WHAT ARE NURSES' PERCEPTIONS OF NURSE-TO-NURSE INCIVILITY IN THE WORKPLACE?

By

Julianne R. House

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Dr. Lynn Musto, Supervisor

Dr. Sheryl Reimer-Kirkham, Second Reader

Dr. Maggie Theron, Third Reader

TRINITY WESTERN UNIVERSITY

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Abstract

While nursing has flourished into an autonomous, compassionate and scholarly profession, an insidious, pervasive problem exists within some nursing environments: workplace incivility. Disrespectful and disruptive behaviour including incivility, bullying, and harassment are well documented in the nursing literature but little research has examined the perceptions of nurses who witness nurse-to-nurse incivility. This qualitative study examines nurses' perceptions after witnessing incivility in their workplaces. Semi-structured interviews were conducted with 11 registered nurses to examine their perceptions after witnessing workplace incivility. Using interpretive description methodology, the overarching theme of *avoiding confrontation* was identified. Main themes generated from data analysis included *normalizing incivility* and *the relationship between incivility and the workplace*. Recommendations for the nursing profession include: increasing awareness and education regarding workplace incivility and how to manage it; fostering supportive work environments for frontline staff and management; and educating nursing students and registered nurses that this behaviour is not acceptable and teaching them how to respond to incivility.

Keywords: incivility in nursing, bullying in nursing, moral agency in nursing, qualitative, interpretive description

Dedication

As with many things in life, my intentions about what would happen through this thesis were different than what I did learn and experience. While completing my thesis I have learned and grown in all areas of my life and in some that were unexpected. With the patience and wisdom of my academic advisors, I learned that you can adjust your plan and timeline to accommodate 'life' AND that you need to extend yourself the grace to do so. My personal, professional and academic growth would not have been possible without individuals who had the courage to participate in this study.

I would like to dedicate this thesis to all of the participants who voluntarily shared with me about very vulnerable and emotional times in their lives. Their rich descriptions not only contributed to my research and the completion of this study, but more importantly, to the nursing community by shining a light on uncivil behaviours that have existed in the workplace for far too long. I also would like to dedicate this thesis to all nurses who are in similar situations; hopefully they will be empowered by this research to make a change in their workplace. Because it only takes one person.

Acknowledgements

The process of achieving this goal has been arduous, joyous and overwhelming at times. I had intended on completing my thesis two years ago but God had a slightly different plan which included the birth of my first child. He taught me that you cannot do everything all at one time (even though I wanted to) and He gave me peace about it. I would like to acknowledge the continuous and loving support of my family and friends who listened to me verbally work out thoughts and ideas about the data, cared for my son so that I could study and even the simplest act of sharing a cup of coffee with me. I would like to specifically acknowledge and thank my loving, kind and generous husband, Andrew, who without you, I would not have completed this study. Thank you for listening to me, even when you had no idea what I was talking about. Thank you for always supporting me and taking care of everyone and everything before yourself so that I could work and for always reminding me that I would complete this study, that I just needed to be patient.

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personal life, professional and academic life. This was encouraging to me that with some sacrifice and planning, you could balance it all. Thank you for all of your support and hard work to get me to where I am!

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

"What should move us to action is human dignity: the inalienable dignity of the oppressed, but also the dignity of each of us. We lose dignity if we tolerate the intolerable" *- Dominique de Menil*

Today nursing has grown and developed into a respected, dedicated profession that seeks to promote wellness, prevent illness, and aid in healing. It is a caring profession unlike any other, as nurses are called to be selfless, kind and nurturing caregivers, and yet at the same time, nursing is fraught with workplace bullying and incivility (Longo & Smith, 2011; Nazarko, 2010; Wilkins, 2014). While some incivility comes from physicians or managers, an alarming amount of incivility occurs between nursing co-workers (Kwan, Tuckey, & Dollard, 2014; Longo & Smith, 2011; Wilkins, 2014). Over the years, much research has been conducted to look at bullying and incivility within nursing (Çevik Akyil, Tan, Saritaş, & Altuntaş, 2012; Ganz et al., 2015), but few studies in nursing have focused on the experiences and perceptions of nurse bystanders who have witnessed incivility. This study explored the experiences of nurses who witnessed incivility in the workplace and how these nurses responded to the incivility.

Personal experiences of bullying and incivility from other nurses piqued my research interest in studying this topic. I have experienced fear (e.g. being afraid to make a mistake) and felt undervalued and disrespected by my colleagues. As well, my values and beliefs about the nursing profession, professionalism, delivering quality care to patients, and respecting each other were compromised by these interactions. Consequently, my understanding of the nursing profession became inconsistent with what

I had learned during my nursing education. Throughout my career, I also witnessed bullying and incivility in the workplace between my nursing colleagues. As a bystander, I felt angry and frustrated for the person who was the recipient of the negative behaviours. My response was to speak up for the nurse who was being bullied if I was a part of the conversation. When witnessing the situation from a distance, I would speak with the victim afterward to see how I could help, and offer them a listening ear. I often felt that they just needed to be able to speak about the incident in a private and safe place. As a nurse who has experienced both overt and covert incivility in the workplace from my fellow nurses, I became interested in looking at how incivility affects those who witness it. Nursing is advertised as a caring, supportive culture that provides mentorship and promotes teamwork (Bally, 2007) and actions such as bullying and incivility are a contradiction to those terms. My hope with this research is to bring more attention to a phenomenon reported throughout nursing, specifically what bystanders experience when witnessing incivility in the workplace between their fellow nursing colleagues.

Background

The background information that informed this study included the concepts of moral agency, the problem of incivility, and definitions of various words that have been used interchangeably to describe bad behaviour.

Moral Agency: A Foundational Concept

A concept that informed this project, and is foundational to countering incivility, is moral agency. Moral agency is a person's ability to make a choice from a rational perspective as opposed to an emotional one (Sherwin, 1998), meaning that we make decisions from a place of conscious awareness. Nurses are faced with moral and/or

ethical decisions every day; it is what they decide to do when confronted with these decisions that is moral agency. Storch (2013) suggests that moral agency occurs when a person chooses to direct their "actions to some ethical end" (p. 10). Moral agency is applicable to situations involving the care of patients and to interactions with fellow co-workers.

One commonly made assumption in health care is that all health care professionals embrace moral agency in their interactions with their patients and their fellow co-workers because they want to do the most good for their patients while respecting the patients' autonomy (Sherwin, 1998; Storch et al., 2013). Immanuel Kant is a major influencer regarding the theory of moral agency, "[placing] human dignity and rationality at the center of his moral view" (Rodney et al., 2013, p. 161). The intentional enactment of moral agency means that decision making is brought into an individual's conscious awareness, allowing them to rationally consider their options, as opposed to allowing their emotions to lead the decision making process.

By learning about incivility witnessed between nursing co-workers, it is my hope that more light will be brought to the gap between what we say we will do as nurses when confronted with these situations and what we actually do (McCarthy, 2010). In some areas of nursing, there seems to be a disconnection between who we say we are as nurses and the values of the nurse, profession, and healthcare system. This study provided some insight into understanding moral agency and why nurses make certain decisions in regard to observing incivility. According to Pask (2001), we all have the ability to understand each other if we are present in the situation, listening to each other and not treating each other as physical objects, rather as conscious human beings who can make their own

decisions.

Nurses make many different types of decisions daily. Recognizing these decisions have ethical implications and addressing them on a rational, conscious level is moral agency. Chambliss noted "the great ethical danger,…, is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing [an ethical] decision at all" (as cited in Storch et al., 2013, p. 4). As noted, incivility in nursing is becoming pervasive and how nurses who witness incivility choose to address it becomes one of those ethical decisions.

The Problem of Incivility

When I started my literature review, I initially searched for articles pertaining to nurses witnessing incivility in their workplaces between their nursing colleagues. Little recent research was found in this area. I chose to focus on incivility in my research because of its pervasiveness within the nursing culture (Egues & Leinung, 2013) and because of its ambiguous nature (Hutton & Gates, 2008). As you see below, some authors write about incivility as if it is a lesser form of bullying, while other authors use the term to encompass all forms of bad behaviour.

Nurses have allowed it to remain largely unchecked, and therefore, incivility has not been dealt with appropriately, or at all, due to its lack of recognition amongst staff (Ganz et al., 2015). Incivility is insidious and comes in many forms - incivility can be obvious and apparent, as well as discreet and subtle (Felblinger, 2009; Khalil, 2009). It has been described as psychological, physical, overt, covert, and can be vertical or horizontal violence (Khalil, 2009). Incivility is well documented throughout nursing history (Cox, 1987; Duffy, 1995; Krebs, 1976; Skillings, 1992; Weinand, 2010).

Healthcare organizations have been looking into this phenomena because it affects safe patient care (Felblinger, 2008; 2009; Laschinger, 2014; Longo & Smith, 2011; Pai & Lee, 2011), staff job satisfaction, turnover rates (Felblinger, 2009; Stagg & Sheridan, 2010), quality of care provided (Kwan, Tuckey & Dollard, 2014; Pai & Lee, 2011; Simons & Mawn, 2010), and the well-being of the staff involved (Simons & Mawn, 2010). Incivility is known by various words including bullying (Ganz et al., 2015; Purpora, Cooper, & Sharifi, 2015; Stagg & Sheridan, 2010), workplace violence (Pai & Lee, 2011), disruptive behaviour (Felblinger, 2009; McNamara, 2012), vertical violence (Khalil, 2009), and lateral/horizontal violence (Hippeli, 2009). Below I explore these definitions in greater detail.

Gaffney, Demarco, Hoffmeyer, Vessey, and Budin (2012) suggested "the deliberate, repetitive, and aggressive behaviors of bullying can cause psychological and/or physical harm among professionals, disrupt nursing care, and threaten patient safety and quality outcomes" (p. 1). Bullying has been described as being on a continuum with each of these words falling within the spectrum at varying degrees (see Figure 1). Figure 1 is a visible representation that Musto (2015) adapted from Hershcovis (2011) that represents the lesser to more severe behaviours that can be seen when dealing with negative behaviours in the nursing workplace. As suggested by Purpora et al. (2015), workplace incivility falls at the lower end of intensity while bullying lands on the greater end of intensity. Nurses tend to work in groups, in situations of high stress with complex interpersonal relationships, all factors that may contribute to incivility (Felblinger, 2008). Felblinger (2008) noted that incivility is further perpetuated if a work climate is unsupportive and it "normalizes competitive and

abusive behaviours" (p. 234), resulting in the promotion of a culture of bullying.

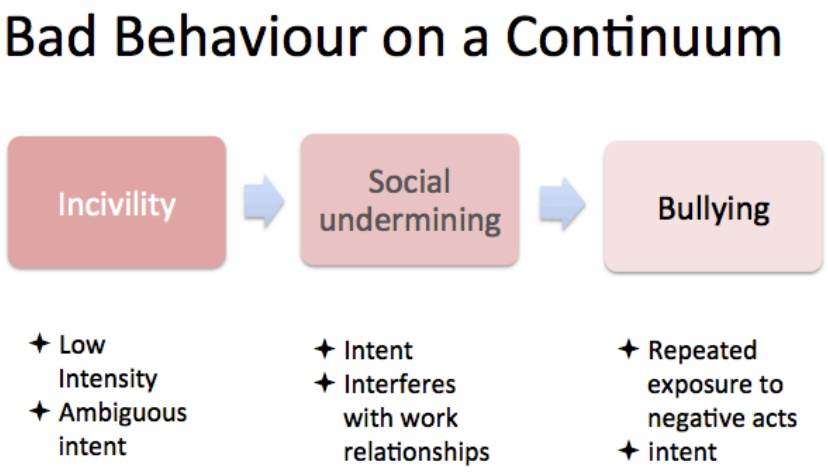

Figure 1. Horizontal Violence. From Musto (2015). Reprinted with permission. (Personal Communication[1]).

In 2010, the Ontario Occupational and Safety Act was amended in regards to workplace violence and harassment. Workplaces in Ontario have since been required to adopt a program that includes measures and procedures for:

- Controlling risks identified in the assessment of risks
- Summoning immediate assistance when workplace violence occurs or is likely to occur, and
- Workers to report incidents of workplace violence.

Workplace violence programs must also set out how the employer will investigate and deal with incidents or complaints of workplace violence.

(Ontario Ministry of Labour, 2010, para. 5)

An online survey by Employment and Social Development Canada (2017) found that

[1] Figure 1 is based on an article by Hershcovis, M. S. (2011). Incivility, social undermining, bullying…oh my! A call to reconcile constructs within workplace aggression research. *Journal of Organizational Behaviour, 32*(3), 499-519.

60% of respondents had experienced harassment in the workplace (Employment and Social Development Canada, 2017). It is alarming that over a third of the reported incidences of workplace violence involves healthcare professionals in Canada (Statistics Canada, 2005). Healthcare professionals are at more risk to witness and experience workplace violence than police officers and prison workers (Public Services Health and Safety Association, 2017). Workplace violence has had detrimental physical and psychological effects on the victims; nurses are at higher risk to experience workplace violence than other professionals due to a high stress work environment, younger age, and working the night shift (Pai & Lee, 2011). It is anticipated that the amended Ontario Occupational and Safety Act will result in increased reporting of workplace violence, including violence that occurs in healthcare settings. This violence does not refer to nurse-to-nurse violence exclusively. These statistics also include patients, family members and visitors to the hospital who may witness or be involved in workplace violence in some way.

Workplace bullying is reported as a common occurrence in the nursing profession, affirming the well-known idiom, "nurses eat their young" (Hippeli, 2009, p. 186). One theory behind the reasons for this occurrence is that nurses were, historically, an oppressed group (Egues & Leinung, 2013; Longo & Smith, 2011; Purpora et al., 2015). Nurses were historically thought of as 'hand maidens' who worked under physicians, simply following orders and not being able to think for themselves or to be autonomous caregivers (Griffin, 2004). Roberts (1983) suggested that nurses were "…controlled by forces outside themselves that had greater prestige, power and status…" (p. 21). Kuokkanen and Leino-Kilpi supported this theory by stating that, "power

imbalance in nursing is associated with restricted autonomy and domination through an authoritative leadership that leaves nurses feeling [a] lack of control" (as cited in Egues & Leinung, 2013, p. 186).

Different forms of bullying also occur within the nursing profession due to power differentials within and between professional groups (Egues & Leinung, 2013), whether it is physician-to-nurse or nurse-to-nurse (McNamara, 2012). An example of a power differential within nursing is the experienced nurse working with novice nurses or nurses new to a department. In many cases these experiences of incivility have gone unreported (Gaffney et al., 2012; Nazarko, 2010) due to fear of repercussions and lack of managerial or organizational support (Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013). In summary, little documented research is available about nurses who have witnessed workplace incivility or bullying. Hence, the purpose of this study was to look at the experience of bystanders of nurse-to-nurse incivility in the workplace and their perceptions.

Definitions

For this research I chose to concentrate on incivility in the nursing workplace while recognizing that these behaviours fall on a spectrum of negative behaviours. Incivility is at the lesser degree of intensity on this spectrum but has been seen to be a stepping-stone for more intense, worse behaviours, all of which are contributing factors to a lack of safety in healthcare. With any research, there are difficulties encountered while completing a study. It became apparent that researching incivility was difficult due to the overlapping use of this concept with other negative behaviours. I also chose incivility as the focus of my research because it is the term that I have most closely

related to in my experience as a nurse.

In the nursing profession, incivility in the workplace is not taken as seriously as it should be. Due to its highly pervasive and ambiguous nature, it can often appear harmless and be difficult to identify as damaging to a culture of safety. Nevertheless, it can easily and quickly escalate into a bigger problem. As noted previously, studying moral agency was not the focus of this research, however, nurses contribute to the development or maintenance of unit culture through their choices of action or inaction. Below, I have highlighted and defined six of the most common terms important to this study, that are also commonly used in literature relating to bullying among nurses. I briefly discuss where these terms lie on a continuum of negative workplace conduct.

Incivility

While incivility falls on the lower end of the bullying spectrum (Purpora et al., 2015), it is nonetheless a serious issue within the nursing workforce and has the potential to have damaging effects on the persons involved, including "devastating emotional, physical and social consequences" (Purpora et al., 2015, p. 52) if not dealt with appropriately. Anderson and Pearson define workplace incivility as "low-intensity, deviant behavior with ambiguous intent to harm the target, in violation of work-place norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (as cited in Hutton & Gates, 2008, p. 168). Incivility comes in the form of psychological attacks and it intends to do harm to the victim subtly and discreetly (Felblinger, 2009).

Bullying

With the dramatic increase of school children bullying through the Internet, which

is also known as 'cyber bullying', bullying has become a popular word within society, including within nursing (Stagg & Sheridan, 2010). Historically, bullying was known as disrespect (Krebs, 1976). Purpora et al. (2015) suggested that bullying is defined somewhat differently between countries and cultures, but with some "commonalities: bullying is persistent and systematic victimization of a target with repeated use of negative acts over a long period of time to the extent that the target(s) struggles to defend him/her/themselves" (p. 52). The all too common and widely accepted saying that 'nurses eat their young' stems from the definition of bullying and refers to negative overt and covert actions towards a victim (Stagg & Sheridan, 2010). Overt and covert examples of bullying "include nonverbal innuendos, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backbiting, failure to respect privacy, and broken confidences" (Griffin, 2004, p. 259). Bullying also "refers to repeated, offensive, abusive, intimidating, or insulting behaviors; abuse of power; or unfair sanctions that make recipients feel humiliated, vulnerable, or threatened, thus creating stress and undermining their self-confidence" (Ganz et al., 2015, p. 506). As Wilkins (2014) suggested, bullying is often not a lone negative interaction, but rather occurs on multiple occasions over time (p. 285). The term could be placed at the greater end of a continuum representing intensity of negative workplace conduct (Purpora et al., 2015).

Workplace Violence

According to the Registered Nurses' Association of Ontario (2009), "violence in the workplace is defined as a multidimensional phenomenon involving the misuse of power and resulting in physical, psychological or sexual abuse of targets" (p. 30).

Workplace violence is a common occurrence in Canada, and one that is seldom reported to managers or police due to the victim's fear of repercussions or of losing their position (Wilkins, 2014). Workplace violence is an exacerbation and escalation of incivility, taken to the extreme by the bully.

Disruptive Behaviour

Disruptive behaviour is the manifestation of bullying and incivility in the workplace. In 2008, the Joint Commission published "Behaviors that Undermine a Culture of Safety" which "emphasized the immediate obligation to address hostile behaviors" (Felblinger, 2009, p. 14) at an individual and organizational level. Disruptive behaviour intimidates others, creates an environment of hostility and disrespect and can increase staff turnover (Feblinger, 2009). Disruptive behavior may include "throwing objects, slamming down telephone receivers or cell phones, purposely damaging equipment, using contaminated equipment on a patient, and unnecessarily exposing others to contaminated fluids" (Felblinger, 2009, p. 16). These types of behaviours create unsafe work environments for the healthcare professional as well as the patients and their families (Laschinger, 2014).

Vertical Violence

Vertical violence is "the abuse of power relationships amongst staff members" (Khalil, 2009, p. 208), which typically occurs between a senior staff member and a junior staff member. Vertical violence is also known as hierarchical violence and "is usually directed from someone in a position of power toward a coworker who has less power" (McNamara, 2012, p. 535). Examples include physician to nurse, manager to nurse, faculty member to student and nurse to student (McNamara, 2012).

Lateral Violence

Lateral violence is also referred to as horizontal violence within the literature. Lateral violence occurs nurse-to-nurse and generally occurs "on a lateral level among staff members in similar places in the organizational structure" (Chipps et al., 2013, p. 488). "Lateral violence is a nurse-to-nurse social devaluation or control of a peer through overt and covert verbal, physical and emotional abuse" (Embree & White, as cited in Ceravolo, Schwartz, & Foltz-Ramos, 2012, p. 599). It has detrimental effects on individual, professional and organizational levels (Ceravolo, Schwartz, & Foltz-Ramos, 2012).

In summary, many different words are used to describe negative behaviours in the nursing workplace and it is important to differentiate between the different words because there is often a lot of overlap amongst nurses when using the words. For the purpose of this study, it was necessary to define and clear up any confusion about the different words used as many of my interviewees used any of these words interchangeably when describing incidences from their workplaces.

Thesis Purpose and Objectives

The purpose of this study was to explore the effect of the experience of incivility in the nursing workplace on nurse bystanders. Incidents from the higher end of the bad behaviour spectrum were also included because many interviewees used incivility and bullying interchangeably in their choice of language, and when those participants were asked if they defined those words differently and they said "no". The questions guiding this research were:

1. What are registered nurses' responses to nurse-to-nurse incivility in the workplace?
2. Do registered nurses who witness incivility in the workplace view themselves as moral agents to address the issue? If so, how?
3. Do witnesses of incivility act upon that experience? If so, how?
4. How do registered nurses manage working in an environment where incivility exists?

Thesis Method

Since my research revolved around understanding nurses and their personal experiences, I chose to use a qualitative research approach with the knowledge that qualitative research methods are flexible and evolve as more information is gathered (Polit & Beck, 2012, p. 487). I was also aware that qualitative methodologies share common tools of analysis. Specifically, I employed the qualitative methodology of interpretive description (Thorne, 2016) and qualitative methods drawn from grounded theory. I interviewed eleven registered nurses about their perceptions of nurse-to-nurse incivility in the workplace. Interpretive description does not follow a strict procedure about how to conduct a qualitative study but it provided a logical operating system that produced meaningful results to the researcher and the audience (Thorne, 2016). True to interpretive description and grounded theory, analysis began after the first interview and continued through to the last interview by means of constant comparison. The interviews were transcribed and analysis was done through coding and subsequent thematic analysis.

Relevance and Significance

It was evident in the research literature that incivility between nurses is a problem

—a problem that can be addressed if an organization is supportive of the victim, and if victims and bystanders make managers aware of the problem (Armstrong, 2017; Feblinger, 2009; Houshmand, O'Reilly, Robinson, & Wolff, 2012). Many nurses are subject to witnessing uncivil behaviours in their work environments (Baker, 2015). However, little is known about nurses' perceptions and actions following the experience. Questions that arose when considering those who witness incivility include: Did they report it? Did they speak with the perpetrator or the victim about the situation? Do bystanders not get involved because they are not the direct target and fear that they will become the target if they do? Are bystanders moral agents to victims after witnessing these events in their workplaces? Through this study, I examined the responses of bystanders to incivility in the workplace. The information gleaned from this study will be useful for organizations, nurses, and others who wish to create a healthy and safe working environment for staff, patients and the organization.

Outline of Thesis

This thesis is comprised of six chapters. Chapter One outlines the background of my research including pertinent definitions, the purpose and objectives of my research, the methodology being used and the relevance and significance of my research. Chapter Two includes a detailed description of the articles that I found relevant to my study as well as how I searched and the strategies that I used to find the articles. Chapter Three focuses on the methodology used during the collection and analysis of my study. Chapter Four is an in-depth look at what my findings are and Chapter Five is a discussion about where my research fits within what is already known in the literature. Finally, Chapter Six provides the implications for nurses and the limitations to my study.

Chapter Summary

Incivility is a growing concern throughout nursing. It has been around for many years throughout the profession; it is pervasive and difficult to deal with. In this research, I viewed incivility as falling onto a continuum of bad behaviour including bullying, workplace violence, disruptive behaviour, vertical violence, and lateral violence. For the purposes of this study, incivility was specifically looked at because there was not a lot of literature about the perceptions of nurse-to-nurse incivility.

CHAPTER TWO: LITERATURE REVIEW

Be brave enough to start a conversation that matters. – Dau Voire

A literature review was completed to determine the current state of the research available in this area of study and to realize the gaps in the research providing justification for this study. The search strategy, including guiding questions for the inclusion and exclusion of articles, are outlined below, as well as the summary of the literature.

Selection of Pertinent Articles

I began my literature search by reviewing the literature related to nurses' responses to incivility in the workplace. A preliminary search was performed using CINAHL, MEDLINE and PsycINFO using the keywords: bullying OR workplace harassment OR incivility OR negative behaviour OR lateral violence OR horizontal violence. Terms about the concept of incivility were linked with the Boolean operator AND to nurse and registered nurse. It should be noted that the nursing community is broad and diverse with other designations of nurses; for the purposes of this study the term "nurse" refers only to Registered Nurses. Then, the Boolean operator AND was used to link the first two concepts to observer OR bystander OR witness OR onlooker. Finally, those searches were linked to the concept of perception (with the terms response OR perception OR reaction). No results from the search were found in PsycINFO, but CINAHL yielded 64 possible articles and MEDLINE had 85 possible articles (n= 149). Once duplicates were removed, a total of 76 possible articles remained. Some articles found through Google Scholar, by means of reference chasing, were also included (n=13). A total of 89 articles remained to which I applied the inclusion and exclusion

criteria.

The inclusion criteria consisted of English language, publishing date within the last ten years, and availability of full texts. Articles about school-age children and bullying were removed, as they did not pertain to health care. Articles that focused on nursing faculty members and nursing students were also excluded because although there appeared to be a large body of literature on both of these topics, it did not fit with my population of nurse-to-nurse incivility. Additionally, editorials were removed, and literature that was focused on managers and leadership styles when dealing with bullying in the workplace were also excluded.

By applying my inclusion and exclusion criteria and my research questions to guide me, I selected five articles (Please refer to Appendix A for Prisma chart) that were related to my research purpose of examining nurses' responses to incivility in the workplace. Then I used my extraction questions to draw out the information pertaining to my research purpose. The extraction questions used were:

1. How do nurses view themselves as moral agents to address incivility in the workplace?
2. How do nurses act when they are witnesses to incivility?
3. Are there any antecedents leading up to these events such as something related to the organizational culture? What are the consequences?

These questions helped finalize my literature search to identify existing evidence pertaining to nurse-to-nurse incivility and the perceptions of bystanders.

Review of Selected Relevant Articles

The five articles selected for this review employed a range of research methods

used to study incivility in nursing, including quantitative, qualitative, and mixed-methods. Kwan et al. (2014) provided an example of qualitative research using formal interviews to obtain information. Stanley et al. (2007) presented findings from a mixed method study using both surveys and quantitative methods. Longo and Smith (2011) presented a summary of the literature regarding horizontal violence, and Wilkins (2014) provided a summary of the literature on studies that explored what is preventing nurses who witness bullying from stepping forward and acting on what they have seen and heard. Finally, Houshmand et al. (2012) conducted a quantitative study using two surveys of Canadian nurses to explore the effects of direct and indirect bullying on nurses' intentions to leave their position. Each of these studies is discussed in the literature review that follows.

Incivility Prevalence

Stanley et al. (2007) conducted a survey to determine the perception of lateral violence within the healthcare workplace. Forty-six percent of respondents responded that it was a "serious problem" and 65% of the respondents reported witnessing lateral violence between co-workers. In the study by Stanley et al. (2007), the term lateral violence captured the range of terms used to describe disruptive behaviours including workplace incivility. From these findings it is evident that incivility in the workplace is a major problem that needs to be addressed. Stanley et al. (2007) also indicated that many nurses have witnessed incivility in their work environments and thus, further research needs to be done with those who are bystanders to such behaviours. This study revealed helpful information regarding second-hand bullying, such as foreshadowing what is to come. This compelled my need to study what nurses do in situations where they

witnessed incivility between colleagues.

Nurses' Actions When Addressing Incivility in the Workplace

Longo and Smith (2011) discussed that "nurses have been characterized as an oppressed group because the profession is composed primarily of women who are practicing within a patriarchal structure dominated by physicians, male administrators, and marginalized nurse managers" (p. 347). This led me to postulate that, as an oppressed group, nurses may not, within the historical and current power structures, see themselves as moral agents. Wilkins (2014) argued, similarly to Longo and Smith (2011), that a predominantly female workforce in nursing and a power differential between health care professionals leads to a culture of bullying. This culture of bullying has been accepted as the 'norm' where "people cease to question its harmfulness" (Wilkins, 2014, p. 284). This culture of bullying could be a contributing factor as to why nurses do not view themselves as moral agents in the workplace.

Kwan et al. (2014) also supported the concept of the influence of the environment on the ability of the nurse to act as a moral agent. These authors determined that if there were high levels of a psychosocial safety climate (PSC), which they defined as having supportive managers and organizations, nurses would more likely choose active strategies to deal with their bully; for example, confronting their bully and discussing the situation. Alternatively, if there were low levels of PSC, nurses would likely choose more passive coping mechanisms such as silence, avoidance, and in some cases leaving that job position. Kwan et al. (2014) described a key learning point, as "when employees feel valued and expect to be listened to, they will voice their concerns to the organization when they encounter a threat in the workplace" (p. 10), thus supporting the enactment of

moral agency in nursing in regards to incivility.

The authors of these studies included in this review supported ways of dealing with incivility that would put the nurse in a stronger position to act as a moral agent. Longo and Smith (2011) suggested that it is time for nurses to act to "reject insidious, often-damaging behaviors in the workplace toward the goals of creating a healthy work environment, enhancing patterns of relating with each other, and improving patient outcomes" (p. 347). The authors suggest that by addressing the power differential between other health care professionals and co-workers, nurses will be able to fight against the status quo and begin making efforts to change the culture through emancipation education and the building of community (Longo & Smith, 2011).

Wilkins (2014) offered suggestions towards changing the culture of the organization, which could result in nurses acting as moral agents. These included using cognitive reappraisal techniques to consciously respond to a situation. In doing so, nurses will be able to deal with a negative situation "in a way that alleviates its emotional impact" (Wilkins, 2014, p. 286). Wilkins (2014) also suggested that humour could be used to help targets and bystanders of incivility in the workplace to deal with its impact in a positive, healthy manner. Some theorists believe that humour is a coping strategy that is essential to survival and provides control to a victim in an otherwise uncontrollable scenario (Wilkins, 2014). Effective leadership could also enact moral agency amongst the nursing staff by creating a culture where it is an expectation to speak up when encountering uncivil behaviours.

Stanley et al. (2007) determined that "education and effective leadership were found to mediate oppressive and negative behaviors, whereas ineffective leadership was

found to exacerbate lateral violence" (pp. 1247-1248). For example, transformational leadership within nursing could be used to effectively mediate a culture of change away from negative behaviours in the workplace by supporting nurses' enactment of moral agency. Increasing morale and fostering leadership qualities amongst staff could motivate a change amongst the staff towards a culture of zero tolerance (Kotlyar & Karakowsky, 2006).

Antecedents and Consequences of Incivility

Strong leadership is foundational to a healthy work environment; whereas, a poor work environment can be an antecedent to, and a consequence of, incivility between nurses. Longo and Smith (2011) described work environments in which the organization and management do not support nurses, or when nurses do not support one another, as resulting in conflict and a high stress workplace. Wilkins (2014) stated that, "the whole workplace is affected when employees are bullied. Witnesses to bullying might live in constant fear of becoming the next target and often experience high levels of stress themselves" (p. 284).

Houshmand et al. (2012) learned through surveying nurses that there are consequences of incivility that impact both the nurse and the organization. The authors found that when employees worked in an area where there were high levels of perceived bullying, there was a higher rate of staff turnover, even amongst the employees who were not the direct targets (Houshmand et al., 2012). These findings indicated that witnessing bullying impacted a nurse's decision to remain in the workplace, which in turn affects an organization's fiscal budget negatively, as it is costly to hire and train new nurses. Houshmand et al. (2012) concluded that "those who experience bullying second-hand,

simply because they work in environments in which others are bullied, can also experience negative attitudes and behaviors, similar to the direct targets of bullying" (p. 913). Thus, nurses who witness bullying and negative behaviours are also affected by the behaviours. High turnover of nurses further contributes to a poor work environment (Almost et al., 2015).

Chapter Summary

In summary, these articles further increased my interest in incivility between nurses by demonstrating that bystanders are affected by bullying within their workplaces, as evidenced by their intention to leave (Houshmand et al., 2012). Kwan et al. (2014) suggested that if nurses are supported by their organizations and their managers with a zero tolerance policy for incivility in the workplace, nurses are then more likely to confront the situation using active coping mechanisms as opposed to passive ones (e.g., silence, avoidance of the situation and possibly leaving their position). Additionally, supportive managers, in relation to this issue, aid in creating a safe work environment for staff and patients (Longo & Smith, 2011).

Effective leadership and education regarding lateral violence can help lessen the oppressive and negative behaviours that are occurring in healthcare workplaces and often being witnessed by bystanders (Stanley et al., 2007). The enactment of moral agency "is an enhanced ability to act to bring about change" (Robertson et al., 2014, p. 12). Effective leadership may foster moral agency so that nurses are prepared to take action in the face of incivility. There was a gap in the literature regarding nurses' perceptions of witnessing incivility in their workplaces and what they did about it. This gap in the literature is addressed in my study. The purpose of this research is to contribute to

fostering change in the culture of health care organizations, disrupting the status quo and to look at why this culture is accepted and perpetuated amongst nurses.

CHAPTER THREE: METHODOLOGY

Education is the most powerful weapon, which you can use to change the world.

– Nelson Mandela

Throughout this study, I examined the responses of bystanders to incivility in the workplace. The information learned from this study will be useful for organizations, nurses and others who wish to create a healthy and safe working environment for staff, patients and the organization. The purpose of this chapter is to examine the process that was used to answer the research questions proposed below.

Study Design

Since my research revolved around nurses and their personal experiences, I chose to use a qualitative research approach with the understanding that qualitative research methods are flexible and evolve as more information is gathered (Polit & Beck, 2012, p. 487). Specifically, I used the qualitative method of interpretive description and interviewed registered nurses about their perceptions of nurse-to-nurse incivility in the workplace. Interpretive description does not follow a strict procedure about how to conduct a qualitative study but it provides a logical operating system that produces meaningful results to the researcher and the audience (Thorne, 2016). Interpretive description draws on many qualitative research methods such as ethnography, phenomenology, and grounded theory (Thorne, 2016). By using interpretive description, I was able to learn more about incivility in the nursing workplace and how it affected nurses who witnessed it and I was able to gain more understanding about if and when nurses enact moral agency.

Sampling

Convenience sampling was used to obtain participants for my study by posting an information letter on the Nursing graduate school website at Trinity Western University (Appendix B). Participants were recruited through snowballing; that is word of mouth from the nurses accessing the Graduate Nursing website. I was able to obtain 11 participants who were registered nurses and had witnessed incivility in their workplaces. Once interested participants contacted me, I emailed them a consent form (Appendix C) indicating that participation would be voluntary and that all information would remain confidential. As my study participants were from across Canada, I conducted interviews on the phone, via Skype, and face-to-face.

Inclusion criteria for this study included registered nurses who had witnessed nurse-to-nurse incivility in their workplaces and who had been nursing longer than a year. Exclusion criteria included all new graduate nurses (working less than a year since graduation) because extensive research is already being done on new graduates, due to the high rate of new graduates leaving the profession within the first year of working (Foreman, 2017).

Data Collection

I conducted semi-structured interviews with eleven registered nurses who had witnessed workplace incivility a minimum of one time. While Thorne (2016) would support that there is no exact number for a sample size within interpretive description, eleven interviews generated enough data to be defendable. Interviews occurred at the place of the participants' choice (e.g. a private meeting room, a park, or their home), but, due to cross-country locations, most interviews occurred over the phone or Skype. The

interviews were recorded digitally. I transcribed eight of the transcripts, and a transcriptionist (who signed a confidentiality agreement) transcribed three. I wrote field notes during and after the interviews to record what was seen and heard, over and above what was actually said by the participant (Streubert & Rinaldi Carpenter, 2011). Throughout the data collection and analysis periods, I wrote reflective journals to "understand how one's own values and views may influence findings [which] adds credibility to the research" (Jootun, McGhee, & Marland, 2009, p. 42). Please see Appendix D for an outline of the guiding interview questions. Immediately following all of the interviews a debriefing time occurred with all participants. Please refer to Appendix E to review the debriefing script.

There is no claim to have data saturation in this study because, since "the possibility of intimate experiential variation plays a leading role" (Thorne, 2016, p. 107), the goal of my research was "to attain a degree of confidence that the findings had become sufficiently well developed to warrant reporting" (Thorne, 2016, p. 108). In order to do so, I sought maximum variation within the sample. Table 1 provides the participants' demographic information. As mentioned earlier, participants had worked across Canada in British Columbia, Alberta, Manitoba, Ontario and Saskatchewan, as well as in Europe, the United States of America, and Saudi Arabia. While participants had worked around the world, they have also worked in multiple different environments including: emergency departments, intensive care units, burn units, public health, medicine units, interventional radiology, the operating room, paediatrics, trauma units, homecare, ambulatory care settings and outpatient clinics. Participants worked as frontline staff members and in management.

Table 1.

Participant Demographics of Nurses who Witnessed Incivility in the Workplace Study

Age	Sex	Level of Education*	Years in Healthcare	Length of time in current position (years)
28	female	Bachelor Degree	5	3
32	female	Masters in Public Health & Nurse Practitioner	11	1
33	female	Bachelor Degree & Health Science Degree	8.5	0**
35	female	Masters Degree	9	4
37	female	Diploma	14	3
43	female	Bachelor Degree	12	4
50	female	Bachelor Degree	30	26
55	female	Bachelor Degree	25	5
55	female	Masters Degree	32	0***
57	female	Bachelor Degree & Certificate in Occupational Health	25	1
60	female	Diploma	40	10

*refers to nursing education unless otherwise specified
**3 months
***8 months

Data Analysis

Data analysis is a very involved and dedicated process for the researcher. As Thorne states, "unquestionably, data analysis is the most complex and mysterious of all of the phases of a qualitative project" (as cited in Streubert & Rinaldi Carpenter, 2011, p. 45). Although Thorne (2016) admits that there is no prescription within interpretive description for data analysis, there are "certain steps and procedures within the process of

the research" (p. 111) that need to be done to promote credibility.

I was informed by a grounded theory approach to data analysis. After each interview, transcription and coding was completed. Coding is "a way of fracturing the data and then grouping it according to the concepts each incident represents. These codes will eventually explain what is happening in the data" (Glaser, 2011, p. 128). Each new transcript was coded separately and then compared with the other transcripts for theme development and patterns within the data, which is also known as the process of constant comparison. "Comparing incident to incident, and then when incidents emerge, incident to concept" (Glaser, 2011, p. 128) was done, and resulted in the ongoing development of themes.

Data analysis occurred concurrently with data collection; by doing this I was able to adjust interview questions to reflect the developing themes. For example, after the sixth interview and the development of my codebook, I added more questions on the advisement of my thesis advisors (Appendix D). For one instance, there were codes and a possible theme about incivility being a personality trait. I added the question "Do you think that incivility is a character attribute" and asked it to my remaining participants.

Scientific Quality

Researchers need to be aware of relying on what the 'experts' are disclosing (i.e., the research participants) and not on what we as researchers think that we know (Streubert & Rinaldi Carpenter, 2011). Thus, researchers need to be aware of their own preconceptions when performing research. Reflexivity (self-reflection) is the awareness as the researcher to know what influences and affects all aspects of the research being done (Streubert & Rinaldi Carpenter, 2011). I used journaling throughout the research

process to assist in recounting specifics about each interview, and to aid in the development of my themes and sub-themes throughout my analysis. I would journal before an interview, and immediately after an interview, as well as while I was transcribing interviews and coding transcripts. This aided to mitigate my bias throughout this process. "Thematic analysis involves not only discovering commonalities across participants but also seeking natural variation. Themes are not universal" (Polit & Beck, 2012, p. 562). Rigor in qualitative research is achieved by "researchers' attention to and confirmation of information discovery" (Streubert & Rinaldi Carpenter, 2011, p. 48) and then by accurately showing the research participants' subjective experiential life story (Thorne, 2016). Lincoln and Guba developed a framework to ensure rigour within qualitative research that includes credibility, dependability, confirmability, transferability and authenticity (Polit & Beck, 2012, p. 175). These five standards were used throughout my analysis, and are explained in the following sections.

Credibility

"Credibility refers to confidence in the truth of the data and interpretations of them" (Polit & Beck, 2012, p. 585). By following a grounded theory approach to analysis, I was able to stay loyal to the truth of what my participants shared because "grounded theory logic presupposes that we will construct categories through the comparative methods of analyzing data" (Charmaz, 2006, p. 100) and developed themes and sub-themes through first and second level coding. During the analysis, grounded theory methods help keep the researcher grounded in the data because codes often reflect participants' language and what they are actually doing (Charmaz, 2006). Constant comparison occurs throughout the process because codes are being compared between

transcripts and being sorted into clusters, which are developing into second level codes. "Coding means naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data. Coding is the first step in moving beyond concrete statements in the data to making analytic interpretations" (Charmaz, 2006, p. 43). For example, a first level code was "But it's just who she is" (Participant 4). This initial code subsequently developed into a second level code of rationalizing incivility, which was a sub-theme in my study. Credibility was also achieved by the strategic guidance of my thesis advisors, who are experts in qualitative research**.** Throughout the process, interviewing techniques, transcripts, and coding (first and second level codes) were reviewed regularly with my advisors.

Dependability

In qualitative research, to have credibility, you need dependability (Polit & Beck, 2012). Dependability "refers to the stability (reliability) of the data of time and conditions (Polit & Beck, 2012, p. 585). Essentially, it means that if you have dependability, then another researcher, within reason, can replicate your study and come up with similar findings. An audit trail was maintained throughout my study by keeping track of all transcripts, notes, journal entries, analysis procedure (code book), discussions with advisors including reviewing interviews and codes and edited copies of thesis chapters.

Confirmability

Confirmability, also known as objectivity, is "the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning" (Polit & Beck, 2012, p. 585). The findings of this study are representative of

what the participants have said and are not an invention of the author. This criterion was achieved in my study by continuous reflective journaling, memos, and including many data excerpts in the findings chapter, to allow the reader to see how interpretations of the data were made.

Transferability

Transferability is the applicability of the findings to other settings or groups (Polit & Beck, 2012). While I understand that my research is qualitative and I did not interview and code enough transcripts to make the data statistically significant, my participants shared that they have worked in many different nursing environments (locations worldwide, cultures, and units) and still voiced that incivility is a common issue across areas. The representativeness of the sample supports transferability to other similar contexts.

Authenticity

Authenticity is the researcher's ability to "fairly and faithfully show a range of realities" (Polit & Beck, 2012, p. 585) even when those realities are contradictory (Thorne, 2016). Through 11 interviews, a range of perspectives was noted, and, although most were in agreement, there were some differing views. For example, when asked, participants did not attribute any of the incivility in their workplaces to the fact that they are female-dominated but the literature stated differently.

Ethical Considerations

Ethical considerations must be at the forefront of one's research methods. Unfortunately, there are many examples in the past when researchers violated human rights, such as the Nazi Medical Experiments (1930s-1940s), the Tuskegee Syphilis

Study (1932-1972) and the Jewish Chronic Disease Hospital (1960s) study (Streubert & Rinaldi Carpenter, 2011, p. 57). I received approval for my study through the Human Ethics Review Process at Trinity Western University. For my study, I obtained informed consent from participants and reminded them that participation was voluntary in my study. As well, I maintained anonymity of my participants by means of removing any identifying information while transcribing interviews (i.e., removing names of healthcare organizations; removing the participants' names and replacing it with a pseudonym. To maintain confidentiality, I ensured all information obtained and related to my research was secured on a password protected laptop. All data was transferred between committee members through a secured and password protected site, OwnCloud. All data will be kept for five years after my study and then destroyed. Any paper copies of documents will be shredded. Only my committee (Lynn Musto and Sheryl Reimer-Kirkham) and myself had access to my data, except for a hired transcriptionist, who signed a confidentiality agreement.

Chapter Summary

Interpretive description is a qualitative research method "for excavating, illuminating, articulating and disseminating…knowledge" (Thorne, 2016, p. 11). As the method of interpretive description allows for 'borrowing' from other methodologies, I was able to use the analysis method attributed to grounded theory that included constant comparative analysis from the first transcript until the last. Each of the 11 transcripts was coded and then themes were developed based on the coding. Reflexivity was accomplished by journaling throughout the project. Rigour was ensured through credibility (i.e., constant comparative analysis); dependability (i.e., agreement between

three researchers on the codes and themes); confirmability (i.e., memos, including many data excerpts in the findings chapter); transferability (i.e., participants having worked in many different nursing environments, locations, cultures and units); and authenticity (i.e., eleven participants allowed for a range of perspectives). Ethical considerations, such as maintaining the anonymity and confidentiality of the participants, were maintained through the use of informed consent, securing all personal information on a password protected laptop, and protecting confidentiality by using pseudonyms to represent participants in all written material. I anticipate that this study, based on sound research principles, will be valuable to the nursing profession by adding to our knowledge base. Chapter Four provides findings from the research interviews with the 11 nurses.

CHAPTER FOUR: FINDINGS

"I think we all have empathy. We might not have enough courage to display it".

- Maya Angelou

In this chapter, I describe the overarching theme, the two main sub-themes, and additional categories that illuminated "relative insight" (Thorne, 2016, p. 188) from interviews with nurses who had witnessed incivility between nurses in their workplaces. The overarching theme deduced from the data is nurses avoiding confrontation with the perpetrator when witnessing incivility in their workplace. Two main themes and several supporting categories were generated. The first main theme, normalizing incivility, had four supporting themes: witnessing incivility; the globalization of incivility; rationalizing incivility; and accepting the status quo. The second theme, the relationship between incivility and the workplace, had two supporting themes: incivility impacts the workplace and the workplace allows for incivility.

Overarching Theme: Avoiding Confrontation

While listening to participants and during analysis of the data, an overarching theme that came through was the concept of nurses avoiding confrontation. Participants shared that when faced with a situation of incivility, they would weigh the risk of harm to themselves if they spoke up for the victim in the situation. In a lot of examples shared by my participants, they mainly avoided the perpetrator due to the high personal risks. Participants spoke of an exception to this avoidance, in that they spoke up or intervened when uncivil behaviour affected the safety of a patient, which occurred more often than not:

> If it's related to safety of an individual [patient], I would encourage somebody to actually step forward and confront them. Just because you are new does not mean that you have to earn your right to speak. You are a human being (Participant 1).

Prior to making this statement, the participant had been speaking about how she chose not to get involved in situations after witnessing incivility if it seemed that the behaviour was rooted in interpersonal differences. However, when incivility impacted on patient safety, or had the potential to impact patient safety, the participant was prepared to risk becoming the target and/or the repercussions of speaking up for the well being of that patient.

Participants weighed the benefits versus the risks before engaging the perpetrator, and reported that in many cases the risk was too high for their personal chances of becoming the target; therefore, they did not intervene. For example, Participant 2 shared that when "you are in a meeting, some people have observed that" staff are rolling their eyes, arms crossed or on their phones, and "how can I go to HR (human resources) because someone is rolling their eyes every time I talk?" (Participant 2). For these reasons, she said incivility was not being reported, but she went on to share that, depending on the situation, she would speak up if she witnessed incivility in the workplace. Others shared that they would not speak up, or intervene, as they had reported incivility in the past and management did nothing to address the situation (Participant 1, 4, 5, 6, 8, 9). Consequently, they stopped reporting incivility altogether. Related to the overarching theme are the main themes normalizing incivility and the relationship between incivility and the workplace. The following sections will discuss the main themes and the supporting themes under the overarching theme.

Main Theme One: Normalizing Incivility

A theme that came to light throughout most of the interviews was that of normalizing incivility. Normalizing incivility meant that nurses just accepted or failed to recognize disrespectful behaviour in the department. Nurses often normalized the existence of incivility in their workplace through the different scenarios the participants shared. The supporting themes include witnessing incivility, globalization of incivility, rationalizing incivility, and accepting incivility as the status quo. Perhaps those who stated that bullying and incivility was the same thing recognized the intangible nature of incivility, and did not have the insight into the differences. They were, however, able to list and describe poor behaviours, unprofessionalism, and disrespect in their workplaces.

Witnessing Incivility

Throughout my study, participants did share that they had witnessed incivility in their various workplaces. Initially, I asked participants what their definition of incivility was, and if they described the terms incivility and bullying differently. Interestingly, six of my interviewees said that there was no difference between the two terms; they would use the words interchangeably in a sentence (Participants 1, 3, 5, 6, 8, 11). The other five described the words differently, explaining that they felt they were on a continuum of severity (Participants 2, 4, 7, 9, 10) with incivility being at the lower end and bullying being more severe. Interviewees used descriptors to describe incivility such as: "intangible" (Participant 2), "subtle" (Participant 2, Participant 7, Participant 8), "rudeness" (Participant 2, Participant 5), "hostility; talking down to them and making them feel dumb" (Participant 4), incivility is "on a spectrum or a continuum" (Participant 4), "unprofessional" (Participant 5), "inappropriate" (Participant 5), "passive"

(Participant 5), "intimidation" (Participant 7), "derogatory and slanderous comments" (Participant 7) and "withholding information" (Participant 1; Participant 4; Participant 7). Most participants shared that they had witnessed incivility in the workplace, and some also shared that they had experienced it personally. Not many participants were able, for various reasons, to express how it made them feel to witness it.

One participant, however, shared that she was witness to an uncivil event at work where three nurses were being passively aggressive towards another nurse. They were being very loud so this participant and a secretary could hear it. In the moment, the participant did not speak up but went on to share, [when I]

> came home, it really, it bothered me so much what had gone on. But what bothered me the most I think was that I hadn't said anything. And I kind of, you know tossed and turned all night long and I thought, I actually thought you are such a hypocrite because I had always told my children that if in a bullying situation if you don't do anything you're as much a bully as the other people (Participant 8).

The next day, this participant did speak up. She was able to have a levelheaded conversation with the three nurses involved, including her manager, to discuss the situation. After that conversation, the union became involved and a large anti-bullying campaign was started throughout the organization. All three of those nurses either quit or were relocated to a different unit. This is an example of the reflective nature of this nurse who needed the time away from the situation to make sense of it. She knew immediately that what she had witnessed was wrong and that it made her feel uncomfortable, yet in the moment she did not know what to do.

Participants shared analogies of when they witnessed different people experiencing incivility in the workplace. These visual examples included "Velcro vs. Teflon" (Participant 2); an "old girl giving 'just a look'" (Participant 3); and it is like "water off of a duck's back" (Participant 9). These are interesting examples that essentially mean the same thing. What the participants had witnessed were examples of their experienced nursing co-workers not allowing incivility to bother them. What happens to a nurse over the years? As with many things, I think that this is a multifaceted answer but includes, having gained confidence in their nursing abilities, having grown as a person and knowing more about yourself as a person could be contributing factors that allowed these nurses to not have incivility bother them.

Globalization of Incivility

Based on the participants' observations, incivility has become a part of the profession and spans across all work environments. It is not exclusive to just one type of clinical practice; rather, it is across nursing specialties and across countries. I interviewed nurses from almost every place imaginable: hospitals (intensive care unit, emergency department, inpatient units- burns, paediatrics, urology, medicine, geriatrics, operating room, post anesthetic care unit, trauma units, orthopedics), outpatient clinics, ambulatory care settings, homecare, management positions, public health units, colleges and universities. Participants also worked in various geographical locations around the world, including Canada, the United States, Europe and the Middle East. Overwhelmingly, all of these nurses shared with me that they had "too many examples" of witnessing and personally experiencing incivility. More than half of participants left their job due to the levels of incivility or they transferred to a different area within the

organization, where they continued to experience and/or witness incivility and/or bullying (Participants 1, 4, 7, 9, 10, 11).

One participant who had worked in the operating room, interventional radiology and intensive care unit settings shared that "incivility is global there, it is just everywhere and everyone is uncivil to everyone" (Participant 1). Incivility is one of the reasons she left the OR early in her nursing career. While she recognized that it was everywhere, as she aged and gained experience she was able to deal with it by being more confident and speaking up.

Two of the participants taught nursing students in clinical settings and they shared that they witnessed incivility towards their students regularly. A participant described that she was a clinical instructor on many different units and regularly witnessed incivility between nursing staff and students. This participant was aware that these behaviours were occurring in various places where she taught and that her students were experiencing incivility, yet did not speak up to the perpetrators. The participant's concern was that if she spoke up, the possible repercussions included loss of the placement setting. She shared that she tried to balance maintaining the placement and protecting the students by providing a space that to discuss the situations with the students and allow them a safe place to talk.

Some participants thought that incivility in the workplace was becoming worse, while others disagreed. A few participants shared that Canada was worse than other countries, while others who had worked in different countries said that there was no difference. All of the participants did agree that there was an increasing awareness about

incivility. In summary, the experiences of the nurses in this study portrayed that incivility is global; it crosses all levels and areas of nursing.

Rationalizing Incivility

Many participants rationalized the incidents of incivility they had witnessed throughout their careers, suggesting the normalization of incivility is part of the nursing profession. Rationalizing incivility in the workplace meant that nurses justified its existence in the workplace. For example, one participant stated that it is tolerated because nursing is "… a female dominated profession, it's kind of a part of nursing that we're kind of bitchy and that's okay. We talk behind each other's backs and it's alright" (Participant 4). As well, Participant 10 thought that, "… because nursing is dominated by women, it's often this like sly, passive aggressive comments that they made to each other" (Participant 10). As a rationale for rationalizing incivility, participants referenced nursing as being a predominately female profession. Other ways participants rationalized incivility included the history of nursing meaning that incivility has always existed in the nursing culture.

Rationalizing incivility emerged early in the interview process when the first participant mentioned, "I mean the senior staff, nurses eat their young and this is what we do. And you know I mean, I remember thinking, I don't think that this is okay… that not necessarily being an acceptable way of being" (Participant 1). I heard this sentiment from almost all of the participants and my impression was that they all rationalized incivility: "it's just always been that way" (Participant 2) or "everyone knows it is happening, even management…. It's a part of the culture" (Participant 4). All of the participants knew the saying, 'nurses eat their young'. It was shared that in a lot of the

areas, the culture for any new hire regardless of being a new graduate nurse, or an experienced nurse from another unit or organization, was that they would have to prove themselves. "…The fact that the senior staff are expecting you to earn your right to be in that environment. I definitely had a trial by fire night kind of half way through my first year where I proved my ability…" (Participant 1). It was shared that, generally, the older, more senior nurses had all gone through this 'right of passage' to become the nurses they are, so all new and/or young nurses should experience it as well.

Another way of rationalizing incivility was by seeing it as a personality trait, "…it's a part of who she (the perpetrator) is" (Participant 6), as opposed to being a part of the workplace culture and environment which could be changed. Many interviewees expressed that they perceived incivility as a personality trait of the perpetrator in their work place. One participant expressed that "it comes down to one individual that could have changed how the environment really was but chose to engage and just stir the pot" (Participant 1). Another participant shared that a nursing colleague with whom she worked was rude to students frequently, and "she *was* the common problem for any team that she was working on" (Participant 6). Participants held the impression that it is "just who these people are" and that it would be difficult to change their behaviours. In these ways, various reasons were given to justify or rationalize incivility amongst nurses.

Accepting Incivility as Status Quo

Participants indicated that incivility is accepted as the status quo and that it is acceptable, or even expected. Participants stated "…a lot of students expect to be treated badly" (Participant 10) "and there is always a nurse…" (Participant 10) that everyone knows about on the unit who would treat students badly. This participant explained that

faculty are aware of it but do not necessarily address the issue because they do not want to lose that placement opportunity (Participant 10).

Participant 10 also describe a 'bullying hotline' that was instituted in the hospital because the behaviour between physicians, residents and medical students became "so bad that they've been concerned that some of the medical students' and residents' suicides have been related to this" (Participant 10), indicating the severe consequences that this type of behaviour may cause. This organizational intervention that was intended to offset the impact of bullying for physicians, however, did not extend to the nursing staff. For example, this participant (10) also shared that she witnessed two senior nurses yelling at each other and disagreeing about the course of nursing interventions for a patient. She did not know what to do so she just started to chart about the situation because she "was so shell shocked" (Participant 10). There was no follow up from her manager in regards to dealing with what she witnessed between the two nurses. She described the work environment as "toxic" because nothing was being done to stop the behaviours and it was accepted amongst the staff to treat one another poorly. She soon left that hospital.

A 15 year veteran to the nursing profession who had worked in different countries and on a wide variety of units with varying acuities of patient populations stated, "I think everyone just accepts that it is the status quo and that's how it is and it's just not going to change" (Participant 4). She did not go into further detail as to why. Six other participants also made comments agreeing with this sentiment.

Another participant shared an example from when she was newer to the profession and working with a "very smart nurse" (Participant 9), who worked casually,

and was well known as uncivil. Her incivility was conveyed in subtle ways that were not easy to recognize or manage, such as rude comments made under her breath. Participant 9 shared that this nurse took extra-long breaks on the night shift. All the staff knew she took a longer break than she was allowed, but no one spoke up. She would also buy coffee

> if she liked you and thought that you were a good nurse, because if she didn't think you were a good nurse, then she didn't have time for you. So why would she ask if you needed coffee because, you know, I don't need to be friendly to you. You need to be better at your job (Participant 9).

Participant 9 explained that although everyone knew this about this particular nurse, they did not want to get on her bad side; and since she worked casually, she was on the unit less frequently. They were fearful of this nurse because she was openly judgmental and could have the other nurses pick sides and possibly turn against them. This same sentiment was shared by many of the participants. They also weighed the risks and benefits to them personally as a nurse in that work environment. By not speaking up, the status quo of incivility was perpetuated.

In summary, the first theme that emerged during analysis was normalizing incivility and the sub-themes that followed included witnessing incivility, the globalization of incivility, rationalizing incivility, and accepting incivility as the status quo. This first theme and supporting themes demonstrated that incivility is a real issue that nurses have to deal with in their workplaces. It is something that nurses see as a part of their job or the profession as a whole whether is it due to nursing being a prominently female profession or if participants shared that incivility was associated with being a

personality trait of the perpetrator. As well, due to the expressed intangible nature of incivility it is difficult to eradicate.

Theme 2: The Interaction Between Incivility and the Workplace Environment

Participants shared their perspectives on how incivility affected the work environment and how the environment, in turn, affected incivility amongst the nursing staff. The subthemes within this theme include: incivility impacts the workplace; and the workplace allows for incivility. Throughout the interviews with my participants, the dialectic relationship between the working environment and incivility became apparent. A back and forth. Positive and negative. This iterative relationship was supported when participants did not address directly bullying behaviour and organizations only superficially supported zero tolerance policies. It became apparent that there was a relationship between incivility and the nursing workplace because participants described examples where the environment supported incivility and allowed it to continue.

Incivility Impacts the Workplace

Participants expressed various expectations about their workplaces such as feeling safe, physically and psychologically; feeling like they are being heard; and feeling respected. An example would be "we want to work in a healthy work environment" (Participant 1). Participants expressed distress when there was a disconnect between policy and practice, for example "there's supposed to be a no harassment policy but there is bullying that goes on for sure. I think about incivility and I don't think people [organizational leadership] really care too much about it" (Participant 4). This participant also shared that when she was in nursing school she learned about nursing and how nurses are to be caring and compassionate, yet once she became a registered nurse her

expectations and the reality that surrounded her were very different. "But then we don't take care of ourselves and our other colleagues and stuff. That's distressing to me" (Participant 4). For these nurses, both the organizational culture and nurses themselves seem to contribute to a dichotomy between a nurse's expectations of the practice environment and the reality.

The distress due to the dichotomy was identified as a contributing factor to why participants leave their position (Participant 1, 4, 7, 8, 10, 11). Nurses in the study reported that they left their positions because of incivility and the toxic environments. Either they were victims of incivility or they witnessed it. It appeared that these nurses did not want to, or believed that they could not, deal with confronting the perpetrator, or they did not have actual supports in their workplace to deal with the situation, despite existing policies. As Participant 6 put it, "even if they don't think that it is appropriate, if that is the workplace culture that you're creating then those behaviours get modeled. Certainly not unique to this workplace" (Participant 6). Even though participants did not agree with what they saw or experienced as a part of the culture it was difficult for them to speak up and/or not be a part of the workplace culture since it was already established.

Doing the right thing when in a confrontational situation directly impacted the workplace environment because if a nurse spoke up when it came to a patient's safety, then better care was delivered and adverse situations could be averted. Many of the participants said that if the uncivil behaviour was going to interfere with the safety of a patient that they would speak up. Yet, if the uncivil behaviours they had witnessed had to do with those nurses' personal lives, topics that did not affect their professional lives, they usually did not say anything. An example of how nurses could positively act to

change a negative culture came from participant one. Participant 1 voiced an alternative view, saying that she was not afraid speak up no matter the situation, even if nurses were not getting along due to "personal reasons." She told them to "leave it [their personal reasons] at the door" and that they were "here to take care of patients". She admitted to me that those comments did not always go over well with her co-workers but she stated that as she got older, she could deal with the situation better then when she was a new graduate nurse. Many participants said that their age and experience made them better able to deal with incivility in the work place (Participant 1; Participant 2; Participant 4; Participant 6; Participant 9; Participant 11).

Other examples of how the relationship between incivility and the workplace are interrelated included how more senior nurses 'eating their young', and new staff coming into a workplace already knowing about the 'toxic' environment and knowing that nothing would be done to address it. Participants shared that when they did report uncivil behaviours in their departments and the behaviour was not addressed, the climate/culture of the workplace was affected, especially if they did not see any repercussions for the guilty staff, and there was no follow up or closure of the situation for staff members involved. As echoed by Participant 5, "she'll [the manager] listen to what you have to say and then say that she is going to deal with it and then you never see anything" (page 5), referring to the response from her manager. This participant experienced disconnection between what was being said and what was actually happening, which led to frustration for her and reinforced to the staff not to report uncivil interactions to their managers.

The Workplace Allows for Incivility

The expectations that a workplace address incivility described in the previous sub-theme are not unreasonable or unrealistic for nurses to have. Many participants suggested that a healthy work environment was a component of leadership/management's responsibilities. The participants' perception that leadership was responsible for the creation of a healthy unit culture also demonstrates that nurses fail to recognize their own contribution to maintaining the status quo by not addressing incivility in the moment. Participants suggested that if leadership led by example, and did not accept uncivil behaviours in their department, the expectation for all of the other staff members would be established (Participant 4, 5, 6, 8, 9). Participants expressed their belief that true leaders should exhibit the qualities that would assist in decreasing the amount of incivility in the work place, such as respect, good communication and being proactive (Participant 1, 5, 6). One participant shared that

> it has been my observation that in the last six years of clinical practice that those who are put into leadership are not always the best leaders. Some people prefer to be liked than to do the hard thing and send a message that this behaviour will not be tolerated. (Participant 6)

Other participants identified a contradiction that if the leadership team was not prepared properly to deal with conflict then how could they be expected to be viewed as a strong leader (Participants 1, 2, 4, 5, 6). Participant 6 explained that leaders are

> nurses with a lot of experience and there is a very big difference between being an experienced nurse and being a leader… [because you need] someone who is willing to make the tough decisions that will benefit the organization and the team

> which sometimes mean being the hated person. Um, someone who looks at all points of view, who doesn't play staff off of each other.

According to this participant, being able to deal with conflict situations with various personalities is a skill that you do not necessarily have even if you are an experienced, skillful bedside nurse. Leadership is a role that requires support and education to learn and grow as a professional as well.

A manager/leader is in a position of authority and nurses expected support. For example, one participant suggested that "… a leader… [is someone] who can stand up and do the right thing for their unit [and] then that stuff can be dealt with" (Participant 1) and "if you have a functional, involved, visionary leader in your unit, then crap like this is not tolerated" (Participant 1). Another participant suggested "you're not being a true leader then if you're not willing to change anything" (Participant 5). The participants found they were putting themselves in a vulnerable state when they reported an uncivil incident to their manager; they were opening up about conflict in their professional lives which could be viewed by some as a weakness; not being able to deal with it on their own and having to involve a manager could reflect poorly on them.

Participants admitted frustration and what could be seen as a failure to deal with conflict on their own (Participant 4, 5, 6). The result was that participants expressed that they felt demoralized to have a manager/leader reassure them to their face that the situation would be dealt with and then have no follow up communicated to them about the process and/or consequences. In such situations, participants felt neglected, unheard, forgotten about and dismissed. Participant 6 summarized this experience when she said:

> we all had different meetings with our boss at different times. Our boss knew as well, that [the uncivil nurse] wasn't necessarily meeting the standards of care and that she is a bit of a bully in the work place. And that she was causing problems for… she *was* the common problem for any team that she was working on. She had had conversations with her, about different things but never acted on any follow up. Discipline was never seen… kind of allowed her to do what she wanted… she was a destroyer of teams.

This is an example that other interviewees shared as well, that they would report incivility or bullying to their manager and never hear or see any follow up. To them, it felt like a waste of their time to share with their manager because they did not see any consequences of the negative behaviour occur to the perpetrator. Thus, this apparent lack of a response or consequence affected the entire workplace.

This kind of behaviour on part of the manager has the potential to breed incivility because it displays to the guilty parties and the rest of the staff that the behaviour is tolerated. Another participant expressed that she knew,

> …very early on, because I wasn't, it wasn't like I was afraid to say something, it just seemed like the place was so toxic and so poisoned there wasn't much point in mentioning it to anyone who worked there because they probably were a part of it. (Participant 10)

This participant knew before starting at her place of employment that it was toxic, and she ended up leaving after a couple of months. She alluded that the manager had contributed to the uncivil behaviours when she spoke about the manager being a bully and hiring bullies as nurses who contributed to the toxic environment (Participant 7).

Participants expressed that it was difficult to expect a change in uncivil behaviours if leadership did not display professionalism and exhibit the expected behaviours themselves. Essentially, participants were asking how could you expect staff to change if what was being modeled for them was not appropriate?

The people who worked in them influenced the environments in which these nurses worked. Many participants shared that if they did not see this behaviour modeled for them or if they saw that incivility was tolerated (or even perpetuated), then they felt powerless and not supported in a way that they could say anything. Others felt that because they were new or had less knowledge (fewer years of experience), they could not speak up when faced with witnessing incivility in the workplace. One nurse described an experience with a few uncivil nurses; she left that area and went to work in a tertiary care centre, where she gained a lot of experience and knowledge. Afterwards, this participant returned to the previous hospital and felt like she could stand up for what was right (Participant 4). Another participant described situations when she was a new nurse and she felt like she could not stand up for herself or her patients because English was her third language,

> and all the time when I see injustice, I would cry right away because the emotion was so strong that I could not put it in my mouth. I want to help people or I want to help myself, if I am the one facing that challenge but I couldn't because my language skills [were] preventing me from explaining myself clearly and advocating for myself (Participant 11).

Evident in this quote is the moral distress that resulted from an inability to do what the nurse knew was right. There seemed to be disconnection between the participant's expectations of the organization and what actually occurred.

Chapter Summary

In conclusion, through the analysis of my interviews, I was able to determine an overarching theme of participants avoiding confrontation with the perpetrator. In order to avoid confronting the perpetrator, various ways of normalizing incivility were undertaken. The supporting sub-themes of the normalizing incivility were witnessing incivility, the globalization of incivility, rationalizing incivility, and accepting the status quo. Participants shared that incivility was very common and pervasive across all areas of nursing work environments, as well as across countries. Over half of my participants shared that they would not define incivility differently than bullying, and many participants would only speak up or intervene if the patient's safety was in question. One nurse did share that in the initial moment she did not speak up. However, after a reflective pause, she was able to realize that she was being a hypocrite by not speaking up in the moment—witnessing it and remaining quiet only condones the behaviour, making it acceptable in the workplace.

As revealed in the second major theme, incivility impacted the workplace and the workplace allowed for incivility in many situations. Incivility and the work environment were interconnected. Participants shared their expectations of a healthy workplace and that if management was not supportive of it, then little change was seen in the department's culture. In the next chapter, these themes will be discussed in relation to extant literature.

CHAPTER FIVE: DISCUSSION

Injustice anywhere is a threat to justice everywhere. – Martin Luther King Jr.

The purpose of the discussion chapter is to compare the findings of my research to what is already known on the topic. I will be using Thorne's (2016) guidelines for this chapter which include:

1. What are the main messages here for the practice field?
2. What is it that I know now, having done this study, that I did not know before?
3. Or, perhaps that I did not know in quite the same way? (p. 221).

There is no shortage of research in the nursing field about incivility, bullying and/or harassment. Recently researchers have been focusing on graduate nurses and negative workplace environments due to the high numbers of graduate nurses leaving the profession within less than a year of starting work (Clark, 2011; Foreman, 2017; Smith, Andrusyszyn, & Spence Laschinger, 2010). An extensive literature review unearthed no research specifically examining the perceptions of nurses who had witnessed incivility between their nursing co-workers. However, research does exist about the prevalence of incivility and negative behaviours in the workplace, how the culture of the workplace affects staff members, and how leadership's role in the workplace can affect the levels of incivility. As well, there is an article, which is discussed below, that looked at nurses who witness bullying in their workplaces. In this chapter, I discuss how incivility is defined by my participants and within the literature, as well as the normalizing of incivility in the nursing workplace. Also, I will explore the impact of gender on incivility, the impact of incivility on a safe work environment, and finally the relationship

between leadership and incivility.

Defining and Normalizing Incivility

I asked participants to share with me the meaning of incivility and if they defined it differently than bullying. Five of my participants shared that they knew what incivility was and the other six shared that they would not define incivility differently than bullying and used the words interchangeably throughout their interviews. Notably, the five who knew the difference had completed an educational session within the last year on healthy workplace environments.

Educational sessions on incivility have been shown to increase nurses' understanding of the terms, as well as how to respond to incivility (Stanley et al., 2007). Indeed, the participants who attended educational sessions on incivility defined incivility with words such as subtle, discreet, intangible, rude, unprofessional, and low end of the intensity spectrum, all of which are similar to descriptions of incivility found in the literature (Hershcovis, 2011; McNamara, 2012; Purpora et al., 2015). Houshmand et al. (2012) stated, "bullying tends to be less insidious and subtle than the subset of behaviors that capture constructs such as incivility" (p. 902). These participants also recognized that incivility was on a continuum, as described by Hershcovis (2011). Figure 1 (inserted in Chapter 1) is a visible representation that Musto (2015) adapted from Hershcovis that represents the lesser to more severe behaviours that can be seen when dealing with negative behaviours in the nursing workplace.

Feblinger (2009) suggested, "the question of intent to harm distinguishes incivility from bullying or other forms of aggressive behaviour" (p. 14). Feblinger (2009) went on to suggest incivility "is psychological in nature, a form of low intensity,

inconsiderate conduct…associated with an ambiguous intent to harm the target" (p. 14). This sentiment was echoed in my research when Participant 2 stated, "since you cannot see it, it is intangible". Incivility, by definition, has ambiguous malicious intent, ergo no physical damage is done to the victim, but it is psychologically damaging according to my participants.

In this study, examples of ways in which incivility was intangible included co-workers withholding information at report about a patient's care if they had a problem with that nurse, or when a nurse would not extend the offer to buy the participant a coffee because she only made that offer to nurses whom she 'trusted'. These examples speak to undermining relationships in the workplace. As stated by Almost et al. (2015), "interpersonal workplace relationships are an important component of working life and poor relations with colleagues strikes at the heart of why so many frontline nurses are stressed, disheartened and on the verge of burning out" (p. 2). When a nurse is uncertain about their position on the team, she or he may start to feel insecure with their nursing actions and the care that they deliver. As well, if a nurse is not given all of the information during shift change regarding a patient's status, or the care that the patient received, it could well have detrimental effects on the care the nurse delivers and be detrimental for the patient. Withholding information is an example of uncivil behaviour where the impact may not be immediately apparent. However, the ripple effect could be astronomical, personally and professionally for the nurse, and medically for the patient. Katrinli, Atabay, Gunay, and Cangarli (2010) stated that,

> we lack dignity when we find ourselves in inappropriate circumstances, when we are in situations where we feel foolish, incompetent, inadequate

> or unusually vulnerable. It is obvious that the victims of bullying find themselves in many inappropriate circumstances… Dignity involves respect and value to individuals, but bullying strongly violates nurses' right to dignity at work. (p. 615)

The harm that incivility in the workplace can cause to a patient and to that nurse is unacceptable. There are many other factors that influence optimal patient care that cannot be mitigated but incivility in the workplace can be.

It was unclear during my interviews if participants were more aware of what incivility is because of the increased education they have received in the recent years that allowed them to recognize incivility, or if the incidence had actually increased. The literature does support the escalating occurrence of incivility. For example, Stanley et al. (2007) conducted a survey to determine the perception of lateral violence within the healthcare workplace. Forty-six percent of respondents returned the survey that it was a "serious problem" and 65% of the respondents reported witnessing lateral violence between co-workers. Although lateral violence is different from incivility, as lateral violence "is described as nurse-on-nurse aggression and inter-group conflict" (Duffy, 1995; Farrell, as cited in Stanley et al., 2007, p. 1248), it is a negative behaviour that nurses notice in the workplace and could be argued as an acceleration of incivility as per the continuum (see Figure 1 in Chapter 1).

During the interviews, I specifically asked participants to share an example of when they witnessed incivility between nursing co-workers. What surprised me about this prompt was that many of my participants, initially shared an example in which they were the victims of uncivil behaviours. As well, it was disheartening to hear all of the

nurses indicate they had witnessed "too many" incidences to share. These stories led me to the interpretation that incivility was being normalized. Literature shows that nursing has been aware of the problem of incivility for decades, as evidence by the phrase "nurses eat their young" (p. 52), coined in 1986 by Judith Meissner. This phrase continues to be frequently used and can reinforce the normalizing of incivility. Along these lines, Wilkins (2014) noted that the culture of bullying has been accepted as the 'norm' where "people cease to question its harmfulness" (p. 284). Yet participants in this study clearly identified harms that resulted from incivility.

Further to the idea of the normalization of incivility, many of my participants stated that they expected to encounter incivility when going in to work or starting a new position. "…Everyone expects it…that's just how it is and it's not going to change" (Participant 4). Participants shared that many of the perpetrators were more experienced nurses who had learned through "trial by fire" (Participant 1) when they started their careers, hence they believed that new nurses should go through similar training. Yet many newer nurses to the profession had been exposed to uncivil behaviours throughout their education and clinical placements, thus they already knew the behaviours and started to engage in them thereby perpetuating the behaviours themselves (Lewis, 2006).

Participants indicated that incivility was accepted as the status quo, to the extent that it is even expected, and that they had to balance tolerating incivility with the consequences of addressing it directly. This expectation is even true for nursing students "…a lot of students expect to be treated badly" (Participant 10) "and there is always a nurse…" (Participant 10) that everyone knows about on the unit. Yet, this participant went on to explain that, even though faculty were aware of the difficult nurse, they did

not necessarily address the issue because they did not want to lose that placement opportunity (Participant 10). Marchiondo, Marchiondo, and Lasiter (2010) noted that such interactions "model negative behaviour for students, implicitly teaching them that incivility is acceptable in the nursing field" (p. 610). Yet, by not speaking up and being complacent with the negative behaviours in the workplace, the acceptance of incivility was perpetuated. Balancing the consequences of speaking up, and a lack of knowledge and confidence could lead to not dealing with a situation, which, in turn, perpetuated the behaviours and further normalized them.

Some participants required a lot of prodding to provide an example of incivility that was not directed towards them but an example that they witnessed. It could be speculated that some participants had difficulty describing a specific uncivil experience because it is so common that nurses are not recognizing that it is unacceptable and not the norm. As McNamara (2012) stated, "nurses must raise their awareness and the awareness of others about these behaviors; recognize behavior that undermines a culture of safety when it occurs; and become empowered to address, confront, and move beyond bullying" (p. 535).

Prevalence of Incivility

Research shows that bullying is a severe problem for health care professionals in many countries. For example,

> Niedl reported that 26.6% of a sample of Austrian hospital employees were victims of bullying. In Denmark, Mikkelsen and Einarsen noted that 16% of the hospital employees they studied were exposed to bullying at least weekly over a six-month period. Similarly, 5.3% of hospital staff studied in Finland and 38% of

> a group of NHS employees in the UK were shown to be victims of bullying. (Katrinli, Atabay, Gunay, & Cangarli, 2010)

While I acknowledge that these statistics were based on the term bullying and not incivility specifically, it can be assumed that incivility was also occurring because these behaviours fall on a spectrum of lesser to greater in severity (Purpora et al., 2015). Incivility is at the lesser end of the spectrum and is usually a starting point for more severe behaviours (Purpora et al., 2015). Participants shared that they felt that incivility was the status quo and therefore it was not going to change. Baker (2015) acknowledged that nurses care for sick people whom they do not know, but more often than not, "participate in and perpetrate nurse-on-nurse bullying" (p. iii). Nurses will care for almost complete strangers while they are in a highly vulnerable state in their lives yet at the same time will demonstrate negative and hostile behaviours towards their own co-workers whom they generally know better than their patients. Almost et al. (2015) would agree with Baker (2015) that incivility has a greater impact on burnout rates, job satisfaction, patient satisfaction and patient mortality. Incivility in the workplace touches all aspects of a nurses' life and it can and must be modified.

Impact of Gender on Incivility

There was a discrepancy in participants' interpretation of the impact of gender on incivility. On the one hand, when participants were asked, they unanimously agreed that gender did not contribute to the uncivil behaviours and negative cultures in the workplace. Yet, on the other hand, when participants described their workplaces and the uncivil behaviours they witnessed, they referenced nursing as a "female dominated profession" (Participant 4) and used descriptive words such as "kind of bitchy"

(Participant 4) and "sly, passive aggressive" (Participant 10) to justify the existence of incivility.

Existing research tends to support the premise that gender contributes to the negative culture. Longo and Smith (2011) suggested that, "nurses have been characterized as an oppressed group because the profession is composed primarily of women who are practicing within a patriarchal structure dominated by physicians, male administrators, and marginalized nurse managers" (p. 347). As well, Roberts (2000) stated "that powerless groups have difficulty taking control of their own destiny because internalized beliefs about their own inferiority lead to a cycle of self-hatred and inability to unite to challenge the inequality of power" (p. 71). Wilkins (2014) argued similarly to Longo and Smith (2011) that a predominantly female workforce in nursing and a power differential between health care professionals leads to a culture of bullying. Perhaps my participants did not see gender as a contributing factor to the levels of incivility reported in their areas of work because they too are female and are oblivious to incivility (given its prevalence in society generally). When you are directly involved with the situation and problem, it is difficult to have the insight and reflection to see the issue from the outside.

Impact of Incivility on a Safe Work Environment

During the data collection and analysis process of this study, it became apparent that incivility does influence the workplace environment. Incivility affected nurses personally and professionally. Participants shared that they expected a safe workplace environment when they went to work. Such a workplace enabled them to be productive, caring, and provide safe patient care. Participants shared that they expected to feel safe—physically and psychologically; to feel that leadership and fellow co-workers were

listening them; and to be respected. Kwan et al. (2014) described a key learning point, as "when employees feel valued and expect to be listened to, they will voice their concerns to the organization when they encounter a threat in the workplace" (p. 10).

Participants shared that many of them left positions or units due to incivility, unprofessionalism, or toxic environments. Some of the participants admitted to knowing that the area had a negative culture but they wanted the nursing experience in that area. The literature does show that there is an increase in staff turnover and difficulty with recruitment and retention when there is a known area with negative behaviours and poor workplace culture (Almost et al., 2015; Felblinger, 2009; Laschinger, Cummings, Wong, & Grau, 2014). Baker (2015) conducted a study about the lived experience of nursing educators who have witnessed bullying either between their students or nursing colleagues and found that witnessing bullying between nursing co-workers and/or nursing students did have an effect on that nurse's attitudes and beliefs about the nursing profession (Baker, 2015). Participant experiences in this study echoed some of the themes outlined by Baker, such as unprofessionalism, effect on practice, and effect on person. Almost et al. (2015) would agree with Baker (2015) that incivility and bullying have an impact on burnout rates, job satisfaction, patient satisfaction, and patient mortality.

However, Almost et al. (2015) also identified elements of organizational culture that countered incivility, explaining, "collegiality, respect, cooperation, teamwork, social support, mentorship and collaboration are the terms often used to describe positive relationships among colleagues" (p. 2). Having these positive relationships fosters communication and collaboration amongst frontline staff members, which in turn

increases the positive outcomes individually, and organizationally (Almost et al., 2015, p. 2). "Effective teamwork and communication" (Almost et al., 2015, p. 1) has been shown to help mitigate these negative behaviours of "emotional abuse, bullying and incivility" (Almost et al., 2015, p. 1).

Houshmand et al. (2012*)* reported that by working in an area where there are high levels of perceived bullying, there was a higher turnover rate even amongst the employees who were not the direct targets. Participants in my study shared that they too had left jobs because of the culture there. In the words of Participant 6: "I loved the work but the interpersonal conflicts and the disrespect that was rampant". Incivility impacted the workplace by affecting nurses professionally – in both my study and Houschmand et al.'s (2012) study, many nurses left jobs due to the toxic environments and possibly not providing the best care that they could provide due to fear or lack of information from nursing co-workers. Houshmand et al. (2012) concluded that "those who experience bullying second-hand, simply because they work in environments in which others are bullied, can also experience negative attitudes and behaviors, similar to the direct targets of bullying" (p. 913).

Many interviewees expressed that they perceived incivility as a personality trait of the perpetrator in their workplace, reflected in these comments "…respect and inclusion were not a priority for her" [referring to the perpetrator] (Participant 9). I did not find this perspective that incivility was a personality trait in the literature. Lewis (2006) looked at bullying, the cultures within the workplaces, and management's involvement with the culture. She found that "the overall findings from the research point strongly to bullying activity being essentially learned behaviour within the workplace rather than any

predominantly psychological deficit within individual perpetrators and targets" (p. 52). This seems to contradict the comments of the participants that incivility was a personality trait and inherently a part of who they are. The attribution of incivility as a personality trait amongst my participants may be due to a lack of knowledge about the influence of practice environments, or perhaps a desire to excuse nurses in some way (i.e., if a personality trait is innate and therefore not easily amenable).

Leadership and Incivility

The majority of the nurses who participated in my study shared that in their experience, what made a difference in the level of incivility of a unit was the management/leadership. Participants held that if management were to say "no" and not tolerate the behaviours, the culture of a unit would be very different. Lewis (2006) suggested that the workplace environment and managers contribute to the level of negative behaviours, specifically bullying. She postulated that managers needed to actually deal with negative behaviours within their units and stand true to a 'zero tolerance' bullying policy (Lewis, 2006, p. 58). McNamara (2012) and Farrell (2007) also supported a 'zero tolerance' policy to decrease the level of negative behaviours in the nursing workplace.

Participants also shared that if management 'led by example' then it sets the tone for the whole department. Yet, if managers preferred "to be liked as opposed to making the tough decisions" (Participant 6) a negative culture amongst the staff was perpetuated. Houshmand et al. (2012) suggested that in work environments where the organization and management do not support nurses or when nurses do not support one another, conflict occurs. As well, Stanley et al. (2007) determined that "education and effective

leadership were found to mediate oppressive and negative behaviors, whereas ineffective leadership was found to exacerbate lateral violence" (pp. 1247-1248).

Kwan et al. (2014), through his study of nurses who had experienced and witnessed bullying within their workplaces, found that a psychosocial safety climate (i.e., supportive managers and organizations) resulted in nurses choosing active strategies to deal with their bully, for example, confronting their bullying and discussing the situation. Alternatively, if there were low levels of a psychosocial safety climate, nurses would likely choose more passive coping mechanisms such as silence, avoidance and in some cases leaving that job position (Kwan, 2014). Laschinger et al. (2014) in their study titled "Resonant Leadership and Workplace Empowerment: The Value of Positive Organizational Cultures in Reducing Workplace Incivility" concluded, "nursing leaders are indispensable in creating positive nursing work environment that retain an empowered and satisfied nursing workforce" (p. 5). Their research contributes to the growing body of knowledge supporting positive leadership practices to enhance the frontlines for nurses and in creating healthy workplace environments.

Transformational leadership within the nursing profession may effectively mediate a culture of change towards negative behaviours in the workplace, which could lead to nurses confronting perpetrators of uncivil behaviours. Leadership within an organization plays a crucial role in setting the tone and expectations in the workplace, which inevitably creates the culture. Longo and Smith (2011) suggested that it is time for nurses to act to "reject insidious, often-damaging behaviors in the workplace toward the goals of creating a healthy work environment, enhancing patterns of relating with each other, and improving patient outcomes" (p. 347). Felblinger (2009) agrees when he

states, "administrators are in a pivotal, powerful position to spearhead development of a code of conduct that clarifies appropriate behavioral norms for all professionals" (p. 14).

A perspective that was not put forth by my participants, but that I found in the literature, is that nurses need to be the change agents within their units if they expect to see a change in culture (McNamara, 2012). McNamara (2012) suggested that nurses accepting "the way things are" is a "dangerous factor that supports disruptive behavior" (p. 537). All frontline staff have the ability to control how they respond to a situation through their communication, collaboration, and by being a contributing member of the team, thus modeling the appropriate behaviours to support a positive culture shift (McNamara, 2012). A possible reason why this perspective was not brought up by my participants could be due to their ability to rationalize the presence of incivility in their workplaces and that most participants believed that it was someone else's responsibility to act (i.e., the manager).

Participants in my study shared that they were aware of uncivil behaviours, either towards them personally or amongst fellow co-workers. Many of the participants admitted that they stopped reporting the negative behaviours to their manager because nothing was being done, the perpetrator was still working, and no apparent disciplinary action was taken. A few of the participants shared that they would speak up when witnessing an uncivil interaction between co-workers, recognizing that this behaviour would eventually affect all of the staff. However, this confidence to speak up came with years of experience. As new graduate nurses, they would not have felt comfortable saying anything.

Chapter Summary

There was an abundance of rich information shared through the lived experiences of my 11 participants. They were willing to open up about vulnerable situations from their nursing careers that brought a lot of valuable information to light. Their accounts revealed the normalization of incivility in the workplace through acceptance of the negative behaviours, either by ignoring them or not confronting them due to fear or complacency.

Participants further justified the normalization of incivility by accepting it as the status quo of the working environment. The literature supports that incivility is a learned behaviour and exposing nursing students to it only perpetuates the behaviours. The interaction between incivility and the workplace was also apparent from both participants and the literature, whether positive or negative. Both participants and the literature emphasized the role that leadership has in the workplace culture development. Leadership can either perpetuate incivility or create a culture that does not tolerate uncivil behaviours. There were differing opinions about the role of gender in the nursing workplace. My participants felt that a female dominated profession did not contribute to the levels of uncivil behaviours, yet the literature supported that due to the amount of women in nursing it perpetuated the issues and increased the power struggle in the workplace.

CHAPTER SIX: CONCLUSIONS AND IMPLICATIONS

Be the change you wish to see in the world - Mahatma Ghandi

The purpose of this chapter is to summarize how my initial research questions were answered and to share implications of my research for the nursing community. In this chapter, I will include a summary of the research, implications and recommendations, the limitations of my research and conclusions.

Summary of Research

Back to the beginning to where this all began: this study started with a nurse researcher who was curious about a phenomenon that plagued nursing throughout history and to her disbelief was still happening in the 21st century. Having been a victim of incivility and bullying, I was determined to learn more about these negative behaviours: why were they happening; how were they happening? Nursing has been known as a caring, selfless profession, where we, educated professionals, tend to the needs of people in their most vulnerable state. So why can we not even extend the same courtesy to our fellow co-workers?

Thorne (2016) pointed to the need to discuss "what… you think needed to be known and who needed to know it" (p. 229)? My participants were all registered nurses who shared first hand experiences across all different areas of nursing in multiple countries. The presence of incivility in the workplace does not discriminate; it affects all nursing workplaces. It also appears to be a global issue (Khalil, 2009). The discussion about witnessing incivility in the workplace between nursing co-workers is important because it brings awareness to the growing problem. Recognition of what uncivil behaviours are is the first step to decreasing this phenomenon in the workplace. It is

crucial that more nurses, frontline and leadership, start recognizing incivility, because dealing with these behaviours or not dealing with these behaviours will be the defining point that promotes a positive or negative culture in the work environment.

Throughout the collection and analysis process, the overarching theme of avoiding confrontation became obvious, supported by themes of normalizing incivility and the interaction between incivility and the workplace environment (reported in Chapter Four). In Chapter Five, I discussed these themes unearthed from the data, and how and where they were situated within the published research. Scholars, researchers, and nursing clinicians have discussed how incivility has been normalized, or tolerated, across much of the nursing profession, starting while nurses are in school. The prevalence of incivility in the workplace amongst nursing staff is well documented and without the help of strong leadership to address the situations, incivility within nursing does not seem to be going anywhere. Thankfully, many other researchers have put forth recommendations to change these behaviours and the overall cultures in the nursing workplace.

This social injustice did not sit right with me; I often had a visceral response when on the receiving end, as well as when listening to what my participants were sharing with me about their experiences. This led me to develop this study and I proposed these research questions at the beginning of my journey.

1. What are nurses' responses to nurse-to-nurse incivility in the workplace?
2. Do nurses who witness incivility in the workplace view themselves as moral agents to address the issue? If so, how?
3. Do witnesses of incivility act upon that experience? If so, how?

4. How do nurses manage working in an environment where incivility exists?

I will address the answers to these questions here.

1. What are nurses' responses to nurse-to-nurse incivility in the workplace?

With full transparency, as the lead researcher, I admit that even as this study was going on, I experienced and/or witnessed uncivil behaviours in my own workplace and I did not know what to do or what to say every time, and this is what many of my participants shared as well. They did not know what to do and they did not want to become the perpetrator's next victim so they would not speak up and intervene in the moment unless it would otherwise directly compromise patient care. Yet, several participants shared that as they gained more years of nursing experience they felt more confident to act when witnessing or being the victim of uncivil behaviours. Nurses responded to incivility by balancing addressing incivility directly with the potential consequences. This led to avoiding confrontation, as well as rationalizing, and normalizing the behaviour.

It is important to note that all of my participants said that incivility was very common in all of the areas where they worked and that staff expected it. Based on this widespread prevalence, it appears that there is a level of tolerance for such behaviours.

2. Do nurses who witness incivility in the workplace view themselves as moral agents to address the issue? If so, how?

None of my participants were familiar with the term 'moral agent' but many of them described acting as moral agents in their workplaces. Enacting moral agency was more common with the participants who were older and had been nursing longer. Possibly because "moral agency is about creating a space so that the agent can reflect on

the moral/ethical aspects or values of a situation and then intentionally choose action" (Musto, personal communication, 2018). Participants shared that now that they had more experience in the nursing culture, witnessing and/or directly experiencing uncivil behaviours did not bother them because they had more confidence and competency in their skill set and a better understanding and insight into whom they were as individuals. These individuals would address the perpetrator in the moment when witnessing an uncivil interaction between nursing co-workers.

3. Do witnesses of incivility act upon that experience? If so, how?

Participants explained that they thought about what the implications would be to them personally and to the patient when they witnessed incivility in their workplaces. The majority of the participants avoided speaking up when they had witnessed an incident due to fear of retaliation from the perpetrator but if the event was going to cause harm to a patient, then every participant would intervene. Yet, it could be argued that nurses do not fully appreciate how moral distress affects their practice, moral distress caused from witnessing incivility in the workplace. It is known that incivility and other disruptive behaviours do affect patient care (Feblinger, 2009) so it would be reasonable to speculate that nurses might not always notice the harm that incivility causes.

4. How do nurses manage working in an environment where incivility exists?

The participants in this study described different ways of managing incivility in the workplace. Some nurses ignored incivility, for example, saying it was a part of a personality trait. When nurses did report incivility, it appeared to them that nothing was being done by management to deal with the situation because there was no visible follow-up from the manager with the nurse who reported the incident. Depending on the number

of years of working experience, some nurses would speak up. And depending on how toxic the culture was, nurses left their units and even the organization at times. Overall, my findings generally reflect what is written in the literature.

Recommendations and Implications

All eleven participants shared their personal experiences about witnessing incivility in their workplaces, which provided rich and meaningful data. Data analysis resulted in practice, policy, education recommendations, and research implications.

Practice Recommendations

The first practice recommendation related to making the organizational values visible, in a practical way, at the level of direct care in an effort to foster a healthy work culture. Three examples of values statements from hospitals from across Canada include

- Respect, Trust and Collaboration (London Health Sciences Centre, n.d.);
- Compassion, Leadership, Integrity, Family Centred Care & Excellence (Children's Hospital of Eastern Ontario, n.d.);
- Respect people, be compassionate, dare to innovate, cultivate partnerships & serve with purpose (British Columbia Children's Hospital, n.d.).

These organizational values underpin the policies that support a respectful workplace. While healthcare organizations typically post such value statements, the challenge arises in how to operationalize these values in ways that prevent incivility in the workplace. Wilkins (2014) offered suggestions for responding in a way that may change the culture of the organization, such as using cognitive reappraisal techniques to consciously respond to a situation, providing a technique that will allow nurses to deal with a negative situation "in a way that alleviates its emotional impact" (Wilkins, 2014, p. 286). For

example, humour can be used to help targets and bystanders of incivility in the workplace deal with the impact in a positive, healthy manner (Wilkins, 2014).

Every member of a team is essential to the completion of the work but the leader or team captain is crucial to its success. Having an experienced, motivational, and influential leader who supports effective communication and collaboration and someone who also models the desired behaviours is essential to creating and growing a positive workplace culture. Chu (2016) examined the mediating effects of positive moods of 269 nurses employed at various Taiwanese hospitals Findings showed that when nurses experienced compassion at work (i.e., nurses felt listened to by managers and coworkers) then there was an increase in job performance and organizational citizenship behaviour. This study stressed the importance of the need for nurse managers and hospital leadership teams in hospitals to create and cultivate a caring and compassionate workplace environment, as it will benefit everyone, including the patients.

Wilkins (2014) and Chu (2016) both suggested that such an environment would positively affect the moods of the staff and could ultimately change the nursing culture in the environment. Organizations can foster compassionate environments by enforcing "current policies against workplace incivility and creat[ing] an environment open to teaching the importance of teamwork" (Logan, 2016, p. 51). These polices need to be based on the values of the organization and be seen throughout every decision made, because all decisions eventually affect the frontline staff and their patients.

Policy Recommendations

In the area of policy, multiple researchers, Felblinger (2009), McNamara (2012) and Farrell (2007) all suggest having strong, influential leadership teams that have well

laid out code of conducts and zero tolerance policies that are enforced. Felblinger (2009) stated "administrators are in a pivotal, powerful position to spearhead development of a code of conduct that clarifies appropriate behavioral norms for all professionals" (p. 14). As echoed by many of my participants, managers and leadership need to lead by example and display behaviours they would want in their workplace. This is supported by McNamara (2012) when he states "bullying is allowed for 3 reasons: because it can; because it is modeled; because it is left unchecked" (p. 537). This is also where management comes into the equation of lessening incivility in the workplace. For a code of conduct and zero tolerance policy to be effective, it must be applied to everyone equally and it must be concrete, with management being fully committed (Farrell, 2007; McNamara, 2012). This means that management cannot play favorites with staff members, turn a blind eye, or not deal with uncivil incidences that are reported to them. It is the responsibility of a manager to lead by example and model the appropriate behaviours to support a positive workplace culture and it is the organizations responsibility to support those managers. Organizations need to provide education and professional development courses to their managers in an effort to prepare them and give them the skills they need to deal with these behaviours and to support positive cultures. The Registered Nurses Association of Ontario designed the Healthy Work Environment Best Practice Guidelines. These recommendations are to help develop "a practice setting that maximizes the health and well being of nurses, quality patient outcomes and organizational and system performance" (Registered Nurses' Association of Ontario, n.d.). This is a well-researched and applicable guideline to institute within organizations when educating managers and frontline staff alike.

An organization has a responsibility to provide the resources for team building, such as inter-professional team education, time for discussing unit specific concerns, mentorship training and other professional development opportunities. Positive interpersonal workplace relationships have been connected with the culture in a workplace, including "collegiality, respect, cooperation, teamwork, social support, mentorship and collaboration" (Almost et al., 2015, p. 2). As well, organizations need to educate staff about how to deal with conflict in a safe and appropriate a manner when it arises. These values are needed to foster a positive culture within the workplace environment. Healthcare is a team sport and requires the assistance of a vast, multidisciplinary team to provide optimal care to a patient and their family but a team is only as strong as its weakest member. It is documented that toxic working environments and poor communication can affect the care a patient receives because it undermines a culture of safety (Huntington et al., 2011; McNamara, 2012).

As well, a negative workplace environment has been shown to affect retention and recruitment of nurses to the profession (Huntington et al., 2011). Huntington et al. (2011) found that organizations were more concerned about power than they were about providing the best patient care and caring for their own staff but did suggest that having more managerial support would help to change this idea. They shared from their research that there was "still a climate of nurses 'eating their own' out there… and that nurses were not good at supporting each other" (p. 1417), which is similar to what my participants shared in their interviews. Musto, Rodney, and Vanderheide (2014) stated, "that a morally habitable work environment that is supportive of and encourages discussion on ethical issues intentionally fosters a positive, reciprocal relationship

between healthcare structures and moral agents" (p. 7). This desirable work environment can be achieved through primary prevention of incivility (Vessy, DeMarco, & DiFazio, 2011). As Vessy, DeMarco, and DiFazio (2011) suggested, these primary prevention activities can include, "organization wide awareness …strengthening those individual, interpersonal, and organizational factors, campaigns, policy development, and the use of risk markers to target high-risk groups and/or individuals for educational interventions and follow up" (p. 150). These types of activities can result in a workplace culture that fosters respect and discourages incivility, a bullying hotline for nurses, for example.

Education Recommendations

Nursing students are, in essence, the future of the nursing workforce. As such, education to inoculate students against incivility should begin as soon as nursing students enter their program. Modeling and teaching them during the educational years that incivility is not acceptable and giving them the knowledge and tools to deal with the behaviours when confronted, either as a student or a working nurse are essential to their success. Griffin (2004) and Griffin and Clark (2014) concluded that cognitive rehearsal was key for students to be able to deal with difficult situations during their education. Griffin (2004) and Griffin and Clark (2014) found that "being well-prepared, speaking with confidence, and using respectful expressions to address incivility can empower nurses to break the silence of incivility and oppression" (p. 541).

Armstrong (2017) conducted a study in acute care settings and "found that facilitated educational training sessions related to workplace incivility, in combination with experiential learning activities, assisted nurses in improving their understanding of workplace incivility and their communication skills. It has also been found to reduce

workplace incivility" (p. 100). Armstrong (2017) then applied a similar model and conducted sessions with nine nurses who worked in rural healthcare settings to see if the results would be the same. While the educational sessions did not change the number of uncivil events that nurses were privy to on the rural unit; she did see a change in the participants' ability to recognize incivility and that had increased confidence to intervene (p. 101). Educational sessions about what incivility is and how detrimental it is to the workplace culture are needed. As well, education about how to gain more insight and reflection about you as a person and professional will help individuals to be able to cope when confronted with these behaviours at work (this suggestion came from my participants).

Research Implications

My literature review in the area of nursing unearthed no research specifically examining the perceptions of nurses who have witnessed incivility between their nursing co-workers. As well, I noted that my participants seldom responded to my question about witnessing incivility, instead they responded by telling a story about being a victim of bad behaviours in their workplace. This indicates that there is room for continued research into how witnessing incivility and bullying in healthcare environments to learn why participants could not readily share about a time when they witnessed incivility between their nursing co-workers.

Limitations

A limitation to this study includes the low number of participants (11) and that I did not have any male nurses in my study. I did not exclude males but no males asked to participate. I was able to engage nurses from numerous workplaces and geographic

locations from across Canada; however, a larger number of respondents would contribute to the transferability of the study.

Another limitation to my study could be the number of working years of my participants as they were all fairly experienced nurses (one with five years and eight participants who had 10 years or more of experience). While an exclusion criteria was new graduate nurses, it is unknown if nurses with less working experience (i.e., 4 or fewer years of experience) would have changed any of the findings and recommendations of this study.

Conclusion

By delving into the experiences and perceptions of nurses who have witnessed incivility in the workplace, the findings of this study suggest that it not only exists, but also that little appears to be done about it. The nurses in this study described a strong culture of avoidance and 'looking the other way', perhaps partly because they were unsure how to take action or to enact change. As nurses, co-workers, managers, and bystanders, we need to be committed to facing this very real problem. We can start by no longer normalizing it through responses of rationalizing or tolerating incivility in the workplace. We can make a difference by educating ourselves about incivility and taking action when we see it. We can make a difference by putting supports in place for nurses at all levels with actionable plans for when incivility takes place. We can make a difference by educating student nurses about this issue and teaching appropriate responses to incivility. With over 360, 000 registered nurses in Canada (Canadian Institute for Health Information, 2013), we have a strong voice to enact change but we as nurses have to choose to use that voice and not accept the status quo of a culture of

incivility. Nursing is known as a caring and sometimes selfless profession; we must stand up for each other if change is to happen.

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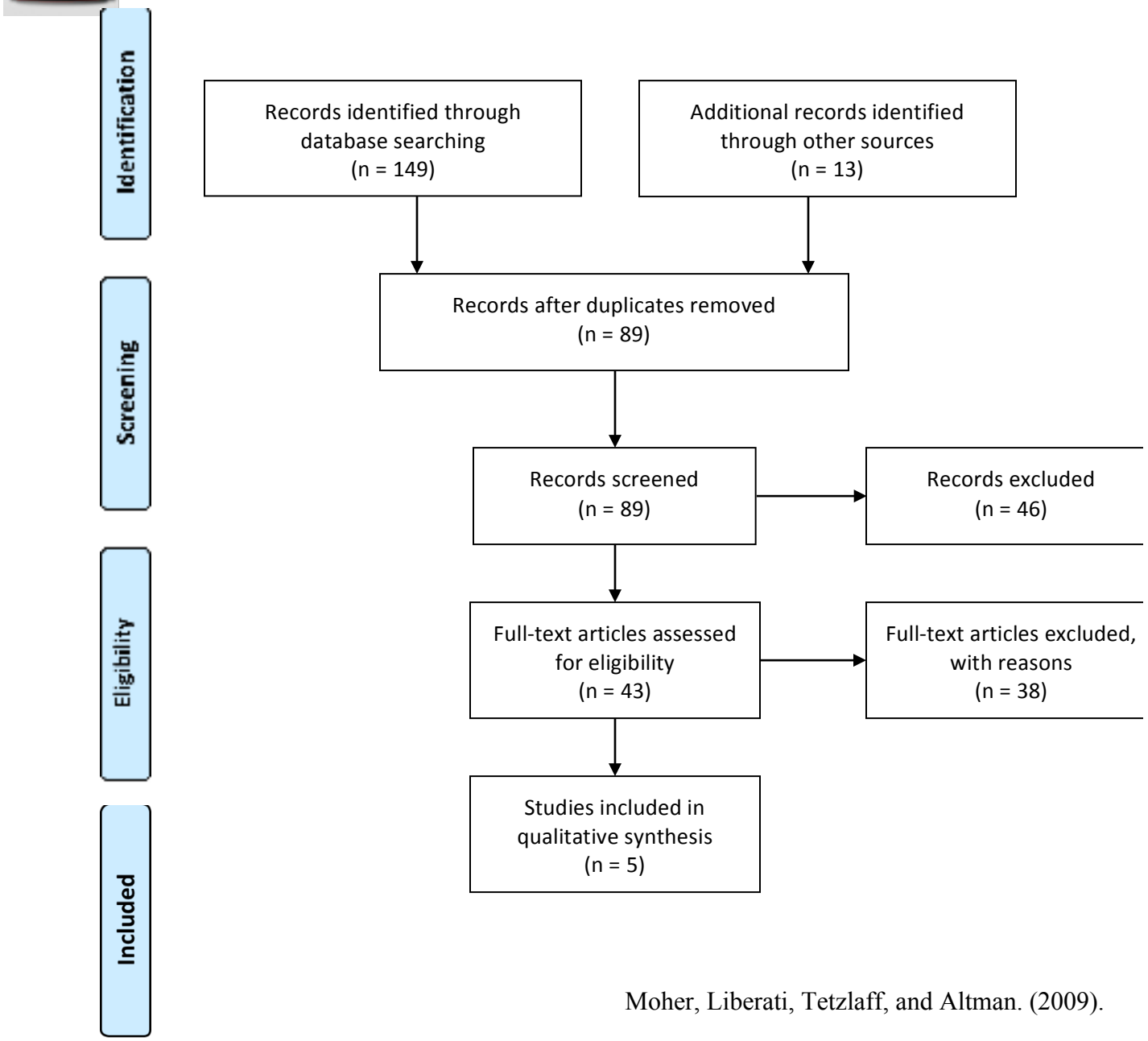
Appendix A: Prisma Chart

PRISMA 2009 Flow Diagram



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Appendix B: Research Information Letter (on TWU letterhead)

What are nurses' perceptions of nurse-to-nurse incivility in the workplace?

Date

My name is Julianne House and I am a graduate student at Trinity Western University in British Columbia. I am exploring the impact of witnessing nurse-to-nurse incivility in the workplace. As a nurse working in the health care system you may have experience working with other nurses and may have witnessed nurse-to-nurse incivility. I am inviting you to share your knowledge and experience of incivility through participation in this study.

If you participate, what will you be asked to do?

If you agree to be in this study, you will be asked to take part in a 30-60 minute interview on nurse-to-nurse incivility in the workplace. The time and location of the interview will be mutually agreed upon between yourself and I. The interview will be audio recorded for transcription and I will take notes during the interview. Following the interview I may contact you and ask for clarification of information you shared or if you have any further thoughts to contribute. This conversation will occur via telephone or email, which ever you prefer. Once I have completed analysis of all the data, and if you agree, I may ask for your thoughts on the patterns that have come out of the conversations.

How can you join this study?

If you would like to be a part of this study or have further questions, please contact Julianne House at _

If you have concerns about the study or would like to know more about Trinity Western University, please contact my supervisor Lynn Musto, Trinity Western University at _

Participation is completely voluntary. Thank you for considering this opportunity to take part in this study.

Julianne House
Principal Investigator

Appendix C: Consent Form (on TWU Letterhead)

Date (in header)

What are nurses' perceptions of nurse-to-nurse incivility in the workplace?

Graduate Student Investigator: Julianne House, RN, BScN; Trinity Western University School of Nursing

Supervisors: Lynn Musto, RN, PhD(c). Trinity Western University

Dr. Sheryl Reimer-Kirkham, RN, PhD; Trinity Western University

Purpose: My name is Julianne House and I am a graduate student at the Trinity Western University in British Columbia. I am conducting a study that explores the experience of nurses who have witnessed incivility between other nurses while in the workplace. There is a growing body of research suggesting that incivility in the workplace (or in health care), and witnessing incivility in the workplace, may have a significant impact on personal and professional lives of nurses. You have been asked to participant in this research study because you are a registered nurse who has experience working in health care and may have witnessed nurse-to-nurse incivility in the work place.

How to Participate: To be involved in this study I will ask you to participant in a semi-structured interview whereby I will ask you a series of questions that explores your experience of witnessing nurse-to-nurse incivility in the work place. The interview will last approximately 30 – 60 minutes and you will be given a list of the potential questions prior to the interview. There will be possible follow up emails or phone calls once the data is analyzed.

Potential Risks: You may experience some emotional distress related to your past experiences with incivility in the work place. If this does occur during interviewing, I will pause the interview and ask you if you would like to continue. Consent is ongoing and you may choose to end the interview at any time with out repercussions. As well, I will direct you to your organizational employee assistance program contact information.

Potential Benefits to Participating: Potential Benefits to Participating: By participating in this study you will be furthering our knowledge about the impact of witnessing incivility on bystanders in the workplace. As well, participants will be contributing to the nursing community by helping to create change in a difficult situation and the information gleaned from this research will be used to help develop recommendations or strategies to support individuals and organizations in dealing with incivility in the work place.

Confidentiality: Your confidentiality will be respected. No information that discloses your identity will be released or published without your specific consent unless required by law. No records that identify you by name or initials will be allowed to leave the Investigator's offices. All data collected will be kept in a locked filing cabinet or on a password protected laptop. Research participants will not be identified by name in any reports of the completed study.

Contact for information about the study: If you have any questions or desire further information with respect to this study, you may contact Julianne House (_) or her

supervisor, Lynn Musto; (_).**Contact for concerns about the rights of research participants:** If you have any concerns about your treatment or rights as a research participant, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at _.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment or studies if you are enrolled. You may withdraw from the study at any point before the end of the interview.

Signatures

Your signature below indicates that you have had your questions about the study answered to your satisfaction and have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that your responses may be put in anonymous form and kept for further use after the completion of this study.

_____ _____

Research Participant Signature Date

_____

Printed Name of the Research Participant signing above

Appendix D: Interview Questions

1. Tell me about a time when you experienced incivility in the workplace as a bystander.
2. What did you do after witnessing that event?
3. What or who was helpful in this situation?
4. What advice would you give a nurse who is in the same situation you were?

Updated Questions

1. Define incivility. Differences between bullying?
2. Tell me about a time when you experienced incivility in the workplace as a bystander.
3. What did you do after witnessing that event? What were thinking? How were you feeling? Did you respond in the moment? Should you have?
4. What impact did the incivility have on you? What did you do? What was it like for you? What do you think would help to decrease it?
5. Do you think that incivility is a character attribute?
6. What or who was helpful in this situation?
7. What advice would you give a nurse who is in the same situation you were?

Interview Prompts

- What were your options after witnessing this event?

- Were there options that you felt were not open to you?

- Were you supported in the decision you made in how you responded to the situation?

- What are your perceptions about incivility in the workplace? Is it an issue? What

is the seriousness of it?

- How did you respond to this situation?

- Do you still work with these people or person who is the bully? Has that relationship changed since your response?

Appendix E: Debriefing Script

Thank-you so much for your participation in the project.

Is there anything you would like to tell me about what it was like for you to participate in this project?

What did you gain from the experience?

Were there any negative aspects to your participation? And if so, what were they?