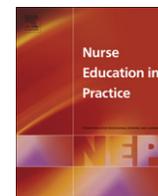


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Incivility in the practice environment: A perspective from clinical nursing teachers

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ABSTRACT

This paper advances a notion of incivility as a precursor to a continuum of antisocial acts culminating in bullying behaviour. Clinical teachers (CTs), working with undergraduate nursing students in a variety of clinical settings from a large urban centre, were studied. Using a mixed method design, CTs were asked to define and describe the nature, type and frequency of uncivil encounters. Data was collected across four practice settings, which included, acute care, maternal child, community and mental health. To unpack the complex nature of incivility we applied a conceptual model based on bullying behaviour which permitted us to analyze CTs narratives for both form (i.e., direct vs. indirect incivility) and function (i.e., reactive vs. proactive). The results suggest that indirect incivility was the most prevalent subtype narrative reported. One of the implications of this study is that nurse educators can help new clinical students recognize the different subtypes of in/civility in the practice environment as an essential first step before targeted intervention programs can be developed and implemented to create civil learning and safer working environments.

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Background and study purpose

Research on incivility specific to practice education is limited and the impact that this may have on student learning and the work satisfaction of clinical teachers is rather sparse. Nurses are seen as moral agents (Benner et al., 2010) and they exercise their moral autonomy through actions, words or by silence as they participate in civil or uncivil interactions. The purpose of this study was to examine the rich and dynamic nature of civility and incivility in clinical teaching environments using narratives from clinical teachers (CTs). Three specific objectives were pursued: (1) develop a conceptual framework (i.e., The Multidimensional In/Civility Identification Model (MIIM)) (Hunt and Marini, 2010) to capture the complex and multi-layered aspects of in/civility (the term in/civility is used to capture the continuum from civility to incivility), in the context of clinical nursing education, (2) collect in/civility narratives from CT, and (3) evaluate these narratives using the MIIM to investigate the frequency and distribution of the four different subtypes of incivility (i.e., direct vs. indirect and reactive vs. proactive), across areas of practice.

Literature review

While it may seem somewhat paradoxical to study incivility in a profession long regarded as the epitome of caring, nursing has not escaped the increasing presence and contagious effect of incivility in society (Lashley and De Menesses, 2001; Luparell, 2004; Clark, 2008; Felbinger, 2008; Cleary et al., 2010; Anthony and Yastik, 2011). According to Andersson and Pearson (1999), the term “incivility” encompasses low-intensity behaviour that lacks a clear intent to harm, but nevertheless violates social norms and can cause harm. Feldmann (2001), proposed that incivility in academic settings is evidenced by actions that impede the development of a “harmonious and cooperative learning atmosphere” (pg. 137).

Employees who experience uncivil behaviour report greater job stress and dissatisfaction, greater psychological distress and substance abuse (Cortina, 2008), headaches, eating disorders, depression and suicide have also been cited as the costs of incivility (Hastie, 2002; Dunn, 2003; McKenna et al., 2003; Randle, 2003; MacIntosh, 2005). Incivility impacts on inter-professional team function through disruption of relationships and poor cooperation, grievances, and diversion of management time (Forte, 1997; Slaikeu and Hasson, 1998; Cortina, 2008; Pearson, & Porath, 2004). The costs of incivility have recently been demonstrated revealing 66% of employees admitted to a decline in work performance, 78% stated

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a decrease in work commitment and 80% lost time worrying about the incident (Porath and Pearson, 2009).

Health care environments may be more susceptible to incivility due to stressful conditions, constant changes, challenging and difficult work, large number of staff, and diversity of interactions. In several studies, nurses working in acute care settings have indicated that conflict is occurring more frequently in their current work environment than in the past (Hesketh et al., 2003; Rolleman, 2001; Warner, 2001). Nurses who have less than satisfactory relationships with their coworkers are more likely to leave their jobs (Lambert et al., 2004). Workplace relationships that consist of conflict, rather than collaboration and support, leave nurses feeling angry, betrayed, frustrated and dismayed (Bishop, 2004). With the ageing nursing workforce and nursing shortage, creating work environments emphasizing civility will retain nurses in practice as well as in clinical education. In order to develop strategies that will reduce incivility, research is needed to define more thoroughly the concept of incivility in nursing work environments.

Clark (2008) characterized the ebb and flow of incivility between nursing faculty and students as a dance; “one dancer leads the other follows and sometimes the dancers do both”. She uncovered themes of stress, negative attitudes, lack of effective communication and intentional disengagement all contribute to the dance of incivility. Unlike Clark, the metaphor emerging from Luparell’s study (2004) was a ‘battlefield’, most frequently triggered by student failure or student perception of negative feedback. Others have analyzed student reports of incivility and found them to be disruptive (Clark and Springer, 2010; Beck, 2009; Marchiondo et al., 2010; Rieck and Crouch, 2007).

While these studies provide evidence that incivility has a range of negative impacts on students as well as faculty, there is limited evidence of investigations on incivility specific to the clinical environment from the perspective of clinical teachers who in many nursing programs represent by far the largest number of teaching faculty.

Linking incivility to bullying

Most research on maladjustment has focused predominantly on serious antisocial behaviours of great intensity, such as aggression, harassment and bullying, and less on low-level interpersonal stressors such as incivility (Lim et al., 2008; Eggertson, 2011). For a long time, incivility has been regarded as a “low-intensity deviant behaviour with ambiguous intent to harm the target and that uncivil behaviours are characteristically rude and discourteous, displaying a lack of regard for others” (Andersson and Pearson, 1999; p. 457). This type of attitude has led researchers to give less credence to the impact incivility may have. Bullying on the other hand is a subtype of aggression where social, academic and learning relationships can become coercive and unhealthy, and therefore it has received a great deal of research attention (Marini et al., 2006; Marini et al., 2010a,b; Pepler et al., 2008).

Marini (2007) has suggested that there are similar antisocial roots between bullying and incivility, and therefore investigation of the extensive bullying literature may be helpful to examine the nature of incivility. In other words, typical behaviours exhibited in classroom incivility spring from similar cognitive and emotional structures as those involved in bullying, which is, a fundamental failure to connect and relate to other people to form healthy social and academic relationships (Marini et al., 2006, 2010a,b; Pepler et al., 2008). The building of a conceptual bridge between incivility and bullying has involved substantive and detailed comparisons related to the “form” (i.e., direct vs. indirect) and “function” (i.e., reactive vs. proactive) of the two behaviours. For instance, our understanding of incivility has been considerably enhanced by

making a sharper distinction between subtypes of incivility along the form and function dimensions. Focussing on the form explains “how” acts of incivility may be committed, namely overtly (i.e., directly) or covertly (i.e., indirectly or relationally). Focussing on the function, explains “why” acts of incivility may be committed, namely as a result of reactions to a “perceived” provocation (i.e., reactive) as opposed to planned and intentional actions (i.e., proactive). Another way of characterizing the distinction in function is that incivility could be the result of lack of self-control (or impulsivity) where students may over react to a comment that one does not agree with, to those unsettling acts of incivility that tend to be planned and intentionally aimed at acquiring either goods and/or status, generally referred to as instrumental aggression (Marini, 2009; Marini et al., 2010a,b). Linking incivility and bullying conceptually and viewing some types of incivility as a precursor to bullying may offer greater insights into the dynamics of the practice environment, but also offer potential opportunities to intervene at an earlier stage.

The development of the Multidimensional In/Civility Identification Model (MIIM)

The MIIM was adapted from previous work and developed for the present study to be a visual representation of its bullying equivalent (Marini, 2009; Marini et al., 2010a,b) see Fig. 1. The MIIM model was used as a guide in analyzing the narrative data to identify and pictorially display the four subtypes of in/civility. By focussing on the major dimensions of form and function, the descriptors of in/civility could be unpacked according to where they may lie along the two continua (along the form (i.e., direct vs. indirect) and along the orthogonal axis of function (i.e., reactive vs. proactive)). On the dimension of form direct incivility may occur in the open with no effort made to conceal them. From the bullying literature, we know that these instances are about overt events in which both parties – the instigator and the target are present. In contrast, indirect incivility is about covert acts; where one party – the target is usually not present. An example may be spreading rumours. On the dimension of function, reactive incivility occurs when an event is perceived as a provocation and the person involved reacts by unreflectively retaliating. In contrast, proactive incivility is represented when the perpetrator’s aim is to intentionally acquire some resources such as goods (for example, steal class notes) or social status. These four quadrants have the potential to capture the complexity and the interaction between form and function of incivility, and it is illustrated in Fig. 1.

Method

Data was collected during lunch break of an onsite CT program orientation. As incivility has not been widely studied in nursing

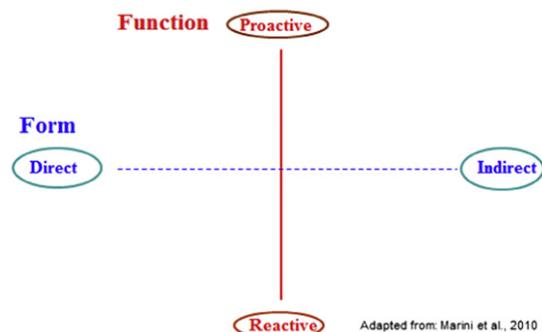


Fig. 1. Multidimensional In/Civility Identification Model.

practice (Hunt and Marini, 2010), a mixed methods approach was selected. We reasoned that this approach would permit us to capture the frequency of the behaviours as well as the richness of the responses (Creswell, 2003). Participants were asked to complete an expanded and revised survey instrument called the Perceptions on Incivility Survey (PICS) in order to describe and assess participants' experiences with incivility in the practice environment. The original instrument assessed the direct and indirect forms of incivility and the Cronbach's alpha of each subscale were .72 and .86 respectively (Marini et al., 2010a,b). Our survey combined existing questionnaires and new elements as no instrument specific to CTs perceptions of in/civility in the clinical practice environment has been reported in the literature. The revised survey was piloted by two senior nursing professors with teaching experience.

The quantitative measures on the PICS provided cross-sectional data on respondents' demographic information such as, age, gender, area of practice, years of experience, and the frequency of incivility events experienced in their practice environments per week. Quantitative measures were analyzed using SPSS. Qualitative data collected on the PICS included definitions of civility (e.g., "How would you define incivility and civility in nursing practice?") and personal narratives on incivility (e.g., "Please think back to a time in your nursing practice whereby you encountered a situation that caused you to ponder about incivility in nursing practice"). The qualitative narrative data was coded using Fig. 1 as a guide. Consensus with the two investigators using the MIIM was 95%. Disagreement on 5% of the narratives by type of incivility was resolved by discussion between the two investigators.

Results

Thirty seven clinical teachers completed the survey, resulting in a 71% response rate, Two male and 35 female respondents, ranging in age from 25 to 69 years, with a span of nursing experience from 3 to 47 years. The majority of the participants reported their area of practice as acute care (51%), followed by maternal/child (30%), and community/public/mental health (19%). Responses from public/community/mental health were aggregated as the number of responses in these areas were low.

Table 1 suggests that the CTs who reported their main area of practice as maternal/child health were the youngest study participants, with a mean age of 34, and also had the fewest years of nursing experience with a mean of 10.3 years. They reported the lowest mean number of uncivil acts at 1.5/week, compared to acute care CTs at 5.4/week, and community/public/mental health practice at 3.6/week. All study participants wrote a story about an experience with incivility.

Participant responses to the open ended question "How would you define incivility and civility in nursing practice?" captured experiences that support the in/civility continuum. Examples of key words used to define civility by practice area of CTs included "calm and safe" (acute care), "sharing information" (maternal/child health) and "kindness and dignity" (community/public/mental health). Incivility was described as "hurtful and disruptive" (acute care), "opinion of others not heard" (maternal/child health) and "impolite" (community/public/mental health).

Table 1
Clinical teacher responses by age, practice and frequency of incivility.

	Acute care	Maternal child health	Community/Public and mental health	Total study population
Study participants (% of total)	19 (51%)	11 (30%)	7 (19%)	37 (100%)
Mean age (range)	44.3 (27–63)	34 (25–53)	48 (35–69)	42 (25–69)
Mean years of nursing experience	15 (3–30)	10.3 (2–30)	18 (3–47)	14.2 (2–47)
Mean number of uncivil acts/week	5.4 (1–15)	2.5 (1–5)	3.6 (1–10)	4.2 (1–15)

Fig. 2 illustrates the MIIM coded results by percentages of incivility narratives across the four subtypes. Direct incivility occurs when both parties (target and instigator) are present and interacting. An example of a direct incivility narrative reported by a study participant was "a senior staff belittling new hires in front of the patient so that the patient no longer had faith in the new nurse". An example of a narrative in the category of indirect incivility (usually the target is absent) reported by a CT was, "a group of nurses discussed how disliked another nurse or her leadership style. It made me uneasy to hear that nurses could not address their issues face to face and instead used gossip as a means of venting". Indirect incivility was the most prevalent subtype of narrative reported.

In terms related to function, the reactive subtype of incivility was the highest reported among the narratives collected. In this category one is retaliating as one feels they have been provoked or offended. An example of reactive incivility reported by a CT was, "a nurse yelling at a client who was questioning her care and advocating for themselves. The nurses thought the client was questioning her standards of practice and the nurse became very defensive by yelling". The final category was proactive incivility and we observed the fewest responses in this category. With this category of incivility the narrative has a tone of power assertion, intentionality and an edge to acquire both physical and social resources by getting a leg up on someone. One example of a narrative fitting the proactive incivility category was; "Incivility was shown when two nurses spoke in a language not understood by the client and then proceeded to laugh and stare at him."

Discussion

Investigating incivility in a nursing practice environment has many challenges. While the MIIM classification used in our study was meaningful, and relatively easy to code by forms (i.e., direct & indirect) and functions (i.e., proactive & reactive) there remains ambiguity in appraising incivility in this type of dynamic environment. For example, it may not be clear from the instigator, target or observers that the instigator has harmful or malicious objectives. Cortina and Maley (2009), identified several key determinants of the appraisal of workplace incivility including target characteristics, incivility characteristics, and coping characteristics. They found appraisals depended on the variety and frequency of uncivil behaviour and few employees bring workplace incivility to the attention of management feeling it may be too minor, and as such, incivility goes unreported and uncorrected (Cortina and Maley, 2009).

All CTs in our study reported experiencing some forms of incivility. These high rates are similar to self-reports from nurses of workplace incivility in other geographical locations, 85% in a nursing department (Smokler Lewis and Malecha, 2011) and 75% in a non-nursing work environment (Cortina, 2008).

In this study acute care CTs, reported the highest incidence of incivility with a mean of 5.4 episodes per week, compared to maternal and child CTs reporting a mean of 2.5 episodes per week. This is similar to the research reported in another study investigating incivility across different practice area. Smokler Lewis and Malecha (2011) found that the workplace incivility varied by

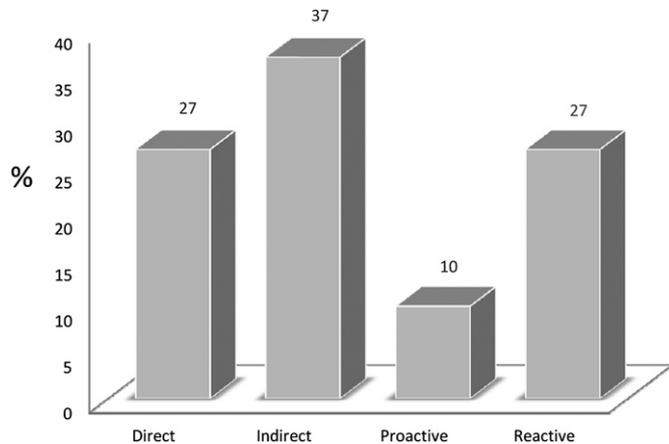


Fig. 2. Percentage of incivility narratives by form and function.

practice area (acute care compared to general medical). Even the definitions provided by acute care CTs reflect a much more serious and “weighty” perception of incivility “hurtful and disruptive” whereas maternal child nurses characterized work place incivility as ‘opinions of other not heard’.

Bad events have been shown to influence people more strongly than do positive events (Baumeister et al., 2001). Incivility has been linked to new graduate burnout (Laschinger et al., 2009). Since clinical placements provide a long established venue to learn and practice nursing, even lessons in incivility as experienced by CTs can be a valuable resource for nursing education. As educators, the goal for sharing stories of incivility is to help students recognize the different subtypes of incivility in the practice environment. Recognizing incivility is an essential first step before targeted intervention programs can be developed. As already mentioned, nurses are seen as moral agents (Benner et al., 2010) and they exercise their moral autonomy through actions, words or by silence to participate in civil or uncivil interactions. Recognizing incivility can help guide students in the development of moral receptivity (Peter, 2011) to become moral agents. Acting as moral agents nurses can be powerful professionals in bringing positive change to the health care system (Peter, 2011). Just as important, and perhaps more so, is the fact that by setting the tone of civility in a practice environment it may go a long way in preventing acts of incivility from escalating into full blown antisocial behaviours.

Conclusion, limitations, and future research

Our research has provided a window for CTs to share their personal stories of incivility. Incivility during the critical socialization period related to the education of nursing students may have a negative effect on student learning and performance (Lashley and De Menesses, 2001; Forni et al., 2003; Luparell, 2004; Clark, 2008; Felbinger, 2008; Cleary et al., 2010; Anthony and Yastik, 2011). Student dissatisfaction in nursing may in part be a result of incivility in the practice environment as many programs spend over half of the curriculum in the practice setting. Interventions need to be targeted to the different subtypes of incivility in order to maximize the potential for effective prevention and management (Marini et al., 2010a,b).

There are several limitations to this study. Unequal representation across a variety of practice areas was noted. The inherent limitations of self reported data among a small sample set from one educational institution may limit generalizability and so a broader sample is required for future research, as well as giving voice to others appraisal of incivility in the work place, such as the students.

Future translation of the CTs stories to co-create realistic teaching vignettes will enrich nursing curricula to take a proactive approach towards understanding the many subtypes of incivility and how to recognize it, and ultimately intervene.

Further research involving the MIIM to explore the relationship between in/civility and health care team functioning and inter-professional collaboration will be useful.

Research focussing on specific interventions for subtypes of incivility will help contribute to creating a civil learning and a safer working community. Our research questions could be enriched by inviting participants to not only ponder on past experiences of in/civility but include what the CTs did after the incivility encounter.

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References

- Andersson, L., Pearson, C., 1999. Tit for tat? The spiralling effect of incivility in the workplace. *Academy of Management Review* 24, 452–471.
- Anthony, M., Yastik, J., 2011. Nursing student's experiences with incivility in clinical education. *Journal of Nursing Education* 50 (3), 140–144.
- Baumeister, R.F., Bratslavsky, E., Finkenauer, C., Vohs, K.D., 2001. Bad is stronger than good. *Review of General Psychology* 5 (4), 323–370.
- Beck, J., 2009. Deconstructing student perception of incivility in nursing education triad. PhD. Dissertation, Louisiana State University. Retrieved from ETD: Full Text. (Publication No.10312009-095845).
- Benner, P., Surphen, M., Leonard, V., Day, L., 2010. *Educating Nurses. A Call for Radical Transformation*. Jossey-Bass, Stanford, CA.
- Bishop, S.R., 2004. Nurses and conflict: Workplace experiences. M.N. Dissertation, University of Victoria, Canada. Retrieved from Dissertations & theses. Full Text. (Publication No. AAT MR02074).
- Clark, C., 2008. The dance of incivility in nursing education as described by nursing faculty and students. *Advances in Nursing Science* 31 (4), 37–54.
- Clark, C., Springer, P., 2010. Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education* 49 (6), 319–325.
- Cleary, M., Hunt, G., Horsfall, J., 2010. Identifying and addressing bullying in nursing. *Issues in Mental Health Nursing* 31, 331–335.
- Cortina, L.M., 2008. Unseen injustice: incivility as modern discrimination in organizations. *Academy of Management Review* 33 (1), 55–75.
- Cortina, L.M., Magley, V.J., 2009. Patterns and profiles of response to incivility in the workplace. *Journal of Occupational Health Psychology* 14 (3), 272–288.
- Creswell, J., 2003. *Research Design*, Second ed. California Sage Publications, Thousand Oaks.
- Dunn, H., 2003. Horizontal violence among nurses in the operating room. *AORN Journal* 78 (6), 990–997.
- Eggertson, L., 2011. Targeted: the impact of bullying and what needs to be done to eliminate it. *Canadian Nurse* 107 (6), 16–20.
- Felbinger, D., 2008. Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 37, 234–242.
- Feldmann, L.J., 2001. Classroom civility is another of our instructional responsibilities. *College Teaching* 49, 137–140.
- Forni, P.M., Buccino, D.L., Greene, R.E., Freedman, M.N., Stevens, D., Stack, T., 2003. The Baltimore Workplace Civility Study. Retrieved from: <http://www.ubalt.edu/jfi/jfi/reports/civility.PDF>.
- Forté, P.S., 1997. The high cost of conflict. *Nursing Economics* 15, 119–123.
- Hastie, C., 2002. Birth international specialists in birth and midwifery: horizontal violence in the workplace. Retrieved from: <http://www.acegraphics.com.au/articles/hastie02.html>.
- Hesketh, K.L., Duncan, S.M., Estabrooks, C.A., Reimer, M.A., Giovannetti, P., Hyndman, K., Acorn, S., 2003. Workplace violence in Alberta and British Columbia hospitals. *Health Policy* 63, 311–321.
- Hunt, C.L., Marini, Z.A., 2010. June. Sharing stories: understanding the nature of in/civility in nursing education. In: Poster Presentation to the Annual Conference of the Society for Teaching and Learning in Higher Education, Toronto, Ontario.
- Lambert, V., Lambert, C., Ito, M., 2004. Workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health of Japanese hospital nurses. *International Journal of Nursing Studies* 41, 85–97.
- Laschinger, H.K., Finegan, J., Wilk, P., 2009. New graduate burnout: the impact of professional practice environment, workplace incivility and empowerment. *Nursing Economics* 27 (6), 377–383.

- Lashley, F., De Meneses, M., 2001. Student civility in nursing programs: a national survey. *Journal of Professional Nursing* 17 (2), 81–86.
- Lim, S., Cortina, L.M., Magley, V.J., 2008. Personal and workgroup incivility: impact on work and health outcomes. *Journal of Applied Psychology* 93 (1), 95–107.
- Luparell, S., 2004. Faculty encounters with uncivil nursing students: an overview. *Journal of Professional Nursing* 20 (1), 59–67.
- Marchiondo, K., Marchiondo, L., Lasiter, S., 2010. Faculty incivility: effects on program satisfaction of BSN students. *Journal of Nursing Education* 49 (11), 608–614.
- Marini, Z.A., 2007. Understanding and fostering civility in university classrooms: Seminar leaders as agents of civic engagement. Research proposal: Brock Chancellor's Chairs for Teaching Excellence. Unpublished manuscript, Brock University.
- Marini, Z.A., 2009. The thin line between civility and incivility: fostering reflection and self-awareness to create a civil learning community. *Collected Essays on Learning and Teaching* 2, 61–67.
- Marini, Z.A., Dane, A., Bosacki, S., YLC-CURA, 2006. Direct and indirect bully-victims: differential psychosocial risk factors associated with adolescents involved in bullying and victimization. *Aggressive Behavior* 32, 551–569.
- Marini, Z.A., Dane, A., Kennedy, R., 2010a. Multiple pathways to bullying: tailoring educational practices to variations in students' temperament and brain function. In: Ferrari, M., Vuletic, L. (Eds.), *Developmental Interplay of Mind, Brain, and Education: Essays in Honor of Robbie Case*. Springer, New York, pp. 257–291.
- Marini, Z.A., Polihronis, C., Dane, A., Volk, A., 2010b. Towards the development of a civil learning community: differentiating between intentional and unintentional In/Civility. In: Poster Presentation, Society for Teaching and Learning in Higher Education (STLHE) 30th Annual Conference, Toronto, Ontario.
- MacIntosh, J., 2005. Experiences of workplace bullying in a rural area. *Issues in Mental Health Nursing* 26 (9), 893–910.
- McKenna, B., Smith, N., Poole, S., Cloverdale, J., 2003. Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing* 41 (1), 90–96.
- Pearson, C.M., Porath, C.L., 2004. On incivility, its impact, and directions for future research. In: Griffin, R.W., O'Leary-Kelly, A.M. (Eds.), *The Dark Side of Organizational Behaviour*. Jossey-Bass, San Francisco, pp. 403–425.
- Porath, C., Pearson, C., 2009. How toxic colleagues corrode performance. *Harvard Business Review* 87 (4), 24.
- Pepler, D., Jiang, D., Craig, W., Connolly, J., 2008. Developmental trajectories of bullying and associated factors. *Child Development* 79 (2), 325–338.
- Peter, E., 2011. Fostering social justice: the possibilities of a socially connected model of moral agency. *Canadian Journal of Nursing Research* 43 (2), 11–17.
- Randle, J., 2003. Bullying in the nursing profession. *Journal of Advanced Nursing* 43 (4), 395–401.
- Rieck, S., Crouch, L., 2007. Connectiveness and civility in online learning. *Nurse Education in Practice* 7, 425–432.
- Rolleman, R., 2001. The nature of interpersonal and informal conflicts in the West Kootenay Region of the British Columbia Nurses' Union: a general inquiry. M.A. dissertation, Royal Roads University (Canada), Canada. Retrieved from Dissertations & theses. Full Text. (Publication No. AAT MQ62036).
- Slaikue, K.A., Hasson, R.H., 1998. *Controlling the Costs of Conflict*. Jossey-Bass, San Francisco.
- Smokler Lewis, P., Malecha, A., 2011. The impact of workplace incivility on the work environment, manager skill and productivity. *Journal of Nursing Administration* 41 (1), 41–47.
- Warner, I.J., 2001. Nurses' perceptions of workplace conflict: Implications for retention and recruitment. M.A. dissertation, Royal Roads University (Canada), Canada. Retrieved 147 from Dissertations & theses. Full Text. (Publication No. AAT MQ62041).