Incivility in Pre-registration Nursing Education: A Phenomenological Exploration of the Experiences of Student Nurses, Nurse Tutors and Nurse Mentors in a UK Higher Education Institution

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Abstract

This study provides a unique insight into incivility in pre-registration nursing education through a phenomenological exploration of the experiences of student nurses, nurse tutors and nurse mentors. Incivility is the display of intimidating, rude, disruptive or undesirable behaviours which, in the context of nursing education and practice, has the potential to impact negatively on student learning and patient outcomes. However, despite the potential consequences and the fact that it is a globally recognised phenomenon, very little is known about incivility in nursing education in the United Kingdom.

A phenomenological qualitative design was used to explore the experiences of students, mentors and nurse tutors who were assessing, teaching or studying, on a three-year degree level pre-registration nursing programme. Data was collected by conducting twenty-five in-depth, semi-structured, face-to-face interviews which were audio-recorded and transcribed verbatim and the framework for analysis was informed by the work of J. A. Smith, Flowers, & Larkin (2009) and Miles, Huberman, & Saldana (2014). Overall, four major themes emerged (*Distraction; Power; Impact on Learning; and Invisibility*) along with five minor themes (*Emotional Impact*, *Knowing and Not-knowing; Verbal and Non-verbal Incivilities; Lack of Interest; and Lack of Respect*). There were also minor themes specific to the individual participant groups such as *Being Nameless* (students) and *Lateness* (mentors).

The findings demonstrate the links between incivility, learning and emotion, and bring to the fore previously unseen dimensions such as *Invisibility* and *Knowing and Not-knowing.* They also identify a wide range of potential contributory factors. Of particular importance is the explication of learning impact as this aspect has hitherto been little explored and yet is of great significance to student learning outcomes and therefore ultimately, to patient care. Consequently, the recommendations have policy and resource implications for the providers of nurse education.

The research was conducted in a higher education institution in the south east of England where the researcher, a registered nurse teacher, works in an academic leadership role. It appears to be the first phenomenological exploration of incivility in the context of nursing education in the UK, and as such it provides a rich and contextualised exploration that others working in similar settings can learn from. It also adds a UK perspective to a phenomenon that is reported by nurse educators around the world, and so makes an original knowledge contribution to the global nursing community.

Acknowledgements

To my supervisors, Dr Di Duncan, Dr Denise Dollimore and Dr Adenike Akinbode, I couldn't have wished for a more dedicated, generous and supportive team, thank you from the bottom of my heart. To Di in particular, your confidence in me gave me the wings I needed to fly solo. I can't thank you all enough.

Contents

List of Tables

List of Figures

Chapter 1 Introduction

Chapter 1 introduces the subject of incivility in education, healthcare and society generally, and presents the primary and secondary research questions for initial consideration. The chapter concludes by setting out the 'shape' of the thesis with a description of its component parts, to facilitate navigation through the document.

1.1 Incivility in Education and Healthcare

Behaviours associated with incivility can be viewed on a continuum, ranging from the mildly disruptive, such as making snide comments or sighing heavily, to the overtly threatening, involving abusive language and sometimes even physical violence (Clark, 2013). For those on the receiving end, incivility may present as a minor, fleeting annoyance or as something that has a more significant meaning and/or long-term impact (Cortina, Magley, Williams, & Langhout, 2001; Del Prato, 2013; Lim & Lee, 2011; Pope & Burnes, 2009). As well as impacting at a personal level, incivility also has the potential to impact negatively on student learning (Gallo, 2012; Mikaelian & Stanley, 2016).

Reports of uncivil behaviour in higher education (HE), started emerging more than twenty years ago (Boice, 1996) with subsequent research identifying student-to-tutor incivilities such as unreasonable, aggressive, rude, threatening and even violent behaviour (Clark & Springer, 2007a; Jere, 2015; Lee, 2006, 2007; Morrissette, 2001). In one UK report, one thousand incidents of student aggression towards university staff were reported over a five year period (Tahir, 2007). However, incivility in HE settings is not limited to student behaviour; research has also identified many incidents of tutor-to-tutor and tutor-to-student incivility with examples including belittling and exclusionary actions, unfair and subjective treatment and demeaning or bullying behaviours (Anthony & Yastik, 2011; Clark, 2008c, 2008b; Lasiter, Marchiondo, & Marchiondo, 2012).

In healthcare settings, and particularly in hospitals, a rise in reports of incivility from around the world (Bar-david, 2018; C. Chan et al., 2009; Clark et al., 2010; Eka et al., 2016; C. Hunt & Marini, 2012; Ibrahim & Qalawa, 2015; Kim & Son, 2016; Natarajan et al., 2017; Rad et al., 2015) has been coupled with concern about its potential to impact negatively on patient care

outcomes (Hutton & Gates, 2008; S. Jenkins, Kerber, & Woith, 2013; Joint Commission, 2008; Randle, 2003).

The potential for incivility to impact on student learning, as well as its potential to impact on patient care outcomes, make this an important phenomenon for nurse educationalists to understand so that the design of nurse education curricula can incorporate strategies to teach, prevent, and manage uncivil behaviour. Currently, a lack of knowledge about incivility as it arises in nurse education in the United Kingdom (UK), prevents this from happening.

The thesis makes an original contribution to the evidence-base for nurse education by providing a unique insight into the complex and globally recognised phenomenon of incivility as seen from the perspectives of those who play a critical role in the student nurse's journey toward qualification as a nurse in the UK: the nurse tutors, nurse mentors and the students themselves.

1.2 Incivility in Society

The success of every society relies on the ability and willingness of its members to live together co-operatively and peaceably. Modern ideas about the behaviours necessary for a functional and well-ordered society can be traced back to the early civilisations of Rome and Greece, where considerable thought went into deciding what kind of behaviour was expected of citizens (Durrant, 1939; L. A. White, 2016). In subsequent years, behaviour favourable to the survival of societies has been influenced by religious, philosophical, legal, and political notions of what constitutes civilised behaviour, or civility. These notions continually evolve and re-form according to the dominant influences of the time and vary widely according to geographical and cultural context.

Traditionally, British society is known for its civility, with levels of politeness and tolerance that compare well to other countries (Griffith, Norman, O'Sullivan, & Ali, 2011). Nevertheless, standards of public behaviour are periodically debated (Buonfino & Mulgan, 2007; Ferguson, 2012), sometimes in response to highly publicised incidents of offensive or rude behaviour (Vincent, 2016). Commentators on civility attribute declining standards to factors such as the widespread use of personal technologies (Putnam, 2000; Schuldt, Tooten, Adrian, & Cox, 2012) and a growing dependency on social media (Anderson, Brossard, Scheufele, Xenos, & Ladwig, 2014; Papacharissi, 2004; Rowe, 2013; Shaw, 2013). The rapidity, informality and openness of

these technology-enabled modes of communication can contribute to information overload, confused self-identity and impaired family relationships (Keller, 2013). They can also demand a level of attention that detracts from time spent building conventional face-to-face relationships based on genuine levels of mutual understanding and appreciation.

Others see lowered standards of behaviour as a symptom of a society in which individualism and selfishness have increasingly replaced civic-mindedness (C. Cooper, 2008; National Centre for Social Research, 2013; P. Smith, Phillips, & King, 2010:2). Certainly, societies where individuals' behaviours are orientated towards helping others may be harder to develop in today's busy, transitory communities (Griffith et al., 2011), perhaps because of the limited time available to establish a sense of belonging and inter-personal responsibility. It remains to be seen whether politically-led initiatives to counter this, such as promoting civility through volunteering, charity work and social enterprise, will make any difference (Gov.UK, 2018).

At an individual level, it is the civil behaviours between one person and the next which smooth the passage of everyday life. Better still that our interactions should be kind, compassionate and selfless, but at the very least civility provides a socially acceptable way for people to behave with each-other and provides an important counter-focus to the types of negative behaviours associated with incivility.

1.3 Research Aim and Objective

The aim of this study is to gain an insight into the nature, impact, and contributory factors of incivility in pre-registration nursing education in the UK, as seen from the perspectives of the three key participant groups; student nurses, nurse tutors and nurse mentors.

The objective is to develop an understanding of the nature of incivility in pre-registration nursing education to inform educational policy and strategy which will minimise incivility in the learning environment and support student nurses to develop the professional behaviours expected of qualified nurses.

1.4 Primary Research Question

i.   What is the nature of incivility in pre-registration nursing education as seen from the perspectives of student nurses, nurse tutors, and nurse mentors?

1.5 Secondary Research Questions

ii.   What commonalities and/or differences exist between the experiences of student nurses, nurse tutors, and nurse mentors, in relation to incivility in pre-registration nursing education?

iii.   What is the impact of incivility in pre-registration nursing education?

iv.   What factors have the potential to contribute to, or cause incivility in pre-registration nursing education?

The link between the research questions and what is currently known about incivility in pre-registration nurse education, is explored through a review of the contemporary literature in Chapter 4.

1.6 The Shape of the Thesis

The overall shape of the thesis (Figure 1) is outlined here chapter by chapter to show the logicality of its structure and the progressive development of the ideas presented therein. There are nine chapters in total, the first six (1-6) of which lay the foundation of the thesis by setting out the research rationale, defining the research questions, key terms, and concepts, establishing the research context and identifying the approaches taken to fulfil the research aim. The subsequent chapters (7-9) focus on presenting and making sense of the findings; drawing conclusions in relation to the research aim and questions; identifying the originality of the contribution; and making recommendations for future research.

The following provides a brief overview of each chapter's content:

Chapter 1 introduces the research subject in order to set the scene for the thesis proper.

Chapter 2 offers a literature-informed rationale for improving the understanding of incivility in pre-registration nursing education along with an experientially-informed rationale which brings to the fore my personal interest in incivility.

Chapter 3 offers a portrayal of nursing and nurse education which draws on current and historical sources in-order to illustrate the relevance of the thesis to contemporary nursing in the UK. This further supports the rationale offered in Chapter 2. The chapter also introduces key concepts and terms of relevance to the study and clarifies what does and does not constitute incivility in the context of this study.

Chapter 4 provides a review of the contemporary literature which establishes what is currently known about incivility followed by the research aim, objective and questions which arise directly out of the knowledge gaps and omissions identified in the review.

Chapter 5 offers a rationale for adopting an interpretative phenomenological methodology and demonstrates the alignment between the aim, questions, methodology, and methods. It also addresses issues of credibility, quality and trustworthiness; considers the insider perspective; and sets out ethical considerations.

Chapter 6 explores how being a reflexive researcher has helped me to shape a credible and ethical thesis and includes an acknowledgement of my personal influences and biases along with an explication of my epistemological and ontological views which inform and influence the way I work.

Chapter 7 presents the thematic and non-thematic findings from each of the three participant groups.

Chapter 8 brings the findings together to make sense of them by framing them in the context of the existing evidence base to enable the originality of the contribution to be demonstrated.

Chapter 9 returns to the original research questions for a final consideration of the findings; acknowledges the study's strengths and weaknesses; and makes explicit the originality of the contribution. The thesis is drawn to a close with recommendations for practice and future research.
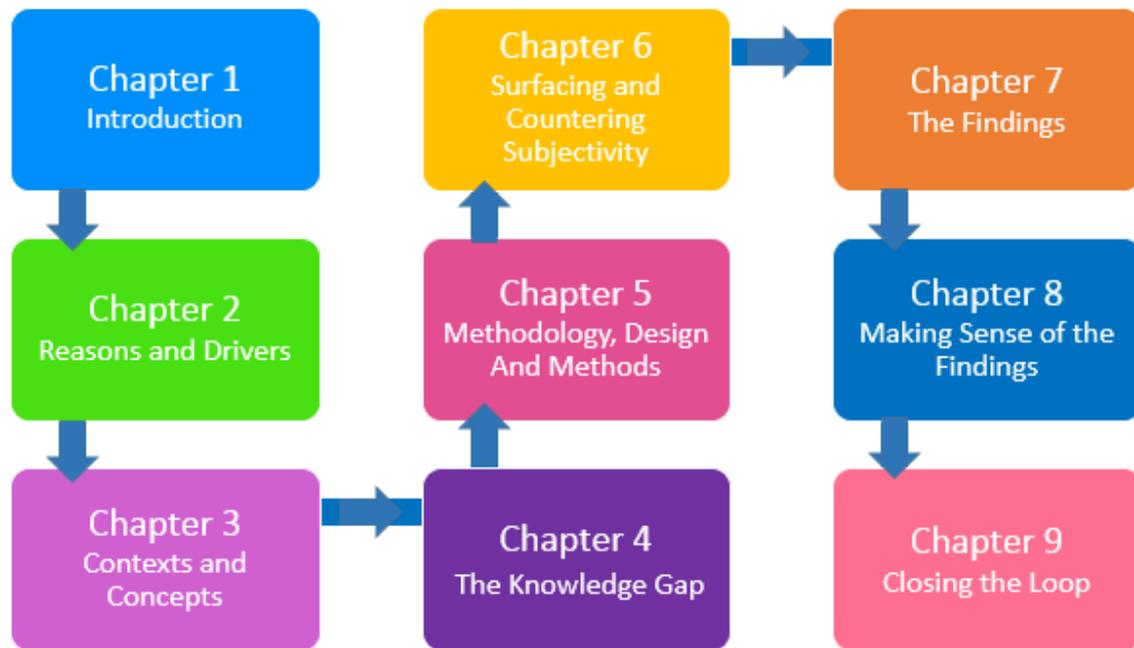
Figure 1 The shape of the thesis

1.7 Citation Style, Abbreviations and Glossary of Terms

The citation style used throughout is based on the American Psychological Association 6th Edition (APA 6th), the main features of which are described in Appendix A. A list of abbreviations and a glossary of terms is appended at Appendix B. The inclusion of this information is intended, in conjunction with the previous section, to enhance the clarity and readability of the document.

1.8 Chapter Summary

This short introductory chapter has provided an initial overview of the research subject area, established the primary purpose of the study and provided navigation and content-related information to guide the reader through the remaining chapters. Now that the subject, purpose and shape of the thesis have been established, the reasons and drivers behind the research will be set out for consideration in Chapter 2.

Chapter 2   Reasons and Drivers

The purpose of this chapter is to establish the rationale for undertaking research into incivility in nurse education and for focussing specifically on the experiences of student nurses, nurse tutors, and mentors. The chapter opens with an introduction to the concept of incivility in nursing education and a discussion about the key drivers for conducting research in this area. This is followed by a commentary concerning the relationship between incivility and the expected standards of behaviour and core competencies for nursing. The gap in knowledge that the study seeks to address is then identified and a justification for focussing on the three participant groups is put forward, along with a rationale for choosing to undertake the study in the researcher's own workplace. The chapter also offers a personal perspective on incivility as a precursor to Chapter 6 where issues of insider research and subjectivity are explored in more detail.

2.1   Incivility in Nursing Education

Incivility in education has been described as a speech or action which can disrupt the harmony of the learning environment so much as to effectively terminate learning (Clark & Springer, 2007b). Research in this area started to appear in earnest in the 1990's (Boice, 1996; Braxton & Bayer, 1999; Tiberius & Flak, 1999) possibly as a result of changing social norms of behaviour in the preceding decades (Boyd, 2004, 2006; Putnam, 2000). Braxton and Bayer (2004a) described the 1990's as a watershed period for the expanding focus on classroom incivilities. Research into incivility has continued into recent decades with both nurse tutors and students reporting encounters with incivility (V. Gonzales & Lopez, 2001; Moonaghi, Rad, & Sahzevari, 2014; Morrissette, 2001; Rowland & Srisukho, 2009; Todhunter, Cruess, Cruess, Young, & Steinert, 2011).

Incivility in nurse education refers to uncivil behaviour that arises in either clinical (practice-based) or classroom settings. Research in this area started to emerge at the start of the century and although literature originating in the United States (US) predominated in the earlier years (Clark & Springer, 2007a; Felblinger, 2008; Kolanko et al., 2006; Lashley & DeMeneses, 2000; Luparell, 2004; Marchiondo, Marchiondo, & Lasiter, 2010; J. E. Robertson, 2002), today it is by no means a US only concern with research arising from a diverse range of countries around the world including Egypt, Iran, China, Korea, Indonesia, South Africa, Oman and Canada (C. Chan

et al., 2009; Clark et al., 2010; Eka et al., 2016; C. Hunt & Marini, 2012; Ibrahim & Qalawa, 2015; Kim & Son, 2016; Natarajan et al., 2017; Rad et al., 2015; Vink & Adejumo, 2015). Exposure to incivility can bring about a range of negative consequences including fear of being failed; feeling disrespected, powerless or helpless; being upset and angry and loss of self-esteem, self-efficacy and confidence (Altmiller, 2012; Clark, 2008a; Del Prato, 2010). It can result in physiological or psychological distress for those involved and, at its most extreme, may even develop into life-threatening situations (Holguin, 2002).

For a full exploration of the concept of incivility, see Chapter 3.

2.2 Researching Incivility in Pre-registration Nursing Education – Key Drivers

There are two key drivers for exploring incivility in pre-registration nursing education, the educational period that prepares students to join the UK's register of qualified nurses. The first is the impact that incivility can have on learning and the second is the impact it can have on patient care.

2.2.1 Impact on learning

Incivility in educational settings can impact negatively on learning and on the creation of positive learning environments (Boice, 1996; Connelly, 2009; McClure, 2003). Positive learning environments can facilitate engagement in learning and deep approaches to study (McIntosh, 2010). This is of particular relevance for nursing where a strong knowledge base is considered the single most important tool a nurse can bring to the bedside (Ditmer, 2010).

From the student perspective, the impact of incivility on learning can take the form of reduced engagement with, or total disengagement from, the learning process (Biggs & Tang, 2011:34-57; Tantleff-Dunn, Dunn, & Gokee, 2002). Exposure to incivility has also been found to impact negatively on students' perceptions of their academic and intellectual development and students who are frequently exposed to classroom incivilities are thought to spend less energy thinking critically during the class and to be less engaged with educational materials afterwards (Hirschy & Braxton, 2004). Students have also been found to have a reduced commitment to their

institution when classroom incivilities are poorly managed which in turn impacts on their academic persistence (Braxton, Sullivan, & Johnson, 1997).

Lack of engagement with learning could ultimately impact on student nurses' ability to practice nursing competently and safely. It is therefore important to create learning environments where student nurses are able to engage fully in the learning process in-order to become the skilled and competent professionals the profession's regulatory body and the wider public expect them to be (Nursing and Midwifery Council, 2018b).

2.2.2 Impact on patient care

Incivility in healthcare settings, where patient care is the focus, can impact negatively on working relationships and standards of care. Students who are routinely exposed to uncivil behaviours, can internalise them as nursing norms, viewing them as acceptable, or even desirable nursing attributes (Corlett, 2000; Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011; Perry, 2009; Randle, 2003; Wilkes, 2006). The impact of incivility in clinical settings can be seen in the form of damage to the collaborative working relationships on which safe, effective patient care is reliant (Interprofessional Education Collaborative Expert Panel, 2011; Lancaster, Kolakowsky-Hayner, Kovacich, & Greer-Williams, 2015; Lemetti, Stolt, Rickard, & Suhonen, 2015). When these relationships are impaired, negative consequences such as decreased work satisfaction, increased staff turnover, reduced productivity, omissions in care, medication errors, substandard care and impaired patient safety, can arise (Hutton & Gates, 2008; Institute for Safe Medication Practices, 2004; S. Jenkins et al., 2013; Joint Commission, 2008; Randle, 2003).

Clark (2010), a leading researcher in the field of incivility, suggested that nursing education has a pivotal role to play in fostering civility in academic and practice environments by promoting civility among nursing students. Civility matters, she proposed, because treating each-other with respect is necessary for effective communication without which opportunities to understand other points of view are missed (ibid. 2010). Jenkins (2013) develops this idea further by suggesting that it is effective communication that fosters the collegial relationships that enable the delivery of safe, high quality care.

In summary, incivility in healthcare settings threatens the communication of care requirements, the working together to resolve problems and the pooling of effort and expertise that ensures that patients get the best care possible available to them.

2.3 The Link between Incivility and Standards of Professional Behaviour in Nursing

The teaching of professional behaviour, and through it the formation of a professional identity, is considered by many to be central to the purpose of nurse education (Guo, Shen, Ye, Chen, & Jiang, 2013; Hanson & Stenvig, 2008; Jokelainen et al., 2011; Kelly, 2007; Price, Hastie, Duffy, Ness, & McCallum, 2011; Wilkes, 2006). In the UK, standards of professional behaviour in nursing are determined by the profession's regulatory body, the Nursing and Midwifery Council (NMC), which sets out the expected standards in a written code of conduct (Nursing and Midwifery Council, 2018b). The standards are presented under four main headings: Prioritise People; Promote Professionalism and Trust; Practise Effectively and Preserve Safety; those of particular relevance to incivility are:

1. Treat people with kindness, respect and compassion;
2. Recognise when people are anxious or in distress and respond compassionately and politely; maintain effective communication with colleagues;
3. Work with colleagues to preserve the safety of those receiving care;
4. Support students' and colleagues' learning to help them develop their professional competence and confidence;
5. Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times.
6. Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
7. Be aware at all times of how your behaviour can affect and influence the behaviour of other people

The standards clearly demonstrate the expectation that nurses behave civilly, by being respectful and polite to others, communicating effectively, treating others kindly, and being self-aware. These are behaviours that are the antithesis of incivility.

Adopting professional behaviours is central to the development of professional identity. Del Prato (2013) suggested that this often happens as a result of informal experiences which occur beyond conscious awareness as part of an observed rather than taught curriculum. This 'hidden curriculum' is communicated in the way that teachers teach and behave in their relationships

with students (Bevis & Watson, 1989). Phillip Jackson, reportedly the first to coin the phrase 'hidden curriculum', suggested that the hidden curriculum emphasised certain skills which were not learning orientated but which were still necessary in-order to make satisfactory progress in education, such as conducting oneself courteously (Jackson,1968 p10-33 in Margolis, 2001). The influence of the hidden curriculum on professional formation in nursing has been reported widely in the literature (Allan, Smith, & O'Driscoll, 2011; Benner, Sutphen, Leonard, & Day, 2010; Field, 2004; Hall, 2006; Margolis, 2001). Del Prato's (2013) research on student nurses' lived experience of faculty incivility, concluded that nurse tutors that model caring and respect in the hidden curriculum contribute to the positive formation of future nurses. Similarly, student nurses in a study by Keeling and Templeman (2013) identified the observed behaviours of registered nurses as being significant in the development of their own professional identity whilst nursing graduates in a study by Hanson and Stenvig (2008), identified being a good role model as a valuable attribute of nurse tutors. It therefore appears that the behaviour modelled by nurse tutors and mentors is as important, if not more so, than the taught component of pre-registration nursing education (Corlett, 2000; Jokelainen et al., 2011; Wilkes, 2006).

The rationale for exploring incivility in nursing is grounded in the need to ensure that student nurses enter the nursing profession equipped with the professional behaviours expected of them and that patient care will be delivered by courteous, respectful, and caring nurses. The risk of failing to address incivility, is that uncivil behaviours will spill into practice affecting not only working relationships but patient care too (Clark & Springer, 2010).

2.4 The Link between Incivility and Core Competencies for Nurses

Entry to the UK nursing register requires student nurses to be assessed as competent, a concept defined as '"*the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions*" (Nursing and Midwifery Council, 2014). Standards for competence are set out by the NMC for each of the four fields of nursing: adult, mental health, learning disabilities, and children. They are organised into a framework with four domains: professional values; communication and interpersonal skills; nursing practice and decision-making; leadership, management and team working (Nursing and Midwifery Council, 2014).

The standard of competency for the second domain, communication and interpersonal skills, states that '…their [nurses] communications must always be safe, effective, compassionate and respectful'. For nurses to meet this competency standard they must do more than demonstrate they are cognisant of it, they must visibly uphold it in their daily conduct and behaviour. The standard requires them to be, at the very least, respectful in their interactions with others but also to work with others in such a way that standards of care are optimised. Having a competency standard which emphasises the importance of communication and interpersonal skills, sends a clear signal that nursing is as much about the way things are done as the things that are done.

2.5   Identifying the Gap in Knowledge

A review of the contemporary literature on incivility in nursing education revealed a substantial body of existing research. However, there was very little pertaining to nurse education in the UK. Given that the context in which nursing education takes place varies from country to country, it cannot be assumed that experiences of incivility elsewhere echo those of nurse students, nurse tutors, or mentors in the UK. Factors such as the way that nurses are trained and the way that healthcare is provided are two significant variants as are those of culture, language, and tradition, all of which contribute to the way that people behave and are expected to behave in social, education and workplace settings. As there is evidence to suggest that incivility can impact on both student learning and patient care, it is an important area in which to develop as full and as contextualised an understanding as is possible.

The gap in knowledge that this synopsis presents is therefore one of understanding the nature, impact and contributory factors of incivility in the context of pre-registration nursing education in the UK.

2.6   Focussing the Enquiry on the Key Actors in Pre-registration Nursing Education

In the UK, qualified nurses are prepared for professional practice via undergraduate and post-graduate degree programmes all of which must be approved by the NMC (the profession's

regulatory body), as well as the institution within which they reside. Successful completion of an approved programme leads to registration on the NMC's register of qualified nurses.

All nursing programmes, known as pre-registration programmes, are required to have 50% taught content and 50% supervised clinical practice. The taught component of the pre-registration programme is delivered by NMC registered nurse tutors in an approved higher education institution (HEI) of which there are approximately eighty in the UK. The supervision of clinical practice is undertaken by registered nurses, who are also qualified nurse mentors, working in a variety of settings including hospitals, community teams, general practice surgeries, and nursing homes. The responsibility for helping student nurses achieve their competency standards is therefore generally viewed as a shared one between nurse tutor and nurse mentor (Nursing and Midwifery Council, 2014). However, ultimately it is the student who is responsible for how they behave and what they learn; therefore, the sharing of responsibility would be more accurately viewed as a tripartite arrangement between nurse tutor, nurse mentor, and nursing student. Exploring the perspectives of these three key actors in the student nurse's educational journey is essential in-order to improve the understanding of incivility as it arises in pre-registration nursing education.

2.7   A Personal Interest in Incivility

The chapter so far has focussed on establishing the importance of exploring incivility in pre-registration nursing by virtue of its potential to impact on student learning and patient care. However, as a researcher who is adopting a subjective, post-positivist stance, it is important for me to declare my personal interest in the subject as well, as it is this personal interest that has nourished the study throughout. This section also provides a backdrop to Chapter 6 in which the use of reflexivity to counter subjectivity, will be discussed.

My interest in the phenomenon of incivility, is born of a myriad of personal, social, and professional experiences which, over the course of fifty years, have shaped my expectations of how people should behave with each-other. This includes informing my fundamental belief that civility is a cornerstone of good nursing practice and one which nurse tutors have a duty to promote if our future nurses are to establish effective relationships with those they work with and care for.

I grew up in the 1960s and 1970s in what was probably a fairly typical family setting of the time; self-employed father working hard to buy the family home, stay at home mum doing part-time cleaning jobs to earn 'pin' money and two children (my sister and I) attending the local comprehensive for a fairly non-aspirational secondary school education. At home, my sister and I were expected to be polite and well-behaved. We wrote thank you letters after receiving gifts, asked for permission to leave the dinner table, sat quietly when my Dad watched television and went to bed when told. It was the same at school; we didn't arrive late; talk in class or 'backchat' the teachers. In fact, the expectation of good behaviour on the basis of being seen and not heard, was the norm in my childhood.

In the early 1980s, I left home and started my nurse training where the expectation of 'good' behaviour continued. As a student nurse, I stood up if a senior nurse came onto the ward, did lots of unpleasant tasks in the sluice without question, and never challenged a doctor's opinion or decision. These 'good' behaviours were instilled into me by an older generation of nurse tutors who had been trained in the 'Nightingale' way, a method which was characterised by discipline, respect and subservience (Nightingale, 1860). Although the legacy and reach of this way of training was starting to recede by this point in time, it remained sufficiently intact to be of significant influence in the development of my values and beliefs as a young nurse.

In the relatively protected environment of the training school, it felt like everybody had the same way of doing things and the same high expectations of behaviour. However, this was not the case on the wards. Early on in my training I experienced a memorable instance of incivility when I was admitted as a patient to my training hospital for an operation on my feet. Afterwards I was lying on the bed with both feet in heavy plaster, in considerable pain and feeling very sick. When the night nurse came on duty I asked her if she could put the bed cradle (a device to lift the sheet clear of a patient's feet) in for me. She turned to me and said very coldly, that if I wanted it so much I could get it myself. I was so surprised that I burst into tears and didn't touch the call bell again all night. To this day I can still recall the shock of her response. I would now class this as an incivility, although at the time it was not a phrase I was familiar with.

My encounter with the abrasive night nurse wasn't the only time I experienced incivility during or after my nurse training. Although it wasn't especially common, the occasions that it did happen stay in my memory clearly. There was a consultant who swore at me because I refused to strap a dirty wooden plank under a patient's leg to keep it still and the ward Sister who told me she didn't want me back on the ward after my Grandma had died on a neighbouring ward, in case I had brought any 'germs' back with me. I also experienced passive-aggressive types of incivility

26

including an incident when a consultant surgeon introduced me to a patient as the Bottom Nurse (I was a clinical specialist in skin care at the time).

When I moved into HE as a nurse tutor I saw a few small instances of incivility; people talking over one another in meetings, students coming late to class and an occasional abrupt or rude email. Although I did not work in the pre-registration nursing teaching team, I heard various anecdotes about incivility in this context as well. These included the story of the student who stood up in class and told a lecturer her lecture was boring and the student who made obscene gestures to another student who was doing an oral presentation. On one particularly memorable occasion, a number of nursing students were asked to leave the University's library because they were being 'rude' to members of staff.

When I think back over my twenty years as a clinical nurse, and a further fifteen as a nurse tutor, I realise that for the majority of the time people behave civilly to each-other. However, whenever I personally experience incivility or see colleagues being treated uncivilly, it always strikes a discord. The more serious the incident the greater the impact and yet I know that I am capable of incivility too, even though I would not willingly upset or disrespect another person. In reality, there are times for most of us when tiredness, stress or distraction negatively influence our behaviour and however infrequent, it is the instances of incivility that tend to leave a longer, lasting impression than those of civility. It was these impressions that captured my interest, sufficiently to want to understand more about this most human of phenomena and how it manifests in the context of my dual professions of nursing and education.

2.8 Research for Practice

As a registered nurse tutor working in an HEI in the UK, the topic focus has allowed the researcher to engage in research that has everyday relevance for teaching practice. It has also maximised the opportunity to realise the research objective by involving and influencing colleagues as the research progresses. Costley, Elliot, & Gibbs (2010) highlight that undertaking research within the researcher's own community of practice means that colleagues are more likely to have a vested interest in the process and outcomes and therefore be co-operative in terms of access and data collection. However, there are both advantages and disadvantages to conducting research as an insider and these issues are explored further in Chapter 5, section 5.8, and Chapter 6.

2.9 Chapter Summary

This chapter has established the rationale for undertaking research into incivility in pre-registration nursing education by highlighting the potential for incivility to impact negatively on student learning and standards of patient care. The gap in knowledge that the thesis addresses has been identified as one of *understanding the nature, impact, and contributory factors of incivility as it arises in pre-registration nurse education in the UK;* this gap is explored more fully through a critique of the literature in Chapter 4. The reason for exploring the perceptions of the key actors in the pre-registration education period (nurse tutors, nurse mentors and nursing students) has been given and the links between incivility and nurses' professional behaviour and core competencies have been established. The chapter concludes with an outline of the researcher's personal interest in incivility and a brief explanation of the reason for choosing to conduct the study in her own practice setting.

Having provided a rationale for the research in this chapter, the next one will establish the context for the study and define the key concepts which lie at the heart of the thesis.

Chapter 3 Context and Concepts

Building on the rationale offered in Chapter 2, this chapter provides a further foundational layer to the thesis by providing a rich context for the chosen subject area and clarity on the key concepts informing the study. Firstly, a portrayal of nursing and nurse education which draws on historical and contemporary sources is offered, so that the relevance of the thesis to the context of modern-day nursing can be appreciated. Secondly, the key concepts explored in the study are defined and distinctions made between similar or related concepts in-order to promote a common understanding of terms between researcher and reader. As well as adding depth to the findings, this articulation of context and concepts will enhance the transferability of the findings to other settings by enabling other healthcare professionals to judge for themselves how the findings of the study relate to their own sphere of practice.

3.1 Nursing and Nurse Education - Past and Present

A portrayal of nursing and nurse education which draws on historical and contemporary sources.

3.1.1 The evolution of nursing

"The story of nursing is very old. Throughout the ages, crimson with the blood of battle and aflame with cruelty and greed and lust, there were those who dressed the wounds of friends and foe, who fed the hungry, who clothed the naked, who comforted the sick, held out to them the hand of healing and brought gladness to weary eyes" (Bett, 1960, p11).

With a history rich in battle, disease, and disaster, modern humans have always had those who need care and those who were prepared to give it. Whilst it is beyond the remit of this chapter to undertake a detailed exploration of nursing history; it is possible to identify the key historical markers in the making of the nursing profession as it is known today in the UK.

In ancient times, medical care existed in various guises and the role of the physician was already an important one in society. However, there was scant mention of nurses and certainly limited reference to nursing as being anything more than a familial duty (Seymer, 1957). Where nurses are mentioned it is commonly with reference to an attendant type role, typically working

under the direction of a physician. In Ancient Rome, the male slaves were trained to serve as hospital attendants in the military hospitals whilst family nursing duties fell into the province of the women of the house. Likewise, in Ancient Greece the care of the seriously ill was entrusted to the physician and his students whilst general caring duties were left to the women of family (Bett, 1960; R. Porter, 1999).

However, as populations grew and civilisation advanced so did the need to manage larger numbers of people with illness, injury, or disease. One of the earliest hospitals on record was Basileas, founded by the Greek bishop, St. Basil. Built in 370 A.D just outside the town of Caesarea in Asia Minor, Basileas, comprised separate buildings for lepers, the elderly, the mentally ill, convalescents, and orphans. St. Basil himself is said to have taken a keen interest in nursing which he described as the most noble of all professions (Bett, 1960). Around the same time (in 390 A.D.) a free hospital was established in Rome by a wealthy Christian woman called Fabiola, who is said to have spent much of her vast fortune on the poor and sick. After her death, a letter written by her contemporary St. Jerome, referred to her "gathering in all the sufferers from the streets of Rome, with maimed noses, leprous arms and diseased flesh, and giving all a nurse's care" (Bett, 1960). This letter has been referred to as the first literary document in the history of nursing (Seymer, 1957).

As the popularity of Christianity rose in the Western world, monasteries and convents were built to house the Christian communities who wished to devote their life to Christ. At the same time many of these communities adopted the role of caring for the sick as an act of Christian devotion (Porter, 1999; Seymer, 1957). In many cases the care was carried out by women from wealthy families who joined the convent as widows, to seek sanctuary or in pursuit of a devout and pure life. These were considered gentlewomen, of high social standing, good manners and sound morals (Bett, 1960).

Over time, the knowledge of the origins of sickness gained by ancient civilisations such as those of India, Greece, Egypt and Rome, became lost and the nature of care became dominated instead by the Christian doctrine of the time (Seymer, 1957). Nursing continued to be an act of religious duty, charity, and kindness throughout the middle-ages (from 500 to around 1450), with the nurse's primary duty being to prepare the immortal soul to meet its maker rather than to nurse a sick body back to health (Bett, 1960).

In England, hospitals as separate entities started to appear around 800 A.D., although still firmly

linked to various religious communities or orders. There are mentions of hospitals in St.Albans in 794, in York in 937, in London in 1123 and Worcester in 1268 (Porter, 1999). However, when King Henry VIII broke his papal bonds in 1534 the monasteries and convents of England were dissolved, their goods confiscated and the various religious orders within them widely scattered. The gentlewomen who had pursued nursing as a vocation were left with no sanctuary, and the poor and the sick were left to fend for themselves. It was only on his deathbed in 1547 that Henry recognised the need for hospital care in place of the monasteries and formally founded London's two Royal Hospitals; St. Bartholomew's and St. Thomas's.

In the centuries that followed, charity (voluntary) hospitals continued to be founded in London and the wider country, typically staffed by women from the local population. The hospitals varied in size and type from the local cottage hospitals to the specialist ones and the large city types. As well as these voluntary establishments, there were municipal hospitals such as those set up for the psychiatrically ill and the impoverished and sick, the latter of which evolved into the paupers' workhouses of the 19th century (R. White, 1985). There is little evidence about nurses during these years although many are purported to have come from the lower classes and to be of ill-repute (Baly, 1977). Florence Nightingale famously described them as "those who were too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else" (Nightingale 1857 in University Of Glasgow, 2013), a dramatic change from the image of kindness and care that the nurses of the religious orders had embodied.

By the 19th century, England's population had expanded greatly, and the country's economic base had moved from an agricultural to an industrial one. The densely populated towns, rudimentary sanitation, high levels of malnutrition and poor working conditions of the newly industrialised nation had escalated the need for effective healthcare. Against this backdrop, the provision of care under the old Poor Relief Act 1601 (United Kingdom, 1601) was changed by the Poor Law Amendment Act of 1834 (United Kingdom, 1834). The passage of this act resulted in much harsher conditions in the workhouses with all but the neediest being given relief leading in turn to a larger portion of the workhouse population needing nursing care as well as food and shelter. In 1859, Louisa Twining, a social activist, wrote to The Times about the poor quality of workhouse nursing. "What else could be expected?", she wrote, "for to be the lowest scrubber in a hospital was considered a higher post than to be in sole charge of a workhouse ward" (Twining, 1859 in Rivett, 2013). The Lancet Commission on workhouses, described the early pauper nurses as ignorant and rough (Lancet Commission, 1880), echoing Twining's observations on their lowly status.

It is not until the latter half of 19th century that the image of nursing started to improve again as it became more organised and more standardised (R. White, 1985). This was mainly due to the efforts of Florence Nightingale who founded the first nurse training school in England at St.Thomas' Hospital, London in 1860. The move toward proper training programmes for nurses began to resolve the disparities between nurses in different settings and by the end of the 19th century the Lancet Commission observed that the ignorant, rough poor law infirmary nurses were slowly being replaced by nurses who they described as intelligent, trained nurses who, they said, 'Performed their onerous duties skilfully' (Lancet, 1880).

The increasing respectability of nursing was helped by the Government's commitment to establish a national nursing register. This was enabled by the passage of the Nurses Registration Act just after World War I (United Kingdom, 1919), which prescribed the setting up of the General Nursing Council (GNC) and led in due course to a mandatory curriculum and common examination for all nurses. In effect, the Act acknowledged the importance of nursing to the nation by recognising the need for nation-wide standards of education and examination. As nursing was changing so too was the context in which it took place. The two World Wars gave British nurses opportunities and experiences on a scale and of a type not seen before, both at home and abroad. First-hand evidence describes them caring for terrible physical and psychological injuries, winning medals for bravery and honour and even dying in action (Appleton, 2013; Stokes, 2013). Through both wars they worked in difficult conditions, with low pay and long hours (R. White, 1985). Not surprisingly the public image of nurses as a result of their work during the wars was greatly enhanced (Baly, 1977), as nurses were depicted in the media as angelic, kindly and brave.

When the NHS was established just after the war in 1948 (United Kingdom, 1946), it became imperative to organise nursing on a national basis. Most significantly, the coming of the nation's new health service, delivered free at the point of need, signalled the end once and for all of nursing as a charitable activity. Nurses across the nation would all now be paid, trained and registered in the same way as a result of the changes required by the Nurses Registration Act (Seymer, 1957). The implementation of the Act signalled the final step in the transition of nursing from vocation to profession and with it was lost, once and for all, the idea of nursing as a purely altruistic and charitable calling.

Nursing was a respectable and popular career choice throughout the 1960s and 1970s. It also continued to be dominated by women drawing its students mainly from the school leaver population, typically of middle-class background (R. White, 1985). With a two-tier training

structure in place, the more academically able students could undertake the State Registered Nursing exam and the more practically focussed, the State Enrolled Exam. Either way, nursing was an attractive job choice offering a measure of social independence and lifelong, varied employment opportunities. At a time when women had relatively limited lifestyle, career, or academic opportunities, these were important considerations.

Although there were huge social and cultural changes in the post-war years, particularly for women, the hierarchical tendencies of nursing persisted, as exemplified by reports of fierce ward Sisters, staff segregation and strictly regimented nursing routines (O'Dowd, 2008). Despite this, or perhaps because of it, nurses continued to be held highly in the public's esteem, their goodly image fuelled by their portrayal in the media variously as hard done by angels and willing handmaidens.

Today, the image of nursing in England is different again. Nurses are no longer held to be infallible or beyond criticism; instead public opinion seems to have them lying on a virtual scale somewhere between 'angel above reproach' and 'scrubber of ill-repute'. The human side of nurses, flaws and all, has been portrayed in many television programmes such as the BBC's 'Casualty' and Channel 4's 'Confessions of a Nurse'. Some individuals, like Beverley Allitt (a nurse who was convicted of murdering four children in her care), have fallen spectacularly from grace, taking their nursing reputation with them (Batty, 2007), whilst the revelation of appalling standards of care such as those experienced at the Mid-Staffordshire Trust (Francis, 2013) and the Winterbourne Residential Home (Department of Health, 2012c) cost the entire profession's reputation dear. However, for every nurse who gets it wrong there are many more who are doing it right; nurses who are working to the same ideals as their forebears, who are passionate about what they do and who do it with care and compassion.

This exploration of nursing's historical hinterland illustrates how nursing has evolved from its earliest homely beginnings to what, in the UK, is a nationally regulated and uniformly educated profession. Throughout this evolution, nurses have been held for the most part in high public regard, known for their caring and altruistic concern for others. The occasional slippage of image in recent years, lends weight to the importance of understanding a phenomenon like incivility which, if allowed to escalate, threatens not only the public's perception of nurses but the actuality of providing the kind of exemplary standards of patient care that the traditional values of the profession demand.

3.1.2 Nursing in the UK - the contemporary reality

The majority of the UK's nurses are employed by the National Health Service (NHS) (NHS Confederation, 2018). Since its establishment in 1948, the NHS has developed into one of the world's largest publicly funded health services and as a result is a highly diverse and complex organisation to work within. Originally designed to serve the combined populations of England and Wales (around thirty eight million at the time), it now serves an estimated population of fifty-four million for England alone (Office for National Statistics, 2018). Along with the challenge of providing for a vastly increased population size, today's NHS, along with its sister health services in Scotland, Ireland and Wales, must meet the complex health needs of an ageing population in a climate of severe financial constraint.

In the UK and in England specifically, healthcare services have been subjected to multiple reforms during the last twenty-five years, most recently in the shape of the Health and Social Care Act 2012 (Department of Health, 2012b). Along with frequent restructuring of services there has also been an ongoing drive to improve productivity (Appleby, Ham, Imison, & Jennings, 2010; NHS England, 2014; J. Smith, 2012) within long-standing budget constraints (J. Ford, 2013; Ramesh, 2013; R. Robertson, Wenzel, Thompson, & Charles, 2017). These conditions have made working within the healthcare challenging, worsened in many circumstances by the rapidly ageing population, increasing levels of comorbidity (concurrent disease or illness), increased lifespan and the growth of increasingly complex and technical healthcare interventions (Department of Health, 2010; Health Education England, 2014). It is unsurprising therefore that the national healthcare system sometimes fails, dramatically so on some occasions. Highly publicised cases like Mid Staffordshire Hospitals NHS Trust (Francis, 2013) and Winterbourne Residential Home (Department of Health, 2012c), as stated previously, will have done little to re-assure the public that the nation's health and well-being are in safe hands.

For nurses, job losses (Royal College of Nursing, 2011), increasing expectations of performance (Royal College of Nursing, 2013) and high staff turnover (Health Education England, 2014; Limb, 2017) have further contributed to what for many are already stressful working conditions. Overall, the nursing workforce is an ageing one with a disproportionate percentage of older workers in the profession (Buchan & Seccombe, 2011), and falling numbers of incoming trainees (House of Commons Health Committee, 2018). Although the impact of inadequate nursing numbers on healthcare delivery has long been recognised (Buchan, 1999) attempts to counter it with a 'widening participation' agenda in the 1990s were only partially

successful. For many older nurses, working part-time or taking early retirement are attractive choices in a job that places high physical and emotional demands on its employees (Buchan et al., 2008, Royal College of Nursing, 2007). The emotional strain of caring for people who have extreme physical and/or emotional needs leaves nurses vulnerable to stress and burnout (V. M. Mason et al., 2014; Melvin, 2015). Sickness due to stress has increased significantly in recent years (Kirk, 2015; Royal College of Nursing, 2013) and UK nurses report one of the highest rates of burnout across Europe (Heinen et al., 2013). Nurses leaving the profession early cite factors such as stress, exhaustion, lack of autonomy, competing family demands, and the difficulty of adjusting to the rapidly changing needs of the modern NHS (Andrews, Manthorpe, & Watson, 2005; Bennett, J. and Mabben, 2007; Buchan et al., 2008; Merrifield, 2017).

In real terms, the number of qualified nurses fell from 317,370 in May 2010 to 315,525 in December 2014 (Royal College of Nursing (RCN), 2015), partly as a result of a reduction in the number of training places offered between 2010 and 2013 (King's Fund, 2013). Now, despite calls to the Government to increase the number of nursing applicants urgently or risk 'patients paying the highest price' (Royal College of Nursing, 2018), the staffing crisis is set to get worse due in part to the removal of the NHS bursary in 2017 which contributed to a 23% fall in applications for nurse training in 2017-18 (S. Ford, 2017). It seems that the link between chronic staffing shortages and low standards of care, as identified in the public inquiry into the Mid Staffordshire Hospitals NHS Trust patient care scandal (Francis, 2013), has yet to translate into a lesson learned.

This synopsis of contemporary nursing in the UK, shows that nurses are often working in highly challenging and stressful environments. It is in these same environments that student nurses spend 50% of their time and so it is pertinent to consider that uncivil behaviours arising between nursing students and their mentors do so in circumstances that differ greatly to those of the academic setting, where the other 50% of the students' time is spent. Therefore, incivility that arises in the clinical environment (commonly referred to as 'placement') may be different in nature and impact to that which arises in the university setting. It may also differ to that which arises in nursing education in other countries where the training model may differ and where the context of nursing care delivery may be quite different.

3.1.3 The evolution of pre-registration nursing education in the UK

The third strand of the UK nursing context to consider is the educational one. When considered alongside the historical backdrop and contemporary reality of nursing, the past and present

context of nursing education completes the overall picture of how nursing in the UK has evolved to where it is today.

In the years following the establishment of the NHS, the education of nurses was the subject of much debate as exemplified by the Platt Report (Royal College Of Nursing and National Council of Nurses of the United Kingdom, 1964) and the Briggs Report (Committee on Nursing, 1972), both of which stressed the importance of reforming nurse education. At the time, training was still delivered apprentice style by 'Schools of Nursing' attached to hospitals, with student nurses receiving support from school-based nurse tutors, clinically based nurse tutors and qualified nurses on the wards or in the community; a model of education based on that of the earliest pre-NHS nursing schools. However, despite the calls for reform, it took until the 1980's for any real change to happen. It did so with the advent of the 'Project 2000' initiative (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1986), an ambitious initiative designed to move nurse education away from the control of the NHS and into the province of higher education (Lord, 2002). As a result of its implementation in the early 1990s, all Schools of Nursing were dissolved, and nurse training moved into HEIs where students completed either a diploma or degree route to their nursing qualification. In 2009 (National Archives, 2009). it was announced that from 2013, the only route into the profession would be via undergraduate or post-graduate degree and as a result the diploma route was phased out.

Although the changes to pre-registration nursing education in the 1990s were of major significance to the profession, there was one more important change still to come. This came as a result of the 'Making a Difference' report (Department of Health, 1999), which expressed concerns that nurses emerging from the new educational model did not possess the full range of skills required for safe, effective practice. The report argued for the re-establishment of the links between HEIs and clinical settings to ensure gaps between theory and practice were minimised. The adoption of a mentoring framework (English National Board and Department of Health, 2001) mitigated the problem to some extent, by providing training for qualified nurses to support students in the clinical practice setting. Although uptake was optional at this point, the role was to became a cornerstone of pre-registration nursing education when mentorship for nursing students became a mandatory requirement in 2006 (Nursing and Midwifery Council, 2006). This requirement bound together clinical practice and academia with assessment in practice undertaken by the nurse mentor and assessment in the university setting by the nurse tutor.

The move from hospital-based training schools to university marked the dissolution of an educational structure that had been in place for more than a century. Two changes of particular note took place as a consequence: firstly, students were given supernumerary status which meant they were no longer part of the clinical areas' staffing numbers. This move aimed to ensure students could make the most of the learning opportunities their clinical placement offered them. It was also intended to prevent them being used as 'another pair of hands', where the opportunity to learn takes second place to the clinical demands of the area. However, the move also created a sense of separation from the clinical team i.e. in the minds of some clinical staff the student was no longer 'theirs', they had instead become 'the University's'. For the student it sometimes led to a lack of responsibility or commitment to their placement and a lack of sense of belonging to either their University or their placement area as they moved regularly between the two. In addition, the pressure on healthcare services has led to reduced availability of clinical placements for nurse students and staff shortages along with staff development cuts have resulted in fewer mentors to assess them. This means that mentors often mentor one student after another for long periods of time which can lead to overload and dissatisfaction (Omansky, 2010). It is important to understand this aspect of the student nurse experience when considering their experiences of working with nurse mentors.

The second change of note was the amalgamation of the School of Nursing tutor and clinical nurse tutor roles; these became university-based teaching roles instead. At the same time, most Schools of Nursing moved into university premises thereby becoming distanced from the clinical areas they served. Nurse teaching roles became caught up in academia with the benefit of raising the scholarly standard of nurse education but with the disadvantage, some would say, of creating a disconnect between education and the clinical area (Corlett, 2000; Hatlevik, 2012; Rolfe, 1996). Being aware of this so-called gap between education and practice, one that certainly exists on a physical plane but possibly on a cognitive one too, is necessary when considering the experiences of all involved in pre-registration nursing education.

3.1.4 Pre-registration nursing education in the UK – the contemporary reality

As stated previously, contemporary pre-registration nurse education is delivered via undergraduate or post-graduate degree programmes comprising 50% of taught content and 50% supervised clinical practice, the latter of which can only take place in an approved placement area. All programmes must be validated by the Nursing and Midwifery Council (NMC), the profession's regulatory body. The taught component must be delivered by NMC registered nurse tutors (or working toward) and the clinical element must currently be

supervised and assessed by a qualified nurse mentor or sign-off nurse mentor (Nursing and Midwifery Council, 2008; Nursing and Midwifery Council, 2011), although this model is set to change soon (Nursing and Midwifery Council, 2017). As described in Chapter 2, students have to achieve core competencies before registration and adhere to the profession's code of professional behaviour (Nursing and Midwifery Council, 2018b).

The decision to make nursing an all graduate profession from 2013 was the last step in a long journey toward professional recognition. Many nurses join the profession today with the same values and beliefs as those that joined 100 years ago; however, the role of the nurse has changed dramatically. Today's nurses are driven by targets and outcomes and work in a climate where stress is often the norm. The NHS is unwieldy, complicated, and financially crippled. Survival rates are higher due to advances in medical care, but survival is not the same as recovery and for many patients there are prolonged periods of serious illness or slow rehabilitation which place further demands on nursing services. Factors such as the ageing population and bed closures result in constant pressure on in-patient beds resulting in higher numbers of sick patients to be cared for as those that are only just well enough are discharged home to make way for those that need the hospital bed more. Meanwhile successive Governments have focussed on moving care into the community and now highly dependent patients are often nursed at home rather than in a hospital, leading to a greater strain on community nursing services.

The experience of student nurses is tightly bound to whatever is happening in the NHS, where the majority of clinical placements are undertaken. The intense pressure on healthcare services has led to fewer clinical placements for student nurses and staff shortages, along with cuts to staff development budgets, have resulted in fewer mentors to assess them. In this and other respects, the student nurse's experience differs significantly to that of the typical undergraduate university student. The placement aspect in particular brings many additional challenges that other students do not have to deal with including dealing with patient death and emergencies (Gidman, McIntosh, Melling, & Smith, 2011).

Compared to other undergraduate students, nursing students also have fewer hours available for part-time work, so finances can be tight. When this research commenced, all student nurse places in England were commissioned from HEIs on behalf of the NHS through the Local Education and Training Boards (LETBs). Students commissioned through this system had their student fees paid and were eligible to apply for an NHS bursary to support themselves during their studies. By the end of the study, the Government had dismantled the commissioning and

bursary system and introduced standard student fees for all nursing students in England (HM Treasury and Osbourne, 2015). Arrangements for reimbursement for placement travel and parking, both of which can be considerable, were unclear at the outset of the changes adding further to the financial uncertainties that students face. In addition, mature students, of which there are many in nursing, often have to cope with the demands of children and/or family dependents (Shepherd, 2009) as well as the associated costs of child and/or social care.

Added to these considerations is the fact that pre-registration nursing programmes are longer than standard undergraduate programmes because of the need to complete a minimum number of placement hours before registration. Unsurprisingly, given the demands on nursing students, pre-registration programme attrition rates can be high and the causes complex (Glossop, 2002; Urwin et al., 2010).

The fact that student nurses have a 'non-traditional' academic life in which their study pattern and placement activity differs greatly to that of most university students, means that their experiences of incivility may be very different to those of other students in UK higher education. As stated previously, understanding the context of contemporary nurse education is therefore important in enabling the reader to fully contextualise, and make sense of, the findings.

3.2 Defining the Key Concepts

As well as understanding the professional and educational context of the study, it is also important to establish a common understanding of the key concepts of civility and incivility. Walker and Avant (1988:20) describe a concept as a mental image of a phenomenon, an idea or a construct in the mind about a thing or an action. Communicating these mental constructs can be problematic, particularly when the concept is complex or new. However, as concepts are the basic building blocks of theory (Rodgers, 2000), it is important to define their key attributes so that they can be explored and discussed effectively. This can be done through a process of concept clarification which advances the classification or characterisation of phenomena (Tofthagen & Fagerstrøm, 2010). This is an important process in research because poorly articulated or ambiguous concepts will be open to misinterpretation and ultimately limit the value of the findings by creating a 'weakness' in the fabric of the theory.

In this section, the process of defining key concepts includes an exploration of each concept in relation to common everyday context as well as their usage in language and literature. Similarities and differences between the key concepts and respect and bullying are also considered, as these terms are often used in overlap or in conjunction with the key concepts.

3.2.1 Key concepts: civility and incivility

The concept of incivility, which is central to the study, is used to describe behaviours that are considered by nurse tutors, mentors, and students to be inappropriate, impolite or disruptive to learning and healthcare delivery. However, before considering incivility, one must first determine what civility means as these are conjoined and inseparable concepts; that is to say, it is impossible to understand one without understanding the other.

Civility is a term in such widespread use it is difficult to pin it down to a single, commonly understood definition, not least because it is used in two quite different ways. There is the civility that relates to social or political standing as in 'civil rights' or 'civil disobedience' and the civility that refers to the face-to-face interactions of everyday life (Boyd, 2006). It is the latter usage that is of interest to this study, and so it is on this aspect that the discussion will focus. In this sense, the word civility simply refers to 'the way we treat one another' (Forni, 2003; Griffith et al., 2011). This could include any every day interaction from saying thank you when somebody holds a door open for you to apologising for arriving late for a meeting. At its simplest level, civility is about the day to day niceties that make every day human interactions more pleasant to participate in.

Originally stemming from the Latin *civilis*, which meant of or relating to civilians, early uses of the term civility include 'the position or status of being a citizen' (as illustrated by examples dating from 1384 in the Oxford English Dictionary (OED); 'the observance of the principles of civil order; orderly behaviour; good citizenship' (as illustrated by examples from 1537-1759) and 'the behaviour or speech appropriate to civil interactions; politeness, courtesy and consideration' (as illustrated by examples from 1561-1991) (OED, 2013). In later OED entries the term loses its overtly positive tone and becomes more suggestive of a minimum behavioural requirement, as in 'an act or expression demonstrating a minimum degree of courtesy' and 'the minimum degree of courtesy required in a social situation or the absence of rudeness'. For example, 'She was obliged for civility's sake to dance several times' (quote dated 1953).

In dictionaries and beyond, there is no single, agreed definition for civility or indeed for incivility. Given that these are everyday human phenomena which are perceived in a multitude of ways by differing societies and cultures around the world, this is unsurprising. However, many definitions for civility have been proposed, a sample of which are given below to illustrate that there is a broadly similar understanding between them of what it means to be civil.

Clark & Springer (2007b) described civility as an authentic respect for others that requires time, presence, willingness to engage in genuine discourse, and intention to seek common ground whilst civil behaviours are described as ones which convey politeness, respect and decency to another person or persons (Clark, 2010). Scales (2010) described civility as a collection of respectful and courteous behaviours by which our own interests are sacrificed for the sake of public order and harmonious relations with strangers. Self-sacrifice and respect is also embodied in the definition offered by Buonfino and Mulgan (2009:17), who propose that civility is a 'learned grammar of sociability that demonstrates respect and entails sacrificing immediate self-interest when appropriate'. Both Oakeshott (Boyd, 2006) and Bryant (2002) refer to the role of inclusiveness in civility with Oakeshott suggesting that civility entails 'democratic equality' and 'inherent inclusivity' and Bryant suggesting that civility is a 'common standard' which requires that people afford each-other certain decencies, regardless of the differences between them. Inclusiveness is also apparent in the views of Guinness (2008) who talks about 'respecting differences' as well as treating each-other with dignity. In other writings, civility has been referred to as the consideration of others in interpersonal relationships (Ferriss, 2002), a desire to do what is right by others (Casson, 2012) and being kind, decent and respectful to others (Buonfino & Mulgan, 2007). This sample of definitions suggest the essence of civility lies in notions of respect, self-sacrifice, inclusivity, dignity, kindness, courtesy and consideration to others. No wonder then that civility plays an important role in moderating behaviour in society. Indeed, Papacharissi (2004) suggested that civility is one indicator of a 'functional democratic society'.

For further conceptual clairty, Buonfino & Mulgan (2007) suggest that civility has different dimensions which can be understood in terms of surface and deep civility and visible and invisible civility; they depict this in the form of a framework which is reproduced in Figure 2 (Permission granted by Alessandra Buonfino, 29th January, 2018).

```
· GIVING SEATS TO ELDERLY/            · CHARITABLE BEHAVIOUR
  PREGNANT WOMEN                       · VOLUNTEERING
· SMILING AND GREETING STRANGERS      · VISIBLE PHILANTROPY
· RESPECTING NORMS
· PICKING LITTER UP                                  Visible
· RESPECT FOR NEIGHBOURS ETC.
· AMICABLE RELATIONS WITH
  EMPLOYEES AND EMPLOYERS

──────── Surface ────────              ──────── Deep ────────→

· RESPECT IN 'LESS PUBLIC'            · PHILANTHROPY (ANONYMOUS)
  RELATIONSHIPS TO STRANGERS          · LOVE
  (WORKERS IN SUPERMARKET             · PRIVATE COMPASSION
  COUNTERS, CALL CENTRES,PARKING      · DAILY CARE
  ATTENDANTS,COUNCIL WORKERS,          Invisible
  FAMILY MEMBERS)
· POLITENESS IN THE HOME
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Figure 2 A framework of civility

The surface and deep aspect of the framework identifies the difference between civilities such as politeness and courtesy, typified in public interactions with strangers (with shopkeepers for example or on public transport) but lacking any real depth of feeling, and those civilities which draw on empathy and mindfulness to show an authentic appreciation of others' feelings, be the person known to us or not (such as listening to a friend's problems, or helping out a housebound neighbour). The visible and invisible aspect identifies the difference between those civilities which are enacted in public and those which take place in private, for example the same person can be reservedly polite in public and deeply compassionate in private. In either case, the differences in surface and deep, or visible and invisible are not overtly problematic for those concerned.

However, when the Buonfino and Mulgan framework was used to plot the dimensions of incivility as understood for this study, the perspective changed considerably (Figure 3). Surface incivilities, such as spitting or dropping litter, may not be deeply felt but can still cause offence or upset to others, whilst deep incivilities, such as spreading malicious rumours, have the potential to create long lasting and more deeply felt harm. Visible incivility can create a level of discord which can disrupt and harm relationships whilst invisible incivility could be the most problematic if they cause deeply felt emotional or physical harm that is not known or seen by others outside

of the situation. Plotting the framework provoked further thinking about the distinction between bullying and incivility, an issue which is discussed in section 3.2.
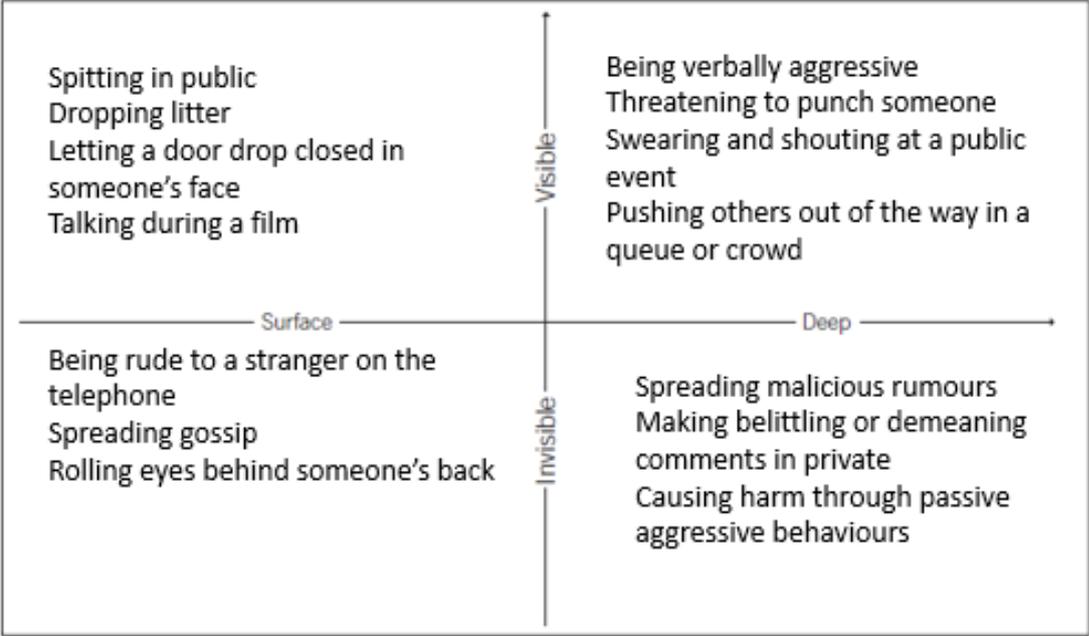
Figure 3 A framework of incivility

The framework illustration shows that incivility is not simply a lack of civility and it is not therefore explainable simply as the flip side of civility; on the contrary it is a complex and multifaceted concept in its own right. Defined by the OED as 'the quality or condition of being uncivil', examples of historical use include 'want of good manners or good breeding; ill-bred behaviour' (examples dated 1603-1671) and 'Ill-bred, uncivil, or uncourteous behaviour towards others; want of civility or politeness; discourtesy, rudeness' (examples dated 1612-1849). Today, the essence of incivility remains one of rude or discourteous speech or behaviour or as Gallo (2012) described it, 'A disrespect for others, an inability or unwillingness to listen to others' views and a lack of appreciation of the relevance of social discourse'. Incivility is therefore usually considered to be a negative construct, although there is a view that it can provide an important means for the disempowered to express dissatisfaction (DeMott, 1996) and give voice to 'passionate impulses' such as fear and anger (Elias, 2000) which can play a vital role in triggering political and social change.

In defining incivility, it is important to recognise the impact it can have as it is the level of impact which determines the severity with which it is viewed. Clark (2010) recognises this in her definition of incivility as 'rude or disruptive behaviour which may result in psychological or

physiological distress for those involved'. Impact is also considered by P. Smith, Phillips, & King (2010:11) who describe incivility as, 'Whatever is taken to be offensive, impolite or crude'. I would add 'at a given point in time' because like civility, incivility is a subjective reality that is determined by a personal notion of what is and isn't acceptable behaviour. As these notions can change over time, so too can the meanings we impose on the behaviours we observe or are subjected to. For example, the jostling of a bus queue may be acceptable to us in our youth but considered uncivil when we are aged or infirm. How we experience a given situation is influenced by a multitude of factors including mood, stress, prior experience, and presence of pain, all of which can increase or decrease our tolerance to the behaviour of others.

As well as being a subjective experience, incivility is also heavily context-bound (Millie, 2008). Factors such as geographical place and cultural norms can influence whether a specific behaviour is perceived as uncivil or not. For example, a man shouting late at night in a quiet residential area may be construed very differently to man shouting in broad daylight in a busy market place. The importance of considering concepts in various contexts in-order to better understand them, is affirmed by the Walker and Avant (2011) framework for concept analysis.

One such context is the workplace. This kind of incivility takes place in an employment setting and has been described as 'low-intensity deviant behaviour' where there is an 'ambiguous intent to harm the target' (Andersson and Pearson, 1999:456). There has been a great deal written about workplace incivility (Almost et al., 2015; Corney, 2008; Cortina, Kabat-Farr, Leskinen, Huerta, & Magley, 2013; P. R. Johnson & Indvik, 2001; Lim & Lee, 2011; Porath & Pearson, 2013; Torkelson, Holm, & Bäckström, 2016) and it is of direct relevance to this study in that 50% of pre-registration nursing education takes place in a workplace setting (placement). Another context is that of education, as in the focus for this study. Incivility in educational settings specifically, has been described as behaviour that intentionally disrupts or interferes with the learning process of others (Morrissette, 2001). This could apply to any type of educational setting for any age group (Paton, 2014) and as cited previously, has been the subject of extensive debate in nurse education globally.

Behaviour in politics provides yet another context within which to consider incivility. Like healthcare professionals, politicians are in the public eye for much of the time and likewise are expected to behave with civility in their many public interactions. Speaker John Bercow (Bercow, 2013) affirmed this in a parliamentary opening statement by saying 'everybody has a right to expect that his or her Member of Parliament (MP) will behave with civility'. In Canada, MP Nathan Cullen was so aggrieved by the uncivil behaviour of his fellow MPs, that he

launched a movement to promote civility (The Civility Project) which called for new powers to enable MPs to be suspended for displaying uncivil behaviours (MacKinnon, 2013).

There is one context more than any other which can act as a breeding ground for uncivil behaviour and that is social media. Social media is an umbrella term for a range of technologies that allow users to create and share their own content via online social spaces. Antoci (2016) defines incivility in this context as an, 'Offensive interaction that can range from aggressive commenting in threads, incensed discussion and rude critiques, to outrageous claims, hate speech and harassment'. These behaviours are similar to those described in other contexts except for the 'outrageous claims' which may be due to the anonymity conferred by many social media spaces which allows people to lay claim to all sorts of thoughts and behaviours without fear of contradiction.

Whilst anonymity in virtual spaces can promote freedom of expression in a positive way (Ruiz et al., 2011), it can be problematic in that it can encourage people not only to make outrageous claims, but to say the kind of rude or aggressive things they would not say to somebody in person. One study of online incivility showed that this occurred significantly more often where users were able to maintain their anonymity (Rowe, 2013). In an extreme form, online incivility can become cyber-bullying, a form of incivility that arises in digital environments and which includes circulating rumours, false information, gossip, or posting defamatory and/or humiliating materials (Clark, Werth, & Ahten, 2012).

Online incivility can also arise from the speed of online communication, with a 'no time to be nice' attitude (Pearson & Porath, 2005). Dodds (2016) reflecting on, 'the depressing incivility of social media' reported on the staggering level of hate comments a 'leave supporter' received via Facebook™ following the so-called Brexit vote (UK vote to leave the European Union in 2016). Others have linked online incivility with sexual harassment (E. Hunt, 2016), trolling (the process of anonymously and purposively, creating online discord by starting arguments or posting inflammatory, extraneous or off-topic messages) (Manjoo, 2014) and the disruption of democratic dialogue (Anderson, Yeo, Brossard, Scheufele, & Xenos, 2016). Even when the intention to cause harm is absent, the absence of non-verbal communication cues in the majority of virtual spaces (Papacharissi, 2002), can easily lead to uncivil interactions simply as a result of misunderstanding or miscommunication.

The point of exploring how incivility is manifested in different contexts, is that it is the where, when and how that influences whether people experience something as uncivil, i.e. it is the act

of interpretation that dictates whether a person perceives something as being rude or not (P. Smith et al., 2010:11). As Maya Angelou (American civil rights activist) said, 'People will forget what you said, people will forget what you did, but people will never forget how you made them feel' (Angelou, 2014).

Beyond these real-world contexts, the concepts of incivility and civility (and their companion adjectives uncivil and civil) appear many times over in fictional contexts, reflecting their long-standing usage in the English language. Jane Austin, for example, presents an excellent example of both in Pride and Prejudice, first published in 1813 (Austen, 2003). In this extract the main character, Elizabeth Bennett, is rejecting Fitzwilliam Darcy's marriage proposal:

> Mr Darcy asks 'I might, perhaps, wish to be informed why, with so little endeavour at civility, I am thus rejected…' to which Ms Bennett replies 'I might as well inquire, why with evident a desire of offending and insulting me, you chose to tell me that you liked me against your will, against your reason, and even against your character? Was not this some excuse for incivility, if I was uncivil?'

Another 19th century writer takes a somewhat blacker, albeit slightly tongue-in-cheek, view of incivility. Thomas de Quincey (De Quincy, 2015), puts incivility just five steps away from murder in his 'Treatise on Murder' (published first as 'Murder As A Fine Art' in 1827) in which he stated, 'If once a man indulges himself in murder, very soon he comes to think little of robbing; and from robbing he comes next to drinking and Sabbath-breaking, and from that to incivility and procrastination'.

In contemporary fiction too, many references to one or the other are made. Deborah Maxie, a character of the author P.D. James, purposely alters a discourteous comment of her brother's into a 'semblance of civility' for the benefit of a panicked villager in her debut crime novel 'Cover Her Face' (James, 1962:174). More recently, Sue Monk-Kidd showed the sense of restraint that civility can evoke in 'The Invention of Wings' (Monk-Kidd, 2014) a novel set in the deep south of 19th century America. In it, the main character Sarah Grimké, finds out that her brother Thomas has broken off her engagement without her knowledge. To herself Sarah says, 'I wanted to shout at him for making so arrogant a claim but when I whirled about I saw his eyes were filled with tears and I forced myself to speak with civility. 'I would like to be alone. Please.'

Finally, to conclude the concept exploration, there are two important distinctions to be made; one is between civility and respect and the other between incivility and bullying. These terms

are sometimes used interchangeably in the literature and but for the purpose of this study their meanings are understood to be distinct and different.

3.2.2 The difference between civility and respect

The OED (2013) defines 'respect' as a word that denotes 'some form of regard or consideration'. Of the many definitions and uses listed, the one that most obviously relates to civility/incivility, is that of 'deferential regard or esteem felt or shown towards a person, thing, or quality'. The Cambridge English Dictionary (Cambridge University Press, 2016) also links respect with actions toward something or someone as in 'politeness, honour, and care shown towards someone or something that is considered important' or as in the 'admiration, felt or shown, for someone or something that you believe has good ideas or qualities'. Elsewhere, respectful behaviour has been defined as the 'manifestation of believing another person has value' (Grover, 2013). This definition is drawn from an appraisal of the organisational sciences literature in which, Grover stated that the notion of respect has been conceptualised multiple times. Examples cited include, 'Being treated politely' (Bies & Moag, 1986) and, 'How worthy and recognised one feels' (De Cremer & Tyler, 2005). Grover also draws on the philosophical literature which has a long history of analysing the concept of respect. Kant (1964, cited in Grover, 2013) for example, as part of his work on categorical imperatives, suggested that respect for persons is demonstrated by treating them as ends in themselves and never merely as means to an end. Specifically, he described it as a moral principle that implies valuing another person's essential dignity and worth.

In the nursing literature, Parse (2010) links respect with 'concern for others' and 'reverence' and comments on the 'blatant lack of respect' that sometimes manifests in nursing education and practice settings where, she suggests, concern for others should be the hallmark of the profession. However, she also uses the terms civility and incivility almost interchangeably with respect and disrespect respectively suggesting, for her at least, a blurring of definitional boundaries. In other research, the conceptualisation of respect emerges through the eyes of the participants who describe how they would know they are being respected if they are taken seriously and have good relationships with staff (Bradbury-Jones, Sambrook, & Irvine, 2007).

In some cases, respect is poorly-defined, even when it is a core concept of the study. Portoghese et al. (2014), in their investigation into nursing students' perceived respect, make little attempt to define it whilst Sabatino et al. (2014) in their study about the concept of professional respect, offer no definition at all. It appears for some at least then, that respect is

difficult to define just as incivility is, or that there is an assumed common understanding that negates the need for further explanation.

The Kant definition captures the essence of respect as it is understood for this study, especially if it is further framed as an authentic belief or act i.e. a genuine feeling or action toward another. It is the authenticity of respect that distinguishes it from civility. Whilst like civility, respect may be characterised by behaviours which are polite, considerate, and courteous; there is another dimension to civility which can be referred to as the 'for appearances sake' element. This is the aspect of civility which is about behaving in a certain way, a way which is expected by society, because it is the right thing to do and because to do otherwise would inflame or aggravate a social situation unnecessarily. It is not always therefore an authentic behaviour but one that is adopted or manufactured for appearances sakes. This view is contrary to Clarke and Cornosso's (2008) perspective which is that civility is an 'authentic respect for others during encounters of disagreement, disparity, or controversy'. However, it is in keeping with the OED's (2013) view that more recent uses of the word (examples given 12a 1953, 1991 and 12b 1883, 1919, 1949) frequently have negative overtones as in 'The minimum degree of courtesy required in a social situation; Absence of rudeness' and 'An act or expression demonstrating a minimum degree of courtesy'.

3.2.3 The difference between incivility and bullying

Another type of negative behaviour identified in a number of nursing-related studies is bullying. Bullying is the persistent, demeaning and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem (A. Adams, 1992); it involves issues of power, control, hostility and intentional targeting (A. Adams, 1992; J. Cooper et al., 2009; J. Cooper, Walker, Askew, Robinso, & McNair, 2011). Bullying goes beyond incivility; it is a more deliberate and repetitive form of interpersonal mistreatment that impacts on the health and well-being of the victim (Felblinger, 2008) with a variety of reported consequences including anxiety, fear, depression, weight loss, fatigue, headaches and hypertension (McKenna, Smith, Poole, & Coverdale, 2003).

Bullying in the workplace is sometimes referred to as lateral or horizontal violence although the two terms are not entirely interchangeable. Lateral or horizontal violence specifically refers to the bullying of one person by another employed at the same level (Dunn, 2003) often in the context of highly pressurised, crisis oriented, stress-inducing work environments (Rainford, Wood, McMullen, & Philipsen, 2015). However, as with bullying, key features are repetition,

persistence and negative impacts on the victim including erosion of self-esteem, increased stress and damage to relationships (Forni, 2008) as well as the potential for significant and adverse health impact (Hodgins & McNamara, 2017). Of these, it is the repetitive and persistent characteristics of bullying and laterally violent behaviours that distinguish them most distinctly from the behaviours associated with incivility. Despite this distinction, there are important insights to be gained from the literature on bullying and lateral/horizontal violence, both of which are considered to be fairly common place in nursing workplaces (Edward, Ousey, Warelow, & Lui, 2014; Wilson, 2016).

Randle (2003) suggested that the frequency of bullying behaviours in nursing mean that they can be readily assimilated as the norm resulting in chronic scenarios of negative behaviour and low standards of care. In one study, student nurses described how lecturers who displayed bullying behaviours needed to know that their responses to students could 'crush' them (Seibel & Fehr, 2018). Many of the quotes in these studies exemplified what in other circumstances might have been described as uncivil behaviour, for example a description of belittling comments made by a ward Sister about a student. It would seem reasonable to suggest that routine incivility, even if not targeted at an individual, could also be assimilated as a norm just like bullying and that it could likewise impact detrimentally on standards of care.
Other terms that appear in the literature are psychological aggression, workplace aggression and relational aggression (Cortina et al., 2001; Stokowski, 2011) each of which can be distinguished from incivility by virtue of being conscious and intentional behaviours.

3.2.4 Key concepts summary

This conceptual exploration shows that civility and incivility can be understood in terms of personal relevance, depth of feeling and level of visibility. It also shows how they can manifest in different context including political, workplace and social settings. Their use in fictional dialogue shows they have a place in everyday English language, whilst the dictionary definitions show their historical roots and modern-day meanings. The exploration of the differences between civility, respect, bullying and incivility provides a level of differentiation which will optimise clarity of meaning as the thesis progresses.

3.2.5 Working definitions

For the purposes of the study the following provide working definitions of the two principle

concepts of interest.

Civility - a collection of respectful and courteous behaviours by which our own interests are sacrificed for the sake of public order and harmonious relations with strangers (Scales, 2010).

Incivility - whatever is taken to be offensive, impolite or crude at a given point in time (adapted from P. Smith et al., 2010).

3.3 Chapter Summary

This chapter has provided a rich historical and contemporary context for the study and defined the key concepts which lie at the heart of the enquiry. Along with the study rationale provided in Chapter 2, this creates the foundation on which the rest of the thesis is built. It is now possible to move on to a critical examination of the literature pertaining to incivility in nursing education. This will establish where the gaps in knowledge and understanding are and demonstrate the alignment between the research questions and the existing evidence base.

Chapter 4 The Incivility Knowledge Gap

This chapter sets out a review of the contemporary literature on incivility which identifies what is, and is not, currently known about this phenomenon in-order to show where the gaps in knowledge are and how the research undertaken contributes to closing them. The evidence base on incivility is substantial in size so for clarity the review is presented in six sub-sections: tutor, mentor, and student perspectives; measuring incivility; impact; contributory factors; interventions; and theoretical explanations. The research aim and objective set out at the end of the chapter are a direct reflection of the gaps and omissions identified in the review.

A critical appraisal framework (CASP, 2018) was used as a quality measure to guide the review process. A completed appraisal of a study by Clark (2008a) is appended as an example of how the checklists in the CASP toolkit were used (Appendix C).

4.1 Incivility in Nurse Education

Incivility in nurse education has been described as a speech or action which can disrupt the harmony of the learning environment so much as to effectively terminate learning (Clark & Springer, 2007b). These behaviours can be viewed on a continuum, ranging from disruptive behaviours such as making snide comments or sighing heavily which are at worst distracting or mildly annoying, to overtly threatening behaviours which can erupt into physical violence (Clark, 2013). It has been described as a moderate to serious problem (Clark & Springer, 2007b) as well as one that is on the rise (Lashley & DeMeneses, 2000). Although these perspectives relate to nurse education in North America specifically, the increasing number of global publications in this area (See Chapter 2, section 2.1) suggests a ground swell of interest in incivility and its effects on students, nurses, patients and healthcare environments generally.

4.1.1 Nurse tutor, mentor and student perspectives on incivility

Luparell (2004) explored American nurse tutors' experiences of student incivility using a critical incident technique. This interpretative qualitative methodology uses participants' rich descriptions to gain an understanding of why certain decisions were made or particular actions taken in a given situation or event (Schluter, Seaton, & Chaboyer, 2008). In the study, twenty-one nurse tutors representing nine different nurse training programmes in the US were

interviewed. The interviewees reported thirty-six critical incidents in total, taking place across a time span of several weeks to fifteen years preceding the interviews. In the interviews, participants gave various examples of uncivil student behaviour including sarcastic retorts, arguing about grades, hostile or aggressive gesturing, foul language, physical intimidation, and threats to personal safety.

Whilst the length of time between incident and interview led to patchy recall of details in some cases, the participants were all able to describe how the incident had impacted on them personally. These impacts ranged from emotional consequences such as disturbed sleep, reliving the event and loss of confidence to financial losses as a result of paying for legal fees and enhanced security systems. In all the cases described, incivility had a significant impact on the nurse tutors involved with three of those interviewed subsequently leaving the teaching profession citing incivility as a contributory factor. The study provided an important insight into the impact of incivility but due to the time lapse between event occurrence and recollection, offered little indication of how current or wide-spread the issue was at the time the study was conducted.

In another study, nurse tutors' experiences of student incivility in Iran were explored through one-to-one interviews with eleven nurse tutors (Masoumpoor, Borhani, Abbaszadeh, & Rassouli, 2017a). Content analysis revealed ten categories: disrespect, dishonesty, indelicacy (such as fake yawning to indicate boredom), self-centredness, violence, indiscipline, inattentiveness, lack of effort to learn, poor time management and harassment. These were grouped into one of three main themes termed disruptive ethical, communication and learning environments. A unique aspect of this study, was the link made between people's compliance with Islamic teaching and the extent of disruptive behaviour students might be expected to exhibit, i.e. some authors have reported death threats (Luparell, 2008) but this would not be expected because of the Quran's teaching. However, aggressive behaviour was described and included slamming doors, shouting at teachers, rage, fights and destroying tutors' personal effects.

Students' experiences of incivility in American pre-registration nurse education were explored by Clark (2008b) who conducted a phenomenological study exploring the experience of nursing students who had encountered incivility from their nurse tutors. A phenomenological approach focusses on capturing the subjective experience of the participants, usually by one-to-one interview. In this case seven students were interviewed, each of whom gave detailed descriptions of their experiences and the impact of them. The incidents included descriptions of

gender bias, being 'scolded' by nurse tutors and being threatened with assignment failure for not doing as they were told. Three major themes emerged from the data analysis: nurse tutors making demeaning and belittling remarks; nurse tutors pressuring students to conform and nurse tutors treating students unfairly. The time lapse between incident and interview ranged from two weeks to seven years although even with the long time lapse participants felt able to recall the impact of the experience clearly, just as the participants in Luparell's study had. Recalling similarly negative impacts, Clark's interviewees said the experience had left them feeling powerless, helpless, upset, and angry. As with Luparell's research, Clark's study provides a valuable insight into the impact of incivility, albeit this time from the perspective of students rather than nurse tutors. However, the length of time over which incidents were recalled, and the small number of participants interviewed (although appropriate for the research design), again make it impossible to gauge how wide-spread the issue of incivility was at the time of the research. It is also of note that both Luparell's and Clark's studies were conducted in the US, where nurse education programmes are delivered differently to those in the UK and where there are many other socio-cultural, educational and healthcare differences which limit the transferability of findings to the UK context.

Altmiller (2012) also adopted a phenomenological approach to explore the perspectives of nursing students. A total of twenty-four students (four male and twenty female) ages eighteen to forty-five, from four universities in the US, participated. They were interviewed using focus group technique, a qualitative data collection method which harnesses group dynamics to elicit the participants' various perspectives and experiences. Content analysis identified a number of themes including: unprofessional behaviour such as nurse tutors talking negatively about other students; poor communication techniques such as being disrespectful; power gradients resulting in fear of being failed; inequality including racial bias; and difficult peer behaviours such as cheating.

Altmiller's participants identified laughing, talking in class, watching a small TV, talking on the phone in class, and being habitually late as uncivil peer behaviours with quiet behaviours like sleeping and reading still being considered inappropriate but more acceptable. Two findings were of note, one was that the students shared similar views of incivility to those expressed by nurse tutors elsewhere in the literature and another was that students believed that their own incivility is justified when they perceived incivility is demonstrated toward them. Altmiller concluded from his findings that students want their nurse tutors to set the example for civility and to maintain control over classroom behaviour.

A more recent study of students' experiences involved interviewing thirteen students from five different university-based schools of nursing in Iran (Masoumpoor, Borhani, Abbaszadeh, & Rassouli, 2017b). Content analysis of the transcripts revealed nine sub-themes: poor teaching skills, humiliation, distrust, lack of support, coercion and aggression, poor time management, self-centredness, harassment and indiscipline headed under one of the three main themes: ethical, learning and communication. Masoumpoor et al. concluded that the educational environment 'plays a major role in fostering committed, ethical, and devoted nurses' and urged the healthcare authorities to 'end the growing trend of incivility in nursing education' to protect patient safety and health.

Luparell's, Clark's, Altmiller's and Masoumpoor et al.'s work described the potential consequence of uncivil encounters including the negative impact on learning, a concern echoed by others (Del Prato, 2010; Rowland & Srisukho, 2009). However, although the incidents reported had significance for the participants, others in the same situation may not have perceived the same slights or suffered the same consequence, nor may they have come forward to talk about their experiences. In relation to the latter, a study conducted in the US by Del Prato is interesting because she did not actively seek experiences of incivility but set out instead to explore the lived experience of student nurses undertaking an associate degree in nursing (Del Prato, 2010). Using a phenomenological approach, she interviewed a convenience sample of thirteen students between nineteen and forty-two years of age about their experiences of being on the programme. Nurse tutor incivility emerged as a theme in two of the nine categories identified and comprised four inter-related experiences which Del Prato described as: verbally abusive and demeaning experiences; favouritism and subjective evaluation; rigid expectations for perfection and time-management and targeting and weeding out practices (routinely failing less able students). The students' narratives identified impacts on learning, self-esteem, self-efficacy, and confidence.

The students in Del Prato's study were on an associate degree nursing programme (ADN), a two year practically focussed nurse training programme which differs significantly from the UK pre-registration nursing programme in terms of entry requirements, curriculum content, mode of delivery and exit qualification. Whilst the study raises interesting points about the nature of perceived incivility, the difference in context again restricts the transferability of the findings to the UK context.

The issue of subjective interpretation means that no one behaviour describes incivility in nurse

education; however, the literature review thus far has helped to develop a clearer picture of the types of behaviours that characterise it. The knowledge base is further informed by the use of quantitative approaches. One such study, conducted in a North-Western American university, adopted a survey method to capture the views of a larger number of people than is possible with interview-based approaches. A bespoke survey tool was developed (the Incivility in Nursing Education (INE) Survey) to ask nursing students and nurse tutors about their perceptions of uncivil behaviours (Clark & Springer 2007a, 2007b). The survey was completed by three hundred and twenty-four nursing students and thirty-two nurse tutors and responses were grouped into in class and out of class behaviours for ease of categorisation. Nurse tutors included not paying attention, using mobile phones, disapproving groans, and sarcastic remarks in their descriptions of student behaviours, whilst students included belittling remarks, overly-fast paced lectures, and cancelling classes when describing the behaviour of teaching staff.

The survey also considered participants' perspectives on the frequency of behaviours and on those behaviours they considered 'beyond uncivil'. Nurse tutors responded that talking in class was the most frequent of in-class disruptive behaviours followed variously by making negative or disrespectful remarks, lack of punctuality, inattentiveness, sleeping, and wearing immodest attire. The most common out-of-class incivility they described was students verbally discrediting academics followed by late assignment submission and inappropriate emails. Students cited other students talking in class, texting messages to friends, sending inappropriate emails, sighing out loud and bad-mouthing professors out of class as examples of uncivil behaviours. Behaviours considered to be more than just uncivil included verbal vulgarity, threats, and harassment.

Another large scale survey targeted both nursing staff and students in Iran (Rad et al., 2015). The open questionnaire comprising a single question asking for the respondent's opinion on incivility, was completed by five hundred undergraduate and forty postgraduate nursing students along with one hundred nurse academics. A content analysis of the responses revealed that academics considered humiliation of other students, coming unprepared to class, playing with cell phones, bad sitting posture and non-observance of Islamic standards to be the most uncivil behaviours. Whilst students considered the most uncivil behaviours of faculty to be incompetence in managing the class, discrimination, insult and threat, wasting class time, distraction and bad (poorly designed) assessment.

A survey approach was also used to explore students' (n=155) and academics' (n=40) perceptions of incivility in Oman (Natarajan et al., 2017). In this study, the authors used a self-

administered questionnaire to collect the data. A variety of behaviours were reported on including most commonly: acting bored or apathetic in class; holding conversations that distract others in class; using cell phones during class; arriving late for class and being unprepared for class. The authors noted significant differences between teacher and student perceptions of severity of some behaviours such as sleeping in the class and not paying attention, which students did not perceive to be a problem.

In other studies, students have given examples of uncivil behaviours by nurse tutors which include eye-rolling and snickering from peers (Schneider, 1998) and feeling that nurse tutors are overly critical, unfair, discriminatory and rigid (S. P. Thomas, 2003). Other researchers have identified uncivil student behaviours such as inattentiveness, tardiness and class absence (Lashley & DeMeneses, 2000) as well as profanity and racial slurs (Schneider in Kolanko et al., 2006). A number classed academic dishonesty such as plagiarism and collusion as uncivil behaviour too (Clark, Farnsworth, & Landrum, 2009; Clark & Springer, 2007b).

Overall, there is a wide-range of uncivil behaviours described in the literature (Table 1).

Table 1 Uncivil behaviours described in the literature

Academic dishonesty	Fights	Scolding
Aggression	Foul language	Slamming doors
Aggressive gesturing	Giving poor marks	Unfairness
Anger	Harassment	Wasting class time
Attendance, irregular	Hostility	Watching TV in class
Bad-mouthing people	Humiliation	Wearing immodest attire
Being overly critical	Inattentiveness	Self-centredness
Belittling remarks	Lack of interest	Sending inappropriate emails
Cancelling classes	Lack of support	Shouting
Cheating	Laughing	Sighing
Class absence	Physical intimidation	Sleeping
Coercion	Poor classroom management	Snickering
Destruction of property	Poor sitting / posture	Submitting assignments late
Discrimination	Poor teaching skills	Swearing
Disrespect	Poor time management	Talking
Distrust	Power / control games	Tardiness / Being late
Eye rolling	Racial slurs	Texting in class / playing with cell phones
Failing to observe religious standards	Rage	Threatening personal safety
	Rigidity	
Fast-paced lectures	Sarcasm	

The types of behaviour reported in the various studies discussed are broadly similar to those expressed in a focus group conducted with academic colleagues in a nursing department in the UK (J.C. Vuolo, unpublished work, February 26[th], 2014.). However, there are

marked differences in the severity of behaviour described, with the US literature in particular often referring to highly aggressive and confrontational behaviours (profanity, threats to personal safety, aggression) with significant negative consequences, for example, mental ill-health, financial loss and job loss. These extremes do not relate to the researcher's experience of incivility in nurse education which is more typically low-level disruptive behaviour. What is notable from the research reviewed is that there is little which considers the nurse mentor perspective, possibly because the mentor role is not typical of training models in use beyond the UK. However, there is one UK-based discussion piece which explores the reasons for uncivil student behaviour in the community and sets out how this may be managed (Carr, Pitt, Perrell, & Recchia, 2016). In this article, the authors suggest that 'quiet' uncivil behaviour such as failing to engage is particularly problematic as it is not immediately visible to others and can therefore leave the mentor doubting their own perception of what is happening or making excuses for the student who may just be shy or quiet in nature.

4.1.2 Measuring incivility

Anthony, Yastik, MacDonald and Marshall (2014) describe the development and validation of a tool to measure American nursing students' experiences of incivility in the clinical learning environment (CLE). The Uncivil Behaviour in Clinical Nursing Education (UBCNE) is a multi-item tool which represents three themes; hostile/mean, exclusionary and dismissive. Each of the questions has a 5-point Likert-type scale for the response and results are calculated by taking a mean of the respondents' scores across all items. The themes used emerged from student nurse focus groups facilitated by two of the authors, Anthony & Yastik (2011). Overall, twenty-one students participated in these groups during which they were asked to recall a personal experience during which they had felt that a staff nurse in the CLE had treated them in an uncivil manner. The tool was tested out on a group of nursing students at a private school of nursing in the US. One hundred and eighteen students were invited to participate, and one hundred and six completed surveys were returned. The majority of respondents were female (eighty-nine), sixteen were male and one was unknown. The aim of the survey was to evaluate the extent to which the UBCNE demonstrated reliability and validity with results suggesting the tool had good internal consistency and was easy to administer. Subsequently, a reduction in overlapping items led to a reduction in length making the tool quicker and easier to use.

The UBCNE was developed specifically for use in clinical settings. Whilst some of the items are fairly general others focus specifically on what happens in practice, for example, item 9 'did not involve you in a patient care decision you should have been involved in'. This limits the value of

57

the tool for use in academic settings although it has potential to be adapted for use in UK clinical settings providing the language used is familiar to UK students.

Another instrument developed for use in clinical settings is the Nursing Student Perception of Civil and Uncivil Behaviours in the Clinical Learning Environment (NSPCUB) (Tecza et al., 2015). This tool was designed to gain insight into student nurses experiences of uncivil behaviour from Direct Care Nurses (nurses who provide hands on care as opposed to nurse administrators or leaders). The choice of survey items was informed by a literature review and the views of clinical nursing instructors. It comprises Likert-response questions headed under three constructs; mutual respect, guided participation and student centeredness. Content validity was confirmed by expert review (local faculty) and focus group discussion (four nursing students). After minor revision, the instrument was tested for reliability with the inter-item correlation matrix and Cronbach's alpha (measures of internal consistency), using data collected from four hundred and ninety nursing students. The authors' concluded that the instrument was a valid and reliable tool for measuring nursing students' perceptions of uncivil and civil behaviour.

As with Anthony et al.'s tool, the NSPCUB instrument was designed for use in a clinical setting limiting its usefulness for use in the broader context of nurse education i.e. five of the twelve survey questions refer specifically to situations which would only happen in a clinical setting. The instrument is also designed to elucidate a student nurse perspective and therefore, like Anthony et al.'s instrument, could not be used to elicit other perspectives without amendment. Additionally, there are several issues which throw into question the validity of the instrument. The method for selecting the survey items is only described in vague terms with no detail about how either the literature review or the collection of verbal reports from clinical instructors were conducted. The focus group questions are written in such a way that their meaning may not be readily understood by student nurses. For example, '*If you had thought about other constructs to civility or incivility what would those be?* That only four student nurses were involved in the instrument design is acknowledged by the authors as a limitation as was the fact that the survey sample was a homogenous group of predominantly white (self-identifying) students of between twenty and twenty-five years of age. In terms of usefulness for the researcher's own setting, this population differs considerably in age and ethnicity a fact which, along with the focus on the clinical environment and questionable validity, renders the instrument of limited use.

Whilst the tools discussed so far were designed specifically to measure the perceptions of nursing students, the Incivility in Nursing Education (INE) survey instrument was designed to

measure the presence and frequency of incivility from nurse tutor and student perspectives (Clark et al., 2009). It was based on the 'Defining Classroom Incivility' survey tool (University of Indiana Center for Survey Research, 2000), the 'Student Classroom Incivility Measure' and 'Student Classroom Incivility Measure-Faculty' tools, the latter two being based on some earlier research (Hanson, 2000 cited in Clark et al., 2009). All three tools were designed specifically to measure classroom incivility in higher education. The INE was subjected to a content validation process, then piloted and the inter-item coefficients calculated to ensure validity and reliability (Clark et al., 2009; Clark & Springer, 2007b). It was then further tested for its psychometric properties (Clark, Barbosa-Leiker, Gill, & Nguyen, 2015). The survey is divided into several sections: demographic information; a list of uncivil behaviours and whether any have been encountered in the previous twelve months; perceptions of the extent of the problem; who engages in it; possible causes and preventative measures.

Although the INE is a valid instrument for measuring perceptions and frequency of uncivil behaviours (as defined by an American audience), it does not address personal impact despite it being raised as an issue of importance by many authors (Anthony & Yastik, 2011;Del Prato, 2010; Luparell, 2004; Thomas, 2003). Personal impact is also omitted in the Nursing Education Environment Survey (NEES) (Marchiondo et al., 2010). This tool was designed to measure students' experiences of incivility from nurse tutors and considers the type of behaviours encountered, the frequency and whereabouts of occurrence and the type of coping response adopted. The NEES design utilised elements of the INE (Clark et al., 2015) and the Workplace Incivility Scale (WIS) (Cortina et al., 2001), both established instruments. All three have been tested for content validity and internal consistency. However, the NEES does not allow the respondent to provide much information beyond the options given and it focusses only on faculty to student behaviour and not student to student. This latter, along with the failure to address impact, is an important omission because student to student incivility is an issue cited regularly in the literature (Clark et al., 2015; J. Cooper et al., 2009; Gallo, 2012).

Another survey tool focussed on students' perceptions is the Nurses' Intervention for Civility Education Questionnaire (NICE-Q). Developed by Kerber, Jenkins, Woith and Kim (2012) the NICE-Q was designed to measure students' pre-test and post-test perceptions of incivility in the context of a journal club intervention to foster student to student civility. Specifically, the instrument was developed to test whether the intervention changed students' behaviour or not with the findings showing that students were generally more aware of civility, more likely to be helpful to their peers and better equipped to cope with episodes of incivility, post-intervention.

A slightly different perspective is offered by Hunt and Marini's study (2012) which explored incivility in the practice environment from the perspective of clinical nursing tutors (CNTs) in a Canadian healthcare institution. They used a survey instrument called the 'Perceptions on Incivility Survey (PICS) to assess participants' experiences of incivility in practice. The survey was an adaption of a previously designed instrument for measuring indirect and direct incivility, which was amended to meet the needs of the CNTs in practice environments specifically. It comprised quantitative and qualitative measures and was therefore analysed in two ways: SPSS and narrative analysis. The narrative analysis was conducted using a simple conceptual model called the Multidimensional In/Civility Identification Model (MIIM). The model enabled the researchers to analyse the responses in terms of their form and function as conceptualised by two intersecting axes. Proactive versus reactive forms of incivility were plotted on the horizontal axis and direct versus non-direct functional aspects of incivility were plotted on the vertical axis. Thirty-seven CNTs completed the survey (two male and thirty-five female) the majority of whom were working in acute care areas. All the CTs reported experiencing some form of incivility with those working in acute settings reporting the highest frequency of occurrence. Narrative analysis against the model showed indirect incivility (such as spreading unpleasant gossip) and reactive incivility (such as responding angrily to a perceived insult) to be the more common forms and functions respectively. Whilst the survey instrument (which was not included in the publication) would not be directly applicable to this research the MIIM could be a useful way of categorising interview data.

Of the five instruments reviewed the INE is by far the most comprehensive facilitating measurement of frequency, perceptions, perpetrators, possible causes, and preventative measures from both student and nurse tutor perspectives. However, none were developed with the UK nurse educational context in mind. Four of the five tools were developed in the US, the other in Canada. Given the socio-cultural, educational, and healthcare differences between these countries and the UK, there is significant potential for there to be differences in peoples' experiences and expectations and therefore their perceptions of incivility. Tools developed in other countries do not therefore transfer readily to a UK context.

4.1.3 The impact of incivility

Anthony and Yastik (2011) conducted a qualitative study exploring American student nurses' experiences of incivility in the clinical setting. Collecting their data through focus groups, the researchers identified a higher frequency of positive experiences to negative experiences. However, the negatives ones (the uncivil ones) were felt to have had the more profound effect

such as impacting on self-confidence and causing the students to question their choice of career. In another qualitative study (C. A. Thomas, 2018), the experiences of twelve nursing students were explored in relation to incivility in clinical settings and impacts described included physical turmoil and stifled learning.

Marchiondo et al. (2010), found a strong link between perceived faculty incivility and students' dissatisfaction with their programme and a high number of participants (n=133 or 88%) reported feelings of anxiety or depression as a result. Lasiter et al. (2012), conducted a study whereby they used a survey instrument (the NEES) and an open-ended question to elicit students' experiences of uncivil faculty behaviours. A total of one hundred and fifty-two students participated although not all completed the narrative question. Of those that did, twenty-nine students reported feeling incompetent, incapable, dumb, or stupid as a result of nurse tutor behaviour and fifty-one reported feeling belittled or unimportant. One student described how uncivil behaviour prevented her from pursuing a Masters in the faculty and another recalled how intimidation had led to her making a clinical error. Elsewhere, consequences to students described include negative impacts on efficacy, self-confidence and psychological well-being (Clark, 2008b), dissatisfaction with and sometimes withdrawal from, the programme of study (S. P. Thomas, 2003) and the potential to have 'a devastating impact on students' professional formation' (Del Prato, 2013).

From the academic perspective, a study by Luparell (2004) described the impact of incivility on time, money, productivity and well-being giving examples which included sleep disturbances, loss of confidence, incurrence of legal fees and resignation. Consequences described by Thomas (2003) included lowered self-esteem, depression and burnout. From the qualified nurses perspective, a literature review by McNamara (2012) referenced impacts which included fatigue, weight change, substance abuse and gastrointestinal upset whilst a cross-sectional study conducted by Spence Laschinger et al. (2012) found impacts which included decreased job satisfaction, low morale, and increased staff attrition.

Impacts and consequences derived from the literature reviewed are listed in Table 2.

Table 2 The impact of incivility

Anger	Fear of being failed	Learning, loss of
Anxiety	Feeling belittled /	Medical / clinical errors
Attrition, increased	unimportant	Morale, low
Burnout	Feeling incompetent /	Patient satisfaction, decreased
Career choice doubts	dumb / stupid	Physical turmoil
Confidence, loss of	Feeling disrespected	Self-esteem, loss of
Decreased efficacy	Feeling traumatized	Staff retention, decreased
Depression	Financial loss	Stifled learning
Dissatisfaction	Gastrointestinal upset.	Substance abuse
Disillusionment	Helplessness	Substandard care
Disturbed sleep	Job satisfaction,	Weight change
Impaired professional formation	decreased	Withdrawal from study
Fatigue	Loss of control	Professional formation

4.1.4 Contributory factors

Buonfino & Mulgan (2007) propose three sources of civility: individual disposition and genetics; the influence of family, friends and peers, and the laws and regulations that promote or limit behaviours. Individual dispositions are present at birth but evolve over time and in the presence of other influences. These influences, such as those exerted by family, friends and peers, shape what behaviours we think are and are not acceptable, motivating some and disincentivising others (Buonfino & Mulgan, 2007). The third source that of laws and rules, is less about shaping behaviour and more about dictating it. It sets out the expectations of a civil society, such as do not smoke within ten meters of a building and metes out punishments for uncivil acts such as fines, injunctions and detainment. Uncivil behaviour may therefore be a consequence of individual personality traits, a result of the influence of others, a direct response to statutory or societal limitations to freedom and choice, or more probably, a combination of one or more.

Many more contributory or influencing factors have been cited, some of which are specific to the type of incivility and others which are more general. For example, Michaels and Miethe (1989) cited parental and peer pressure as factors that may contribute to academic cheating, whilst Nikstaitis & Simko (2014) found that being white, between the ages of twenty and thirty-nine years, part-time and in nursing for more than five years, were all predictors.

Whilst angry behaviour may be cited as an uncivil behaviour (P. R. Johnson & Indvik, 2001), anger can also be a pre-cursor for uncivil behaviour. Thomas (2003), described how the academic response to anger is most commonly displayed as passive-aggressive behaviour such as lowering student grades. Alternatively, student responses to anger include acting out

their own anger, either in the classroom or by confronting the academic concerned, covert passive-aggressive responses such as giving poor tutor feedback or complete inaction.

Alexander-Snow (2004) suggested that tutors' responses to disruptive students can contribute to further incivilities although the degree to which classroom incivility is the result of the tutor's inability to manage students and how much is to do with student hostility isn't known. What is known, she says, is that students evaluate their tutor's competence, credibility, and authority in light of their cultural perceptions so students who perceive that their tutor is unable to control the class are more likely to behave uncivilly. Differences in cultural perceptions can also give rise to misunderstandings. For example, not knowing that in some cultures speaking loudly is considered aggressive and in others it is seen as a sign of confidence and stature. Kearney, Plax, Hays, & Ivey (2009), emphasise the important role that students' perceptions of teachers' behaviours play in influencing students' motivation, achievement, and attitudes; factors which could in turn affect how students behave towards them.

Other contributory factors include gender and racial bias (Cortina, 2008), instigator ignorance and oversight (Cortina et al., 2001), emotional disturbance such as frustration, anxiety or fear of failure (Vink & Adejumo, 2015) and when students are under stress, especially if there is a pre-existing psychiatric disorder (Berman, Strauss, & Verhage, 2000). Large classes and over-crowding are also cited (Elder, Seaton, & Swinney, 2010), as are inter-student competitiveness and increased student expectation as a result of the move towards a consumerist mode of education (Bunce, Baird, & Jones, 2016; Morrissette, 2001; Vink & Adejumo, 2015) and ineffective handling of racial micro-aggressions in the classroom (Wing, Regan, & Laschinger, 2013). In the clincal setting, incivility has been linked with ineffective leadership styles (Kaiser, 2017), plus a lack of insight into behaviour, poor clinical knowledge and a sense of entitlement to behave a certain way (McNamara, 2012).

Braxton and Bayer (1999) describe the interlocking nature of faculty and student incivility, whereby incivility is seen as a bidirectional phenomenon arising between the two parties; this suggests that the nature of the relationship between the parties determines to an extent whether incivility will arise or not. Bray and Del Favero (2004) concur, suggesting that a history of suboptimal relations and poor interaction in the classroom can contribute to uncivil behaviour. Teacher immediacy is thought to be of particular relevance in this bidirectional view of incivility (LaBelle, Matin, & Weber, 2013). Immediacy refers to the communication techniques used to reduce physical and psychological distance between teachers and students (Golish & Olson, 2000). These may include leaning forward to show interest and eye contact with verbal prompts

to show active listening. Immediacy behaviours communicate greater 'liking' for students whilst non-immediate behaviours indicate greater 'disliking' (Golish & Olson, 2000). A student who feels disliked is less likely to engage positively with their tutor, mentor, or peers; indeed immediacy is thought to be critical for student learning, particularly in large classes (Summers, Bergin, & Cole, 2009).

Whilst this 'two-way street' view of incivility, goes some way towards explaining why some forms of uncivil behaviour occur, it does not explain why the same student sends texts during lectures regardless of who is teaching or why it is the same mentor who is always rude to their students regardless of their age, gender or ethnicity. In these cases, whilst the context of the situation and the persons involved are still key as to whether or not incivility arises, or is perceived to have arisen, the behaviour is not instigated in direct response to another's behaviour but manifests despite it. This is particularly so for incivility that happens in circumstances where this is no prior relationship or history between the two parties, such as when somebody lets a door fall closed in the face of the stranger walking behind them. Therefore, whilst teacher incivility may be a primary determinant of disruption in the classroom (Keating, 2016), poor student behaviour may have nothing to do with the teacher at all and instead be a result of factors completely extraneous to the classroom (or placement) situation (Kuhlenschmidt & Layne, 1999).

4.1.5 Incivility interventions

Altmiller (2012) highlights the importance of implementing interventions that de-escalate incivility and foster appropriate professional behaviours whilst Leiter, Day, Oore, & Laschinger (2012) stress the importance of implementing effective interventions that have enduring impact on the quality of working relationships. One such strategy is the CREW intervention (Civility, Respect and Engagement in the Workplace) which specifically targets workplace incivility through the provision of a 6-month facilitated process which aims to improve civility and associated attitudes through group activities, excercises and discussion (Osatuke et al., 2009). The CREW method was developed for use by the Veterans Hospital Administration (US), in response to employee feedback that low levels of civility were negatively affecting job satisfaction. The intervention has been evaluated using validated scales to determine civility and respect, incivility, work attitudes and distress and has been shown to have a positive impact on civility and attitudes in the short term (Leiter, Spence Laschinger, Day, & Gilin-Oore, 2011; Osatuke et al., 2009) and to be effective at sustaining civility for at least one year post-intervention (Leiter et al., 2012).

Another intervention, which took place across a six-month timeframe, was implemented by Clark (2011). This intervention was based on a framework for collaborative partnerships and comprised a series of workshops with staff and students. Clark conducted pre and post-intervention assessments using a previously validated tool to measure student and nurse tutor perceptions of incivility (The Incivility in Nursing Education (INE) Survey (Clark et al., 2009)). Using an action research approach, the goals of the workshops were to re-establish trust between students and staff, improve understanding of incivility and formulate an action plan to foster civility. The pre and post-test survey responses (40% and 40.1% respectively), showed a decline in levels of moderate to severe perceived incivility (82% to 74.6%). However, it is notable that the rate of improvement as perceived by nurse tutors was far higher at 85.8% than that reported by students which was 50%. That nurse tutors and students had such differing perspectives on whether incivility was occurring or not, is worthy of further investigation. It is also notable that 50 students joined the group after the pre-test which may have affected the results as their views were only captured by the post-test; in addition they may have missed some or all of the intervention. As neither of these possiblities are discussed by the author, the crediblity of the results is questionable.

Jenkins, Woith, Stenger, & Kerber (2014) sought to promote civility by running a journal club with a cohort of seventy-nine, final year nursing students. The intervention comprised six fifty-minute sessions delivered over one semester, which each included tutor-led discussion based on an assigned journal article. The topics covered included being ignored, gossiping, coping with stress, burnout, lateral violence in the clinical setting, academic dishonesty and bullying. An assessment of the students' perceptions of civility and academic integrity, and an evaluation of their coping skills was conducted pre-intervention. The assessment of civility perceptions was conducted using a previously validated tool called the Nurses' Intervention for Civility Education Questionnaire (NICE-Q) (Kerber et al., 2012) which examines six aspects of civility; participants' awareness of incivility, academic dishonesty, role-modeling civil behaviour, accepting others, helpfulness and refusing to participate in incivility. The coping skills evaluation was conducted with the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1998). Following the final session, the students completed the same questionnaires along with one additional question which asked how participation in the journal club had impacted their behaviour. The findings indicated that participants in the study had an increased awareness of civility, were more likely to be helpful to their peers and were better equipped to cope with episodes of incivility (Kerber et al., 2012). The research team recognised the limits imposed by the relatively small sample size and the potential influence of the pre-intervention assessment, which may have

predetermined the participants' behaviours to an extent. However, given the findings were positive overall, the journal club method appears worthy of further evaluation.

Other researchers have used much shorter intervention periods. Nikstaitis & Simko (2014), for example, piloted a 60-minute educational programme with twenty one nurses working in an intensive care setting. The programme, comprising case studies and discussion of nurses experiences, aimed to increase awareness of incivility and decrease the incidence of occurence. The Nursing Incivility Scale (Guidroz, Burnfield,-Geimer, Clark, Schwetschenau, & Jex, 2010) was used to measure nurses' pre- and post-intervention experiences of incivility using a 5 part Likert scale. Post the educational intervention, the scores indicated that more instances of incivility were perceived; however the actual impact on incidence is not discussed. It is not clear whether the researchers' intention was that an increase in awareness would automatically lead to a decrease in incidence or whether there was a separate intervention to address this aspect.

The four interventions described all utilised workshop-type approaches albeit delivered in different ways over varying time periods. Shanta and Eliason (2014) took a different approach based on empowerment. Empowerment refers to the process of gaining power (Clark & Davis Kenaley, 2011); it involves the provision of support, resources and opportunities for learning, to accomplish professional and personal goals (Faulkener & Spence Laschinger, 2008). Shanta and Eliason developed a framework for empowerment for use by faculty based on a previously described empowerment model (Worrell, McGinn, Black, Holloway, & Ney, 1996).The framework comprises four components; communication, collegiality, autonomy and accountability each of which is understood as a separate and distinct concept. However, the authors determine that it is the use of them in unison that has the potential to create civility in both education and practice environments.

Various other interventions are described in the literature including introducing student conduct codes (Authement, 2016; Williams & Lauerer, 2013) and using guided democracy (Rad, Moonaghi, & Ildarabadi, 2017). Overall, given the range of intervention methods available, there appears to be sufficient opportunity to select one that fits best to the context in which it will be applied.

4.1.6 Theoretical explanations for incivility

Bray and Del Favero (2004) cite multiple sociological theories that can be used to account for incivility in the classroom. Akers (1977:114) suggested that deterrence theory could be used to explain why incivilities arise when the perception of punishment is low and why behaviours such as talking in class are deterred when noticeable efforts to root out and correct the behaviour are made. Similarly, rational choice theory (RCT) (Hechter & Kanazawa, 1997) recognises the relationship between undesirable behaviours and negative consequences, and more so, the influence of reward or benefit for behaving in a particular way. An example of a teaching practice based on RCT would be whereby students lose marks for being late to class (the deterrent) and gain marks for being there on time with their preparatory work completed (the reward).

Durkheim's anomie theory (Gainey, Inderbitzin, & Bates, 2016; Hilbert, 1989) considers not just deterrent and reward but feelings of community, attachment, commitment, and involvement between members of social groups. Anomie exists where there is an absence of these things; where people feel less attached to society and less bound by its rules (described as a state of normlessness). In education, this could be translated to students who feel they are recipients of education rather than participants. For example, the passive nature of their involvement may lead to a sense of disconnection and isolation which in turn may lead to uncivil behaviours such as failure to engage in group work or arriving late on placement.

Social bond theory (Hirschi, 1969) focuses on social bonding rather than social disconnect. This theory proposes the existence of four main modes of bonding between individuals that prevent or limit inappropriate behaviour: attachment, belief, commitment, and involvement. It has been suggested that these social bonds may play a role in constraining classroom incivility (Bray & Del Favero, 2004). Attachment to a student peer group that is rule-abiding may reduce the chance of incivility. Commitment to behaviour norms and belief in their appropriateness may sustain 'good' behaviour and involvement in shared activities, may strengthen inter-student bonds, and affirm positive behaviour norms. However, social bonding only limits incivility if the behaviours adopted are positive ones, if not then the theory could be used just as readily to explain how uncivil behaviours flourish.

Whilst social bond theory makes links between the way individuals bond and their behaviour, Bandura's social learning theory (Bandura, 1977) considers how individuals' behaviour can differ from group to group depending on the individual's level of commitment and attachment to

each (Akers, 1977). Accordingly, two of the most significant factors in determining the level of classroom incivility are the behaviours and beliefs of peers (Bray & Del Favero, 2004). Therefore, if a student's friends are behaving in a certain way he/she is far more likely to copy their friends' behaviour than the behaviour of the people they have less sense of attachment to such as the nurse tutor standing at the front of the class. This goes some way towards explaining why incivility seems more likely to arise in large classes because large social groups are usually comprised of lots of smaller social groups and within these sub-groups the sense of attachment between members is likely to be much stronger than within the group as whole.

The theories discussed thus far can be used to explain *why* incivility happens and *how* it can be prevented or managed. Symbolic interactionism, which stems originally from the ideas of George Herbert Mead (Carreira da Silva, 2007) which were then developed extensively by Hubert Blumer (1998), is of help when trying to understand *what* is happening when incivility is perceived.

Symbolic interactionism is a sociological school of thought which provides a pragmatic framework for understanding how people interpret and make sense of the various gestures and symbols which are exchanged between them in the process of social interaction. According to Blumer (1998) the theory rests on three basic premises. The first is that human beings' actions towards things or people are based on the meanings that the things have for them. The second is that the meaning of such things arises from social interaction and is subject to change. The third is that the meanings are perceived and modified through an interpretative process by the person who encounters them and therefore different people will assign different meaning to things.

Blumer (1998) described the tendency of psychologists and sociologists to treat human behaviour as a product of the various factors that play upon humans, for example psychologists are concerned with factors such as stimuli and attitudes and sociologists with factors such as cultural influences and social circumstance. Through these perspectives, it can be seen where factors such as gender bias and over-crowded classrooms fit in relation to contributing to uncivil behaviours. However, determining that certain types of behaviours arise simply as a result of the factors that produce them, neglects to take account of the role that meaning plays in the formation of human behaviour. Blumer stresses the importance of understanding the meaning things have for human beings, as well as the source of that meaning, i.e. in symbolic interactionism, meaning is central to understanding why humans behave in the way they do. The source of this meaning arises in the process of people interacting, in other words, the

meaning of a thing grows out of the way in which other people act towards the person with regard to the thing (Blumer's use of the word 'thing' can be taken to mean a stimuli, gesture or behaviour).

Blumer identified two forms of social interaction between humans: non-symbolic interaction where one actor responds directly to another without interpreting that action, as in the case of a reflex action, and symbolic interaction whereby the actor tries to make sense of the meaning through a process of interpretation. In symbolic interactionism, the symbols can take the form of anything including gestures, behaviours, objects and language. These are then responded to according to what the symbols or gestures mean to the recipient. The meanings symbols have for people are influenced by their social experiences.

The interaction happens in two stages, firstly as the actor identifies to himself the thing towards which he is acting (an internalised process whereby the actor is communicating or interacting with himself) and second, where the actor handles or interprets the meanings. Blumer stated that this interpretation is a formative process in which meanings are used as instruments for the guidance and formation of action, explaining further that 'in the face of the actions of others one may abandon an intention or purpose, revise it, check or suspend it, intensify it or replace it' (Blumer, 1998:8). Social interaction therefore is a process which forms human conduct rather than being just a means of expressing it.

The relevance of symbolic interactionism to incivility lies firstly in the notion that people make sense of the symbols they see or are exposed to, through a process of interpretation. When people perceive an incivility to have occurred, it is because they have interpreted somebody's action or behaviour to be rude. This interpretation is based on the person's prior social experience which will have influenced what they view rude or uncivil behaviour to be. This viewpoint will differ from person to person and may change over time as their social interactions continue to shape their beliefs and attitudes. The second point of relevance is that the process of interpretation guides a person's subsequent response, i.e. once incivility has been perceived, the person who interprets the action as uncivil decides how to respond. The response may be to react, respond or do nothing.

4.1.7 Literature review summary

The literature review suggests that incivility is a phenomenon which is recognised by a wide range of behaviours from the mildly disruptive to the overtly destructive, with variations in

experience between different cultures and countries. The factors contributing to incivility are numerous and there are several theories that can be used to explain what is happening when it arises. It can have physical and emotional consequences, can impact on student learning and has a specific relevance to nursing education, where there is potential for overspill into patient care. A number of incivility measurement tools have been developed although they fail to consider impact despite it arising as an issue in the literature. In addition, none are readily transferable to the UK context because of socio-cultural, educational, and healthcare differences. There are also several intervention strategies available although there is insubstantial evidence of effectiveness. Finally, there are various theories which are helpful in explaining why, how and what is happening when incivility occurs. The most useful of these is symbolic interactionism which offers a way of explaining the process of incivility in terms of the meaning we attach to the actions and behaviours of others.

Overall, there is a large global body of literature about incivility in nursing. However, despite this, there are still numerous gaps in the body of knowledge most particularly in relation to the UK. Specifically, there is a lack of knowledge and insight into the nature, impact, and contributory factors for incivility, and a very limited mentor perspective.

4.2   Research Aim and Objective

The findings of the literature review informed the aim of the study which was to gain insight into the nature, impact, and contributory factors of incivility in pre-registration nursing education in the UK from the perspectives of student nurses, nurse tutors and nurse mentors.

The objective is to develop an understanding of the nature of incivility in pre-registration nursing education to inform educational policy and strategy which will minimise incivility in the learning environment and support student nurses to develop the professional behaviours expected of qualified nurses.

4.3   Primary Research Question

i.   What is the nature of incivility in pre-registration nursing education as seen from the perspectives of student nurses, nurse tutors, and nurse mentors?

4.4 Secondary Research Questions

ii.   What commonalities and/or differences of perspective exist between student nurses, nurse tutors, and nurse mentors, in relation to incivility in pre-registration nursing education?

iii.   What is the impact of incivility in pre-registration nursing education?

iv.   What factors have the potential to contribute to, or cause incivility in pre-registration nursing education?

4.5 Chapter Summary

This chapter provides a critical review of the contemporary literature on incivility which identifies a gap in knowledge in relation to understanding the nature, impact, and contributory factors for incivility in pre-registration nursing education in the UK. The research questions developed as a result aligned with the review findings whilst the research objective ensured the practice-based focus is maintained.

As the study progressed, further literature emerged beyond that which related directly to the gap in knowledge about incivility. This literature is incorporated into Chapter 8 and supports the interpretative discussion of the findings. Here, new areas are explored in relation to the findings which include power, expectation, supernumeracy, self-esteem and confidence.

Having established an evidence-informed rationale for the research, it is now possible to turn to a consideration of how the study was conducted.

Chapter 5 Methodology, Design and Methods

In this chapter, a rationale for adopting an interpretative phenomenological methodology is presented and the alignment between the research aim, questions, design, methods, and analysis is shown. The methods used are detailed and issues of quality and trustworthiness are discussed. In the latter half of the chapter, ethical considerations are explored, and the research setting is profiled to aid decisions about transferability. Overall, the aim of the chapter is to set an ethically informed and logically reasoned research process which will theoretically underpin the credibility and robustness of the findings.

5.1 Working within a Post-Positivist Paradigm

A paradigm is a shared belief system or set of principles (Walliman, 2005) which describes the overarching belief system that informs the way that the research is conducted. The dominant paradigm for many hundreds of years was that of the scientific method which is characterised by systematic, controlled, empirical, and critical investigations about the presumed relationships between natural phenomena (Kerlinger, 1970, cited in Cohen, Manion, & Morrison, 2011:4). In this paradigm, also known as the positivist paradigm, researchers aim to generate knowledge that is value-free and objectively truthful.

An alternative paradigm, the post-positivist paradigm, contests the primacy of the scientific method, particularly in relation to the social sciences. Commonly held beliefs of post-positivists include that people construct their own social reality, that situations are significantly affected by context, that there are multiple interpretations of single events and that reality is multi-layered and complex (Cohen et al., 2011:17; Nisbett, 2005). Proponents hold that social phenomena, including human behaviour, can only be understood from the perspective of the individuals who are part of the circumstance being investigated. This requires an exploration of their interpretation of the world and therefore it is commonly referred to as an interpretivist approach. Researchers working within the post-positivist or interpretive paradigm utilise approaches where conjecture, subjectivity and reflexivity all play a part (Cohen et al. 2011:5), and where the value-laden nature of the social world is recognised (Popper, 1980).

Neither paradigm is beyond criticism; the post-positivist's focus on personal experience could be criticised for excluding more readily quantifiable facets of knowledge whilst the positivists

might be accused of dehumanising research by excluding notions of free-will and interpretation (Cohen et al., 2011:20-21). Nevertheless, where the purpose of the research is to gain insight into the human experience of a particular phenomenon, in-order to better understand the nature of that phenomenon, the methodology of the study will inevitably arise from within the post-positivist paradigm. This befits this study where understanding, rather than knowing, is the primary purpose.

5.2 Adopting a Phenomenological Approach

Phenomenology is a post-positivist methodology that seeks to explore and understand how phenomena are experienced by individuals (Smith, 2013); consequently it is an approach that is well-suited to the research aim which seeks to understand the nature of incivility in the context of pre-registration nursing education.

Phenomena can be described as things that are known to us through our senses; that is they are directly experienced rather than being abstract or conceptual (Denscombe, 2007:77). Phenomenological enquiry is therefore characterised by descriptions of experiences and perceptions (Polit & Beck, 2004:253). However, phenomenologists seek to understand more than just the sensory perceptions of experience. They attempt to gain a rich understanding of what it is to experience a phenomenon by looking for the meaning things have in our experience as well as the direct perception of them. This attempt to understand the significance of things such as objects, events, the flow of time, the self, and others, as they are experienced in our "life-world" (D. W. Smith, 2013), is central to the phenomenological approach. It is in this way that phenomenologists seeks to find 'critical truths' about reality (Polit & Beck, 2004:253). Phenomenologists are also concerned with the construction of social life by those that participate in it. Denscombe (2007:78) suggested that phenomenologists do this in two ways: firstly by regarding people as creative interpreters who through their interactions with the world make sense of it and secondly by recognising that the process of interpreting experiences is not unique to individuals but shared with others in the group. It is this commonality that allows people to interact effectively in social groups; without it people would be unable to communicate or to grasp the intentions or implications of others actions and there would be no basis for social life (Denscombe, 2007:79). However, the construction of social life by one group may differ to that of another depending on factors such as situation and culture. The acknowledgment of variation between groups results in the concept of multiple realities, each of which may be

different but no less valid than others; a view which conflicts directly with the view of positivists who seek explanations for one assumed reality (Denscombe, 2007:79).

Phenomenology is practised in different ways. The German philosopher Edmund Husserl, focussed on the study of the conscious experience as experienced from the first-person point of view (D. W. Smith, 2013). In his seminal text 'Ideas: General Introduction to Pure Phenomenology', Husserl defined phenomenology as the science of the essence of consciousness (Husserl, 1962). He suggested that the study of consciousness must be very different from the study of nature (the positivist view that had long been dominant), insisting that information and insight emerge from intense study of experiences rather than from large quantities of data. Specifically, Husserl focussed on pure descriptions of the lived experience, the beginnings of a methodology which became known as descriptive phenomenology (Polit & Beck, 2004:253). Central to the success of this method was the concept of bracketing, the process of putting aside, or holding in abeyance, one's preconceived beliefs and opinions to maintain an objective view of the phenomena (Balls, 2009; Polit & Beck, 2004:254). Smith, Flowers and Larkin (2009:14) describe the process of bracketing as proceeding through a series of reductions each of which offers a different way of thinking about the phenomenon in question. In doing this the inquirer is moved toward the true essence of the experience and the phenomenon is viewed in its purest form.

Martin Heidegger, once an assistant to Husserl and later an influential philosopher in his own right, stressed the importance of not just understanding but also interpreting the phenomenon under investigation (Polit & Beck, 2004:253). He believed that the latter could be done by relating events to context, especially social and linguistic context (D. W. Smith, 2013). His concern for what he referred to as 'Dasein' or 'being-in-the-world' (Denscombe, 2007:77) was central to his view on phenomenological enquiry. Dasein is described by Smith et al. (2009:16) as referring to the uniquely situated quality of human being. It is about being inextricably part of the world, about how the world appears to us, and how we make sense of it. From a research perspective, the idea of being-in-the-world is central to the interpretative approach which recognises that all experiences are perspectival, temporal and always related to something else (J. A. Smith et al., 2009:18).

Heidegger's belief in the importance of interpretation in context, or hermeneutics, led to the approach known as hermeneutic phenomenology. An important distinction between Heidegger's hermeneutic phenomenology and Husserl's descriptive phenomenology is the belief that it is impossible to rid the mind of preconceptions (Balls, 2009; Polit & Beck, 2004:254). Hermeneutic

phenomenologists believe that our own experiences are fundamental to the interpretation of those of others. The hermeneutic approach therefore presupposes some prior understanding on the researcher's part (Polit & Beck, 2006:221). This does not mean necessarily that the researcher will know about the subject of interest but because they are interpreting something in which they themselves exist, they cannot have a completely detached standpoint either (Koch, 1995). Hermeneutic (also known as interpretative) phenomenology therefore relies on our interpretations of others' interpretations of their experiences of phenomena.

Whilst there are now numerous different ways in which phenomenology is practised, the focus here has been on the two main ones: descriptive and hermeneutic (interpretative), because the fundamental difference between the two influenced the choice of which approach to adopt for this study. Whilst descriptive phenomenology initially had appeal as a means of getting a supposedly pure understanding of the phenomenon of incivility, it was felt that prior knowledge and personal experience of incivility would make it difficult to create sufficient distance from the data, even with the use of reductionist bracketing (the putting to one side of our taken-for-granted world in order to focus purely on our perceptions of the world (J. A. Smith, Flowers, & Larkin, 2009:13). It was also felt that any attempt to effect a complete separation of the experience from the context would result in the loss of valuable information such as the identification of factors that could contribute to incivility. As the interpretative (hermeneutic) approach recognises the intertwine of experience between researcher and participant as well as the relevance of context, it was chosen as the more suitable of the two approaches for responding to the research question.

Framing the study as an interpretative phenomenological enquiry kept the focus of the study on the phenomenon as experienced, whilst recognising the inevitability of the researcher's presence throughout the process.

The decision to explore incivility from the perspectives of three different groups of people acknowledges the different realities of both the groups and the individuals within them. In seeking to understand these various realities, and to find commonalities and differences between them, it was recognised that only one possible view of incivility would be presented in the findings; one that had been constructed by researcher and participants together.

5.3 Selecting a Qualitative Research Design

Having chosen to work within an interpretative framework, a method was required which allowed the participants to articulate their experiences in such a way that they could be comprehensively interrogated for the purposes of answering the research question. Qualitative methods do this by giving voice to the human experience through in-depth understandings of meanings, actions, behaviours and attitudes (L.Gonzales, Brown, & Slate, 2008). Qualitative data can be drawn from a number of sources, including interview and observation (Preissle, 2006). Qualitative methods, because of their focus on the human experience, are ideally suited for locating the meanings people place on the events of their lives and for connecting those meanings to the social world around them (Miles, Huberman, & Saldana 2014:11). The design selected for the study was therefore a simple qualitative design which comprised undertaking in-depth, one-to-one interviews with three different participant groups. The following sub-sections detail the methods adopted.

5.3.1 Data collection

In phenomenological enquiry, the most usual method for capturing the nature of an experience is interview because interviews enable researchers to hear first-hand narratives about participants' experiences, the focus for all phenomenological enquiries. However, in the interests of thoroughness, several other methods were considered before a final decision was made.

Ethnography, with its focus on 'individual's perspectives and interpretations of their world' (Miles, Huberman, & Saldana 2014:8), was a possibility. However, ethnography is concerned with both the mundane and unusual day-to-events of people's lives so the focus on incivility is likely to have been lost in a more general view of everyday life. Ethnography also requires sustained contact with a community over a long period of time (Miles et al., 2014:8) and on a practical level this would not have been possible, particularly given the interest in incivility as seen from the perspectives of three different groups of people.

Observational methods may also have revealed uncivil behaviour, but similar limitations of time and relevance would apply as in ethnography. None of the literature reviewed prior to commencing the study described using ethnography or observation as a primary method of

exploring incivility, and so there was no indication that other researchers had found them to be effective either.

Surveys were another consideration as they have been used by a number of researchers exploring incivility (see Chapter 3). Spence Laschinger, Leiter, Day and Gilin (2009), for example, used questionnaire responses to establish links between nurses' perceptions of supervisor incivility; empowerment and cynicism; job satisfaction; organisational commitment; and intention to leave. This enabled them to work with a large sample size (n=612), one of the key advantages of using surveys (Cohen et al., 2011:256). They can also be used to ask the same specific questions sets of everyone, thereby making post-survey data analysis easier. However, what is gained in terms of size and ease of analysis is lost in terms of depth and insight which are restricted by the pre-planned nature of the survey method, which lends itself to data collection of the 'what' or 'how many' kind. Whilst survey methods have been used effectively in incivility research, a survey could not give the kind of detailed, interviewee-led insight into the nature of incivility that was sought. Therefore, after due consideration of the alternatives, interviews were selected as the most suitable data collection method for the purpose.

Interviews can be defined as an interchange of views on a topic of mutual interest (Kvale, 1996:14, in Cohen et al., 2011:409), much as a conversation is. However, an interview differs from a conversation in that it has a specific purpose which is to collect the information of interest to the researcher. Specifically, Cohen et al. (2011:409) suggested that interviews can be used to enable people to express their interpretations and perspectives; a feature that aligns fully with the research aim. Interviews also allow the researcher to determine the course of the conversation, clarify points, and probe for further information, something which cannot be done easily using self-completion methods such as surveys or diaries. Likewise, the participants have the same opportunity, an important consideration when asking questions about a topic that is poorly understood. Denscombe (2007) suggested that the potential of interviews is best exploited in the exploration of complex and subtle phenomena, particularly those that are focussed on opinions and experiences. Incivility is such a phenomenon; it is not easily defined, and the nature of the experience is a question of personal perception, expectation, and prior experience.

Numerous other researchers have successfully adopted the interview method to explore incivility (Altmiller, 2012; Clark, 2008b; Del Prato, 2013; Ibrahim & Qalawa, 2015; Luparell, 2007; Papp, Markkanen, & von Bonsdorff, 2003). Altmiller (2012) for example, interviewed

twenty-four undergraduate nursing students about their perceptions of incivility in nursing education and compared it to the perspectives of nurse tutors as found in the literature. His use of interview technique allowed the phenomenon to be explored in depth and, although the number of participants was fewer than could have been achieved in a survey, the data was much richer. It was the richness of data achievable through interview that ultimately drove the choice of data collection method; a choice validated by the amount and richness of data subsequently captured.

5.3.2 Interview type

The choice between one-to-one and group interviews was informed by the research question i.e. the desire to explore participants' experiences in detail. In a group interview the dialogue can be hard to follow especially if several people speak at once. It is also harder to follow up individual comments, probe for more information, or discuss sensitive or confidential issues, something that was anticipated with the phenomenon in question. Although, group interviews do offer the advantage of time efficiency and a particular kind of dialogue generated through group dynamics (Denscombe, 2007:177), one-to-one interviews have the advantage of ensuring the only opinions heard are those of the participant and not those of the other members of the group. one-to-one interviews also allow the kind of in-depth exploration of the individuals' perceptions necessary to answer phenomenologically focussed research questions (Cohen et al., 2011; Polkinghorne, 1989). Given that talking and listening are 'everyday tools' of the nursing profession, it was also felt that a one-to-one interview would provide a familiar and reassuring medium for participants where they would feel able to share their experiences freely and fully.

5.3.3 Interview structure and consent

As interviews are usually planned events (Cohen et al., 2011:409) there is ample opportunity to decide how the process will be managed to maximise data value. To this end, interviewees were reminded at the outset as to what the interview was about, the consent form (Appendix D) was explained and their rights as research participants were reiterated. A simple conceptual diagram (Appendix E, The Pre-registration Nursing 'Tennis Court') was shown to all participants to focus their thinking on the area of interest and the interviews were all opened with the same two open-ended questions: 'Can you tell me what your understanding of incivility is' and 'Tell me about your experiences of incivility'.

Although the interview was intentionally loosely structured, the use of a simple interview guide (Appendix F) as suggested by Polit & Beck (2006:291), proved to be invaluable in ensuring that key areas of interest were covered whilst allowing the participants' individual experiences to be explored fully. The guide was developed following a focus group with nurse tutors, an informal discussion with mentors and students, and a review of the literature. After conducting two pilot interviews, an additional area of interest was added for the mentors and nurse tutors about their own experience of nurse training.

An advantage of using a guide rather than following a set of questions, was that it enabled new areas of interest to emerge naturally. Most notably, in one of the early interviews, a mentor talked about her experiences of working with students from Black and Minority Ethnic (BAME) backgrounds. As a result, the topic guide was revised to heighten awareness of this aspect of mentorship in subsequent interviews. The value of using the guide was evidenced by the richness of data gathered and its relevance to the research question. An overly structured interview can prevent this by allowing the researcher's own ideas and assumptions too much prominence in the interview thereby restricting the spontaneity and flow of the interviewee's responses.

5.3.4 Interviewer preparation

Bishop and Shepherd (2011) suggested there is much to think about when conducting research interviews including actively listening and maintaining positive, open body language. Skills specific to phenomenological interviewing have also been identified and include maintaining critical self-reflection and inhibiting the ego (Bevan, 2014). Therefore, to maximise the chance of conducting data rich, participant-focused interviews, interview preparation included attendance at an interview workshop for qualitative researchers, conducting two pilot interviews to practise questioning and listening skills, and discussing the qualitative interview process with a colleague who had recently completed her own phenomenologically-focussed doctoral research.

5.3.5 Data capture

All interviews were audio-recorded as the primary means of data capture. Audio-recorded interviews are the standard for phenomenological interviews as the focus is on the interpretation of the content of the participants' accounts rather than the prosody (rhythm or tune) of the

narrative (J. A. Smith et al., 2009:74). The transcription process was carried out in all cases within seventy-two hours of the interview so that the detail could be readily recalled. When the researcher carries out their own transcription, the narrative becomes embedded into the mind ready to return to many times throughout the rest of the analysis (J. A. Smith et al., 2009:75). This can bring the researcher closer to the data and provide a means of building theoretical sensitivity (Corbin & Strauss, 1990). From a personal perspective, transcribing the interviews had the additional benefit of enabling a critical reflection on the way each interview was conducted which in turn led to an improvement in interview technique as the research progressed.

5.3.6 Participant selection (sampling)

Probability sampling is based on the notion that every person in the study population has an equal chance of being selected; this ensures the sample is representative of the population being studied (Denscombe, 2007:14). The randomisation of the sample and the choice of study population (sampling frame) are also key to minimising the chance of sampling bias, where one characteristic (or more) of the sample is over or under represented (Polit & Beck, 2006:264) thereby skewing the results. A suitably sized randomised sample from a carefully chosen study population therefore enables the findings to be generalised to other, similar populations. However, phenomenological enquiry is about quality not quantity (J. A. Smith et al., 2009:51) and the purpose is not to generalise but to gain insight into the experience of a particular phenomenon. The focus of participant selection was therefore on selecting participants who had relevant experiences to share. Non-probability sampling strategies do this by moving the aim of the 'sampling' process away from objectivity and representativeness towards the elicitation of meaningful data. Some authors suggest that the term sampling shouldn't be applied to qualitative research as the phenomenon or individual being researched is only representative of itself, it doesn't need to be and nor is it usually, a 'sample' of any population (Cohen et al., 2011:161). The use of participant selection is therefore adopted here as a more meaningful term in the context of this type of study.

There are several non-probability strategies available; of these, convenience and purposive (or purposeful) were the two most broadly suited to the selection of interview participants. Convenience selection involves using the research participants that are most easily available (Cohen et al., 2011:155-156) . However, Polit and Beck (2004) caution against using convenience selection because although it can be more efficient it can also result in information-poor participants. Purposive selection is a more focussed approach than convenience selection.

Sometimes used interchangeably with the term purposeful or sometimes referred to under the general umbrella of purposeful strategies, purposive selection is the selection of participants who are most likely to be able to provide the right kind of information for the study purpose. This was the selection strategy adopted because selecting participants specifically because they have the characteristics being sought (Cohen et al., 2011:156; J. A. Smith et al., 2009:49) is more effective than adopting a strategy which could exclude the very people who have experienced the phenomenon of interest (as is possible if using a probability sample) or simply fail to capture them because too few people have experienced it (as is possible in a convenience 'sample').

Patton (2002:230) suggested that it is the selection of information-rich sources that is the key to the 'logic and power' of purposeful selection whilst Polit & Beck (2006:270) describe the importance of selecting interviewees who are articulate, reflective and willing to talk at length to a researcher. However, the latter also note that for phenomenological enquirers this approach should not go so far as to exclude the diversity of individuals or of individual experience (Polit & Beck, 2006:274). In reality, neither of these circumstances arose, as all participants who came forward were interviewed regardless of their interviewee 'credentials' and the strategy chosen was justified by the rich and relevant data that was yielded as a result.

Finally, a note on the choice of the term participants. This term was chosen because it best describes the nature of the interviewees' involvement in the research. They are not passive actors in the interview; they are actively contributing to and participating in a process where meanings are constructed as a consequence of the experiences they have shared. Terms such as 'subject' suggest a passivity which does not marry with the concept of eliciting personal perspectives and the term informant has a legal/surveillance type connotation which is contrary to the ethos of phenomenological methodology.

5.3.7 Participant recruitment

Student nurses were recruited by placing an advert as a news item on the school's virtual learning platform (VLE). Permission to recruit student nurses was obtained from the programme leader and the relevant senior academic manager (Appendix G).
Nurse tutors' interest in the research topic was sparked initially by bringing together a group of them to talk informally about incivility as part of the preparation for the pilot study (conducted to test out the interview process). All those who came indicated a willingness to be interviewed at a later date and so were among those first approached to participate. Invitations to participate

were made by email. Further on in the study, a poster sharing the small-scale study findings was displayed at the school learning and teaching conference prompting two more colleagues to come forward and declare their interest in being interviewed. One nurse tutor was approached directly because she had experienced behaviour problems with a group of students and it was felt she may have an interesting experience to share. All those that agreed to participate had something of relevance to share and there was a gender and ethnicity mix which reflected the wider staffing group although these were not sought out specifically. Permission to recruit nurse tutors was obtained from the relevant senior academic manager (Appendix G).

Recruitment of nurse mentors was challenging due to their time limitations. Many nurses in hospital settings do twelve hour shifts which restricts the time for participating in interviews before or after a shift. Those working in community settings find it equally difficult to spare the time and are also on the move constantly and unpredictably. Break times for nurses are limited and it was felt that it would not be ethical to encroach on this much needed rest time. Offers to meet mentors at a place of their choosing away from work had limited success as had recruitment via mentorship update workshops and enlisting the support of a hospital-based education facilitator.

The mentor participants were being sought from the HEI's two main partnership NHS trusts where student nurses were placed for the clinical aspects of the pre-registration programme. The perceived advantage of using local mentors included that they were geographically accessible and that the local pre-registration education and placement working framework was known and understood, a fact which it was felt would facilitate the contextualisation of the findings. An aspirational advantage was the potential to use the findings to enhance practice locally, something that would be harder to do if the study took place in an organisation unrelated to the researcher's own practice area. Permission to recruit was obtained from the relevant senior nurse manager in each Trust (Appendix G). However, despite having permission to access two large nurse mentor communities, the numbers recruited were lower than hoped for.

5.3.8 Participant numbers

The difficulty of knowing how many qualitative interviews are required, is well recognised and to be expected given the exploratory nature of qualitative research (Cohen et al., 2011:143-163). Baker & Edwards (2012) suggested that the starting point is to interrogate the purpose of the research. The original aim was for six-seven interviews from each participant group (eighteen to twenty in total) with the hope that this would provide a good depth and range of experiences

from each of the participant groups. In keeping with a phenomenological approach, the main aim of the interviews was to get to the rich detail of each participants' experience so that what emerged was a well-rounded picture of the phenomenon as perceived by the participants. Baker and Edwards (2012) report the need for this 'richness, complexity and detail' as a basis for building a convincing analytical narrative. The number of interviews therefore needed to be sufficient to get the desired detail but not so many as to become repetitive or unmanageable in the analysis stage.

Some cite saturation as being central to qualitative sampling (Baker & Edwards, 2012) but knowing if it has been achieved requires data analysis to be an ongoing process so that the numbers of planned interviews can be adjusted in a timely manner. Mid-way through the data collection the data was reviewed, and many recurring themes were noted, along with a couple of possible new ones. It was therefore decided to conduct further interviews (with new participants) to see if saturation could be achieved (the point at which no new perspectives or themes emerged from the narratives). Mason (2010) described this is as the point of diminishing return whereby more data does not necessarily lead to more information. Similarly, Strauss and Corbin (1998:136) suggested that saturation is about reaching the stage where there is nothing new to add to the overall story. The eighteen interviews with nurse tutors and students did reach a point where no new information or insights emerged but the mentors were a smaller group who were very difficult to recruit and who gave shorter interviews. Saturation was therefore not reached with any certainty and so stands as a limitation to the research findings.

Twenty-five interviews were conducted in total (nine tutors, nine students and seven mentors).

5.3.9 Data analysis and management

Miles et al. (2014:12-14) describe qualitative data analysis as comprising three concurrent flows of activity: data condensation; data display; drawing and verifying conclusions. Data condensation refers to the process of selecting, focussing, simplifying, abstracting, and/or transforming data. It starts at the earliest stages of the research design when research questions and data collection methods are decided and continues to the stages of coding and developing themes through to the final reporting phase. Miles et al. (2014:12) stress that data condensation is not separate to analysis, it is the part of it which 'sharpens, sorts, focuses, discards and organises data in such a way that final conclusions can be drawn and verified'. Data display is the process of deciding what data to display and how to do it so that it is in an accessible, compact form which allows the analyst to see what is happening easily. Display

design can be in the form of lists, tables, charts, and diagrams and includes decisions about how data in spreadsheets is organised and what data, in which form is entered (overlapping with data condensation activity).

The third activity is drawing and verifying conclusions which starts with data collection as the analyst interprets the meanings of what they see, making notes of patterns, explanations, and propositions. The process of verification can happen through various means including cross-checking of notes, peer review, and further data collection to confirm plausibility. Miles et al. (2014:13) describe how early conclusions should be 'held lightly' and an openness and scepticism maintained before allowing conclusions to be become more explicit and grounded in the final stages as a result of verification. Overall, these three activities represent the ongoing, iterative nature of qualitative data analysis and provided a useful framework against which to consider the process of data analysis in more detail.

The primary influence on the approach to data analysis was Interpretative Phenomenological Analysis (IPA) (J. A. Smith et al. 2009:1-3). This approach draws on three theoretical perspectives: phenomenology, hermeneutics, and idiography, to explore how individuals make sense of their life experiences. The phenomenological component of IPA is found in the selection of a phenomenon, commonly experienced or otherwise, that is explored through a lived-experience perspective. J.A. Smith et al. (2009: 11-21) describe how the notion of the lived-experience is informed by the theoretical works of four phenomenological philosophers: Husserl, Heidegger, Merleau-Ponty and Sartre. The interpretative (or hermeneutic) component, informs IPA as the researcher, in a conscious and systematic way, attempts to make sense of how the participant is trying to make sense of their experience, in this case incivility. However, access to the experience is always via the individual's own account of it, so the researcher can only ever interpret the experience at second-hand, making it in reality, a double hermeneutic process. Finally, the idiographic element of IPA is found in the strong focus on the individual experience whereby the researcher tries to understand what it feels like to have a particular experience. By understanding how an individual makes sense of their experiences there is a focus on the personal and individual experience, in great detail but often with small numbers (J. A. Smith et al., 2009:3). In keeping with an idiographic approach, IPA does not aim to make generalisations, but rather to give an in depth account of experiential phenomena (J. A. Smith & Osborn, 2003).

IPA is a relatively new approach developed originally to capture experiential data in psychology. However, it translates comfortably to any research where the focus is on the human

predicament (J. A. Smith et al., 2009:5); it therefore works well for the human, health and social sciences including education. Importantly for this research, IPA aligns fully with Heidegger's postulation of phenomenology as an explicitly interpretative activity (Watts, 2014).

In IPA studies, which usually involve relatively homogeneous samples, the researcher investigates differences and similarities between cases as well as the individual perspectives of participants (J. A. Smith et al., 2009:3). This approach is characterised by the application of a set of common principles and processes which are used flexibly according to the analytic task in question (J. A. Smith et al., 2009:79). This is described as an iterative and inductive process which draws on a number of different strategies (J. A. Smith, 2007) whereby one must look at the whole to understand the parts, and look at the parts to understand the whole. These strategies include line by line coding, identification of emergent themes; the development of a dialogue between researcher and coded data about what it might mean for participants to have these concerns, the testing of coherence and plausibility of the interpretation and the development of a commentary on the interpretation. Although the analytical process focusses strongly on the phenomenon as experienced by the participant, the end result is always an account of how the analyst thinks the participant is thinking (J. A. Smith et al., 2009:80), that is to say, it is their interpretation of the experiences described.

J.A. Smith et al. (2009:79) are at pains to stress that IPA is an approach rather than a prescribed method. However, the authors do offer a step-by-step guide as a means for helping the novice researcher to get started (J. A. Smith et al., 2009:79-103). This is intended as a platform from which a more sophisticated analysis can be developed by moving from the particular to the shared, and from the descriptive to the interpretative (J. A. Smith et al., 2009:79-107). This step-by-step approach was adopted along with some minor additions which drew on the work of Miles et al. (2014). The combination of approaches resulted in the development of a bespoke process guide which promoted rigour and consistency throughout the analysis process. Consistency of approach was also applied retrospectively, for example where an additional layer of coding was added during the analysis of the mentor data which was the last to be interrogated, the student and nurse tutor data which had already been analysed were then revisited using the same approach.

Table 3 shows the data analysis process guide with the key steps in the analysis process as set out by J.A. Smith et al. (2009:70-103) with additional steps drawn from the work of Miles et al. (2014) shown in blue. An example coded transcript at 'initial noting' stage, is attached at Appendix H.

Table 3 Data analysis process guide

Component	Action	Purpose
1. Reading and re-reading transcripts	Note any relevant observations immediately post-interview. Transcribe interview audio with 'ums', 'ers', pauses and notation of significant non-verbal sounds and body language. Listen to the interview audio and re-read the transcript. Become familiar with the flow and rhythm of the interview, the stories within the story, the key points and micro-detail.	Active engagement with the data / data immersion. Focusses on the person. Prevents quick reduction and hypothesis.
2. Initial noting	Assign first cycle codes (inductive coding). Maintain open mind and work line by line. Interrogate rather than just read. Examine semantic content and language (descriptive and linguistic comments). Look for time frames. Look for things that matter to the participant and the meaning of things. Think about the context of their concerns. Deconstruct if needed to bring words into focus. Add interpretative notations and general jottings as they arise. Identify abstract concepts to help make sense of the account (often moves away from the explicit claims of the participant). Revise and discard code labels as necessary.	Allows the retrieval of the most meaningful material. Produces comprehensive notes and comments. Focusses on participant but also adds interpretation. Recognises influence of own experiences and/or professional knowledge. Part of the inductive process.
3. Developing emergent themes	Assign second cycle codes (cluster similar codes together to create categories). Using the notes, map the interrelationships, connections, and patterns between the exploratory notes. Develop themes (categories, causes/explanations; relationships among people; theoretical constructs) to identify what is important – in the line and in the wider text (particularity and abstraction). Continue adding interpretative notations and general jottings as they arise.	Shifts analysis to interpretive phase whilst remaining closely involved with the experience of the participant.

4. Searching for connections (patterns) across emergent themes	Consider how the themes fit together (put on a list or print them out separately, move them around, group and sub-group until reduced). Group according to context, frequency of occurrence, function, similarity, or difference. Discard as necessary. Abstraction or subsumption leads to superordinate themes over groups of sub-themes. Test themes against the transcript and revise as necessary. Continue adding interpretative notations and general jottings as they arise.	Moves the analysis forward by separating themes into top level and sub-level level themes.
5. Moving to the next case	Repeat with new transcript. Keep open mind and set aside previous interpretations.	Allows new themes to emerge. Safeguards against deciding themes too early in process.
6. Looking for patterns across cases	Look for patterns across the cases. Look at all the transcripts together as a group to make connections, look for omissions and identify outlying comments. Compile superordinate and subordinate themes. Look for visual ways of displaying data. Use analytic memos to document thinking and reflections about the data (throughout). Test assertions and propositions.	To ensure rigour and consistency of process.

The primary means of managing the data was electronic which entailed working between a word-processed document and a spreadsheet. The insert comments function enabled me to add general annotations and then label and code the transcribed interviews whilst the spreadsheet enables me to organise the codes into categories. Version controlled documents and the addition of electronic 'notes to self' provided me with a dated trail of documents reflecting the emergence, revision, and consolidation of new codes, categories, and themes.

5.4 Acknowledging and Minimising Researcher Bias

The means by which researcher impact was reduced included being prepared to modify presuppositions during the process and recognising the extent of influence of prior knowledge on the process, both as described by Cohen et al. (2011:179). To account for this, an analysis of personal biases and presuppositions was conducted as suggested by Polit and Beck (2006:211). This was used to increase self-awareness and enabled a reflexive stance to be adopted during the research process. This aspect of the study is explored further Chapter 6.

5.5 Quality and Trustworthiness

Miles et al., (2014:311-12) offer some practical guidelines to help qualitative researchers consider the quality and trustworthiness of their findings. The application of these to the study is outlined below.

Objectivity and confirmability – A neutral stance has been maintained wherever possible whilst the inherent subjectivity of the chosen methodology and topic area has been acknowledged. Suppositions are supported by data extracts (Chapter 7) and personal assumptions, values, and biases are articulated along with a critical evaluation of how they may have impacted on the study (Chapter 6). The data analysis method has been detailed so that the processes utilised are transparent and reproducible (Chapter 5). The overall aim is to show how the research findings have arisen from the data rather than from a set of personal bias and influences.

Reliability / dependability / auditability - The reliability and dependability of the study can be seen in the alignment between the aim, methodology, methods, and study design; the detailing of the methods, and the care shown in maintaining the integrity of the findings (Chapter 7 and 8). An experienced researcher was asked to act as a 'sense checker' in the latter stages of data analysis. This was done by means of meeting to discuss the emergent themes and the data extracts supporting them. This was particularly helpful in terms of refining the themes.

Internal validity / credibility / authenticity - Presenting the findings at several meetings, confirmed the presence of Saldana's (Miles et al., 2014:313) 'That's right' factor, which indicates that the findings resonate with the audience. To resonate, they need to be believable as the plausibility of the participants' accounts will have a bearing on how credible and authentic the

findings are judged to be. The findings chapter has particular relevance here as it seeks to share the participants' first-hand accounts in a simple, easy-read format which allows the authenticity of the stories to come through.

External validity / transferability / fittingness - The detailed (thick) participant descriptions and rich contextual information will help readers to assess the potential for transferability. Miles et al. (2014:314) contend that it is the overall persuasiveness of the write-up that determines the transferability of the findings to other contexts.

Utilisation / application / action orientation - The final standard described by Miles et al. (2014:314) relates to the applicability of the findings or in other words, what the study does for its participants and for its consumers. Locating the study in the researcher's own area of practice ensures the findings can be used to enhance local nurse education practice. To date, the findings have been used to influence change in a number of ways including through involvement with the University's Black and Minority Ethnicity (BAME) Group (promoting equality of opportunity for BAME students), the establishment of an Attainment and Inclusivity Group (promoting equality of opportunity for all students regardless of ethnicity, gender or age) and by working with mentors to raise awareness of how students experience placement.

5.6   Ethical Considerations

This section shows how ethical thoughtfulness informed key stages of the research process although ethical considerations arose at every stage from the decision to explore incivility to the decision as to what to include in the findings and what to leave out.

Approval to proceed was granted by the University's Ethics Committee in 2015 (Appendix I) and again in 2016 (Appendix J) when a request to extend the numbers of participants was submitted. As described previously, permission to undertake the research in the various settings was obtained through the relevant personnel (Appendix G).

The consideration of the rights of individuals and other ethical issues are an important dimension of all well-conducted research. This requires that researchers should act with honesty and avoid deception or misrepresentation throughout the research process (Denscombe 2007:141). One aspect of this is ensuring that the participants know the truth

about the research they are being asked to participate in and their role within it. This was achieved through the provision of written information (Appendices K, L, M) which was given out at the invitation stage, providing the basis for obtaining informed consent in a one-to-one discussion which took place before the interview.

Consent, confidentiality, and consequences are described by Cohen et al., (2011:442-443) as the three main ethical issues relating specifically to interviewing. Consent is the formal stage of ensuring that participants know exactly what the research is about and what their involvement entails (Denscombe, 2007:145). The signing of a consent form not only ensures that the participant's willingness to participate is recorded; it also protects the researcher from any accusation of impropriety relating to the recruitment process (Denscombe, 2007:145).

Long (2007:53) described how even with informed consent, external pressure (coercion) can prevent free choice, and how this may be brought to bear unintentionally in the selection of participants. One aspect of this is where there is a perceived power differential, i.e. where one person is in an apparent or actual position of seniority or influence over another. This was an important consideration for somebody working in a senior position in the research setting, particularly in relation to the nurse tutors and the students. It was less of an issue with the mentors because they had relatively little contact with the institution and none with the researcher directly. The potential power differential was managed by taking care to separate out the researcher and academic roles. For example, the researcher's name/title badge was removed before interviewing and interviews were conducted in meeting rooms rather than in the researcher's everyday work office.

Given the potential of the interviews to identify people and places in a negative light, the principles of confidentiality and anonymity (Long, 2007:56-57), were given particular attention. Participants were asked to avoid revealing the names of people and places during the interview and where mention of these or any other potential identifier was made, it was removed during transcription; the completed transcripts were then sent back to the participants to be double checked for any missed breaches. The wording on one of the transcripts had to be changed as a result of this because a participant had referred to having a husband during the interview and she felt this this may have identified her. Confidentiality and anonymity were further preserved by using pseudonyms in the writing up of the findings.

Breaches of confidentiality have the potential to lead to embarrassment, financial loss and even legal action (Denscombe, 2007:143). All research-related data were therefore secured on a

password-protected laptop backed-up on an encrypted memory stick kept in a locked drawer in the researcher's home office. Furthermore, all interview data were handled by the researcher, so the risk of data loss or misdirection was minimised.

The third of Cohen et al.'s three main ethical issues is consequences, by which it is meant that participants have the right not to be harmed as a consequence of their involvement in research. Harm is often thought of in terms of trauma caused by physical intervention but consideration of psychological harm is just as important (Denscombe, 2007:143). Some interview topics can be emotive and even those subjects that are not overtly sensitive can elicit a degree of upset (Williamson, 2007:14). As discussion about incivility has the potential to surface a wide range of emotions, referral routes to support personnel were identified so that participants could be referred onward if needed. Johnson (2007:40) suggested that this kind of strategy illustrates a risk-benefits approach rather than a rights-based one because it moves away from the notion of protecting the participant at all costs and introduces the idea of weighing up the risks and benefits of various actions and taking the least harmful, most beneficial course of action.

Another area of potential harm was in knowing the individuals being referred to at interview, or of knowing the interviewees themselves. In this respect, the potential for harm lay in responding negatively to a situation or decision because of something that had been heard at interview. As this information could not be 'un-known' once heard, it was important to maintain a high level of awareness about the interview content, not just at the point of interview but in everyday working practice as well (Chapter 6).

One further aspect of potential harm did not become fully apparent until the later stages of the research. This was in relation to the findings, some of which may reflect negatively on the research setting (both the institution and its NHS partners), for example the incidents of bullying and racism. In this situation, a decision had to be made about how the findings could be shared with the wider nursing community whilst still protecting the identity of the setting. The alternative would be to not share the findings at all which would be unethical in itself given the participants commitment to sharing their stories for the improvement of the nursing profession. To fail to act on the findings would therefore be to knowingly allow poor practices to continue unimpeded. Other issues of an ethical nature included ensuring the right of participants to withdraw from the research at any time with no negative consequence (Williamson 2007:347). This was particularly relevant given the researcher's seniority in relation to the nurse tutors (albeit with no line management responsibility) and in relation to the students who might have wondered whether their grades could be negatively influenced if they withdrew. It was also recognised that

participants might need to withdraw for practical reasons such as assignment pressures or clinical commitments. The freedom to withdraw without consequence was explained to participants during recruitment and at the interview outset. In addition, they were emailed two days before the interview to check if it was still convenient to proceed; this ensured they had opportunity to delay or cancel the interview if needed.

Once in the interview, there were experiences that were shared that raised concerns from an ethical perspective such as hearing about substandard patient care and bullying behaviours. In these cases the interviewer's responses were guided by the profession's code of conduct (Nursing and Midwifery Council, 2018b) and the British Educational Research Association guidelines for ethical research (BERA, 2011).

Further ethical considerations including the right not to be over-researched and conversely, the right to be researched, were upheld through the recruitment process and the relatively short data collection period. The research was theoretically open to any student, nurse tutor, or mentor with relevant experience to share and there was no pressure to participate or otherwise. The participants involvement of approximately one hour in an interview was not onerous in terms of time commitment or physical demand, both factors to take into account when protecting participants from being overly burdened (Williamson, 2007:11).

Finally, incentivising through payment was considered for the mentor participants due to the difficulty of recruiting them; however, it was decided against because of the potential impact on the quality of the data collected. As described by Head (2009), payment could result in participants volunteering just for the payment and not because they had anything of relevance to share. As the value of the phenomenological interview lies in the depth and detail shared by the interviewee, there would have been no gain in interviewing people with little of relevance to say. The recruitment 'adverts' therefore appealed instead to participants' interest in the development of civil learning and working environments for the benefit of all.

5.7 The Research Setting

The research setting is an NMC approved HEI and its partner NHS healthcare settings. The HEI is a post-1992 campus based-university in the south of England, serving an overall student community of around 25,000. The pre-registration nursing programme is one of approximately

eighty NMC approved programmes offered in the UK and has an average intake of about four hundred student nurses per year based on the last five years.

The programme offers pathways into all four fields of nursing: mental health, children, adult and learning disability. For the duration of the study there was an average of seven hundred and eighty (780) adult, one hundred and sixty mental health (160), one hundred and eight (108) children's and one hundred and eighty-five (185) learning disability nursing students at any one time; an overall total of about twelve hundred (1220) students.

The demographic profile of the student population varies between the fields. A typical profile for each field based on the most recent data (2016-17) can be seen in Table 4 which shows the numbers of students against each category sub-heading and the percentage breakdown in brackets.

Table 4 Student demographics

Field	Age		Gender		Ethnicity	
Adult	18 – 24	= 538 (64%)	Male = 63 (7%)		Black/Black British	= 356 (42%)
	25 – 39	= 228 (27%)	Female = 781 (92%)		White	= 310 (37%)
	40+	= 78 (9%)			Asian/Asian British	= 122 (14%)
					Other/Info refused	= 56 (7%)
	Total	**= 844**	**Total** **= 844**		**Total**	**= 844**
Children's	18 – 24	= 93 (83%)	Male = 3 (3%)		Black/Black British	= 20 (18%)
	25 – 39	= 16 (14%)	Female = 108 (97%)		White	= 72 (64%)
	40+	= 2 (2%)			Asian/Asian British	= 11 (10%)
					Other/Info refused	= 8 (7%)
	Total	**= 111**	**Total** **= 111**		**Total**	**= 111**
Mental Health	18 – 24	= 80 (45%)	Male = 38 (21%)		Black/Black British	= 69 (39%)
	25 – 39	= 75 (42%)	Female = 139 (78%)		White	= 81 (46%)
	40+	= 22 (12%)			Asian/Asian British	= 11 (6%)
					Other/Info refused	= 16 (9%)
	Total	**= 177**	**Total** **= 177**		**Total**	**= 177**
Learning Disability	18 – 24	= 58 (29%)	Male = 23 (11%)		Black/Black British	= 128 (64%)
	25 – 39	= 82 (41%)	Female = 177 (88%)		White	= 56 (28%)
	40+	= 60 (30%)			Asian/Asian British	= 10 (5%)
					Other/Info refused	= 6 (3%)
	Total	**= 200**	**Total** **= 200**		**Total**	**= 200**

NB Percentages have been rounded and so do not add up to 100% in all cases.

The taught element of the programme comprises a mix of generic nursing modules and field specific modules. This structure means that students experience a combination of learning within their field specific cohort and learning with students from all four fields. Generic modules typically include lead lectures for large groups (several hundred students), followed by seminar groups (approximately thirty-five students per group) whilst the delivery of field specific modules varies according to the size of the individual cohort. Clinical skills development and simulation are situated within the taught modules and complement the theoretical aspects of the

curriculum. There are also two interprofessional modules which give the students an opportunity to learn with students studying on other health and social work programmes. Curriculum delivery is supported by approximately fifty nurse tutors, about twenty of whom are part-time. There is an average staff-student ratio of about 36:1.

The HEI works in partnership with its local community (primary) and hospital (secondary) NHS trusts as well as various organisations in the private and voluntary sector to provide clinical placements for students. Placements of between six to eight weeks are interspersed with the taught modules. When on placement, students are allocated a mentor who is responsible for conducting their initial interview and for carrying out the mid-point and end of placement assessment. The HEI supports the training and development of the mentor population via an accredited mentorship programme and annual mentorship updates. Each placement area is further supported by a Link Lecturer who is based in the pre-registration team and, if the placement is within an NHS Trust, there will also be a Practice Educator based in the clinical area.

5.8 Research Setting Challenges

The primary challenge of researching one's own workplace was to ensure a clear differentiation between the role of academic leader (day job) and the role of researcher (doctoral student). This was necessary to ensure that participants felt able to share their experiences without concern that they would be used against them in some way and without the expectation that any concerns raised by them would be pursued outside of the interview, i.e. through the academic leadership role.

In relation to nurse tutors, managing this challenge was made easier by the absence of a line management component which can reduce the power element of the relationship and increase the chance of obtaining credible data (Savin-Baden, 2004). Certainly, it appeared that the nurse tutors felt able to talk openly about their experiences although it is possible that they purposefully revised or withheld information, especially if they felt their narratives might reflect poorly on them as teachers.

The students seemed unaware of the researcher's academic role in the school, most probably because they tend to identify more closely with their programme of study rather than the school

they are studying in. In the interviews, they appeared keen to share their stories although, like the nurse tutors, it is not possible to know whether they revised or amended their experiences because of who was interviewing them.

The nurse mentors were the participants that were most distanced from the academic leadership role. They were employed by an NHS partner trust and the researcher was not involved in any of the mentor training delivered by the HEI. As with the other participants, there was a concerted effort to put aside the academic role during the research process. However, again it was difficult to know whether there was any role-related influence on the data collected.

Although being an insider researcher has challenges in terms of how the researcher-participant relationship is managed and the biases that can arise, it also has distinct benefits over researching an unknown setting. These include having familiarity with the context in which the participants learn and work which makes it easier to identify and explore shared reference points during the research and being able to use the findings to directly influence the practice setting in a way that may be more difficult as an outsider.

The challenges and advantages of being an insider researcher are explored further in Chapter 6.

5.9 Chapter Summary

This chapter has provided a detailed explanation of the methodological influences framing the study and detailed an aligned, informed, and logically reasoned research process in order to establish the credibility and robustness of the findings. Key ethical considerations are highlighted in-order to demonstrate how an ethical approach has informed the research process and the research setting is described to assist with judgements about transferability. Finally, some of the challenges of working as an insider researcher are described as a precursor to the subject matter of Chapter 6.

Chapter 6 builds on the discussion about working in a post-positivist paradigm and explores issues of bias and subjectivity in relation to working as a qualitative, interpretative researcher.

Chapter 6 Surfacing and Countering Subjectivity

The aim of this chapter is to set out how the inherent subjectivity of the chosen research approach has been managed in such a way as to minimise the impact of personal bias on the research process and findings. To do this, epistemological and ontological positions are articulated, and the inherent subjectivity of qualitative research is explored. This is followed by a consideration of the role of reflexivity in countering bias and an explanation of how reflexivity was integrated into the research process. Finally, the chapter considers how being reflexive contributed to the quality and credibility of the findings.

The chapter builds on earlier sections of the thesis where the researcher's personal interest in incivility (Chapter 2) and the nature of working in a post-positivist, interpretivist paradigm (Chapter 5) were discussed. Much of the chapter is written in the first person to convey the personal nature of the perspectives and positions offered.

6.1 Personal Stance - Epistemological and Ontological Considerations

Epistemology is the question of what is regarded as acceptable knowledge in a discipline. A central issue in epistemology is the question of whether the social world can be studied according to the same ethos, principles and procedures as the natural sciences (Bryman, 2008:11). The natural sciences are generally explored from a positivist stance, a position that advocates the application of value free objectivism for the purpose of generating and testing hypothesis. Acceptable knowledge in this context is knowledge that can be confirmed by the senses (Bryman, 2008:10). Interpretivism offers an alternative view, whereby the researcher recognises the distinctiveness of the human experience in contrast to that of the objects of the natural sciences. Bryman (2008:13) suggested that the essence of the difference is in the emphasis on the *explanation* of human behaviour that marks the positivist approach and the *understanding* of human behaviour that defines the interpretivists' approach. It is the latter that is regarded as acceptable knowledge from an interpretivist's viewpoint (Grondin, 1994; S. E. Porter & Robinson, 2011; J. A. Smith et al., 2009) .

My position is rooted firmly in interpretivism, not only because I am seeking to add to what is understood about the experience of incivility which is clearly an interpretivist endeavour, but

also because this type of knowledge is of considerable value to the nursing profession which has a strong focus on understanding human experiences of life, recovery, illness and dying. In keeping with the value I place on knowledge generated through interpretivism, my ontological position is that of a constructivist. This is to say I believe that individuals construct their own contextualised realities informed by their experiences, perceptions and understanding of the world around them. Bryman (2008:17) captures the essence of this position by suggesting that social phenomena and their meanings are continually being accomplished and then revised by people (social actors) through their social interactions. The findings I share in this thesis are therefore reflective of my personally constructed version of reality at a particular period in time and as a consequence they cannot be considered *the* answers to the research questions but rather *one* possible set of answers amongst a wide range of possibilities.

6.2 Personal Stance – from Positivism to Interpretivism

I trained as a nurse at a time (1983-1986) when the clinical practice of many nurses was still steeped in the non-evidence based rituals of the Nightingale era (Nightingale, 1860), from two hourly turning of patients in bed to vigorous skin rubbing for pressure ulcer prevention. However, with the help of some of the earliest and most influential nurse researchers including Virginia Henderson (1897-1996), Hildegard Peplau (1909-1999) and Betty Neuman (1924-present), nurses soon began to understand and embrace the notion of research-informed nursing practice.

Important though it was for nursing to adopt an evidence-informed practice base, the tendency at the time was to produce nursing research in a form that mimicked the medical model of 'good' research. This was a positivist viewpoint which put the double-blind randomised control trial (RCT) at the top of the evidence tree (D. Evans, 2003). My formative nursing years were therefore spent being imbued with the belief that all 'proper' research was positivist. It is only relatively recently that qualitative research has become more widely accepted as a credible source of knowledge for nurses to draw on (Cutliffe & McKenna, 1999) alongside and sometimes in place of the so called 'gold standard' RCT. Although it is true that in many situations the results of RCTs are able to improve the care that patients receive, nursing is a complex, multi-faceted practice, much of which does not lend itself readily to quantification; this is where qualitative research has proved to be of such value.

It was only when I started to teach in HE that I really understood this value, mainly because I could relate it to the kind of subjects I was teaching. During this time, I grew in confidence as a teacher, completed a Master's degree in education, and started writing for publication. As a consequence, I became more knowledgeable about different research methodologies and more confident in my judgement as to what made a piece of research credible. This confidence was further enhanced by the move away from clinical practice and into an academic environment where I came under the influence of colleagues who were regularly engaged in scholarly and research activity. I did not stop valuing quantitative research, but I had found a valid methodology in qualitative research and it is this approach that I still find most interesting and revealing when it comes to thinking about what nurses do and what nursing is.

My upbringing in the positivist paradigm, my later exposure to qualitative approaches and my eventual settling in the post-positivist interpretivist camp brings me to where I am today as a researcher. I have a healthy respect for the types of certainty that the positivist approach can offer but my ontological perspective is primarily a naturalistic one where multiple realities abound and truth is a somewhat slippery concept. This inclination led me to select a research question that seeks understanding and insight rather than issues of fact and frequency. Whilst I believe the value of pursuing the subject in this way will be in being able to use the increased understanding to prevent and manage incivility successfully, I can see that quantitative data collection would offer a means by which to add some broader, more generalised information to the findings in the future.

Adopting an interpretivist approach to my research has required me to be cognisant throughout of the nature and limitations of subjective enquiry. To this end, the rest of the chapter is devoted to a discussion about the subjective nature of qualitative research and the role of reflexivity in maximising the positive aspects of adopting this approach.

6.3   The Inherent Subjectivity of Qualitative Research

Qualitative research in the social sciences is inherently subjective dealing as it does with stories of the lives and experiences of human beings. The telling of these stories is coloured by the values, beliefs, and experiences of the storyteller, who share their story as seen by them and lived by them. The same story told by another will inevitably be similarly coloured by their perspective, their role in the story and their recall of events. So be it subtly or significantly

different, every story is unique, even those that tell of a shared event or experience. The task of the qualitative researcher is to get inside the story and make sense of it. This requires them to collect, analyse and interpret the data that tell the story and in doing so they too, inevitably, become part of the story. This phenomenon is described by Holloway and Biley (2011) as the 'unavoidable presence of the researcher with and through the research'. From choice of design to interpretation of data and dissemination of findings, the researcher influences each stage of the research process be it through the choices they make, the things they do or the perceptions they have. Qualitative research is therefore inherently subjective; a characteristic (not a flaw) that must be accounted for in the methodology in-order to minimise the potential for researcher bias arising from his or her 'unavoidable presence'. Bias, the tendency to be prejudicial, arises out of subjectivity and can affect any aspect of the research process; it is a well-recognised phenomenon in the qualitative research methods literature (Bishop & Shepherd, 2011; Cohen, Manion, & Morrison, 2011:204; Miles, Huberman, & Saldana, 2014:296; Polit & Beck, 2006:219) and can considerably diminish the value and credibility of findings (Lambert, Jomeen, & McSherry, 2010).

6.4 Reflexivity and its Role in Surfacing and Countering Subjectivity

Reflexivity, the process of reflecting critically on the self and analysing the personal values that can affect data collection and interpretation (Polit & Beck, 2006:44), is a method for countering bias that can arise through subjectivity. It is particularly relevant to interpretative phenomenology which focuses on using interpretation to make sense of individual experiences. Denscombe (2007:333) stated that the sense we make of the social world and the meanings we give events and situations are legacies of the values and norms that we assimilate during our lifetime as well as a consequence of the things we experience as social beings. Therefore we have no way of standing outside of the world we are observing and as a result cannot report things as they are but only as we see them (Denscombe, 2007:68). Reflexivity offers a means by which a level of self-awareness can be developed which may reduce any undue effect of this legacy on the sense-making process. This is not an attempt to eliminate subjectivity but rather, as Finlay (2002) suggested, to disentangle perceptions and interpretations from the phenomenon being researched. Used in this way, reflexivity can reduce the effects of researcher bias on the research process and enhance the validity of the findings (Lambert et al., 2010). Minimising researcher bias is therefore central to the notion of qualitative research as a legitimate research methodology.

For Bourdieu reflexivity is the 'systematic exploration of the unthought categories of thought which delimit the thinkable and predetermine the thought' (Bourdieu and Wacquant, 1992: 40 in Schirato & Webb, 2003). This suggests that thoughts buried so deep we have no awareness of them or of their impact on our everyday behaviour, can be brought to consciousness, and examined. The reference to systematic exploration suggests that for Bourdieu reflexivity is a rigorous, pre-meditated process, one that can, as Hertz (1996) proposed, give insight into the 'political and ideological agendas hidden in our writing'. However, a systematic approach alone is inadequate for reflexivity as it is used in research, because it must also respond to the temporal nature of the biographical narrative (Bishop & Shepherd, 2011). This means that the researcher's position in relation to the research must be repeatedly re-examined in light of their ever-changing personal narrative (Giddens, 1991:53). The idea of reflexivity in research as an ongoing and evaluative process is captured by Finlay (2002) who described it as a 'continual evaluation of subjective responses, intersubjective dynamics and the research process itself'. Reflexivity in research therefore is a complex process that requires well-developed cognitive skills including criticality, analysis, insight, and evaluation.

Reflexivity is considered by many to have an everyday dimension as well as a research one. Bourdieu differentiates between the reflexivity used in research and that which is integral to all human behaviour (Deer, 2008:195-209) and Giddens (M. Adams, 2003) referred to it as something that all competent members of society engage in. Benton and Craib (2001:185) describe it as being characteristic of all conscious beings and Archer (2007:4) referred to it as the mental ability of all normal people to consider themselves in relation to their social contexts. This 'everyday' reflexivity is an iterative process which involves both self and others in the construction of personal identity and ways of being. In modern societies, this construction sees the 'self' taking centre stage in the creation of behaviour patterns and personal identity. Giddens (1991) theorises that this is because many people are now dis-embedded from local customs and traditions as a result of developments such as digital communication and global travel. These expose people to a wide range of influences, freeing them to make conscious choices about the identities they create for themselves. This has been described as a move away from the bindings of culturally given identities to the freedom to construct our own (Adams, 2003). These identities are expressed through biographical narratives which tell the story of who we are and how we came to be. These narratives are then constantly revised in response to the ongoing flow of new information and knowledge that each person experiences daily (Giddens, 1991:53). This constant revision of past, present and future is referred to by Giddens (1991:52-5;1992:30) as the 'reflexive project of the self' . So instead of passively inheriting who we are, we actively monitor, reflect on and shape our identities (Routledge, 2011), through a largely

unconscious and ongoing reflexive discourse with ourselves. Therefore, the reflexivity employed by researchers builds on those skills and processes developed through the 'every day' reflexivity that embroils us all.

6.4.1 Drawing a line between reflexivity and reflection

Reflexivity is similar to, but not the same as reflection, an important distinction to make as both are important to research but in different ways. Reflection is a transformational process which involves thinking about, analysing and learning from an experience (Freshwater, 2008:1-8), whilst reflexivity focusses on making sense of the relationship between the researcher and the object of the research (Etherington, 2001). Researchers have need of both: the reflective researcher will continually learn from the experiences they encounter during the research process and the reflexive researcher will maintain a constant awareness of the impact of the self on all aspects of the research process. Guba and Lincoln (1981), Hammersley & Atkinson (1983:18) and many others since, have described the qualitative researcher as being the instrument of their research; if so the researcher who is both reflective and reflexive is more likely to be an effective and credible one.

6.4.2 The role of reflexivity

Reflexivity draws on higher-order cognitive skills to counter the inherent subjectivity of qualitative research, not to negate it, but to lay open the assumptions and prejudices that are part and parcel of all human thinking. It is a conscious, premeditated, and ongoing process, the purpose of which is to deepen our understanding of ourselves as well as of our position in society so that we can better understand the social reality of others. This is why reflexivity is considered by many qualitative researchers to be central to the qualitative research process (Finlay, 2002; Gallais, 2008; Pillow, 2003; Lambert et al., 2010).

However, one of the challenges facing researchers is to judge how visible their reflexivity should be to others; for example, the extent to which reflexive personal accounts should be publicly shared (Bishop & Shepherd, 2011). The primary purpose of reflexivity should always be to strengthen and never to detract from the quality of the research. Researchers who situate themselves at the epicentre of their own research to the detriment of all else may be accused of 'endless narcissistic personal emoting' (Finlay, 2002), 'self-indulgence' (Bishop & Shepherd, 2011) or 'self-absorption' (Holloway & Biley, 2011). For some though, it is the turning of the

personal account into publicly accountable knowledge that makes reflexivity meaningful (Finlay, 2002). The 'public account of the self' described by Denscombe (2007:69) for example, ensures the research audience has access to all the evidence needed in-order to judge the quality of the work. This peer scrutiny results in the research becoming the 'property' of the field in which it resides where, if judged valid, it has the potential to influence practice. As the desire to impact on practice is a key driver behind practice-based research, adopting an openly reflexive approach is clearly justified. Other advantages of adopting a public facing approach to reflexivity include demonstrating moral integrity (Kvale 1996: 241-242) and a commitment to transparent, honest research practice (Finlay, 2002). Reflexivity can also be used to facilitate ethical research practice by providing a means of responding to the day-to-day ethical dilemmas that can arise during the research process as opposed to those that can be anticipated in advance through the ethics approval process (Guillemin & Gillam, 2004).

6.4.3 Being a reflexive, insider researcher

The high level of personal interest I have in the subject area (described in Chapter 2), has the potential to influence every aspect of the research process from the development of the research question, to who is recruited to take part on the research investigation, how I decide which questions to ask, how I interpret the findings and how I present the findings to my peers for scrutiny. For example, when I was in undertaking the initial literature review I wanted to focus purely on incivility because this was the aspect of my personal experience that had been most impactful although feedback from my supervisors suggested I could not look at incivility without civility. I resisted this advice initially because it was not where I saw the problem being and because it meant I would have to do some unplanned reading and writing which I felt was an unnecessary distraction. However, when I adopted a reflexive stance I was able to see that the strength of my personal commitment to exploring incivility was preventing me from seeing the potential value of investigating other aspects of the topic. When I did read around the topic more fully, I moved away from thinking about civility and incivility as two separate concepts and started viewing them as a single entity characterised by a range of behaviours on a spectrum. This conceptualisation was important because it helped me to think about my research in a new way. I started to see civility/incivility as being defined according to the way they are experienced by different people and the impact they have on them.

Although the concept of civility/incivility on a spectrum has been explored by others; Akman (2012) for example when describing the dimensions of civil society and Luparell (2004) when

illustrating critical incidents of incivility ranging from the less severe to the highly aggressive, one of the ideas I began to develop in my work was the concept of person specific spectra i.e. as people's personal experience of the social world they live in is unique to them, the spectrum of civility/incivility will always be person specific. This illustrates how the strength of my personal belief in what was important for my research could have prevented important conceptual developments which only emerged when I opened up to the advice of my supervisors. The critical reflection described in this incident and the subsequent adjustment of behaviour accordingly fits with the Polit and Beck's (2006:44) definition of reflexivity albeit executed rather slowly and inexpertly to begin with .

Another important influence on the way my research developed was that of my dual professional identities of nurse and tutor. Of these two, nursing came first, starting when I was just 17 and working as a healthcare assistant in a psychiatric hospital. I had not done well at school and I ended up in nursing by default rather than choice, but from early on I loved it because I had found something I was good at and was interested in. I completed my nurse training in 1986 and stayed in clinical practice for another seventeen years before moving into higher education. By this time, I had already formed a very strong attachment to my nursing identity and although I have now worked as a nurse educator for many years, I have only begun to see myself as a dual professional in the last three to four years, as my role has become increasingly focussed on learning and teaching and less on nursing specifically.

When I decided that I wanted to explore the phenomenon of incivility it was my nurse-self that drove the initial development of the primary research question because of those earlier nursing-related experiences I'd had and my sense that incivility was important to standards of patient care. As the research progressed, I had to remain mindful of the fact that although patient care was my ultimate interest, it was the education of nurses that formed the focus of my research.

A further challenge of having a strong nursing self-identity was the temptation to adopt a nursing role during interviews. As a nurse my priority would be to actively listen to a patient in-order to gain insight into their experience, but whilst this approach is appropriate for a phenomenological interview, it is not all that is required; it is also necessary to maintain a clear focus on the research aims throughout. My researcher-self therefore had to maintain an upper-hand in the interview to prevent the interview drifting into a therapeutic session. For both the data collection and interpretation stages, I attempted to adopt the perspective of someone interested in the words of the participants rather than someone trying to second guess what a fellow nurse might be trying to say. Despite this effort the interpretation of data was inevitably born in part of my

knowledge of being a nurse as it would not have been possible to step outside of myself to view the data completely objectively. As acknowledged by Holloway and Biley (2011) the presence of the researcher in the data collection, analysis and reporting stages of qualitative research is unavoidable. More than that, I was knowingly engaged in a hermeneutic cycle, where I was interpreting the participants' interpretations as part of an interpretative phenomenological approach to the data analysis (J. A. Smith et al., 2009:3). Whist the issue of conflicting professional identities is not avoidable, I was able to maintain a heightened awareness of it to ensure an appropriate balance and distance was sustained during the research process.

These and various other extended deliberations during the early stages of my research were the consequence of my dual professional identities vying to be heard; my nurse-self ensuring that I do not lose sight of the need to produce work that is of value to the nursing profession and my educator-self ensuring that I produce something that is within my direct sphere of practice and influence. The internal jostling of my dual identities continued to shape my research as it progressed. Long discussions with my supervisors about whether to include nurse mentors or not were partly a consequence of trying to avoid becoming distracted from the education focus by my nurse-self's interests in clinical practice. Unlike the previous example, this time I was making a conscious effort not to be unduly influenced by my interest in nursing. However, as I grew more certain of my research question and more confident in what I was doing, I understood that I needed to include mentors in the study in-order to explore the phenomenon of incivility in pre-registration nurse education from all relevant perspectives. Reflecting on this incident I can see how consciously acting to avoid the effects of personal preference has just as much potential to lead to researcher bias as being completely unaware of the influence of one's personal preferences.

Once the decision to approach nurse mentors for the pilot study had been made I encountered difficulties recruiting participants. After several failed attempts I made a direct approach to two mentors whom I knew had experienced incivility in their relations with their students. Guillemin and Gillam (2004) suggest that our choice of participants can be influenced by our values and consequently who we choose can reveal something of ourselves as researchers. Afterwards, I recognised that my choice of participants in the pilot stage was probably influenced by the fact that I attach a certain value to age and experience and in this case a belief that the two mentors would be 'good' participants i.e. reliable with plenty of interest to say. This was a propensity that I had to be aware of when recruiting participants for the main study particularly as I adopted a purposeful selection strategy and therefore knowingly increased the risks of this occurring. In consequence, invitations to participate in the main study were sent on the basis that people may

have something to contribute and not on the basis that anyone 'looked' like they might be an ideal interviewee.

Another aspect of my involvement in the research to which I was alert was the risk of identifying with the participants as fellow nursing professionals rather than research participants. The intensity and range of experiences in nursing plus the close working relationships which develop in nursing teams, contribute to the feeling of professional belonging and identity. These feelings can be strengthened by the fact that it is difficult to share nursing experiences outside of the nursing 'family' because non-nurses find some aspects of the work difficult to understand and because much of the work must remain confidential. Having practised as a nurse for many years, I identified closely with the nurse mentors that I interviewed in the pilot; a feeling that was compounded by the fact that some were of a similar age and duration of training as I was. This led me to presuppose the sort of answers they would give because I judged them to have similar behaviour standards and expectations to myself having been taught in a similar way thirty-years previously. I was therefore surprised when both interviewees expressed negative views about mentoring students of Black-African ethnicity as these were not opinions I had anticipated arising in the interview; nor therefore, was I prepared for the profound sense of discomfort that resulted from hearing them. This was a lesson in unintended consequences (Merton,1936) and the importance of being prepared for them as a qualitative researcher. However, I believe I maintained a neutral stance, keeping my questions and responses non-judgemental so that they would continue to share their perspectives honestly and openly. Despite this, the experience served as a lesson of the dangers of becoming overly relaxed as an interviewer because of the pre-conceived notion of there being commonly-held ground between interviewer and participant.

It may have been my insider status that led the participants to reveal more about their experiences of mentoring students of Black-African ethnicity than they would have done to somebody from a non-nursing background. The phenomenon of the insider researcher is widely recognised in the qualitative methods literature (Bishop & Shepherd, 2011; Cohen, Manion, & Morrison, 2011:204; Miles, Huberman, & Saldana, 2014:296; Polit & Beck, 2006:219). It describes the researcher who has ready access to the language, knowledge and culture of the participants they are researching through having had common experiences such as holding similar roles, working in the same setting or living with the same people. My insider perspective on nursing meant that during the interviews I had the advantage of understanding the context within which my participants were working, knowledge of the roles they were undertaking and first-hand experience of being a nurse mentor. This may have encouraged them to speak freely

and openly about their experiences on the assumption that I would have a ready understanding of their perspective. Although on this occasion the insider perspective was probably more advantageous than not, it is important to acknowledge the disadvantages that being an insider may bring. Holloway and Biley (2011) suggest these could include difficulty in creating sufficient distance from the research to allow abstract thinking and theorizing as the participants' meanings are interpreted. Reflection on this issue enabled me to develop a heightened awareness of the issue as the main study progressed.

6.4.4 Confronting the difficult

Whilst adopting a reflexive stance allowed a certain level of self-awareness and distance to be maintained, I experienced an incident during the data collection process which illustrated the need to be reflexive at all times rather than trying to switch it on and off for the purposes of a specific piece of work. This incident occurred when a member of the doctoral programme team asked whether I would be exploring the inter-racial tensions revealed in the first of the mentor findings. I said no because it was not central to what I wanted to explore. However, in retrospect I saw that this aspect of the study, which was about different racial perspectives and incivility, was potentially very significant. My reluctance to investigate had been due to feeling anxious that this new area for exploration would take me a long way from what I was interested in. Underneath this anxiety was another layer of concern, this included feelings that race and ethnicity were complex issues to explore and that I might be 'out of my depth' to try and do so. These layers of feelings, some more deeply buried than others, seem illustrative of the 'unthought categories of thought' which Bourdieu (Bourdieu and Wacquant, 1992: 40 in Schirato & Webb, 2003) refer to. They only surfaced later as I reflected on the conversation and came to realise the potential importance of race and ethnicity as the data collection proceeded.

There were two main learning points for me in this incident. One is about the importance of balancing the need for control over the direction of enquiry with the need to stay open to new and potentially important avenues of interest even if they do mean more work or slower progress. The second is about the necessity of becoming a reflexive researcher rather than being a researcher who acts reflexively at intermittent stages of the research journey. The difficult of achieving a consistently reflexive state is explored by Doyle (2013) who links reflexivity to the capacity to think, which she suggested is the context within which reflexivity is operationalised. Doyle argues that a thinking state of mind is not a constant state but one that fluctuates in response to various events, characteristics, and circumstances; therefore, maintaining a constantly reflexive state is problematic. Whilst she acknowledges that there are

certain intervention points for researchers seeking to be reflexive such as sensitivity to experiences of self and other and being open to the unexpected (which I struggled to be when I encountered the issues of race and ethnicity), she suggests that researchers should also seek to weave reflexivity into the broader ontological and epistemological framework of their research. Relating Doyle's thinking to my own position, I became aware that I needed to continue to be consciously reflexive at key points in the research process as well as to develop a reflexive way of being that became part of my everyday thinking as a researcher and an integral part of my research methodology.

As a reflexive researcher, I have sought to maintain a consistently high level of critical self-awareness to protect the integrity of the research process. However, as described in this chapter, my personal and professional identities will always have the potential to influence the choices I make as a researcher, as will my experiences of being a nursing student and a mentor and my insider status as a senior nurse academic in the research setting.

6.5 Chapter Summary

In this chapter, I have shared my epistemological and ontological perspectives, acknowledged the inherently subjective nature of qualitative research, and explored the role of reflexivity in surfacing and countering bias. I have also considered the influence of my dual professional identities on the research process and reflected on my position as a reflexive, insider researcher. Examples of reflexivity in action have been used to illustrate how I have used reflexivity to maintain a level of critical awareness and responsiveness to enhance the quality and credibility of the findings.

The findings are presented in the next two chapters. The first of these, sets out the participants' experiences in as pure a form as possible, with minimal commentary. The second, surfaces new knowledge and insights through an interpretative commentary and shows how the findings link to what is already known in the literature. The findings are presented in this way to ensure transparency of process in moving from the participants' narratives to my own interpretations.

Chapter 7 The Findings

This chapter presents the findings of the analysis of the twenty-five interview transcripts. These are presented in three separate sections; students, nurse tutors, and mentors. Each section contains the superordinate and subordinate* themes for that participant group, supported by participant quotes. Participants' names have been changed to pseudonyms and all identifying information has been removed. Data omitted for the latter purpose is indicated by closed square brackets [ ], whereas information added to clarify or add context is included in curved brackets ( ). Dotted lines indicate pauses.

The term superordinate and subordinate are used in the IPA approach to indicate a higher and lower ranking of importance respectively.

The themes presented reflect only those aspects deemed salient to the primary research question:

i.   What is the nature of incivility in pre-registration nursing education as seen from the perspectives of student nurses, nurse tutors, and nurse mentors?

After the themes, a non-thematic data set is presented for each group. This is organised under the various category headings which emerged early in the analysis before the superordinate and subordinate themes were developed. These categories and/or items did not evolve into themes during the phenomenological analysis but when viewed alongside them, provide additional information to inform the secondary research questions:

ii.   What commonalities and/or differences exist between the experiences of student nurses, nurse tutors, and nurse mentors, in relation to incivility in pre-registration nursing education?

iii. What is the impact of incivility in pre-registration nursing education?

iv.   What factors have the potential to contribute to, or cause incivility in pre-registration nursing education?

The data in this chapter is presented with minimal comment, analysis, or interpretation. This has been done to ensure a clear demarcation between the presentation of the experiences as described by the participants (the findings) and the final stage of interpretative analysis (the discussion).

A summary of participant information to facilitate reading is given in Table 5.

Table 5 Participant information

Group	No. of participants	Pseudonyms	Age range	Field of Nursing
Students	9	Amy, Rebecca, Millie, Lisa, Iris, Ben, Debra, Nial, Acha	21 - 46	3 Mental Health; 5 Adult; 1 Learning Disability
Nurse Tutors	9	Liv, Kirsty, Connor, Nesta, Marie, Peter, Brenda, Joy, Eve	35 - 51	7 Adult, 1 Learning Disability, 1 Mental Health
Mentors	7	Atos, Gina, Bridie, Lim, Susan, Maz, Charlotte	28 - 55	1 Mental Health, 5 Adult, 1 Children's
Total	**25**			

7.1 Students' Experiences of Incivility

In answer to the initial question, "Can you tell me what your understanding of incivility is", the students offered a range of descriptors (Table 6):

Table 6 Incivility descriptors (students)

Angry	Impolite
Arrogant	Not listening
Belittling	Rude
Curt	Uncaring
Disrespectful	Unruly
Disregarding	Self-centred
Inconsiderate	Selfish

Although not asked about civility explicitly, some students did refer to it (Table 7):

Table 7 Civility descriptors (students)

Polite
Courteous
Professional
Allowing people to speak
Not making people feel stupid

In response to the second question "have you had experience of incivility whilst studying here as a student nurse and if so can you tell me what that experience was like", all participants answered yes and went on to cite examples of their experiences. Analysis of the interview

transcripts yielded five superordinate (major) themes and fourteen subordinate (minor) themes (Table 8).

Table 8 Themes (students)

Superordinate Themes	Subordinate Themes
Distraction	• Lateness • Personal technologies • Noise
Power	• Position • Hierarchy • Hostility
The invisible student	• Being namelessness • Misuse • Feeling in the way • Being ignored • Being bullied
Knowing and not-knowing	• Asking questions • Clinical knowhow • Unacknowledged knowledge
Impact on learning	-

7.1.1 Distraction

Incivility in the form of distraction was characterised by behaviours which disturbed concentration and detracted from learning. Distraction-related incivilities arose in the classroom rather than in placement, possibly because students have a relatively passive role in the classroom which leaves them more vulnerable to distracting noises and behaviours such as talking and texting.

Lateness

The issue of lateness generally applied to students coming late to class and the impact this had on those already in the room. Rebecca described how ground rules on late entry to class were set by the students but were then ignored with people coming in up to 45 minutes after the agreed latest entry time (ten minutes after the lecture start). This aroused strong feelings:

> It's disruptive, impolite and I feel it goes back to that whole disregard for others. How rude, how rude is it to that lecturer that you can't be bothered to come and listen to what they have to say.

Rebecca also described the physical response to latecomers, referred to by Nial as the 'head-turning effect':

> It has like a ripple effect, so when someone comes in late everyone looks towards the door to see who has come in and then for some reason, I don't know why, people start having a moan. Oh look who it is again, so you have a moan then you have a further a ripple and then it really disrupts the flow. (Rebecca)

Sometimes the disturbance continues after the latecomer has entered the room:

> …crashing up the stairs, bang, bang along the side or up the stairs if you are in [ ] lecture theatre, to just trying to find a seat, you know, and wanting to sit in the middle so everyone has to stand so they can get in. (Nial)

Nial also described the impact of being distracted from notetaking during lectures:

> I look down on my notes and they don't make sense to me because I've only got half of what I want and that's frustrating.

Debra didn't find lateness rude, unless it was the same person repeatedly coming in late but did feel it was disruptive if the lecturer had to stop and then 'find the train of thought'. Acha and Rebecca made similar observations, with Rebecca noting how some lecturers just 'power through' whilst others are 'put off their flow'.

Amy and Debra both felt the late entry rules, i.e. students cannot enter the classroom if more than ten minutes late, could be unfair on those students who are late with good reason. Amy thought that lecturers who stopped students from entering the room after the agreed time were the real problem:

> She stops them and says, 'Sorry (emphasising the first syllable) you are seventeen minutes late, this is highly disruptive please don't continue into the classroom,' but she (the nurse tutor) disrupted it. Sorry, just let them in and get on with it.

Millie also commented on the way that latecomers were managed

> It annoys me especially when the lecturer says oh we'll just wait ten minutes and I think no I got there 15 minutes early. I mean if it's someone who is usually on time and something has delayed them like childcare or something then of course its ok; I'm not a monster. But if it's someone whose never on time, then I don't see why we should sit and wait for them at all.

However, there was tolerance for students who despite being late, clearly wanted to learn:

> There are some people who come in late all the time and they don't want to do nothing, they just sit on their phone but if they are just late and it's not their fault and you can see they really want to contribute, they really want to learn and they do all those kind of things then you have to put that into context. (Acha)

The disruption and frustration of late entries is mirrored when students leave and re-enter the classroom mid-session, as Nial described:

> Well it's like the lateness, its distracting. You'll see two people and they'll get up and go to the toilet. Oh, what a coincidence that you both desperately need the toilet at the same time. It really does frustrate me, you know because we are grown-ups and I think it is about being grown up and respectful and it's not hard to sit there for two hours. If you don't want to listen, you just want to sit there and zone out then that's fine but don't disrupt the people around you. I find that really frustrating.

Personal technologies

The use of personal technologies such as phones, iPads™ and laptops was another source of distraction in the classroom, even when the noise settings were off. Rebecca was affected by students playing games on their phones in close proximity to her:

> They sit there on their iPads™ and looking at their phones but I came here to get an education, I want to get the most out of every class I come to. I take it personally when there is somebody sat next to me playing Candy Crush™, yes it does affect me.

Millie was also distracted by the use of personal technology and like Rebecca, took the use of devices by others as an insult to her own desire to learn:

> Students being on Facebook™ in class, it really distracts me, partly because I'm trying to read the screen. It really annoys me because I think you're here to learn and you're taking the mick out of what I am doing.

Acha described the physical sensation she experienced when another student was texting during a guest lecture:

> There's a few people, you know visitors who have come to talk to us and you know there was this one guy sitting next to me and he was texting the whole time, it was distracting me because he was being really rude, and I could feel my chest going (clenches fist to chest).

Nial felt the inappropriate use of devices in class was both disrespectful and frustrating:

> If I look forward and they are scrolling ASOS (an online shopping site) looking at pairs of shoes or playing a game on their phone, I think that's rude, well not rude but its disrespectful. If all I can hear is the text tone of somebody's phone again, again, and again, then that yes, it is frustrating.

Noise

Another classroom distraction described was noise, especially talking in class which can make it hard to hear what the lecturer is saying:

> When he says something that is very pertinent and you are trying to write it down and you can't hear because people behind you are having a chatter, yes that is very disruptive. (Debra)

The talking doesn't need to be loud to create a distraction:

> What is a problem sometimes is people whispering because once you hear it you get a bit fixated on it and all you can hear is what they are saying. (Nial)

Lisa and Debra both found it difficult to tell people to stop:

> You want to listen and there are people just talking or giggling next to you and you think, 'Why are you here, I want to listen', and I tell myself I should be assertive and I should say shush I want to listen. (Lisa).

> No, no I just try to hear because you think, 'Woh, there's a sea of us,' and you don't want actually to seem like the odd one because you alone are the one that turns around to say something. Then the focus becomes on you not on them because they were talking in class and shouldn't be, but it comes on you because, 'She's a bit odd', for saying something. (Debra)

Maria found noisy eating in class a problem:

> There was this group once in my class that just sat and ate crisps and we had a visiting lecturer who was really good and they just ate through it and the lecturer eventually said, 'Are you ok?' and they just carried on talking and eating.

Nial found noisy eating both 'frustrating' and 'rude':

> Some people love to have a little snack, a little bag of crisps at the back of a lecture that kind of thing. It's noisy, it's distracting, it smells and I just think it is rude and at the end of the day for the person stood at the front who's worked really hard to get where they are and to try and educate us and give us their time and you're just there eating and drinking, you know

113

your stomach is more interesting than what is going on.

Talking and eating were not the only noisy distractions. Millie described how a student in her cohort was singing in one of the large lecture theatres:

> Once in [ ] there was a woman singing. She was just singing. I don't know if she had headphones on or what, but she was singing and other people were just looking. Nobody said anything they just looked. We did that British thing of just looking. Tutted and looked!

I asked Millie if she challenged this kind of behaviour and when she said no, I asked why not. One reason she gave was fear of retribution:

> If there's a group of people eating or talking behind you then you don't want to turn around and say can you stop because I won't be able to concentrate for the rest of the lecture in case they stick something in my hair or spit on me or something.

Millie wasn't the only one who didn't challenge incivility in the classroom despite the impact on concentration. Reasons given for deciding not to challenge uncivil behaviour included: fear of retribution, being 'British', not wanting to undermine the nurse tutor, not wanting to draw attention to themselves and a lack of assertiveness.

7.1.2 Power

The theme is dominated by issues of power and the contention of power, between or over the individuals concerned. In the transcripts, students described themselves in situations where others made use of their position to gain advantage over them or to assert a superior position in relation to them. Hierarchical elements were evident as 'pecking orders' were established or challenged through various uncivil behaviours and many hostile exchanges were described, some of which were physical in nature.

Position

The relationship between students and nurse tutor or mentor, is by its nature one that is unequal in terms of power because the student, the least powerful of the three, is reliant on the others to help them to progress through the pre-registration programme successfully. This theme captures the potential for mentors and nurse tutors to use their position to assert their power over the student beyond what is naturally inherent in the relationship. Amy, for example, described how her clinical mentor refused to complete her practice assessment document

(PAD) (mentors must sign the student's PAD to confirm what skills have been gained in practice) and then proceeded to ask her for a personal favour:

> Any time we sat down she wouldn't tick them (the skills) and I said to her even if you put a cross in every box or say unachieved, I need a mark on this page…and then she said can you give me a lift home. She knows I can't say no and I wasn't even going that way.

Amy was caught between the need to get her documents signed by the mentor and not wanting to give her a lift home, a scenario in which all the power sat with the mentor. Ben and Iris also referred to the reliance on the mentor to get their PAD skills 'signed off'.

Ben described being 'caught between the two worlds' of university and practice when trying to practice on placement in accordance with what he had been taught in the university and being met with an attitude of, 'What do you know?' He felt unable to practice in accordance with what he had been taught by his tutors because he did not feel empowered to oppose the views of the qualified nurses. The dilemma created by the unequal power distribution in the student-mentor relationship was summed up by Ben as:

> Your life as a student is in their hands so you're caught between the deep blue sea and the devil, do you just carry on or do you just stand up to it?

The change in position and status Ben experienced on becoming a student, showed the dichotomy between his everyday experience as a mature adult (a middle-aged man) and that of being a student:

> It's a big change, a big switch round from being an ordinary person. From being a man of authority to being subject to another person's control.

Examples of positional power were not confined to clinical areas. Acha reported how nurse tutors tried to 'intimidate students to do their best' sometimes in a 'very aggressive way'. She described one incident which made her very angry:

> You know when you have a moment like when they are fixing the computer or something and there is low level chatting and I didn't realise that he (the lecturer) had stopped and he was waiting. You know some people say, 'Ok we're ready now, but he had just stopped, and I was looking the other way and he just barked at me 'when you have quite finished' and I was like 'oh'. You know you want to die, the room fell silent and I could feel my face blushing and I think because it was quite a big class I could feel myself…. I said, 'Are you talking to me', because I wasn't quite sure. I remember thinking 'Oh he could never be talking to me, it could

115

be anyone in the class', but he just looked, he didn't say anything, and then turned away and carried on, and I thought he is not serious and I spent the whole lesson angry. I didn't want to talk, and I was so angry I didn't contribute I just sat there and I didn't contribute, I thought that was really rude.

Hierarchy

Hierarchies are all about the positions that people are ranked in, in terms of status or authority, within a group; the common perception is the higher the position the greater the power. All the students made links, either implicitly or explicitly, to their perceived position in a hierarchy and their experiences of incivility. In Debra's case, it was right at the bottom of the clinician's hierarchy, with the doctors at the top:

> I think when you go on the ward you generally feel, well at least I felt, as though you are the bottom of the list, that it is very hierarchical and everyone pays attention to what the doctors say…If you sit and the doctor comes along you have to move anyway because you have to give up the seat for the doctor.

Nial also commented on hierarchies in placement, reflecting on his understanding of his position which improved as his confidence grew:

> In the first year you don't know where you are, you don't know where you stand in the hierarchy, you don't know any of the people that you work with whereas by the third year you've got the confidence, you know, this is my role, I am an advocate, I need to be able to stand in front of a consultant and say this needs action.

In some instances, hierarchical power was made explicit, as when Iris asked a Senior Nursing Sister how to pronounce her name and was told, 'It's Sister to you'. Other times it was implicit, as when Ben described lecturers talking 'down' to students.

Nial observed the influence of different cultural perspectives on hierarchies:

> Some people in our cohort of African background have a lot of respect for nurse lecturers as teachers and sometimes I think they feel uncomfortable calling them by their first name. I've only witnessed that once in my first year and I said to the person why do you call the lecturer Miss and she said because it is disrespectful to call them by their first name, they are an academic. If you look at someone who has been educated in England, then I think we feel much more on a level with our academic staff.

Hostility

Hostile behaviour is used here to mean being unfriendly or antagonistic to others. Hostile behaviours may arise as a result of students or staff asserting their power in a one-to-one or

116

group context. Low level hostilities such as students being sarcastic to each-other and inter-student arguing were reported by Ben and Iris respectively. Nial described how a student swore at him when he turned round to look at him because he was talking during a lecture:

> The person was like oh, 'F off' and all I did was look, and that's where it becomes uncivil, that is rude because all I've done is look at you meaning you to be quiet and I got sworn at.

Acha experienced hostility from another student when she (the other student) jumped the queue in an arrangement for a number of students to observe Electroconvulsive Therapy (ECT) at different times. When Acha questioned the student as to why she had taken Acha's allotted time slot, the student replied in a loudly raised voice:

> I will do what I want to do, if I want to go on this day then that's what I will do, I'm not here to try and make friends.

Acha had also seen students getting caught up in inter-staff hostilities:

> We have had students in their first couple of placements crying in their car because of the attitudes and behaviours of the (qualified) nurses and how they are treating each-other; they've got caught up in the middle of it.

Hostility in the form of race-related comments, was described by both Ben and Iris. Ben (a black student) experienced hostility in a class discussion during which another student (a white student) said, 'The white race is superior to other races'. Iris (a white student) was accused of racism by other students because of a question she asked in class:

> I had a question to ask and it was 'do black people burn' and it was a scientific question but I got people emailing me and got told how racist I was and it is not racist it is an actual query. You know my husband is black but I didn't know if he burned, he always complained if he got too hot but I didn't know what to look for so it was a genuine question, a scientific query, but I get all this (shrugs shoulders and raises hands), what I can't say the word black because I don't have the skin colour?

It wasn't clear in the interview whether the other students knew that Iris's husband was black or if they realised that her question was about sun-burn but the incident illustrates how swiftly personal judgements can be made and how readily the perception of incivility can arise as a consequence.

Hostility can also take a physical form as Millie described when recalling her first day at university and crowding into a lecture theatre with around 300 other students:

I thought we'd all be like Mother Theresa and we'd all be like angels and we'd all have our hands together and we'd be you know after you no after you, but it was the sharpest elbows first, getting the best seats and this was the first lecture, the first time we ever went into the hall and it was shocking, I couldn't believe that people were elbowing you out the way. It really upset me.

7.1.3 The invisible student

In this theme, invisibility is characterised by situations in which students were either not treated as individuals or were not recognised as learners. As a result, they were to all intents and purposes invisible to those around them.

<u>Being nameless</u>
Having a name gives us a sense of who we are and at the most basic level, enables us to distinguish one person from another. In this subordinate theme, students described their experiences of being denied what some might consider a fundamental mark of civility which is to be referred to by name.

Lisa recalled how a doctor referred to her as either 'the student nurse' or 'my student' for the duration of her placement (six weeks) whilst Millie described the effort she had put into learning the qualified nurses' names on one ward only to be continually referred to as 'the student' by one of them. Debra, spent her entire second placement (six weeks) being referred to by the ward manager as ' darling ' which she found condescending. She said the lack of individual recognition was normal, despite being amongst people who knew each-others' names, and despite wearing a name badge:

> It's quite normal for you to not even be recognised in any part, they refer to you as 'can you get the student to do it' or 'ask the student to do something' and you're walking around with a badge and everyone knows most peoples' names but often you are just seen as the student.

Rebecca described how she dealt with one qualified nurse who refused to refer to her by name:

> She would shout at me from one end of the ward to the other, 'Student, student, where are you? Where is my student?' and by the end of the seven weeks I refused to acknowledge that and then she shouted at me for ignoring her. To which I said, very politely, and with a smile on my face, please call my name, call me by my name and then I will come and help you.

However, despite her efforts the nurse's behaviour continued. Rebecca described how demeaned this made her feel:

> I said to her to her please can you call me by my name, there are four other students on the ward and if you call me by my name then I would come and help you, but she just reverted to shouting 'student' which is so demeaning, so demeaning.

Acha had also experienced the lack of individual name recognition, although she said was not unduly bothered by it:

> 'This student', 'Your student', you do get that, 'Your student' and I'm thinking, 'My name is not student'. Not that it bothers me that much but when you said it (in the presentation) I thought, 'Oh that is so true'. Where's your student? What like a bag of crisps? You do get that a lot.

Like Acha, Nial was not so bothered about not being called by his name, putting it down to the high turnover of students in placement areas. However, he was annoyed about being defined by his gender:

> I get called the male student instead of the student and that annoys me. You know it defines you a bit more if they say it's the male student in bay Four but you wouldn't say go and find the black nurse in bay five; I do consider that to be rude.

One of the nurse tutor participants (Joy) also reported the lack of name recognition as a common experience for students.

Misuse

In this subordinate theme, the students' status as learners (their 'studentness') was apparently invisible to the qualified staff. This was evident when they were asked to do things they had not been properly prepared for or missed key learning opportunities because they were directed to do routine nursing tasks instead.

Acha explained the importance of getting placement induction right so that students' learning needs are recognised at the outset of each placement experience. Placement induction comprises meeting the allocated mentor, discussing learning objectives, and an orientation to the clinical area. The placement induction should happen within a week of the student starting in a new placement area but this hadn't yet happened for Acha, who felt that she had either been just 'left' or given 'rubbish' jobs to do:

> My (induction) interviews were never in the first week, they were always in the second week and then you are left and that is really horrible when you are

kind of left, or still doing stuff but it's not in a teaching kind of way, it's more a bit like the skivvy, you're here to do the rubbish little jobs we don't want to do like make the beds, do this and do that.

In this quote, Acha makes the distinction between doing things and being taught to do things because for students, the whole point of being on placement is to be taught why and how to do things, not to just be given tasks to do.

Sometimes the expectation that students are just there to provide extra help is made very explicit, as when Iris asked to spend the day on a different hospital ward to get some extra surgical experience. Having agreed reluctantly to have her for the day, the ward Sister (senior nurse) went on to tell her that she was not to ask any questions whilst on her visit as 'you're only going to be a pair of hands'. Even in her own placement area Iris described feeling she was seen first and foremost as an extra member of staff as she was left unsupervised with patients for long periods of time. The impact on learning of misuse was recognised by both Lisa and Amy:

> I ended up specialling (close supervision) patients with dementia a lot and they put them all in a bay and then I'd be there, and I was with another student nurse and some of them were very violent as well and this was our first placement. We spent a large chunk of our time with these patients which kind of cuts back on learning, so I mean we were learning because you always do but…(Lisa)

> Basically, I was there for 7 weeks as an HCA*, not that there is anything wrong with an HCA but that was not what I was there for. I wasn't taught anything. (Amy)

Healthcare Assistant

Debra told how as a first-year student she often missed key learning opportunities such as listening to the handover (the passing of patient care information from one team to the next) because she was sent off to do routine 'obs' (clinical observations such as pulse and temperature) even when there was a clinical support worker available to do it instead. However, in her second year, when one mentor repeatedly sent her off to do other things when she (the mentor) was going to do the drug round because 'there is no point in both of us doing the drugs', Debra's response to her mentor was more assertive, 'I had to explain to her, actually no, I'm going to be assessed on this so I need to stay with you'. When I asked Debra why she lacked that same assertiveness when she was a first-year student she said:

There is so much you don't know and you are unsure and you are like, 'How do I argue for something when I can't explain to you why I think I should be doing this?'

Debra's example illustrates how difficult it is for new students to assert their learning needs in placement when they don't know how to articulate the learning value of the various clinical activities. If the mentor hasn't recognised a particular activity as a learning opportunity, and the student doesn't know how to argue for taking part in it, then the student can miss out on the learning altogether.

Being used as 'a pair of hands' undervalues the student's position as a learner and as a future member of the nursing workforce. To counter this student nurses are supposed to be supernumerary (not counted in the team numbers), however, in reality this is not always the case. Lisa described how being counted in the team numbers made her feel:

I heard a matron count us in her numbers and that made my blood boil because I was thinking you are not supposed to count us.

Whilst the principle of supernumeracy is there to protect the students' status as learners, it can bring about problems of its own for the students, as can be seen in the next sub-theme.

Feeling in the way

Being supernumerary can leave students without a clear role in the clinical area which in itself can lead to a different kind of invisibility, the kind that comes from feeling that they are getting in the way of the real work of placement staff. Lisa recalled how as a first-year student on placement her mentor was too busy to help her which left her feeling 'brushed aside' and Rebecca said she felt 'a burden' from the outset of one placement when her mentor greeted her with 'Oh no not another student'. Acha recognised that feeling:

When you go there (to placement) you can almost see, even if they don't make the noise, you can almost see the 'Oh God' (accompanied by deep sigh)'. You're already nervous and worried, you know how is this going to be, are they going to like me, am I going to be able to learn stuff and then if you are there and people are (sighs) 'Oh yes my student, oh yeh, got to find her something to do …'

Debra described how being uncertain about her role led to her trying to appear busy by staying on the move all the time:

You are standing there and often well nobody has told you what to do and then you know its 'What are you doing standing there?' So you think

121

> ok I have to appear busy so I have to keep moving and there's that fear
> if I do sit then I'm not allowed to be sitting…

The experience of feeling in the way arose primarily in the clinical areas rather than in the classroom setting although a comment of Rebecca's suggested that students can feel they are in the way wherever they are:

> When we go out and placement it's off out into the world, off you go you're
> your mentor's problem now.

Being ignored

Another facet of invisibility was being ignored when students can be physically present but still invisible to those around them. Millie, Amy, Nial, and Debra all described being ignored at various times. Debra for example, was ignored by her mentor in favour of a new nurse who had just started on the ward:

> She (the mentor) basically ignored me but paid attention to a new staff member
> starting. She was a completely different person, so open and so smiling towards
> this…and I sat there and was a bit shocked because I was thinking to myself,
> 'Woh what a difference', because she actually didn't say anything to me.

She also described how she was ignored by a ward manager following a patient handover and allocation meeting:

> The ward manager was the one who was leading the staff meeting and at the
> end she told everyone ok you work with…and you work with…and the new staff
> nurse was there so she was like oh you work with this person and then I sat
> there (pause) and nothing.

Nial recalled trying to get into a secure clinical area and being ignored by a doctor, 'Who made eye contact through the door and just kept going', several times over. When he did eventually gain entry, he asked the doctor why he had ignored him but the doctor 'Just rolled his eyes at me and went back to what he was doing'.

Acha came forward to be interviewed after seeing me present some of the initial student data at the University's annual mentor conference. In the interview she described her experiences of being ignored:

> Students are just left in the corner. Some of the things you were saying in the
> presentation I was thinking oh my God this is exactly what it is like.

122

When I asked her if the recognised the idea of the 'invisible student', she replied:

> Yes definitely, a lot of the time [ ] if you don't have the confidence to speak
> up you will be left, or they might turn around and say, 'Oh yeh you're here'.

Debra knew of other students who had experienced being ignored too:

> I heard a group of students saying there is another ward where students
> weren't even spoken to and they were going to raise it with their link lecturer.

Link lecturers are nurse tutors who provide support to students on placement. One of the nurse tutor participants (Joy) reported how, when acting as a link lecturer, one of her students on placement had reported to her that she felt invisible when the qualified nurses talked about other members of staff in front of her.

Being bullied

Three students, Iris, Rebecca, and Ben, described experiences of the kind of repetitive, targeted behaviours that typify bullying (Bowllan, 2015) such as being ridiculed in front of others, being excluded from conversations and being spoken to rudely. Although bullying and incivility are defined differently in the literature (see 3.24), the experiences were identified by the students as incivilities and so, regardless of academic definitions, from the students' respective perspectives, these were uncivil behaviours.

The invisible aspect of their experiences arises because the students' situations were not seen or commented on by those around them which suggests that they, and their needs, were invisible. They were also invisible to the antagonists themselves, who presumably did not see the students as people who were worthy of any respect or kindness.

Rebecca had found one mentor's behaviour so difficult that she kept a diary record of it throughout the duration of the placement in question. She asked for it to be included in the research data because she did not want other students to go through the same kind of experience. The following extracts illustrate the repetitive, demoralising nature of her mentor's bullying behaviours:

> *Monday 19th May: Met with mentor briefly at the end of her night*
> *shift/beginning of my first early shift. Mentor was very vocal about having*

to have another student and her displeasure at the prospect. I attributed this to her having just finished a night shift and being tired.

Thursday 22nd May: Met with mentor briefly at start of her night shift/end of my late shift, told me that my training with her would be purely observational. Mentor's manner was aggressive and dismissive and I finished that shift feeling disappointed and disheartened.

Sunday 25th May: I worked a long day with mentor. When I asked her if she could do my orientation and first interview, she refused. She told me that it should have been done when I was on shift earlier in the week. I tried to explain to her that I had been told to wait until I was on shift with her but she wouldn't listen. All this in front of charge nurse and I felt humiliated. Mentor later relented and did both the orientation and first interview. It was a very brief interview as there was very little discussion and her written comments on my learning objectives are minimal. I was ignored by my mentor for the majority of the shift, only being called upon when the patients' bells were ringing. Cried in the car on the way home.

Monday 26th May: Worked a long day with mentor and was ignored for most of the day. I attempted to observe an ECG being done but my mentor called me out of the patient's room to go back to the end bay as "there was nobody down there". In fact, the HCA was in that bay and I believe my mentor knew this. Later that day, my mentor took a blood culture from a patient but did not let me know that this was being done and so I was unable to take part. I feel I am being excluded.
Mentor made a comment about me being deaf. The reality of this was that I was speaking with a patient in the end bed in the end bay. I feel it was very unprofessional of her to make comments about my hearing ability and for shouting at me rather than addressing me in closer proximity. Mentor continues to ignore me unless obs need to be done or a patient needs assistance to the toilet/commode.
Cried in car on way home.

Friday 30th May: *My mentor did the evening medication round without involving me and ignored me until I went home*

Saturday 31st May: *Mentor actively ignored me all day. My presence seems to annoy her. I find her intimidating. Overheard a very public discussion between my mentor and Sister about the problems of having so many students on the ward and the lack of mentors. I found their open hostility intimidating and very unprofessional. Went home questioning why I am doing this. This placement is making me doubt myself and my (limited) abilities and I feel I have gone backwards rather than move forwards in my practical education. I'm becoming increasingly disheartened.*

A series of extracts from Iris' transcript illustrate how one of her mentors bullied her from the day she arrived on the placement:

> She ridiculed me on my very first day because I was like I'd never really been in a hospital before and I'd never looked after anyone and I remember that beeping noise going on and I looked around and said, 'Oh what that's beeping noise' and she looked at me (pulls face to demonstrate) and said 'Haven't you ever been in a hospital before?' You know out loud in front of everyone.

> I was finding out from the patient what they eaten and stuff like that and from in the room she shouted across 'Why haven't you done the beds yet?' you know from right across 'Why haven't you done the beds' (raised voice loudly) in front of everyone 'You need to come down and do the beds now'.

> I was meant to go to break at the same time as she (the mentor) was and do you know that she swopped my break and then made out I was stupid because I didn't know when my break was.

> I'm not joking she just looked at me like (demonstrates long hard look) for a good minute…

The students described the physical and emotional consequences of their experiences.

> I'll never forget it, because I was going into work shaking and thinking will she be in and being so relieved when she wasn't. (Iris)

> I spent a lot of time weeping in my car, it was a difficult time. (Rebecca)

> It was demeaning, his remarks were very demeaning. I was scared to ask questions. (Ben)

Despite the impacts described, none of the students made an official report about how they were treated, choosing instead to just work through it, so that they could progress on to the next placement.

7.1.4 Knowing and not-knowing

This theme captures the incivility that arises out of students either not knowing something or being thought not to know something. The subordinate themes identify three different facets of the theme; Asking Questions, Clinical Knowhow and Unacknowledged Knowledge.

<u>Asking questions</u>

Students asked questions either because they didn't know the answer or because they didn't think they knew the answer. They were looking for help but did not always get a helpful response, as Lisa described:

> A student was asking about references and she (the lecturer) just snapped
> and said 'I'm not going to sit here and go through your assignment with you'
> and everyone's face was 'all right then'.

Although the incivility might be directed at one person, sometimes there was a scatter-gun effect on everyone in the vicinity:

> You can email the tutors and say I'm really sorry I can't find it can you tell
> me where it is and you get a sharp reply back to the whole class 'I have
> put it onto the VLE' which is a little bit like 'Oh you are so stupid'. (Millie)

Millie went on to describe how it felt to be made to feel stupid:

> I don't like feeling stupid I don't think many people like feeling stupid but
> I really, really… it really hurts.

Several other students reported being made to feel stupid for not knowing something. Lisa said 'not being made to feel stupid' was a part of being civil and Iris described how a qualified nurse 'made out she was stupid' for not knowing when her tea break was. Nurse tutors who make students feel stupid risk closing down student-staff dialogue, as Ben explained:

> The lecturer's response was like 'Why are you asking the question when we have not
> taught you that?' When the lecturer said that they shut the student down.

126

Students need to ask questions to find out things. If they don't ask questions for fear of the answer they might get, they may miss opportunities for learning as well as lose confidence and/or disengage from the learning process with consequences for their development into qualified nurses.

Clinical knowhow

Lack of clinical 'knowhow' emerged as another facet of Knowing and Not-Knowing. This is when the incivilities described by students happened on placement and related to their not knowing something about clinical practice. Lisa, for example, described how a fellow student had been 'shouted' at for not realising she needed to use something sterile over a bleeding wound and Iris recalled being 'ridiculed' in front of others for asking what was making a beeping noise on the ward during her first day. Ben said that if he asked his mentor a question the response was just 'You should know' and Acha had observed how the qualified nurses on one ward were repeatedly uncivil to another, much younger student for what she did not know:

> I would have to keep defending her and I found that really uncivil, it was like
> don't do this and don't do that, it's almost degrading because you're young
> you don't know, or you can't do this.

Debra described how she was asked to complete a series of clinical observations for a group of patients and record them when complete in a special book which she had been shown how to use a few days previously. Debra initially felt pleased about taking responsibility for completing the book, however, she had not been shown how to do an extra section which was needed if a patient was identified as being at risk of falls. As a result, the ward manager called her to the front desk to tell her she had not completed the book correctly. Debra described what happened:

> There were all the doctors and everyone and the way she speaks, it was not like
> she was very quiet spoken she's very loud so everyone looks around, everyone
> is looking round at me and I'm feeling okay I'm on the spot so she says well you
> didn't fill in this and I'm like ok, ok and then she turns, after saying that to
> me, she turns and 'I don't want students doing this book anymore' (loudly), she
> just announces it, 'I don't want students doing this book anymore' and then she
> goes to another staff nurse and says 'I don't want students doing this anymore, I
> want everyone to start signing it' so at that point I felt really small…

All the incidents happened within the first year of being on the programme, when it is particularly important that students know it is all right to 'not know' things because the reason they are there is to learn. But instead, the students felt they were being judged (being shouted at, made to feel

small, ridiculed) for not knowing something, a feeling that, as identified in the previous sub-theme, could readily impact on learning and confidence.

<u>Unacknowledged knowing</u>

Although most students come to pre-registration nursing with little, if any, prior knowledge of the nursing, they all come with knowledge and experience of some kind. However, this subordinate theme identified that general knowledge and experience can go unacknowledged or be disregarded. When this happens, it can contribute to a loss of confidence between student and lecturer, as Ben described:

> An argument erupted in class about the spelling of 'c a u s e', and the lecturer said that the student (who had written it on the board) is wrong, it is 'c o u r s e'. We knew that that wasn't right and he became aggressive, well let's not use aggressive, more his approach was rude, like he was 'You are trying to teach me you know better than me'.

Acha said that it felt like being treated as a school leaver despite years of work and life experience, 'I haven't been to school since the 1990's so I haven't had this, so I was like, this is really, really patronising to me'.

Prior nursing knowledge can go unacknowledged too. Lisa had two years' experience as a health care assistant (HCA) but her opinion was of no value because she was 'just the student nurse'. Her clinical skills went unrecognised too:

> In my ward that I worked on for two years I had lots of opportunities to learn things because they really trained up their HCAs and I felt I was competent enough to try things, but I wasn't given the opportunity to.

The lack of recognition for prior knowledge could impact on learning as opportunities to build on existing knowledge are lost (as in Lisa's case) or trust in the ability of nurse tutor is impaired (as in Ben's example).

7.1.5 Impact on learning

The potential for incivility to impact on learning can be seen in all four of the above themes. It is evident in the narratives about the various distractions including the use of phones, talking in class and people arriving late, which disrupted the students' concentration in the classroom. It can also be seen in the description of the mentors who failed to offer students learning

opportunities or ignored the students' need to complete the practice assessment document. It is demonstrated in the descriptions of students who did not ask questions because they were fearful of what their mentor or lecturer, would say in response and it can be seen in the incident described by the student who lost confidence in their tutor's knowledge because they would not acknowledge their mistake. In other examples, poorly managed inter-student hostility disrupted teaching, and several students described how the behaviour of a nurse tutor or mentor had stopped, or shut down, learning completely.

7.2 Students' Experiences of Incivility – Non-thematic Findings

In this section, the thematic findings are complemented by data which were coded and categorised as part of the analysis, but which did not subsequently evolve into themes. This data presented in this section goes toward addressing the secondary research questions.

7.2.1 The emotional impact of incivility

The emotional impact of incivility was revealed in the language the students used to describe their experiences (Table 9).

Table 9 Emotional descriptors (students)

Angry	Disrespected	Rage, full of
Annoyed	Dread	Rejected
Bullied	Embarrassed	Sacrificial lamb, like a
Blood boil	Frustrated	Scared
Brushed aside	Guilty	Shocked
Burden, felt a	Harassed	Stupid
Confidence, loss of	Hated it	Surprised
Demeaned	Helpless	Unfair
Demoralised	Hurt	Unimportant
Depressed	Impotent	Unsure
Disappointed	Offended	Upset
Disheartened	Peed off	

The following quotes further illustrate the emotional impact of incivility:

> I'll never forget it, because I felt I was going into work shaking and thinking
> will she be in and being so relieved when she wasn't and when I saw her in
> the morning crapping myself thinking, 'Oh god she's here', and then being
> so relieved because she was coming off a night shift. (Iris)

129

I hated it. Every minute. (Acha)

It was just frustrating, and it was soul destroying but it's made me a better nurse. I just wish they would go back ten-fifteen years to when they were students to remember what it's like to not know. (Rebecca)

I felt quite depressed in some ways because when I started that ward I asked myself why am I doing this? Why have I signed up myself to be treated and to be spoken to like this. (Debra)

7.2.2 The sound of incivility

The 'sound' of incivility came across in the words that the students used to describe their experiences, the sound evoking words are highlighted in orange:

- Her mentor was really cross with her
- One of the other girls stood up and shouted at the tutor for being rude to the other girl
- The student was screamed at by lecturer to sit down
- The nurse was shouting and threatening an elderly patient
- She was having a go at the patient
- A threatening tone
- She told the student off loudly
- She became very aggressive in the way she spoke

7.2.3 Where it happens

Incivility happened in both University and placement settings; in front of patients and non-nursing clinical staff, in both seminar and large lecture classes.

7.2.4 When it happens

Experiences of incivility were commonly described as happening early on in the programme although not exclusively so.

7.2.5 Contributory factors

Students cited a wide range of possible contributory factors related to uncivil behaviours (Table 10).

Table 10 Potential contributory factors (students)

Age	Behaviours varied between age groups. Rebecca talked about the younger students liking to chat and gossip and whose attention was not as good as it could be, and the older students who could be more assertive, sometimes bordering on the aggressive. As well age groups behaving differently, some incivility occurs because of the age of the 'recipient' as Amy said, 'If a student is a mature student, the tutors will speak to them differently because of their age.'
Aggression	Aggression was cited as a factor by Ben when talking about his mentor.
Apathy	Rebecca recognised apathy as a result of pressure, 'You get pushed so far, and you become apathetic.'
Arrogance	Arrogance was cited by Millie when describing nurses of African background, 'I don't want this to sound racist, but to me they come across as a race as being quite arrogant and rude and offhand and just not very English.'
Bored	Students leaving the class regularly, for example for toilet breaks, can be thought of as uncivil but it may actually be a sign of boredom (Dominic).
Burn out	One mentor described having, 'Yet another student' and another said she had 'So much going on she had nothing left to give me.'
Busy / Understaffed / Working under pressure	Amy describing one placement said, 'It's just relentless, it's under-staffed and everything.' Lisa said, 'When you are understaffed or there is lots of drama going on around you that can rise tensions and you can say things you probably shouldn't or if you are not very good at handling your own emotions or even if you've not had a very good day that can come out when you talk to people.'
Care, lack of	Amy talked about the lack of care that people have for each-other making for a bad society where people don't behave well towards to each-other.
Childcare	When childcare commitments are prioritised over course requirements such as attendance and time-keeping (cited by Acha and Dominic), the resulting behaviour may come across as being uncivil.
Choice	Lack of choice. For example, students may not get a good experience from nurses who would not be mentor by choice; student behaviour may be affected if nursing is not their first choice of profession; students may be unhappy when on placement outside their own field of nursing. Making choices. For example, Amy said she would make different choices about punctuality depending on the context, 'I wouldn't take it so seriously, you know if I was late for university I'll just show up late but if I'm late for a job I'd ring them and say oh I'm just running 5 minutes late, I'll be there.'
Competitiveness	Competitiveness within cohorts was described as a factor in inter-student conflict (Rebecca).
Confidence	Students may appear uninterested because of lack of confidence (Dominic). Alternatively, students who have had prior healthcare experience may find it hard to not overstep the limit of being a student nurse (Ben) and as a result be seen to be overly confident or assertive.
Cultural and ethnicity	All the students recognised how different cultural and ethnic backgrounds could influence behaviours and perceptions. Ben saw it in himself, 'There is a manner of speech, the way we talk most often where I am from people talk loud. I am a Nigerian, it is not the same as your typical English person. When you see an Englishman raise his voice, you tend to pull back.'

	Iris said, 'It's not acceptable to be speaking in your own language in front of patients and I've seen that a lot. Why should you be able to speak your own language at work, because there will always be problems, it breeds mistrust doesn't it? The first thing anyone thinks of when two people speak their own language is that you are saying something about me, it breeds distrust straight away.' She also commented on the behaviours of overseas nurses, 'I do find with a lot of the foreign nurses they bring their own styles. I've been there when two Filipino nurses starting spraying the spray (because a patient had opened their bowels) and giggling away, lovely girls but totally inappropriate laughing away and saying ooh this stinks.' A lack of understanding and/or tolerance of each-others' cultural backgrounds was also seen as a factor, 'I think we have a lot of diversity teaching from a white British middle-class point of view but we don't necessarily look at it the other way round. We expect people from other cultures to fit into our society and not upset us (Millie).'
Defensiveness	Amy recognised that she had a 'chip on her shoulder' about looking younger than she actually was and so she responded angrily if she felt she was being treated as young or naive.
Discomfort	Physical discomfort can result in behaviours that can seem uncivil to others. Millie talked about impact of sciatica on her mood and Lisa talked about the impact of hunger on behaviour.
Education	There can be a range of prior-educational experience in a group which can affect how students behave with each-other and with their tutors, especially if education has taken place abroad (Dominic).
Self-awareness	Millie said inter-student conflict could be caused by students' lack of insight into the impact of their behaviour. Dominic said, 'Students can get wrapped up in what they are doing and forget everyone around them.
Expectations	Rebecca suggested that lecture attendance was affected by the students' expectations of tutor behaviour, i.e. whether they were known to be a 'soft touch' or not. Debra reported how a ward manager's unrealistic expectations of her led to a situation where she was reprimanded in front of other staff members for something she didn't know how to do. Amy said, 'Sometimes but I would say it is a little bit to do with pride and ego, so although we all deserve respect I think to expect everyone to treat you with the upmost respect and talked to you politely on every single occasion is ideal but it isn't going to happen.'
Gender	Rebecca commented on being in a large cohort (two-hundred) of mainly women, 'When you get a whole bunch of oestrogen together it can be, it can be quite catty'.
Insecurity	Insecurity was cited as a factor influencing one student's behaviour which then impacted negatively on the whole class group.
Interest, lack of	Students who lack genuine interest in being nurses may fail to participate or appear bored. Rebecca described how some students (who at the time of writing were NHS funded), 'Don't necessarily want to be nurses but they don't want to eighteen grand in debt'.
Jealously	Rebecca was told by other staff that jealousy could be a factor in the way her mentor treated her because she was more outgoing and patient-focused than her mentor.
Lack of reprimand	Behaving uncivilly can become the norm if such behaviour is never reprimanded (Debra). Bullying appeared to have become the norm for at

	least one mentor despite it being a known problem amongst the placement staff (Iris).
Self-awareness	Millie said inter-student conflict could be caused by students' lack of insight into the impact of their behaviour. Dominic said, 'Students can get wrapped up in what they are doing and forget everyone around them.
Travel problems	Some students were known to travel long distances to get to class or placement, 'People travel for miles sometimes; you can't help getting in a bit late' (Amy).
Voice, lack of	Lisa described how having no voice felt, 'I heard a matron coming and count us in her numbers and that made my blood boil because I was thinking you are not supposed to count us.'

7.2.6 Coping responses

The students' narratives revealed the use of various responses to cope with uncivil encounters (Table 11):

Table 11 Students' coping responses

Seeking help from others	Rebecca described how she had tried to get help from both a senior manager and a link lecturer when she found herself in a difficult relationship with her mentor and Iris said how she had 'hinted' to the matron of the problems that her mentor was creating for her and the patients. In both cases, the attempts to seek help were unsuccessful, with managers and academics failing to recognise and/or respond to the requests. In contrast, Debra spoke with her link lecturer about her mentor's ongoing failure to sign her assessment documents and the problem was resolved as a result.
Helping themselves	Amy, Acha, and Rebecca each described how they actively sought learning opportunities from other members of staff when their own mentors weren't supporting them. When Debra's mentor failed to support her, she made a list of the skills that she needed to accomplish and then ticked them off when she had achieved them; she then used the list as evidence if anyone challenged her on whether she had actually achieved them or not.
Putting up with it	Several students described how they put up with uncivil behaviour citing various reasons. Ben said he wanted to avoid the stress of reporting it and tried instead to turn it into a learning opportunity, Millie talked about fear of retribution if she reported it and Lisa and Rebecca seemed to lack confidence in the reporting system although their reasons were not made explicit. Some students decided to pretend that everything was fine like Iris who said, 'thank you, thank you very much' to the sister who said she could come to her ward for a shift but warned her that she would 'just be a pair of hands'.
Rising above it	Students also made efforts to 'rise above' uncivil behaviour. Millie, for example, talked about letting it go and Iris said she refused to engage in questioning which she thought was vindictive. Rebecca said she had decided not to behave in the same way when she became a mentor herself and Debra described putting aside her dislike of a nurse who had been rude to her in order to get what the patient needed.
Avoidance	Avoidance tactics were described by several participants. Iris for example said she avoided having to eat with a particular member of staff at

	lunchtime and Millie said she purposely didn't make eye contact with the nurse tutor who was belittling another student so that she couldn't be brought into the situation.
Deferring action	Some students were prepared to tackle incivility in placement but only at a later point in time. Iris told herself she would report the problem after her placement had finished and Ben said he would address things at another time. Millie decided to be ready with a calculated, professional response 'if it happened' again.

7.2.7 Preventing and managing incivility

None of the students talked about preventing incivility although one mentioned the importance of the first ten minutes in placement were the student is made to feel welcome and part of the team.

7.3 **Nurse Tutors' Experiences of Incivility**

In answer to the question, "Can you tell me what your understanding of incivility is", the nurse tutors offered a wide range of descriptors (Table 12).

Table 12 Incivility descriptors (nurse tutors)

Aggression / fuming	Lying
Behaviour, poor	Manners, lack of
Being above others	Misbehaving
Blocking behaviour	Non-attendance
Consequences, it has	Not listening
Courtesy, lack of	Not preparing before class/tutorial
Defiance	Politeness, lack of
Disrespect	Respectful, not being
Disruptive	Rudeness
Eating in class	Sleeping / tiredness
Huffing / tutting	Speech
Ignoring people	Talking in class
Interest, lack of	Unacceptable behaviour
Kindness, lack of	Unprofessional attitudes/behaviour
Lateness	Using the phone in class

Nurse tutors also offered a range of descriptors for civility as listed in Table 13.

Table 13 Civility descriptors (nurse tutors)

Being respectful	Kindness
Communicating	Listening
Courtesy	Open
Giving constructive criticism	Pleasant
	Polite
Good manners	Professional
Gracious	Respectful
Honest	

In response to the second question "Have you had experience of incivility whilst working in pre-registration nursing education and if so can you tell me what that experience was like", all participants answered yes and went on to cite examples of their experiences. Analysis of the interview transcripts yielded five superordinate themes and ten subordinate themes (Table 14)

Table 14 Themes (nurse tutors)

Superordinate Themes	Subordinate Themes
Distraction	• Lateness and non-attendance • Personal technologies • Talking
Power	• Position • Passive-aggressive behaviour
The invisible tutor	• Overt ignoring • Passive ignoring
Verbal and non-verbal Incivilities	• Body language • Verbal hostility • Non-verbal noises
Impact on learning	-

7.3.1   Distraction

This superordinate theme encompasses all incivilities that shift the focus away from learning through the means of some kind of distraction; all the examples relate to classroom learning.

Lateness and non-attendance

This subordinate theme captures all forms of lateness or non-attendance whether it be arriving late, not turning up at all, not letting people know or not acknowledging or apologising for lateness. Eve described her frustration when new students were persistently late despite having been given a delayed start time to help them get used to travelling into the University:

I think we were initially giving people the benefit of the doubt when they first, you know, got to find their way da, di da di da, but after a couple of weeks people know

where we are and they know what time we start etc, etc, and we had agreed that
you know, that there were certain days when it could be a ten o'clock start because
we were enabling people to you know, travel certain distances. So ten o'clock
seemed reasonable, and still people can't get there and then, so we started to put
the, you know, like if it's gone ten minutes, you know, you're going to have to wait
until the break time, and still people would open the door and say, 'Oh it's alright if I
come in isn't it', and you're like, 'No actually, it's not, you know, no, you need to go,
go and wait until the break time'. And sitting here it sounds like it's being quite futile
and pedantic, but actually, if these are going to be the practitioners of the future,
you can't have practitioners turning up for duty ten minutes late.

Marie described trying to explain the implications of lateness on placement to students:

Another issue is students being late, sometimes for every shift. You know if you
explain to them the cost implications of them being late you know for fifteen
minutes every day, or the implications to the rest of the team you know for
tea/coffee breaks you know they get it but why should it need to be explained?

Although students are not counted in the staffing numbers when on placement, the qualified
nurses, especially the nurse mentors, still have to organise their work around supporting the
students. In this way, student lateness can have a direct consequence on the qualified nurses'
time and ultimately therefore on patient care.

In the classroom, Joy found lateness rude partly because she would always try to be on time
herself. She acknowledged that most students would say sorry but that others disturb everyone
because they want to sit with their friends. Liv and Kirsty agreed that lateness could be
distracting both for them and for the students. Kirsty described how it could look:

Sometimes you are delivering a lecture and somebody comes in late, bag over
their arm, phone in their hand, march up to the back of the lecture theatre
demanding that everyone move, not a word, no apology.

Marie, reported a similar experience and the students' response to being asked to leave:

With this new cohort that have come in we've got students turning up half an hour
into the lecture and not even acknowledging that they are late. They just turn up
and sit down and then you go over to them and say I'm really sorry but you are
going to have to leave the class because we have a ten-minute rule which I know
is made clear to them on induction and it's this sort of gobsmacked, oh you're
really actually going to do that then?

Liv described the response of students to others lateness as, 'I was here on time why can't you
be?' Eve and Connor both described students 'tutting' about latecomers and Brenda noted the

'rolling of eyes' which told her when the other students had had enough of it. One impact for tutors is having to decide whether to repeat information for latecomers or not, as Eve said:

> So, I might have just set out what, you know, what the session is going to focus on, what we're going to do, how it's going to run, da, di, da, and then somebody walks in and you're like 'OK'. So, do I need to go through that all again or do I just carry on and then somebody who's come in late will say, 'Oh can I just ask…' and you think, 'Well actually if you'd been here when we started, you would have heard that.'

She also highlighted the potential for impact on planned activities such as group work:

> You set people into groups with the number of people that were in the room when you started and then people arrive late and you're like, 'OK, so do I just say, 'Right, OK, you form your own group' or do I then split you so you go and join respective groups? (Eve)

As reported in the student findings, lateness can cause a physical disruption as well. People coming in late cause heads to turn and lecturers and students to lose concentration. Some students make other people move so they can sit with friends and then bags are opened and coats are taken off:

> Demanding that everyone move, not a word, no apology. (Kirsty)

> They disturb everyone, they want to sit at the back, sit with their friends. What tends to happen is that start taking off their coats, they will be getting their bag, get their drink so this disrupts my teaching or my train of thought. Most of the others tend to be disrupted too, they look to see who it is and they start whispering. (Joy)

> It disrupts, you know it's sitting down, putting their coat round and then getting their bags and getting whatever out and, you know. It's little things that...there's the noise and the movement and, and the head turning. (Eve)

It was evident that nurse tutors could also see the impact of lateness on students, especially if they (the students) felt it wasn't being managed by the teaching staff. Kirsty reported how an angry student came to her about a colleague's failure to manage lateness:

> She was absolutely furious about lateness and why the lecturers don't do anything about it, 'They just let them come in and I wouldn't dream of coming in that late'.

Lateness or non-attendance at tutorials was also perceived to be uncivil:

> When the student doesn't turn up or doesn't phone in. (Joy)

137

> If it's a one-to-one tutorial and I was on time and the other person didn't bother to let me know that they were going to be late then that is uncivil. So, in a student tutorial it would make me very angry actually. (Liv)

Lateness at tutorials can have a direct time impact on the tutor as Nesta's example shows:

> I had a student yesterday who came late on (sic) tutorials, group tutorials, and I had like fifteen of them, and she was the only one who came late, ten minutes late, not ten minutes late, actually less, about five. She went to the toilet between the exam and the tutorial and I couldn't wait for her because there is (sic) another 15 waiting but I did tell her that I would go through the questions that she missed later.

As was apparent in the student narratives, lateness was not always seen as being disruptive; it depended on the circumstance. Liv said she tended not to worry too much about it and said that she didn't want to turn anybody way from the classroom if they were late. Nesta described trusting the students' reasons for being late:

> I do consider it uncivil, but I take consideration, like I do receive some emails sometimes, that I'm going to come late, which I do appreciate, and I take this in consideration, to be honest with you. I trust them, and I consider if somebody will come late they must have had a reason to do so.

Personal technologies

This subordinate theme captures the disturbance caused by the use of personal technologies, such as phones and laptops, which can be distracting in a variety of ways. For some of the nurse tutors it was what the devices were being used for that bothered them:

> One was behind her laptop tapping away which I don't have a problem with them taking notes but you kind of get the feeling when they are not taking notes. (Kirsty)

> Sometimes they shop on their devices [ ] and I take that as very (emphasises word) rude. If I think manners is related to being civil, then manners would say that you don't use your phone and you don't go on Facebook™ in class, that you at least have the decency to listen even if you don't partake. (Joy)

> I don't have a problem with the use of technology, but I do stop at them Snapchatting™ and Facebooking™ or Amazon™ shopping, so I will highlight if someone is doing that then I'll stop what I am doing then look at the student and nine times out of ten they will stop. That's an ongoing battle with them, an ongoing battle with them and technology. I tell them whether you are interested or not I still get paid the same, so it is up to you what you do but I do think that for your peer group it is more disrespectful to them than to me. (Brenda)

The disrespect to other students referred to by Brenda was also commented on by Marie, who recalled how upset it made her on one particular occasion:

> Students don't show each other respect when it comes to phones. I had groups doing presentations so we set the scene at the beginning not just the ground rules but listening, engaging, body language all that sort of stuff and turning your phones off with bleeps, vibrations and once even Siri started to talk in one group's presentation and they were only informal you know they weren't marked or anything so it was quite a learning curve but I was just so upset that I'd had to say it three times and yet still Siri went off and I almost you know I felt like dropping the phone out the window, you know I was so angry that they would be that disrespectful. (Marie)

For one tutor it was the loss of eye contact that device use can cause that bothered her, because it can reduce the interaction between her and her students:

> What bothers me about it is I think, I get quite a lot of feedback from eye contact and body language so if somebody's got their head down and they're looking at this (a laptop) rather than engaging with what's going on, I worry about whether or not they're actually fully engaged with the discussion that's taking place. (Eve)

Mobile phones going off in class were also considered uncivil by Connor, Eve and by Peter. The latter shared his experience of a disruptive phone call and a case of 'extreme' shopping in class:

> Her phone went, it was right at the beginning of the lecture, and she picks the phone up and started talking, having her conversation on the phone. So I stopped the lecture and then challenged her after she had finished on the telephone call and said if you have an urgent phone call coming in you leave the room, you know slip out if it's an important call you can't just take the call in the class. Also, your behaviour is disruptive to the rest of the group.
>
> There was one girl who had 2 iPads™ going with nothing connected to the session, she was shopping in the classroom.

Liv felt that there could be advantages to students' using phones in class to find out things, but she had also seen how they could disrupt the learning environment:

> There was three of them looking at their phones, all three of them (laughing), and you know that some of the other groups were having really in depth discussions about their experiences of death and dying and the three of them were sitting in a certain way and one in particular, you know body language, and the way she was sitting in her chair, and her facial expression, you know she didn't want to be there and the other too as well were looking at their phones at something I thought was probably not related to what we were doing.

Talking

The nurse tutors described the various ways in which talking can be distracting from students talking over each-other, talking when the lecturer is talking and dominating class discussions. Joy, for example, described the difficulties of students talking when in large class groups:

> The bigger the group the more difficult it is [ ]. So that talking while the lecturer is talking, whether it is related to what the lecturer is saying or not, is an issue and I think that can be disrespectful, a rude thing to do but it can vary widely, you can have a whole 150 transfixed to what you are saying and deliver the same lecture to another group and you are stopping every few minutes and then that's a problem.

Kirsty related a similar experience also with a large cohort:

> Two hundred and forty on the module although not all there but quite a large number there, three girls, three student nurses they just wittered, kept talking amongst themselves, you're sitting down in this lecture theatre and you just get this buzz buzz, buzz.

Eve had also experienced problems with excess talking in class. On one occasion, a student had signalled rudely to the nurse tutor that she was unhappy about ground rules being discussed in class for a second time. Other students then became annoyed at the disruption caused by the discussion between student and tutor as the tutor tried to resolve the issue. The result was an increase in noise levels as the students started talking about it amongst themselves:

> There's definitely a dynamic of people in the class…of 'She surely didn't, she didn't do that did she' or, 'God, here we go again'. That sort of dynamic starts to happen and it detracts from the purpose of the (sic) what's meant to be happening in that session. It detracts from trying to have, you know, have that, that discussion and that debate, or, or just, you know, if it's stuff you've literally got to just, you know, get the information over and then have a debate or a discussion about it, it detracts from that quite significantly.

Nesta described how students who were supposed to be doing group work were talking about something completely different:

> You know, when they sit in a group, like talking about critical analysis, and they are doing some kind of work, and then you go to the group and you listen to them and they don't even talk about the critical analysis, they are talking about different topic.

In some cases, the talking in class was a significant problem:

> In one of my classes this year, the xxx cohort, their behaviour was atrocious at the beginning - talking over each other holding personal conversations while you're trying to go ahead with the lecture and when you stop and say to them, 'Is there something you would like to share with us? [ ] They totally ignore you (pauses) - complete indifference to what you've just said. (Peter)

In other cases, the class discussion is dominated by just one student, as Joy described:

> I had one student who came along and said, 'Oh I knew that answer but you didn't ask me' and I said, 'Well why do you think I didn't ask you? and he said, 'Why? and I said, 'Because you've answered all the questions' and he said, 'But the other students don't like to talk' and I said, 'Well I wouldn't talk if you were answering everything, I would just sit back'.

7.3.1 Power

As with the student theme of Power, this theme references positioning behaviours where people, consciously or otherwise, position themselves in-order to assert power or influence over others, or specifically to gain advantage. The examples given illustrate interactions shaped by perceptions of position, culture, ethnicity, and differing expectations.

<u>Position</u>

In this subordinate theme, nurse tutors described their experiences of incivility related to issues of position and status. Joy explained how it was more difficult to deal with incivility from senior academics because of the issue of power whilst Connor described how junior academics had been impacted by the uncivil behaviour of senior ones:

> Well a couple of the new lecturers have been in tears recently, in part because of the expectations on them and the lack of support, not their willingness to do what was required of them or their motivations they were really, really, keen you know, but some people have had them in tears regarding quite simple stuff; senior to junior usually. (Connor)

The power imbalance created by the respective positions in the mentor-student relationship was also evident. Connor described how a student had told him that their mentor was lazy and rude and delegated tasks to her (the student) all the time. He said that in his experience, incidents like this were usually down to staff shortages which resulted in students saying they were being (mis)used as a pair of hands (as reported by student participants in the student findings section). Like the student participants, he also commented on the reliance of students on their

mentor to sign their PAD, which left them in a dependent position in the student-mentor relationship.

Peter described an incident in which he felt that a mentor misused her position when she led the student to believe she was doing well on her placement only to tell her at the end that she had failed:

> They were saying every week that she was fine and that she would make
> a great nurse and they were passing her and doing all the paper work but at the
> end the mentor turned around and said we want to fail you. That is the worst bit of
> behaviour I have ever seen. I spent four hours trying to sort this one out because
> the student was in tears and pieces.

The tutors reported how students established positions in the classroom. Brenda and Liv described students' tendency to divide themselves into groups:

> It tends to be divided by ethnicity, significantly so. It tends to be the continent
> of Africa on the right-hand side, Europe on the left side' (Brenda).
> Like sits with like, so older woman tend to sit together, sometimes all the men sit
> together which is funny as they get so competitive and then people from the same
> ethnic group tend to sit together' (Liv).

Peter observed that male students, of which there are relatively few, tend to group together:

> It's interesting to find the lads do stick together the tendency of male
> students to stick together; there was a group with two young guys and
> they used to, on a few occasions, they used to go for a drink before
> they came for a lecture, didn't come in drunk or anything, but they
> used to stick together.

These positioning behaviours do not necessarily lead to problems, however they can, as was illustrated in several of the narratives:

> There was racial bullying alleged between two groups which escalated. It has now
> been managed and it sounded like it got quite ugly. There were two groups from
> two different cultures working in the classroom setting and it wasn't my class and I
> don't have all the ins and outs of it but comments were made which led to bullying
> outside of the classroom. During the sessions the negativity escalated, and the
> students were quite uncivil in the behaviours they presented. (Marie)
>
> Well one of the girls went over to the other group and accused her of being a racist
> you know and 'You're not a nice person' and 'Everybody knows' which isn't a nice
> thing to be accused of and she just said that in the classroom to her face which I

142

hadn't heard but it came to my attention after the class and we did deal with it and she was going round telling other people outside the group this girl was a racist so it was malicious talk, and I believe that girl has since taken a break from the programme. (Peter)

Peter also noted how students sometimes sit in 'racially divided groups' saying that it was obvious that one group didn't like another; in his words, 'You could feel the tension in the room'. This tension sometimes spills out into student-to-student incivility as Joy described:

I have one student who has got a very thick accent and I had to strain to hear what she was saying, and she never used to talk in my class and she used to answer questions and there would be some snickering and I had to stop it and say, 'Right, what so funny?

Nesta commented on how groups from different ethnicities behaved with each-other:

I think within themselves they're happy, like within each culture and background, and ethnicity, they're happy with each other but you can tell sometimes when there is a discussion then this is when they want to overtake the discussion from each other and I must say that black Africans and white you can tell that it's more than when how the Asians take it, 'cos the Asians will keep quiet and they won't aggravate, and won't discuss it more. But if it's between these two (rolls eyes, shrugs and laughs).

Several nurse tutors described intervening in race-related conflict. Peter took several students out of a class to discuss a report of racial harassment made by another student in the class and Marie went out to a placement to investigate a report of racism made by a student against a qualified nurse.

Some uncivil behaviours were seen as a result of how students used, or tried to use, their position amongst their peers. Peter and Marie gave examples of this:

He was playing up to the audience (the other students) and was quite flippant in his remarks and the way he speaks to you and answers questions with wisecrack answers; not really seriously. (Peter)

They were doing some group work and two of the members came to me to say are that the three other group members hadn't attended any of the other meetings and the reasons they gave were things like, 'We've all got children, so you will have to do the bulk of the hard work'. Can you believe that? (Marie)

Passive-aggressive behaviour

This subordinate theme, highlights how nurse tutors employed passive aggressive

143

behaviours to peers, including not answering requests for help or failing to handover teaching resources in advance of when needed. The latter scenario happened to Kirsty:

> When modules aren't prepared, and you don't have resources ready, that's something else. For example, to get a presentation on a Friday afternoon and expect you to be able to deliver on a Monday morning at 09.00 and do a good job for students, I think that's uncivil behaviour to students and disrespectful to the team. (Kirsty)

There were examples of nurse tutors purposely withholding help and of nurse tutors flouting agreed ground rules. In the first of the next two extracts, Nesta is talking from the perspective of being a fairly new member of staff and in the second she is referring to a rule agreed by staff and students that students who arrive more than ten minutes late are not admitted into class until there is a pause in the teaching:

> When you are seeking clarification about a certain thing, there are some people that will kind of tell you off or block you of going further, then you'd avoid asking them, if you understand what I mean. (Nesta)

> I think it has been uncivil, because they still wanted to do what they want, they don't follow the guidelines of the module, we have agreed from the beginning, and still they don't behave that way. They set up the rules for themselves, they just wanted to do whatever they want. I think that there are factors affecting them being uncivil, but they are being uncivil. (Nesta)

7.3.2 The invisible tutor

When this theme arose for students, it was because their needs as individuals and as learners were seemingly invisible to the mentors and other qualified staff in the placement areas. For the tutors, the notion of invisibility arose through their needs as individuals and as tutors, being invisible to the students. This was manifested through overt ignoring, as in defying a tutor's instructions and passive ignoring such as failing to prepare for seminars.

Overt ignoring

Intentional or conscious ignoring was cited a number of times. Peter for example shared how one small group within a class behaved:

> When you stop and say to them, 'Is there something you would like to share with us?' and they totally ignore you… complete indifference to what you've just said. They just carry on and disrupt the whole lecture for everyone.

Kirsty made conscious efforts to greet her students as they arrived in class. Initially they just ignore her but their behaviour changes as the module progresses:

> On the first day I stand at the front of the lecture hall and they come in and they make no eye contact, they don't look at me, I'm stood there smiling and they don't even make eye contact...then a couple of weeks down the line they are all hello, hello.

Both Marie and Joy gave examples of students ignoring instructions or requests from staff in placement:

> It just blows my mind really the amount of times I've been called into placements to talk to students that are refusing to work weekends, refusing to work late, they think that because their friend is on another ward and their shift finishes earlier then so should theirs. (Marie)

> I said, 'Can you put your mobile phones back in your bags, I don't want to see them' and still they didn't. (Nesta)

Passive ignoring

This subordinate theme captures a passive type of ignoring which is when students fail to take responsibility for their learning by coming unprepared for seminars or tutorials or failing to participate as requested by the tutor during taught sessions. Nesta described how one group of students repeatedly ignored the group allocations they were given:

> I was amazed by them saying that they don't remember which groups they were in, and I said, 'You know, come on, we're not going to finish till you sit in your groups'. In the third lecture they still came back and sat with their friends.

Joy found student's lack of preparation for class, as well as their lack of interaction rude, as she told one student whose lack of participation she challenged:

> You sit at the back of the class and you never talk to me, you never prepare, and I consider that being rude.

She also recalled how she had tried to explain the problem of being unprepared to another student, who had come for a one-to-one tutorial with one of Joy's colleagues and had been told that it couldn't go ahead because she had not done the required preparation before-hand:

> She came to see a colleague of mine on the same day and she brought nothing with her and she rightfully said, 'No thank you we can't see you'. She was really

145

upset so she was having a moan to me and I said, 'Put yourself in that colleague's shoes, you brought nothing with you'.

Nesta also found students the lack of preparation uncivil:

> What I think is very uncivil, when you give them a piece of work that they have to critique for the seminar, for the purpose of the seminar for example, and they come unprepared. Out of thirty-three students, when you have only two that they have done the reading.

7.3.3 Verbal and non-verbal incivilities

This theme captures the incivility that is perceived through lexical (word-based) and non-lexical (non-word based or paralinguistic) dimensions of communication. It can be unconsciously or consciously acted out and is illustrated here by use of physical gestures and movements and verbal and non-verbal sounds.

Body language
Body language is the communication of attitudes and feelings through the conscious and unconscious positioning and movements of the body (Pease & Pease, 2006). Nesta and Liv described how students had portrayed incivility to them through their body language:

> The way that she talked, her body language and her eye contact and facial expressions wasn't civil. (Nesta)

> If you go into the classroom and there is a young woman sitting on the chair with her bottom hanging out you know that's rude and that's giving me a stronger message that they don't want to be there. (Liv)

I asked Liv whether she thought it was the clothing or the sitting position that signals a student doesn't want to be there and she said she felt it was a combination of both, along with no effort to sit in the chair properly and look interested.

Eva described how she perceived one student's body language as being disengaged:

> It wasn't any particular words that she used, it was just the manner in which she then started to get stuff out of her bag, she started to slump her way down (Eve illustrates by sliding down in her chair) and then just disengaged.

Sometimes the nurse tutor participants couldn't articulate exactly what it was that indicated

incivility, despite being certain it was there:

> For the first time ever, I was really feeling irritated. Normally it just washes over me but I just...there was something about their attitude and I just thought they were so rude and so disrespectful. (Kirsty)

At other times the reporting was hearsay or second-hand. Peter, for example, recalled a second-hand report of non-verbal incivility made to him by one of his students:

> I had a student come to me recently and said she had walked out of the lecture crying because a member of staff had come down and sat beside her and put her arms on the desk and was staring at her (demonstrates staring intently); she said she felt victimised.

The student said this had happened when the students were doing group work, but she did not know why the tutor had approached her in this way. As this extract illustrates, it is even harder to make sense of second-hand reports of incivility than first-hand reports, given all the factors in any one situation which can influence an individual's perception of events and which are unaccounted for in the second-hand recollection.

Another form of incivility linked to body language is conveyed by the sleeping student:

> When they are just here for lecturers and they do start at 09.00, sometimes you think well why are you falling asleep at 09.30am? Or its not falling asleep but when it's that they are literally rolling their eyes and you see their body almost going to sleep. (Marie)

Marie was asked if she saw this often:

> Yes, not all the time (laughing), tends to be on a Friday. I have got two students who struggle to stay awake and actually when they participate they've got really valuable things to say, it's not...I don't think they are genuinely trying to be rude but nevertheless their behaviour is uncivil.

Marie said she was not alone in encountering sleeping students:

> A couple of my colleagues they have said that they have had students fall asleep and they've had to go and tap them on the shoulder or they tapped them on the wrist or said something you know you are missing a key part of this session and the students have been very apologetic and embarrassed about it.

Sleeping did not arise as a theme in the student data but Acha, one of the student participants, did feel sleeping in class was rude:

> He's fallen asleep in a small seminar and he's had the nurse tutor say
> you need to get out splash some water on your face and come back
> and I'm thinking why are you even here, sleeping? I find them rude,
> but not enough to stop me from learning.

Verbal hostility

In this subordinate theme, uncivil behaviours were conveyed in words and tone of voice. This was usually accompanied by body language indicators too, as illustrated in this incident which happened when three students who were persistently talking in class were asked to give their names to the nurse tutor so that she could report them to the year tutor:

> Then she says 'you've no right to take our names' (mimicking the student's
> voice, speaking loudly and angrily) and off she went again (hands on hips)
> shouting at me. Everyone heard them shouting on the ground floor when
> they came in. (Kirsty)

Nesta felt 'aggression' from a group of students who were unhappy with their assignment results although nothing specific was said to her. She had tried to explain that the feedback, which was formative, was there to help them:

> They were angry about it, they weren't happy, they didn't take it this way; they were
> very aggressive. (Nesta)

Brenda described what happened when one student said something hostile to her during a class. Although she did not hear what was said, others in the room clearly did:

> There was one particular young lady who was quite hostile, which I thought
> fine bring it on, it doesn't bother me, but it was for no necessarily apparent
> reason. Anyway, she said something to me and I can't even remember what the
> conversation was, but she said something to me and everyone else in the
> group went (demonstrates sharp intake of breath and audible gasp) because
> they couldn't believe she'd actually said this out loud to me. I didn't actually hear
> what she said, and it is just water off a duck's back to me and anyway they were all
> (demonstrates drawn out gasp, eyes wide open, shocked expression) so I didn't
> address her, I addressed the rest of the group and I said you know she's been
> rude, and obviously she feels that's appropriate but I don't know this young lady it's
> the first time that I've met her but obviously she feels communicating in this way is
> fine. I said me I'm too old and too ugly to be worried about that kind of rude
> behaviour and I didn't acknowledge her at all, I acknowledged the response from
> the room.

On another occasion, Peter experienced verbal hostility from a student who he approached about wearing uniform in a public place:

> I went up very politely and said are you a student of the University and she said, 'Yes what's it got to do with you?' I said, 'Well I'm not on duty but it is against University policy you being in here in your uniform', and she said, 'Have you got any ID on you?' and I said, 'No I'm sorry, like I say I'm not on duty at the moment' and she said, 'I don't have to listen to you then do I?'. She was second year on the MSc and it was her attitude…if she had said I'm sorry oh yes, but it was her attitude, I was quite shocked at her behaviour, she was very rude, but I expected her to say, 'Wow I'm sorry' and she was just really rude…I was quite shocked.

Verbal hostility between students was reported too. Liv described one incident where a student turned around and 'slagged off' another student in class for asking a question and both Joy and Liv reported incidents of students swearing to each-other in class.

Hostile exchanges between younger and older students were seen by Peter as being healthy as long as they are not allowed to degenerate too far:

> They really go back at them, really go back at them but I class that as healthy debate obviously because I'm there I'm not going to let it descend into a fracas but they do go back at them, and it really gets their backs up...

Hostile exchanges in the form of students shouting at staff in placement were reported by Marie but shouting was not just confined to students. Peter described how another nurse tutor had shouted at him over the phone and Joy recalled:

> I've observed lecturers, well a particular lecturer, shouting at a student not to come in the lecturers' room because the student wanted to come into get her document signed and she should have knocked. That's fair enough but this lecturer just shouted and [ ] they tried to involve me but I just said I don't want to, can we just speak to the student nicely?

Non-verbal noises

Non-verbal noises can be used to make a person's feelings known very effectively, sometimes without them even realising they are doing it. Non-verbal noises lend themselves particularly well to the communication of negative feelings as Millie, Kirsty and Peter all described:

> Every now and then you get a personality within the classroom that is always sighing, is always huffing. (Marie)

> She gives me her name huffing and puffing and blowing and then the next

149

one gives me her name and the third one gives me her name. (Kirsty when describing how she had asked for three students for their names because they had been disruptive in class)

When the mentor spoke to her (about always being late), the mentor said she was shrugging her shoulders and was puffing and blowing and wasn't happy that the mentor was talking to her about it. (Peter)

Eve described how when talking to a group of students about ground rules, one student used non-verbal sounds to communicate her response:

The student did what I can only describe, I can, I'll have to make the sound because it was just so stark, was the (Eve demonstrates by makes 'sucking teeth' sound), that sort of sucking in of the teeth and the eye rolling. So rather than saying 'I disagree' or 'can we have a discussion...', 'I'm not really sure that that doesn't sit with me' or 'I don't agree with you', that was the response from the student in particular. And I had to, I had to, I sort of did a bit of an intake of breath and thought right, OK, well it's not appropriate, I don't feel it's appropriate right now in this class of 35 students to say something right now because I'm going, I need to remain professional, but I was, I was really struck by just how, how rude I thought that that student had behaved at that particular moment in time, and then continued through the rest of the lesson to be quite disruptive in her manner and behaviour.

Marie described how incivility displayed by students through non-verbal noises can impact on other students too:

They didn't notice it before (referring to the huffing and sighing of one student) but when she was asked to participate in group work the group felt challenged by her behaviour.

7.3.4 Impact on learning

The potential for incivility to impact on learning is evident in all four of the above themes. Nurse tutors also made explicit reference to instances of incivility that impacted directly on student learning or on the learning environment more generally. For example, nurse tutors described how the distraction of latecomers could cause them to forget what they were going to say next in a lecture:

I will get distracted and I think oh god now what was I gonna say? (Connor)

It stops my flow. Sometimes I have been known to say to students, 'What was I saying?' (Joy)

Marie described how she had to work hard to regain the students' attention when there had been a significant distraction in the classroom:

> I had to really work hard to get the class back to what we were talking about with their summative work so it did have a huge impact …the impact of it is that you've got to really work to pull them back.

Power-related incivilities such as receiving teaching resources late from colleagues, can result in poorly prepared lectures as Kirsty described, 'You are just turning up and reading from the slides and the students say they hate that'. She also described how noise in the classroom, as described in the Distraction theme, can impact directly on learning when information is missed because students can't hear what the tutor is saying. Another example given was when students slept in class, as described in the 'Verbal and non-verbal incivility' theme. The sleeping student may not only miss important information but also the chance to actively participate in learning activities. Similarly, so will those who do not take responsibility for their learning by doing the pre-class preparatory work, one of the incivilities identified in the 'Invisible tutor' theme.

7.4 Nurse Tutors' Experiences of Incivility – Non-thematic Findings

In this section, as for the student findings, the phenomenologically derived themes presented in the previous section are complemented by data which were coded and categorised as part of the analysis, but which did not subsequently develop into themes. As before, this section goes toward addressing the secondary research questions.

7.4.1 The emotional impact

The emotional impact of incivility was revealed in the language the nurse tutors used to describe their experiences. The key descriptors used are listed in Table 15:

Table 15 Emotional descriptors (nurse tutors)

Angry	Disrupted	Shaken
Angst (worried)	Distracted	Staggered
Annoyed	Frustrated	Struck
As if not doing enough	Had enough	Surprised
Bad	Letting others down	Upset
Blows my mind	Narked	Victimised
Bugged	Ready to swipe her one	Wanted to walk out
Conflicted	Sad	Worried, really worried
Disbelief	Shell-shocked	
Disrespected	Shocked	

7.4.2 The sound of incivility

The 'sound' of incivility came across in the words that the nurse tutors used to describe their experiences. As with the student findings, the sound evoking words are highlighted in orange:

- Kept talking amongst themselves,
- Behind her laptop tapping away
- You just get this buzz, buzz, buzz
- You get tutting
- She gives me her name, huffing and puffing and blowing
- Off she went again shouting at me
- Rummaging around
- They were angry about it
- Have been in tears recently

7.4.3 Where it happens

Incivility took place in University, mostly in large lecture classes and seminars as opposed to one-to-one tutorials or in placement settings.

7.4.4 When it happens

Four of the nurse tutors noted that uncivil behaviours were more likely to happen in the evenings. From Nesta, 'It was quite late, five to six lecture, and they came after two hours of a lead lecture to a seminar, you feel for them to be honest with you, they come kind of agitated, bored, they don't want to listen, they just want to finish off'. Peter said the same, 'It seems to be worse in the later classes and at night' as did Marie, 'It was an evening session so they are always at that level of fatigue aren't they, yes so it was hard work all round'. Liv and Marie identified Fridays with a tendency for sleepiness. However, in some cases the time of day was

irrelevant as Marie reported, 'Well I always think evening teaching is hard on them but this incident with the three girls happened in a 09.00am session so…'

7.4.5 Contributory factors

When asked, nurse tutors cited a wide range of possible contributory factors to uncivil behaviours (Table 16). As with the impact on learning, they gave this considerable thought in the interview, resulting in more detailed explanations than those offered by the students.

Table 16 Potential contributory factors (nurse tutors)

Age	Eve thought that 'age and generational' differences in upbringing could be a factor as could 'professional qualifications' and 'culture' (although not necessarily ethnic culture). Nesta and Peter both felt that it was more likely to be the younger students who 'misbehave' possibly due to a lack understanding or of care about how their behaviour impacted on others. Talking about one student's behaviour (sighing in class, not participating in group work), Marie said, 'I think had she been aware of it she wouldn't have done it, I think it was just a late teens things, in the stage of life when they are not full self-aware yet, I don't think it was meant as harmful'. Peter noted how older students could fuel the difference in outlook between the age groups, 'I've seen this happen a few times, I've seen it in their remarks to them, sort of not valuing them (the younger students), they are inexperienced, that type of thing, that can come across especially when you are discussing issues like religion, social economic status, you know how can you know what it's like you're just a youngster'.
Belonging, lack of	Nursing students spend their time between university and placement, a factor which may make it hard to develop a sense of belonging in either setting. As Kirsty explained, 'They don't have the holidays off (unlike other undergraduate students), they don't have all the perks, but they are not part of the hospital trust either so they kind of fall in the middle. So, I think they sometimes feel they don't really matter, they can do what they want, I can come in late, nobody's going to tackle it'.
Boredom / lack of stimulation	Kirsty described how she felt that having a naturally quiet and melodic voice could lead to students falling asleep in class as a medical student once said to her, 'I'm so relaxed when I am in your session I could just doze off'. Other nurse tutors identified long lectures (2-3 hours) as leading to boredom or tiredness which then triggers behaviours such as online shopping or talking. Marie described the importance of maintaining a constant awareness of the students' attention levels and adjusting teaching accordingly, 'If you say or do the right thing all of a sudden they wake up again. Then they are back on it for the rest of the class, so sometimes it is just recognising, 'Oh perhaps I am being a bit monotone and its boring or perhaps I'm waffling a bit'.

Confidence	Marie said, 'They become more confident in what they can get away with and what boundaries they can push'. Connor made a similar observation, 'The first years are really testing us out as much as we are testing them.'
Culture, ethnicity and religion	Liv described how a class can have groups within groups that nurse tutors are not always aware of, 'There were students who seemed to be having a joke, I think they were from different African tribes so it's not just between different cultures, but it can be within you know like, 'You used to be a slave'.
	Brenda thought that disagreements between ethnic groups depended on the subject matter. She described teaching health to a group which comprised approx. Thirty-five to forty white and sixty non-white ethnicities where everybody was open and comfortable talking about race. However, she had also taught race and diversity in a class where the differences between students' prior experiences were marked, 'You have an eighteen-year old White girl from the country who said, 'I've never saw a black person until I came to London' and others couldn't believe that. I said, 'How old are you?' and she said 'twenty-three' and all the people from London could not understand that, they were like 'What! What! In the 21st century, in the United Kingdom?'
	Brenda and Joy both talked about cultural differences in relation to what is considered civil and what is respectful. Marie gave an example of this when she spoke about people talking loudly, 'Some cultures speak very loudly naturally in their home countries, it's the norm to speak very loudly, and so when they come to a ward where mostly the staff are very quiet it's a bit (demonstrates surprised face)'.
	One example of differing cultural norms is the concept of being on time. Kirsty said that she thought it was Black and Minority Ethnic (BME) students that tended to come in late, but she was not sure if this was because of culturally different perspectives on time-keeping or the fact these students had to travel further.
	Religious differences as well as cultural differences can also play into disagreements in class, as Brenda said, 'Sometimes, when you are talking about some issues, let's say for example you are talking about homosexuality, or like today we were talking about LBGT, there can be issues of religion, the churches can be very strong, you know the Christian and Muslim etc. and then sometimes there are other groups, you know like the Somalis.
	Eve noted how students from some cultural backgrounds will not make eye contact and or contribute in class and that this could be misinterpreted as uncivil. One tutor noted that sometimes the tutors themselves used inappropriate terms such as 'coloured' which she felt could contribute to tensions.
Education	Two participants (Kirsty and Peter) reflected on the role that school can play in uncivil student behaviour, linking it to how pupils are allowed to behave at school and more generally how children are socialised and raised. Marie said, 'When I went to school you got told off if you didn't have the correct uniform on for example or for back chatting the teacher. Teachers aren't allowed to do that nowadays, so schools are very

	different. They are a much freerer learning environment so maybe they (the students) don't come with that because they don't have it in school'. Connor said that some students come to university with a group of friends they already know well and with whom they have therefore developed certain ways of behaving that they view as normal, 'I think it has a lot to do with the way that they've been educated prior to coming here. You know what they've been getting away with and some are sitting in little cliques that they have been in together since primary school and secondary school and then they come here'. Peter observed differences between the nursing fields, 'The mental health students are very different, they come prepared and ready to learn, I don't know if it is because they come with more UCAS points, but there is a difference in their behaviour...I don't know what it is but there is a definite difference between the adult, children's and mental health students'.
Expectations	Liv said that mentors and nurse tutors can have unrealistic expectations of students based on their own nursing training experience, 'You hear it a lot; you are third year now, you should be able to…' or 'When I was a third year I could do this, that or the other, but they don't always see that the experience may be different to what it was in their day'. Joy described how unrealistic mentor expectations can leave the students thinking the mentor is rude because they don't know the level of training they are at. Peter described how in his training, expectations were clearly set, 'The training was no different from what these guys are doing but a lot of our lecturers were from a bygone era and were very strict, this is how you behave this is what you do. There weren't many younger lecturers in post, they were mainly older, they set clear boundaries, ground rules, that you had to follow but I don't know what has happened in the intervening time'. Brenda also talked about expected behaviours in relation to her own training, 'It was in the late 80s and so the training was very different to what it is now and in practice you would never, you just would never, she could be horrible to you, absolutely horrible to you but that position (referring to the ward Sister) regardless of how that person behaved, got respect and you just didn't challenge that ever. There is this sort of open rule that whatever they say or want they can have nowadays'. Kirsty identified how a failure to set expectations clearly could lead to students' failing to engage with their studies: 'We don't take registers properly in the first year, we don't make students feel they are on a full-time course, that they should be here, that we are expecting them to engage'.
Failing to listen	Nesta described how some students, particularly the younger ones, have under-developed listening skills, 'They start putting their views before others finish'. Failure to listen to others can result in disagreements as groups either don't or won't listen to or consider other's points of view, as Nesta noted, 'They don't agree with what others are doing, or because they want their point to come across, they want to be dominant.' Connor said that sometimes students fail to listen because they think they have more experience than others: 'There can be cockiness sometimes,

	always interrupting and saying I was this and I was that and I was the other'.
Fear	Kirsty said, 'I do think there is a lot of fear especially if they've been made to feel silly in class before for asking a question' and, 'I think she was just very frightened because she'd been asked to do something she shouldn't have been, and she didn't know how to handle it.' Liv talked about fear from the mentors' perspective, 'The mentor can be fearful of the education that the student nurse is having which may be different from what they had'. She also felt that age and experience had a role to play in the level of fear (or not) that students can experience when going into practice.
Inconsistency	Kirsty, Peter, Marie, and Connor, all identified inconsistency as a factor, for example, when tutors don't apply ground rules consistently. Talking about managing lateness, Kirsty said, 'We're saying one thing and doing something else'. Peter agreed, 'I think it's down to what's been said in the first year, if they followed the ten-minute rule it would probably improve'. Marie thought the same, 'Most lecturers are very compliant with the ten-minute rule, but it's not across the board'. Similarly, Connor thought, 'The most obvious one is people arriving late, some lecturers let them in, and some categorically will not'.

It is not just about consistency of applying rules but also about staff being consistent in upholding the rules themselves. As Kirsty described, 'It's like we are saying there is a ten-minute rule, but we are not abiding by it ourselves. So, the students see that, they come to some lectures and the lecturer is there all prepared, but they come to others and they are late'. Connor described the potential for students to experience inconsistency of approach in other ways, 'Some people are very hands on and some people are very hands off …some have all the information there in a big fat folder, some are more interactive, and some are very prescriptive. This inconsistency can make students very anxious'. Liv agreed, 'I think this is what makes them very anxious, when one of us says something different to another member of staff, it's inevitable but it can make them feel very unsafe, you know how am I going pass this assignment if this one says this and this one says that'. |
| Inexperience | Marie reflected how, as a new lecturer, she had failed to notice that some students in her class were talking so much they were distracting others, until the students complained after the lecture, 'I was so worried about getting my points out and didn't realise it was going on to the depth it was because I was nervous and you're worried about microphones and clickers and everything flowing in your presentation…' Nesta also thought her 'newness' might play a part, recalling an incident when she regretted allowing students to view their feedback before a lecture because they were then 'fuming' at what they had read and she could not then manage the seminar in the way she had planned. Connor, an experienced lecturer, had a similar view on inexperience, 'I think that with new people especially it takes them a while to know the ropes and the tricks the students can get up to'. |
| Over-crowding | Nesta described how sometimes there isn't enough room for the students to sit comfortably, 'They're too close to each other, even if you want to put them in a group, then there will be no space, they say, 'Oh how are we going...' and I don't blame them to be honest, because yes there isn't any space'. Connor described an incident between two groups of students |

	which took place in a very cramped learning environment, 'The classrooms (numbers of students) were double what they should have been'.
Role-modelling	Peter linked incivility to the example that people set through their own presentation and behaviour, 'I do think it is about how we behave, hence why I come to work dressed like this (points to self, wearing shirt and tie), it sets an example, they see I am professional. I've got everything working, everything on, if I've got a PowerPoint then it's on and ready to go, if I am using references then they are there correctly put up. I'm not saying do as I say, it is look at what I am doing, how we behave and the example we set for the students is what matters'. Marie recognised the influence of placement staff, 'When students feedback into class about some of the things they see in practice it makes you wonder how they get through the three years especially if they are seeing poor standards or negligence.'
Technology	Kirsty recalled the pre-email generation where people took more care in how they spoke to others, especially if they needed something, 'You had to speak to somebody to arrange an appointment, so you had to speak civilly if you wanted to see them you couldn't just fire off an email'. Maria attributed some incivilities to social media specifically, 'They (the students) grow up in the world of me, me, me, so everything in an adolescent's world is all about social media isn't it and projecting this self to the world'.
Tiredness	It is common for nursing students to work part-time especially on night shifts which they try to fit around their lectures. Kirsty said, 'You can tell those because they doze off completely and you think ok you were working a shift last night.' It isn't just the students' tiredness that could contribute to incivility. Kirsty questioned the role her own tiredness played in a situation where three girls were disrupting a large lecture room, ''I was tired that day, I was very tired and normally when you say to students can you be quiet they do settle down even if they start talking again you see some recognition of the fact they are disrupting the class and some apology but there was nothing from these girls. I get back to my office and sitting at my desk thinking perhaps because I was tired I didn't handle it so well'.
Voice, lack of	Connor said how frustrating students find it if uncivil behaviour isn't corrected as the students move from module to module, 'It frustrates the students even more because they say nobody's listening to me.' Liv described the potential consequence of feeling unheard: 'It's the straw that broke the camel's back, it can be explosive'. Nesta highlighted that it can be hard for students to raise concerns about the way patient care is delivered if they feel nobody will listen to them, 'It's a challenging job to be a student...they're kind of frustrated from what they see, and they are very frustrated that they can't kind of escalate issues, and concerns.'
Unseen factors	Marie highlighted how unseen factors could lay behind apparently uncivil behaviour, 'I mean not just dyslexia and reading the timetables but if you've got a condition like diabetes where for example you've got to get up and eat earlier or a condition like multiple sclerosis where there are days when you could be on time and others late.'

7.4.6 Prior educational experience and perceptions of incivility

Nurse tutors were clear about their expectations of student behaviour, often relating them to their own experiences as students. Kirsty talked about the small hospital where she had trained in the early 1980s, where it was formal and everyone was called nurse followed by their surname. Brenda also trained in the 1980s but towards the latter end. She described how different the interactions between students and qualified staff were then, especially the senior ones. For example, she said that students would never answer back to a senior nurse however unpleasant they were to them.

As well as seeing the difference between what students in the 1980s and the students of today would put up with, Brenda also commented on the social changes that have influenced how people in general behave:

> There wasn't any give and take in the late 80s. Whatever rosta you got, that's what you did. If you got a late on your birthday that was too bad, you did it, you were too scared to ask her to change it, if it was Christmas whatever it was. Now they are, I can't do this, and I can't do that (referring to shift patterns on placement) which you would never have done so there has been a change in the profession but also in society. Society has changed. I relate it to politeness and manners and so on I think there has been a shift, a change in how people view it, being less important than it was.

Connor, who also trained in the late 1980's, described how the 'old school' values of the NHS continue to support student development, 'If you are NHS born and bred the patient is the centre of everything you do'. Peter, reflecting on the poor attendance record of his present-day students, recalled how different his own experience as a student in the early 2000s had been: 'I was shocked because we wouldn't have dared do that in our classes. If we didn't attend lectures for example a letter went out warning you and you had to come into a meeting; you had to attend 100% you had to be here'. Once in the lecture he said he, 'Would not have dared misbehave either'.

Some nurse tutors recognised the link between their own standards and what they expected of the students and colleagues as Kirsty said, 'I do have high standards I know I do but I have high standards of myself as well as everybody else for the patients at the end of the day, that's what we are here for.' She also had higher expectations of the older students, 'I am sometimes more shocked at the older ones because I have higher expectations of them whereas with the young ones I am just pleased when they are not being silly'.

7.4.7 Preventing and managing incivility

The interviews identified how nurse tutors utilise a range of strategies to prevent and manage incivility (Table 17).

Table 17 Preventing and managing incivility (nurse tutors)

Involving other students	Several of the nurse tutors described seeking the help of other students. Karen asked the students in class to help her make the decision as to what to do with a latecomer, 'What are we going to do shall we let this student in or shall we ask them to wait outside?' Brenda described a similar scenario: 'I opened the door (to the latecomer) and I looked at the rest of the group… (demonstrates looking to group for answer), and (nodding), I said you are very lucky, sit there.' Likewise, when a student swore in class, Joy asked the rest of the group what they felt should be done about it, 'Did everybody else hear that? What are we willing to do about it?' Sometimes the approach described was more about allowing the students to impose their own order as Liv said when describing excessive talking in class: 'They (the other students in the room) do tend to shush people'.
Setting expectations	There were numerous references to setting expectations of conduct as a means of managing or preventing uncivil behaviour. Peter explained how he role-modelled courtesy to a group of students when a student had forewarned him that they would be late, 'I make a point of saying thank you for letting me know you were going to be late, so the rest of the group know'. In this way nobody is left thinking that this student has 'got away' with it. Connor described himself as 'very strict' adding, 'I do not tolerate poor behaviour'. He gave the example of, 'hammering home the NMC requirements and professional standards' to a cohort of students following a fall out between two groups in his class. Joy said her students tell her she is strict but fair.
Lowering expectations	Marie delayed confronting students about sleeping in class seemingly because she had lowered her expectations of what was acceptable behaviour, 'I haven't confronted them actually because it hasn't got to the point where they actually been asleep for 10 minutes'. In a similar context with sleepy students, Kirsty described either ignoring the situation or making light of it, 'I tend to just leave them, or I might say early night for you tonight or can you give her a poke please'. Another strategy was to accept the inevitable and adjust expectations accordingly, as Liv said in relation to lateness, 'I tend to start a little late anyway especially if I'm in a lecture theatre. I just feel it's inevitable'.
Challenging uncivil behaviour	Descriptions of direct challenges to uncivil behaviour were common in the interviews. Participants described asking noisy students to be quiet or to stop using the phone (Peter) and giving them the choice of being quiet or leaving the room (Kirsty). Brenda told how students using technology for matters unrelated to learning were told to stop and how students who were unacceptably late were not allowed to come into the

	class. Joy described challenging the behaviour of a group of students when they were making fun of another student's accent and taking challenging another student about her persistently disinterested behaviour in class. Peter described how challenging the students directly about disruptive conduct usually worked well, ''99.9 per cent of the time they just say oops sorry'. However, in extreme situations, both Peter and Brenda said that they had asked students to leave the room and Connor knew of tutors who had 'thrown a few people out' although he had never done so himself. Connor also stressed the importance of confronting any issues promptly, 'If you let it go on then that is when you lose the respect and it's very hard to change them then'. On placement, Brenda described supporting ward Sisters to challenge unacceptable student behaviour, 'I say send them home, that's outrageous; send her home'.
Using humour	Some of the nurse tutors described using a form of humour to manage or defuse uncivil situations. Peter for example, explained how he had tried to be humorous with a student to 'bring him back into line without conflict'. At other times humour was used to underline a more serious point. When a student turned up late to class saying that she had got lost, Brenda's light-hearted comment, 'But I see you had enough time to get a Frappuccino' made the class laugh but the message was clear, don't expect me to believe your excuse for lateness if you turn up with a hot drink in hand from the nearest café outlet. Likewise, Joy's message to students using the internet in class was, 'Are you shopping for all of us?' to reinforce the need to pay attention to the learning task in hand. Joy also described using humour against herself to soften the delivery when challenging poor behaviour, 'I always laugh and say I am being mummy now', whilst Brenda jokes with students who are not paying attention, 'I tell them whether you are interested or not I still get paid the same'. Marie also used humour in the classroom. Her approach to phones going off in lectures was to 'make a bit of a thing out of it especially if it is some random tune or dance track or something, I'll stand there and have a little dance whilst its going on or ask if anybody would like to stand up and dance whilst this person answers their phone call'. Humour was also used to manage the uncivil behaviour of colleagues, in this case lateness to meetings, although Kirsty was not sure that people always got the message: 'Well I make jokes, dock their pay, what about the ten-minute rule, but then nobody picks up on them'.
Being consistent	In the student interviews, consistency of approach was mentioned a number of times but in the nurse tutor interviews only Brenda mentioned it. Referring back to her own experience of programme leadership and specifically in relation to upholding the ten-minute rule (after which students cannot enter the classroom), she said 'I do stick to the rule because I know what it is like when half your lecturers are doing something different'. Other participants were inconsistent in their approach to that same rule, as Peter said: 'In the first couple weeks I don't enforce it strictly'.

Learning from experience	Many comments showed how the nurse tutors were prepared to learn from their experiences. Peter, for example, said that he had learned the importance of asking questions of those on the back row as well as those on the front, in order to keep everyone in the room engaged whilst Marie had decided to encourage the use of smart phones in class rather than banning them, so that their use became part of the learning which she felt would create better compliance. Nesta said she would alter her approach to managing group work in-order to be firmer in the future and Brenda described adopting a more 'lax' approach to class management as she had become more experienced.
Seeking support of others	On a couple of occasions, nurse tutors talked about getting support from other members of staff. Peter, a new tutor, sought help from an experienced member of staff because he wasn't sure how to deal with a student behaviour problem. Whereas Brenda, an experienced tutor, had been in lecture theatres 'policing' behaviour to help colleagues who couldn't manage alone. Connor, also an experienced tutor, described involving colleagues from practice in-order to manage student problems together.
Improving students' understanding	One preventative strategy described was to teach students about understanding the perspectives of others. Marie explained how she talked with students about the use of phones in the clinical area, asking them to imagine what a patient would think if a nurse had a phone in her pocket and it went off. Joy tried to help her students understand why their mentors might each behave differently by telling them, 'Just as we all like our tea differently so your mentors will all approach things in different ways'. Brenda, explained how she tried to teach students the advantages of being civil, 'Be civil and polite, it will get you a long way on the ward especially with the ward manager'.
Soft techniques	The nurse tutors described using various 'soft' techniques to keep classroom behaviour under control. Connor for example, explained how he walks to the section of the room where the students are talking and holds out his hands to them, both hands together palms facing outward, whilst continuing to talk to the rest of the group. This he said, was usually enough to quieten them down. Joy also described a soft approach to latecomers, 'I always say welcome come in and sit down and we're starting from…I think if I shout at somebody I wouldn't like that, so I try to make it, if that was my daughter what would I do'. Nesta described how she managed students who came to class unprepared by summarising what they needed to know on a piece of paper and distributed it to them at the beginning of the class so that their lack of preparation did not impact on the other students. Usually the strategies described focussed on being supportive first and foremost. Peter talked about managing a student whose behaviour was consistently poor by inviting him in to discuss it away from the class to see if there was any underlying problem. Similarly, when Joy asked a student to stay back after a problem in class she described starting the conversation by asking the student if everything was ok.

7.5 Mentors' Experiences of Incivility

In answer to the question, "Can you tell me what your understanding of incivility is", the mentors offered a range of descriptors (Table 18).

Table 18 Incivility descriptors (mentors)

Aggressive	Lateness
Chewing gum	Not helping out
Demanding	Participation, lack of
Disinterested	Rude
Failing to call in sick	Taking excessive breaks
Inappropriate behaviour	Unclean uniform
Integration into the team, lack of	

Mentors also offered a range of descriptors for civility as listed in Table 19.

Table 19 Civility descriptors (mentors)

Engaged in learning	Proactive
Finding opportunities to help others	Polite
Finding opportunities to learn	Respect for qualifications and knowledge
Getting along with people	Respect for others
Looking interested	Smiling
Being keen	Team worker
Interacting with other nurses and patients	Wanting to be involved
Observing what's happening	Participating
Learning through observation	Questioning independently
Pleasant	Using staff as a learning resource

In response to the second question, 'Have you had experience of incivility whilst working in pre-registration nursing education and if so can you tell me what that experience was like', all participants answered said yes and went on to cite examples of their experiences. Analysis of the interview transcripts yielded five superordinate themes and no subordinate themes (Table 20). The lack of subordinate themes is explained by the smaller participant group and the shorter interviews (in comparison with the other groups).

Table 20 Themes (mentors)

Superordinate Themes	Subordinate Themes
Distraction	-
Lack of interest	-
Lateness	-
Lack of respect	-
Impact on learning	-

7.5.1 Distraction

This theme relates to the use of personal technologies in the clinical learning environment and how students are distracted by them and as a result are unable, or unwilling, to access learning opportunities. Atos had a student who spent a lot of time looking at her phone rather than engaging with the learning opportunities on offer; the student's behaviour had also been noted by other members of staff:

> I had a student a couple of months ago and I explained to the student that she had half an hour for lunch and she said was happy with that but what I found out after was that every time she had lunch she was having one hour and that she was not interested in going back afterward and she keep just sitting on the chair there in the staff room, and I said to her, 'Is there anything we can do?' You know you have to go and learn but she was more interested in her telephone and I find that rude really, and this is I think is incivility.

> The anaesthetist you know she said I need to talk to you about your student she is not interested in anything. I've tried to talk to her but she didn't bother to even listen, she was all the time looking in her pocket at her phone.

Lim also talked about a student who constantly checked or played on the phone:

> Well she didn't make eye contact much, and she was always checking her phone or playing with it and she just never looked ready to get up and do anything, you know she just sat looking a bit, a bit sort of vague really.

From Bridie's perspective, the younger students had a problem:

> I think the younger generation are (pauses)...we do have an issue about mobile phones because they are generally born just completely attached to their phones and they can't move without checking them constantly.

163

Gina acknowledged that students who are using their phones may be copying the behaviours of qualified staff:

> Sometimes they are bit distracted by their technology, by their mobile phones. We have had students in the past that have been a bit obsessed with the phone and we've had to say something to them... Yes people can be glued to them or it can be a distraction if somebody calls them. Also we have doctors using them, although they are using them for mostly clinical reasons but you don't know exactly what they are doing and of course the students see them and think 'Oh maybe I can'.

Carol was concerned that students would not be concentrating on what the patients needed if they were using their phones:

> I asked a male student to leave the house once because he kept looking at his phone and checking it. The trouble is they're so busy checking their phones that they aren't concentrating on what is needed and it really looks unprofessional to the patients.

Although the theme has been headed as distraction, the challenge for mentors is knowing whether the student is genuinely distracted by the device or whether the phone is being used as a defence against shyness or as a means of hiding from difficult clinical situations.

7.5.2 Lack of interest

This theme captures the perceived incivility of students who appear uninterested in learning and who are missing learning opportunities as a result. Lim had a student whose lack of interest was noticeable:

> We had one student who spent most of the time in the staff room, she only came out when we went looking for her, and even then she looked so bored it was embarrassing to have her in the room with you, I'm sure people noticed. I don't know, maybe she was shy or something, but she really did look like she'd rather be anywhere but with us.

Carol also had a student who appeared uninterested in the learning opportunities offered to her:

> She was just a bit, you know, sort of flat, uninterested, like you couldn't get a response from her even if you tried to involve her in something really interesting, a chance to learn something new, she just seemed totally unbothered about being here most of the time.

Susan described how a student's body language could convey lack of interest:

> Sometimes the way they stand says volumes without them even opening
> their mouth so you can see quite often just by looking at them they are either
> not interested not listening or they don't really care what you say.

Maz described the difficulty of managing a student's apparent lack of interest at the same time as undertaking a patient assessment:

> I think the most difficult thing I've had to deal with is doing a duty assessment
> (assessing a mental health service-user) and I had this student in with me
> and she sat at the back of the room with her coat on, she didn't actually
> sit at the table with me (pauses, shakes head) she just seemed disinterested,
> not willing to interact and you know when I said would you like to take your
> coat off, no.

I asked Maz what it was about the student's body language that signalled a lack of interest to her:

> Well she had her arms crossed, she seemed to bit kind of disinterested in the
> whole process. I felt she wasn't willing to listen or learn anything from the
> experience. I think I found that hard because what I expect from the student is
> interest, I'm not saying they have to be perfect at everything, but I would like to
> see some interaction.

Bridie had also observed the role of body language in signalling a lack of interest:

> You can tell if a student is interested just by their whole demeanour. If they
> are watching what's happening and if they are interacting with all of the nurses
> and the patients but if they tend to be slouching in a corner or at any opportunity
> you find them on their mobile phone in the coffee room...it's a good indication
> that they are not engaged (laughs).

Susan described how some students just stood and ticked the hours off and described how that felt: 'Our job is hard enough without having to contend with someone who doesn't want to be here'.

7.5.3 Lateness

In this theme, the mentors described how failing to fit into the time expectations of the placement team would be unacceptable in real-world employment and how it could impact on students' ability to meet placement learning outcomes. Unlike in the student and nurse tutor findings, the lateness described here was not about distraction in the learning environment but about professional and employment expectations. Gina, for example, described how students

arriving late to placement may be perceived as rude even though they are supernumerary (not counted on in the staff numbers):

> Yes, when it becomes a habit, you know it is a bit rude really, you know
> we are not relying on you as such because you are supernumerary but in
> the real world you know when you qualify you won't be able to keep people
> waiting like that.

The issue of lateness in relation to employment was also mentioned by Maz:

> When I was co-mentoring he (a young male student) would just turn up
> late and there was no kind of sorry or anything else and I was just thinking
> if I just turned up late for work, that would be a major thing.

Although the students are supernumerary, their lateness can still impact the clinical environment if the qualified nursing staff have to stop what they are doing to repeat patient care information:

> I get frustrated but also annoyed because it is such a waste of our time, we
> have to do handover again and if, if it goes on we have to get the link lecturer
> out and it all takes time. (Carol)

> I find some students are late and that is a problem, it costs us time to catch them
> up and they can miss important information about what's happening, then it all
> has to be repeated for them which means you have to stop what you are doing
> so. (Lim)

Lateness was also seen as a factor in students failing their placement learning outcomes:

> Sometimes they have difficulty getting in, you know we had one student
> where it was really a problem, you know he kept coming up with excuses,
> my car is being repaired, the bus didn't come, and that student ended
> up failing the placement. (Gina)

> My colleagues were saying, 'Why isn't she here on time?' Looking for her
> in the morning, 'Why isn't she here again, she is late what is going on?'
> So it was aggravating everyone and she started coming on time but it
> was too late we had already called the link lecturer and she didn't pass
> the placement. (Atos)

Although lateness was seen as a problem, the mentors were appreciative of the possible causes behind it, as Lim observed:

> I think maybe because they are not part of the numbers they think it doesn't
> matter whether they are here or not or sometimes they are hiding from the

work or are scared of what they might have to be involved in.

Me – scared?

Yes, we see a range of youngsters (young patients) here, some very sick indeed and it can be hard for the students.

7.5.4 Lack of respect

In this theme, various behaviours were described which were seen as being disrespectful to the mentors and/or other qualified staff. In the first quote, Susan, talks about students' lack of respect for qualified staff accompanied by what she felt was resentment:

> When they show they don't respect you as a professional sometime the way they actually talk to you or address you as I say we don't expect the Sister this, Staff Nurse that bit but sometimes it is just the tone, you can hear there is an underbelly of resentment.

She compared the lack of respect to qualified nurses with her own nurse training experience:

> Well I feel that they obviously haven't got any respect for authority, I wouldn't have thought…when I did my training it was obviously a long time ago (thirty-one years) I wouldn't have thought of saying no to a Sister if she gave me an order but it's different these days they seem to feel that they are beyond being told what to do.

Carol made a similar comparison to her own training of twenty-one years ago when she described students as being the 'lowest of the low' and having a 'heathy respect' for others. Bridie described a student who refused to go to lunch when asked. In this extract, Bridie is trying to justify her request to the student in terms of the needs of the ward team and the patients:

> I said well I'm sorry but that's not how it works in nursing you have to go at a time that is suitable for the team and the patients and we can't all decide when we would like to go. Our relationship began to break down after that and I had a lot of issues with this student.

I asked her what made her feel that the relationship had broken down:

> Well everything I asked I would get either a negative or a very grudging response to do what I'd requested, and she had no…she didn't respect anything that I had to tell her or suggested to her…some of it was because she wasn't enjoying the placement and we did discuss that and I said I know that this is not everyone's cup of tea, but you still need to listen…

167

Similarly, Lim had a student who was unhappy with the shift times she had been given and who made it very clear how she felt:

> I had this student who was very rude, just one girl about three years ago. She came onto the ward and she didn't want the off duty we had worked out for her and she said her friend had been before and she had not had to do shifts and she didn't want to shifts either and when I explained to her that she needed to work with her mentor, do the same shifts as her, she said 'Well I'm not going to do that because I have a part-time job in the evening and I need to be off so I can't do it'. She was standing over me with her hands on her hips, really quite angry, I'm a bit small so I had to look up at her and I just said, 'Well I will speak to my manager about it but I don't think you can' and she said, 'I can work what I want 'cos I'm not part of the staffing numbers' and then she sort of tossed her head and walked off, just walked off. She had no respect whatsoever.

Sometimes the behaviour may seem disrespectful but could be down to what Gina described as a 'bit of bravado':

> There is one particular student that sticks out in my mind from a number of years ago, and I remember being a mentor to him and he came across as a bit of a know it all and that's fine, I'm not bothered by that, it's a bit of bravado but I do remember at one point that I went to sit with him and at one point I went to shake his hand and he wouldn't shake my hand (gestures withdrawal of hand). Yes, as I went to put my hand out, yes, he just pulled away, which was a bit embarrassing.

It is not possible to know what role cultural or religious differences might have played in this scenario, but in some cultures hand contact, particularly between men and woman, would not be appropriate. However, what is of interest here is Gina's perception that this action was uncivil.

7.5.5 Impact on learning

The mentors' narratives identified several ways in which incivility could impact on students' learning although they did not make explicit references to it in the way that the nurse tutors did.

Mentors and other qualified staff ceased to offer support if they felt the student wasn't interested, as identified in the 'Lack of interest' theme. This was either because they were too busy to keep trying or because the student's apparent lack of interest was impacting directly on patient care, as described by Gina when she recalled the student who sat at the back of the room with her coat on during a patient assessment. Learning was also negatively affected when

students were distracted by their phones, sometimes because they failed to see the learning opportunities around them or at other times because they appeared uninterested and so were not invited to take part.

Learning opportunities were also missed if the students were not there at the time they happened, as when Atos' student arrived half an hour late every day as a result of which he always missed the patient care handover. Poor timekeeping generally meant that mentors were less able to accommodate their students' learning needs or that students could not meet the placement learning outcomes because they missed key learning opportunities. Finally, incivility impacted on student learning when the mentor-student relationship broke down as a result of disrespectful behaviour, as described by both Lim and Bridie in the 'Lack of respect' theme.

7.6 Mentors' Experiences of Incivility - Non-thematic Findings

In this section, as for the student and nurse tutor findings, the phenomenologically derived themes presented in the previous section, are complemented by data which were coded and categorised as part of the analysis, but which did not subsequently develop into themes. As before, this section goes toward addressing the secondary research questions.

7.6.1 The emotional impact

The emotional impact of incivility was revealed in the language the mentors used to describe their experiences. The key descriptors used are listed in Table 21:

Table 21 Emotional descriptors (mentors)

Annoyed	Makes me mad
Attacked	Thrown
Disbelief	Uncomfortable
I hate it	Upset
Embarrassed	Reeling
Frustration	Wasted time
Hard	Wound up

7.6.2 The sound of incivility

The 'sound' of incivility came across in just one of the mentor's phrases, highlighted in orange as previously:

- A student nurse shouting at a patient.

7.6.3 Where it happens

Incivility on placement took place in the staff room, in clinical areas and in the patients' own homes.

7.6.4 When it happens

Uncivil behaviour was linked to poor time-keeping such as being late on shift and taking overly long breaks, but it could happen at any point of the day.

7.6.5 Contributory factors

A number of potential contributory factors were identified by the mentors (Table 22).

Table 22 Potential contributory factors (mentors)

Adaptability	Participants described how some students find it hard to adapt between different settings, such as moving from placement to placement every 6-8 weeks. A new placement means getting to know new staff, new ways of working and a different kind of patient/service-user. Failure to adapt quickly could leave some students vulnerable to incivilities from others.
Age	There was a perception of there being different views about politeness and respect between age groups. Bridie said, 'I think that the younger generation have different views about common politeness than perhaps my own generation'. Maz said, 'I think age can come with differences. There can be expectations about life and then it isn't quite what you thought but then you can have a very grounded twenty-one year old or an immature one.'
Arrogance or over-confidence	Some students were described as being arrogant or over-confident which then led to misunderstandings and/or disagreements. Atos talked about students who were, 'Too familiar with the patients, over confident'. Bride felt that over-confidence could spill into arrogance and that male students were generally more arrogant than female ones.
Childcare and transport issues	There were descriptions of students who were juggling other parts of their lives in-order to study and who as a result were always late or tired. Maz had a student who was often late because of childcare and transport issues. Carol and Lim both described students who were late because of transport issues.
Choice	Pre-registration nursing is not necessarily the choice of the student. When Maz try to explain why she thought a student declined to participate in a service-user interview, she said, 'She was very young and to be fair I don't think it was her choice to train. I think it was her family's, so I think it was almost like she was expected to do rather than what she wanted to do'.
Confidence	Gina observed that some of the students, 'Come across as very shy and introverted and not wanting to talk'. Carol and Lim both put shyness forward as a possible reason for appearing uninterested. Atos suggested shyness could be misinterpreted as being 'aloof'.
Fear and stress	Some of the mentors recognised that students could be frightened or stressed by what they were experiencing on placement and that it could affect their behaviour. Atos explained how stressful the theatre environment can be for students, 'You never know for example what will happen, a patient with laryngospasm, that is very stressful or them, you know they are not familiar with that environment.' Gina agreed, I think it can be quite daunting really, especially if you've got a new first year student who might be quite green, it can be quite daunting especially if you know they are not quite understanding the whole aspect of mental health'. Lim commented that some students could be scared about the nature of the illnesses they were confronted with.
Lack of interest	Lack of interest came up multiple times in the transcripts. Maz felt that there was no excuse for students, 'Sitting around doing very little'. What she expected from the students was interest, 'I'm not saying they have to be perfect at everything, but I would like to see some interaction. For me the interest is essential'. Apparent lack of interest in the placement or the learning opportunities available were a frequently cited source of frustration for the mentors.

7.6.6 Preventing and managing incivility

A number of preventative and management measures were identified from the transcripts (Table 23).

Table 23 Preventing and managing incivility (mentors)

Forming relationships early	The importance of forming a relationship with the student early on was recognised. Susan described making a connection straight away by using first names which she felt helped to remove barriers, 'You do almost see them relax as soon as you say you don't need to call me sister call me whatever, you notice then their shoulders drop and they are not so on edge'.
Making allowances	Bridie described making allowances for students' different needs, 'We don't say you can't stand there or don't touch this because that will frighten people so we're quite relaxed about having students, you know they can do as much as they like or as little, not everyone likes the blood and guts bit, we are not going to force anyone'.
Role-modelling expectations	Gina acknowledged the importance of role-modelling good behaviour to students, 'I always say to people (students) if you need to make a phone call and you've got your phone in your pocket then ask to leave the clinical area and come and sit in the tea room…I also say it to the trained staff because if they got their phones out I say we can't tell the students don't do it if you are sitting there doing it'
Being flexible	There was also a willingness to be flexible in support of students for example working around their transportation problems (Bridie) or resolving shift pattern difficulties (Atos).

7.7   Bringing the Findings Together

In this section of the chapter, the thematic findings are brought together (Figure 4; Tables 24 and 25) in-order to provide an 'at a glance' view of the differences and similarities between the experiences and perspectives of the three participant groups. This section also serves as a reference point for the discussion of the findings presented in Chapter 8.

Figure 4 sets out the superordinate themes for each participant group with the subordinate themes in brackets. Key points to note are:

- *Distraction* and *Impact on Learning* arise as superordinate themes in all three participant groups.
- *Power and Invisibility* appear as superordinate themes in two of the three participant groups.
- *Lateness* arises in all three participant groups as either a superordinate or a subordinate theme.
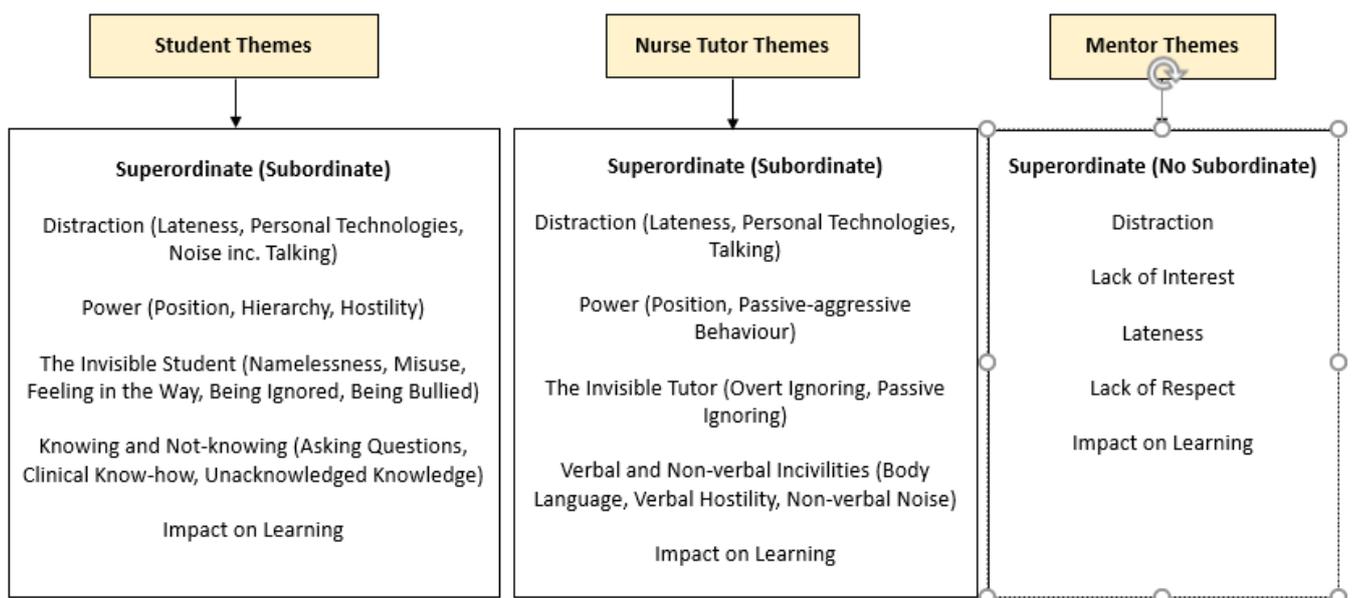
Figure 4 The themes at a glance

The themes that recur across the participant groups are illustrated in Table 24, i.e. this table shows only those themes that occurred in more than one participant group, whether as a superordinate or subordinate theme.

Table 24 Recurring themes

Superordinate Themes	Subordinate Themes
Distraction (Students, Nurse Tutors and Mentors, with mentors focussed on use of Personal Technologies) **Impact on learning** (Students, Nurse Tutors and Mentors) **Power (**Students and Nurse Tutors) **Invisibility** (Students and Nurse Tutors) **Lateness** (Mentors only but appears as subordinate theme for Nurse Tutors and Students)	• Being Ignored (Students and Nurse Tutors) • Personal technologies (Students and Nurse Tutors) • Talking/Noise (Students and Nurse Tutors) • Lateness (Students and Nurse Tutors) • Position (Students and Nurse Tutors) • Hostility (Students and Nurse Tutors)

What can be seen from this simple analysis is that students and nurse tutors had more commonality of experience than was the case with the mentors. This is further illustrated in Table 25 which shows a side by side comparison of the recurring themes as they arose in each participant group.

Table 25 Participants' experiences compared

Student themes	Nurse Tutor themes	Mentor themes
Distraction (Lateness, Personal Technologies, Noise including Talking**)**	**Distraction** (Lateness, Personal Technologies, Talking)	**Distraction** (through Personal Technology use)
Impact on learning	**Impact on learning**	**Impact on learning**
Power (Position, Hostility)	**Power** (Position, Hostility)	**Lateness**
Invisibility (Being Ignored)	**Invisibility** (Being Ignored)	

The distribution of themes illustrated in Figure 4, and Tables 24 and 25, is used to guide the sequence of the discussion in Chapter 8 so that the themes are explored in order of dominance and frequency.

7.8 Chapter Summary

The findings presented in this chapter offer a response to the primary and secondary research questions, through the perspectives and experiences of the individual participants. The themes identified show both commonalities and differences between the participant groups with some themes, such as *Distraction*, being evident across the three groups whilst others, such as *Lack of Interest*, being specific to just one group.

The main findings are illuminated by the adjunctive (non-thematic) findings which help to contextualise the participants' experiences as well as offering a broader frame of reference for incivility than would be obtained by considering the individual experiences alone. Viewed holistically, the findings offer a rich picture of incivility as viewed by a particular group of people learning and working in a specific pre-registration nursing setting. This provides a platform for Chapter 8, in which the analytical process commenced in this chapter is extended by means of an interpretative commentary and a literature-informed discussion.

Chapter 8 Making Sense of the Findings

This chapter provides an interpretative commentary on the findings focussing firstly on the thematic findings (major and minor themes) and secondly on the non-thematic findings. It should be noted that the terms superordinate and subordinate (terms used in the IPA approach), were related specifically to the ordering of themes as they emerged for each participant group. As these themes have now been combined to give a perspective that reflects the experiences of the whole participant group, the terms major and minor have been adopted in their place. These terms indicate the theme's level of dominance in the overall data set rather than the level of impact in a specific group, for example *Knowing and not-knowing* was impactful for the students but is termed minor as it only arose for one group of participants.

The new literature incorporated into this chapter reflects the novel directions that the findings led to during the analytic process. These areas go beyond the gap in knowledge literature explored in Chapter 4. For example, whilst lateness is cited as a perceived incivility by other researchers, the causes are not explored. Other examples, such as the notion of students being nameless, are present in other, related areas of research such as the literature on socialisation of student nurses into the nursing profession. Links to the wider literature have therefore been of additional benefit in terms of making sense of the findings.

A closing discussion at the end of the chapter, brings together the main findings of the study and highlights where new understanding and insights have emerged.

8.1   Thematic Findings

In this section, a commentary on the major themes (those which occurred in more than one participant group) is followed by a commentary on the minor themes (those that occurred in only one participant group). For reference, the diagram in Figure 5 shows the themes as they were first presented for each participant group (as seen in Chapter 7, Figure 4) and then as they appear when combined and ordered in terms of overall dominance.
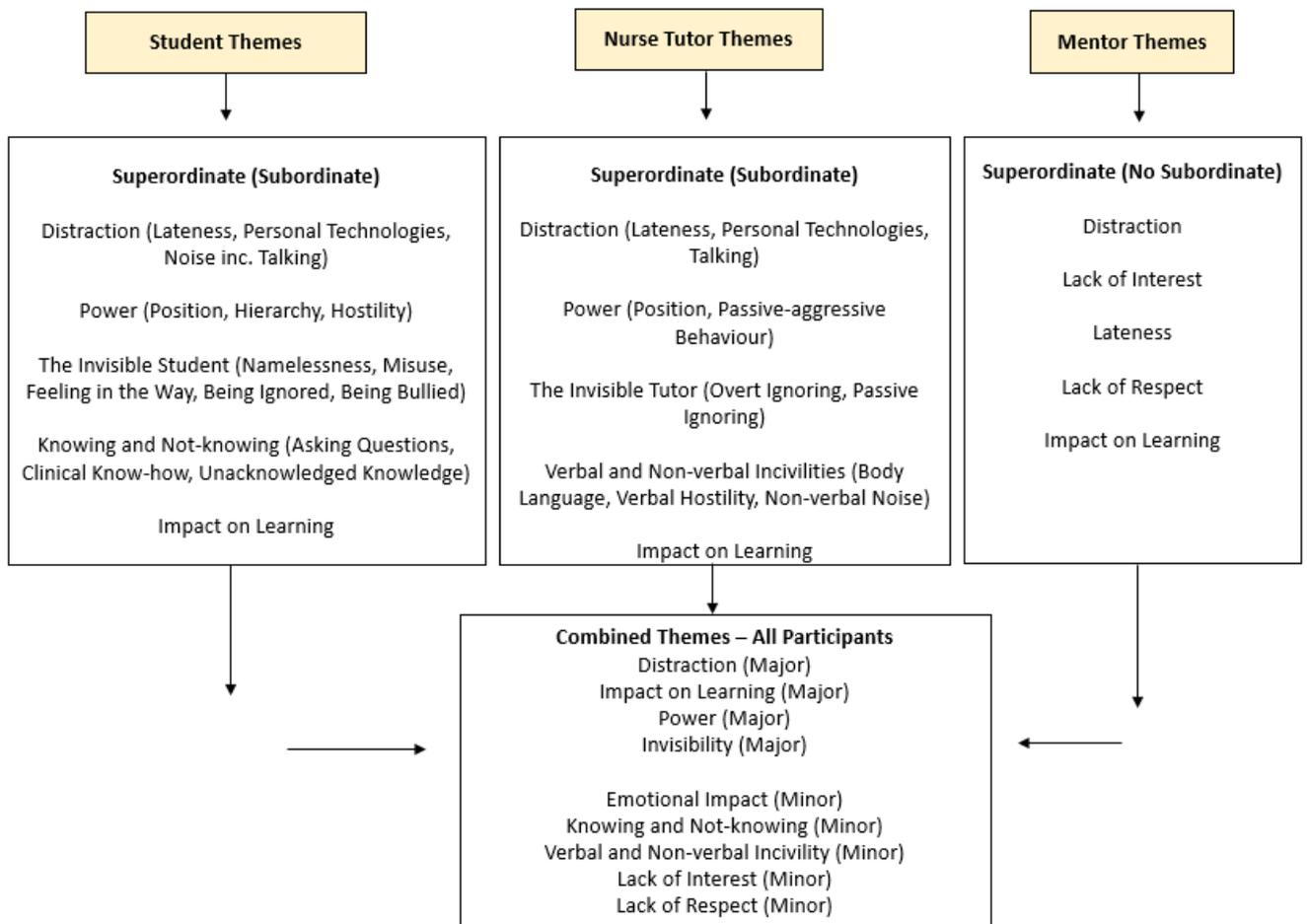
Figure 5 Combined themes (all participants)

8.1.1 Distraction (major theme)

The emergence of distraction as a form of incivility was unsurprising. Most of us have experienced times when we are distracted by someone or something and whilst it may not always concern us there will be times that it may be frustrating or irritating. This is particularly so when people need to concentrate on what they are doing as is the case when studying, teaching or caring for patients. Although distraction arose as a theme in all three participant groups, it differed in nature for each of the groups.

For the students, distraction came in the form of other students' behaviour in the classroom. Latecomers gave rise to feelings of frustration particularly when they were 'repeat offenders' whilst the 'head-turning' and 'ripple effects' described were evidence of loss of concentration. The noise of students talking, eating, and even singing, were also sources of distraction, as was the use of personal technologies such as phones and laptops. The latter caused distraction in

three ways: noise disturbance, attention grabbing (wondering what people were doing with their personal technology) and triggering an emotional response (such as feeling annoyed when students were playing on their devices rather than engaging in the class).

There is little reference in the literature to the impact of student lateness on other students in the context of higher education, although there is reference to the frequency and causes of lateness in school and employment settings. There is, however, evidence relating to the factors influencing punctuality which may be of relevance when determining strategies for preventing and managing lateness. These factors are most likely to be situational (for example, where it takes place), and sociocultural (for example, the influence of school or family), as opposed to personality traits, with the existence of a wide range of norms for different cultural groups (L. T. White, Valk, & Dialmy, 2011); so what is considered unacceptable in one cultural setting may be perfectly acceptable in another. Research has also identified links between employee lateness and factors such as age of youngest child (Dishon-Berkovits & Koslowsky, 2002) and low job satisfaction (Gupta & Jenkins, 1983), which may correspond to student lateness in nursing because of childcare issues and lack of satisfaction with the classroom experience. Childcare and other caring duties are an issue for many pre-registration nursing cohorts which typically have a large number of female mature students, often with dependants (Kiernan, Proud, & Jackson, 2015).

Lateness also arose as a theme in the mentor transcripts, but it was not related to distraction; rather it was seen as either a patient safety issue, in that qualified staff were taken away from patient care to repeat patient handover information to the latecomer, or as a professional issue in that arriving late was seen as indicative of being unprepared to commence nursing duties.

Unlike mentors, nurse tutors were distracted by student lateness, primarily because it caused loss of concentration or train of thought. Experienced nurse tutors seemed able to recover their own focus reasonably quickly but regaining the students' full attention was sometimes more difficult; it was also more difficult to recover if the lateness affected planned learning activities like group work. Like the students, the tutors were aware of the loss of concentration caused by lateness as students looked to see who was coming in or started whispering to their neighbours. Röer, Bell, and Buchner (2014) suggested that recovery from attentional capture (distractions) may be partially dependent on working memory capacity with people with greater cognitive control adapting to distracting stimulus more quickly. Cognitive control allows behaviour to be adapted from moment to moment in response to new information, rather than remaining rigid and inflexible (Mackie, Van Dam, & Fan, 2013). This ability may come more readily to

experienced teachers, who have a wider range of knowledge and skills to draw on when responding to unexpected distractions in the classroom, than to the less experienced ones. However, even the most experienced of teachers can find adapting to lateness difficult when the numbers for their carefully planned group work keep changing as each new latecomer arrives. Another distraction for nurse tutors was talking, with students either talking between themselves or talking over each-other instead of taking turns. There is considerable reference in the literature to positive and negative impacts of talking in school classrooms but very little that focusses on the impact in HE. One study referred to college students' preferences for how disruptive talking in class is managed (Carter & Punyanunt-Carter, 2009), but most commonly talking in class is identified as an incivility without reference to learning impact (Clark & Springer, 2007b; Keating, 2016; Pyles, 2016).

Whilst nurse tutors did not always mind the use of personal technology in class, it was considered rude and disrespectful when used for non-learning related activities like shopping and looking at social media sites. The noise of technology was also cited as disturbing concentration. Both Röer, Bell and Buchner (2014) and Gill, Kamath and Gill (2012), refer to a large body of evidence pointing to the detrimental effects of irrelevant sounds (such as electronic games and message alerts) on cognitive performance. Research by Shelton et al. (2009) for example, found that the noise of a mobile phone ringing during a lecture led to poor recall of information presented during the ring relative to other information presented in the lecture. Similarly, Röer, Bell, & Buchner (2014) identified a significant impact on short-term memory performance in a serial recall task investigating the disruptive effects of mobile phone ringtones on concentration. The perceived incivilities of device use, mirror the findings of other nursing incivility studies (Aul, 2017; Clark & Springer, 2007a; Keating, 2016; Natarajan et al., 2017; Pyles, 2016).

Although nurse tutors described distractions that were similar to those described by the students, they seemed less frustrated about them, possibly because they were in a much better position to manage them. Whilst the students had little influence over their peers' behaviours and were reluctant to challenge them, the nurse tutors were able to use their authority to prevent students from entering the room late, ask them to stop talking or tell them to turn off their technology.

Authority, and therefore power, is inherent in the role of the teacher and is not necessarily a negative influence; from the teachers' perspective power can be used to open up new possibilities just as much as it can be used to close them down (Brookfield, 2017). Tutors can

therefore use their authority to create positive learning environments through the effective management of student behaviour, something that students are far less able to do. However, even though tutors are better placed to minimise the impact of distraction on learning, it is clear that distractions in the classroom can and do have a negative impact. This happens most obviously through loss of concentration (for both tutors and students) but also by disrupting the teaching process as tutors either stop teaching or have to alter their teaching plan, in-order to manage the distraction and its consequences.

For both student and nurse tutor, the theme of distraction was about being distracted by someone or something else but for the mentors, distraction was not about being distracted themselves but about seeing the students being distracted, primarily by their phones. Students who were distracted in this way often appeared uninterested in learning and unable, or unwilling, to engage fully in the placement experience. Phone usage in placement settings may be a strategy to evade boredom (Nett, Goetz, & Daniels, 2010), or it may give students a means of coping when they feel in the way (as described in the Invisibility theme). Regardless of reason, phone usage is likely to impact on learning as nurse mentors, who are often conflicted between their responsibilities towards students and their responsibilities towards patients (Atkins & Williams, 1995), are more likely to focus their attention on their patient than on an apparently uninterested student. At a simple level, students who are looking at their phones are less likely to see the learning opportunities around them.

More generally, the use of mobile phones for clinical communication in healthcare settings has been associated with a worsening of inter-professional relationships and impaired communication (Wu et al., 2011) and reduced situational awareness (McBride, 2012). They are also known to decrease reaction time, reduce focus, and lower performance of tasks needing mental concentration and decision making (Gill et al., 2012). So, for students and qualified clinicians, the use of mobile phones in clinical areas is a serious issue because of the potential to impact negatively on patient care.

Overall, whilst there are various forms of distraction and what is distracting for one person will often differ for another, the evident potential to impact on learning and patient care, is of relevance and importance to nurse education.

8.1.2 Impact on learning (major theme)

The narratives of all three participant groups illustrated numerous ways in which incivility can impact on learning. The consequence of this impact was set out previously in Chapter 2, section 2.2.1, and includes reduced or total disengagement from the learning process, impaired critical thinking and reduced academic persistence. Understanding the impact, or consequence, of incivility on learning is clearly important, not least in providing a justification for the study objective, which was to minimise incivility in educational settings. However, it is equally important to understand the different ways in which learning and teaching processes can be impacted.

Whilst there are frequent references to impacted learning in the incivility literature, and many examples of how incivility arises in learning environments, there is relatively little reference as to how learning is actually affected. For example, in Clark and Springer's (2007b) study, nursing faculty report how disruptive students are when they use phones in class but there is no discussion about what it is about the use of phones that impacts on learning. In common with most examples in the literature, the link to learning is implied rather than explicit. One exception is Luparell's (2003) qualitative study on the effect of student incivility on academic staff, in which faculty said that they changed their pedagogy or modified assessment grades to avoid conflict with students. Another is Rad et al.'s (2015) study, in which nurse educators referred to students who insisted that classes were ended early or took unnecessary breaks and so missed key content.

To make the connection between incivility and learning and teaching more explicit, the findings have been organised into three categories (Figure 6) which show the different ways in which learning can be affected when incivility arises. These categories are described below.

Teaching – learning was impacted when tutors could not, or did not, conduct their teaching in the most effective way. For example, a teacher planned group work but could not proceed because some students did not do the preparatory reading whilst another did not acknowledge their mistake in class and so the students lost confidence in their ability to teach them.

Concentration –concentration was disrupted by the various interruptions and distractions that students and tutors experienced, including talking, mobile phone use and the arrival of late-comers to class.

Opportunity – opportunities to learn were lost because some students could not, or did not, actively participate in learning. This happened for a variety of reasons including inadequate preparation, lack of confidence, feeling intimidated and failure to recognise the learning opportunities on offer.

Figure 6 Impact on learning

8.1.3 Power (major theme)

The theme of power reflects how little influence the students felt they had over the actions of nurse tutors and mentors and the change in position and status they experienced when moving between home and student life. When on placement, they were dependent on the mentors to sign their practice assessment documents, a dependency which prevented them from disagreeing with decisions or challenging poor practice (as when Ben said he had to follow the practice of the qualified nurses even when it was contrary to what he had been taught in university). In the classroom, they sometimes felt intimidated or dismissed by the way the nurse tutors spoke to them. The students' perceptions of being low in the staffing hierarchy on placement and their perceived lack of power when dealing with mentors and nurse tutors, left them with a corresponding inability to mount an assertive response to the incivilities they experienced, especially early on in their training.

Power has been described as the ability to have influence over the decisions and behaviours of others (Katriina et al., 2013). It can be used as a positive force in nursing whereby practitioners

are influenced to change their attitudes and behaviours for improved clinical outcomes and patient satisfaction (Sepasi, Abbaszadeh, Borhani, & Rafiei, 2016). Unsurprisingly, given the advantages of professional knowledge and experience, the balance of power between teacher and student in clinical placement usually lies with the teacher (Kuokkanen & Leino-Kilpi, 2000). Students may consider this as being acceptable, and indeed necessary, for the safety of patients (Chan et al., 2017b), as well as for their own development. However, there is no benefit when power is used to disadvantage or disempower the learner. Power as a negative influence can manifest itself in the form of domination, coercion, self-interest and monopolisation (Sepasi et al., 2016), features which were recognisable in the student transcripts along with a corresponding loss of learning as when students lost confidence in their mentors and their ability to support or facilitate a positive placement experience.

The relationship between student and mentor has been described as being crucial to the student's learning experience in clinical practice (Wilkes, 2006), with a positive student-teacher relationship being regarded as a key factor in creating an ideal clinical environment (Rebeiro, Edward, Chapman, & Evans, 2015) and a positive learning experience (Atack, Comacu, Kenny, LaBelle, & Miller, 2002). Conversely, the term 'toxic mentoring' has been used to describe the kind of mentor-student relationship which is so dysfunctional as to suppress learning (Morton Cooper & Palmer, 1999). Nurse tutors were aware of (and sympathetic about) the power imbalance that students experienced in practice but seemed unable to do anything about it. Overall, it is evident that students need the nurse tutors and mentors more than the nurse tutors and mentors need the students and that this is a critical factor in creating a power imbalance in the relationship, with the students being the least powerful of the three. As a result, those with the 'upper-hand' in the relationship can use their power either to facilitate learning or to restrict it, with little or no direct consequence to themselves.

Another aspect of power for students was the low level inter-student hostility that played out mostly in the classroom rather than in placement; this was usually verbal although it could be physical. Some of the hostility had a racial element to it which was sometimes inadvertently fuelled by the nurse tutors as a result of failure to manage student-to-student interactions effectively. Tutors were also aware of how students vied for position in the classroom and of the role of ethnicity and culture in fuelling hostile exchanges. Hostile behaviours mostly mirrored those found by other researchers such as making sarcastic remarks (Aul, 2017) and the use of racial or ethnic slurs (Clark et al., 2015), although there is little written about physical behaviours or student-to-student incivility specifically.

Passive aggressive behaviours between tutors, such as denying a co-worker the resources they need to deliver a lecture, were similar in nature to those widely reported in the US literature (Peters, 2014; Sills, 2016; Worthington, Salamonson, Weaver, & Cleary, 2013) although reference to these types of behaviours was limited. Tutor-to-tutor incivility does not feature in the wider UK literature either, suggesting that the experiences of UK nursing academics may differ to those of their US counterparts.

Most significantly in this theme was the loss of learning for students. This happened in a number of ways including: being prevented from testing out their theoretical learning when in placement; being unable or unwilling to ask questions of their tutor or mentor; and being denied learning opportunities as a result of poor mentoring or teaching practices.

8.1.4 Invisibility (major theme)

Invisibility was characterised by situations in which people were not seen as individuals with their own identities and needs, nor in the case of the students, as learners needing the support and help of those around them. As a result, those affected became, to all intents and purposes, invisible. This theme was particularly strong from the student perspective. For example, all the students talked about the notion of being nameless when on placement. The issue of being referred to as 'the student' rather than by name has been identified previously in the UK literature (Allan et al., 2011; Hoel, Giga, & Davidson, 2007; Webb & Shakespeare, 2008). In the latter study, student nurses reported that being referred to as 'the student' was an experience shared by many and which the majority found upsetting. Students feel very excluded when all around them nurses are promoting name identification between themselves as a result of widespread social media campaigns such as 'Hello My Name is…' (which encourages healthcare staff to introduce themselves to their patients by name). A student who does not feel they are part of the nursing team will be less likely to seek out learning opportunities whilst with them and equally, if the team members themselves do not acknowledge the student's existence, they will not seek out or promote learning opportunities to them.

There are also implications for patient care. Windt-Val (2012) highlights the close connection between a person's given name and their sense of self and identity, which in turn is linked to self-esteem, a fundamental part of professional and personal identity (Begley & White, 2003) and the key to providing therapeutic patient care (Randle, 2003). Similarly, confidence is an essential quality in a profession where the courage to speak up about poor standards of care is

a key attribute (Department of Health, 2012a). Lowered self-esteem and confidence therefore both have the potential to impact negatively on patient care.

The Invisibility theme also encompassed the misuse of students, whereby students were given tasks which were either inappropriate or unsafe ("like a skivvy"). The lack of supervision described by some students runs counter to the expectations of the profession's regulatory body, can lead to loss of learning and leaves both students and patients vulnerable to harm. Misuse (aspects of which were also identified in the Power theme) was particularly evident when the students were junior and knew less about the learning opportunities available to them and felt less confident to challenge their mentor's decisions.

The students' experiences of being used as an 'extra pair of hands' or of being required to take on responsibilities beyond their capability echo the findings of other UK-based researchers with students identifying for themselves the negative impact on their learning (Hoel et al., 2007; Jack et al., 2018; Webb & Shakespeare, 2008). Although mentors may not intend to put their students' learning at risk by misusing them in placement, they may find themselves doing so if they are struggling to meet the competing demands of a busy healthcare setting (McIntosh, Gidman, & Smith, 2014). In these situations, even the best mentor must prioritise the demands of patients over students (Omansky, 2010), which can leave little time for student support. It is of concern then that the UK's leading trade union and professional body for nurses, the Royal College of Nursing (RCN) has suggested that patient care suffers drastically as a result of inadequate student supervision (Fleming, 2007). In their survey of more than 1,500 nursing students, 44% reported being regularly left unsupervised when caring for patients, and of these one in seven reported witnessing adverse events, such as patient falls and rapid clinical deterioration (Fleming, 2007) .

Another aspect of invisibility was when students felt in the way of the qualified nurses on placement, mostly it would seem, because their role in the clinical area was unclear. As supernumerary members of the team, students are expected to deliver nursing care as directed, but also to make the most of whatever learning opportunities arise during their time there. Although supernumerary status was seen as being important by the students, they did not want to be left with nothing to do or to feel a burden on the nurses whom they saw as always being busy; it is also clear from the previous theme, that the students did not wish to be given just any task to do either (misused). Elsewhere in the literature, students report how being used as a 'gofer' (to go and get things) denies them their supernumerary status (Webb & Shakespeare, 2008) and how 'being in the way' can leave them feeling like outsiders in the placement arena

(Anthony & Yastik, 2011), confirming the problem as one that exists beyond the experience of this particular participant group. Allan et al. (2011) described how effective student nurses negotiate their way around their supernumerary status to take control of their learning but although the transcripts showed evidence of this negotiating activity (as when Iris sought to work in a different unit for a day to learn about a new area of care), it was clear that the students' negotiating positions on placement were not strong and that their negotiating skills, particularly as new students, were relatively under-developed.

Invisibility was also encountered when students described being ignored by mentors, other clinical staff, and even other students. The experience of being ignored was different to that of namelessness, where students were addressed but not by their name, and different to that of feeling in the way, where students felt uncertain of their role or a burden. Instead, this theme captured the experience of feeling ignored, arising it seems because some placement staff were too busy to notice or just lacked awareness about the presence of students in their area. Students being ignored on placement has been reported numerous times by other UK researchers, (Hoel et al., 2007; Monrouxe, Rees, Dennis, & Wells, 2015; Randle, 2003). More recently, thematic analysis of a mixed methods study which included a survey of 1425 student nurses (Jack et al., 2018), identified 'feeling ignored and unsupported' as a major theme. Although, the problem is clearly well-known, it is difficult to know whether students are actually ignored or just feel ignored when the staff around them are otherwise engaged with patients. Certainly some students categorise 'being ignored' as a form of bullying (K. Stevenson, Randle, & Grayling, 2006) and so whether real or imagined, the personal impact can be significant.

All of the incidents that happened on placement occurred within the first year of being on the programme, when it is particularly important that students know it is all right to 'not know' things because the reason they are there is to learn. But instead, the students felt they were being judged (being shouted at, made to feel small, ridiculed) for not knowing something, a feeling that could readily impact on learning and confidence. First year students may be particularly vulnerable to the effects of incivility because they are unfamiliar with the norms and expectations of the classroom and placement environments.

There may be multiple reasons why being ignored (or feeling ignored) happens, the most obvious being busy staff focussing on patients' needs rather than those of their students. However, this does not explain why some students ignore each-other which may be due instead to factors such as lack of confidence or anxiety. Although students were upset by this, the main concern is for the student who is ignored by their mentor and/or the wider clinical team. In this

respect, an ignored student is one whose learning needs will be insufficiently, or incompletely, met and whose negative experience may impact on their own behaviour in subsequent placements.

Nurse tutors described two forms of being ignored; an overt form where direct questions, requests or greetings were ignored by students and a passive form such as ignoring pre-class/tutorial preparation or teaching instructions when in class. It may be that students' failure to take responsibility for learning, could trigger tutor incivility in return (Altmiller, 2012), however, it is not possible to gauge whether this was an issue due to the self-reporting nature of the interviews. Nevertheless, it was clear from the vocabulary and tone of voice used, that being ignored is a cause of frustration for tutors and that it can impact on teaching. Examples of the latter include time lost trying to engage students who are ignoring instructions in class and needing to provide additional content for students who have failed to bring prepared materials to class.

The final aspect of the Invisibility theme was being bullied. Three of the students described being subjected to bullying behaviours whilst reflecting on incivilities they had experienced. As in Corney's (2008) study of bullying in nursing, the participants did not recognise the behaviour as bullying themselves, but the targeted and repetitive nature of the behaviour they experienced suggested that this is what it was. It was also evident from the interviews that the bullying happened in front of others, sometimes with others being complicit in the behaviour. Students talked about weeping, shaking, and feeling demeaned, but despite the emotional and physical impact, their desire to get their PADs completed and move on to the next placement played a major part in their decision not to report the bullying. Under-reporting of bullying in nursing is a recognised issue, with factors such as fear of retribution and punishment being cited as reasons (Corney, 2008). The invisibility aspect arises from the fact that students' needs were invisible to the mentors as well as to other members of staff, and perhaps even to themselves given they did not use the term bullying when talking about their experiences.

Bullying goes beyond incivility; it is a more deliberate and repetitive form of interpersonal mistreatment that impacts on the health and well-being of the victim (Felblinger, 2008) and involves issues of power, control, hostility and intentional targeting (A. Adams, 1992; J. Cooper et al., 2009, 2011). As with other behaviours identified in this theme, bullying can impact negatively on self-esteem and undermine confidence (J. Cooper et al., 2009; Randle, 2003) as well as impact on the resilience of newly qualified nurses (Bowllan, 2015). Rebecca and Iris's transcripts indicate their bullying experiences had a negative impact both on their learning and

187

their emotional wellbeing, with a conversely positive impact in their determination to behave more appropriately with their own students when their turn came to be mentors.

Overall, the impact of invisibility was to render students' learning needs invisible to others. Students who were ignored or who went unnamed in placement were not then able, or invited, to take part in learning opportunities, whilst those that felt misused did not see the tasks they were given as being relevant to their learning. Students who felt in the way on placement were left unsupported whilst regular staff were busy and so were unable to access or recognise appropriate learning opportunities. Those that were bullied not only missed out on learning but suffered emotionally too and yet felt unable to report what was happening.

8.1.5 Emotional impact (minor theme)

The descriptors used by each participant group ranged from the relatively mild (bugged, uncomfortable, disappointed and thrown) to the deeply felt (blood boil, shell-shocked, attacked and rage). Some descriptors arose in each group, for example, annoyance and frustration. Others arose in two of the three groups, for example embarrassment and shock. The depth and breadth of emotion experienced, from short-lived frustration to deeply felt shock, was matched by the variation in duration and level of impact from the momentary distraction of a head-turn to the longer-term loss of concentration.

Overall, the range and type of feelings described by each group were broadly similar, demonstrating that incivility, regardless of who perceives it, impacts on the emotions at a variety of levels.

8.1.6 Knowing and not-knowing (minor theme)

Knowing and Not Knowing arose as a theme for students in which they talked about the difficulties of asking questions, of being ridiculed or made to feel stupid, about their lack of clinical know-how and of possessing knowledge that wasn't recognised. In the classroom, nurse tutors risked closing down student-staff dialogue when responding to students' questions abruptly or rudely and on placement student confidence was repeatedly put at risk when students were ridiculed or made to feel small for not having the clinical know-how of the qualified nurses.

The issue of students being made to feel stupid has been reported in other studies about incivility in nursing (Clark, 2008d; C. M. Thomas, 2010). In one American study (n=152 student nurses), one of the four categories identified was explicitly labelled 'It made me feel stupid' (Lasiter et al., 2012) with similar examples cited as shared by my own student participants including speaking up in class only to be made to feel that what they had said was 'ridiculous'. Students also described feeling that their prior knowledge was dismissed as irrelevant or went unrecognised, leaving them feeling patronised and resulting in a loss of trust in their tutors. Fry, Ketteridge and Marshall (2003) suggested that lecturers should be aware that they are rarely 'writing on a blank slate', that is to say all students come with some form of prior knowledge or understanding. Learning occurs when new knowledge and understanding is added to, extends or supplants this prior (old) knowledge and understanding. This constructivist view of learning (Piaget, 2001) goes beyond the adding of new facts to old and involves instead a transformational change in the learner as old constructs are revised or replaced in the light of new knowledge and understanding (Fry et al., 2014; Mezirow, 1992). This transformational change cannot take place if the student is denied the opportunity to examine the relationship between their old and new knowledge.

The lack of acknowledgement of prior knowledge does not appear to have been identified elsewhere in the literature in terms of uncivil behaviour, but the impact was clearly the same as for students who felt unfairly treated for what they did not know. When prior knowledge is treated by tutors or mentors as having no relevance or value to the student's training, the student loses trust in the educator or feels patronised (as Lisa, Acha and Ben each described), and as a result, learning is compromised.

Although this was identified as a separate theme during the analysis, it is evident that there is a strong link with the invisibility theme in so much as the students' needs as learners were invisible to those who either ignored what the students already knew or dismissed their questions as stupid.

8.1.7 Verbal and non-verbal incivilities (minor theme)

This theme arose from the nurse tutor interviews and encompassed body language, verbal hostility and non-verbal noises. Reported student incivilities included sleeping in class, shouting, sighing, swearing and huffing. Tutors' behaviour was not exempt with tutors reporting incidents of other tutors shouting at both staff and students. Similar behaviours have been reported by other researchers (Clark & Springer, 2007b; Keating, 2016) including that of faculty shouting (J.

189

Cooper et al., 2011) and students sleeping in class, both in nursing and non-nursing programmes (Clark & Springer, 2007b; Eka et al., 2016; Rowland & Srisukho, 2009; Wahler & Badger, 2017). All the behaviours described were likely to have a negative impact on the relationship between tutors and students as well as on the learning environment because when verbal or non-verbal incivilities occur, the focus shifts, momentarily or otherwise, away from the business of learning.

8.1.8 Lack of interest (minor theme)

This theme from the mentors, included reports of students staying in staff rooms instead of engaging in clinical activities, not listening to the qualified nurses, and not interacting with staff generally. The students' apparent lack of interest may be indicative of some impediment to their integration into the placement team, such as a lack of confidence or limited sense of belonging, or of a lack of interest in or being bored by, the experiences on offer.

Lack of confidence may stem from role uncertainty, particularly in the early stages of training when being in placement is a new experience and students have to build the confidence to find opportunities for self-development quickly (Robins, 2014). Despite a considerable amount of pre-practice preparation, Bowllan (2015) described how student nurses can be laden with fears of incompetence and powerlessness as they socialize into the profession. These feelings can contribute to low confidence which may be further compounded by the uncertainty of supernumerary status. Being supernumerary can put the student on the periphery of the clinical team, making it hard for them to feel they truly belong in the setting. The need to belong, which drives much of human behaviour and thinking (Maslow, 1987), has been shown to be integral to creating a positive learning experience on placement (Cope, Cuthbertson, & Stoddart, 2000). A lack of belonging can impact on students' confidence as well as their capacity to learn (Levett-Jones, Lathlean, Higgins, & McMillan, 2009). The 'arms crossed', 'slouching in corners' and 'looking bored' behaviours that the mentors described as being suggestive of lack of interest, may in fact be behaviours designed to mask the students' lack of confidence, sense of uncertainty and/or lack of belonging.

A genuine lack of interest may arise if students cannot see the value of learning simple nursing tasks, for example washing patients, or have unmet expectations of the setting, for example expecting to see cardiac arrests regularly in a minor injuries department. Lack of interest may be confined to a specific placement or extend to nursing in general, i.e. some students will find out during their first placement that nursing is not the right choice for them, whilst others may

have been attracted into the profession by the offer of a financial bursary (replaced by the student fees in 2017), rather than a genuine desire to nurse. Both Rebecca and Millie (mentors) expressed frustration at the behaviour of students who they felt didn't really want to be on the course.

Some students may be bored rather than uninterested. A lack of interest implies no desire to engage with an activity whereas boredom arises when none of the things that can be done appeal to the person in question (Mann & Robinson, 2009), typically triggering an impulse to escape the situation altogether (Daschmann, Goetz, & Stupnisky, 2014). Boredom in the classroom, may be signalled by behaviours such as yawning (simulated and genuine), empty gazing, and exchanging glances (Daschmann et al., 2014; Mann & Robinson, 2009). Boredom on placement may reasonably be expected to consist of similar behaviours: certainly, poor posture ('slouching in corners') and empty gazing ('looking bored') were described in the mentor interviews. The question then becomes why a student might be bored.

Pekrun, Frenzel, Goetz and Perry (2007) suggest that monotonous activities which make little demand on students can result in boredom, as can activities which demand more capability than the student has. In the placement setting, boredom may arise when students feel insufficiently challenged such as when undertaking apparently routine nursing care. Debra, for example, talked about being 'sent off to do routine obs' (clinical observations such as pulse and temperature) and Lisa and Amy both referred to having to do basic nursing duties for long periods. Therefore, what looks like a lack of interest in placement may actually be the students signalling that that they feel unchallenged by the tasks they have been allotted. Robins (2014), a student nurse herself, described how missed opportunities for learning tend to arise from qualified nurses' misconceptions of what supernumerary status really means. Pekrun et al.'s alternative scenario, of the student who is bored because they find the activity too difficult to participate in, is more likely to present in a classroom than in placement where highly complex clinical situations would typically provoke anxiety or distress rather than boredom.

What is important is that when a student appears uninterested, whatever the reason, mentors are less likely to facilitate learning opportunities for them and so students who present this way will not have the same learning experiences as those students who look interested to learn more about what is happening around them.

8.1.9 Lack of respect (minor theme)

The mentors referred to a lack of respect from students, with examples including refusing instructions and being rude. These views may be attributable to the different expectations of mentors and students in terms of entitlement to support, flexibility in working hours and contribution to clinical workload which may differ considerably, especially if the mentor trained before supernumerary status for students was implemented. Generational differences of this kind could inhibit the formation of good mentoring relationships, just as Bridie reported when own mentee refused to go to lunch when asked (Chapter 7, section 7.54).

Differing expectations of what students should and shouldn't do, may also include how mentors expect students to behave towards them in view of their senior status. Although students are clearly aware of staffing hierarchies and their place within them (section 7.12), some mentors feel students do not acknowledge the hierarchy appropriately. Adopting traditional modes of respectful behaviour, such as following the qualified nurses' instructions without question, was normal for nurses who trained in the 1980s but is less common today. If respect implies valuing another person's essential dignity and worth (Grover, 2013), then mentors who feel their seniority (and the greater knowledge and experience it implies), is not valued by the student, are less likely to invest time or energy into building an effective mentoring relationship with them. The same applies from the student perspective, students who feel their existing knowledge and skills are not valued by their mentors (as highlighted in section 8.15), may find it hard to contribute to a mutually respectful relationship with them. This could signal a change in expectation on the part of today's students, who desire a reciprocal professional relationship with their mentor (Fernandez, Sheppard-Law, Curtis, Bancroft, & Smith, 2017), in a way that was not considered part of the student support model of thirty years ago. In the literature, reports of student incivility include nurse tutors' reports of disrespectful student behaviour (section 4.1). However, little has been written about respect from the mentor perspective despite the evident impact on learning as a result of the breakdown of the mentor-mentee relationships.

8.2 Non-thematic Findings

The non-thematic findings provide further insight into the participants' experiences and, when viewed alongside the major and minor themes, provide a more rounded, in-depth understanding of incivility.

8.2.1 The sound of incivility

Although not all incivilities have sounds attached to them, many do. Various examples are reported in the literature: Bar-david (2018) referred to lip sounds, sighs and muttering; Clark and Springer (2007b) described the sound of sighing to express displeasure with assignments; Aul (2017) referred to groans; Thomas (2010) referred to shouting, yelling and tapping of fingers to indicate impatience; Cooper et al. (2011) referred to shouting and yelling; Jack et al. reported shouting (2018); Masoumpoor et al. (2017b) described the slamming of doors; and Keating (2016) reported the sounds of laughing, sniggering and yawning.

When viewed together, the sounds and sound-evoking descriptors the participants used, illustrate how sound can be an effective vehicle for communicating uncivil feelings and behaviours (Figure 7):

Figure 7 The sound of incivility

8.2.2 Where and when it happens

According to the participants, incivility happens in wards, staff rooms, seminars and large lecture theatres, in tutorials and in front of patients, nurses, and non-nursing clinical staff.

Nurse tutors noted a tendency for classroom incivilities to occur in the late afternoon and evening. Sleepiness in particular, was likely to manifest itself towards the end of the day presumably as energy levels fell, especially if the day had started early as it does for many nursing students, whether in the form of early classes, work, or caring duties. Mentors did not identify specific times of day that incivility occurred although they did report on a range of time-keeping issues such as students turning up late for shift or taking overly long breaks.

Several students referred to incidents that took place early in their programme of study, i.e. in the first year. This may be because the inexperienced student is more sensitive to the uncivil behaviours of others or because their own under-developed professional behaviours may be perceived as uncivil by others.

The possibility for incivility to take place in both clinical and placement settings is consistent with other research findings although the time of day that incivility happens does not seem to have been considered. Nor does there appear to be mention of the stage of learning at which incivility commonly presents for students although a systematic review by Edwards et al. (2014) suggested that younger, less experienced nurses were more at risk of workplace aggression than older, more experienced registered nurses.

8.2.3 Contributory factors

Across the three participant groups, a wide range of factors were cited as potential contributors to incivility (Table 26). Some factors were cited by all three groups, for example, ethnicity and age/generational differences. Some were cited by just two of the three groups, for example, education and lack of voice (students and tutors) and arrogance and childcare issues (student and mentors). Some factors were suggested by one group as contributing to incivility by another but were not recognised by that group themselves, for example, tutors said tiredness may be a factor in student behaviour, but the students did not mention it. Likewise, students identified burnout as a factor in mentor behaviour, but mentors did not refer to it themselves. It was notable that the group that reported the most deeply felt uncivil experiences (the students) also listed far more possible contributory factors than the nurse tutors and mentors.

Table 26 Contributory factors (all participants)

1. Adaptability, lack of	19. Gender
2. Age / Generational differences	20. Failing to listen
3. Aggression	21. Fear
4. Apathy	22. Inconsistency
5. Arrogance	23. Inexperience
6. Belonging, lack of	24. Insecurity
7. Boredom / lack of stimulation	25. Interest, lack of
8. Burn out	26. Jealously
9. Busy / Understaffed / Pressure	27. Over-crowding
10. Childcare issues	28. Reprimand, lack of
11. Choice	29. Role-modelling
12. Competitiveness	30. Self-awareness, lack of
13. Confidence (over and under)	31. Stress
14. Defensiveness	32. Technology
15. Discomfort	33. Tiredness
16. Education	34. Transport and travel
17. Ethnic, cultural, and religious diversity	35. Unseen factors
18. Expectations	36. Voice, lack of

Possible contributory factors as cited in the literature are discussed in Chapter 4, section 4.1.4. Some of these marry to the factors cited by the study participants including the influence of role-modelling (Kearney et al. 2009), issues related to ethnicity, race and cultural diversity (Cortina, 2008; Sue, Lin, Torino, Capodilupo, & Rivera, 2009), fear of failure and prior education (Vink & Adejumo, 2015), stress (Berman et al., 2000), over-crowding of classrooms (Elder et al., 2010), inter-student competitiveness and student expectation (Bunce et al., 2016; Vink & Adejumo, 2015). Factors that do not appear in the literature include jealously, discomfort (pain, hunger), childcare issues and lack of self-awareness.

Overall, there is a wide range of factors that can play a part in the development or perception of uncivil behaviours. Whilst it is not possible to say which of these will actually result in uncivil behaviour at any given point in time, knowing that so many contributory factors exist highlights the difficulty of preventing or managing this complex social phenomenon.

8.2.4 Coping responses

Coping responses are the constantly changing cognitive and behavioural efforts that individuals use to manage internal or external stressors (Lazarus & Folkman, 1984). A study of student nurses' stress and coping responses (W. Evans & Kelly, 2004) identified a number of stressors that are remarkably similar in nature to the incivilities identified in the student findings. These included: feelings of inferiority; personality clashes with tutors; unfriendly ward atmosphere;

aloof attitude of senior staff; being reprimanded in front of staff and patients; lack of teaching and interest in learners; and being left for short periods on the ward without trained nurses being present.

The most common methods of coping with stress were identified as: talking to relatives and friends; talking to peers; carrying on; and trying to stay out of trouble. Again, there is a similarity to the coping responses described by the student participants which were: seeking help from others; helping themselves; putting up with it; rising above it; avoidance; and deferring action. These findings were also consistent with a recent literature review of students coping responses (McCarthy et al., 2018) which identified a range of strategies including: family and social support; avoidance; and denial. Other strategies identified in the review, such as smoking, alcohol and drugs, were not referred to but as coping responses were not a focus of the study, the lack of reference to them may not be of significance.

Nurse tutors and mentors made little mention of ways of coping which may reflect the fact that the incivilities they experienced were less impactful and/or more transient in nature. It may also be a reflection of their more powerful positions, in so much as they had more choice and control when it came to coping with the incivilities they encountered.

8.2.5 Preventing and managing incivility

Given the relative experience of the qualified nurses (tutors and mentors) and their positions of influence, it is perhaps unsurprising that they were the ones who had the most to say about the prevention and management of incivility, whereas the students made relatively little mention of either. All the strategies identified were supportive rather than punitive and focused on the needs of the students rather than the needs of the tutors or mentors (Table 27).

Table 27 Prevention and management (all participants)

Prevention	Management
1. Be consistent in approach 2. Be flexible 3. Establish relationships early on. 4. Learn from experience 5. Make allowances for different needs 6. Remove unnecessary barriers 7. Role-model good behaviour 8. Set expectations from the outset	1. Challenge uncivil behaviour 2. Improve students' understanding of expectations 3. Involve other students in management of problems 4. Revise expectations of others 5. Seek support of others outside of situation 6. Use humour appropriately 7. Use soft techniques such as speaking quietly, being kind, offering support

The literature identifies a range of interventions for preventing and managing incivility (Chapter 4, section 4.1.5). Some have clear links to the measures suggested by the participants including the fostering of professional behaviours (Altmiller, 2012); the building of relationships (Clark, 2011); the involvement of peers (Kerber et al., 2012) and the setting of expectations (Authement, 2016; Williams & Lauerer, 2013). Whatever methods are adopted, understanding the context in which incivility arises is key. If incivility is an issue when students are on placement then the mentors must be involved in managing the situation, such as when students are repeatedly late on Sundays due to reduced public transport and the mentoring team discuss whether offering flexible weekend shifts would help. Similarly, if incivility is an issue in the classroom, then part of the solution lies in clarifying the expectations of staff and students in terms of punctuality and noise disruption.

8.3 New understanding and insights

The aim of this section is to identify new understanding and insights that have emerged as a result of the data analysis. The discussion will concentrate on the most pertinent and substantial of these, in-order to keep the focus on the original research questions.

8.3.1 Incivility, invisibility and impact on learning

Invisibility was a theme for both staff and students, but it was for students that the consequences were greatest. Encompassing the sub-themes of *Namelessness*, *Misuse*, *Feeling in the way*, *Being ignored* and *Being bullied*, the impact of feeling invisible on students' learning, was evident throughout the findings. The notion of invisibility was also apparent in the theme of *Knowing and not-knowing* and again, the findings made clear the impact on learning for students who felt their knowledge, or lack of knowledge, was of no importance or relevance to the educator.

Student nurses are being prepared for a professional career that can be highly emotionally and physically demanding; a career which will see them taking responsibility for people's lives in a way that few other jobs do. The role of the educator, be it tutor or mentor, is to help students to successfully navigate their way through what is often an intense, and sometimes stressful, personal learning journey. The learning environment that students are exposed to must therefore be the best it can be, so that students have every opportunity to graduate successfully

with the knowledge, skills and understanding they need to undertake the role of the qualified nurse effectively and compassionately.

Effective learning environments are created through curricula that promote student engagement through active learning methods, are cognisant of students' different ways of learning and facilitate ways of students learning together that are reciprocal and cooperative (Chickering & Gamson, 1987; Gibbs, 1988; Healey, Flint, & Harrington, 2014). Curricula that draw on experiential learning methods are also important for nurse education, because it is a practice-based profession. Experiential learning (Kolb,1984) is based on a constructivist approach to education which centres on the idea that experience gained through life, work and education plays a central role in learning (Fry et al., 2014). A well-structured experiential approach provides students with opportunities to experience real-world situations, either in placement with the support of a mentor or in a simulation setting with the support of a nurse tutor. This approach helps students to contextualise their theoretical learning, develop and refine their practical skills and gain a much deeper understanding of the complexities of nursing than can be explained in a lecture alone. Other important aspects of creating an effective learning environment, are positivity and enthusiasm from the educator (Webb & Shakespeare, 2008), the provision of educational, emotional and social support (Heydari, Yaghoubinia, & Roudsari, 2013), clinical supervision and leadership (Z. C. Y. Chan, Tong, & Henderson, 2017a) and the creation of a sense of belonging and inclusion (Gidman et al., 2011; Levett-Jones et al., 2009).

When some or all of these various factors are absent, learning is impacted. Being bullied, ignored or going nameless is not synonomous with a sense of belonging nor does it suggest the student's emotional or social needs are being met. Being denied the chance to partake in new experiences does not allow for students to grow in knowledge or confidence just as disregarding existing knowledge negates the chance to modify or refine new knowledge in light of the old. Finally, being asked to undertake tasks that bear no relation to the students' learning needs does not translate to being given effective clinical supervision in an inclusive and supportive learning environment.

When the two themes of *Invisibility* and *Knowing and not–knowing* are considered together, it is evident that the notion of the 'Invisible Student', is one of the most important findings of this study because of the strong links between incivility, invisibility and impact on learning, and the significance therefore to educational practice.

8.3.2 Incivility, emotion and impact on learning

It seems that incivility, which is based on the perception that some kind of rude or impolite behaviour has taken place, is always accompanied by an emotion of some kind. This may be in the form of an outwardly imperceptible, mental flicker which simply records the individual's perception that an incivility has occurred; perhaps in the form of a fleeting irritation or momentary upset. In other situations, there may be a more powerful and deeply felt emotion such as anger or fear, perhaps with an outwardly visible sign such as shouting or shaking. There have been several attempts to find a consensual definition of 'emotion' but with little success (Izard, 2010; Kleinginna & Kleinginna, 1981; Mulligan & Scherer, 2012). In Izard's study for example, thirty-five highly distinguished scientists in the field of emotion research were asked for their definitions of emotion which were then analysed for commonalities. However, they offered such wide-ranging definitions that it was impossible to synthesise them into a single unitary definition. Nevertheless, Izard was able to bring together the most commonly described features into a single description of sorts:

> 'Emotion consists of neural circuits, response systems, and a feeling state/process
> that motivates and organizes cognition and action. Emotion also provides
> information to the person experiencing it and may include antecedent cognitive
> appraisals and ongoing cognition including an interpretation of its feeling state,
> expressions or social-communicative signals, and may motivate approach or
> avoidant behaviour, exercise control/regulation of responses, and be social or
> relational in nature.'

Strong emotions, when associated with some level of pleasure or displeasure, are thought to be capable of having a substantial influence on cognition, including perception, problem solving, learning, memory, reasoning, and attention (Clark, 2008c; Jung, Wranke, Hamburger, & Knauff, 2014; Tyng, Amin, Saad, & Malik, 2017; Vuilleumier, 2005). Positive emotion tends to be linked with enhanced learning and negative emotion with reduced retention or actual loss of information (Elnicki, 2010), although some authors have argued for the use of emotional manipulation to create negative emotional responses in order to engender deep learning, for example to embed learning about patients' experiences of vulnerability (Taylor, 2010). However, for negative emotion to have a positive learning impact, it needs to be part of a carefully considered pedagogical approach. Negative emotions arising through incivility do not fit this category; they are unplanned and uncontrolled and as such are likely to be detrimental rather than beneficial to learning. Trigwell, Ellis and Han (2012), suggested that students who experience negative emotions (such as anger and shame) are more likely to take surface aproaches to learning and have lower achievement scores, whilst students who experience

stronger positive emotions (such as hope and pride) are more likely to take deep approaches to learning and attain higher achievement scores

Despite the obvious emotional impact, students did not report incivility, not even the serious bullying behaviours. They chose instead to put up with it or do their best to ignore it. Factors such as fear of failing placement, lack of confidence and lack of support may all play a part in 'failure to report' (Bellefontaine, 2009). Whatever the reason, students who are feeling 'demeaned', 'hurt', 'stupid' or 'shocked', are not in an emotionally suitable frame of mind for learning.

Overall, the impact of emotion wrought by incivility, whether mild or intense, detracts attention away from learning whether momentarily or for longer.

8.3.3 Incivility, power and control

Aspects of power and control featured explicitly or implicitly in all the major themes. This is unsurprising given that the world of nurse education is, in effect, a mirror of the larger society it exists within and like it, has the same kind of societal relations replete with power, hierarchy and privilege (Johnson-Bailey & Cervero, 1997). These relations are influenced by a range of factors including gender, race and age, which don't just disappear when people enter the classroom or arrive on placement. However, the juxtaposition of everyday societal relations and those experienced as a student nurse, can reveal stark differences in the power the student possesses in each different setting, making it difficult for them to adjust as they move from one to another. In particular, the students' lack of control over their own learning meant they repeatedly missed out on important opportunities to gain new knowledge and experience. Similarly, power played a role in the incivility that some new or inexperienced lecturers experienced both from students and their own peers. The impact of power-related incivility on learning can therefore take a variety of forms including students being unable to voice their learning needs and new or inexperienced tutors having insufficient support to teach effectively. Power therefore plays an important role in incivility and incivility linked to a misuse of, or perceived lack of power, has a negative impact on learning.

8.3.4 Incivility, reciprocity and unidirectionality

The findings demonstrate that incivility can be either a reciprocal (two-way) or a unidirectional

(one-way) phenomenon. The issue of 'unidirectionality' is an aspect of incivility that does not appear to have been explored elsewhere. It counters Clark's 'Dance of Incivility' metaphor, whereby incivility is described as being like a dance where 'one dancer leads and the other follows, and sometimes the dancers do both' (Clark, 2008d). The use of dance as a metaphor draws on the need for interaction, engagement, and communication, which Clark suggests represents the dynamic and reciprocal nature of incivility in the student-faculty relationship. This view of incivility as a two-way interaction aligns with that of Braxton and Beyer (2004b), who explicitly reject the notion of incivility as a unidirectional phenomenon. In a scenario where the tutor is rude to a student for being late and the student pulls a face in response, the reciprocity of incivility is evident. However, when a student is asleep in class and is ignored by their tutor (as described by one participant), the incivility is surely unidirectional, i.e. the tutor was annoyed but there was no corresponding incivility.

The notion of reciprocity is important to incivility because there is often a complex interplay of behaviours occurring between the actors involved, but so too is the notion that it can be a 'one-way only' behaviour with a relatively passive recipient response. This doesn't mean there is no response, but that there is no responding (uncivil) behaviour which furthers exacerbates the situation. I propose therefore that incivility can be either a one-way action (unidirectional) or a two-way interaction (reciprocal).

To understand the directional possibilities of incivility is to recognise that it is first and foremost a phenomenon which is about perceptions of rude behaviour independent of whether that rude behaviour elicits an uncivil response in return.

8.3.5 Incivility: targeted and non-targeted

Some incivilities described were indiscriminate i.e. not targeted at any one person specifically. An example of this is where a student regularly enters the class noisily and late and with no awareness of the impact they are having on the lecturer and other students. Ibrahim & Qalawa (2015) found that regular classroom disruption can impact on academic achievement, whilst Feldman (2001) suggested that it could be so disruptive as to effectively terminate learning altogether. On placement, as already described in section 8.14, non-targeted incivilities such as providing inadequate supervision can result in lost learning opportunities and reduced patient safety (Fleming, 2007).

Other incivilities described were targeted, for example the student who was ignored after patient handover when all the others present were allocated tasks to do. These episodes had a greater personal impact often with negative consequences for self-esteem and confidence. Lowered self-esteem and lack of confidence have the potential to impact negatively on learning and patient care (Kinman & Leggetter, 2016). In the case of not calling students by their name for example, Windt-Val (Windt-Val, 2012) suggested that there is a close connection between a person's given name and their sense of self and identity, which in turn is linked to self-esteem, a fundamental part of professional and personal identity (Begley & White, 2003) and the key to providing therapeutic patient care (Randle, 2003). Similarly, confidence is an essential quality in a profession where the courage to advocate for high standards of care is a key attribute (Flatt, 2012).

In summary, incivility can be targeted or non-targeted but whichever it is, there can still be consequences for student learning and patient care.

8.3.6 Incivility, race and ethnicity

The interplay between incivility, race and ethnicity is well-recognised (Alexander-Snow 2004), although it did not actually emerge as a theme in terms of the participants' experiences of incivility. However, racial tensions were identified as a contributory factor in student-to-student incivility and issues of race and ethnicity were referred to numerous times across the three participant groups, mostly as part of the general commentary rather than in relation to uncivil behaviour specifically.

Given the frequency of mentions, it is important not to ignore this aspect of the data which has in effect emerged as an incidental theme. A nurse tutor, for example, said 'they sat in racially divided groups and it was sort of that group across there didn't like that group across there and you could feel the tension in the room'. This was an observation from a newly arrived teacher who had not worked with ethnically diverse groups before. One of the students, when referring to the ethnicity of her mentor said, 'I don't want this to sound racist but to me they come across as a race as being quite arrogant and rude and offhand and just not very English'. One of the mentors, when referring to black students said, 'I think it is a big issue that we as white people can't say something to coloured people, but they can turn it on us'.

The nursing cohorts in the research setting are very ethnically diverse with the exception of children's nursing. For example, almost half the adult nursing cohort is of black or minority ethnic background. With such a rich mix of backgrounds and cultures it is perhaps unsurprising

that misunderstandings can arise on occasions, nevertheless nurse tutors have an important role to play in creating inclusive teaching environments where all students feel equally valued and respected (Wray, 2013).

A review published more than fifteen years ago suggested that nurse educators need to examine the ways in which their own actions and values reflect racism in order to challenge the structures that make racism an inevitable part of nurse education in the UK (Condliffe, 2001). Although relatively little research has explored these issues since then, one study that did, described racist incidents affecting both nurse tutors and students (Markey & Tilki, 2007), whilst another explored the relationship between internationally recruited mentors and white students in an English university, and concluded that nurse education is seen through a white lens (Scammel and Olumide, 2012).

Despite the dearth of research on race and ethnicity in nurse education, there are clearly concerns about racism in nursing generally. Racial harassment has been described as having serious consequences for the recruitment and retention of a diverse nursing workforce (Bheenuck, Miers, Pollard, & Young, 2007) and nurses from black, Asian and minority ethnicities are poorly represented in senior positions (Brathwaite, 2018). In higher education, the 'Race for Equality' report (National Union of Students, 2011) identified that 1 in 6 black university students had experienced racism and a Higher Education Academy (HEA) summit report (J. Stevenson, 2012) highlighted a significant attainment gap between black and white students, which still exists in many universities today.

The findings highlight how racial or ethnic tensions can contribute to uncivil behaviours in the classroom. They also suggest there is much more that could have been explored in relation to race and ethnicity, had that been the focus of my research.

8.3.7 Incivility in nurse education in the UK

The types of incivility described were broadly in keeping with those reported by researchers in other countries, although the severity of behaviour fell far short of the violence reported in the US (Gallo 2012) and there was no reference to religious aspects such as those described by Eka et al. (Indonesia) (2016) and Ildarabadi (Iran) (2015). Other differences include the newly reported aspects such as *Knowing and Not-Knowing*. Overall, the findings suggest that although incivility is a globally recognised phenomenon with many common features, it is best

understood when considered in context so that factors such as professional, societal and religious expectations and norms, can be taken into account.

8.3.8 Incivility and symbolic interactionism

As discussed in Chapter 4, various theories can be used to explain why incivility happens and how it can be prevented or managed. The most relevant and useful of these is symbolic interactionism, which provides a pragmatic framework for understanding how people interpret and make sense of the various gestures and symbols which are exchanged between them in the process of social interaction (Blumer, 1998).

To further illustrate the relevance and applicability of symbolic interactionism to incivility, I have mapped three examples arising from the participant data against its core components: symbols, interpretations, and responses (Table 28).

Table 28 Incivility and symbolic interactionism

Example No.	Symbol identified in participant data	Interpretation that incivility has taken place	Response(s)
1	Nurse tutor shouting at student (nurse tutor data)	'That one episode with the student trying to come and get the signature, I was upset by it'	Asked the tutor to speak nicely to the student; avoided getting involved further.
2	Student arriving late (student data)	'How rude, how rude is it to that lecturer that you can't be bothered to come and listen to what they have to say'	Felt annoyed and frustrated. Rolls eyes but doesn't say anything.
3	Student behaving as though they were uninterested (mentor data)	'She looked so bored it was embarrassing to have her in the room with you'	Embarrassed. Talked to student about it

In example one, the nurse tutor participant witnessed another tutor shouting at a student who wanted to get her PAD signed. The participant described the incident as an example of incivility and reported feeling upset by the interaction. She then asked her colleague to speak nicely to the student and when this didn't work she avoided any further involvement. In terms of symbolic interactionism, her initial response (to ask the tutor to speak nicely) was based on the meaning she placed on the symbol (the shouting) and her interpretation of the situation which was that the tutor was behaving rudely. The meaning she placed on the shouting and the way she interpreted, or made sense of, the situation was influenced by her personal experience of the world. The uniqueness of personal experience is key here, as even when exposed to the same

social situations people's responses can differ enormously. For example, being raised in a household where there is a lot of shouting between family members could make someone feel that shouting is a normal and socially acceptable thing to do or alternatively, it could make someone adverse to hearing raised voices of any kind. Had the tutor interpreted her colleague's shouting as being friendly her response would have been quite different. This placing of meaning on an action or symbol by an individual and their response to it, is the essence of symbolic interactionism.

In example two, the participant (a mature student) expresses her frustration at students who arrive late to class. Her response to the symbol (the lateness), arises from her belief about what is and isn't acceptable behaviour in a classroom situation; this in turn has been informed by her personal experience of the world. Her belief then influences how she interprets and responds to the lateness, i.e. the rolling of eyes was her way of expressing her disapproval of what she saw as uncivil behaviour. However, she might have responded very differently had the same situation occurred at a different point in her life. For example, a sixteen-year old with no caring responsibilities and no employment experience may view punctuality very differently to the same person at thirty-five years of age who now has two children, an elderly parent to care for, and is studying full-time to be a nurse. This notion of modifying meanings over time through an interpretative and experiential process is central to the idea of symbolic interactionism.

In the third example, the mentor participant described the embarrassment (her initial response) of having a student who looks bored (the symbol) during a service-user consultation. She goes on to say that she talks to the student about it (her secondary response). The response element of symbolic interactionism can therefore be a dynamic process which is subject to change as the actor tries to make sense of the situation. In this example the mentor perhaps decides that taking to the student about her apparent boredom will move it from being an embarrassing situation which could impact negatively on the service-user experience, to one which can be resolved by providing feedback and support to the learner. Blumer (1998:8) referred to the fluidity of the response aspect of symbolic interactionism when he says 'in the face of the actions of others one may abandon an intention or purpose, revise it, check or suspend it, intensify it or replace it'.

8.4 Chapter Summary

This chapter has brought together the findings from each of the three participant groups enabling commonalities and differences between them to be readily seen, as well as illustrating how dominant or otherwise each theme is in relation to the whole data set. The analysis of the findings was further extended by way of a literature informed discussion which has added additional meaning and context to the findings.

The impact of incivility on student learning emerged as a common thread connecting all the themes. This is viewed as the most significant of the study findings because wherever learning is impacted, there are serious consequences for student nurses' development into knowledgeable and confident qualified nurses and ultimately, for patient care. Key also to the relationship between incivility and learning, is the concept of the invisible student who finds themselves excluded from the learning environment, whether incidentally or by intention.

In addition, the findings highlighted the emotional impact of incivility, the role of power and the influence of race and ethnicity. They also shed further light on the factors that contribute to incivility and offer an insight into the nature of incivility, showing how it can be a non-targeted behaviour with a generalised impact, or a targeted action with a much more personal impact. It is also shown to be a phenomenon which may or may not be reciprocal in its nature, thereby challenging the view held by some researchers that reciprocity is a core feature of incivility. Finally, the chapter returns to the theory of symbolic interactionism, demonstrating with examples drawn from the data its applicability to the perception of uncivil behaviour.

Chapter 9 Closing the Loop

In this final chapter, the findings discussed in Chapter 8 will be considered in relation to the original research questions to establish how that understanding has advanced in new and original ways. In addition, the strengths and limitations of the study will be considered and recommendations for practice and future research made.

9.1 Returning to the Research Questions

i. What is the nature of incivility in pre-registration nursing education as seen from the perspectives of student nurses, nurse tutors, and nurse mentors?

Incivility is a complex, multi-faceted and globally recognised social phenomenon which can be experienced in a multitude of ways, from eye rolling and sighing to sleeping in class and shouting. It can be, amongst other things, rude, frustrating, annoying and hurtful.

Incivility can be targeted or non-targeted and can be unidirectional (one way) or reciprocal (eliciting an uncivil response).

Incivility is inextricably linked to emotion. Without an emotional response of some kind, regardless of whether it is barely registered surprise or intense anger, incivility doesn't exist. It is therefore a phenomenon that is in the 'eye of the beholder', i.e. our interpretation of what we are experiencing is what determines whether an act or behaviour is uncivil or not. One person's perception as to what is or isn't uncivil will differ to another's, just as our perception of incivility can differ from day to day as we ourselves change in mood and tolerance and circumstances around us alter. Incivility is therefore not just subjective but is also temporal and context-bound.

Incivility and invisibility are closely linked concepts. Uncivil behaviour throws a cloak of invisibility over those that it affects, i.e. those that experience incivility do so because those that are uncivil to them cannot see, or do not care, about the effect of their behaviour. When this happens in the context of education, learning can be impacted in a multitude of ways.

The relationship between incivility and emotion, its ability to be unidirectional or reciprocal, and its potential to impact on learning as a result of rendering the student(s) invisible, can be illustrated as a 'Model of incivility and learning' (Figure 8).
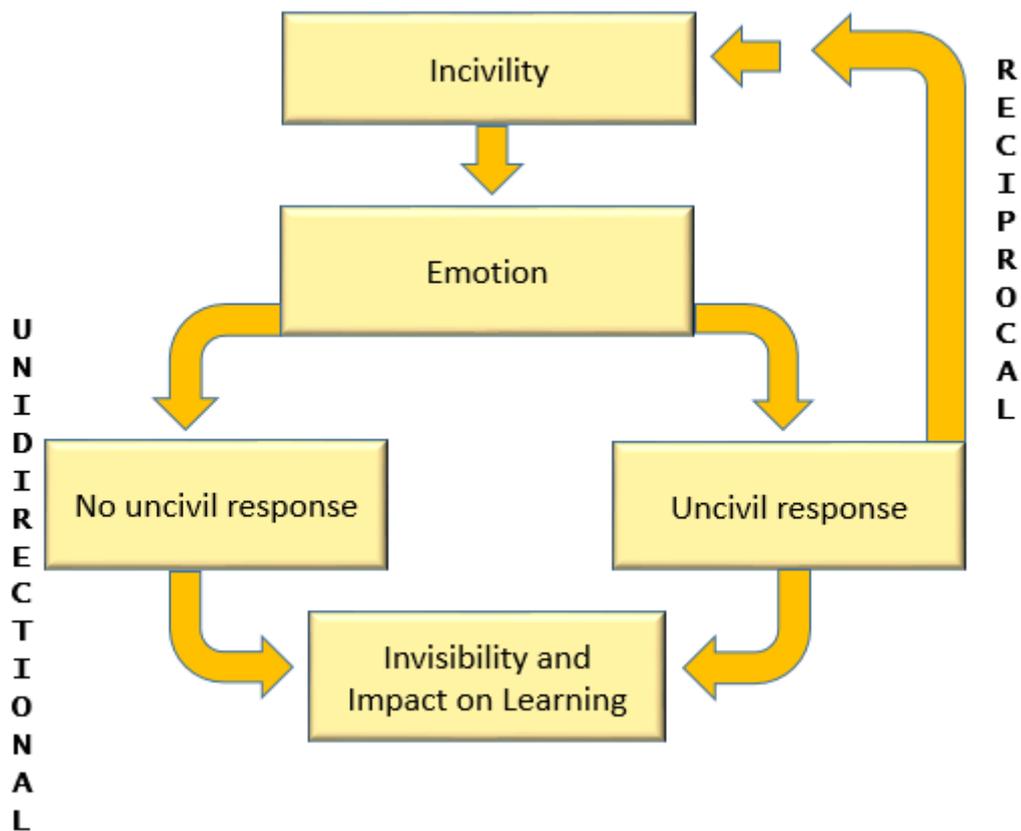
Figure 8 Model of incivility and learning

ii. What commonalities and/or differences exist between the experiences of student nurses, nurse tutors, and nurse mentors, in relation to incivility in pre-registration nursing education?

Students are the most vulnerable group in the triad because of the power elements in the relationships between student, mentor and tutor; this was particularly notable when students were in the earlier stages of their learning journey and/or on placement. When incivility arises, it is students who stand to lose the most because it is their learning that is impacted.

Nurse tutors are also affected by incivility but to a lesser extent, partly because they are in a better position to manage it, as they have the power and authority to do so. However, like the students, novice tutors appear to be more vulnerable to incivility than their more experienced colleagues, whether from being uncertain how to manage it or from being taken advantage of because of their lack of experience.

Like the tutors, the mentors are impacted by incivility but are able to use their status as qualified nurses to manage the situation. Although frustrated by student incivility, the consequence is mostly felt in terms of time lost to patient care.

All three groups described the emotional experience of incivility. The nurse tutors and students expressed a wider range of emotions than the mentors and the students experienced the most deeply felt ones.

iii. What is the impact of incivility in pre-registration nursing education?

Incivility can have a substantial and detrimental impact on learning by various means which can be broadly grouped under three headings; Teaching, Concentration and Opportunities.

Incivility can result in a wide range of emotions from mild surprise to embarrassment, shock and anger whilst physical effects can include sighing, shaking and crying. The more extreme types of incivility, such as bullying, can have a long-lasting effect.

iv. What factors have the potential to contribute to, or cause incivility in pre-registration nursing education?

There are multiple factors that contribute to uncivil behaviour. Some factors were cited by all three groups, such as expectations, ethnicity, and generational differences, and some arose in only two of the three groups, such as prior education, boredom and lack of voice/not being heard (students and tutors) and arrogance, confidence, lack of interest, lack of choice and childcare issues (student and mentors). The wide range of potential contributory factors further reflects the complex nature of incivility.

9.2 Strengths and Limitations

A key strength of this research lies in its relevance to the professional practice of nurse education, focussing as it does on a research problem which arose directly out of the practice of teaching student nurses. The study is further strengthened by the adoption of a phenomenological approach which was in keeping with the desire to make sense of incivility through the eyes of those that have experienced it. In doing so, the phenomenon has been

illuminated in a manner that is both deeply personal to the individuals concerned and highly insightful. Finally, the richness of background detail and context will enable those working in similar settings to consider the relevance to their own setting, and so the study is further strengthened by the potential to influence nurse education beyond the boundaries of the researcher's own practice.

The study also has limitations. The number of mentors recruited was lower than hoped for and, coupled with the relatively short interviews they gave, meant that the mentor perspective felt underexplored in comparison to the other two groups; this also limited the opportunity to achieve data saturation.

Another possible limitation was the nature of insider research and its potential to influence participants' responses. Additionally, the researcher's own experiences of being a student nurse, tutor and mentor, increased the risk of bringing a personal perspective to bear on the research process. With these issues in mind, it was necessary to minimise the effects of bias and influence by learning the skills of reflexivity, keeping a diary of events and by drawing on the expertise of the doctoral supervisory team to guide key decisions. Ultimately, the nature of qualitative, interpretive research is such that the researcher and the research process are inextricably linked and as such, the decisions made, and the conclusions reached in this study are inevitably, to a certain extent, a reflection of the researcher who led the enquiry process.

The issues described above are an acknowledgment of the limitations of the study, but they do not undermine the rigour or credibility of the findings and nor therefore, the validity of the recommendations.

9.3 Recommendations for Practice

The findings identify a need to develop practices that promote effective, empowering and enabling learning environments for student nurses. The recommendations therefore focus on the education of those who teach and assess student nurses, and the education of the student nurses themselves. The recommendations have implications for those local and national policy-makers who determine how nurse education is provided and what resources are made available to support it.

9.3.1 Nurse mentor and tutor education

The study concluded just as the professional regulator, the NMC, issued its revised standards of education for the profession (Nursing and Midwifery Council, 2018a). The standards are divided into three separate parts: Part 1 Standards framework for nursing and midwifery education; Part 2 Standards for student supervision and assessment; Part 3 Standards for pre-registration nursing programmes. Across these standards, the need for nurse tutors and practice supervisors (to replace the current mentorship model) to have the appropriate support and resource to prepare for the responsibility of supervising students to achieve their learning outcomes, is clearly stipulated. This requirement is consistent with the existing standards (Nursing and Midwifery Council, 2008) and signifies a continuing commitment from the professional regulator to ensuring that students are properly supported when on placement. However, unlike the current situation whereby mentors must have preparatory training and an annual training update, the new standards do not detail any specific training requirements for the supervisor role. What is stipulated is that approved educational institutions and their practice partners must ensure that supervisors are readied for the role by receiving 'ongoing support to prepare, reflect and develop for effective supervision and contribution to, student learning and assessment'. This ambiguity fails to address concerns about the consequences of inadequate student supervision on patient care, as raised by others (Fleming, 2007) and as reinforced by my own findings. It also allows for a great deal of variation between educational providers and therefore it is inevitable that nationwide inconsistencies in supervisory practice will emerge. The NMC's commitment to providing support to students in practice, as articulated in the new standards, therefore actually does very little to engender the level of confidence that patients and members of the public require that student nurses will receive the necessary level of supervision, support and guidance when working in 'live' clinical settings.

Given the fundamental importance of practice-based supervision for student nurses, it is recommended that preparation for the role is given in the form of a standardised training programme which draws on the evidence base for creating effective learning environments for higher education learners in classroom and practice settings (Biggs & Tang, 2011; Fry et al., 2014; McIntosh, 2010). Core content should include teaching practice supervisors how to create an enabling and confidence building learning environment where students are respected as individuals and valued as learners and future nurses; this could be framed within an understanding of incivility and the power it has to impact on the learner experience. The same core content should be part of the teacher training qualification which all nurse tutors complete

in order to be recorded by the NMC as a registered nurse teacher. This could include teaching n aspects such as the importance of calling students by their name, creating a sense of belonging in the learning environment and of valuing students' prior experiences as well as their need to learn new knowledge and skills. Tutors and practice supervisors should also be taught about the influence of role modelling and power in the nurse-student relationship.

Focussing on the above components would specifically support Part 1 of the standards, which articulate the need to provide students with the learning opportunities they need to achieve their core nursing proficiencies, to value education and training in all learning environments and to act as professional role models at all times.

Adopting the recommendations for practice supervisor and nurse tutor training would support the NMC position, as stated in the standards, of only approving programmes where the learning culture is 'ethical, open and honest, and is conducive to safe and effective learning that respects the principles of equality and diversity'.

9.3.2 Pre-registration nursing curricula

The findings provide a rationale for designing pre-registration nursing curricula which foster civil learning environments. The link between incivility and learning should be explicated at the outset of the programme so that the implications of uncivil behaviour and the potential consequences for patient care are clear. Notions of civility and incivility, and the implications of each could then be threaded throughout the curriculum. Examples cited by the participants, such as lateness in class and use of phones, could be used as the basis for exploring what the expectations of behaviour are and for agreeing ways of managing them. The tutor participants in particular, had several ideas about the prevention of incivility including setting expectations and challenging poor behaviour. Methods already shown to be effective in doing this, such as the use of civility codes (Williams & Lauerer, 2013) and journal clubs (S. Jenkins et al., 2013), could be considered for adoption into the curriculum as a means of further supporting student learning.

In addition to the taught curriculum, it is also important to be aware of the influence of the hidden curriculum (Allan et al., 2011), and therefore to ensure that expected behaviours are modelled by nurse tutors and mentors in their everyday practice, regardless of whether they are teaching or supervising students or not. Civil behaviours developed during pre-registration training and modelled as the norm by the wider nursing community will contribute to upholding

the standards of the profession and earn the trust of the public as is expected by the profession's regulating body (Nursing and Midwifery Council, 2018b).

These recommendations are supported by the findings of Health Education England's 'Shape of Caring Review' (Willis, 2015), which recognised the link between ongoing learning for nurses and the provision of high quality patient care. The review set out thirty-four recommendations, two of which are particularly pertinent: 'Assuring high quality, ongoing learning for registered nurses' and 'Assuring a high-quality learning environment for pre-registration nurses'. The 'Model of incivility and learning' (9.1, Figure 6 refers) and the 'Impact on learning' (8.2.4, Figure 4 refers), provide a means by which the nature and impact of incivility can be explored with nurse tutors, practice supervisors and nursing students, in the context of implementing the recommendations.

9.4 Recommendations for Further Research

The findings indicate several areas for future research in the field of incivility, each of which would further inform educational practice:

- Research to determine the perceived frequency of occurrence would help to establish the extent or otherwise of incivility in pre-registration nursing education in the UK.

- Further exploration of the mentor (to be replaced by the supervisor role) perspective on student incivility would be beneficial as the supervision of nursing students in practice is a critical component of the pre-registration journey and yet the mentor experience is relatively unexplored.

- Research to establish whether first-year student nurses are more likely to experience incivility than second and third-year students, would help to identify where the focus of support for students should be.

- Research into issues of culture and race in relation to incivility as these aspects were raised several times in the findings and yet are underexplored in the UK research literature.

- The findings complement what is already known about incivility more generally in higher education in the UK (Keating, 2016). However, little if anything is known about incivility in other healthcare fields, such as physiotherapy and midwifery. Research into these areas would be of value because of the links between incivility and impaired patient care.

9.5 Contribution

This study is the first phenomenological exploration of incivility in the context of nursing education in the UK, and as such it provides a rich and contextualised exploration from which other healthcare professionals working in similar settings can learn. The study also adds a UK perspective to what is a global phenomenon by identifying similarities and differences between the UK and other countries and in doing so adds to the knowledge-base of nurse educators around the world.

The findings make explicit the links between incivility, learning and emotion, and reveal new insights into its nature including the concept of invisibility. They also bring to the fore previously unseen dimensions such as *Knowing and not-knowing*. Of particular importance, is the explication of learning impact as this aspect has hitherto been little explored and yet is of considerable significance to nurse education and therefore also to patient care. This has implications for nurse education policy and practice which are particularly important given the context of financial constraint, qualified nurse attrition and nationwide difficulties in student recruitment, in which the nursing profession currently operates.

The results counter the frequently referenced 'Dance of Incivility' conceptual framework (Clark, 2008c) which describes incivility as a reciprocal phenomenon, suggesting instead that it can be either reciprocal or unidirectional in nature. Challenging this view has resulted in the development of a new conceptual framework which can be used as a basis for improving the understanding of incivility as at arises in contemporary nurse education settings.

Finally, the use of symbolic interactionism as a means of explaining what is happening when incivility is perceived, offers a novel way of thinking about this phenomenon which can be applied to real-world settings to further improve our understanding of how incivility can appear in everyday education and healthcare settings.

9.6   Impact on Professional Practice – a personal perspective

Undertaking a doctorate has had a significant influence on my professional practice. It has exposed me to many previously unread writers and researchers, sharpened up my research skills and brought about a significantly different and more critical way of thinking. In the classroom, I find myself constantly drawing on my findings to inform the way I manage the learning environment and student interactions.

As somebody working in an academic leadership role, I have also been able to use my research findings to influence the practice of others. For example, in 2016 I established a school-level group that aims to enable and empower all students to be successful in their chosen pathway of study. This group arose directly out of my realisation that student learning can be impacted in many ways as a result of incivility. The group is now a well-established part of the school and has undertaken a range of teaching enhancement initiatives involving both staff and students. In particular, the participants' reports of incivility linked to race and ethnicity has resulted in a strand of work focussed specifically on reducing the gap in academic attainment between students from black and minority ethnic backgrounds and white students.

Another aspect of practice that I have been able to influence has been that of student support. Listening to the students describe how they felt when being ignored, ridiculed or bullied, motivated me to think about what we as educators could do to help them cope with the various difficult experiences they will encounter as students and then in the future, as qualified nurses. The result of this was a project established in 2017, which aimed to find an effective model for delivering resilience training for students. The project has involved many students and staff and has led to cross-disciplinary working with other schools of study. At the time of writing, the project team were putting together a set of practice-related recommendations for the school's management team to consider.

Finally, I have been able to share my research at conferences and by publication. This has enabled me to share the findings beyond my own institution and gain valuable peer feedback to inform and shape the thesis. Overall, undertaking a doctorate has had a significant impact on my professional practice, including enabling me to influence the work of others and improve the educational experience of students.

9.7 Concluding Remarks

One problem with taking a deep dive approach to research, where one works with a relatively small group of people in a single setting, is that the richness of the findings can bleed into the bigger picture causing the overall image to blur or distort. This is certainly true of this study. Where uncivil behaviour exists, it is a serious concern for all the reasons identified in the findings, but that does not mean that it is the behaviour norm for all those working or studying in nurse education. In most cases, the experiences shared were confined to particular people or specific points in time and the participants were at pains to share the many positive experiences they had also had. Nevertheless, because of the risk to student learning and patient care, it is imperative that a zero-tolerance approach to incivility is adopted. The insight and understanding gained from this research has the potential to inform the development of educational standards and policies that support *all* students to learn effectively.

Incivility in nurse education is a globally recognised phenomenon, with many more countries reporting it now than did so at the beginning of my doctoral journey five years ago. Developing a shared understanding of this phenomenon is therefore of critical importance if nurse educators the world over are to provide the kind of transformational learning experiences that will enable their students to flourish into confident and competent qualified nurses. That I have been able to contribute something to this collective professional endeavour is entirely thanks to the generosity of the tutors, mentors and students who freely shared their experiences with me. I feel privileged to have been gifted their stories to work with and am acutely aware of the responsibility of doing the right thing with them for the betterment of nursing practice and the nursing profession as a whole.

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Appendix A Citation Style

The American Psychological Association (APA) citation style was developed in the 1920s by a group of social scientists and is now used widely in the social and behavioural sciences. It is not dissimilar to the Harvard style of citation but there are some differences that can lead to confusion if the reader is unfamiliar with the style. The most distinctive of these are noted here:

In the APA system page numbers are cited by 'year: page number', for example 2010:82. The same is referenced in the Harvard System as (2012, p.82).

Authors with the same surname are distinguished by the use of an initial before the surname regardless of whether the year of publication is the same or not. For example, an in-text citation for two authors with the surname Adams, could be (M. Adams, 2003; T. Adams, 2010).

Electronic sources are described as 'Retrieved January, 10th, 2018 rather than Available from or Accessed from, both of which feature in other styles.

When citing an edited book using APA style the first letter of the editor abbreviation is capitalised, as in 'Eds' whereas in Harvard style the abbreviation is lower sentence case as in 'ed'.

Multiple authors cited within parenthesis are joined with an ampersand (&). Multiple authors cited in the txt and without parenthesis, are joined by 'and'.

Appendix B Abbreviations and Glossary of Terms

Abbreviation	In full
APA 6th	American Psychological Association 6th
BME	Black and Minority Ethnic
CASP	Critical Appraisal Skills Programme
HE	Higher Education
HEI	Higher Education Institution
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NMC	Nursing and Midwifery Council
PAD	Practice Assessment Document
RCN	Royal College of Nursing
UK	United Kingdom
US	United States

Terms	Definitions
Critical Appraisal Skills Programme	A framework approach to critiquing research papers
Interpretative Phenomenological Analysis	A framework for analysing qualitative data.
Mentor	A qualified nurse who has undertaken additional training to be able to assess a student nurse on their clinical practice
Nursing and Midwifery Council	The nursing profession's statutory regulatory body.
Placement	A clinical setting that has been approved to support and assess student nurses
Practice	The setting where clinical activities take place. Also used to denote the application or use of an idea, belief, or method.
Practice Assessment Document	The assessment document that mentors sign for students when they are in placement
Qualified nurse	Somebody who has successfully completed an approved pre-registration nurse training programme to enable them to provide clinical care to support the health and wellbeing of others.
Registered nurse	A qualified nurse who is on the national register of qualified nurses held by the profession's regulatory body, the NMC.
Royal College of Nursing	A professional membership body and trade union for nurses.
Service-user	Somebody who uses or has used healthcare services. Sometimes also referred to as an expert by experience.
Sister	An experienced qualified nurse who is working in a senior role usually providing leadership and/or, managerial support to other nurses.
Staff nurse	A qualified nurse who may or may not be experienced but who has limited managerial responsibility. Junior in salary terms in comparison to a Sister.
Supernumerary	Referring to students who are not counted in the placement staffing numbers

Symbolic interactionism	A social behaviour theory that emphasizes symbolic (linguistic or gestural) ways of communicating and the meanings people place on them
The Code	The code of professional conduct that governs and informs nurses' professional behaviour.

Appendix C   Critical Appraisal Skills Programme (CASP) Qualitative Checklist

Example of the CASP checklist in use with a qualitative research study: Clark (2008a) Faculty and student assessment and experience with incivility in nursing education: A national perspective. *Journal of Nursing Education*, 47(10), 458-465

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✔

Can't tell

No

Comments: *The purpose of the study was clearly stated as 'To examine nursing faculty and student perceptions of the factors that contribute to incivility in nursing education, the types of uncivil behaviors each group exhibits, and remedies for prevention and intervention'.*

2. Is a qualitative methodology appropriate?

Yes ✔

Can't tell

No

Comments: *This was a mixed methods study using a previously validated survey tool (the INE) which included four open-ended questions at the end. The overall study aim was stated as 'To examine perceptions...' and as perceptions are not quantifiable a qualitative methodology was an appropriate choice.*

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✔

Can't tell

No

Comments: *The purpose of the qualitative aspect of the survey was described as being 'designed to garner respondents' opinions about why and how faculty and students contribute to incivility and gather suggestions for remedies to deal with the problem'. It was targeted at a large sample group and therefore it was a suitable method to adopt for this aspect of the study although a different approach would have been required for gaining any depth of insight into experiences or perceptions. The researcher explained how the tool was validated but did not discuss why the design was chosen over others.*

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ✔

Can't tell

No

Comments: *The survey was self-administered to a convenience sample recruited from delegates at two national nursing conferences in the US. The audience included both students and academics. The conference theme is not mentioned so it is no known whether the convenience sample was biased towards the subject of the research.*

5. Was the data collected in a way that addressed the research issue?

Yes ✔

Can't tell

No

Comments: *The means of data collection was suitable to address the research questions listed in the article. The author describes gaining ethical approval and consent and states that participation was voluntary. She also states that she was not present for any phase of the survey administration. The data was collected during a conference but there is no further information about how exactly it was done or why this particular conference setting was chosen.*

6. Has the relationship between researcher and participants been adequately considered?

Yes ✔

Can't tell

No

Comments: *This author is now well-known in the field of incivility but at the time of the article's publication was less so. It is not known therefore whether her role as researcher would have introduced any influence on the participants' responses. Using a survey approach did distance the researcher from the participants in a way that would not have been possible with interviews and she does make clear that she was not present during any aspect of the survey administration. The development of the research questions is clear and arises out of her previous work. The validation of the survey tool instrument is described and the use of an independent researcher during the analysis is explained, both of which suggests she was aware of the need to maintain an objective stance.*

Section B: what are the results?

7. Have ethical issues been taken into consideration?

Yes ✔

Can't tell

No

Comments: *Ethical approval and individual participant consent was obtained. No other ethical issues were discussed in the article although identification of bullying behaviours by students and faculty suggest that ethical concerns were present.*

8. Was the data analysis sufficiently rigorous?

Yes ✔

Can't tell

No

Comments: *Data analysis was explained clearly and in a reasonable amount of detail. Qualitative data is presented in the forms of quotes which evidence the themes described. The author described the use of processes to 'evaluate the consistency of theme development so that an accurate assessment of the findings resonates with people other than the researcher'.*

9. Is there a clear statement of findings?

Yes ✔

Can't tell

No

Comments: *The findings are explicitly stated and thoroughly discussed in relation to the original research questions and the wider body of literature. Limitations are acknowledged including the need to do further psychometric testing on the survey tool and difficulty of generalising the results to the wider population of nurse academics and students due to the use of a non-representative convenience sample.*

Section C: Will the results help locally?

10. How valuable is the research?

Comments: *The research is valuable because it a) sheds light on the nature of incivility b) has a good sample size of staff and students. However, it is specific to the US and therefore the context of nurse education has to be considered in terms of relevance to UK practice. The article was published 10 years ago but the themes identified still resonate with more recent research including my own. The author sets out areas where more research is needed, much of which she has subsequently done. As one of the largest mixed methods studies on incivility from which the concept of the 'dance of incivility' was developed, it can be considered a seminal piece of work in the field.*

Appendix D Consent Form

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..………………………………………………………………………………………………………

hereby freely agree to take part in the study entitled

Incivility in pre-registration nurse education; exploring the perceptions of nurse teachers, student nurses and nurse mentors

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people, potential risks and benefits. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been told that should I feel any concern or distress about the experiences shared during the interview I will be offered appropriate support at the time of the interview as well as follow-up support should it be required.

3 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

**5** I have been told that I may be contacted again to clarify or confirm information given during the interview.

Signature of

participant………………………………………………………………………Date…………………..

Signature of (principal) investigator……………………………………………Date……………………

Name of (principal) investigator

……………JULIE VUOLO…………………………………………………………………………....

Appendix E   The Pre-registration Nursing 'Tennis Court'

A conceptual diagram illustrating the positions of the three key participant groups in relation to their primary working / learning environments, to each-other and to the patients.
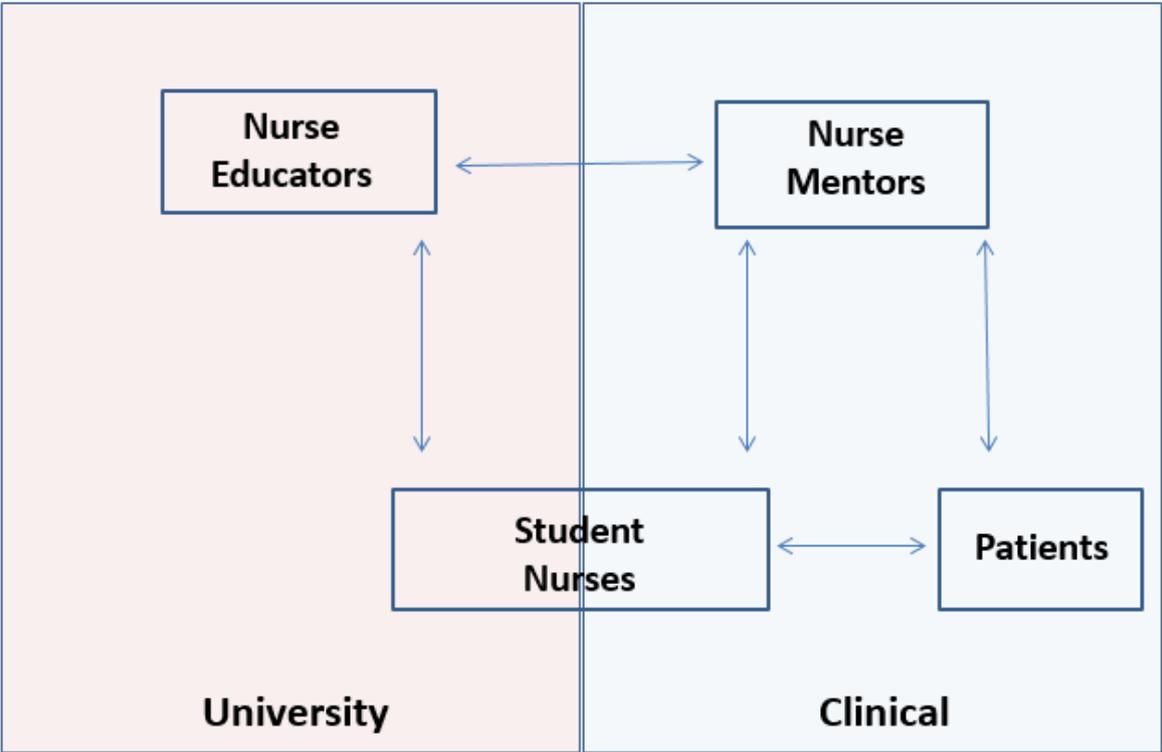
Appendix F Interview Guide

INTERVIEW GUIDE
ETHICS NUMBER: cEDU/PG/UH/00816 (1)

TITLE OF RESEARCH: Incivility in pre-registration nursing education; exploring the experiences of student nurses, nurse tutors and nurse mentors in a UK Higher Education Institution.

Interview Process Guide

- Introduction of self and thanks for agreeing to participate.
- Introduction of research interest (using 'Tennis Court' diagram)
- Check consent is signed and participant information understood
- Reminder that the research has been approved by the relevant Ethics committee and that even though the consent form is signed they are free to withdraw from the study at any time should they wish; this includes discontinuing the interview at any point and requesting for interview data to be withdrawn from the study post interview.
- Re-iteration that the interview is confidential and that all results will be anonymised.
- Reminder that the interview will be recorded and that a copy of the interview transcript will be sent post-interview to confirm, amend, or add to, if wished.
- Switch on and check both recorders

Opening Questions

- 'Can you tell me what your understanding of incivility is?'
- 'Tell me about your experiences of incivility'.

Topic Guide

- Definitions
- Examples of incivility
- How it feels to experience it
- Impact on learning
- Expectations of behaviour
- Possible contributory factors
- Issues related to race, ethnicity, gender and age
- Qualified nurses only: year of qualification, own experience of nurse training
- Students only: year of study

Appendix G Permission to Research

RE: Permission to Research
Say, Jane E
To: Julie Vuolo
Sent: 02-12/2014

Dear Julie
Thank-you for this formal request. Of course, permission is granted. Please do let me have the ethics approval number when it is in place. More than happy to discuss at any time.
Good luck with it all.
Best wishes, Jane
Jane Say, Programme Leader, Pre-registration Nursing

From: Vuolo, Julie
Sent: 01 December 2014 11:34
To: Say, Jane E
Subject: Permission to Research

Dear Jane
I am writing to you in your capacity as programme tutor to seek your permission to recruit participants from the pre-registration nursing student body for a research study exploring student nurses' perspectives on aspects of professional behaviour.

Details:
My particular interest is in uncivil behaviour as it is seen from the perspectives of pre-registration nurse students, nurse mentors and nurse teachers. I will be seeking to recruit approximately ten students to conduct interviews of approximately 1 hour each. The recruitment and interviews will take place at some point between March 2015 and March 2017 depending on student availability and my own time constraints. Given the vagueness of dates I would get back in touch with you nearer the time of recruitment so that you knew when it was happening.

Ethical approval:
The permission to proceed with recruitment is part of the UH ethics approval application which I plan to submit in February 2015 after which I will have an ethics number to share with you.

Students first:
Please be re-assured I am fully aware how often the students are asked to give information and that their programme of study must be prioritised. If you are happy to give overall permission I would welcome a discussion nearer the time about how best to recruit them with these issues in mind.

Best wishes
Julie Vuolo

RE: Research Permission

Armstrong-Griffiths, Carys
To: Vuolo, Julie
Sent: 07/12/2014 22:06

Good Evening Julie,

This is fine from my perspective – there is a Semester B delivery over the time period you have mentioned so please let me know as you do if you need to speak to our students and we can find you a slot on the timetable.

Kind Regards, Carys A-G

Carys Armstrong-Griffiths

Programme Tutor BSc (Hons) International Nursing/Healthcare Mentorship Lead/ Senior Lecturer Adult Nursing
c.armstrong-griffiths@herts.ac.uk 01707 285915 / 07930251844

From: Vuolo, Julie
Sent: 01 December 2014 11:55
To: Armstrong-Griffiths, Carys
Subject: Research Permission

Dear Carys

I am writing to seek your permission to recruit participants from the Mentorship update training sessions for a research study exploring nurse mentors' perspectives on aspects of professional behaviour.

Details:
My particular interest is in uncivil behaviour as it is seen from the perspectives of pre-registration nurse students, nurse mentors and nurse teachers. I will be seeking to recruit approximately ten mentors to conduct interviews of approximately 1 hour each. The recruitment and interviews will take place at some point between March 2015 and March 2017 depending on student availability.

Ethical approval:
The permission to proceed with recruitment is part of the UH ethics approval application which I plan to submit in February 2015 after which I will have an ethics number to share with you.

Students first:
Please be re-assured I am fully aware how time constrained these students are and that participation in the interviews would be entirely voluntary.

As you know I have accessed this group before with little success so this time it is likely that I will recruit directly from the trust; however I would value your permission to come back to your groups for recruitment purposes if necessary.

I would be happy to provide any more details that you require.

Best wishes

Julie Vuolo

RE: Research Permission

Fowler Carolyn (EAST AND NORTH HERTFORDSHIRE NHS TRUST)
To: Vuolo, Julie
CC: Fowler Wendy (EAST AND NORTH HERTFORDSHIRE NHS TRUST)
Sent: 19/12/2014 18:18

Dear Julie

I would be delighted for you to meet the mentors. I am happy for you to discuss this and arrange it with Wendy. I would be grateful before you meet the mentors that I am aware of your approach and the expectations for them.

An over view in an e-mail will be fine.

Kind Regards, Carolyn

Carolyn Fowler
Assistant Director of Nursing, Education and Research
East & North Herts NHS Trust
Lister Hospital, Corey's Mill Lane, Stevenage SG1 4AB
Extension 4937
Mobile No 07785456435

From: Vuolo, Julie [mailto:j.c.vuolo@herts.ac.uk]
Sent: 19 December 2014 12:57
To: Fowler Carolyn (EAST AND NORTH HERTFORDSHIRE NHS TRUST)
Subject: Research Permission

Dear Carolyn
My name is Julie Vuolo and I work in the School of Health and Social Work here at the University of Hertfordshire.
I am undertaking some doctoral research into ways of behaving between nurse mentors, students and teachers and I am looking for permission to approach some of your mentors (8-10 in total) to be part of the study and of conducting interviews on hospital premises. I have had a discussion with Wendy Fowler about this proposal and we talked about the possibility of approaching the mentors at the time of the trust mentor updates. Wendy gave me your name as the appropriate person to ask for permission to proceed (subject of course to Ethics Committee approval).
I appreciate your time is heavily committed, but I am happy to talk through details at a time to suit you either on the telephone or I can come up to the trust if it is easier. I look forward to hearing from you and thank you in advance for your consideration,
Best wishes
Julie Vuolo

RE: Research Permisssion

Charles, Michele B
To: Vuolo, Julie
Sent: 01/12/2014 12:14

Dear Julie
Yes, you have my permission to approach staff in ANP, subject to getting the ethical approval.

Kind regards, Michele
Michele Charles

Head of Department of Adult Nursing and Primary Care,
School of Health and Social Work, University of Hertfordshire

From: Vuolo, Julie
Sent: 01 December 2014 11:43
To: Charles, Michele B
Subject: Research Permisssion

Dear Michele
I am writing to seek your permission to recruit participants from the Adult Nursing teaching staff
for a research study exploring nurse teachers' perspectives on aspects of professional
behaviour.
Details: My particular interest is in uncivil behaviour as it is seen from the perspectives of pre-
registration nurse students, nurse mentors and nurse teachers. I will be seeking to recruit
approximately ten teachers to conduct interviews of approximately 1 hour each. The recruitment
and interviews will take place at some point between March 2015 and March 2017 depending
on staff availability.
Ethical approval:The permission to proceed with recruitment is part of the UH ethics approval
application which I plan to submit in February 2015 after which I will have an ethics number to
share with you.
Staff first: Please be re-assured I am fully aware how time constrained colleagues are and that
participation in the interviews would be entirely voluntary.
I am happy to provide any more details that you require,
Best wishes
Julie Vuolo

RE: Permission to research

Vincent Jacky (RWR) Hertfordshire Partnership University FT
To: Vuolo, Julie
CC: Padmore Jane (RWR) Hertfordshire Partnership University FT
Sent: 15/03/2017 22:07

Dear Julie.

I understand that this should not need NHS ethics approval as the participants are NHS staff who are being
selected by virtue of their involvement as mentors in UoH courses & will therefore only be discussing this aspect of
their work. I am happy for the staff to take part & that they will do this on a voluntary basis.

Kind regards,

Jacky Vincent, Interim Deputy Director of Nursing & Quality
Hertfordshire Partnership University NHS Foundation Trust | The Colonnades, Beaconsfield Road, Hatfield, Herts.
AL10 8YE |☎ 01707 253863| ✉jacky.vincent@hpft.nhs.uk |📠 www.hpft.nhs.uk

It think the majority of the cases students are they are very civil to us especially at the beginning because you may have noticed up here it is not sister this and staff nurse that but when they first come here they do say sister and staff nurse but we then say to them that they don't have to so because I think it can be a little bit.. you can get closer I think if you are first name terms not just with mentors but with the rest of the staff you get that connection straight away there is not a barrier most of the students we have here are fine..they are absolutely brilliant I think you do almost see them relax as soon as you say you don't need to call me sister call me whatever you notice them their shoulders drop and they are not so on edge

So you set the tone?

we set the tone yes. Basically it is going to be professional but we can also see that we all have to get on together and by cutting some of the … it will make our life easier and their life easier they are still going to get the training they need and obviously if things needed to be said then they would be said but the students know they are being given a fair chance think is the way forward we have had the odd few students who can be who have been quite hard going (laughing)

can you tell me a little bit more about what you mean by hard going?

Weve had some students where they don't like being told what to do which is obviously a bit difficult uuhm and its about quite often it's about silly things they're told I can remember one who was told to go to lunch and she said I don't want to go to lunch I'm meeting my friend but obviously we needed her to go to lunch at this point so that she was back for the next session in the afternoon but she couldn't see that and refused to go basically you do get some that can be difficult to work with uuh (laughs)

Handwritten annotations (left margin):

'At the begining' - staying until world is change? What shape perfective lense. don't have to use first names. Easy barriers don't need to, calls me Sister. Most are fine, a few who have been hard going

Actions
Set the tone
Say don't call me Sister
Professionalism
have to all get on together
cutting some of the
If things need to be said
Relationships
make our life, make their life easier
If they need sorting
Students know they are getting a fair chance

Handwritten annotations (right margin):

Complexity?

Physical signs of tension - see them relax, not so on edge
Getting a connection
Shoulders drop
Standoffish
Don't look engaged
Just stands there ticking the hours off.
Don't want to learn
The way you are spoken to
Perceptions
+ definition

Appendix I Ethics Approval

University of Hertfordshire UH

UNIVERSITY OF HERTFORDSHIRE
SOCIAL SCIENCES, ARTS AND HUMANITIES

ETHICS APPROVAL NOTIFICATION

TO Julie Vuolo

CC Dr D M Duncan

FROM Dr T Parke, Social Sciences, Arts and Humanities ECDA Chairman

DATE 25 March 2015

Protocol number: **cEDU/PG/UH/00816**

Title of study: Incivility in pre-registration nurse education; exploring the perceptions of student nurses, nurse teachers and nurse mentors.

Your application for ethical approval has been accepted and approved with the following conditions by the ECDA for your school.

Approval Conditions:
The applicant explaining on the Participant Information Sheet
1 that she has dual roles as Associate Dean and researcher;
2 [in the Participant Information Sheets to be given to UH students and UH employees]: the processes that are in place for mitigation, together with the statement that they are absolutely under no obligation to participate .
This approval is valid:
From: 24 March 2015
To: 28 February 20118

Please note: Your application has been conditionally approved. You must ensure that you comply with the conditions noted above as you undertake your research. Failure to comply with the conditions will be considered a breach of protocol and may result in disciplinary action which could include academic penalties. Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol. Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken. Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct. Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study. Students must include this Approval Notification with their submission.

Appendix J Revised Ethics Approval

UNIVERSITY OF HERTFORDSHIRE
SOCIAL SCIENCES, ARTS AND HUMANITIES

ETHICS APPROVAL NOTIFICATION

TO Julie Vuolo
CC Dr D Duncan

FROM Dr Tim Parke, Social Sciences, Arts and Humanities ECDA Chairman

DATE 13/7/16
Protocol number: acEDU/PG/UH/00816 (1)

Title of study: Incivility in pre-registration nurse education; exploring the perceptions of student nurses, nurse teachers and nurse mentors
Your application to modify the existing protocol as detailed below has been accepted and approved by the ECDA for your School.

Modification:
Number of participants increased to 25

This approval is valid:
From: 13/7/16
To: 28/2/18

Please note:
Any conditions relating to the original protocol approval remain and must be complied with.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken. Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct. Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study. Students must include this Approval Notification with their submission.

Appendix K Participant Information Nurse Mentors

PARTICIPANT INFORMATION SHEET – NURSE MENTORS

Approved under UH Protocol of Studies Involving the Use of Human Participants UPR RE01

Title of Research

Incivility in pre-registration nurse education: exploring the perceptions of nurse teachers, student nurses and nurse mentors.

Introduction

I would like to invite you to take part in a research study but before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask for any further information you need to help you make your decision.
Thank you for your time,
Julie Vuolo, Doctoral Research Student /Associate Dean of School (Learning and Teaching).

What is the aim of this study?
The aim of the study is to find out more about how mentors and students interact with each-other in pre-registration nurse education.

Do I have to take part?
It is your choice whether you decide to take part in this study or not, you are absolutely under no obligation to participate. If you do decide to participate you will be given this information sheet to keep and be asked to sign a consent form.

What will my involvement be?
You will be asked to participate in an interview which will take approximately 1 hour. The interview will be recorded with a digital voice recorder.

How will my taking part in this study be kept confidential?
Any identifying details will be removed when the interview is written up, e.g. names, physical descriptions. Your name and place of work/year of study will not appear on any documentation relating to the study or any publications that arise out of it.

What will happen to the data collected within this study?
The data collected in this study will be analysed as part of the process of answering the research question. Some direct quotes may be used to support the written commentary about the findings but the individual sources of these will not be identified. All data will be stored on a laptop with password access, backed-up on a password secure cloud drive and deleted at the end of the study period. No personal data will be shared with anyone else at any time.

What are the possible disadvantages or risks of taking part?
No disadvantages or risks are anticipated but should you feel any concern or distress during the interview you will be offered appropriate support at the time of the interview as well as follow-up support should it be required.

What are the possible benefits of taking part?
Understanding how people work together in pre-registration nursing is an important part of promoting positive professional behaviours. The benefit for you as a mentor will be more constructive and enjoyable learning relationships with your students.

What will happen to the results of the research study?
The anonymised findings will be used to facilitate discussions about preventing and managing incivility. There is also the potential for wider dissemination through publication and conference presentation.

Who has reviewed this study?
This study forms part of a doctoral programme of study which is run at the University of Hertfordshire. It has ethical approval from the Social Sciences, Art and Humanities Research Institute (Ethics Number: cEDU/PG/UH/00816 (1)) and permission to carry out the study in the trust has been granted from the Assistant Director of Nursing, Carolyn Fowler.

Who can I contact if I have any questions?
If you would like further information or would like to discuss any details, please get in touch with me by email: j.c.vuolo@herts.ac.uk or by phone on 01707 286428.
If you have any concerns about the nature or conduct of this study please feel free to contact my research supervisor Dr. Diane Duncan at dm.duncan@ntlworld.com to discuss.
Although I hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix L Participant Information Nurse Tutors

PARTICIPANT INFORMATION SHEET – NURSE TUTORS

Approved under UH Protocol of Studies Involving the Use of Human Participants UPR RE01

Title of Research

Incivility in pre-registration nurse education: exploring the perceptions of nurse teachers, student nurses and nurse mentors.

Introduction
I would like to invite you to take part in a research study but before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask for any further information you need to help you make your decision.
Thank you for your time,
Julie Vuolo, Doctoral Research Student/Associate Dean of School (Learning and Teaching).

What is the aim of this study?
The aim of the study is to find out more about how teachers and students interact with each-other in pre-registration nurse education.

Do I have to take part?
You are absolutely under no obligation to participate. If you do decide to, you will be given this information sheet to keep and asked to sign a consent form. Please be reassured that your choice to participate or not will not impact in anyway on your role within the school or the work that you do. The same applies if you decide to participate initially but choose to withdraw at a later stage.

What will my involvement be?
You will be asked to participate in an interview which will take approximately 1 hour. The interview will be recorded with a digital voice recorder.

How will my taking part in this study be kept confidential?
Any identifying details will be removed when the interview is written up, e.g. names, physical descriptions. Your name and place of work/year of study will not appear on any documentation relating to the study or any publications that arise out of it.

What will happen to the data collected within this study?
The data collected in this study will be analysed as part of the process of answering the research question. Some direct quotes may be used to support the written commentary about the findings but the individual sources of these will not be identified. All data will be stored on a laptop with password access, backed-up on a password secure cloud drive and deleted when the study is completed. No personal data will be shared with anyone else at any time.

What are the possible disadvantages, risks or side effects of taking part?
No disadvantages or risks are anticipated but should you feel any concern or distress during the interview you will be offered appropriate support at the time of the interview as well as follow-up support should it be required.

What are the possible benefits of taking part?
Understanding how people work together in pre-registration nursing is an important part of promoting positive professional behaviours. The benefit for you as a teacher will be more constructive and enjoyable learning relationships with your students.

What will happen to the results of the research study?
The anonymised findings will be used to facilitate discussions about preventing and managing incivility. There is also the potential for wider dissemination through publication and conference presentation.

Who has reviewed this study?
This study forms part of a doctoral programme of study which is run at the University of Hertfordshire. It has ethical approval from the Social Sciences, Art and Humanities Research Institute (Ethics Number: cEDU/PG/UH/00816 (1)) and permission to carry it out has been granted by the Head of Department, Adult Nursing and Primary Care.

Who can I contact if I have any questions?
If you would like further information or would like to discuss any details, please get in touch with me by email: j.c.vuolo@herts.ac.uk or by phone on 01707 286428.
If you have any concerns about the nature or conduct of this study please feel free to contact my research supervisor Dr. Diane Duncan at dm.duncan@ntlworld.com to discuss.
Although I hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix M   Participant Information Student Nurses

Title of Research

Incivility in pre-registration nurse education: exploring the perceptions of nurse teachers, student nurses and nurse mentors.

Introduction

I would like to invite you to take part in a research study but before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask for any further information you need to help you make your decision.
Thank you for your time,
Julie Vuolo, Doctoral Research Student/Associate Dean of School (Learning and Teaching).

What is the aim of this study?

The aim of the study is to find out more about how students and teachers interact with each-other in pre-registration nurse education.

Do I have to take part?

You are absolutely under no obligation to participate. If you do decide to, you will be given this information sheet to keep and asked to sign a consent form. Please be reassured that your choice to participate or not will not impact in anyway on your position as a student or on your academic progress. The same applies if you decide to participate initially but choose to withdraw at a later stage.

What will my involvement be?

You will be asked to participate in an interview which will take approximately 1 hour. The interview will be recorded with a digital voice recorder.

How will my taking part in this study be kept confidential?

Any identifying details will be removed when the interview is written up, e.g. names, physical descriptions. Your name and place of work/year of study will not appear on any documentation relating to the study or any publications that arise out of it.

What will happen to the data collected within this study?

The data collected in this study will be analysed as part of the process of answering the research question. Some direct quotes may be used to support the written commentary about the findings but the individual sources of these will not be identified. All data will be stored on a laptop with password access, backed-up on a password secure cloud drive and deleted when the study is completed. No personal data will be shared with anyone else at any time.

What are the possible disadvantages, risks or side effects of taking part?

No disadvantages or risks are anticipated but should you feel any concern or distress during the interview you will be offered appropriate support at the time of the interview as well as follow-up support should it be required.

What are the possible benefits of taking part?
Understanding how people work together in pre-registration nursing is an important part of promoting positive professional behaviours. The benefit for students will be more constructive and enjoyable learning relationships with nurse teachers and mentors.

What will happen to the results of the research study?
The anonymised findings will be used to facilitate discussions about preventing and managing incivility. There is also the potential for wider dissemination through publication and conference presentation.

Who has reviewed this study?
This study forms part of a doctoral programme of study which is run at the University of Hertfordshire. It has ethical approval from the Social Sciences, Art and Humanities Research Institute (Ethics Number: cEDU/PG/UH/00816 (1)) and permission to carry it out has been granted by the Head of Department, Adult Nursing and Primary Care and the Programme Tutor, Pre-registration Nursing.

Who can I contact if I have any questions?
If you would like further information or would like to discuss any details, please get in touch with me by email: j.c.vuolo@herts.ac.uk or by phone on 01707 286428.

If you have any concerns about the nature or conduct of this study please feel free to contact my research supervisor Dr. Diane Duncan at dm.duncan@ntlworld.com to discuss.
Although I hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.