Student Registered Nurse Anesthetists' Perceptions of Incivility and Bullying by Healthcare Providers in the Clinical Setting

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We hereby certify that this dissertation, submitted by Holly A. Chandler, conforms to acceptable standards and fully fulfills the dissertation requirements for the degree of Doctor in Education from Bryan College of Health Sciences

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Dedication

This dissertation is dedicated with love and gratitude to my family. To my husband Matthew who is my true North. My children Meghan, Gerald, Mason, and Chloe who educate me every day about the true meaning of civility and kindness. Lastly, to my granddaughter Quinn, who brought me light, hope, joy, and happiness when I needed it most, I wish for you a civil world.

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Abstract

Background and Significance: Limited research exists regarding Student Registered Nurse Anesthetists' (SRNAs') perceptions of incivility and bullying by healthcare providers in the clinical setting. Outcomes of incivility and bullying include effects on learning, physiological, and psychological needs. Purpose: To explore SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. Methods: Purposive sampling was utilized to select SRNAs who were full-time second or third-year nurse anesthesia students from a midwestern nurse anesthesia program actively attending clinical rotations. Private interviews were conducted using semi-structured questions. Data analysis was completed through Tesch's Eight Steps (Creswell & Poth, 2018), bracketing, member checking, and triangulation. Results: The coding process revealed six themes: 1) educational experiences, 2) professionalism, 3) relationships, 4) coping, 5) health and well-being, and 6) perceived prevalence of incivility and bullying. Conclusions: SRNAs perceive the prevalence of incivility by healthcare providers in the clinical setting to be pervasive. All 10 participants perceived they had experienced incivility by healthcare providers in the clinical setting. SRNAs perceive the prevalence of bullying by healthcare providers in the clinical setting to be common. All participants had witnessed or heard of bullying, while four of the ten had experienced it.

Keywords: bullying, incivility, healthcare provider, preceptor, clinical rotation, school of nurse anesthesia, anesthesia services, student registered nurse anesthetist, and certified registered nurse anesthetist

Student Registered Nurse Anesthetists' Perceptions of Incivility and Bullying by Healthcare Providers in the Clinical Setting

CHAPTER I: INTRODUCTION

Student Registered Nurse Anesthetists (SRNAs) are bachelor's-prepared Registered Nurses who have been admitted to a Nurse Anesthesia Program. There is extreme competition to enter these programs. All programs incorporate both didactic (classroom) learning and clinical learning. Some programs are front-loaded with didactic, adding in clinical rotations later in the program. Other programs merge classroom and clinical learning, so they occur at the same time. All SRNAs are expected to meet criteria set by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) regarding the number of anesthesia cases they participate in during the clinical phase of their program. Due to this expectation, SRNAs may experience many different clinical sites to obtain the required anesthesia cases. The education of SRNAs while participating in clinical is provided by clinical preceptors. A clinical preceptor for SRNAs is most often a Certified Registered Nurse Anesthetist (CRNA). Occasionally the preceptor might be an Anesthesiologist (a medical doctor specializing in anesthesia).

In addition, SRNAs encounter many other healthcare providers during the clinical phase of their education. These encounters have the potential to expose SRNAs to incivility and bullying. Incivility and bullying have the potential to affect learning and well-being. This research study seeks to explore SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting.

This chapter will discuss the purpose of this study in addition to the background and rationale regarding why this research is important to SRNAs, healthcare, and the

public. The problem statement, guiding research questions, and definitions of terms will be described. The theoretical framework utilized throughout this study is discussed, and assumptions, limitations, and delimitations are presented and examined.

Background and Rationale

Incivility and bullying permeate many aspects of our lives today. This is evident in public discourse, politics, and the media. Research reveals incivility and bullying are prevalent in the workplace and academic environment as well. Clark (2017b) defines the academic environment as any place where learning occurs. This includes the clinical setting.

Incivility may be described as behavior (rude or discourteous) which may disrupt the academic environment (Feldman, 2001). Incivility and bullying can cause damage to one's dignity, ability to learn, perform, and affect a person's intrinsic value of self-worth (Clark, 2017a).

Bullying is present when workplace culture allows dominant individuals to attack those who are more vulnerable. Bullying is dangerous to an organization's culture and can result in dissatisfaction, disengagement, and absenteeism (Vessey, DeMarco & DiFazio, 2011). Bullying in the nurse anesthesia culture must be monitored because this culture is a highly stressful, high acuity environment (Emblad, Kodjebacheva, & Lebeck, 2014).

Hierarchies in healthcare have the potential to promote bullying. Certified Registered Nurse Anesthetists are susceptible to incivility and bullying when working in practice environments such as medical direction (an anesthesiologist medically directs or supervises CRNAs in all aspects of their practice) and supervision (physicians supervise CRNAs while allowing them to maintain some independent billing ability). These are

environments in which incivility and bullying are more prevalent due to the hierarchical structure of practice. (Sakellaropoulos, Pires, Estes, & Jasinski, 2011).

In addition to the aforementioned hierarchies, CRNAs practice in operating rooms. "The operating room is highly volatile and does not function under the same protocols as those found in other private, public, or hospital work settings" (Sakellaropoulos et al., 2011, p.55). The hierarchal structure in healthcare, and specifically in an Anesthesia Care Team supervision model (utilized most in urban academic settings), was shown to cause stress for CRNAs (Sakellaropoulos et al., 2011). Clinical experiences are vital to educating future CRNAs. Student Registered Nurse Anesthetists' clinical experiences with preceptors differ from nursing students' clinical experiences with preceptors in that SRNAs do not have one consistent preceptor. An SRNA may have one to five preceptors in a day and up to 100 preceptors in a month.

Communication is a vital tool healthcare providers utilize to educate future professionals. Student Registered Nurse Anesthetists ranked clear communication as the third most important characteristic of a clinical preceptor (Elisha & Rutledge, 2011). Elisha (2008) reported CRNA clinical preceptors believed their communication skills with SRNAs were highly effective. Effective professional communication and collaboration are necessary components of anesthesia practice. Incivility and bullying can interrupt interprofessional communication, which predisposes healthcare professionals to errors and deleterious patient outcomes (Vessey et al., 2011).

Many learners (nursing students, medical students, and SRNAs) report being the victims of incivility or bullying during the clinical phase of their programs (Elisha & Rutledge, 2011; Luparell, 2011; Thomas & Burk, 2009; Yasser, Mutaz, & Baraa, 2016). In a cross-sectional descriptive study by Elisha and Rutledge (2011), 70% of SRNAs had

experienced verbal abuse. These findings are alarming and indicate the need for further research. A thorough examination of the literature revealed a definite gap in the research regarding SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting.

Purpose of the Study

The purpose of this qualitative phenomenological study is to explore SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting.

Concepts

The primary concepts of the study are incivility and bullying. Incivility is defined as actions that are ambiguous in intent, non-physical, involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation or exclusion). The behaviors create a disruptive environment and may lead to, or escalate to, bullying. Bullying is defined as repetitive, harmful mistreatment of a person or persons by one or more people, which can affect health. Bullying is abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3) intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior, which causes harm.

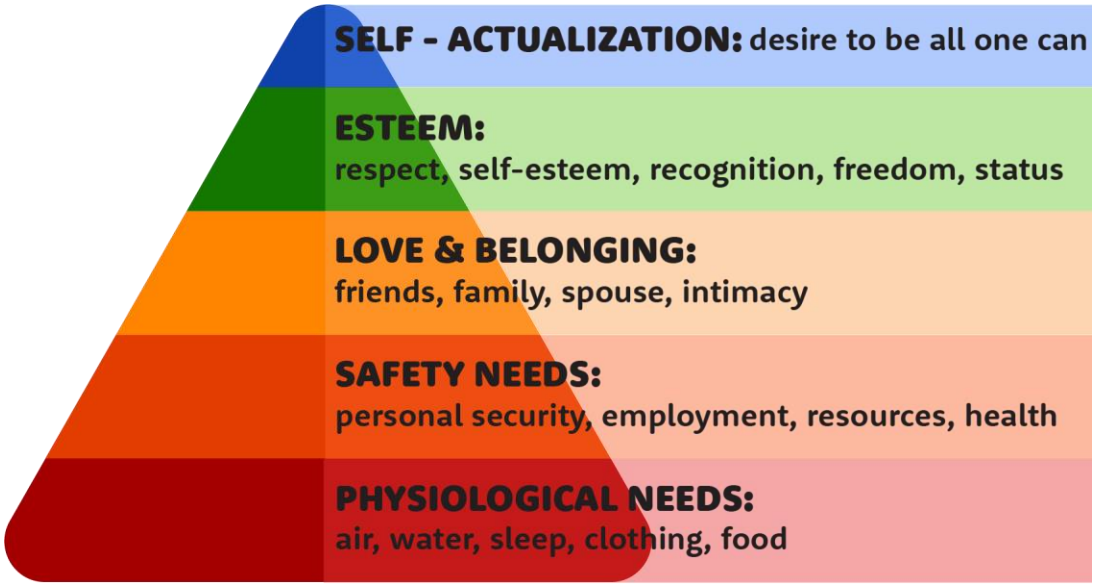
Research Questions

The research questions guiding this qualitative phenomenological study include:

1) What experiences do SRNAs have with incivility by healthcare providers in the clinical setting? and:
2) What experiences do SRNAs have with bullying by healthcare providers in the clinical setting?

Theoretical Framework

Incivility and bullying may cause damage to one's dignity, ability to learn, perform, and often affect a person's intrinsic value of self-worth (Clark, 2017b). Maslow's Hierarchy of Human Needs is the theoretical framework guiding this qualitative study. In 1943, Maslow introduced his Theory of the Hierarchy of Human Needs, which postulates each human need is built upon the satisfaction of the previous need. For humans to achieve self-actualization, they must first meet the needs of each previous level. The five hierarchical needs are as follows: 1) physiological, 2) safety, 3) love and belonging, 4) self-esteem, and 5) self-actualization, defined as the realization or fulfillment of one's talents and potential (Maslow, 1943). Pictured below is a graphic showing the five levels of Maslow's hierarchy.



Maslow's Hierarchy of Needs as described by Maslow in 1943

Basic needs can be altered by depression, leading to not eating and lack of sleep. Not feeling safe at work could also disrupt the hierarchal level of safety in which humans have a need to feel safe. In addition, psychological needs could be affected by isolation or attacks on character. Finally, self-actualization can be altered if a healthcare worker

chooses to leave the profession. Incivility and bullying have the potential to interfere with each level of Maslow's hierarchy.

Assumptions, Limitations and Delimitations

This research study included some assumptions. The first assumption was that SRNAs have recall and will be able to verbalize their perceptions and experiences with incivility and bullying regarding healthcare workers. The second assumption was that the participant's responses would accurately represent their opinions. Lastly, it was assumed that participants would answer all interview questions honestly and to the best of their abilities.

Limitations of this study included the small sample size and the small number of educational programs included. In addition, it was possible that participants who chose to participate may have had a previous bias due to personal experiences in which they may have experienced incivility and/or bullying.

Another limitation identified was that each program's policies and procedures might have differed regarding incivility and bullying. Lastly, each clinical site and program was likely to encompass differing cultures, which may have influenced the experiences of the participants.

Delimitations in the study included the utilization of only three accredited Midwest schools of nurse anesthesia and having four participants from two of these programs and two from the third. Another delimitation that was considered was the inclusion criteria. Inclusion criteria specified each participant must have been in the second or third year of their nurse anesthesia program and must have completed at least one clinical rotation and have started a second clinical rotation in at least two different institutions that provided anesthesia services (a hospital or clinic).

Definition of Terms

A definition of the following terms referenced in this study is provided for clarity. Healthcare provider, preceptor, clinical rotation, school of nurse anesthesia, anesthesia services, a student registered nurse anesthetist, and certified registered nurse anesthetist will all be defined.

Healthcare provider. A person who is qualified by education, training, licensure, and institutional privileging who performs a professional service within their scope of practice to the public.

Preceptor. A teacher or instructor in the clinical setting of SRNAs.

Clinical rotation. A portion of a nurse anesthesia program where learning takes place in institutions (hospitals and clinics) that provide anesthesia services. The students shadow preceptors and obtain hands-on experiences.

School of nurse anesthesia. A program of study where students are educated to become CRNAs. These programs offer either master's degrees or doctorates upon completion.

Anesthesia services. Providing the administration of medications to allow medical procedures, surgery, and exams to occur without pain and at times, without awareness.

Student registered nurse anesthetists. A student enrolled in a school of nurse anesthesia program. These students are Registered Nurses who are striving to become anesthesia providers.

Certified registered nurse anesthetist. An advanced practice registered nurse who has graduated from a school of nurse anesthesia program and passed the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

Significance of the Study

Many learners (nursing students, medical students, and SRNAs) report being the victims of incivility or bullying during the clinical phase of their programs (Elisha & Rutledge, 2011; Luparell, 2011; Thomas & Burk, 2009; Yasser et al., 2016). In a cross-sectional descriptive study by Elisha and Rutledge (2011), 70% of SRNAs had experienced verbal abuse. Sakellaropoulos et al. (2011) found that 92% (n=205) of CRNAs had experienced aggression in the workplace. These findings are alarming and indicate the need for further research.

A thorough examination of the literature revealed a pronounced gap in the research regarding SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This study sought to add to the current research by providing a phenomenological study that described SRNAs' perceptions of both incivility and bullying. By exploring the perceptions of SRNAs' experiences with incivility and bullying, further research could be recommended. Currently, no research exists which attempts to define the SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. There is also potential to decrease learning barriers SRNAs encounter in the clinical setting which incivility and bullying can create. Through identification and description of the concepts incivility and bullying, participants may also experience a decrease in both physical and mental stressors through identifying and describing their experiences involving them.

This study may also create a pathway to improving policy. By identifying and describing SRNAs' perceptions of incivility and bullying, creating a policy to mitigate these behaviors may become a more straightforward process. The creation of education

for CRNAs may become more trouble-free once the concepts are described from the participant's point of view.

Summary

Clinical experiences are vital to the education of SRNAs. Incivility and bullying may have negative effects on every level of Maslow's hierarchy. This fact indicated the need to explore SRNAs' perceptions of incivility and bullying by healthcare professionals in the clinical setting.

The study is presented in five chapters, a bibliography, and appendices as follows. Chapter two presents a review of literature related to incivility and bullying. This review revealed the need to further explore SRNAs' perceptions of incivility and bullying by healthcare professionals in the clinical setting. Chapter three describes the research design, methodology, procedure, and sample selection. Chapter four presents an analysis of the data. Chapter five contains a summary, conclusions, and further recommendations. Lastly, the study concludes with a bibliography and appendices.

CHAPTER II: LITERATURE REVIEW

Historical Context

We live in a time where incivility and bullying permeate many aspects of our lives. This is evident in public discourse, politics, and media. The research revealed incivility and bullying are prevalent in the workplace as well as in education. Some of the research examined the perceptions and prevalence of incivility and bullying, specifically in healthcare.

The incidences of incivility and bullying are increasing at an alarming rate (Clark, 2008; Luparell, 2011). Incivility and bullying invade our neighborhoods, places of employment, and institutions of learning. Incivility and bullying have multiple deleterious outcomes. For this reason, it is imperative incivility and bullying be examined.

Recent research has provided data regarding the harmful outcomes incivility and bullying can have on individuals, organizations, patients, and institutional culture. Schneider (1998) argued these issues must also be addressed in higher education. Three nursing faculty were shot and killed by a nursing student unhappy with his grades in 2002 in Arizona; afterward, the student took his own life (Clark & Springer, 2007). The aftermath of this event created a surge in the research regarding incivility and bullying in healthcare and education.

In 2004, the Institute of Medicine (IOM) (2004) produced a report addressing safety and healthcare. This report placed significant emphasis on the workplace environment of nurses. The IOM report discussed the need to provide a safe workplace. This report also discusses the need to address incivility and bullying in the workplace. The Occupational Safety and Health Administration's (OSHAs) recent report regarding

violence in the workplace addressed the scope of the problem. The OSHA report found 21% of nurses and student nurses reported being physically assaulted, while 50% reported verbal abuse. These assaults and verbal abuse were from other healthcare workers, patients, and families (OSHA, 2018). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published "Improving Patient and Worker Safety" to raise awareness regarding incivility and bullying. The report stated civility is a necessary component of safe workplaces. Furthermore, JCAHO emphasized care team members must be treated with respect. JCAHO included the idea that leaders play a crucial role in the mitigation of incivility and bullying (JCAHO, 2012).

Most professional organizations have professional standards and regulations addressing incivility and bullying. Many professions have disseminated data on incivility and bullying to help address these issues in the workplace. Until only recently, employers and educators were unaware of the damage incivility and bullying may cause.

Roberts (2010, p. 86) states, a "comprehensive, up-to-date literature review allows you to get to the frontier in your area of research and, at the same time, become an expert in your field." Additionally, she states, "the insights and knowledge you gain provide the basis for a better-designed study and enhance the possibility of obtaining significant results. A review of the literature is a vital part of the research process." (Roberts, 2010, p. 86). The purpose of this literature review is to examine current evidence as it relates to incivility and bullying in healthcare, specifically nursing, nursing education, nurse anesthesia, and nurse anesthesia education. Examination of this evidence is of utmost concern for the public due to the effects incivility and bullying have on the victims, patients, organizations, and healthcare team.

Theoretical Context

Incivility and bullying cause damage to one's dignity, ability to learn, perform, and often affect a person's intrinsic value of self-worth (Clark, 2017b). In 1943, Maslow introduced his theory of human motivation, also known as Maslow's hierarchy of needs. This theory postulates each human need is built upon the satisfaction of the previous need. For humans to achieve self-actualization, they must first meet the needs of each level. The five hierarchical needs are as follows: physiological; safety; love, affection, and belongingness; self-esteem; and lastly, self-actualization (Maslow, 1943).

Incivility and bullying have the potential to interfere with every level of Maslow's hierarchy. Basic needs can be altered due to depression, while not feeling safe at work may also disrupt the hierarchal level of safety. In addition, psychological needs could be affected by isolation or attacks on character. Finally, self-actualization can be altered if a healthcare worker chooses to leave the profession.

The transition from student to practitioner can be difficult. For nurse anesthetists this transition requires many skills learned during their program. These skills include the application of practice, professionalism, accountability, critical thinking, and responsibility. Students go on to utilize these skills in their professions. Tracy (2016) identified five important factors that promote this transition. These factors are as follows: mastery of self-efficacy and confidence; expert coaching and guidance; supportive work environment; peer support; and previous experience. Without these skills, SRNAs are unable to enter the profession and be capable practitioners. Incivility and bullying can cause gaps in the achievement of these necessary skills. The aforementioned skills are all represented within Maslow's hierarchy; outside interference could disrupt SRNAs on their path to achieving self-actualization. Disruption in Maslow's hierarchy may prevent

progression, once SRNAs are practicing in the profession of anesthesia, into realizing their talents and potential.

Incivility and bullying share some sub-themes. Those sub-themes include organizational factors, cultural factors, and educational factors. At the same time, incivility and bullying differ as they relate to behavioral factors. For this literature review, incivility and bullying will be examined together concerning the first three sub-themes and separately when addressing behavioral factors. It is important to realize some of the literature combines the two terms, while they are separate concepts. In the next section, a deep dive into the literature will provide information on incivility and bullying, along with their sub-concepts and associated themes.

Incivility and Bullying

The American Nurses Association (ANA) Code of Ethics is a statement addressing the ethical obligations and requirements for every nurse. This statement provides the ethical standards for each nurse and their commitment to society. ANA mandates nurses exercise civil behavior and communication in all interactions. The ANA further stipulates that a nurse's behavior "demonstrate respect and a professional demeanor to help reinforce civility and positive norms" (2015, p. 8). There are several definitions in the literature for incivility. Luparell's (2003) and Clark's (2017) definitions have been combined for this paper and incivility is described as actions that are ambiguous in intent, non-physical, or involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation, or exclusion). The behaviors create a disruptive environment and may lead to or escalate to bullying or lateral violence.

Bullying is defined in several ways in the literature. The Joint Commission on Accreditation of Healthcare Organization (JCAHO) indicated that bullying behaviors

consist of repetitive, harmful mistreatment of one or more people (the targets) by one or more persons. JCAHO also described bullying as abusive conduct, verbal abuse, threatening, intimidating, or humiliating behaviors, and sabotage. There are five categories of workplace violence listed by JCAHO, which include the following: threat to professional status (public humiliation); threat to personal standing (name-calling, insults); isolation (withholding information); overwork (setting impossible deadlines); and finally, destabilization (failing to give credit when earned). The JCAHO (2016) list does not include illegal harassment and discrimination. The American Association of Nurse Anesthetists (AANA) and the ANA described bullying as behaviors intended to intimidate, offend, humiliate, and cause distress (AANA, 2014; ANA, 2014). For this paper the above sources were combined and bullying is defined as purposeful, repeated, and violent behaviors that cause harm.

Incivility and bullying have been widely studied in nursing and nursing education. There is very little literature regarding incivility and bullying regarding CRNAs; very little research is available as it relates to SRNAs as well.

When incivility and bullying are present in the workplace, there is a threat to safe, collaborative, and interprofessional practice (Jones, Echevarria, Sun, & Ryan, 2016). The literature revealed sub-themes in incivility and bullying. These sub-themes include organizational factors, cultural factors, educational factors, and disruptive behaviors. Each of these sub-themes will be examined in the following sections.

Organizational factors. It is important to realize the role an organization assumes regarding incivility. Healthcare is riddled with hierarchical structures. Without a robust human resources department and effective policies and procedures, an organization could wind up contributing to incivility. Smith, Morin, & Lake (2018) produced a study that

examined the effect the work environment has on incivility. They discovered the nurse work environment was dramatically inversely associated with coworker incivility. Put another way, the higher the quality of the work environment, the less incivility occurred among co-workers. Another study by Kutney-Lee, Wu, Sloane, and Aiken (2013) demonstrated how improvements in nurse work environments over time were associated with less burnout ($p<0.01$), less intent to leave ($p<0.01$), and less job dissatisfaction ($p<0.01$). This longitudinal study was conducted in 137 hospitals over a five-year period. Positive changes in resource adequacy, leadership, support of nurses, and physician-nurse relationships led to improved satisfaction and retention (Kutney-Lee et al., 2013).

Bullying has been linked to a low commitment by the organization (Demir & Rodwell, 2012). Bullying is prevalent in healthcare. Students in clinical settings may find themselves victims of their own preceptors (McKenna & Boyle, 2015; Daugherty & Rowley, 1998; Laschinger, Spence, Grau, & Wilk, 2010). This is especially true in organizations experiencing low commitment levels.

Hierarchical structure in healthcare and policies and procedures are two important concepts related to organizational factors in incivility and bullying. Following is a description of how both concepts have an impact on incivility and bullying in healthcare.

Hierarchical structure. Hierarchical structures in healthcare are organizational structures where each entity or person is subordinate to another. In healthcare, a hierarchical structure is frequently seen as physicians at the top and students at the bottom.

Student Registered Nurse Anesthetists attend graduate school after obtaining their bachelor's in nursing degrees. They are required to practice in an Intensive Care Unit for a minimum of one to two years before applying to an anesthesia program. Most

programs are three years in length. A large portion of education is done in the clinical setting. After passing boards, CRNAs have several practice setting options. These may include urban, rural, and academia. CRNAs also have many different practice options, including being medically directed by an anesthesiologist, independent practice, supervised practice, an all CRNA group, and hospital employee. Due to the different practice options and the urban need for CRNAs, many CRNAs are part of a hierarchal system. The Anesthesia Care Team (ACT) model for the delivery of anesthesia services is one such system. ACT is utilized in most urban organizations. This system places an anesthesiologist with a CRNA, and there is potential for an SRNA to be assigned to the team as well. This hierarchal structure has been shown to cause stress for CRNAs who report a lack of independent practice, discomfort with ethical decisions, and lack of control over their practice (Sakellaropoulos, Pires, Estes, & Jasinski, 2011). Radzvin (2011) reported 38% (n=300) of CRNAs felt powerless in interactions with physicians.

In 2010, the Institute of Medicine (IOM) reported in their *Future of Nursing* report that nursing must promote and engage in interprofessional collaboration (Institute of Medicine, 2010). Equally, the ANA (2015) mandates that a nurse's conduct be free of prejudice, harassment, and threatening behavior in all interactions with others. As previously mentioned, the ANA also provides a code of conduct for all nurses.

Of note is how contributing factors were divided into personal and systemic. Systemic factors were identified by Lim and Bernstein (2014), which they believe contribute to incivility in healthcare. Systemic factors included job pressures, productivity demands, fear of litigation, and hierarchical structures or differences in autonomy and empowerment. Individual factors included self-centeredness, immaturity, and altered coping skills.

Another study concluded uncivil behaviors are utilized in order to maintain power or control over others (Jones et al., 2016). In a qualitative study that explored why experienced nurses were leaving the profession, oppression was found to be a significant factor. Oppression was described by one of the nurses stating, "I really felt as a pawn between administration, staff, and doctors…I was a job…" (Freire, 2000, pg. 50). Further, another nurse added, "the oppressed have been destroyed precisely because their situation has reduced them to things…to regain their humanity, they must cease to be things." (Freire, 2000, pg. 50). In addition, Jacobs and Kyzer (2010) produced a study in which nurses listed other more experienced nurses as the more frequent perpetrators. Perception of power is a common cause of incivility and bullying in healthcare. Laschinger et al. (2010) expressed that structural empowerment was statistically significantly and negatively related to workplace bullying exposure. Similarly, Jones et al. (2016) stated that uncivil behaviors are best understood as ways of maintaining power or control over others. Oppression and power both contribute to an atmosphere of incivility and bullying.

It is in the operating room where CRNAs teach. The operating room is also where SRNAs practice and learn skills. Hierarchies exist in the operating room. Hierarchies have the potential to promote bullying. "The operating room is highly volatile and does not function under the same protocols as that found in other private, public, or hospital work settings" (Sakellaropoulos et al., 2011, p. 55). It is important to realize that aggressive and disruptive behaviors among doctors and other members of the healthcare team may jeopardize patient safety, cause harm to the victim's self-esteem, and contribute to negative attitudes (Sakellaropoulos et al., 2011). Also reported in the Sakellaropoulos et al. study, 58.4% of CRNAs indicated that supervisors are the most

likely offenders of bullying. They go on to document, "CRNAs are made to feel incompetent by [physician's] remarks about them without foundation for it and made to feel they cannot work without [physician] supervision" (Sakellaropoulos et al., 2011, pg. S55). Work relations between CRNAs and anesthesiologists or other health professionals contribute to the CRNA stress more so than any other stressor (Boyd & Poghosyan, 2017).

Mitigation of unhealthy hierarchical structures in healthcare can occur via education regarding multidisciplinary teamwork. Riskin et al. performed a study involving 24 Neonatal ICU teams. The teams performed a scenario depicting a septic preterm infant whose condition deteriorated. Examined was whether rudeness or incivility altered the team's performance. Teams consisted of doctors, nurses, and advanced practice nurses (APRNs). The study concluded that rudeness and incivility had adverse consequences on the performance of the team. Information sharing and help-seeking mediated incivility and bullying (Riskin et al., 2015).

A hierarchical structure has the potential to contribute to a hostile work environment for healthcare providers. Organizations need to be aware of the dangers hierarchies can present. Another key point that influences incivility and bullying in healthcare is the organization's policies and procedures and their availability to healthcare workers.

Policies and procedures. An effective human resources policy must be easily defined and eliminate barriers to the person reporting a violation. It needs to reach beyond simply defining the behaviors. A clear plan must be provided. "Given the negative consequences and high costs of workplace incivility, it is imperative for academic institutions to develop, implement and broadly disseminate policies to foster civility that

support a healthy academic work environment" (Clark & Ritter, 2018, p. 326). Clark and Ritter (2018) gave an example of a policy that assisted in supporting a healthy academic work environment. The example included what a healthcare worker should do if they are subjected to abusive conduct, and how to file a written complaint with a supervisor or with human resources.

Leiter, Lashinger, Day, and Oore (2011) explained that the failings of individuals do not create incivility, but patterns of social interaction which are sanctioned by the management environment most certainly do—instituting clear and fair policies and procedures for incivility assists in mitigating uncivil behaviors caused by social interaction at organizations.

With this in mind, the National League for Nursing (NLN) revised the Healthful Work Environment Toolkit in 2018 so organizations could assess and develop healthy academic nursing workplaces (NLN, 2018). The tool kit included nine elements NLN described as constituting a healthy environment: salaries, benefits, workload, collegial environment, role preparation and professional development, scholarship, institutional support, marketing and recognition, and leadership (Brady, 2010). Clark (2017b) offered the addition of three more. These three included "establishing and committing to a shared vision, mission, values and norms; engaging in effective communication and constructive conflict negotiation; and fostering individual, team and organizational civility" (Clark, 2017b, p. 120).

By instituting fair and confidential policies and procedures for the reporting of incivility and bullying, mitigating those behaviors within organizations can be assisted. It has been suggested by Boyd and Poghosyan (2017) to develop and utilize a zero-tolerance policy on bullying. When developing a policy, Boyd and Poghosyan (2017)

identified four themes that are important to consider: collaboration and communication, professional identity and autonomy, work relations of CRNAs, and CRNA outcomes regarding practice. Consideration of these themes promote CRNA practice and assist in creating an organizational environment in which CRNAs will experience less incivility and bullying.

Workplace culture contributes to the work environment. Workplace cultural factors play a role in the occurrence of incivility and bullying at institutions. Workplace cultural factors will be examined in the next section.

Workplace cultural factors. Members of healthcare teams deserve to have a healthy workplace culture where each professional is valued, respected, and treated with dignity (Clark & Ritter, 2018). Workplace culture can have positive or negative effects on the institution, employees, students, and patients. Culture is often the sum of a workplace's values, traditions, beliefs, behaviors, and attitudes. Positive workplace culture impacts happiness and satisfaction (Clark & Ritter, 2018). In a literature review conducted by Brinkert (2010), it was determined that conflict is rampant in nursing and may have many effects, including higher absenteeism and increased turnover.

Bullying is present when the workplace culture allows dominant individuals to attack those who are more vulnerable. Students are at risk for bullying because they are a more vulnerable population. Bullying is dangerous to an organization's culture and can result in dissatisfaction, disengagement, and absenteeism (Vessey et al., 2011). Nurse anesthesia culture is a highly stressful, high acuity environment and frequently calls upon the use of critical thinking skills. This culture differs from and expands outward from nursing culture (Emblad et al., 2014).

Sub-themes contributing to the culture of organizations are leadership or leadership milieu, isolation or exclusion, and collaboration and communication. All the previously mentioned sub-themes join together and can positively or negatively affect the organization's culture.

Leadership/administration milieu. Incivility develops from the repetitiveness or patterns of social interaction which have been allowed by leadership (Leiter et al., 2011). Nurse leaders and managers can support subordinates in working through conflict by utilizing proactive and reactive interventions (Brinkert, 2010). Brinkert (2010) also suggested nurse leaders can assist by building integrated management systems. Kaiser (2017) discovered leadership style was not a definitive factor of incivility. However, behaviors emulated by leaders and administrators have a direct effect on the level of incivility among nurses. Nurse leaders who display civil behavior will be emulated. Kaiser stated, "The relationship between leaders and staff and the empowerment of staff has the strongest impact on nurse incivility" (Kaiser, 2017, p. 110). Smith et al. (2018) found supportive nurse managers have a positive impact on coworker incivility. Evidence suggested that leaders and managers should act as a good example for others to follow (Brinkert, 2010; Emblad et al., 2014; Kaiser, 2017).

Leadership plays a vital role in the creation of a culture within an organization. Because of this important role, it must be remembered that leadership may also be the path to positive change. In a study of surveyed nurses (N=108) who were asked who was doing the bullying, 61.1% reported having witnessed bullying by another nurse, 49.1% by a physician, and 26.9% by a charge nurse (Wilson, Diedrich, Phelps, & Choi, 2011). Physicians and charge nurses are in positions of leadership. These data help explain why

bullying is still occurring in healthcare. Team members must be able to rely on their leadership and supervisors.

Isolation/exclusion. A qualitative report on nurse abuse by Tinsley and France (2004) reflected upon how the participants describe the behavior of nurses along with how nurses did not support each other. One participant recalled how nurses in her unit developed the hatch mark system. They would place a hatch mark under each new nurse's name for every mistake made. These behaviors contributed to feelings of isolation and exclusion. Sakellaropoulos et al. (2011) discovered one of the themes which emerged in their study was how SRNAs felt indirect aggression could be classified as ostracism or exclusion. One example was not being relieved for breaks.

Feelings of exclusion are not unique to nursing. In a qualitative study of students in a variety of health professions (midwifery, physical therapy, occupational therapy, and others), students reported having guidance or teaching withheld along with being socially excluded from the working community (Hakojarvi, Salminen, & Suhonen, 2014).

While the number of perpetrators may be small in healthcare, the potential is present for these perpetrators to significantly corrode the workplace environment via behaviors that isolate and exclude healthcare providers (Clark & Davis-Kenaley, 2011).

Collaboration and communication. Collaboration and communication can set the tone for workplace culture. Likewise, inadequate communication was one root cause of most learners' perceived mistreatments and dissatisfactions (Daugherty & Rowley, 1998). In addition, Daugherty and Rowley (1998) stated communication classes should be added to all medical school curriculums to aid in addressing incivility and bullying. A breakdown in communication can lead to anxiety and stress, which then may lead to patient errors. SRNA students ranked clear communication as the third most important characteristic of

a clinical preceptor in a study by Elisha and Rutledge (2011). As stated previously in this literature review, CRNA clinical preceptors believed their communication skills with SRNAs were highly effective (Elisha, 2008). Effective professional communication and collaboration are necessary components of anesthesia practice. Incivility and bullying can interrupt interprofessional communication, which predisposes healthcare professionals to errors and deleterious patient outcomes (Vessey et al., 2011).

To summarize, team leaders and administration have direct impacts on the culture or milieu of an organization. Isolating or oppressing groups or individuals can have negative effects on employees, patients, and students. Effective collaboration and communication between team members assists in resolving conflict and aids in creating a positive and civil culture.

Educational factors. Feldman (2001) stated incivility is described as behaviors (rude or discourteous) which may disrupt the academic environment. The educational environment is described by Clark (2017b) as "any location associated with the delivery of education, including live or virtual classrooms as well as the clinical setting." Many students (nursing, SRNAs, and medical) reported being the victims of incivility or bullying during the clinical phase of their programs (Baldwin, Daugherty, & Eckenfels, 1991; Benner, Sutphen, Leonard, & Day, 2010; Luparell, 2011; Elisha & Rutledge, 2011; Thomas & Burk, 2009; Yasser et al., 2016). Due to incidents demanding critical thinking, high-stress situations are the norm in the professions of medicine, nursing, and nurse anesthesia. When students are experiencing incivility, their stress levels rise. This may impair learning, and students may even consider withdrawing from their programs. A code of conduct, coupled with strong policies and procedures, provides students with resources to assist in mitigating incivility.

Equally important is the concept of threading the topic of civility throughout a program's curriculum (Luparell, 2011). This philosophy is important because students may enter the profession as change agents after exposure to material on civility. Students exposed to a threaded curriculum, code of conduct, and strong policies and procedures will go on to become strong, kind, and civil clinical preceptors (Luparell, 2011). SRNAs encounter significant stressors while enrolled in graduate school. Included in the stressors identified by Phillips (2010) is conflict with faculty or clinical preceptors.

The sub-themes which emerged from the literature relevant to education and incivility included how incivility and bullying affect learning, attrition, use of a code of conduct, and clinical preceptors. Each of these sub-themes will be explored.

Learning. The students in healthcare today are the future of their professions. Students need to be able to learn while they are in clinical. Barriers to this learning can harm or halt the learning process. Nursing students, SRNAs, and medical students all are required to attend clinical training in preparation for practice (Luparell, 2011). In a cross-sectional descriptive study by Elisha and Rutledge (2011), 70% of SRNAs had experienced verbal abuse during their program. These findings are alarming and indicate the need for further research.

Unsuccessful communication and collaboration between CRNAs and SRNAs create a barrier to learning. In a capstone project from 2018 1500 SRNAs were sent invitations, yielding a 9% participation rate (N=133). The project found 89.2% of SRNAs who were bullied or treated uncivilly could not think clearly as a result.

Attrition. Incivility can have negative outcomes on student attrition rates and sick leave. Wilson, Gibbons, and Wofford (2015) discovered that each student who leaves a program is a significant loss of time, money, and effort. Cook, Arora, Rasinski, Curlin, and Yoon

(2014) found 61% (N=919) of medical students reported at least one occurrence of incivility by faculty. Mistreatment and incivility were found to be associated with high burnout. Likewise, Wilson et al. (2015) conducted a study regarding attrition rates in SRNAs. They found 16 of 40 SRNAs who left their programs had experienced a loss of motivation to complete the program. Motivation can be diminished by incivility.

Wilson et al. (2015) discussed how faculty could perceive student attrition or sick leave as being caused by cognitive factors. The results found that personal and motivational factors can significantly affect attrition and sick day use. It is important to note that students who exhibited more external loss of control believed other forces (clinical instructor or professor) were the cause of their decision to withdraw.

Code of conduct. A well-written code of conduct serves the purpose of instilling behavioral expectations in students. This concept is important because students who learn civil behaviors during their education will go on to emulate those behaviors in the profession. Elisha and Rutledge (2011) suggested implementing standards of conduct for all healthcare team members. Standards will decrease the amount of incivility and bullying which occurs. Put another way, "Developing and implementing a comprehensive code of conduct that includes clear ground rules may be a viable pedagogic approach to battle incivility" (Authement, 2016, p. 19).

Clinical educators. Research revealed students might be treated poorly by clinical preceptors during clinical rotations (Luparell, 2011; Thomas & Burk, 2009). Vessey et al. (2010) reported nurses who experienced bullying themselves are more likely to bully others.

Bandura's Social Learning Theory is based on the constructivist thought that there is a direct relationship between learned or observed behavior and our actions (Bandura,

1986). Often humans will mimic the behavior of others. This theory could explain the negative effects of incivility and its prevalence on the education of clinical students. This is especially true if the preceptor had an educator who practiced incivility or bullying (Elisha & Rutledge, 2011). The theory would support the idea that CRNAs may be emulating their own experiences with the clinical preceptors they have had in the past.

During the clinical phase of their education, SRNAs are taught by CRNAs or clinical educators. Certified Registered Nurse Anesthetists believed they communicated effectively and clearly with students and that their communication skills were highly effective (Elisha, 2008).

In a descriptive study by Clark and Springer (2007), uncivil actions by faculty towards students were described as belittling, taunting, sarcastic, humiliating, intimidating, and refusing to answer questions.

Due to the high stress of school, healthcare students need a positive barrier-free clinical experience. Educating the clinical preceptors could help in changing any previous behaviors the educator may have learned from their own preceptors. If Bandura's theory is true, incivility and bullying could be being passed down from teacher to learner.

The literature revealed differences regarding incivility and bullying as they relate to behaviors. The next two sections will discuss these behaviors specific to each topic.

Behaviors in incivility. Some researchers postulate that aberrant behavior at work is the result of stress and overwork (Elmblad et al., 2014). Sakellaropoulos et al. (2011) found a positive correlation between job stress and direct verbal aggression. Chipas and McKenna (2011) described the high rates of burnout due to the monotony of the nurse anesthesia profession, coupled with moments of intense rapid critical thinking. They also

expressed that CRNAs experienced frequent and intense interactions with other healthcare team members; these intense interactions can increase the likelihood of incivility to occur. These intense interactions include situations where patients are critically ill.

Anderson & Pearson (1999) described workplace incivility as "the occurrence of low-intensity behavior exhibiting an ambiguous intent to harm" (pg. 457). The ANA released a position statement in 2015 which reviewed some of the behaviors included in workplace incivility; these included "discourteous actions, gossiping, spreading rumors, refusing to assist a co-worker, name-calling, and public criticism" (p. 2). These defining characteristics are a broad range of behaviors that are non-violent, could affect self-esteem, and have ambiguous intent. In a 2012 study of 370 participants, 38% of physicians, nurses, and staff linked disruptive behaviors to adverse events (Rosenstein & Naylor, 2012). Outcomes from incivility have been linked to mental and physical health issues, burnout, and lost productivity (Read & Lashinger, 2013; Lashinger-Spence et al., 2010).

Incivility differs from bullying because incivility is described as having ambiguous intent, being non-physical, and harmful to self-esteem. The triad of these factors assists in differentiating incivility from bullying. Behaviors in bullying will be discussed next.

Behaviors in bullying. After initial exposure to an act of aggressive behavior or bullying, the victim will assess whether the act was intentional or could have been influenced by extenuating circumstances. If it is perceived to have had malicious intent, and there are no signs of remorse or explanation, the likelihood of an aggressive response will increase (Sakellaropoulos et al., 2011). Bullying in the workplace is carried out by

one or more persons towards a target and is perceived as intentional (Zapf, Einarsen, Hoel, & Vartia, 2003). Workplace bullying repeatedly occurs with intention, unlike incivility which occurs typically only once. The occurrence of the bullying usually occurs weekly over a six-month timeframe (Johnson & Rea, 2009).

Bullying is intentional and purposeful. Violence and aggression are important factors in defining how bullying differs from incivility. In addition, bullying is repetitive and occurs over a span of time.

Outcomes of bullying and incivility. As previously mentioned, outcomes from incivility have been linked to mental and physical health issues, burnout, and lost productivity (Read & Lashinger, 2013; Spence et al., 2009). Recipients of incivility and bullying can fall victim to many physical ailments. These include reflux, ulcers, substance abuse, fatigue, and headaches. Hakojarvi et al. (2014) conducted a qualitative study in which students in a variety of healthcare professions reported symptoms such as sleeping disorders, fatigue, headaches, sweating, and abdominal symptoms. Psychological and altered mental health are also outcomes of being the victim of incivility and bullying. Hakojarvi et al. (2014) observed in the same study that students reported symptoms of anger, lowered spirits or depression, powerlessness, loss of self-esteem or confidence, anxiety, fear, and suicidal ideation.

In addition, healthcare workers reported career dissatisfaction, leaving the profession, absenteeism, and showing up late (Hakojarvi et al., 2014). This can influence organizations and educational institutions in the form of turnover, patient errors, and cost.

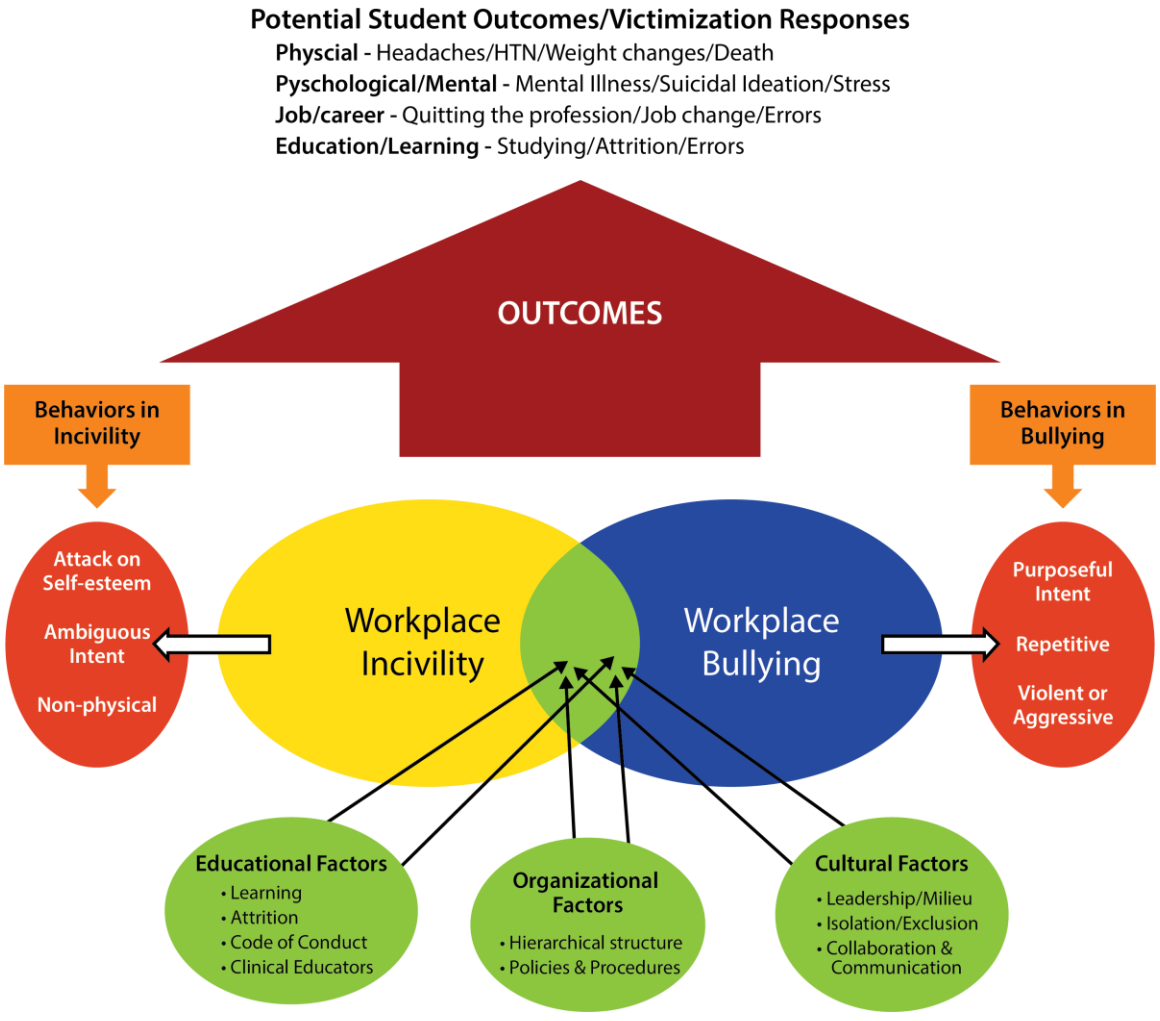
Incivility and bullying can have negative outcomes as they relate to education as well. Students reported wanting to quit school. Students also reported becoming disillusioned with the profession they chose. Furthermore, students stated when incivility

and bullying occurred, learning was not meaningful, and they experienced decreased motivation (Hakojarvi et al., 2014; Elisha & Rutledge, 2011).

Certified Registered Nurse Anesthetists also suffered implications from these behaviors. More research was conducted recently due to the increased incidence of incivility and bullying and loss of workforce (Boyd & Poghosyan, 2017). In a study of 800 CRNAs, Radzvin (2011) discovered that CRNAs generally experienced moderate moral distress (regarding ethical decisions), and a small number of them experienced high levels of moral distress. This included situations in which CRNAs felt they knew what they should do, but felt they were unable to follow through with what was right due to consequences. When employees work under these kinds of stressors, they will only be able to work for a limited amount of time (both physically and mentally). Another study examined the prevalence of incivility and the effects of burnout and discovered there exists a statistically significant, direct relationship between workplace incivility and professional burnout. Emblad et al. recommended the most notable deterrent was to utilize a zero-tolerance policy for practice, regardless of the person's title or role (Elmblad et al., 2014). In Emblad et al.'s (2014) study, a mean composite score of incivility experienced from CRNA supervisors was 37.6, with a median of 31.4. The mean composite score was 62.3 from physicians with a median of 62.8. A limitation of the study was that the authors did not describe the high and low range of the subscales, and therefore, an interpretation of the study was challenging. Boyd & Poghosyan (2017) found 92% of CRNAs experienced active aggression, 90% verbal aggression, and 83% physical aggression from supervising physicians, defined as surgeons and anesthesiologists. In a culture of incivility, employees are likely to burnout, leave, or retire. This will influence current and future students' abilities to succeed.

Incivility and bullying can have negative effects on every aspect of a healthcare worker's life. Healthcare workers can suffer from physical and psychological effects. The obstacles incivility and bullying may present to students' educations may be insurmountable. The next section will reveal the gaps in the literature and summarize the key themes.

The following graphic is a summary of the literature review. The three sub-themes which may contribute to, or mitigate incivility and bullying are depicted below the two concepts. The behaviors specific to incivility and bullying are listed on either side of the concepts. The outcomes from workplace incivility and bullying are displayed at the top.



Summary

This literature search revealed three gaps in the literature. The first and most prevalent and significant gap revealed in the literature search was regarding SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This gap was evident as the literature search revealed only one capstone project relevant to the topic. The second gap was the occurrence of incivility and bullying towards SRNAs by healthcare providers in the clinical setting. The only literature on this topic was the same capstone previously referenced. The third gap relates to healthcare providers' perceptions of inflicting incivility or bullying on SRNAs in the clinical setting. Daugherty, Baldwin, and Rowley (1998) suggested that decreasing the perception of mistreatment would enhance learner satisfaction. Inadequate communication was one root cause identified by learners who perceived this as mistreatment and dissatisfaction. In Elisha's (2008) study, CRNA clinical preceptors believed they communicated well with students, that they were highly effective, and they created an environment that promoted learning. Some SRNAs, according to the Elisha and Rutledge study, stated that often professional and constructive communication was lacking during instruction.

Further research is needed in all three of these areas. Providing data on these gaps and researching incivility and bullying will allow healthcare team members to navigate Maslow's Hierarchy of Needs and achieve self-actualization. Furthermore, incivility and bullying have been proven to be detrimental to organizations, the culture within organizations, and education. Incivility and bullying differ in the behavioral factors they encompass. While incivility is ambiguous in intent, is non-physical, and attacks the self-esteem, bullying is purposeful, violent or aggressive, and repetitive.

Vessey et al. (2011) concluded in their systematic review that the overall quality and available evidence regarding incivility and bullying was lacking. Furthermore, there is a paucity of data-based research available for the clinical setting. SRNAs invest much of their education in the clinical setting. Prior to researching the prevalence of incivility and bullying regarding SRNAs in the clinical setting, a description needs to be defined of what SRNAs perceive these two concepts to mean. Defining these concepts will assist in knowing how to conduct further research regarding their prevalence. Researching SRNAs' perceptions of incivility and bullying by healthcare workers in the clinical setting is imperative and will assist in filling in the gap in the current literature.

CHAPTER III: METHODS AND PROCEDURES

This chapter describes the methods and procedures which were utilized in this study. In addition, data collection and analytical procedures will be presented.

Research Design

Phenomenology design was utilized in this research study. Phenomenology strives to extract data from the lived experiences of participants (Creswell & Poth, 2018). This study sought to extract rich data from the participants who were actively experiencing clinical while in nurse anesthesia school. Purposeful sampling was used in order to be able to obtain the rich and value-laden stories of the participants. The Principle Investigator (PI) also utilized qualitative methods such as triangulation, member checking, bracketing, winnowing, and iterative process in order to generate detailed participants' perspectives intact so that the phenomenon might be understood, and the research questions answered. These methods also provided for validity and reliability.

Population and Sample

The participants selected for this phenomenological study through purposive sampling were Student Registered Nurse Anesthetists (SRNAs). Purposive sampling allowed access to a particular population because that population had an understanding regarding the phenomenon or research to be explored (Creswell & Poth, 2018). The participants were chosen based on their exposure to clinical settings and healthcare providers. The anticipated number of participants for this study was between 10 and 15. Creswell and Poth (2018) define a heterogeneous group as one which should vary from three to fifteen individuals. An equal number of participants from each of three midwestern nurse anesthesia programs was desired; however, this number did vary depending on participant response. The study's sample consisted of full-time second or

third-year students from a Council on Accreditation (COA) credentialed nurse anesthesia program in the midwest, who had experienced more than one clinical rotation. Completing more than one clinical rotation allowed the participants to have had clinical experiences at multiple clinical sites. Using multiple clinical sites in the study also aided in the protection of the clinical sites and participants' identities while offering a wider sample to explore.

The PI and committee chair had both obtained the National Institute of Health certification (Protecting Human Research Participants; see appendices A and B). On March 31, 2019, an individualized introductory email was sent to each of the three program directors inquiring about their willingness to allow their students to participate in the study (see appendix C for an example). All three program directors responded and agreed to allow access to their student population. Upon IRB approval (obtained on July 1, 2019; see appendix D), an email was sent to each of the three Program Directors with a request to forward to potential participants an attached individualized email for recruitment. The email was requested to be forwarded to all SRNAs in their respective programs via their college (.edu) email addresses only (see appendices E and F). The attached invitation to participate email to the SRNAs was individualized as well for each program. Since the PI is faculty at one of the programs, the PI's chair was included on that invitation as a contact. This was done to create an added layer to prevent coercion in the event potential participants had questions regarding the study. A second email was sent after two weeks if the desired number of participants had not responded. Potential and interested participants were asked to contact the PI via the PI's student email address provided in the recruitment email forwarded by the directors. The PI allowed two weeks for potential participants to respond.

Upon receiving email responses, the PI contacted each prospective participant by their personal email and gave an overview of the study. The PI explored inclusion/exclusion criteria with the prospective participant and determined if they met the study criteria. If they agreed to participate in the study, then arrangements were made to meet individually with the participant at a private predetermined and agreed upon location. This location was not located at the participants' clinical sites or educational facilities.

The goal was to enroll four eligible participants from each of the three nurse anesthesia programs. Therefore, the first four eligible respondents from each of the three nurse anesthesia programs were selected. There were three participants who volunteered but did not meet the inclusion criteria. The PI did not have a greater number of participants than desired, so there was no need for an alternate list to be created. When the number of primary respondents did not meet the anticipated participant number goal, an individualized email reminder with the attached invitation to participate was sent to the Program Director. This email was sent two weeks following the original email utilizing the participants' college email addresses.

Demographics

Inclusion criteria for participation in this study included full-time second or third-year nurse anesthesia students from a COA credentialed midwestern nurse anesthesia program who were actively attending clinical rotations. The participants must have completed at minimum one clinical rotation and have begun a second clinical rotation prior to participating in the study. Clinical rotations must have been at two different institutions that provide anesthesia services (e.g., hospitals or surgical centers). Participants must have been able to read and speak fluent English.

Exclusion criteria included any part-time students. First-year students were also excluded. Any students who had experienced just one clinical rotation at an institution that provided anesthesia services (e.g., hospital or surgical center) were also excluded.

The anticipated age of the participants was that they would be older than 22 years of age and younger than 60 years of age. According to the National Board of Certification and Recertification for Nurse Anesthesia (NBCRNA), 2,439 students took the certification exam in 2018. NBCRNA reports 92.7% of these are under the age of 40.

According to the NBCRNA Annual Report (2018), approximately 69% of nurse anesthesia students are White, 10% are Hispanic/Latino, 7% are African American, 7% are Asian, 4% are unreported/unavailable, 2% report more than one race, 1% are Native Hawaiian/Pacific Islander, and 0.5% are American Indian/Alaska Native. From this demographic data on SRNAs, and given the geographic region, it was anticipated that 69% or greater of the study's sample would be white, with the possibility of a few participants having other ethnic backgrounds.

Description of Setting

SRNAs from three midwestern nurse anesthesia programs were interviewed for this study. All three programs offered a Doctorate of Nurse Anesthesia Practice. All three programs were accredited by the Council on Accreditation. The average class size for the three programs was approximately 23 students. The programs will be referred to in the study as programs A, B, and C. The SRNAs attended clinical at university hospital settings, urban private hospitals, rural hospitals, and clinic settings. The practice models the SRNAs were experiencing included medically directed, supervision or anesthesia care team (ACT), CRNA solo practice, and CRNA group practice.

Instrumentation

In this phenomenological study, open-ended questions were asked in face-to-face interviews to extract the rich lived experiences of participants related to incivility and bullying in the clinical setting. The PI incorporated the use of an interview protocol with these questions (see appendix G). Data collected during the interview included time and date of interview, location, who was obtaining the consent, the general milieu of the location, the interviewer, and the interviewee by their chosen pseudonym. The use of an interview protocol may assist in the extrapolation of the rich data desired from participants (Creswell & Creswell, 2018).

Procedure

The adult consent form was emailed to all selected participants using their personal email for review prior to answering questions and obtaining signatures of the consent form at the face-to-face meeting. A face-to-face meeting was scheduled at a private, mutually agreed pre-determined site. No interviews were conducted at the participant's clinical site or educational institution. The PI obtained private meeting space at a local business (library or restaurant private reserved room).

As a precaution to reduce the risk of coercion, the PI had the dissertation chair obtain consent from the students at program A. A training session took place where the PI and the dissertation chair discussed the information provided during the consenting process.

The PI or the dissertation chair brought colored official IRB stamped consent forms to the interview and provided the participants with a copy of the consent form. After introductions at the scheduled location, the PI or the dissertation chair provided a detailed explanation of the consent form and sufficient time for reflection. Participants

could cease participation in the study at any time during the process. Participants were told they would not suffer any repercussions if they withdrew from the study. Every effort was made to assure there were no negative consequences with the institutions, the faculty, or their respective schools or future clinical sites. The participant's clinical grades, clinical evaluations, or grades would not be affected in any manner. The student's relationship to the program and its faculty was not affected in any manner. Each consent form was tailored to include the local resources each participant may need (see appendix H for an example).

Upon completion of an explanation of consent, the PI or the dissertation chair obtained the participant's voluntary signed consent forms. These forms were placed in a locked box for transport back to the PI's office, where they were kept in a locked filing cabinet drawer in the locked office of the PI.

Interviews were recorded on two password-protected digital audio recorders. The participant was notified after obtaining consent, and prior to reading the interview protocol, that the recorders would be activated. The recorders were transported in the locked box in the locked compartment of the PI's vehicle. The participant was informed that the PI would be taking field notes during the interview.

The participant was asked to choose a pseudonym for the purpose of de-identification and confidentiality protection. Pseudonyms were used during data analysis to conceal the participants' identities.

In order to more accurately understand the perceptions of a participant, the PI developed and used the interview protocol, which included the interview questions.

A brief description of the study was provided to the participant which included the purpose and research questions. In addition, printed and laminated definitions of the

concepts incivility and bullying were provided to reduce confusion when answering interview questions (see appendix I). Laminated individualized resource cards were also provided to the participants. Bottled water and facial tissues were also available should the need arise. The PI then began the interview. The PI implemented key tools for conducting an interview in qualitative research. These tools included active listening, observation, staying within the study boundaries, respecting the time boundaries, being respectful and courteous, and utilizing the interview protocol (Creswell & Poth, 2018).

The same open-ended, semi-structured questions were asked of each participant. It was stressed to the participants at the start of the interview that the questions pertain to healthcare providers and not to patient interactions. Should a participant begin to discuss an interaction involving a patient, the participant would be redirected gently by the PI to the purpose of the study. The definition of each concept (incivility and bullying) were read to the participant prior to asking interview questions pertaining to each concept.

If a participant identified anyone by name, the PI used a coding system to de-identify these individuals. The coding system assigned a random letter of the alphabet as the identified individual's code. Any reported data utilized this coding to de-identify these individuals. In addition, if any participant identified an institution or program they attended, the PI utilized a coding system to de-identify the institution or program. This coding system randomly assigned a number to each institution and/or program.

Once interviews were completed, participants were thanked for their time. All participants were encouraged to take the laminated card with the list of resources specific to their region with them.

Prior to leaving participants were informed they would be receiving an email with the preliminary results sent to their personal email for member checking. Member

checking increases the rigor of qualitative data analysis. Member checking is utilized to verify the validity of the returned data. This is a validation technique used in qualitative research involving participants (Creswell & Creswell, 2018). Participants were asked to scan the preliminary themes extracted through data analysis and verify accuracy. The participants were asked to respond if they saw any corrections or errors. If no changes were needed the participant was asked to respond with confirmation. Any identified changes to the data by the participants were considered and completed. Member checked data indicated no changes necessary with initial themes and results.

Data were downloaded immediately following the interview to an encrypted USB drive. The encrypted USB drive was only utilized on the PI's password-protected personal laptop. Before inserting the USB drive into the laptop, the PI deactivated access to the internet, and did not reactivate internet capabilities until the USB drive had been removed from the laptop. When the data were not being actively used, the USB drive was locked in a locked metal box along with the paper data collection tools. The locked metal box was kept in a locked filing cabinet, inside the PI's locked office. The locked metal box was only accessible to the PI. Recordings will be deleted from digital recorders upon completion of the study. During transport of data the locked box was transported in a locked compartment in the PIs vehicle.

Audio recordings were shared with an employed transcriptionist via the PI's google drive which required a passcode (after signing a confidentiality agreement). Only the PI and the transcriptionist had access to the password required google drive. Data were transcribed into a Word document by the transcriptionist. The transcriptionist sent the Word document via the same PI's passcode google drive back to the PI. The Word document was stored on the PI's laptop which required two passwords and was

stored in a locked file cabinet in a locked office. The printed Word documents were stored in the PI's locked office in a locked filing cabinet, or in the locked box when transported. The transcriptionist deleted all work once transcribing was completed and verified by the PI.

All names and identifiers were removed from data collection tools and documents (computer, transcripts, and recordings). A master list of participants' information with their pseudonyms and personal emails was kept separately from the rest of the data in the PI's locked filing cabinet in the PI's locked office. The encrypted flash drive containing the interviews, word documents of the interviews, and all other data were kept in a separate locked drawer in the locked office of the PI. There was also an electronic copy of the interviews kept on the PI's laptop, which required two passwords and was kept in the PI's locked office. All research data will be destroyed upon the dissemination of the study.

Analytical Procedures

The following steps describe the process for data analysis utilized in this study. Upon return of Word documents from transcriptionist, the PI reviewed the written transcripts. The PI read all the transcripts. The PI then read all the transcripts a second time. The PI then began organization and preparation for analysis and coding utilizing Tesch's Eight Steps (Creswell & Poth, 2018). These steps are as follows:

1. The first objective was to obtain a sense of the whole meaning of the interview. The PI read all transcriptions thoroughly and carefully. The PI recorded ideas as they occurred while reading.

2. The documents were examined (one interview at a time) with the question "what was this about?" in mind. The underlying meaning of the information was sought, and thoughts were written in the margins.
3. Once the aforementioned task was completed for all data, the PI clustered similar topics together (the PI called these "categories"). These topics (categories) were formed into columns.
4. These columns of topics (categories) were then color-coded and appropriate sections of the interview text were color coded and placed in the corresponding topic (category). The data were then searched again to investigate if any new topics (categories) emerged.
5. Topics (categories) were examined for the most appropriate descriptor words, and these words were utilized to form themes. Similar topics (categories) were grouped together to reduce the number of themes.
6. A final decision was made on the appropriate descriptor for each theme.
7. The data were then assembled into the appropriate theme, and a preliminary analysis was performed.
8. If necessary, the existing data would be re-coded.

The initial themes were identified. The meaning of these themes was interpreted. Reliability was performed by careful review of transcripts and consistent comparing of the data to the codes. The utilization of bracketing was completed to avoid any researcher bias.

If clarification of any data were necessary, participants had been notified that additional meetings may be needed. Follow up meetings would have been conducted via

phone or in-person and would not have lasted more than 30 minutes. That information was included in the consent form. No additional meetings were needed.

Each participant had the preliminary results sent to their personal email addresses for member checking. Member checking increases the rigor of qualitative data analysis. Member checking was utilized to verify the validity of the returned data. Participants were asked to scan the preliminary themes and results and verify accuracy. Participants were asked to respond to the email with any corrections or errors. Participants were informed that if the PI did not hear back from the participant, the PI would be assuming they had no changes to the data. Participants were instructed to respond to the email (from their personal email addresses). Four of the ten participants responded to the member checking email stating they agreed with the findings and had no changes to make.

The dissertation chair reviewed the preliminary findings to support the triangulation of data. Any identified changes after this meeting were made to the data. After member checking and triangulation, themes were finalized. The meanings of the themes were interpreted. Reliability was insured through careful review of transcripts and consistent comparing of the data to the codes (categories).

The utilization of bracketing was completed to avoid any researcher bias. Bracketing allowed the PI to identify and set aside any personal beliefs the PI may have had (Creswell, 2018). Bracketing occurred when the PI identified personal preconceptions and beliefs and consciously set them aside throughout all phases of the research study.

The researcher winnowed the data at this point in the process. This included the process of narrowing down the memos or quotes the researcher would use in the

presentation of the results section of the study. Repetitive and memorable quotes were noted. The P.I. again met with the dissertation chair and discussed the final results.

After data analysis was completed, results were presented to the PI's dissertation committee. Upon approval, data was disseminated.

Ethical Considerations

Due to the sensitive nature of the concepts, it was necessary to acknowledge many ethical considerations. The nature of an interview raises concerns regarding authority and power versus participants feeling free to express lived experiences (Creswell, 2012). In addition, the PI is faculty to some of the participants. Coercion was an ethical consideration that needed to be addressed in the study, along with the following risks to participants.

Risks to Participants

There was a potential risk for loss of privacy, loss of time from participating, loss of confidentiality, and psychological or emotional distress related to reliving uncivil, painful, and/or traumatic experiences to the participants. Psychological or emotional distress may include damage to participant's self-worth, feeling humiliated, feelings of isolation, feelings of exclusion, and depression. In addition, participants were at risk for psychological, emotional, and physical distress in the event they relived a bullying experience where they encountered sexual harassment/abuse, verbal abuse, or physical abuse in the clinical setting. Participants were also possibly at risk for alterations in their ability to learn.

Evidence has shown when students are experiencing any of the above risks, their ability to learn may be negatively affected. Participants may have also been at risk of incivility and bullying or potential future employment prospects being compromised

should their data have become lost, or if in some way they became identifiable. Participants were at risk of coercion since the PI is faculty in the classroom to some of the participants.

Protection against risks

There were risks to the participants of this study. They included the risk of coercion, loss of privacy, loss of time, and loss of confidentiality. In addition, there was the risk of psychological, physical, and/or emotional distress related to incivility or bullying, and a risk of an alteration in the ability to learn. Next, the steps to protect against these risks will be discussed.

The risk of coercion was carefully considered by the PI. To lower the risk of coercion, the PI's dissertation chair obtained consent from the participants who attended program A. This aided in protecting this group of participants from the risk of coercion since the PI is also their faculty for didactic courses at program A. The consent form and invitations to participant for program A were tailored specifically to mitigate for this risk by listing the chair as the contact. This allowed any prospective participant the ability to freely ask questions they may have had regarding participation in a study in which their faculty was the PI. They were then able to decide whether they wished to participate freely.

Every effort was made to prevent a loss of privacy for the participants. All study materials were kept on a double password-protected laptop. An encrypted flash drive was utilized. The flash drive was kept in a locked box or in a locked file cabinet in the PI's locked office. Only the PI had access to secure study materials. All recordings were on an encrypted recording device and deleted upon dissemination of the study. The transcriptionist signed a confidentiality agreement. The original consent forms were

stored in a separate locked drawer in the PIs locked office. In addition, privacy was protected by transporting the data in a locked box in a locked compartment in the PI's vehicle.

Regarding the loss of time, every effort was made by the PI to respect the participants' loss of time by being on time to agreed meetings. In addition, the PI made every attempt at effectively using the participants' time by preplanning timely communication and interactions. Interviews were scheduled for 60 minutes. The PI was mindful to adhere to this timeline; however, the PI did not stop a participant in the middle of sharing an experience at the end of one hour. In addition, the PI did make every attempt to schedule interviews based on the convenience of the participant. Participants were also allowed to cease participation in the study at any time without any repercussions should the loss of time become a burden.

To prevent the loss of confidentiality, the PI scheduled face-to-face interviews in a predetermined private and mutually agreed upon site. These interviews were not conducted at the participant's clinical site or educational institution. All participants were de-identified using a pseudonym. All institutions, clinical sites, and/or healthcare providers were de-identified utilizing a coded system. All electronic communication took place utilizing the participant's personal emails. All data were transported in a locked box. All data were kept on encrypted USB drives and on the PI's double password-protected laptop. Original consent forms and the master list were kept in the PI's locked office in a locked drawer separate from the rest of the data, which was kept in a locked file drawer in the PI's locked office. All recorded data will be destroyed at the dissemination of the study. In order to attempt to mitigate the loss of confidentiality risk, the PI asked that all email communication after initial contact (from the program

directors) with participants to be via their personal emails that were not associated with any clinical site, educational institution, or employer.

In addition, audio recordings were uploaded into an encrypted flash drive and kept in a locked box inside a locked office with a locked filing cabinet. Only the PI had access to this data. Audio recordings were delivered to a transcriptionist after a confidentiality agreement had been signed. Audio recordings were uploaded via private google drive to the transcriptionist. Transcription transfer occurred on the PI's locked google drive, to which only the PI has the password lock. The returned written Word document transcripts were kept inside the locked filing cabinet in the locked office and were only accessible by the PI.

Participants were also at risk for loss of confidentiality in the event they disclosed a Title IX violation (Title IX protects students from discrimination, assault, or harassment related to sex or gender) to the PI. This risk is described below, and participants were informed that under such a circumstance, the PI had a moral/ethical/professional obligation to report to the designated Title IX coordinator at the institution the participant attended (see below for details). The Title IX coordinator is an expert trained in investigating allegations of sexual abuse or harassment based on sex or gender. Encrypted personal emailed were utilized by the PI as well as a locked google drive for transcription.

Psychological, physical, and/or emotional distress related to incivility was addressed as well. The topic of this study and reliving painful experiences had the potential to cause psychological and/or emotional distress to the participants. Psychological or emotional distress from reliving uncivil experiences may include damage to a participant's self-worth, feeling humiliated, feelings of isolation, feelings of

exclusion, anxiety, and depression. Every effort was made to mitigate this from occurring. Steps included utilizing an interview protocol to provide a relaxed and comfortable environment for the participants. In addition, participants were provided with resource contact information individualized to their location, including phone numbers and addresses, and for Employee Assistance Programs at their individual institution, should they need assistance with depression, anxiety, low self-worth, humiliation, isolation, or exclusion (see below for example). Participants were also provided the local and national numbers for emergency centers. This included local emergency room numbers as well as the national suicide hotline (included in the example below). These numbers were provided to the participants in the event they experienced any risks after the interview, and the study was complete. Participants were also encouraged to contact their healthcare providers if they experienced physical symptoms such as lack of sleep, weight loss/gain, or any concerning symptoms. Should the participant have stated at any time during the interview process they are actively suicidal/homicidal with a plan to execute, the PI planned to call 911 immediately. It is the ethical/moral/professional obligation of the PI to respond to any threats of harm or violence to the participant or others in this manner. These resources were included in the participant's consent forms and printed and laminated on wallet-size cards for the participant to take home.

Also addressed was the psychological, physical, and/or emotional distress related to bullying. Psychological, physical, or emotional experiences related to reliving a bullying experience where the participant encountered sexual harassment/abuse, verbal abuse, or physical abuse in the clinical setting were possible. In order to provide the utmost protection for the participants, the PI utilized the experts in the field. The PI

scheduled an appointment with a Title IX coordinator to obtain exact information to provide a participant who may share information related to verbal, physical, or sexual harassment or abuse. Title IX federally guarantees the protection of all students, regardless of their gender, against sexual misconduct and abuse. Title IX coordinators have a thorough knowledge and are the experts of Title IX law and campus policies. The coordinator is also the person who investigates and enforces disciplinary actions as they relate to Title IX offenses. In the event a participant should disclose any Title IX situation to the PI, the PI would confidentially inform the Title IX coordinator at the participant's institution. This information was included in the consent form and disclosed in the consenting process. The PI had an ethical/moral/professional obligation to report any Title IX violations to ONLY the Title IX coordinator. It is the Title IX coordinator's role to collaborate resources once aware of a violation. Participants were provided the Title IX coordinator (contact) at their institution (see list below). Each participant had this procedure explained in the consent process by the PI or the dissertation chair.

Participants might have experienced an alteration in their focus, concentration, memory, or ability to critically think due to the reliving of traumatic experiences. All participants were provided a resource to a learning help center at their individual institution should this occur (see example below).

The consent included a statement for the participants, which explained that any monetary charges/fees incurred by the participant for treatment would be the participant's responsibility. Separate consent forms for each institution were individually created (with the previously mentioned resources included) to uphold the integrity and confidentiality of the participants and institutions (see appendix I for an example). Each participant was presented with the laminated resource card to take with them prior to

ending the face-to-face meeting which listed all the resources specific to the participant's location. Participant referrals for resources for the three programs included:

Program
Title IX Coordinator/Dean of Students: Phone provided
Currently: Name Provided
Office: Address Provided
Police Department: 911
Student Success Center: Phone provided
EAP: Phone Provided
Program 1 Emergency Room: Phone provided
Professional Development Counselor: Name and phone provided
National Suicide Prevention Lifeline: 800-273-8255
National Substance Abuse Hotline: 800-662-4357

This study may benefit society but may or may not benefit the participants. The literature review identified a gap in the research regarding the perceptions of incivility and bullying by healthcare providers in the clinical setting. Any research which may help identify and define these terms may be useful in mitigating the occurrence of them in the future. This study may be beneficial to current and future SRNAs. This study may also be useful to other healthcare disciplines that struggle with incivility and bullying in the clinical setting. As stated earlier, incivility and bullying may cause physical, emotional, or psychological harm. In addition, they can cause an alteration of a student's ability to learn. Determining a definition of SRNAs' perceptions of incivility and bullying may lead to the mitigation of these behaviors in clinical practice and could benefit participants by improving the educational, clinical setting. SRNAs may experience a heightened awareness of incivility and bullying by participating in the study. Participants may also feel empowered by sharing their stories.

The benefits outweighed the risks of this study. The risks to participants were minimal in comparison to the potential benefit to current and future SRNAs, the

healthcare team, patients, and society in general. The risks to the participants were greatly reduced by processes which were rigorously researched and considered by the PI.

Summary

In this chapter, the rationale was provided regarding the reason the phenomenological research design was chosen for this study. Inclusion and exclusion criteria were presented along with the participant selection process. The anesthesia programs and type of clinical sites participants had experienced were discussed. Open-ended interview questions were presented along with the interview protocol. The data collection procedure and data analysis procedure including Tesch's Eight Steps were provided (Creswell & Poth, 2018). Lastly, the ethical considerations, risks to participants, and benefits of the study were addressed. Plans to mitigate these risks were presented which included extensive resources provided to the participants on the individual consent forms.

The next chapter will present the results of the study. The research questions will be presented. Each of the themes will be presented and discussed with supporting evidence provided.

CHAPTER IV: RESULTS

Introduction

As stated in Chapter One, the study described in this paper examined the perceptions Student Registered Nurse Anesthetists (SRNAs) have of incivility and bullying by healthcare providers in the clinical setting. This chapter discusses methods used to analyze the data, the data results, and it concludes with a summary of the results.

Data

This phenomenological study used a purposeful sample of 10 SRNAs who were currently enrolled at one of three midwestern schools of nurse anesthesia credentialed by the Council on Accreditation (COA). All participants met the inclusion criteria. Eight of the participants were female and two were male. Audio recorded, semi-structured interviews were conducted to examine SRNA's lived experiences with incivility and bullying by healthcare providers in the clinical setting. Audio recordings were professionally transcribed. Content analysis was conducted utilizing Tesch's Eight Steps (Creswell & Poth, 2018). The researcher first read through each transcript twice while making notes in the margins to achieve understanding. After reading twice through and getting a sense of the whole, while making notes in the margins, seven categories or codes were extracted and placed on poster boards.

Bracketing through self-reflection was conducted multiple times throughout the process to set aside personal beliefs or biases. Bracketing is necessary as researchers can affect the qualitative research process. Descriptive phenomenology involves the researcher setting aside personal beliefs to act in a non-judgmental manner (Sorsa, Kiikkala, & Astedt-Kurki, 2015). The researcher did, as recommended by the authors,

keep a journal or notes regarding feelings or personal beliefs related to the topic. The PI also discussed her beliefs and bias with her chair and a colleague.

Initial analysis was done by hand-coding the transcripts. Each transcript was read again, and 'memos' were highlighted with a specific color. The memo was written on a sticky note in the same color and placed on the corresponding poster board with the code to which it related. Once all the transcripts had the memos extracted, the PI created a word table and inserted all of the memos into it. Next, the PI met with the dissertation chair to discuss categories, memos, and formulation of the themes. This triangulation provided validity to the study. After coding the memos, six themes were extracted. Another word table was created, and each memo was placed with the theme to which it belonged. These six themes provided a more in-depth understanding of SRNA's experiences with incivility and bullying by healthcare providers in the clinical setting.

Results

There were two research questions identified in this phenomenological study. These two research questions were utilized to assist in guided coding. They included: 1) what experiences do SRNAs have with incivility as related to healthcare providers in the clinical setting, and 2) what experiences do SRNAs have with bullying as related to healthcare providers in the clinical setting? Multiple themes emerged from this phenomenological research study. The results section is presented by research questions, and each theme is examined with an explanation of its relationship with the research question. It is important for the reader to note in the results section when reading quotes from participants that unless otherwise specified by the participant or researcher, the quote may be referring to any healthcare provider (i.e., CRNA, MDA, surgeon, M.D., SRNA, and RN). In addition, participant pseudonyms are used when presenting the

results. Participant pseudonyms include: 1) Squeakers, 2) Perry, 3) Mary, 4) Carmen, 5) Mattie, 6) Suzie, 7) Betty, 8) Mr. Glass, 9) Joy, and 10) Julia.

Research Question One, Incivility.

The purpose of the study was to define SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This was achieved through interviews that captured the lived experiences of the SRNAs. The first research question sought to explore the experiences SRNAs had regarding incivility by healthcare providers in the clinical setting.

Incivility was defined for the participants as actions that are ambiguous in intent, non-physical, and involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation, or exclusion). The behaviors create a disruptive environment and may lead to or escalate to bullying.

Six themes emerged from the coded data and memos, which were extracted from the interviews. Those themes included educational experiences, professionalism, relationships, coping, health and well-being, and the perceived prevalence of incivility. What follows are the results of the study regarding SRNAs' perceptions of incivility by healthcare providers in the clinical setting. These results are categorized by themes and presented using the participant's chosen pseudonyms.

Educational Experiences.

Participants in the study overwhelmingly expressed that educational experiences were negatively affected (particularly during the first year of clinical) when incivility was present in the clinical setting. For example, when referring to the educational experiences to which they were exposed, participant Perry stated, "you get cutting edge cases at big universities [hospitals], but it is a huge trade off when it comes to the

learning environment." In addition, Perry also noted, "There are a few times incivility makes you afraid to ask questions. It blows my mind in something like anesthesia with really critical times in the perioperative period you are sorta looked down on if you ask a question in front of an MDA (Medical Doctor of Anesthesiology)." Likewise, when describing the clinical educators, Suzie responded, "I think there are two kinds of intimidating people, smart ones you learn from who want to teach, and the ones that just want to show you they are smarter than you, you don't learn anything from them." Also noted by Suzie was, "I don't think any of it stems from 'I want this SRNA to learn more,' the providers who are uncivil do it because they don't want you to have a good day. They are not there to teach you; they are there to make sure you walk away knowing they know more than you." Further, Suzie added, "I don't learn anything on days I am with those CRNAs. I go home questioning myself feeling like it was an unsuccessful day of clinical." In addition, Carmen had this to add, "The CRNA may be smart and a good clinician but I can't learn if they talk to me like this." When explaining learning, Betty stated, "The psychosocial side of it definitely impacted learning. There are days that I feel like it is just tense. You can just feel people's negativity you know." Mr. Glass added, "Early on I felt like I couldn't learn because I was so nervous about all of it and it kept me from learning." Lastly, Joy stated that "when I was first in clinical I wanted to be a good student, I didn't want to be the person who didn't know what they were doing because they [healthcare providers] talk about that sort of thing. I had that consuming my mind when I should have been able to be studying."

Professionalism.

The study found SRNAs felt an overarching disappointment with the lack of professionalism in healthcare providers in the clinical setting. SRNAs described this lack of professionalism as linked with perceived experiences of incivility.

When discussing communicating with healthcare providers, Mr. Glass noted: "You will get snarky remarks or comebacks through text message instead of professional replies." Betty indicated while communicating with healthcare providers they (SRNAs) were told, "There have been CRNAs who have said [to SRNAs] 'these are the good people and these are the bad people in your class' how do you respond to that?"

When describing interactions with healthcare providers Squeakers stated, "preceptors will change things (your setup for the anesthetic) when you aren't looking, or they themselves will mess up and then throw you under the bus when the MDA comes in the room and questions them." Another interaction detailed by Perry was, "We [SRNAs] go in the breakroom people will look at their watches as soon as you enter, they don't ask what kind of day I'm having, they ask if I need another case or room to go into. Your entire break or lunch is spent being harassed." When detailing the healthcare provider's attitudes regarding the unprofessionalism, Mattie stated, "The CRNAs know they are like this, they don't care. They talk and joke about it." In addition, Mattie also stated that "the minor incivility of eye-rolling and whispering I guess I would have hoped that adults, professional adults could be beyond that."

Relationships.

The research discovered SRNAs described their perceived experiences of incivility as having had a negative effect on their clinical relationships. However, the

participants also described the rewards of a multitude of positive clinical preceptor relationships with a honed-in focus on their rotations away from primary clinical sites.

Relationships in the clinical setting were described as being negatively affected by incivility. Julia reported that "when you are walking on eggshells, you are less focused on learning and a lot more focused on not saying something to get scolded. You focus on navigating tricky relationships." Likewise, Perry described the relationship as "it's very speak-when-spoken to."

Adding to the negative aspect of the relationship dynamic, participants described several occasions in which they overheard healthcare providers discussing students in public areas. Betty noted, "I heard CRNAs in the breakroom talking about students and so then I am wondering what they are saying about me when I am not sitting there?" Betty went on to say, "I watched an MDA in the breakroom making fun of a CRNA they were supervising that day." Squeakers added, "The CRNAs have to listen to the physician, I don't know if that plays a part in it."

In contrast, and of note, the study revealed SRNAs felt very positive about several clinical preceptor relationships, and some described these relationships as the thing which kept them motivated to return. Squeakers stated, "It isn't everyone, there are some really great CRNAs out there. The majority are very supportive." This participant went on to add, "You find someone who is kind and even if you have two weeks of terrible experiences, you have one good day with them, and it brings you right back." In addition, Perry stated, "I prefer the smaller rotations; people know your name and say hi to you." In addition, Perry added that "once I was further into the program I found it was very rewarding." During the interview Mary indicated, "Everywhere I have gone for my rotations has been really excited to have students." Joy goes on to say, "The rotation I

was on, their teaching style [was] they push you and want you to excel but it is not overbearing or demeaning in any manner. They are just respectful."

Coping.

This study revealed that SRNAs described a variety of coping mechanisms in response to perceived incivility by healthcare providers in the clinical setting. Some of the coping mechanisms involved utilizing resources such as school counselors, clinical coordinators, advisors, or talking with a friend. However, most did not. Some participants explain they were unaware of resources that were available to support SRNAs dealing with the effects of incivility. SRNAs describe utilizing classmates and spouses as support systems.

It is important to note 100% of the participants reported a plan of action that involved "laying low" or "keeping their head down" to get through it. For example, Squeakers stated, "I was told by others to keep my head down, don't post anything or tell people anything." Squeakers added, "yes, resources are available, people just see them as more of a burden to reach out and have nothing done or make something worse, and it's easier to just take it." In addition, Carmen added, "the resources told us we should suck it up and just do it." Likewise, Mr. Glass noted, "I have never heard of any resources. I mean, I am sure there are, I think you can go to this lady" (pointed to a resource on the card). Joy added, "yes, but I feel we are students, and we put our heads down, and we get through it. We are not allowed to say anything because that is what being a student is."

SRNAs found support from their classmates and cohorts when dealing with incivility. Perry noted they "found support from a classmate because they are an amazing person." Similarly, while Squeakers described, "the greatest support is from my class."

Health and Well-Being.

Health and well-being are described as being negatively affected when SRNAs perceive incivility by healthcare providers in the clinical setting. In interviews, SRNAs described the anxiety, stress, inability to study, insomnia, medications, feeling of low self-worth, isolation, a need for counseling, and thoughts of leaving the program/profession.

Describing some of these Squeakers reported, "You have the regular stress of school, and then you are warned about the social environment too. It piles on and makes you so nervous and tired." In addition, Suzie stated, "It is hurtful. It can cause a complex in you. It's an extra stressor; you don't need to have all these providers knowing you're awful at something. We have enough stressors." In a like manner, Betty described a day at clinical after experiencing incivility, "I felt like crying at clinical. The whole rest of the time I couldn't do anything right. It's like you failed for the day."

Participants mentioned that experiences with incivility by healthcare providers in the clinical setting caused them to reconsider their career choice or influenced where they would consider working. For example, Joy noted, "I want to go into a job that I know I am going to love and if I am hating it and hating the people while I am going through school, well." Joy added, "I was crying all the time, a lot." Regarding the decision of where to work after graduation, Mary stated, "the SRNAs who are picked on continuously don't want to stay after graduation. They won't consider taking a job there just because of their experience. They can't wait to get away and don't want to come back." It was of equal importance when Mattie pointed out, "I have learned some stuff, I have learned I never want to work at this place, and I don't want to be here."

According to the SRNAs, incivility takes a toll on self-worth as Carmen explained, “it makes me feel stupid, I feel like I am not worth their time which is unfortunate because I might be taking care of them someday. Shouldn’t you be teaching me?” In addition, Squeakers brought light to the same issue when they stated: “you feel as though you are at the bottom, you get used to it, you don’t have as much help as you wish you had.”

SRNAs discussed the need for medications for themselves and by peers in attempting to mitigate incivility by healthcare providers in the clinical setting. Squeakers noted, “there are students on beta blockers and anxiety meds just trying to get through.” Perry reported that “the treatment makes you feel sad.”

Perceived prevalence of Incivility.

The evidence revealed SRNAs perceived a pervasive prevalence of their experiences with incivility by healthcare providers in clinical settings. Each of the ten participants described incivility as occurring daily by healthcare providers in the clinical setting.

When describing incivility, Squeakers pointed out, “it is so normalized you assume it is like that everywhere and it is something everyone had to go through, you don’t want to complain, you just accept it and get through it.” Likewise, it is important to note Mr. Glass’s description of the prevalence of incivility when he stated “I feel like incivility happens every day at the large institution every 30 min, it’s a fact you must learn to deal with as an SRNA and be able to throw it under the rug so you can move on with your education.” In addition, Suzie referred to the frequency (of incivility) in her statement noting, “there is a lot of eye-rolling, which is a huge one. When you are

talking to a preceptor if you aren't saying just what they want you to say you get an eye roll or frustrated look."

When considering the perceived pervasiveness of incivility by healthcare providers in the clinical setting, the SRNAs described the potential for escalation into bullying. As Perry mentioned, "I am met with a bunch of dismay. I underwent a lot of bullying as a child growing up and entering a profession and doctoral program to find you are still being met with what right now is incivility but could very easily step into bullying is dismaying." By the same token, Squeakers described worrying about the escalation of incivility to bullying when stating this, "I think it inhibits our potential. I am always worried because incivility happens to everyone; only a few escalate to bullying, but you never know when, so you have to keep your head down."

Research Question Two, Bullying.

The purpose of the study was to define SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This goal was achieved through interviews that captured the lived experiences of the SRNAs. The second research question sought to explore the experiences SRNAs had regarding bullying by healthcare providers in the clinical setting.

This study defined bullying as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3) intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior, which causes harm.

Regarding bullying, the same six themes emerged from the coded data and memos. Those themes included educational experiences, professionalism, relationships,

coping, health and well-being, and the perceived prevalence of bullying. What follows are the results of the study (categorized by themes) describing SRNAs' perceptions of bullying by healthcare providers in the clinical setting.

Educational Experiences.

Participants in the study overwhelmingly acknowledged that educational experiences were negatively affected (particularly during the first year of clinical) when bullying was present in the clinical setting.

Negative effects were illustrated by Carmen when she described a clinical teaching situation, "I was brand new, drawing up meds. The CRNA began screaming at me to hurry. I mean like screaming. I pulled my syringe out of the vial too soon and a small amount sprayed, and he screamed at me 'JUST GO' in front of the whole O.R." She followed this up by noting, "he went on to yell, 'How long have you been a nurse? Don't you know how to draw up f****** meds?' He never apologized." SRNAs described how the feelings of bullying elicited in them caused a barrier to education. For example, Mary stated "scared, not scared but uncomfortable coming to clinical every day because you are dreading it, instead of making it a good learning experience you are dreading, just hoping you won't be with certain CRNAs because you know it won't be a good day and will hinder learning." In a similar fashion, Julia explained, "the first two semesters it really got to me it was upsetting. Shame and humiliation—those are uncomfortable feelings." While Betty stated, "you are scared to even ask questions, I mean, if I am just there to please that person and not ask questions, I just don't learn in an environment like that." Equally, important Joy added, "I 100% did not learn anything when I was humiliated except that I will never, ever, ever, treat a student that way."

Professionalism.

The study found SRNAs felt an overarching disappointment with the lack of professionalism in healthcare providers in the clinical setting. SRNAs described this lack of professionalism as linked with perceived experiences of bullying.

SRNAs described a high level of shock when referring to the low level of professionalism encountered when bullying was present in interactions with healthcare providers. For example, Mr. Glass reported that "the O.R. is like a theater and induction is the most silent part, and everyone is watching and staring at you waiting for you to get done. So, preceptors will be saying snippy things like 'where I trained we didn't have to deal with such stupidness." Two participants referenced the language healthcare providers used in the clinical setting when educating. Carmen noted, "I couldn't do anything right. Everything was stupid or wrong. The CRNA dropped the f-bomb at everything I did." When referring to the lack of professionalism Joy indicated, "I was so mad; I wasn't prepared to be personally attacked. It made me not want to go back. I don't want to be part of something like this."

Relationships.

The research discovered that SRNAs describe their experiences with bullying as having negatively affected their clinical relationships. When referring to the motivation behind the bullying behavior, Mattie stated: "it is 100% to make me feel bad and cause harm." Mr. Glass went on to discuss the CRNA/SRNA relationship juxtaposed to the MDA/CRNA relationship and had this to say, "We feel the conflict of the MDA/CRNA battle constantly, I feel that is why we get bullied constantly." In referencing a relationship with a preceptor, Carmen noted: "I spoke with another CRNA who was

friends with the abusive CRNA, and they said ‘that CRNA is great if you aren’t a student.”

Coping.

The study revealed that SRNAs utilize a variety of coping mechanisms when confronted with bullying. Some SRNAs described being aware of resources including the Title IX coordinator, counselors, clinical coordinators, Deans, and faculty. However, most SRNAs did not utilize the resources and in fact, deliberately did not seek them out and described a fear of making things worse.

Participants discussed leaning on classmates (in an effort to cope). For example, Suzie mentioned, “as students, we all talk to each other and tell each other our good and bad stories.” In a like manner, Mr. Glass described, “it’s hard to have an outlet other than my classmates to talk to about it. It isn’t something my spouse can fathom or understand. There is no way to describe what it is like.”

When describing accessing resources for bullying, Carmen had this to say, “I don’t feel like resources are specifically laid out for bullying. You kind of have to figure it out on your own.” In addition, Carmen added, “the CRNA I went to spoke with the bullying CRNA and told them to stop.” When Mr. Glass was discussing resources, they added, “I would never use a resource I would just push through, yah, absolutely.” Likewise, Suzie stated, “no, no resources. I think the dynamics there are just a bit different and I feel like me going to anybody would turn out negatively for me and make the situation worse.”

Health and Well-Being .

Health and well-being were described by participants as being deleteriously affected when SRNAs are confronted with bullying by healthcare providers in the clinical

setting. The data from the interviews revealed participants who experienced perceived bullying suffered from insomnia, anxiety, inability to study/focus on school, isolation, humiliation, feelings of low self-worth, and thoughts of leaving the program/profession. Participants also reported a need for medications and for psychiatric help.

When describing the stress, Joy stated, "I don't want to be treated like a slave because we get tired, and I mean we are still parents, spouses, and full-time students and I get tired, it's a lot." Referring to the anxiety, insomnia, and inability to focus on studies Joy also noted, "every night I have anxiety, every single night. I look to see if those people are on the schedule—to see if I am with them. I think about and have called in sick to avoid being with them."

Participants went on to describe deleterious health effects, such as needing medications to mitigate the effects of the bullying. Squeakers described that "there are students on beta-blockers and anxiety meds just trying to get through it." While Perry discussed a friend's situation, "the student almost left the program and wanted to go home and be a nurse again. Instead of dealing with it. The student is seeing a psychiatrist and is on medication." Julia stated, "I utilized the counseling department. I saw my physician about anxiety." And then went on to describe the following as a result of a bullying situation they had experienced "it is very challenging to feel very isolated in a new school suddenly", then added, "I was prescribed a beta blocker, I think it was affecting me more than I realized the first year. I had quite a bit more anxiety than I was even admitting to myself related to clinical. I was having insomnia before clinical and clinical without sleep is dangerous. I started having chest pain. It took me months to work through that clinical was causing all of this, anxiety from clinical." In another reaction to bullying Mr. Glass noted "at first it was worse, I thought to myself 'maybe

this isn't the program for me, maybe this isn't the career path for me, maybe I shouldn't be doing this because I obviously suck" and he added "there is mental harm from the verbal abuse of bullying."

Perceived prevalence of Bullying.

Evidence in this study revealed that SRNAs' perceptions of bullying by healthcare providers is a common occurrence in the clinical setting. All ten participants described they had witnessed or heard of an account of bullying. In addition, four of the ten participants described a bullying situation they had personally experienced by a healthcare provider.

Intimidating or humiliating behavior is included in the description provided on bullying. SRNAs described feelings of humiliation and intimidation in clinical. For example, Julia stated, "if you say something that is not 100% what they want, then they are going to put you down, especially in front of other people that is fairly humiliating." In addition, Julia added, "it made me feel awful being bullied. I think I have struggled with the social repercussions of school more than anything else the first year." Mattie added, "The level of incivility and bullying I have experienced that surprises me even being warned about it from other students having them tell me they will make you cry, I thought I was prepared for it."

When commenting about bullying, Mr. Glass had this to say, "the personality of a CRNA bully is aggressive and confrontational and looks for ways to demean you and make you look stupid. They ask questions they know you don't know; they say it's ok not to know the answer, and then that is not true." Likewise, Mr. Glass had this to add, "I am a really confident person and very smart, but in those [bullying] situations I crumble,

it is the worst thing I have ever really experienced. For them to make me crumble, I am like whoa, this is bad."

The participants in the study described situations that included verbal abuse, threatening behavior, and intimidating or humiliating behavior, which they described as intentional and purposeful behavior by a healthcare provider. The healthcare provider was sometimes a CRNA, another student, or an anesthesiologist.

Results Summary

This study explored SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. There were two research questions identified in this phenomenological study. These two research questions were utilized to assist in guided coding; they included: 1) what experiences do SRNAs have with incivility by healthcare providers in the clinical setting, and 2) what experiences do SRNAs have with bullying by healthcare providers in the clinical setting? Multiple themes emerged from this phenomenological research study. The themes revealed by the research include educational experiences, professionalism, relationships, coping, health and well-being, and perceived prevalence of incivility and bullying.

The results of this study showed that SRNAs overwhelmingly acknowledged educational experiences were negatively affected (particularly during the first year of clinical) by incivility and bullying. In addition, SRNAs indicated an overarching level of disappointment with the lack of professionalism among healthcare providers they encountered in their clinical experiences when incivility and bullying were perceived to be present. Further, this research discovered SRNAs describe their experiences with incivility and bullying by healthcare providers in the clinical setting as having a negative effect on their clinical relationships. On the positive side, the participants also described

the rewards of a multitude of positive clinical relationships with a honed-in focus on their rotations away from primary clinical sites. Equally important, the study revealed that SRNAs described a variety of coping mechanisms when dealing with incivility and bullying by a healthcare provider in the clinical setting. Many of the participants went on to explain they were not aware of resources (such as counseling, Title IX, clinical coordinators), or would deliberately not access the resources available for fear of making the situation worse. All ten participants described some form of avoidance behavior, such as 'keeping my head down.' This study also revealed SRNA's health and well-being are deleteriously affected when perceived incivility and bullying are occurring by healthcare providers in the clinical setting.

The study also discovered that SRNAs perceive the prevalence of incivility to be pervasive by healthcare providers in the clinical setting. All ten participants described experiences with incivility. Finally, the study revealed SRNAs perceive the prevalence of bullying to be a common occurrence by healthcare providers in the clinical setting. All ten described hearing about or knowing someone who had experienced bullying. Four out of ten discussed experiencing bullying themselves.

The next chapter will include a summary of the study. A discussion with an interpretation of results and correlation to the literature will be provided. The theoretical framework will be presented with correlation to study results. In addition, implications and recommendations for education, as well as future research, will be discussed. Finally, some concluding remarks will be presented.

CHAPTER V: DISCUSSION AND SUMMARY

This phenomenological study explored SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This chapter will discuss the purpose of this study, interpretation of results, and correlation to the literature along with correlation to the theoretical context. In addition, implications and recommendations for education, as well as future research, will be presented. The chapter will finish with concluding remarks.

Summary of the Study

Incivility and bullying are prevalent in the academic environment (Clark, 2017b). Incivility and bullying can cause damage to one's dignity, ability to learn, and affect self-worth (Clark, 2017b). Clinical experiences are vital to nurse anesthesia education. Many learners (including nursing students, medical students, and SRNAs) reported being the victims of incivility or bullying during the clinical phase of their programs (Elisha & Rutledge, 2011; Luparell, 2011; Thomas & Burk, 2009; Yasser et al., 2016). The literature review in Chapter Two revealed a gap in the literature and a need to research SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. This need was based on a paucity of evidence-based research.

This phenomenological study explored SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. The primary concepts were incivility and bullying. Incivility was defined as actions that are ambiguous in intent, non-physical, and involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation or exclusion). These behaviors create a disruptive environment and may lead to, or escalate to, bullying. Bullying was defined as abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3)

intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior, which causes harm.

The two research questions that guided this study were: 1) what experiences do SRNAs have with incivility by healthcare providers in the clinical setting? 2) What experiences do SRNAs have with bullying by healthcare providers in the clinical setting? Maslow's Hierarchy of Human Needs (1943) was the theoretical framework that guided this study. Approval from the IRB committee was obtained on July 1, 2019.

A purposive sample of ten full-time SRNAs from three midwestern anesthesia programs was utilized. Participants must have experienced more than one clinical rotation at two different institutions that provided anesthesia services (e.g., hospital or surgical center). Participants must have been able to read and speak fluent English. Data collection included open-ended questions which were utilized in private face-to-face interviews to extract the real lived and rich experiences of participants. An interview protocol was utilized. Individualized consent was obtained from participants via an institutional review board-approved protocol. Face-to-face interviews were conducted at mutually agreed on private pre-scheduled locations. Interviews were recorded. Recordings were uploaded securely to a transcriptionist. Upon receipt of transcribed interviews, data analysis began. The researcher utilized Tesch's Eight Steps (Creswell & Poth, 2018). Each interview was read twice, seven categories emerged, and memos were extracted and placed into the categories. From those categories, six themes emerged. These themes included: 1) educational experiences, 2) professionalism, 3) relationships, 4) coping, 5) health and well-being, and 6) perceived prevalence of incivility and bullying. Triangulation occurred throughout the process with the researcher's chair to increase rigor. Bracketing also occurred to assure the removal of bias from the study.

Member checking was conducted to assure accuracy of results. Winnowing of data occurred, further triangulation, and final results were obtained.

Discussion

The following sections will discuss the findings (utilizing the participant's pseudonyms) as they relate to the supporting or relevant literature. The sections are divided into the six themes which resulted from the study. How SRNAs' educational experiences were affected by incivility and bullying will be discussed first.

Educational Experiences.

Participants in the study overwhelmingly acknowledged their educational experiences in clinical were negatively affected when incivility or bullying was present (particularly the first year of clinical). The educational environment was described by Clark (2017b) as "any location associated with the delivery of education, including live or virtual classrooms as well as the clinical setting."

Incivility and bullying interfere with a student's ability to learn. A student must be able to transition from SRNA to CRNA as a capable, competent, and ethical practitioner. Tracy (2016) identified five factors that assist in the transition from student to practitioner. These factors are as follows: mastery of self-efficacy and confidence; expert coaching and guidance; supportive work environment; peer support; and previous experience. Without these skills, SRNAs are unable to enter the profession and be capable practitioners. This section of the discussion focuses on coaching and guidance.

Healthcare providers (typically CRNAs or anesthesiologists) are the expert coaches of SRNAs in the clinical setting. SRNAs depend on clinical preceptors for learning the hands-on skills necessary for entering their profession. When these experiences are disrupted by incivility and/or bullying, the result may be a negative

educational experience for the SRNA. For example, Joy stated, "The intimidation and humiliation 100% I do think it is intentional. I can take criticism. They intentionally raise their voices, so the whole O.R. hears. That is not teaching that is direct humiliation and intimidation." While Betty added, "the psychosocial side of it (incivility) definitely impacted learning." When Elisha and Rutledge (2011) asked SRNAs for feedback on what they believed preceptors could possess that would enhance their (SRNAs) clinical learning experiences, they listed a 'need for clinical anesthesia educators to be committed to the educator role' as number two and 'a need for more professional communication' as number one.

It is the responsibility of clinical preceptors to give one-on-one education through instruction and training to SRNAs. The results of this study indicated education is impaired or does not occur at all when incivility and/or bullying were present. Suzie reported, "I don't learn anything on days I am with those CRNAs. I go home questioning myself feeling like it was an unsuccessful day of clinical." This finding correlates with past studies that found students who experienced incivility and bullying reported education was not meaningful and decreased motivation in learning (Hakojarvi et al., 2014; Elisha & Rutledge, 2011).

Incivility and bullying in the clinical setting have negative impacts on SRNAs' educational clinical experiences. Next, SRNAs' thoughts on the lack of professionalism they witnessed when incivility and bullying were present will be addressed.

Professionalism.

The participants in the study reported an overarching disappointment with the lack of professionalism they observed and experienced when they perceived healthcare providers were uncivil or bullying in the clinical setting.

Clark and Ritter (2018) reported that members of the healthcare team deserve to have a healthy workplace culture where each professional is valued, respected, and treated with dignity. Participants of this study reported feeling like they did not have access to a healthy workplace culture.

Most notable were many remarks regarding breakrooms at different institutions. More than half (70%) of the participants mentioned overhearing healthcare workers (CRNAs, physicians, other SRNAs) discussing students in the dedicated breakroom in an uncivil manner. For example, Julia stated, "I heard people discussing the incident in the breakroom," while Perry added, "people avoid the breakroom altogether and eat lunch elsewhere." Incivility and bullying are present in workplace culture when dominant individuals are allowed to attack vulnerable populations. SRNAs are a vulnerable population because they are in a subservient position to their preceptor. As reported by Jones et al. (2016), when incivility and bullying are present in the workplace, there is a threat to safe, collaborative, and interprofessional practice.

There exists a very real danger that these SRNAs may become disillusioned with their choice of profession after witnessing these behaviors they described as unprofessional. Some participants described second-guessing their career choice. Some mentioned going back to nursing or leaving the field altogether. Participants expressed shock at experiencing the level of unprofessionalism they perceived upon entering a doctoral program and high-level medical profession. Wilson et al. (2011) revealed in their study (n=121) of responding nurses that 39.6% (n=48) intended to leave their position due to hostility they experienced in the workplace.

Next will be the description of repercussions incivility and bullying had on the clinical relationships of SRNAs.

Relationships.

The SRNAs in this study described their relationships in the clinical setting as having been negatively affected by perceived experiences of incivility and bullying. In addition, they discussed negative feelings regarding relationships at their primary clinical sites as compared to their rotations away from primary sites. The participants also described the rewards of a multitude of positive clinical preceptor relationships, with a specific focus on their relationships during rotations away from primary clinical sites.

Hierarchical structures are organizational structures where each entity or person is subordinate to another. In healthcare, a hierarchical structure is frequently seen with physicians at the top and students at the bottom. In some anesthesia practice settings, there is a hierarchy present. For example, in the anesthesia care team (ACT) practice setting, there may be an anesthesiologist, a CRNA, and an SRNA, all taking care of one patient. While this relationship is intended to be collaborative and inter-professional, it can, at times, be tenuous. This hierarchal structure has been shown to cause stress for CRNAs who report a lack of independent practice, discomfort with ethical decisions, and lack of control over their practice (Sakellaropoulos et al., 2011). In addition, Radzvin (2011) reported 38% (n=300) of CRNAs felt powerless in interactions with physicians. This is supported by the participant, Mr. Glass, who described the MDA/CRNA relationship by stating, “We feel the conflict of the MDA/CRNA battle constantly, I feel that is why we get bullied constantly.” In addition, Betty added, “I watched an MDA in the breakroom making fun of a CRNA they were supervising that day.” These statements are compelling evidence of how the effects of hierarchal structures in healthcare are influencing incivility and bullying. In other words, the lower you are on the hierarchical structure, the more incivility and bullying you may experience.

Likewise, Boyd and Poghosyan (2017) found 92% of CRNAs experienced active aggression, 90% verbal aggression, and 83% physical aggression from supervising physicians, defined as surgeons and anesthesiologists. While the participants in this survey described the majority of the healthcare providers they experienced incivility and bullying from as CRNAs and SRNAs, some did also mention anesthesiologists and surgeons. Supporting this was a quote by Perry, who referenced incivility and stated, "I see it with MDAs, depending on how they feel about CRNAs." It is quite possible that the incivility and bullying SRNAs were perceiving from CRNAs and SRNAs was occurring in part because of a hierarchical structure.

SRNAs in this study discussed positive relationships and focused primarily on relationships during rotations. It is important to note that the majority of the rotations away from the primary clinical sites are either CRNA-only independent group practices or ACT's where CRNAs practice independently. The SRNAs commented on the differences in practice. Mr. Glass commented, "I went to a rotation—it was wonderful. It was independent practice, and the MDAs worked their own cases." In addition, the participants expressed a lot of positive feedback regarding the commitment and humanization they experienced at these outside rotations. For example, Joy noted, "I was told at a rotation that this is my experience, they want me to get the best out of it, that meant more to me than anything, because I was treated like a human." She added, "On the rotation their teaching style they push you and want you to exceed, but it is not overbearing or demeaning in any manner, they are respectful."

If one juxtaposes the two practice settings and experiences, primary sites (hierarchical, medically directed, ACT) and rotational sites (less hierarchical, CRNA, ACT with MDAs running their own rooms), against each other, one cannot help but

notice the stark differences in the participant's comments and descriptions of the relationships.

The possibility exists this is linked to the CRNA's ability to practice independently in less of an imposing hierarchical structure at the rotation sites. Therefore, these healthcare providers are less likely to be perpetrators of incivility and bullying. Supporting this idea were comments from Squeakers who said, "At my rotation, they really took you under their wing, really supported you and helped you out, it is a smaller group of mostly older CRNAs." In addition, Perry stated, "It is universally known, just bear with it, until you get to a rotation." Finally, Squeakers noted, "The younger CRNAs at the main site create a hostile environment for the students."

Relationship stress can cause errors to occur. It is important to realize that aggressive and disruptive behaviors among members of the healthcare team may jeopardize patient safety, cause harm to the victim's self-esteem, and contribute to negative attitudes (Sakellaropoulos et al., 2011). Patient safety was reported by some participants to have been risked when incivility and bullying were perceived. Mattie noted, "The situation made me feel scared, because I am like, this is patient care at this point. This isn't just being rude or eye-rolling." Work relations between CRNAs and anesthesiologists or other health professionals contribute to the CRNAs stress more so than any other stressor (Boyd & Poghosyan, 2017). Incivility and bullying may put patient safety at risk.

The relationship between clinical preceptors and SRNAs involves a lot of educating. In Chapter Two, Bandura's social learning theory was presented. Bandura based this theory on the Constructivist thought that there is a direct relationship between learned or observed behavior and our actions (Bandura, 1986). This learning theory

would support the idea that clinical preceptors (who have no formal requirements regarding the education of others) may emulate teaching techniques that they observed as students. For example, Carmen noted, "Incivility makes you very uncomfortable, and then you start to do it to them someday and it is just kind of an escalation." Furthermore, Vessey et al. (2010) reported nurses who experienced bullying themselves are more likely to bully others.

The next section will consider the SRNAs' descriptions of coping mechanisms they did and did not utilize for incivility and bullying in the clinical setting. SRNAs' awareness of any resources available for assistance will also be addressed.

Coping.

The results of the study clearly showed SRNAs were not accessing the available resources they have for incivility and bullying. The participants reported utilizing a variety of coping mechanisms in response to perceived incivility and bullying. Some participants utilized resources; however, most did not. All ten participants reported a coping strategy that involved avoidance and denial. Students reported not accessing resources for fear of making the situation worse.

Bullying and incivility were present when the workplace culture allowed dominant individuals to prey on those who were more vulnerable. Students were at risk for bullying because they are a more vulnerable population. Many SRNAs reported being afraid to access resources (counseling, clinical coordinators, Title IX coordinator, deans, human resources) to assist with coping for fear things might get worse. For example, Squeakers reported, "Resources are available. I think people just saw it as more of a burden for them to reach out and have nothing done or make something worse."

In a qualitative cross-sectional study by Chipas et al. (2012), stress within the SRNA population was assessed. One of the areas examined was coping with stress. Many of the participants were currently under mental health treatment. In Chipas (2012) study 17.1% (n=183) of the participants stated they were medicated as a coping mechanism. This study reported that 69.9% of the participants believed they were not in control enough to effect positive change in their learning environment. Similarly, this study found few participants utilized resources for coping available to them, most did not. Most of the participants utilized an ineffective coping mechanism described by all ten participants as "just keeping my head down and taking it," or "just laying low and getting through." For example, Joy noted, "Yes, but I feel we are students, and we put our heads down, and we get through it. We are not allowed to say anything because that is what being a student is."

Discussed in the next section will be the effects of incivility and bullying on SRNAs' health and well-being. SRNAs described a variety of effects on both health and well-being.

Health and Well-being.

Outcomes from incivility have been linked to mental and physical health issues, burnout, and lost productivity (Read & Lashinger, 2013; Spence et al., 2009).

Hakojarvi et al. (2014) conducted a qualitative study in which students in a variety of healthcare professions reported symptoms such as sleeping disorders, fatigue, headaches, sweating, and abdominal symptoms. Hakojarvi et al. (2014) in the same study observed that students reported symptoms of anger, lowered spirits or depression, powerlessness, loss of self-esteem or confidence, anxiety, fear, and suicidal ideation.

Bullying is dangerous to an organization's culture and can result in dissatisfaction, disengagement, and absenteeism (Vessey et al., 2011). Nurse anesthesia culture is a highly stressful, high acuity environment and frequently calls upon the use of critical thinking skills. This culture differs from and expands outward from nursing culture (Emblad et al., 2014). Incivility and bullying may affect student attrition rates and sick leave. Wilson, et al. (2015) produced a study that examined SRNAs' attrition rates. They found SRNAs who had left their programs had experienced a loss of motivation. In a like manner, Joy stated, "I want to go into a job that I know I am going to love and if I am hating it and hating the people while I am going through school, well."

Participants of this study reported the need for counseling for anxiety and depression, as well as the need for medications. Mattie commented, "I think to myself is it worth all of this emotional stress and humiliation and isolation and being treated this way, I don't think so" while Julia added, "I think it affected me more than I realized, I had quite a bit more anxiety than I realized related to clinical. I was having insomnia. I was never depressed or suicidal, but I did have chest pain from anxiety," and lastly, Squeakers noted, "There are students on beta blockers and anxiety meds, just trying to get through." Supporting these data is the study by Chipas et al. (2012) which discovered that stress is a leading cause of depression and found 47.3% (n=554) of SRNAs reported being depressed at some time during their nurse anesthesia education and that 21.2% (n=243) had contemplated suicide. These numbers are staggering. SRNAs have an increased likelihood of having deleterious effects on their health and well-being if they perceive an experience by a healthcare provider as being uncivil or bullying.

In the next section, the SRNAs perceived prevalence of incivility and bullying will be discussed. Corresponding literature will also be presented.

Perceived Prevalence of Incivility and Bullying.

Studies by Clark (2008) and Luparell (2011) both show the incidences of incivility and bullying are increasing at an alarming rate. In a study by Cook et al. (2014), medical students completed a survey regarding mistreatment in clinical rotations. This study discovered that medical student mistreatment was prevalent. Likewise, the participants in this study reported incivility was pervasive, with 100% reporting they had experiences with incivility by a healthcare provider in the clinical setting.

Elisha and Rutledge (2011) reported in their study of 696 SRNAs that 69% of participants reported verbal abuse by a healthcare provider (defined as a CRNA, MDA, RN, or other SRNA). Verbal abuse was included in the definition of bullying for participants in the study presented here. Based on that definition, the findings are similar to the findings of this study regarding the perceived prevalence of bullying by participants. In this study, all ten participants had witnessed or heard of an account of bullying, while four of the ten (40%) participants described a bullying situation they had personally experienced by a healthcare provider. This would indicate that bullying by healthcare providers in the clinical setting is common.

While all the effects of incivility and bullying by healthcare providers in the clinical setting may occur alone, they may also occur in concert. Participants described experiencing multiple effects at one time. For example, Julia stated, "I had quite a bit more anxiety than I was even admitting to myself related to clinical. I was having insomnia before clinical, and clinical without sleep is dangerous. I was never depressed or suicidal, but I did start having chest pain. It took me months to work through that clinical was causing all of this anxiety." It is important to note that the effects do not occur in any specific order. A participant may report experiencing one, such as affected

learning, and then report a feeling of isolation. Another participant may report these in the opposite order.

The theoretical framework of Maslow's hierarchy, which was utilized to guide this study, will be discussed in the next section. The levels of Maslow's hierarchy will be presented with the results of the study to assist in understanding the phenomena this study explored.

Theoretical Context

Maslow's hierarchy was the framework used to guide this study. Maslow's theory postulates that every human need must be satisfied prior to the achievement of the next need. For humans to achieve self-actualization, they must meet the needs of each preceding level. The five hierarchical needs are physiological; safety; love, affection, and belongingness; self-esteem; and finally, self-actualization (Maslow, 1943). SRNAs who have perceived experiences of incivility and bullying by healthcare providers may have their ascension up the hierarchy halted or regressed. This is evident in the results where participants explain in detail each of the six themes and the effects when experiences with incivility and bullying are perceived.

While all of these themes and the effects are interconnected, meaning they could all occur at once or individually and are not a hierarchy as Maslow's needs are, the themes do fall into somewhat similar categories as Maslow's hierarchy.

For example, the participants described their health and well-being as being negatively affected when SRNAs perceive incivility by a healthcare provider in the clinical setting. Participants discussed experiencing anxiety, stress, insomnia, low self-worth, isolation, and need for counseling. These effects may be aligned with Maslow's physiological needs in the hierarchy. It is possible to postulate that if an SRNA

experienced these effects, they would be unable to move up Maslow's hierarchy to meet the next basic human need of safety.

Moving up the hierarchy, the next level is safety needs. Participants described a variety of coping mechanisms in their interviews; few involved utilizing resources. Most of the participants did not utilize resources, and in fact, all ten of the participants reported a plan to lay low and keep their head down to just get through the incivility and/or bullying. Ineffective coping had a direct impact on safety needs. Safety needs are defined by Maslow as security and safety. Squeakers stated, "I try to be quiet and keep my head down and get through it," this participant also noted, "Resources are available. I think people see them as a burden for them to reach out and have nothing done or make something worse. It's just easier to take it." These statements show directly how a student might feel their safety and security could be threatened, whether they utilized a resource or not.

Maslow's next level on the hierarchy is love and belonging. The theme relationships are closely related to this level of the hierarchy because love and belonging describe the need for humans to have intimate relationships and friendships, or to belong to a group. Participants described the negative effects perceived experiences of incivility and bullying have on their clinical relationships. SRNAs also described feelings of isolation. Perry noted, "My classmate had to recluse [sic] themselves back into a hole" while Julia added, "It was pretty crushing the isolation - I expected to make lifelong friends." Juxtaposed to this was the additional result in this theme, where participants discussed the positive clinical relationships they had experienced (particularly during rotations away from primary clinical sites). These relationships align with and promote the love and belonging level of Maslow's hierarchy. Participants shared lived

experiences regarding their relationships at rotations, which reflected the belonging they felt there. Perry stated, "Outside rotations are like a family, everyone works together," and Mary added, "Everywhere I have gone for my rotations has been really excited to have students."

The next level of Maslow's hierarchy is the esteem level, which is defined as feelings of prestige or a feeling of accomplishment. The theme relating to this level is educational experiences. When SRNAs are unable to have a positive educational experience or when learning was impeded by incivility and bullying (particularly the first year) feelings of accomplishment are thwarted, diminished, and negated. This impedes any progress made in the esteem level of Maslow's hierarchy and halts progress.

Lastly, participants described having an overarching disappointment with the lack of professionalism in healthcare providers. This theme relates with the top level of Maslow's hierarchy self-actualization. SRNAs discussed being disappointed with the profession—some considered wanting to leave school. Perry reported, "There was a student who almost left the program and wanted to go home and be a nurse again because of it." Maslow's self-actualization level pertains to achieving one's full potential. Students who consider leaving or who do leave the profession due to incivility and bullying are unable to achieve their full potential.

In summary, Maslow's hierarchy proposes one can only achieve a level once the previous level has been successfully met. The effects (the six themes discovered in this study: 1) educational experiences 2) professionalism 3) relationships 4) coping and 5) health and well-being, and 6) the overall pervasiveness of incivility and bullying have the potential to affect ANY and all levels of Maslow's hierarchy. The effects of perceived incivility and bullying by healthcare providers on SRNAs in the clinical setting are all

interconnected, and none of them is dependent on another occurring first; they are not hierarchical nor linear in nature.

Limitations of the Study

A great effort was made to assure the rigor and validity of this phenomenological study. There were, however, some limitations that must be examined. The first limitation of this study was the small number of included educational programs. The number of included programs was three. All three programs were of similar size, and all three were located in the midwest. This could be another limitation as CRNAs' anesthesia practices are generally more independent in the Midwest. However, each program may have its own unique culture. Another limitation was the number of participants. The initial goal was to interview 12 participants (four from each program). Only 10 responded after two email reminders. The sample itself consisted of two males and eight females. Further, the researcher had a working relationship with some of the participants, as they were current students at the college where the researcher works. Due to this relationship, along with the fact that the researcher is herself a CRNA, there was the potential for researcher bias. As mentioned previously, steps were taken through triangulation and bracketing to eliminate researcher bias. In addition, it was possible that participants who chose to participate may have had a previous bias due to personal experiences in which they might have experienced incivility and/or bullying.

Implications/Recommendations for Education

Based on this study, nurse anesthesia educators need to embrace a movement of change within their profession. The evidence in this study revealed that SRNAs perceive the prevalence of their experiences with incivility as being pervasive, and SRNAs perceive the prevalence of their experiences with bullying as being common. The

following recommendations are made in an attempt to make an immediate impact on the clinical experiences of SRNAs and their perceived experiences with incivility and bullying by healthcare providers.

Education is needed immediately pertaining to student resources and how students gain access to them. This study revealed that not all SRNAs were aware of what resources were available.

In addition, SRNAs need education regarding prevention strategies of incivility and bullying. These prevention strategies include things like emotional intelligence testing, reflection drills, and simulation scenarios set up for incivility and bullying, giving students opportunities to practice dealing with the stress of these situations.

Also recommended is threading education regarding incivility and bullying throughout the anesthesia program curriculum plan. The two concepts of incivility and bullying (due to their effects on the entirety of Maslow's hierarchy) should be revisited throughout the anesthesia program. This is supported by Luparell (2011), who stated that equally important is the concept of threading the topic of civility throughout a program's curriculum. This philosophy is also vitally important because students enter the profession as change agents after they have received years of education on incivility and bullying. Students exposed to a threaded curriculum will go on to become strong, kind, and civil clinical preceptors (Luparell, 2011).

Lastly, education for healthcare providers needs to be provided. This education must include: 1) definitions and causes; 2) effects; 3) resources; and 4) prevention of incivility and bullying. It is likely that healthcare providers are unaware they are perpetrating much of this perceived behavior. However, implementing all the above

proposed educational recommendations will assist in mitigating the high levels of perceived incivility and bullying which are presently occurring.

Future Research

This phenomenological research study discovered several topics that need further research and exploration related to students, healthcare providers, and incivility and bullying in the clinical setting.

This study revealed SRNAs are not utilizing the resources which are available to them when they experience either incivility or bullying in the clinical setting by a healthcare provider. Additional research would be valuable to determine why students are not accessing the resources which are provided to them.

The study identified SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting. Another area that must be further explored is the healthcare provider's perceptions of incivility and bullying in the clinical setting (both being done to them, and by them). There is a possibility that healthcare providers do not perceive themselves as being uncivil or bullies at all. Having a better understanding of the healthcare providers' perceptions will assist in tailoring educational mitigation to be successful.

In addition, there was a surprise finding in this study related to positive relationship effects that SRNAs experience in rotations away from primary clinical sites. Further research would be valuable in identifying if practice setting, autonomy, and hierarchical settings affect the prevalence of incivility and bullying which are occurring at large medical institutions.

This study should be repeated with a sample from other institutions in different locations to validate the findings. There also needs to be further research regarding the

prevalence of incivility and bullying in the clinical arena by healthcare providers on a national scale.

Finally, this research study needs to be expanded to look at other healthcare professions students such as nursing, medicine, physical therapy, pharmacy, etc. Research is needed to determine if the results in this study may be generalized to students across healthcare.

The following graphic was created to encompass an overarching view of this research visually. It depicts an SRNA on the path through clinical. The SRNA has an experience with a healthcare provider (HCP). If the SRNA has a perception of incivility or bullying, it knocks the SRNA off the pathway of moving up Maslow's hierarchy of needs and drops them down into experiencing the effects of incivility and bullying. These effects are interconnected. Any one, two, or all of them may occur in an SRNA at any time once incivility and bullying have been perceived. After the SRNA has a perception of incivility or bullying with a healthcare provider in the clinical setting, the SRNA also forms a perceived prevalence of incivility and bullying by healthcare providers in the clinical setting. The SRNA experiencing these effects of incivility and bullying has also experienced a disturbance in their journey up Maslow's hierarchy. As the graphic shows (through color matching), the effects of incivility and bullying are interconnected with Maslow's hierarchy. The graphic includes proposed ways to mitigate incivility and bullying by healthcare providers in the clinical setting through education. Implementing this proposed education may reduce future incivility and bullying. Providing these interventions might also assist in returning the SRNA to healthy progression up Maslow's hierarchy.

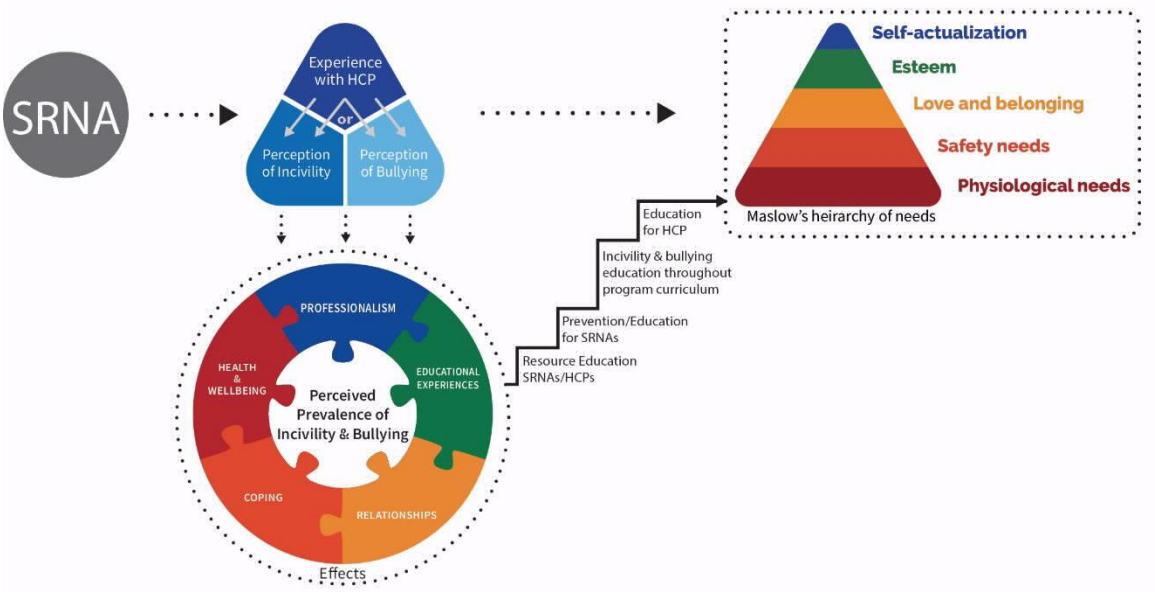


Figure 1: Maslow's Hierarchy within the context of SRNAs facing incivility and bullying

Summary

The study found the perceived prevalence of incivility to be pervasive and bullying to be common by healthcare providers in the clinical setting. All ten participants had experienced some form of incivility, and four out of ten had experienced bullying personally. In addition, the study discovered five themes which were as follows: 1) educational experiences were found to be negatively affected (particularly during the first year) when participants perceived incivility or bullying to have been experienced in the clinical setting; 2) professionalism was described by participants as lacking in healthcare providers when they perceived an experience with incivility or bullying; 3) participants described perceived experiences with incivility and bullying as having a negative effect on their clinical relationships; they did however also describe many positive clinical preceptor relationships with a particular focus on rotations away from primary clinical sites; 4) a variety of coping mechanisms were described. Some participants discussed utilizing resources like counseling and clinical coordinators; most did not. All of the participants described a coping plan which involved keeping their head down and just

getting through because they held a belief that to seek a resource held the potential to make things worse; 5) health and well-being were described by participants as being deleteriously affected by perceived experiences with incivility and bullying. Participants discussed anxiety, insomnia, the need for medication, counseling, low self-worth, feelings of isolation, and thoughts of leaving the program or profession.

These results may not be shocking. We are exposed to incivility quite a lot. Our leaders curse on television. Our media, politicians, actors, and actresses, even people we admire, all seem to have left polite discord and civil behavior in the rearview mirror. However, these students in healthcare, these SRNAs, are entering a profession where civility matters, where kindness counts. Where they will be asked to hold the hand of a three-year-old with cancer to alleviate their fear while selecting and administering an anesthetic for a brain biopsy. In addition, they will need to be actively educating the next generation of healthcare providers at the same time. This is no easy task we ask of preceptors. They have a stressful job. However, the most important takeaway is not the "was that person nice to me" piece; it is the "did I learn" piece. Was the preceptor able to educate the SRNA in a civil enough manner that teaching and learning took place?

This phenomenological study explored the lived experiences SRNAs had with incivility and bullying by healthcare providers in the clinical setting. Findings showed that participants described perpetrators of incivility and bullying as including CRNAs, MDAs, Surgeons, RNs, and fellow students. Behaviors ranged from incivility to bullying. The effects of the behaviors were profound. Effects included alteration in education, disillusionment in the level of professionalism, altered coping mechanisms, and altered relationships. SRNAs reported trying to manage by utilizing avoidance and "just keeping their head down." More serious impacts were on health and well-being and

included anxiety, isolation, lack of self-worth, feelings of leaving the profession/program, need for medications and psychiatric assistance. In conclusion, SRNAs describe their perception of incivility by healthcare providers in the clinical setting as pervasive. They describe their perception of bullying by healthcare providers in the clinical setting as common. Further research is necessary to measure the prevalence of incivility and bullying in both SRNAs and CRNAs. Implementing steps to mitigate incivility and bullying in the clinical setting may assist in providing CRNAs and SRNAs a more stress free environment for teaching and learning to occur.

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APPENDICES

Appendix A

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Holly Chandler** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 05/10/2017.

Certification Number: 2392500.

Appendix B

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Marilyn Moore** successfully completed the NIH Web-based training course "Protecting Human Research Participants."

Date of Completion: 05/14/2018

Certification Number: 2815707

NIH National J11stitutes of Health
Office of Extramural Research

Appendix C
Introduction to Program Directors

Dear (Insert Name),

Hello, my name is Holly Chandler. I am a doctoral candidate in the Ed.D program at Bryan College of Health Sciences. I am conducting a qualitative study which will explore perceptions of the experiences student registered nurse anesthetists have with incivility and bullying by healthcare providers in the clinical setting. This study will be conducted during the summer and fall of 2019. Dr. Sharon Hadenfeldt, Dean of the Bryan College of Nurse Anesthesia suggested I contact you.

I am interested in including your program in my study and would like permission to recruit from your student body. With your agreement and after obtaining all necessary IRB approvals, participant recruitment would begin.

The IRB of Bryan College of Health Sciences is federally registered with the Office of Human Research Protections and complies with the rules of the Code of Federal Regulations 45 Part 46 as evidenced by Federal Wide Assurance compliance. I would like to inquire as to whether your institution would also require an IRB approval.

Please feel free to email any questions to me at holly.chandler@bryanhealthcollege.edu. I very much appreciate your time, consideration, and thoughtfulness.

Holly A. Chandler MS, CRNA
Bryan College of Health Sciences Graduate Nursing Program
Holly.chandler@bryanhealthcollege.edu

Appendix D
Institutional Review Board Approval of the Study

Bryan COLLEGE OF HEALTH SCIENCES

BRYAN COLLEGE OF HEALTH SCIENCES
INSTITUTIONAL REVIEW BOARD
Notification of Action

Date of Notification: 7/1/2019

This letter pertains to IRB actions regarding:
Title of Study/Project: PERCEPTIONS OF INCIVILITY AND BULLYING BY HEALTHCARE PROVIDERS AMONG STUDENT REGISTERED NURSE ANESTHETISTS IN THE CLINICAL SETTING
IRB Number: #1905-002
Submitted by: Holly Chandler

Type of Review Performed:
____Exempt – Performed by_____
____Expedited
_X__Full

Date of Review: 7/1/2019
Document(s) Reviewed: Revised Request for Review; Introductory letter of inquiry; invitation email to deans; invitation to participate; Consent script; Interview protocol and questions; [redacted]

Decision
The Bryan College of Health Sciences' IRB has made the following decision related to your study:

__X_APPROVED: Your study has been found to meet criteria necessary for the protection of human subjects as stated in the Code of Federal Regulations Title 45 Part 46. Data collection may start once all required IRB approvals are obtained.

____PENDING APPROVAL CONTINGENT ON MINOR CHANGES: Your study has been found to meet criteria necessary for the protection of human subjects as stated in the Code of Federal Regulations Title 45 Part 46; however minor changes are necessary to strengthen one or more part(s) of the study. Those minor changes are detailed below. Please resubmit the final amended *Request for Review, Informed Consent,* or any other necessary study documents. After submission of the final documents you will receive an approval letter with the approved, stamped informed consent document if required for the study/project.

____MUST BE RESUBMITTED WITH MAJOR CHANGES: Your study HAS NOT been found to meet all criteria necessary for the protection of human subjects as stated in the Code of Federal Regulations Title 45 Part 46. One or more major change(s) must be made as detailed below. **DATA COLLECTION MAY NOT BE STARTED** until those changes have been made and formal approval has been granted by the IRB.

Obligations to the IRB

The investigators of a study approved by the IRB must fulfill the following obligations in order to retain permission to conduct their study:

CONSENT FORM: If you submitted a consent form for approval, the approved consent will be returned to you marked with a red '**APPROVED**.' **Colored copies** of that **approved** consent must be made and all participants enrolled in the study must sign one of those **colored consent forms.** The original, colored consent forms must be saved with the investigator's study documents. Each participant must be given a copy of the informed consent. The participant's copy may be a black and white copy of the original, colored informed consent.

PLANNED CHANGES TO THE STUDY: Any non-editorial change to an approved study/project must be submitted to the IRB for approval before initiation of the change except when necessary to eliminate immediate hazards to the participant(s). These changes include (but are not limited to):

- Names and roles of study/project personnel;
- The number of enrolled participants;
- Change to the methods used in the study/project;
- Change to the study/project's consent form;
- Additional method(s) used to recruit subjects (beyond those approved with the initial review);
- Proposed communication(s) to potential or enrolled subjects.
- Any change initiated prior to IRB approval (undertaken to eliminate immediate hazards to participants) must be reported as soon as possible to the Chair or Secretary of the IRB.

UNANTICIPATED PROBLEM OR ADVERSE EVENTS: The investigators of an approved study/project are required to submit to the IRB a full report of the following within two (2) business days of the occurrence:

- An unanticipated problem or adverse event occurring to one or more enrolled subjects including, but not limited to:
  - Any breach in confidentiality.
  - Physical or psychological harm.
  - Unresolved complaint of a participant, family member, or other individual.
  - Any other occurrence of an adverse nature related to participation in the study/project.
- Any deviation from the approved study/project protocol with the reason for the deviation and any consequences to the study/project participants or the integrity of the study/project's data.
- The withdrawal of any participant
- If a preliminary review of a study/project's data indicates the probability that continuing with the study/project will result in harm to one or more participants.

ONGOING AND FINAL REPORTS: The investigators of an approved study/project will submit a final report (using the IRB Final Report template) within sixty (60) days of the end of data collection. If an approved study has not completed data collection 12 months after the initial IRB approval date, the investigators must submit an Annual Report (using the IRB *Annual Review* template).

Shannon Peden, PhD, CNA — 7/11/2019

Chair, Bryan College of Health Sciences' IRB — Date

Appendix E
Letter of Invitation to Program Directors Email

Dear (Insert Name),

Hello, my name is Holly Chandler. I am a doctoral candidate in the Ed.D program at Bryan College of Health Sciences. I contacted you in March regarding the possibility of recruiting students from your nurse anesthesia program for my qualitative study. The purpose of this qualitative study is to explore student registered nurse anesthetists' (SRNAs') perceptions of incivility and bullying by healthcare providers in the clinical setting. The research questions guiding this study include: 1) what experiences do SRNAs have with incivility in the clinical setting? and, 2) what experiences do SRNAs have with bullying in the clinical setting? The study will begin in July of 2019.

I am requesting that you forward my attached email to all the SRNAs in your program. In order to add another layer of protection I am respectfully requesting the student's official email assigned by your institution be utilized (.edu) email. The prospective SRNAs will read the attached email you send them and then contact me by their personal email if they meet the criteria for participation and are interested. If they agree to participate, I will schedule a meeting at a mutually agreed upon location away from the clinical site and travel to where the SRNA is located, explain the study to them, discuss the informed consent, and upon obtaining informed consent conduct the interview.

Student protection will be a priority and the SRNAs' campus resources along with others will be provided to participants prior to obtaining consent. This information will be provided in the consent form.

IRB approval from Bryan College of Health Sciences was obtained on (date). The IRB of Bryan College of Health Sciences is federally registered with the Office of Human Research Protections and complies with the rules of the Code of Federal Regulations 45 Part 46 as evidenced by Federal Wide Assurance compliance.

Please feel free to email any questions to me at holly.chandler@bryanhealthcollege.edu. I very much appreciate your time, consideration, and thoughtfulness.

Holly A. Chandler MS, CRNA
Bryan College of Health Sciences Graduate Nursing Program
Holly.chandler@bryanhealthcollege.edu

Appendix F
Letter of Invitation to SRNAs

Dear Student Registered Nurse Anesthetist (SRNA),

Hello, my name is Holly Chandler. I am a doctoral candidate in the Ed.D program at Bryan College of Health Sciences. I would like to invite you to participate in a qualitative study. This study explores the perceptions of incivility and bullying by healthcare providers of student registered nurse anesthetists (SRNAs) in the clinical setting. Research has discovered that incivility and bullying are prevalent in the workplace and academic environment. The academic environment is considered to be anywhere learning occurs, and for SRNAs, this would include the clinical setting. Incivility and bullying can potentially cause both psychological and physical effects. Success in a nurse anesthesia program requires tenacity, perseverance, and adaptability. Experiencing incivility and bullying has the potential to create unnecessary hurdles and roadblocks for SRNAs. This study seeks to define incivility and bullying as described by SRNAs through their own lived experiences.

Inclusion criteria: Full-time second or third year nurse anesthesia students who are actively attending clinical rotations. The participants will have at **minimum** completed one clinical rotation and be experiencing a second clinical rotation prior to participating in the study. Clinical rotations must have been at two different institutions which provide anesthesia services (e.g. hospitals or surgical centers). Participants must read and speak fluent English.
Exclusion criteria: Part-time students will be excluded. First year students will also be excluded. This includes any students who have experienced just one clinical rotation at an institution that provides anesthesia services (hospital or surgical center).

Eligible participants will engage in an individual face-to-face interview with me. Each interview will take place in a private and mutually agreed upon site away from the clinical setting which is convenient for you the participant. Meeting in a private setting is a way to protect the participant's' privacy. After explaining and obtaining informed consent I will ask each participant open-ended questions regarding incivility and bullying in the clinical setting. The interviews will last approximately 60 minutes. All participants will choose a pseudonym as a way to ensure confidentiality with their responses. Resources will be offered to participants' who may experience psychological distress or report personal experiences requiring professional assistance. Participants will not be compensated for their time, however their shared stories may add to understanding and defining SRNAs' perceptions of incivility and bullying by healthcare providers in the clinical setting.

If you meet the inclusion criteria and are interested in participating in this research study, please contact me from your personal email at holly.chandler@bryanhealthcollege.edu. The deadline for responding to this request is two weeks from the date of this email.

I look forward to hearing from you.

Holly A. Chandler MS, CRNA
Bryan College of Health Sciences Graduate Nursing Program
Holly.chandler@bryanhealthcollege.edu

Appendix G
Interview Protocol and Interview Questions
To be included in recorded data:

Time of Interview

Date of Interview

Location of Interview

Person obtaining consent

Milieu of location interview is taking place

Interviewer

Interviewee/pseudonym

This interview will be about incivility and bullying by clinical practitioners/preceptors or any healthcare provider during your clinical rotations. When interpreting the interview questions, remember they do not apply to interactions with patients. Should a situation regarding incivility or bullying from a patient arise, I will gently redirect the conversation.

I would like to stress again reliving these experiences has the potential to cause physical and/or emotional distress. I would like to again point to the resources I have provided for you should you experience any distress. In the event you choose to share any experiences with sexual or physical assault or harassment I am ethically/morally/professionally obligated to report such incidences to the Title IX coordinator at your individual institution. Title IX federally guarantees the protection of all students (regardless of their gender) against sexual misconduct and abuse. Title IX coordinators have expert level training and knowledge regarding these laws and policies. It is important you understand that I will be obligated to report any physical or sexual abuse or harassment to your Title IX coordinator. The Title IX coordinator is the ONLY person this information will be reported to.

I will first ask a set of questions regarding incivility followed by a set of questions regarding bullying. I would like to encourage you to share to your comfort level and remind you again I have provided resources should you need them. Let me know if at any time you are uncomfortable or wish to stop the interview, and we will do so. I will go over the definitions of incivility and bullying for your prior to asking the questions regarding each concept.

Questions:

1. Tell me about your experience as a Student Registered Nurse Anesthetist.

2. What types of clinical rotations have you experienced?

Incivility is defined as actions which are ambiguous in intent, non-physical, involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation or exclusion). The behaviors create a disruptive environment and may lead to, or escalate to, bullying.

3. How would you describe incivility in the clinical setting?

4. Describe for me your own personal experience in the clinical setting with incivility.

    a. Sub questions/Prompts:
        i. Was this observed or experienced – please tell me more about what happened.

        ii. I am going to ask you to describe for me any feelings or emotions you had following any of these experiences while reminding you should you wish to stop at any time due to distress, we will immediately do so.

            1. Provide resources for any distress expressed

        iii. Please describe for me any positive or negative affects these experiences with incivility may have had on you and how you handled those effects.
            1. Provide resources for any distress expressed

iv. Tell me about any needs you might have had after experiencing incivility in the clinical setting? How did you meet those needs? (refer to resources should participant indicate any needs)

Bullying is defined as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3) intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior which causes harm.

5. How would you describe bullying in the clinical setting?

6. Describe for me your own personal experience in the clinical setting with bullying.

a. Sub questions/Prompts:
    i. Was this observed or experienced – please tell me more about what happened.

    ii. I am going to ask you to describe for me any feelings or emotions you had following any of these experiences and will again remind you if you should wish to stop at any time due to distress, we will immediately do so.

        1. Provide resources for any distress expressed

    iii. Please describe for me any positive or negative affects these experiences with bullying may have had and how you handled those effects

1. Provide resources for any distress expressed

iv. Tell me about any needs you might have had after experiencing bullying in the clinical setting? How did you meet those needs? (Refer to resources should participant indicate any needs)

7. Is there anything else you would like to share regarding your experiences with incivility and bullying in the clinical setting?

Lastly the participant will be thanked for their participation, assured of efforts to maintain confidentiality and the potential for future contact regarding member checking. Participants will be asked if they have any needs as a result of this interview. The PI will utilize resource list if necessary. Participants will be handed the laminated resource cards.

Appendix H
ADULT CONSENT FORM

Formal Study Title
A PHENOMENOLOGICAL QUALITATIVE STUDY REGARDING THE PERCEPTIONS OF INCIVILITY AND BULLYING BY HEALTHCARE PROVIDERS OF STUDENT REGISTERED NURSE ANESTHETISTS IN THE CLINICAL SETTING.

Participant Study Title
HOW DO STUDENT REGISTERED NURSE ANESTHETISTS DESCRIBE THEIR PERCEPTIONS OF INCIVILITY AND BULLYING BY HEALTHCARE PROVIDERS DURING CLINICAL ROTATIONS?

Study Personnel
Holly A. Chandler MS, CRNA – Principal Investigator (PI)
Telephone: Provided
Email: Provided

Name– Dissertation Chair
Telephone: Provided
Email: Provided

Key Study Information

- This qualitative study seeks to define incivility and bullying as described by SRNAs through their own lived experiences.
- Consists of face to face interviews at agreed upon location away from the clinical site taking approximately 60 minutes time.
- Title IX - laws which protects people from discrimination, assault, or harassment on the basis of sex or gender.
- Title IX coordinator - an expert trained in investigating sexual assault or harassment allegations.
- National Institute of Health - the agency which protects the rights of human research subjects.
- Incivility is defined as actions which are ambiguous in intent, non-physical, involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation or exclusion). The behaviors create a disruptive environment and may lead to, or escalate to, bullying.
- Bullying is defined as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3) intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior which causes harm
- The risks of participation in this study include your loss of privacy and confidentiality along with the risk of potentially enduring distress related to sharing your lived experience. All participants will be provided with resources to

assist with any risk a participant might experience. Loss of time is also a risk along with impaired learning ability. Participation is voluntary and you will receive a copy of the consent form which has resources for your institution listed for your own records.

Invitation
You are invited to participate in this research study. This consent form and the information contained within are to assist you in your decision whether to participate or not. Please feel free to ask any questions you may have.

Why are you being asked to be in this research study?
You are being asked to participate in this study because you are a full-time second or third year SRNA in a Council on Accreditation (the certifying agency for nurse anesthesia programs) accredited program in the Midwest who has experienced greater than one clinical rotation. You may or may not have experience regarding incivility and bullying in the clinical setting and speak fluent English.

What is the reason for doing this research study?
Clinical experiences are vital to educating SRNAs. Incivility and bullying have been shown to affect everything from learning to personal health and safety. There is little to no research regarding SRNAs perceptions of incivility and bullying by healthcare providers in the clinical setting. The purpose of this study is to explore SRNAs perceptions of incivility and bullying in the clinical setting.

What will be done during this research study?
In this study you will meet with the PI for a scheduled pre-determined location where a face-to-face interview will take place away from your clinical site or educational institution. You will be given ample reflective time to go over the adult consent form and ask any questions. Consent will be obtained and placed in a locked box. You will be provided a copy. The interview will be recorded. Recorders will be turned on. The PI will take notes. You will choose a pseudonym. The PI will read from an interview protocol. PI will ask open-ended questions which allow you to share any experiences you have had in the clinical setting with preceptors/practitioners and incivility and bullying. The recordings are downloaded to an encrypted USB drive and placed on the PI"s password protected laptop. The USB drive is placed in a locked box. It is stored in the PI's locked office in a locked drawer along with the locked box and consent forms. The audio recordings are shared with an employed transcriptionist via the PI's google drive which requires a passcode, the transcriptionist has signed a confidentiality agreement. Once the interview is transcribed and sent back to the PI, the PI will review the transcript twice. The PI will then begin to analyze the transcripts in to themes and subthemes. You will be contacted via email by the PI and provided a copy of the preliminary findings via an email with themes from the study. You will be asked to confirm that the preliminary findings accurately represent what you discussed during the interview. Keep in mind these preliminary findings are themes. You will not be asked to read an entire written transcript or research paper. The PI may contact you at any time following the original interview in order to clarify information or meaning. Any follow-up meetings would be no longer than 30 minutes and may occur via cell phone or in

person. Every effort will be made to keep information confidential at all times during the study.

How will my data be used?

- Your audio recorded interview will be shared with a transcriptionist who has signed a confidentiality agreement prior to receiving any transcripts.
- The data may be used for public presentations or manuscripts
- The data may be used for publication or dissemination
- Your data may be shared with other researchers as a collaboration of the research project. The other researchers include the PI's dissertation committee. All personal information which may identify you will be removed prior to any data sharing.
- Your data WILL NOT be shared with your college OR anesthesia program
- Your data WILL be shared with the Title IX coordinator from your institution should you report any physical/sexual/emotional harassment or abuse. The PI is morally/ethically/professionally required to share this data with the Title IX coordinator and this data will NOT be shared by the PI with anyone else.
- In addition, should you divulge intentions of harming yourself or others the PI is morally/ethically/legally/professionally obligated to call 911.

What commercial benefits will I get from research conducted on my interview data?
Your interview data will not be used for commercial profit.

What will happen to my interview data once the study is completed?
After completion of the study all data (except audio recordings which will be destroyed upon completion of transcription) will be stored for five years and then destroyed.

Will I be notified of the findings from the study?
No, you will not be notified of the results. You may however, request a copy of the completed study.

What are the possible risks to being in the study?
There is a potential risk for loss of privacy, loss of time from participating, loss of confidentiality, and psychological or emotional distress related to reliving uncivil painful and/or traumatic experiences to the participants.
Psychological or emotional distress may include damage to participant's self-worth, feeling humiliated, feelings of isolation, feelings of exclusion, and depression.
In addition participants are at risk for psychological, emotional, and physical distress in the event they relive a bullying experience where they encountered sexual harassment/abuse, verbal abuse, or physical abuse in the clinical setting.
Possibility of retribution from a clinical site should your information be lost
Participants may also be at risk for alterations in their ability to learn.

What is the approximate number of participants in this study?
Anticipated participants for this study is between 12 and 15 SRNAs.

What are the possible benefits of being in the study?
The potential benefits associated with the study may include assisting in increasing the transferable knowledge base regarding SRNAs perceptions of incivility and bullying by healthcare providers in the clinical setting. This research may provide guidance for future mitigation of incivility and bullying in the clinical setting. It is also possible you may not receive any personal benefit from being in the study.

What are the possible benefits to others?
The study may benefit society, patients, SRNAs, and healthcare team members by exploring the perceptions of incivility and bullying by healthcare providers in the clinical setting. Exploring and defining these two concepts may assist in the future with acceptable behaviors in clinical instruction. The study serves to create generalizable knowledge which may add to the definition of incivility and bullying in the clinical setting.

What are the alternatives to being in the study?
An alternative to participating in the study is electing not to participate in the study.

What will it cost to participate in this study?
There is no cost to the participant to be in the study.

Will you be rewarded for being in the study?
There is no compensation for participating in the study.

What should you do if you have a problem at any time during the study?

- Your welfare is the major concern of the PI in this study. If you have a problem as a direct result of being in this study, you should immediately contact one of the individuals listed on the consent form.
- Any immediate emergency care will be available at local emergency rooms, or at any hospital.
- Additional care will be available through the student EAP programs provided by your institutions.
- You may also seek assistance from your health care provider.
- Please note below the resources available for each location and institution.
- You will be responsible to incur any costs related to evaluation or treatment. The costs for any other medical problems unrelated to the study will also be your responsibility. There will be no payments or compensation for lost wages, disability, discomfort, etc.
- If at any time you experience a problem or distress during the interview and wish to stop, the PI will stop the interview and refer you to the appropriate resource from your institution (listed below).
- The Title IX coordinator from your institution is listed below and will be contacted by the PI should any information be shared which violates Title IX laws.
- In addition, should you divulge intentions of harming yourself or others the PI is morally/ethically/legally/professionally obligated to call 911.

You do not give up any legal rights by participating in this study.

Program
Title IX Coordinator/Dean of Students: Phone provided
Currently: Name Provided
Office: Address Provided
Police Department: 911
Student Success Center: Phone provided
EAP: Phone Provided
Program 1 Emergency Room: Phone provided
Professional Development Counselor: Name and phone provided
National Suicide Prevention Lifeline: 800-273-8255
National Substance Abuse Hotline: 800-662-4357

Please contact any of the provided resources should you experience any emotional distress or have thoughts of harming yourself or others.

How will information about you be protected?
All efforts will be made and reasonable steps taken to protect the privacy and the confidentiality of your study data, such as transporting your data in a locked box and storing your data in a locked box in a locked office. The only persons who will have access to your research records are the study personnel, the Institution Review Board (IRB) and any other person or agency required by law which includes the Title IX coordinator in the event a violation of Title IX law is disclosed. The information from this study may be published in scientific journals or presented at scientific meetings, however your information will be de-identified by removing your name and using a pseudonym as a way to protect your identity.

What are your rights as a research participant?
You have rights if you choose to participate in this research study. These rights have been explained in this consent form. You have also been given the Rights of Research Participants brochure. If you have any questions concerning your rights or complains about the research, contact the Bryan Institutional Review Board (IRB):
Bryan College of Health Sciences
Institution Review Board Chair
Telephone: 402-481-3801
Email: IRB@bryanhealthcollege.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?
You may quit the study at any time without affecting the relationship you have established with any of the researchers.

Documentation of Informed Consent
You are freely deciding to participate in this research study. Signing this form means that:

1. You have read and understood this consent form.
2. You have had the consent form explained to you.

3. You have had your questions answered.
4. You have decided to be in this research study and you understand the resources available.

If you have any questions during the study, you should talk to one of the research team members listed below. You will be given a copy of this consent form to keep for your records.

Participant's signature:

_____

Date: _____ Time: _____

My signature certifies that all the elements of informed consent described in this consent form have been explained fully. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research study and is voluntarily and knowingly providing informed consent to participate.

Signature of Person Obtaining Consent:

_____

Date: _____ Time: _____

Authorized Study Personnel

Holly A. Chandler MS, CRNA – Principal Investigator (PI)
Telephone: Provided
Email: Provided

Dissertation Chair
Cell Phone: Provided
Email: Provided

Appendix I

Definitions Provided to Participants

Incivility is defined as actions which are ambiguous in intent, non-physical, involve disruptive behaviors (eye-rolling, telling secrets, rumor spreading, isolation or exclusion). The behaviors create a disruptive environment and may lead to, or escalate to, bullying.

Bullying is defined as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms: 1) verbal abuse, 2) threatening behaviors, 3) intimidating or humiliating behavior, and 4) sabotage. Bullying behavior is intentional, purposeful, and repeated behavior which causes harm.