

Teaching Civility to Undergraduate Nurses

Using a Virtue Ethics-based Curriculum

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### Abstract

As professionals, nurses are expected to engage in respectful relationships with clients, other healthcare professionals, and each other. Regulatory bodies set standards for professional behaviour in nursing that clearly communicate expectations for civility. However, the wealth of literature on civility indicates that nurses often fall short of meeting these standards in their interactions with other nurses. For nurse educators, there are currently few effective strategies for teaching civility to nursing students to prepare them to engage in healthy relationships with their coworkers. In this paper, I argue for using virtue ethics as a philosophical framework for teaching civility to undergraduate nursing students. The pedagogical strategies that I propose may help students contribute to the development of quality workplaces.

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## Introduction

Imagine an excited and nervous group of nursing students on the first day of class. Many have only a rudimentary understanding of what nurses actually do, and yet here they gather, ready to begin the journey from lay person to skilled expert in one of the most demanding professions in the working world. By the time these students become registered nurses, they will need to be prepared to work in increasingly chaotic environments and to adapt to rapidly changing technologies. What motivates these individuals to take on this extraordinary challenge? Researchers have found strong evidence to suggest that the choice of nursing as a career is primarily related to the desire to do good work and to engage in helping relationships (Eley, Eley, Bertello, & Rogers-Clark, 2012; Eley, Eley, & Rogers-Clark, 2010; Thorpe & Loo, 2003). While some authors claim that nursing as a career is an increasingly pragmatic choice (Day, 2005; Price, 2011), fewer than 5% of students in the study by Sand-Jecklin and Schaffer (2006) identified salary or career advancement as a motivation for entering the profession. Altruistic values are deeply embedded in the collective consciousness of nurses and are reflected in professional standards and codes of ethics, which make explicit the primacy of caring in all of nurses' healthcare relationships. In British Columbia, the College of Registered Nurses of British Columbia (CRNBC) *Professional Standards* (2012) and *The Code of Ethics for Registered Nurses* (Canadian Nursing Association, 2008) clearly articulate nurses' responsibility to treat patients, other healthcare workers, students, and each other with respect. When nurses meet these professional expectations in their interactions with one another, a civil workplace is the likely result, with civility defined as "an authentic respect for others when expressing disagreement, disparity, or controversy" (Clark & Carnosso, 2008, p. 13).

Given that individuals entering the nursing profession have a strong predisposition to caring, it comes as an unpleasant surprise that many nursing workplaces are plagued by unhealthy relationships between nurses. Despite explicit professional expectations for caring behaviour, uncivil interactions between nurses are a persistent feature of nursing culture (Eggerstone, 2011; Griffin, 2004; Johnson, 2009; Randall, 2003). Troubled relationships among nurses have been reported both anecdotally (Bartholomew, 2006) and in the nursing literature for decades (Meissner, 1986). The devastating effects on nurses of uncivil intraprofessional behaviour are well documented and include low self-esteem, anxiety, and depression (Embree & White, 2010). New graduates are particularly vulnerable to these effects (Laschinger, Grau, Finegan, & Wilk, 2010), with up to 60% of new graduates leaving their initial places of employment within the first year as a result of the uncivil behaviour of other nurses (Griffin, 2004). In addition to this toll on individual nurses, incivility between nurses affects organizations, resulting in low workplace morale and decreased employee retention (Embree & White). Ultimately, uncivil relationships among nurses are known to have a direct impact on patient care and patient safety (Embree & White; The Joint Commission, 2008; Vessey, Demarco, & DiFazio, 2010).

In this way, it appears that some nurses may not be meeting expected ethical standards in their relationships with other nurses. It is also evident that the reasons for this troubling disconnect are extremely complex, resulting from a range of institutional, hierarchical, and personal factors. Incivility among nurses has been the focus of increasing attention by nurse scholars and healthcare administrators aiming to improve workplace quality. Current strategies to combat incivility among nurses include implementing strict zero tolerance policies with regard to uncivil behaviour, educating staff about incivility, and teaching nurses effective

communication techniques. What is less clearly understood is the role of undergraduate nursing programs in preparing student nurses to meet professional expectations in their relationships with other nurses, both as students and upon graduation. For nurse educators, there is a need for effective pedagogical strategies for teaching student nurses how to engage in healthy relationships with their coworkers, even under challenging circumstances. In this paper, I argue that virtue ethics provides an appropriate philosophical framework for developing just such a curriculum.

I begin by exploring professional standards and codes of ethics as they relate to expectations for professional relationships between nurses. I then review the literature on the extent of incivility between nurses, explain the theory behind the origins of this behaviour, and describe the impact of incivility on nurses and organizations. I identify the gap between professional expectations and present conditions in the nursing workplace and look at current approaches to addressing this gap. I propose a solution to this issue that is grounded in virtue ethics by exploring the place of character development in professional education, and then looking at the state of virtue ethics in nursing education. Finally, I illustrate how nursing students could be supported to develop the skills necessary for healthy relationships with other nurses using the methodologies put forward in the literature on virtue ethics. I then provide an example of how these strategies could be incorporated into an existing curricular framework. With virtue ethics as a philosophical foundation, and by using pedagogical strategies consistent with this philosophy, nurse educators can teach undergraduate nursing students to engage in ethical, professional relationships with other nurses.

### **Professional Expectations for Interactions between Nurses**

In this section, I examine the attributes of a profession and make the assumption that nursing is a profession. I then discuss the documents that reflect the expectations for professionalism in nursing (Canadian Nursing Association, 2008; College of Registered Nurses of British Columbia, 2012; International Council of Nurses, 2006). These documents articulate the values important to the profession and outline professional expectations about nurses' relationships with other nurses.

#### **Nursing as a Profession**

What does it mean to be a professional? Crigger and Godfrey (2011) define a profession as “a collective body of persons who profess to practice a calling or vocation that is recognized by certain sociopolitical and legal bodies to enjoy special privileges that include some degree of autonomy, but from whom special obligations are required” (p. xiv). According to Pellegrino (2002), professionals “make a ‘profession’ of a specific kind of activity and conduct to which they commit themselves and to which they can be expected to conform...(requiring) promise, commitment, and dedication to an ideal” (p. 379). A professional recognizes specific obligations and duties to society and is held to a higher moral standard than the general public (Crigger & Godfrey).

The word “professional” is often used to describe virtually any work done for money. It is possible to engage the services of “professional” carpet cleaners, musicians, and wedding planners. Overuse of the term “professional” leads to misunderstanding and lack of clarity about what is required of professionals, even among professionals themselves (Coulehan, 2005). A true profession shares a number of specific characteristics that go beyond the exchange of fee for

service. According to Pellegrino (2002), an occupation may be defined as a profession only when it has a specialized body of knowledge, exists to fill a recognized societal need, is made up of members who collectively determine necessary standards for education and practice, and is practiced within a specific ethical framework. In his extensive work on education in the professions, Sullivan (2005) puts particular emphasis on this ethical dimension of professionalism, claiming that strict loyalty to a code of behaviour separates professionalism from other forms of work. When professionals agree to abide by an explicit ethical code, the decisions they make in their daily practice should be consistent with the values embedded in that code. It is this personal, ethical domain of professionalism that is the particular focus of this paper.

### **Codes and Standards**

Over the past century, the preparation required for work as a registered nurse has undergone a gradual evolution from hospital apprenticeship, through diploma program completion, to post-secondary degree as entry to practice. In the course of this journey, nursing has struggled to gain legitimacy as a true profession. However, based on the criteria for professional status as put forward by Pellegrino (2002), nursing in British Columbia can be considered a profession. Certainly, regulation of nurses by the CRNBC meets the requirement for collective determination of standards for education and practice. The CRNBC professional standards (2012) are “expected and achievable level(s) of performance against which actual performance can be compared” (p. 12). These standards have been developed by nurses to reflect the nursing professional values—namely justice, honesty, courage, trustworthiness, and open-mindedness (Sellman, 2011)—to state clearly what the profession expects of all nurses, and to provide “criteria against which nurses’ practice in British Columbia is measured by clients,

employers, colleagues, themselves and others” (p. 12). With respect to expectations for engaging in appropriate relationships with other nurses, *The Professional Standards for Registered Nurses and Nurse Practitioners* (CRNBC, 2012) clearly state under standard 4: Ethical practice, that nurses must “treat colleagues, students and other health care workers in a respectful manner” (p. 12).

For added guidance and further clarification of acceptable professional behaviour, nurses in British Columbia refer to the Canadian Nursing Association (CNA) *Code of Ethics for Registered Nurses* (2008). The CNA code and supporting documents pay specific attention to how nurses enact all aspects of their daily practice including their interactions with others (CNA, 2008; CNA, 2010). The emphasis on “everyday ethics” (Doane, Storch, & Pauly, 2009) is what makes the CNA code a practical tool for working nurses. Specific ethical responsibilities are described under the broader nursing values. Within the code, nurses will find clearly articulated ethical responsibilities related to obligations for interactions with colleagues (Table 1). These sections were added in 2008 and were not included in the 2002 version of the code (CNA, 2002).

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Table 1

*Excerpts from the CNA Code of Ethics (2008)*

Nursing Values	Ethical Responsibilities
A: Providing safe, compassionate, competent and ethical care	<p><b>1.</b> Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care as well as with families, communities, groups, populations and other members of the <b>health-care team</b>.</p> <p><b>3.</b> Nurses build trustworthy relationships as the foundations of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people’s needs and concerns.</p>

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D: Preserving dignity	<p><b>1.</b> Nurses, in their professional capacity, relate to all persons with respect.</p> <p><b>10.</b> Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way.</p>
F: Promoting Justice	<p><b>2.</b> Nurses refrain from judging, labelling, demeaning, stigmatizing, and humiliating behaviours toward persons receiving care, other health-care professionals and each other.</p>
Part II: Ethical Endeavour	<p><b>xiii.</b> Working collaboratively to develop a moral community. As part of the moral community, all nurses acknowledge their responsibility to contribute to positive, healthy work environments.</p>

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According to the CNA Code of Ethics (2008), a nursing workplace where common values are made explicit and where these values are seen to direct actions can be considered a moral community. A genuine moral community requires an alignment between publicly acknowledged values and the “lived reality” of the workplace (Webster & Baylis, as cited in CNA, 2008, p. 27). These expectations are not limited to nurses in the Western world, nor to those from developed countries. The globally accepted document, *The International Council of Nurses (ICN) Code of Ethics for Nurses* (2006), in outlining standards of ethical conduct for nurses shares similarities with the CNA Code of Ethics. Under the heading “Nurses and Co-Workers”, the ICN code explicitly states that “the nurse sustains a co-operative relationship with co-workers in nursing and other fields” (p. 3).

To be considered a professional, individual nurses must aspire to the behaviour set out by codes and standards because these articulate excellence in nursing practice. For nurses in today's strained healthcare environment, consistently acting in an ethical manner in this regard can be very challenging. In their research, Doane, Storch, and Pauly (2009) describe ethical practice as constantly in flux in response to contextual changes, a "moving picture" (p. 237) that presents unique challenges to nurses attempting to embody ethical professional practice. However, I would argue that expectations related to nurses engaging in positive relationships with other nurses are exempt from this conceptualization of ethics as constantly changing and context dependent. In this specific area of everyday nursing ethics, it seems clear that nurses should embody professional values in their interactions with nursing colleagues, even in challenging and complex circumstances. That is, in the moment of interaction between nurses, what is recognized and acknowledged as professional behaviour is unambiguous, and any rationale that a nurse may use for knowingly engaging in uncivil behaviour simply falls short of these ethical obligations.

### **Incivility among Nurses**

Given that expectations for professional behaviour among nurses are so clearly articulated, it would seem reasonable to expect that the majority of nurses would be able to meet these minimum standards most of the time. While many nurses can and do sustain positive, respectful relationships with their peers, it is clear from the literature that uncivil behaviour among nurses is common place. Decades ago, Meissner (1986) described the behaviour she observed as "nurses eating their young". More recently, there has been evidence that conflict within the profession is of growing concern (Almost, 2006; Woelfle & McCaffrey, 2007). Nurse peers and nurse supervisors are the two most often reported perpetrators of incivility,

significantly ahead of physicians and other healthcare providers (Dumont, Meisinger, Whitacre, & Corbin, 2012; Farrell, 1997). Incivility among nurses is a global issue (Vessey et al., 2010), and is considered by working nurses to be the most common and most upsetting type of workplace aggression (Almost, Doran, McGilliss Hall, & Laschinger, 2010).

### **The Spectrum of Uncivil Behaviours**

In the past few years, the subject of uncivil behaviour between nurses has received a great deal of scholarly attention. A CINAHL search of peer-reviewed academic journals using the terms “nurs\*” and “bullying” or “horizontal violence” generated a staggering 751 results. Uncivil behaviours exist along a spectrum described by Clark and Ahten (2012) as ranging from rude or irritating interactions, to bullying and intimidation, and more rarely to incidents of physical violence or sexual assault. Other terms that have been used to describe uncivil behaviour among nurses include lateral violence, horizontal violence, mobbing, conflict, aggression (Farrell, 1997) and emotional abuse (Almost, 2006). While these terms are often used interchangeably, differences in terminology are also determined by the intent of the perpetrator and pattern of the behaviour, as well as the existence of a power differential between the individuals involved. For example, behaviour is considered to be bullying if there is intent to harm, there is a pattern of ongoing incidents, and the perpetrator is in a position of power over the target. In their work on bullying, harassment, and horizontal violence (BHHV), Vessey, Demarco, and DiFazio (2010) define BHHV as a single construct consisting of “repeated, offensive, abusive, intimidating, or insulting behaviour, abuse of power, or unfair sanctions that makes recipients feel humiliated, vulnerable, or threatened, creating stress and undermining self-confidence” (p. 136), while incivility in the workplace can be defined as “low intensity, deviant behaviour with ambiguous intent to harm...in violation of workplace norms for mutual respect”

(Anderson & Pearson, as cited in Leiter, Price, & Laschinger, 2010, p. 973). For the sake of consistency, in this paper I will use the term incivility to describe any disrespectful behaviour between nurses that exists along this spectrum, with or without the existence of a power differential.

### **What does Incivility Look Like in Practice?**

Within this definition, incivility encompasses any of the disrespectful behaviours mentioned in the literature on poor relationships between nurses. Examples of the most common forms of incivility that nurses report are humiliation in front of others, excessive criticism, gossip, isolation, verbal abuse, sarcasm, and talking behind someone's back (Longo, 2007). Randle (2003) and others provide rather disheartening lists of the most common uncivil behaviours among nurses (Table 2). In their study, Hutchinson, Vickers, Jackson, and Wilkes (2010) identify three types of bullying behaviours: personal attacks, erosion of professional reputation, and attack through work roles, and then catalogue a wide range of specific tactics used by nurses against their coworkers in these areas. Nurses in this study reported that subtle manifestations of bullying had a more harmful impact than blatantly hostile behaviours, and affected witnesses of bullying as well as targets. Unfortunately, many nurses will recognize these behaviours as common place, having either observed or experienced them first hand.

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Table 2

*Examples of Uncivil Behaviours*

Author/Preferred terminology	Examples of Uncivil Behaviours
Long & Sherman, 2007/ "Horizontal Violence"	Nonverbal behaviours: raising eyebrows, making faces in response to comments Verbal remarks: snide, abrupt responses to questions Refusing to give assistance

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	<p>Withholding information</p> <p>Sabotage</p> <p>Group infighting and establishing cliques</p> <p>Scapegoating</p> <p>Failure to resolve conflicts in a direct manner, complaining to others</p> <p>Failure to respect privacy</p> <p>Broken confidences</p>
Farrell, 1997/ "Aggression"	<p>Failing to speak up in another's defence</p> <p>Refusing to speak to another</p> <p>Spreading malicious rumours or gossip</p> <p>Insulting or derogating another person</p> <p>Refusing to perform necessary tasks</p>
Clarke, Kane, Rajacich, & Lafreniere, 2012/ "Bullying behaviours"	<p>Threats of physical violence</p> <p>Intimidation</p> <p>Impossible expectations set</p> <p>Inappropriate jokes</p> <p>Unjust criticism</p> <p>Discrimination by race, gender, or disability</p> <p>Teasing</p> <p>Humiliated in front of others</p> <p>Destructive criticism</p> <p>Ignored, excluded or frozen out by others</p> <p>Told negative remarks about becoming a nurse</p>
Cleary, Hunt, & Horsfall, 2010/ "Bullying"	<p>Being allocated an unmanageable workload</p> <p>Being ignored or excluded</p> <p>Having rumours spread about you</p> <p>Being ordered to carry out work below your competence level</p> <p>Having your professional opinion ignored</p> <p>Having information relevant to your work withheld</p> <p>Being given impossible targets or deadlines</p> <p>Being humiliated or ridiculed about your work</p>
Dumont, Meisinger, Whitacre, & Corbin, 2012/ "Horizontal violence"	<p>Being harshly criticized</p> <p>Belittling in front of others</p> <p>Complaining about someone to others</p> <p>Eye rolling</p> <p>Pretending not to notice someone struggling with workload</p>
Felblinger, 2008/ "Incivility and bullying"	<p>Exclusion from important work activities</p> <p>Taking credit for another's work</p> <p>Refusing to work collaboratively</p> <p>Interrupting others</p> <p>Disrupting meetings</p> <p>Discounting input from others</p> <p>Berating workers on email</p> <p>Failing to share credit for collaborative work</p> <p>Yelling, screaming, verbal attacks</p>

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Emotional tirades, angry outbursts  
Overt temper tantrums  
Gossiping  
Name-calling  
Condescending speech, rudeness  
Spreading rumours  
Inability to empathize  
Damaging a co-worker's reputation

### **The Extent of Incivility among Nurses**

**Acute care.** Since 85% of registered nurses in Canada practice in direct patient care (CNA, 2009), it is not surprising that most of the literature on incivility is concerned with this setting. The relentless pace and high-stakes nature of hospital nursing put a great deal of pressure on working nurses trying to maintain healthy relationships with their colleagues. In acute care, intra-group conflict is shown to increase as complexity of care increases (Almost et al., 2010). The literature suggests that uncivil behavior is endemic, resulting in what Farrell (1997) describes as a “battlefield” in the workplace (p. 504). In a recent study by Dumont et al. (2012), the authors report that 82% of acute care nurses experienced or witnessed at least one incidence of incivility weekly or daily. However, despite the prevalence of this behaviour, in their study of 303 registered nurses Vessey, DeMarco, Gaffney, and Budin (2009) claim that more than half of those affected did not formally report incivility.

**Student/new graduate experiences in acute care.** Unfortunately, new graduates and nursing students are often on the receiving end of incivility from other nurses. Duchscher (2008) claims that new graduates in their first months of practice are particularly vulnerable to incivility as they struggle to fit in to a traditional, hierarchical nursing culture. A recent study by Berry, Gillespie, and Gates (2012) showed that over 70% of novice nurses were the target of bullying in

the past month, with 21% experiencing bullying daily. Vessey et al. (2009) found nurses with less than five years experiences were the most common targets of uncivil behaviour, while another study of 415 new nurses in acute care found that one third had been the subject of bullying by other nurses (Laschinger et al., 2010). New nurses and students are often reluctant to report these incidents. Longo (2007) discovered that while over 50% of nursing students stated they had been put down by a staff nurse, close to half of those students did not report the incident to their instructor. The cycle of incivility continues as students adapt to the culture of the work place. In Randle's (2003) study of undergraduate nursing students, the author found that students were at first distressed by how they were treated by experienced nurses, but then conformed to the norms of the unit by adopting the negative behaviours themselves. Coulehan et al. (2003) confirm that tacit learning takes place as values in opposition to those espoused by the profession—cruelty, disrespect, irritation, and detachment for example—are exhibited in interactions between nurses in practice.

**Nursing education.** While historical references to incivility among nurses tend to focus on acute care, academic settings have recently come under scrutiny as breeding grounds for uncivil behaviour between faculty members (Heinrich, 2010) as well as between students and faculty (Clark, 2008a; Clark, 2008b; Clark, Kane, Rajacich, & Lafrenier, 2012; Del Prato, 2012; Lasiter, Marchiondo, L., & Marchiondo, K., 2012). Kerber et al. (2012) suggest that incivility begins in nursing school and is then transferred to the workplace. Clarke (2008a) identifies an extensive list of examples of incivility in the classroom from the perspectives of both students and faculty. In a study of 674 undergraduate students, 97% of fourth year students reported being bullied by faculty or staff nurses, with verbal abuse being the most common manifestation (Clark et al., 2012). In Del Prato's (2012) qualitative study, students perceived faculty incivility

as falling under four broad categories: verbally abusive and demeaning experiences, favoritism and subjective evaluation, rigid expectations for perfection, and targeting and weeding out.

For nurse educators working to prepare students for the challenges of practice, it may come as a shock that so many students perceive their interactions with faculty as uncivil. It is important to note that student perceptions of incivility can be influenced by many factors including high stress levels, overwork, and competing demands on their time (Clark, 2008a; Clark, 2008c). In a qualitative study by Clark (2008b), students expressed anger over what they perceived as “jumping through hoops” (p.287) to meet the unrealistic demands or whims of faculty. At the same time, faculty fill competing roles as they work to support students while simultaneously acting as stewards for the profession (Clark, 2008a). What students perceive as the arbitrary and rigid expectations of individual instructors may simply reflect minimum standards for entry to nursing practice, standards that are clearly recognized and upheld by faculty as they strive to meet their own professional obligations.

### **Theories Explaining Incivility among Nurses**

In the literature, scholars suggest a number of theoretical perspectives that may shed some light on why incivility is so common among nurses. Farrell (2001) describes how poor relationships among nurses are traditionally explained by considering the impact of macro, meso, and micro influences on nurses' behaviour.

**Macro level: oppressed group behaviour.** Macro level influences are concerned with how nursing is situated as a profession. Nurses have long been categorized as an oppressed group (Farrell, 2001; Hutchinson, Vickers, Jackson, & Wilkes, 2006) both as women who have historically been dominated by men and as nurses working in institutions dominated by a

medical model of care. Oppressed groups direct frustrations toward one another because of a perceived lack of power (Leap, as cited in Freshwater, 2000). However, Freshwater concludes that constantly reinforcing this stance does nothing but perpetuate a “cultural narrative” of nursing as subordinate (p. 483), and encourage a continuing cycle of uncivil behaviour (Longo & Sherman, 2007).

**Meso level: organizational constraints.** In his work on professionalism and medical education, Coulehan (2005) claims that the healthcare workplace is often hostile to traditional professional values. In today’s burdened healthcare environment, a focus on tasks can cause nurses to become distanced from codes of ethics and professional standards and how these ought to be applied to their daily practice. Increasingly ill patients, fewer resources, and higher patient loads can cause nurses to lash out at one another. When stakes are high and support to meet adequate standards for nursing practice are in short supply, stressors such as heavy workload and lack of control of the work environment can cause nurses to enter into a vicious cycle as incivility further exacerbates the impact of work stressors (Gilin Oore et al., 2010).

Institutional characteristics can also contribute to incivility by establishing norms of uncivil behaviour within organizations and by creating systems that allow these norms to remain unchallenged (Rhodes et al., 2010). Hutchinson et al. (2006) claim that organizational processes can allow nurses to disguise abusive behaviours toward other nurses as legitimate institutional practices, concluding that “by continuing to conceptualize workplace bullying as an inherent feature of nursing, we risk passive acceptance that bullying is a feature of nursing, rather than what it is—an abusive and harmful act perpetuated within organizations” (p. 123). In addition, framing the issue of incivility as an individual one can take the focus off of dysfunctional systems that exist within organizations (Hutchinson et al., 2006; Rhodes et al., 2010). Systemic

factors such as leadership style, workplace culture, and change management approaches are challenging to address yet have a profound influence on how individuals interact with one another (Rhodes et al.). Rhodes et al. argue that it is simpler to blame a few unethical individuals for uncivil behaviour than to hold organizations accountable for creating the conditions that allow incivility to flourish.

**Micro level: individual characteristics.** A micro level approach theorizes that certain individual characteristics influence uncivil behaviour (Farrell, 2001). Gender, generational affiliation, and personality traits have all been considered as possible explanations for poor relationships between nurses. Nursing remains a predominantly female profession, and for this reason gender may have some influence on the quality of the nursing workplace. In a recent study by Escartin et al. (2011), women rated relational forms of aggression as more severe than men did. In other words, women tend to perceive the same interactions as being more aggressive than men. A study of undergraduate students by Montgomery, Kane, and Vance (2004) also found the perception of incivility varied with gender, and that women have a greater tendency to identify patterns of incidents rather than perceive them as isolated occurrences. In addition, Vessey et al. (2010) suggest that aggression among females is manifested in social and relational ways rather than overtly, as women may purposefully damage the relational space between people. Bartholomew (2006) claims nurses fail to acknowledge incivility in the profession because it is contrary to the caring image of nursing. Perhaps in a similar way, women use covert aggressive behaviours because it is socially unacceptable for women to openly engage in conflict with one another.

Some authors suggest that generational differences may be in part responsible for the dysfunctional relationships among nurses, blaming the failure of generation Y to take up values

of the profession (Almost, 2006). However, Dumont et al. (2012) found no differences in prevalence of bullying along generational lines. At the same time, in a study of 522 Canadian nurses, Leiter, Price and Laschinger (2010) reported generational differences in the perception of incivility that saw younger nurses experiencing greater levels of uncivil behaviour from other nurses, resulting in increased distress and poorer health. One possible explanation for this disparity may be that younger nurses have higher expectations of their collegial relationships (Almost, 2006). Other authors have identified individual characteristics that may contribute to uncivil behaviour in nurses related to communication style, lack of trust (Almost, 2006), self-esteem (Randle, 2003), beliefs about self, degree of self-efficacy, locus of control (Almost et al., 2010), conflict management style, and stage of development (Vessey et al., 2010).

### **Effects of Incivility**

Incivility results from a complex interaction of all of the above factors (Almost et al., 2010; Farrell, 2001). Uncivil behaviour is commonplace, and even though it is recognized as a “perpetual violations of the code of ethics” (Clark et al., 2012), it is often accepted as just the way things are among nurses. Is incivility really that serious an issue? The literature describes the costs of dysfunctional relationships among nurses at the individual, institutional, and patient levels.

**On individual nurses.** Incivility has an impact on all nurses involved: the target, the perpetrator, and those who witness the behaviour. A study by Almost et al. (2010) demonstrated higher levels of job stress and lower levels of job satisfaction in 277 nurses in acute care settings in Ontario due to uncivil behaviour, while Laschinger et al. (2010) related the problem to higher levels of burnout. Related psychological symptoms include stress, increased substance use,

depression, anxiety, loss of self-esteem, loss of confidence, self-hatred, and feelings of powerlessness (Embree & White, 2010; Vessey et al., 2010), while physical symptoms include increased blood pressure, sleep disturbance, headaches, and anorexia (Vessey et al., 2010). Of all workplace factors, incivility in the form of bullying had the greatest negative effect on psychological well-being in a survey of over four thousand registered nurses in the United Kingdom (Working well, 2006). Other effects on individual nurses reported by Dumont et al. (2012) include fear of retaliation for speaking up, discouragement, and fear of ridicule. New graduates are particularly vulnerable, as poor communication and other uncivil behaviours lead to disaffection and cause them to consider leaving the profession (Dyess & Sherman, 2009; Evans, Boxer, & Sanber, 2008). Additionally, when new nurses are on the receiving end of uncivil treatment by experienced nurses there are profound effects on the ability of these novices to handle their workload (Berry et al., 2012).

**On organizations.** Organizations with high levels of nurse-nurse incivility experience higher turnover rates (Embree & White, 2010; Vessey et al., 2009), low morale, increased sick time, lower productivity, higher job dissatisfaction, and increased medication errors (Olender-Russo, 2009). In a study involving 130 registered nurses, Wilson, Diedrich, Phelps, and Choi (2011) reported that 40% of nurses intended to leave their workplaces and 20% called in sick as a direct result of bullying. Lack of retention is another symptom of the toxic work environments that result from poor relationships among nurses (Embree & White, 2010).

**On patients.** It comes as no surprise that nurses who experience the emotional and physical impact of incivility may not be able to deliver safe care to their patients (McNamara, 2012). As an example, nurses preoccupied with poor work relationships were shown to be less compassionate toward patients (Randall, 2003). Concern over this issue prompted the Joint

Commission (2008) to issue a sentinel alert addressing standards for accreditation related to patient safety that specifically target dysfunctional work environments.

### **Current Strategies for Combatting Incivility**

Incivility is an ingrained problem that is not responsive to quick fixes (Vessey et al., 2010). Current strategies for managing uncivil behaviour in practice fit into two broad categories: policy and education.

**Policy.** Most authors suggest implementing institutional policies that prohibit bullying and other types of incivility (Clark et al., 2012; Eggerstone, 2011; Johnson, 2009; Vesey et al., 2010; Working well, 2006). Policies are important in that they explicitly state what constitutes unacceptable behaviour. Ideally, policies provide support for the targeted individual (Working well) as well as specify disciplinary action for the perpetrator. However, such policies are only effective if enforced and nurses on the receiving end of uncivil behaviour from other nurses are often reluctant to report the abuse. In contrast, non-punitive approaches put forward by Hutchinson (2009) aim to protect the integrity of all parties while addressing negative behaviour. While necessary, policies tend to put the full responsibility on the individual and ignore systemic conditions that allow incivility to happen in the first place. Any policies put in place must also address these issues (Hutchinson, Wilkes, Jackson, & Vickers, 2010; Rhodes et al., 2010).

**Education.** Berry et al. (2012) recommend education of staff nurses to help them understand the impact of uncivil behaviour on new nurses. Other educational strategies focus on developing effective communication techniques. Wilson et al. (2011) recommend teaching conflict management skills to working nurses, while Leiter et al. (2010) suggest helping nurses learn to engage in explicit communication. Taylor (2001) used three cycles of action research to

address dysfunctional relationships among nurses, employing a facilitator to help working nurses come up with strategies to combat incivility; however, this approach required ongoing support that was difficult to provide. In their systematic review of bullying prevention programs, Stagg and Sheridan (2010) concluded that work on tangible interventions is in its infancy, with the study by Griffin (2004) on cognitive rehearsal providing the most hope going forward.

### **The Gap between Professional Expectations and Reality**

Despite existing measures, many incidents of incivility go unreported (Vessey et al., 2010) and insidious, “low-grade” uncivil interactions remain an accepted part of the prevailing nursing culture (Bartholomew, 2006). It is hard to imagine that any other type of unprofessional nursing practice could become normalized in this way. Even if incivility can be understood as a result of historic injustices, Farrell (2001) suggests that continuing to frame it as a symptom of powerlessness simply “leaves nurses as prisoners of their past” (p. 32). There is no denying that policies that categorize uncivil behaviour as unacceptable are necessary, and that agencies have a responsibility to educate nurses about respectful relationships. The safety and well-being of nurses and their patients need to be protected from the negative consequences of incivility. However, it is clear that deontological approaches intended to guide nurses in their relationships with one another—professional standards as laid out by CRNBC, ethical responsibilities as dictated by CNA, and policies as set out by practice agencies—are not enough to ensure that all nurses meet minimum ethical standards in this area.

Farrell (2001) argues that nurses must become individually accountable for addressing issues of workplace incivility, and it is this idea of individual accountability that provides some direction on how to improve relationships between nurses. In his work on education in the

professions, Sullivan (2005) claims that elaborate rules do not direct moral behaviour within the context of institutions, and argues that individual practitioners embody professionalism through very personal means requiring creativity and energy. In Sullivan's words, the goal of professional education is to inculcate a profound commitment to the values and practices of the profession that results in this embodied state of being. Ideally, students in the professions not only learn to act in ways spelled out by codes of ethic and rules, but, ultimately, are able to do so effortlessly and without hesitation (Begley, 2005). In their work on the Carnegie Foundation's *Preparation for the Professions Program*, Colby and Sullivan (2008) identify the five qualities of a strong and sustainable profession, one of which is "habitual patterns of behavioural response to...peers that are well aligned with the profession's standards and ideals rather than with corrosive counter-norms or overriding self-interest" (p. 415). It is the responsibility of professional schools to act as a bridge between the academy and practice (Sullivan, 2005) and ensure that students are capable of meeting these ideals.

How successful have nurse educators been at meeting this responsibility? Are schools of nursing doing enough to address the issue of incivility in nursing practice? Benner et al. (2010) contend that requiring a baccalaureate degree as entry to practice, as opposed to either an associate degree or a diploma, allows more time for professional development to take place. However, increasing the length and breadth of nursing programs provides no guarantee that nurses will be able to manage conflict successfully. Wilson et al. (2011) found that although nearly all of the nurses in their study held a bachelor's degree in nursing, 90% reported difficulty with confronting others nurses on uncivil behaviour. In her work as a nurse manager, Bartholomew (2006) found that many nurses struggled to acknowledge their own incivility toward their colleagues because it was so contrary to the caring image of nursing. The literature

shows that nurses care deeply about how they are treated in their everyday encounters at work (Almost et al., 2010) and at the same time are often unaware of the impact of their own uncivil behaviour on their peers (Bartholomew). Nurses want to improve their workplaces, and more importantly want to address their own behaviour (Walrafen, Bewer, & Mulvenon, 2012). They recognize when they get “caught up in the drama” (Walrafen et al., p. 12) and regret their inability to meet professional and personal standards in their interactions with other nurses. From this perspective, solutions that penalize individual nurses for uncivil behaviour may do more harm than good.

### **Educating Undergraduate Nurses**

What can nurse educators do at the undergraduate level to better prepare students to engage in professional relationships? The literature provides a few possible answers to this question. Vessey et al. (2010) identify a need for creative solutions, while Walrafen et al. (2012) stress that addressing the problem of incivility at the undergraduate level requires equipping students with constructive ways to deal with conflict. Almost (2006) and Vessey et al. (2009) recommend primary prevention, including curriculum development for undergraduate nursing programs, but provide no specifics. While some authors recognize the need to provide nursing students with skills in this area (Berry et al., 2012; Randle, 2003), few propose concrete strategies to deal constructively with future incidents of incivility in the workplace (Taylor, 2001). One such study by Griffin (2004) provided training in cognitive rehearsal to new graduates as a way to respond to common forms of lateral violence from staff nurses. This one small study showed a marked reduction in uncivil behaviours and has proven to be a beacon of hope for many scholars in this area, having been cited over one hundred times by other authors. Another small study introduced the concept of workplace civility to nursing students using

journal clubs (Kerber, Jenkins, Woith, & Kim, 2012). Nurse educators need to develop curricula aimed at increasing the resilience of nursing students, to help them develop the tools to “defuse and depersonalize” uncivil events (Walrafen et al., p. 12).

While incivility may be perpetuated within the context of organizations (Hutchinson et al., 2006), it is ultimately enacted by individual nurses. As Rhodes et al. (2010) claim, “it is this very relationship, understood as a “face-to-face” encounter with the other, that is the site of ethics” (p. 103). Teaching undergraduate students concrete strategies for dealing with incivility, and helping them understand their ethical responsibility to do so, could help turn the negative aspects of nursing culture around (Bartholomew, 2006; Berry et al., 2012). From a pragmatic perspective, what any nurse ultimately decides to say or do is under the personal control of that nurse. Nurse educators can support ethical practice by providing nursing students with effective tools for acting professionally in the face of incivility.

In this view, virtue ethics can provide a philosophical framework for developing a curriculum to teach civility to nursing students. Within this framework, it is possible to develop educational strategies that help students internalise the values of the profession and to then act in accordance with these values. The following section summarizes the principles of virtue ethics and looks at the current state of virtue ethics in nursing education.

### **Teaching for Virtue in the Professions**

Is it the responsibility of educators to try to influence the character of their students? Teaching for character within the professions is often thought of as less important than teaching for skill or knowledge (Colby & Sullivan, 2008) in part because it is easier to measure competencies based on rules, policies, and so forth than it is to measure character development

(Coulehan, 2005; Crigger & Godfrey, 2011). Nevertheless, the idea of teaching for virtue is gaining traction in professional education (Colby & Sullivan, 2008; Lapsley & Narvaez, 2006; McLean, 2012; Sullivan, 2005). Over the past decades, the focus of the character education movement has been on supporting character development in primary and secondary school-aged children (Noddings, 2002). However, Sellman (2011) claims that, since exceptional standards of character are required for entry to professional nursing practice, students of all ages can benefit from the integration of character education into nursing curricula. Virtue ethics can provide a philosophical framework for developing such a curriculum.

### **Virtue Ethics and Professional Education**

Virtue ethics is a type of normative ethics that is agent-centered, and is concerned more with how an individual “is” than how he or she acts (Sellman, 2011). In a virtue ethics view, behaviour is directed by an “entrenched” disposition rather than habit (Hursthouse, 2012). The major assumptions of virtue ethics are that humans are by nature motivated to be good; that an ideal, or telos, exists; and that virtues can be identified and applied to achieve a “flourishing life” (Crigger & Godfrey, 2011, p. 50). Virtue can be defined as excellence of character (Begley, 2006), while character is defined as “the part of an individual’s psychological self that is developed through a lifelong process to the extent to which the individual is capable” (Crigger & Godfrey, 2011, p. 9). Aristotle said we learn virtue by practice and that the best practice is to model our behaviour on that of a virtuous person (Pellegrino, 2002). Ultimately, it is the commitment to virtue that impacts conduct (ibid).

When individuals are able to live virtuously, they practice phronesis or “practical wisdom”, a quality Sullivan (2005) defines as the ability to act well in context. Pellegrino (2002)

also identifies the importance of context in virtue ethics, defining phronesis as the “capacity for deliberation, judgment and discernment in difficult moral situations” (p. 382). While some argue that traditional ethical theories fail to take the importance of context and relationship into consideration (Armstrong, 2006; Doane et al., 2009; Gastmans, 2002; Jaegar, 2001), it is this emphasis on context that can make virtue ethics a useful framework for action guidance within the complexity of contemporary nursing practice.

A number of authors promote the utility of virtue ethics as a framework for teaching character to professionals (Buyx, Maxwell, & Schöne-Seifert, 2008; Coulehan, 2005). In his extensive work in the area, Pellegrino (2002) argues for a philosophical approach to medical education that is grounded in virtue ethics, but that also compliments deontological and utilitarian approaches. In a virtue ethics-based curriculum, students learn to practice without self-interest and instead to align their values with those of their professional community of practice (Sullivan, 2005). Such an approach requires consistency between what is taught and what students actually see in practice (Coulehan, 2005). Through this transformation, students are supported as they learn to become faithful to the values of the profession and to act out of habit in demanding situations.

This way of learning is consistent with Mezirow’s (1997) work on transformative learning. Mezirow claims that the goal of adult education is to develop habits of mind that allow an individual to become a “socially responsible autonomous thinker” (p. 8) capable of making ethical decisions in times of rapid social change. Transformative learning requires student-centered approaches that are well accepted in present day nursing education (Young & Paterson, 2006). A virtue ethics approach to nursing education could be considered learner-centered in that the goal is to coach students as they develop individual values that align with professional

values. However, it would also be profession-centered in that the purpose of the profession—supporting the well-being of clients and communities—is also the ultimate goal of nursing education (Crigger & Godfrey, 2011). Crigger and Godfrey argue for a reconceptualization of nursing education that makes this centrality of the profession explicit.

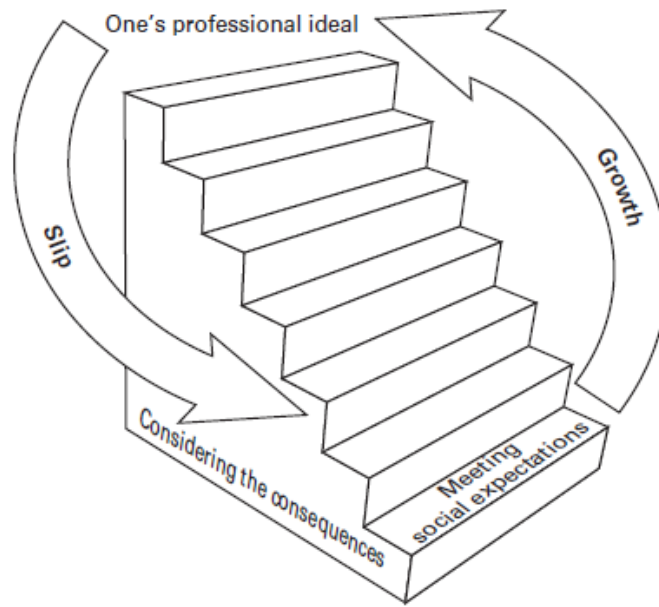
In the course of professional programs, students are exposed to curricular content and experiences aimed at developing professional identity. However, implicit elements of professional curricula such as faculty behaviour, values of the academic institutions, and values of clinical education sites will also influence student socialization and will do so for better or for worse (Coulehan, 2005; Sellman, 2009). In his work on educating for the professions, Sullivan (2005) argues that professional behaviour begins in the academic setting, and that for students in these programs the classroom represents the professional world. Educational settings immerse students in a “living tradition” of standards and practices that closely align with those of the working world (Colby & Sullivan, 2008, p. 417). From this perspective, nurse educators are obliged to support the moral development of students by deliberately creating learning environments that aspire to an ideal of professional practice. Recently, authors have explored this idea in the nursing education literature.

### **Virtue Ethics in Nursing Education**

In their landmark book, Benner et al. (2010) argue for the deliberate and explicit formation of professional identity through radical changes to undergraduate nursing education. The authors define formation as the changes in self-concept that occur as a student moves from lay person to professional nurse. Benner et al. contend that nursing joins other professions in a troubling migration away from ethical service to the public toward a “technical professionalism”

(p. 8), one more concerned with individual accomplishment than with the collective purpose of the profession. The authors argue that external financial pressures and rapid changes in technology have conspired to diminish nurses' ability to enact the core values—justice, honesty, courage, trustworthiness, and open-mindedness (Sellman, 2011)—of the profession.

In response to this call, Crigger and Godfrey (2011) propose a framework for educating baccalaureate nursing students aimed at the intentional development of these values. The Stairstep Model of Professional Transformation (Figure 1) is intended to guide nurse educators as they support the developing internal moral character of their students. From an ontological perspective, Crigger and Godfrey contend that individuals have the ability to choose to act in a certain way. The Stairstep Model, grounded in the principles of virtue ethics, provides a theoretical framework that clearly addresses the ethical development of the student nurse. In this view, both deontology (meeting social expectations) and consequentialism (reflecting on actions) act as a foundation that supports the development of professional virtues. As nursing students use their practical wisdom to make ethical decisions, they contribute to the good of the profession and continue to move up the staircase. In this way, students move closer to the goal of excellence in nursing practice. Crigger and Godfrey argue that the “missing educational piece” (p. 23) in the teaching of nursing ethics is this explicit attention to the day-to-day ethical decision making that arises out of the aspiration toward a professional ideal.



*Figure 1.* The stairstep model of professional transformation. The stairs represent the student's journey toward a professional ideal. The model communicates the unified nature of deontology, consequentialism and virtue ethics in the context of nursing practice. From Crigger, N., & Godfrey, N. (2011). *The making of nurse professionals: A transformational, ethical approach*. Sudbury, MA: Jones & Bartlett.

Crigger and Godfrey (2011) are not alone in their exploration of the role of virtue ethics in nursing education. Over the past decade, a number of other authors have argued for incorporating virtue ethics into nursing curricula in order to influence the values and character development of nursing students (Begley, 2006; Gastmans & Vanlaere, 2007; Miller, 2006; Sellman, 2009). Educators in caring curricula reasonably assume that character will be developed through classroom and clinical experiences even when virtue ethics are not explicitly taught. However, current discourse in this area suggests that virtue ethics should not remain an implicit element of nursing programs. Rather, educators must deliberately shape the values of nursing students to align with those of the profession using theory-based curricular strategies. As Begley (2006) states, “teaching virtue is about influencing hearts as well as minds and

requires a dynamic and sensitive approach which goes beyond that which is needed for pure theoretical ethics” (p. 259).

### **Teaching Civility using a Virtue Ethics Approach**

It is not clear whether virtue ethics is capable of providing a philosophical framework for ethical decision making in every area of nursing practice. Begley (2005) outlines a number of challenges in this regard, in particular difficulty agreeing on the virtues important to nursing and on the characteristics of the paradigm nurse. Others cast doubt on the usefulness of virtue ethics as a guide to action in complex situations. Doane et al. (2009) explore the influence of context on nurses’ ethical decision making, and certainly the importance of context must be considered in virtue ethics approaches (Pellegrino, 2002; Sullivan, 2005). These challenges have been addressed extensively by a number of authors (Armstrong, 2007; Crigger & Godfrey, 2011; Sellman, 2011) and it is beyond the scope of this paper to assess the suitability of a virtue ethics approach to nursing practice in general. I argue, however, that virtue ethics does provide a fitting framework for guiding the behaviour of individual nurses in their relationships with other nurses because nursing values are clearly articulated in this regard, expectations for professional behaviour are unambiguous, and the agent (the individual nurse) has a great deal of control over his or her own behaviour.

### **Recommended Strategies**

As Clark and Carnosso (2008) state, civility “involves time, presence, a willingness to engage in genuine discourse, and a sincere intention to seek common ground” (p.13). To learn civility, nursing students need concrete tools to carry forward in to practice and these tools can be developed within a virtue ethics framework. There are four general pedagogical strategies

supported by the literature on virtue ethics in nursing education: using critical reflection, establishing role models, using case studies, and creating opportunities for practice (Armstrong, 2007; Begley, 2006; Gastmans, 2002; Sellman, 2007; Sellman, 2009). The following sections outline how these strategies might be used to teach students at the undergraduate level to engage in civil relationships at work.

**Role modelling:** The importance of using role models in teaching virtue ethics to novice nurses cannot be overstated (Armstrong, 2006; Begley, 2006; Benner et al., 2010; Crigger & Godfrey, 2011; Gastmans & Vanlaere, 2007; Miller, 2006; Sellman, 2009; Woods, 2005). If nursing students are to compare their practice to that of the paradigm nurse, it comes as no surprise that they will need to be within the orbit of exemplary nurses. These model nurses strive to meet professional ideals even in the most challenging contexts and are themselves in a continual process of professional growth (Crigger & Godfrey, 2012). In looking at different theoretical models of moral development, Baxter and Boblin (2006) conclude that moral growth occurs through close contact with those at higher levels of moral development.

It is clear that identifying clinical exemplars can help students understand how the virtues important to nursing are enacted in everyday practice. It is critically important that those nurses with direct influence over the character development of students embody the virtues most valued by the profession in both classroom and clinical settings, including in their interactions with others. Educators need to acknowledge the negative atmosphere that exists in many nursing workplaces and ensure that preceptors and other nurses overseeing students are carefully chosen. Students can be expected to engage in civil behaviour only if it is consistently modelled for them by practicing nurses and it is the responsibility of educators to ensure that students have role models that they can respect and admire.

Nurse educators, too, must be aware of the influence they have on students and the necessity of exhibiting professional conduct at all times. Given that incivility is known to be a problem in the academic setting, faculty must be aware of their role in modelling uncivil behaviours in their interactions with students and colleagues. However, as previously mentioned, student perception of incivility may be influenced by many factors, including a sense of entitlement or lack of personal accountability (Clark, 2008c). Yet, as Sellman (2009) states, “as nurses we are all teachers of ethics whether we know it or not and for good or for ill” (p. 90), and faculty must navigate these complex situations in ways that model professional ideals. For this reason, codes of conduct that clarify what constitutes civil behaviour should be made explicit by faculty and shared with students (Kerber et al., 2012). Educators must exhibit honesty, caring, and integrity in their interactions with students. As well, ensuring personal accountability through reflection, self-assessment, and peer feedback can help both educators and students meet their responsibilities as nurses in this regard (Begley, 2011; Gastmans & Vanlaere, 2007). Students learn to become excellent nurses by first imitating and then emulating the nurses they admire (Sellman), so it is important that faculty role model civil behaviour at all times (Clark, 2008b; Marchiondo, Marchiondo, & Lasiter, 2010). In the absence of good role models, student nurses are in danger of uncritically embracing the norms of the workplace, for better or for worse.

The influence of educators’ behaviour on students extends beyond the classroom setting (Wilson et al., 2011). Clinical instructors are responsible for the type of character traits that they model for their students, and are thought to provide the most powerful force in professional character formation (Pellegrino, 2002). Students need time and care as they develop professional

virtues (Coulehan, Williams, McCrary, and Belling, 2003) and mentoring by experienced nurses and peers is critical to this process (Eggerstone, 2011; Kerber, Jenkins, Woith, & Kim, 2012).

**Critical Reflection:** In his writings on the importance of critical reflection as a guide to action, Viktor Frankl implores the reader to “live as if you were living already for the second time and as if you had acted the first time as wrongly as the way you are about to act now!” (1992, p. 109). Student nurses are consistently taught to use reflection on action as a strategy for building professional competency. Gastmans and Vanlaere (2007) claim that “people become virtuous by acting virtuously and by reflecting on their acts, thereby making virtuousness purposeful and contemplated” (p. 763). It is necessary for students to have a strong internal commitment to excellence and sufficient insight into their own behaviour for this approach to be used successfully (Gastmans, 2002). Educators can initiate this process by helping students develop a vision of the paradigm nurse. As students begin to engage in nursing practice, it is through reflecting on actions and comparing these actions to those of the ideal nurse that students’ growth toward that ideal can begin to take place. In this way, developing habits of critical reflection as students can increase the likelihood that reflection will be used to guide their future nursing practice.

While certainly desirable, it is not essential or even possible for students to always act in ways consistent with the ideal. Moral development is a dynamic process that acknowledges all nurses will live in a state of imperfection while working to become better professionals. One aim of reflective practice is to learn to develop a more productive response to one’s own wrongdoing (Maxwell & Reinchenbach, 2005), and this can only take place in a safe and supportive environment. Educators must address issues of power in order for students to engage in critical reflection on ethical issues (Sellman, 2007). In their interactions with students,

educators should explore the language and concepts central to virtue ethics, using terms such as morals, character, virtue, and moral perception. A culture of openness and trust must be cultivated by faculty if students are to develop the desired characteristics of the virtuous professional. Along with creating this sense of classroom as moral community, other pedagogical strategies that promote critical reflection include journaling, de-briefing, and post-clinical conferences.

Nurse educators can use reflection as a strategy for teaching civility. For practicing nurses, Almost et al. (2010) recommend self-awareness and reflection on one's own behaviour as a strategy to engage in respectful relationships with other nurses. With this in mind, students could reflect on interactions with peers, faculty, and clinical nurses to determine if their behaviour is comparable to that of the ideal nurse. More precisely, as McLean (2012) states, students need to ask themselves "whether they are now behaving like the practitioner they wish to become" (p. 161). Educators could use this principle to help students reflect on how peer relationships are valued and enacted in practice settings. Heinrich (2010) recommends assessing interactions with others in the moment, advising nurses to slow down and reflect on how their behaviour contributes to the quality of the interaction. Similarly, both faculty and students can learn to reflect on how their behaviour affects the learning environment (Marchiondo et al., 2010).

**Narrative and case study.** Case studies and narratives have proven to be effective tools for teaching virtue ethics to nursing students. Austin (2007) recommends the use of narratives in film and literature as a rich way to explore the actions of "moral heroes" (p. 60), while Begley (2006) encourages educators to use a humanities approach to promoting character development in nursing students. For example, when students read novels written from the perspective of the

patient, they begin to develop moral sensitivity and to appreciate how context and relationship can influence ethical action. Similarly, case studies should be carefully developed to include plenty of real life detail (Begley). Educators can use case studies drawn from their own clinical experience as a starting point for the discussion of ethical comportment, and these can gradually be expanded to include the clinical experiences of students. Such exercises can increase the moral perception of students as they begin to deal with the complexities of the health care context and human relationships (Scott, 1998; Woods, 2005). Again, educators should cultivate an atmosphere of safety and openness in discussions that arise through case study analysis.

Through narratives, students can begin to understand how their personal values impact their reactions to particular clinical situations. However, proponents of virtue ethics urge educators to move beyond values clarification toward actively supporting those specific values important to nursing (van Hooft, 1990). In other words, it is not enough that students identify their values. They must be open to critically assessing whether these values align with those of the profession, and if they do not, then it is legitimate for educators to deliberately support students to adopt those values that do. It is not clear how receptive students would be to this process, even when undertaken with sensitivity. In a culture that privileges the individual, educators who challenge the rights of students to hold certain values are bound to meet resistance. However, codes of ethics, professional standards, and a wealth of scholarly work in nursing clarify the values essential for excellence in nursing practice. These resources can provide students with clarity about the origins and importance of nursing values and allow students to see beyond the demands of individual instructors and to appreciate the expectations of the profession as a whole.

Following these principles, narrative can be seen as an effective tool for teaching civility to nursing students. In his work in medical education, Coulehan (2005) argues that professional behaviour has been “articulated as a meta-narrative that has developed over 2500 years as a summation of, and reflection upon, many thousands of actual physicians’ stories” (p. 893). Similarly, it is possible for nurse educators to immerse students in narratives that illustrate what it means to embody professional behaviour as nurses. This requires a critical look at the stories nurses tell about their practice and what these stories say about the values nurses hold. In a warning to educators, Coulehan claims that students internalize hospital narratives whether these narratives reflect the values of the profession or not. The same may be said of the narratives that illustrate the quality of relationships between nurses. These must serve as exemplars of professional behaviour and can be particularly effective at demonstrating to students how professional standards can be met even in challenging situations. As an example, Grenny (2009) describes in narrative form how “Cora”, a trauma nurse, was able to address a physician’s uncivil behaviour toward her while remaining respectful and professional. Such narratives can provide students with a powerful vision of excellence in practice while countering the often cynical narratives common to hospital settings (Coulehan).

**Practice, Practice, Practice.** In his conceptualization of virtue ethics, Aristotle stresses the importance of acting virtuously in order to become virtuous. Habits of virtue are formed through practice, and this notion of practice as a means to virtue development is put forward again and again in the literature (Armstrong, 2007; Begley, 2005; Crigger & Godfrey, 2011; Doane et al., 2004; Gastmans & Vanlaere, 2007; Woods, 2005). While those drawn to nursing tend to share some common characteristic such as altruism, caring, and empathy, these natural tendencies alone can be inadequate to the task of navigating the complex ethical terrain of many

clinical situations (Sellman, 2011), including those related to the maintenance of civil relationships. For this reason, nurse educators must ensure ample practical opportunities for students to exercise their emerging ethical relational skills and these experiences, whether in clinical or academic settings, must be designed to be as realistic as possible.

Begley (2006) states that learning virtue is a cognitive exercise and new nurses must learn how to train their emotions. Students should be taught that it is possible to choose to act in specific ways, even under challenging circumstances, and it is easy to imagine how interactions with other students, faculty, and nurses could provide excellent opportunities for practice in this regard. However, in order to engage in this kind of practice, students will need contextually appropriate strategies designed to develop specific skills (Vessey et al., 2009). Stagg and Sheridan (2010) claim that there is little evidence of effective interventions at the undergraduate level that address nurse to nurse incivility. As previously mentioned, cognitive rehearsal (Griffin, 2004) and journal clubs (Kerber et al., 2012) have both been used with some success with new nurses and students. A number of other initiatives aimed at combatting incivility among nurses in the workplace might be adapted to the academic setting. These can give students concrete strategies for entering into civil relationship with others and for dealing productively with uncivil behaviour when they encounter it. Deutsch (as cited in Almost, 2006) suggests that nurses can learn to reframe conflict by focusing on mutual goals, while the Civility, Respect, and Engagement in the Workplace (CREW) initiative has been implemented successfully in several healthcare settings. The CREW process has been developed to increase the level of civility in workplace relationships, in part by promoting explicit conversations and by naming incivility (Gilin Oore et al., 2010; Leiter, Price, & Laschinger, 2010). For the most part, authors agree that it is important for nurses to learn to deal with behaviour in direct ways by

employing assertiveness skills, using appropriate conflict management techniques, and knowing how to engage in crucial conversations (Cleary et al., 2010; Taylor, 2001; Vessey et al., 2009). Other authors suggest that cognitive behavioural interventions can help individual nurses determine whether their own mistaken perceptions contribute to conflict in the workplace (Brunero, Cowan, & Fairbrother, 2008). Educators would do well to practice these strategies and to model and teach them to students.

Faculty can encourage students to adopt a number of other personal attributes and habits that contribute to healthy workplaces. Olender-Russo (2009) claims that individual nurses can create a culture of regard through self-exploration. In a similar spirit, Heinrich (2010) suggests a number of specific communications techniques for increasing civility that require individual nurses to adopt an intentionally optimistic outlook. Clark and Ahten, (2012) recommend educators develop explicit opportunities for students to apply new habits, including simulating high anxiety scenarios, practicing meaningful conversations, and rehearsing constructive responses to conflict. Practice can begin in academic settings as students engage in group work with peers and interact with faculty, clinical instructors, and working nurses.

Virtues are by definition ideals that are almost impossible to reach. Individuals work on the development of virtues over a lifetime, and success in taking up virtues varies with pre-existing character traits and contextual challenges (Buyx et al., 2008; Weiss & Schank, 2002). Nurse educators can create an environment for student transformation by providing structured opportunities for practice. As Woods (2005) states,

“...real world practice is that which occurs in actual situations in actual contexts. In this world, knowledge as practical wisdom is gained by

experiences in the learning situation rather than through rational but often thwarted attempts bluntly to apply theory to practice” (p. 13).

It is within this context that faculty have a role in coaching students as they develop the virtues needed to engage in professional relationships.

### **The CAEN Curriculum: An Example**

The above virtue ethics-based strategies for teaching civility could be integrated into existing undergraduate nursing programs. While I believe it would be valuable to be able to weave these strategies into every aspect of nursing education, from a practical standpoint it seems logical to introduce leveled strategies into specific courses. To illustrate, I have used the four year curriculum for the Collaborative for Academic Education in Nursing (CAEN) shared by a number of partner institutions in British Columbia, Canada, including North Island College where I teach. The curriculum overview (Appendix) outlines how the four ‘streams’ of the curriculum—Relational Practice, Health and Healing, Professional Practice, and Nursing Practice—are delivered over eight semesters. In the Appendix, I have highlighted the courses most compatible with the proposed strategies.

In first year, both semesters I and II include professional practice courses that provide an introduction to the profession and the discipline of nursing. Within these two courses, I suggest using existing content on professionalism, self-regulation, codes of ethics, and responsibility to include specific content on how these concepts relate to expectations for professional relationships with other nurses.

In second year, the curriculum places increasing emphasis on building competence in relational practice (Collaboration for Academic Education in Nursing, 2012) and nursing ethics.

These courses provide an opportunity to introduce and practice the communication skills mentioned above. In semester three, the Relational Practice II course focuses specifically on creating health-promoting relationships. Current content of this course focuses on relationships with clients and families; however, I would suggest including explicit strategies that address common challenges in relationships among nurses. The Professional Practice course in semester four is concerned with nursing ethics and provides an ideal opportunity to explore with students the foundational concepts of virtue ethics in the context of nursing practice—the paradigm nurse, practical wisdom, and nursing virtues, for example.

In the first semester of third year, students enrol in Relational Practice III—Connecting across Difference. In this course, students develop strategies for understanding the lived experience of others in more complex circumstances. Course content includes strategies for ethical group work, as well as theory related to collaboration and power differences. Exploring civility among nurses is a natural fit for this course, and could include reflective exercises, narrative and case study, and role modelling as outlined above.

In fourth year, students engage in extended periods of self-directed study and practice. Professional Practice V and Nursing Practice VII, both leadership-based, offer many opportunities for students to put theory from the previous semesters into practice in a supportive environment. Senior students have the capacity to provide role models of civil behaviour for more junior students, and to apply their developing relational skills in all of their interactions with their peers, faculty, and practicing nurses.

### **Challenges**

Challenges exist in using a virtue ethics approach to address serious cases of bullying and workplace violence. Sustainable, healthy relationships require a reciprocal commitment. Certain ingrained characteristics of nursing culture could make such reciprocity unrealistic.

Longstanding patterns of interaction, a general reluctance to be confrontational, and habitual emotional responses all contribute to maintenance of the status quo. To reach the point where virtue is effortless, individual nurses must often undergo a long process of moral development and maturity, and progress in this regard is difficult to assess. In addition, strategies that rely on individual commitment cannot be successful without the simultaneous use of effective policies and educational programs at the institutional level.

### **Summary**

Focusing attention on the individual nursing student's ethical obligation to embody professionalism is one way to strengthen the communal voice of registered nurses. Nurses gain nothing by continuing to tolerate and perpetuate uncivil behavior within the profession. In her analysis of the challenges encountered in establishing a mentoring program for nursing students, Ketola (2009) wrote:

We realized the problem in the [mentoring] relationship was another inheritance from the past. Throughout the literature, the most injurious component of nursing is not the work overload, not the acuity of the patients, not the cantankerous, disrespectful behaviour of some physicians: it is the damaged relationships we have with each other...Our discontent with each other is a by-product of our

discontent with the environment in which we do our work, but this is our problem and our responsibility to correct. (p. 253)

As Aristotle wrote, “it is no easy task to be good” (as cited in Scott, 1998). It takes a great deal of courage and commitment to go against the prevailing current of the workplace, for individual nurses to be and act in alignment with the values of the profession. If the good of virtue ethics education is to be realized, educators and students alike will have to challenge themselves to adopt new values and behaviour in increasingly complex circumstances. Helping students understand their obligation to engage in truly professional relationships with their colleagues may be one way to prepare nurses to more intentionally steer the future direction of the discipline and to ethically navigate the evolving healthcare system.

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## Appendix

## CAEN Curriculum Overview

Semester One Health Across the Lifespan	Semester Two Health Assessment Across the Lifespan	Consolidated Practice Experience				
<ul style="list-style-type: none"> <li>• <b>Professional Practice I:</b> Introduction to the Profession of Nursing (3)</li> <li>• <b>Health and Healing I:</b> Living Health (3-3)</li> <li>• <b>Relational Practice I:</b> Self and Others (3)</li> <li>• English (3)</li> <li>• <b>Health Sciences I:</b> Biology (3-3)</li> <li>• <b>Nursing Practice I:</b> Introduction to Nursing Practice</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Professional Practice II:</b> Introduction to the Discipline of Nursing (3)</li> <li>• <b>Health and Healing II:</b> Health Indicators (3-3)</li> <li>• <b>Health Sciences II:</b> Biology (3-3)</li> <li>• Elective (or English) (3)</li> <li>• <b>Nursing Practice II:</b> Coming to Know the Client</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Consolidated Practice Experience I</b></li> </ul> <p><b>Minimum Hours for Semesters One, Two &amp; CPE I:</b></p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 20px;">Practice Hours</td> <td style="text-align: right;">224</td> </tr> <tr> <td>Seminar Hours</td> <td style="text-align: right;">26</td> </tr> </table>	Practice Hours	224	Seminar Hours	26
Practice Hours	224					
Seminar Hours	26					
Semester Three Chronic and Episodic Health Challenges	Semester Four Chronic and Episodic Health Challenges	Consolidated Practice Experience				
<ul style="list-style-type: none"> <li>• <b>Health &amp; Healing III:</b> Health Challenges/Healing Initiatives (3-3)</li> <li>• <b>Relational Practice II:</b> Creating Health-promoting Relationships (3)</li> <li>• <b>Health Sciences III:</b> Pathophysiology (3)</li> <li>• <b>Nursing Practice III:</b> Promoting Health and Healing</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Health &amp; Healing IV:</b> Health Challenges/Healing Initiatives (3-3)</li> <li>• <b>Professional Practice III:</b> Nursing Ethics (3)</li> <li>• <b>Health Sciences IV:</b> Pathophysiology (3)</li> <li>• <b>Nursing Practice IV:</b> Promoting Health and Healing</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Consolidated Practice Experience II</b></li> </ul> <p><b>Minimum Hours for Semesters Three, Four &amp; CPE II:</b></p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 20px;">Practice Hours</td> <td style="text-align: right;">456</td> </tr> <tr> <td>Seminar Hours</td> <td style="text-align: right;">78</td> </tr> </table>	Practice Hours	456	Seminar Hours	78
Practice Hours	456					
Seminar Hours	78					
Semester Five Complex Chronic and Episodic Health Challenges	Semester Six Community and Societal Health	Consolidated Practice Experience				
<ul style="list-style-type: none"> <li>• <b>Health &amp; Healing V:</b> Complex Health Challenges/Healing Initiatives (3-3)</li> <li>• <b>Relational Practice III:</b> Connecting across Difference (3)</li> <li>• <b>Nursing Practice V:</b> Promoting Health and Healing</li> <li>• Elective (3)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Health and Healing VI:</b> Global Health Issues (3)</li> <li>• <b>Health and Healing VII:</b> Promoting Community and Societal Health (3)</li> <li>• <b>Professional Practice IV:</b> Nursing Inquiry (3)</li> <li>• <b>Nursing Practice VI:</b> Promoting health of communities and society</li> <li>• Elective (3)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Consolidated Practice Experience III</b></li> </ul> <p><b>Minimum Hours for Semesters Five, Six &amp; CPE III:</b></p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 20px;">Practice Hours</td> <td style="text-align: right;">501</td> </tr> <tr> <td>Seminar Hours</td> <td style="text-align: right;">58.5</td> </tr> </table>	Practice Hours	501	Seminar Hours	58.5
Practice Hours	501					
Seminar Hours	58.5					

Semester Seven Nursing Leadership	Semester Eight Transitioning to BSN Graduate					
<ul style="list-style-type: none"> <li>• <b>Professional Practice V: Leadership in Nursing (3)</b></li> <li>• <b>Professional Practice VI: Nursing Research (3)</b></li> <li>• <b>Elective (3)</b></li> <li>• <b>Nursing Practice VII: Engaging in Leadership</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Nursing Practice VIII</b></li> </ul>	<p><b>Minimum Hours for Semesters Seven &amp; Eight:</b></p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 20px;"><b>Practice Hours</b></td> <td><b>664</b></td> </tr> <tr> <td><b>Seminar Hours</b></td> <td><b>19.5</b></td> </tr> </table>	<b>Practice Hours</b>	<b>664</b>	<b>Seminar Hours</b>	<b>19.5</b>
<b>Practice Hours</b>	<b>664</b>					
<b>Seminar Hours</b>	<b>19.5</b>					