-910.
- Matthiesen, S.B. & Einarsen, S. (2004). Psychiatric distress and symptoms of PTSD among victims of bullying at work. *British Journal of Guidance & Counselling, 32*(3), 332-356.
- McNamara, S., A. (2012). Incivility in nursing: Unsafe nurse, unsafe patients. *AORN Journal, 95*(04), 535-540.
- Miner, K.N. & Eischeid, A. (2012). Observing incivility toward coworkers and negative emotions: Do gender of the target and observer matter? *Sex Roles, 66*, 492-505.
- Moayed, F. A., Daraiseh, N., Salem, S., & Shell, R. (2006). Workplace bullying: A systematic review of risk factors and outcomes. *Theoretical Issues in Ergonomics Science, 7*, 311-327.
- Namie, G. & Namie, R.F. (2011). *The bully-free workplace: Stop jerks, weasels, and snakes from killing your organization*. Hoboken, New Jersey: Wiley.
- Namie, G. (2003). Workplace bullying: escalated incivility. *Ivey Business Journal, November/December*, 1-6.

- Namie, G. (2007). The challenge of workplace bullying. *Employment Relations Today*, 34(2), 43-51.
- National Institute for Occupational Safety and Health. (2002). Violence occupational hazards in hospitals. Retrieved from <http://www.cdc.gov/niosh/docs/2002-101/>
- Nikstaitis, T. & Simko, L.C. (2014). Incivility among intensive care nurses: The effects of an educational intervention. *Dimensions of Critical Care Nursing*, 33(05), 239-301.
- Occupational Health and Safety Organization. (n.d.). Safety and health topics: Workplace violence. Retrieved from: <https://www.osha.gov/SLTC/workplaceviolence/>
- Osatuke, K., Moore, S.C., Ward, C., Dyrenforth, S.R., & Belton, L. (2009). Civility, respect, engagement in the workforce (CREW): Nationwide organization development intervention at Veterans Health Administration. *The Journal of Applied Behavioral Science*, 45(03), 384-410.
- Ostrosky, D. (2012). Incivility and the nurse leader. *Nursing Management*, 43(12), 18-22.
- Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. *Journal of Nursing Administration*, 43(10), 536-542.
- Paice, E., & Smith, D. (2009). Bullying of trainee doctors is a patient safety issue. *Clinical Teacher*, 6, 13-17.
- Pearson, C.M., Andersson, L.M., & Porath, C.L. (2000). Assessing and attacking workplace incivility. *Organizational Dynamics*, 29(02), 123-137.
- Pearson, C.M. & Porath, C.L. (2005). On the nature, consequences and remedies of workplace incivility: No time for "nice"? Think again. *The Academy of Management Executive (1993-2005)*, 19(01), 7-18.
- Penney, L.M. & Spector, P.E. (2005). Job stress, incivility, and counterproductive work behavior (CWB): the moderating role of negative affectivity. *Journal of Organizational Behavior*, 26, 777-796.
- Quine L. (1999). Workplace bullying in NHS community trust: Staff questionnaire survey. *British Medical Journal*, 318, 228-232.
- Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6(1), 73-84.

- Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(04), 395-401.
- Randle, J., Stevenson, K., & Grayling, I. (2007). Reducing workplace bullying in healthcare organisations. *Nursing Standard*, 21(22), 49-56.
- Rahim, M. A. (1983). A measure of styles of handling interpersonal conflict. *Academy of Management Journal*, 26, 368–376.
- Reynolds, G., Kelly, S., & Singh □ Carlson, S. (2014). Horizontal hostility and verbal violence between nurses in the perinatal arena of health care. *Nursing Management*, 20(9), 24 □ 30
- Ritter-Teitel, J. (2001). *An exploratory study of a predictive model for nursing-sensitive patient outcomes derived from patient care unit structure and process variables* (Unpublished doctoral dissertation). University of Pennsylvania, Philadelphia, PA.
- Roach, M. S. (2002). *Caring the human mode of being: A blue- print for the health professions* (2nd ed.). Ottawa, ON: Canadian Health Press.
- Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5(4), 21–30.
- Rodriguez-Munoz, A., Moreno-Jimenez, B., Vergel, A. I. S, & Hernandez, E. G. (2010). Posttraumatic symptoms among victims of workplace bullying: Exploring gender differences and shattered assumptions. *Journal of Applied Social Psychology*, 40, 2616-2635.
- Rosenstein, A.H. & O’Daniel, M. (2006). Impact and implications of disruptive behavior in the perioperative arena. *Journal of the American College of Surgeons*, 203(01), 96-105.
- Shapiro, S.S., & Wilk, M.B. (1965). An analysis of variance test for normality (complete samples), *Biometrika*, 52, 591–611.
- Shortell, S.M., Rousseau, D., Gillies, R., Devers, K., & Simons, T. (1991). Organizational assessment in intensive care units (ICUs): Construct development, reliability, and validity of the ICU nurse physician collaboration. *Medical Care*, 29(8), 709-723.
- Simpson, R., & Cohen, C. (2004). Dangerous work: The gendered nature of bullying in the context of higher education. *Gender, Work and Organization*, 11(2), 163-186.

- Sliter, M.T. (2013). But we're here to help! Positive buffers of the relationship between victim incivility and employee outcomes in firefighters. (Doctoral dissertation, Bowling Green State University). UMI Dissertations Publishing. AAT 3528888.
- Sliter, M.T., Jex, S., Wolford, K., & McInernay, J. (2010). How rude! Emotional labor as a mediator between customer incivility and employee outcomes. *Journal of Occupational Health Psychology, 15*(04), 468-481.
- Spence Laschinger, H.K., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management, 17*(03), 302-311.
- Stanley, K.M., Dulaney, P., & Martin, M.M. (2007). Nurses "eating our young": It has a name: Lateral violence. *South Carolina Nurse, 14*(1), 17-18.
- Thomas, K. W. (1992). Conflict and negotiation processes in organizations. In M. D. Dunnette & L. M. Hough (Eds.), *Handbook of industrial and organizational psychology* (2nd ed., pp. 651-717). Palo Alto, CA: Consulting Psychologists Press.
- Trudel, J. & Reio Jr, T.G. (2011). Managing workplace incivility: The role of conflict management styles - antecedent or antidote? *Human Resource Development Quarterly, 22*(04), 395-423.
- Van de Vliert, E. (1984). Conflict: Prevention and escalation. In P.J.D. Drenth, H. Thierry, P. J. Willems, & C. J. de Wolff (Eds.), *Handbook of work and organizational psychology* (pp. 521-551). New York, NY: Wiley.
- Vartia, M. A. L. (2001). Consequences of workplace bullying with respect to the well-being of its targets and the observers of bullying. *Scandinavian Journal of Work, Environment & Health, 27*(1), 63-69.
- Wilson, B.L., Diedrich, A., Phelps, C.L., & Choi, M. (2011). Bullies at work: The impact of horizontal hostility in the hospital setting and intent to leave. *The Journal of Nursing Administration, 41*(11), 453-458.
- Wilson, N. & Holmvall, C.M. (2013). The development and validation of the Incivility from Customers Scale. *Journal of Occupational Health Psychology, 18*(3), 310-326.
- Woelfle, C.Y. & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum, 42*(3), 123-132.
- Yildirim, D. (2009). Bullying among nurses and its effects. *International Nursing Review, 56*, 504-511.

Yildiz, S. (2007). A “new” problem in the workplace: Psychological abuse (bullying). *Journal of Academic studies*, 9(34), 113-128.