Nurse Education in Practice 14 (2014) 82–86

Contents lists available at SciVerse ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/nepr

Application of an empowerment model to improve civility in nursing education

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ARTICLE INFO

Article history:
Accepted 17 June 2013

Keywords:
Nursing education
Civility
Empowerment
Incivility

ABSTRACT

Incivility within nursing education presents clear challenges to both students and faculty. The consequences of incivility extend beyond the educational process and into practice, thereby creating an urgent need for a framework that can guide faculty in the efforts to improve and maintain civility in nursing education. This article reviews the complex problem of incivility in nursing education and utilizes evidence in the application of an empowerment model (Worrell et al., 1996) as a framework to set the standard of civility and one that will guide intervention in the unfortunate event that incivility occurs. The strategies that are presented are supported with current evidence and organized within the model components of communication, collegiality, autonomy and accountability.

Introduction

Academic incivility is defined as "rude or disruptive behaviors which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations" (Clark et al., 2009, p. 7). Acts of incivility in education create learning barriers (Clark and Springer, 2007). As educators recognize the changing face of the classroom, incivility in higher education has been highlighted as a growing problem. Nursing education has not been immune to this phenomenon and emerging research suggests incivility not only negatively affects the faculty and students, but also impacts the profession of nursing (Lashley and deMenses, 2001; Randle, 2003; Walrafen et al., 2012). Even more alarming is that academic incivility perpetuates itself into the clinical area, creating peril for patients in healthcare organizations (Rosenstein and O'Daniel, 2005; Wachter, 2004). Various methods for improving civility in nursing education have been suggested (Center, 2010; Clark and Cardoni, 2010; Clark and Kenaley, 2011; Cleary and Horsfall, 2010). This article will apply an empowerment model developed by Worrell et al. (1996) as a framework to address the problem of incivility.

Case example of academic incivility

At the registration table, a smiling faculty member welcomes students to a workshop designed to enhance student learning and engagement with professional practice. The nursing faculty had worked tirelessly to engage high quality speakers and to book an off campus location for the workshop. The relaxing atmosphere, filled with calming color and music, was designed for fun learning. Into this inviting calmness came the sudden disruption of an angry student who confronted the obviously dismayed faculty member about a perceived injustice relating to a grade, which was lower than expected. The embarrassed faculty member asked the student to make an appointment for a later discussion; however, the student held up the, line loudly arguing about the lack of fairness. After finally leaving the registration table, the student proceeded to complain to other faculty members and students about the "unfair" teacher. The original faculty member was no longer at the registration table with a smile; she was now in a bathroom with tears in her eyes. The discord spread throughout the entire group and the professional outcome the faculty had envisioned for this event was not as likely to be achieved.

Research incivility in nursing education

Current research illustrates incivility in nursing education affects both students and faculty and reduces the quality of the experience for all participants. Incidences of uncivil behavior have occurred among student, between faculty and students, and faculty to faculty. The following is review of current evidence that establishes the urgency of the problem.

Student behaviors identified as disruptive in the classroom included challenging professors, dominating class, side conversations, texting and cell phone use, and complaining about assignments in class (Clark, 2008a; Clark et al., 2009; Clark and Springer,

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http://dx.doi.org/10.1016/j.nepr.2013.06.009

2007; Luparell, 2004). Incivility did not just occur in the classroom. Destructive student behaviors also occurred outside of the classroom. For example, instances of uncivil behavior included overt threats or publicly maligning professors and discrediting faculty members' competence (Clark and Springer, 2007; Luparell, 2004).

Clark (2009) found student and faculty members viewed the etiology of uncivil student behaviors in the much the same way. Specifically, both groups identified the multiple roles that nursing students held in addition to being a student resulted in stress leading to increased incidences of incivility. Faculty perception differed in that they viewed a level of "consumer mentality", where some students equated tuition with guaranteed success. Clark (2009) opined that stress and an attitude of entitlement contributed to the prevalence of student incivility in nursing education and could result in psychological and physiological damage to students and faculty.

In contrast, Clark (2008a) reported that students attributed many of the incidences of incivility to faculty behavior (arrogant behavior, making condescending remarks, poor teaching methods, unclear communication, criticizing students in front of peers, and threatening to fail students). Students also voiced anger over unexpected changes (clinical, schedules, syllabi) and other actions that students viewed as capricious decision making (Clark and Springer, 2007). Student reactions to perceived faculty incivility included feeling traumatized, helpless and powerless. Ultimately, students experience emotional distress when they are treated with disrespect by faculty because they felt devalued (Clark, 2008b). A widening circle of distress is cast when incivility begins in the classroom leading to frustration and isolation, thus decreasing students' ability to critically think necessary in the clinical setting (Rowland and Srisukho, 2009).

The effect of incivility on faculty can range from irritation to physical and emotional burnout. The feelings described by educators were illustrated through use of battlefield language, which included words such as "assaulted, attacked, wounded and injured" (Luparell, 2004, p. 63). The fallout of these behaviors was mistrust, anger, and burnout with the eventual resignations of faculty members. These critical incidents caused injury to educators' self-esteem and confidence, resulting in emotional retriggering akin to post-traumatic stress. Faculty members were stunned by the extent of the legal and psychological resources necessary to deal with the follow-through on incidences of incivility (Luparell, 2004).

Notwithstanding clear evidence of instances of incivility between students and faculty, the faculty-student dyad cannot be held solely responsible for uncivil acts in education. Faculty also described incivility generated by fellow faculty persons. Heinrich (2006) described the lack of collegiality between faculty members as "joy-stealing" and opined that this type of disrespect between faculty members may be motivated by insecurity, jealousy, or insensitivity that resulted in the phenomenon of "eating their young". Allowing incivility to continue within a faculty produces a destructive cycle of negative emotions with loss of confidence and ultimately burnout among the members (Gaza, 2009; Heinrich, 2006; Luparell, 2004). Stressors that caused burnout included large workloads, high faculty turnover, and the lack of qualified educators (Luparell, 2004). Those who are unable to cope with the strain of escalating incivilities among students and other faculty leave the academy for more lucrative administrative and clinical positions (Luparell, 2004). This cycle of abuse threatens the entire profession. Qualified nursing educators are an essential part of maintaining a qualified pool of nurses. Incivility in nursing education puts the profession at risk for greater shortages if there are not enough qualified nursing faculty members.

Another particularly troubling consequence of academic incivility is the perpetuation of uncivil behaviors into the clinical area. Randle (2003) found that nurses who experienced regular verbal abuse were stressed, missed work, and/or delivered substandard care. Sadly, incivility in the form of bullying was reported as common during the transition from student to nurse. Even more alarming was the report of patients being bullied by qualified nurses (Randle, 2003). These disturbing findings illustrated how a cycle of violence beginning in academia may continue well into practice. Students who experience incivility while trying to internalize nursing norms, can misinterpret the uncivil behavior as normal (Lashley and deMenses, 2001; Randle, 2003). This begins a damaging sequence that threatens nurses and patients (Rosenstein and O'Daniel, 2005; Wachter, 2004). Not only does the incivility amongst team members serve as a direct threat to patient safety, continued hostility in the workplace creates nursing turnover (Walrafen et al., 2012), which in turn further compounds the threat to patient well-being (Lashley and deMenses 2001; Randle, 2003).

The need to address this problem is immediate. Nurses at all levels within the profession must insist on civility in all professional interaction. Civility is defined by Clark and Carnasso (2008) as "an authentic respect for others when expressing disagreement, disparity, or controversy. It involves time, presence, a willingness to engage in genuine discourse, and a sincere intention to seek common ground" (p. 13). Civility is a foundational aspect for professionalism (Rowland and Srisukho, 2009) and is described in the American Nurses' Association's Code of Ethics (ANA) provision 1.5 (2005).

The next section of this article seeks to assimilate the work of others (Center, 2010; Clark and Cardoni, 2010; Clark and Kenaley, 2011; Cleary and Horsfall, 2010; Espeland and Shanta, 2001; McCarthy and Freeman, 2008; Worrell et al., 1996) in order to provide a plan to address incivility in nursing education. Nurse educators are charged with the responsibility of creating an educational experience through which students not only learn the psychomotor skills for patient care, but also the affective competencies necessary for working as a part of a healthcare team. The American Nurses Associations' Code of Ethics for Nurses (2001) states, "Nurse educators have a responsibility to…promote a commitment to professional practice prior to entry of an individual into practice" (p. 13).

Empowerment

Empowerment has been described as both a process and an outcome (McCarthy and Freeman, 2008). Hokanson–Hawks (1992, p. 610) defined empowerment as "the interpersonal process of providing the resource, tools, and environment to develop, build, and increase ability and effectiveness of others to set and reach goals for individual and social ends". This definition aligns with Kanter's theory of structural empowerment, which relates to provision of resources, support and opportunities for learning to accomplish personal and professional goals (Faulkner and Laschinger, 2008). As an outcome, empowerment has been defined as possessing elements of self-efficacy, competency, autonomy and having meaning in ones' existence (McCarthy and Freeman, 2008; Spreitzer, 1995).

In a model presented by Worrell et al. (1996), empowerment in a RN-BSN program was depicted as both process and outcome. Espeland and Shanta (2001) utilized the components of this model for a framework that faculty could use to empower students' development of clinical judgment and advocacy for their patients. This article will utilize the same framework as an evidence-based guide to prevent and address incivility in nursing education (refer to Table 1).

Applying the empowerment model as a framework to promote civility

In the following discussion, the model components are separated to illustrate the influence of each in maintaining civility in