INCIVILITY IN NURSING EDUCATION: A CASE STUDY IN INDONESIA

Ni Gusti Ayu Eka

Thesis submitted to the University of Nottingham

for the degree of Doctor of Philosophy

March 2017

ABSTRACT

Background: Many problems of incivility/uncivil behaviour have been faced by nursing education globally from disrespectful to violent behaviour. However, most research on this subject has been carried out in Western countries with regard to psychological viewpoints (e.g. physical and emotional disadvantages). Indonesia is an excellent case study as a developing country with over 700 ethnicities and diverse socio-economic backgrounds and six official religions; these conditions can shape behaviours in nursing education.

Purpose: To develop a model to provide an educational framework of the techniques and strategies of teaching and learning for managing civility in nursing education that is congruent to Indonesian culture based on nursing students and academic staff's perceptions.

Method: Multiple-case study research design. Respondents (students and lecturers) were purposely sampled from two nursing faculties (private and public) in West Indonesia. University IRB and settings approval were obtained. Data collection was by survey, observations and semi-structured interviews from September 2012 to April 2013.

Findings: Uncivil behaviour in nursing education is a vital problem that needs to be prevented. It is affected by individuals' cultural backgrounds and professionalism in context, including religious beliefs and values. New understandings for managing uncivil behaviour in this context were identified. Improved understanding of individuals' backgrounds can manage uncivil behaviour in nursing education. Strategies for addressing uncivil behaviour in nursing education include effective communication and relationship, self-awareness, role modelling and effective rule implementation.

Limitations: Despite the high participation rate and the demographic homogeneity of the sample (although only one Hindu was recruited), the two nursing faculties are located in West Indonesia, which limits generalisation for nursing education in Indonesia as a whole. Future research could explore incivility from nurses' perspectives.

Key words: Incivility, Uncivil behaviour, Nursing education, Indonesia

LIST OF OUTPUTS

Eka, N., Chambers, D., and Narayanasamy, A. 2016. Perceived uncivil behaviour in Indonesian nursing education. **Nursing Education in Practice**, 20, pp. 99–108.

Eka, N., Narayanasamy, A. and Chambers, D. 2014. Faculty and student perceptions of uncivil behaviour in nursing education in Indonesia. Oral presentation, **25th International Networking for Healthcare Education Conference**, NET2014 Conference: 2-4 September 2014, Cambridge, UK. Available at: http://www.jillrogersassociates.co.uk/images/stories/NET_conf_pdfs/NET2014/Abstracts/group_1-internationalisation_and_global_challenges_abstracts.pdf

Eka, N., Narayanasamy, A. and Chambers, D. 2014. Perceived uncivil behaviours in Indonesian nursing education. Oral presentation, **5th International Nurse Education Conference** on 22-25 June 2014- NH Conference Centre Leeuwenhorst Langelaan, 3. 2211 XT Noordwijkerhout, The Netherlands. Available at: http://www.netnep-conference.elsevier.com/conference-programme.html

Eka, N., Narayanasamy, A. and Chambers, D. 2014. Uncivil behaviour in nursing education in Indonesia. Oral presentation, **RCN 2014 Annual International Nursing Research Conference** on 2-4 April 2014- University of Glasgow, Glasgow Scotland, UK. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0005/568103/Research_Conference_Book_of_Abstracts_2014.pdf

Eka, N., Narayanasamy, A. and Chambers, D. 2013. Incivility in Indonesia nursing education: a pilot study. Poster Presentation, **Third European Transcultural Nursing Association (ETNA) International Conference**, Hagoshrim Israel, 24-27 June 2013. (Appendix nine).

Eka, N., Narayanasamy, A. and Chambers, D. 2013. Incivility in nursing education: An Indonesian perspective. Oral presentation, **RCN Education Forum International Conference and Exhibition** 2013, 05 June – 07 June 2013 – The Glasgow Marriott Hotel, Scotland, G3 8RR, UK. Available at: http://www.rcn.org.uk/development/communities/rcn_forum_communities/education/rcn_education_conference_presentations

ACKNOWLEDGEMENT

First and foremost, praise and thanks goes to my Lord Jesus Christ for His blessing and strength during this challenging and amazing journey.

I would like to express my gratitude to my supervisors Dr. Aru Narayanasamy and Dr. Derek Chambers for their intellectual generosity, critical feedback, and constant support that made the completion of this work possible.

I would like to recognise the financial support given by the Directorate General of Higher Education/ DIKTI Indonesia for the funding of this study. This scholarship has been an invaluable resource.

I would also like to acknowledge and thank the Universitas Pelita Harapan as well as the Faculty of Nursing and Allied Health Sciences that supported me in every aspect. My colleagues who are too numerous to mention one by one, I thank for their support including their moral support, time, prayers and proofreading.

Thanks and appreciations are also extended to the management of the research settings (faculties of nursing and hospitals) for their permission and to the respondents (academic staff and students) for their contributions to the field. Each setting and participant brought something unique to this study.

Finally, to Okhen Parningotan and Daniello Jokhenka who came with me on this life-changing journey. Unquestionably, my debt is great and my love for them is enormous.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION

This chapter begins by providing an overview of the thesis. It then goes on to describe the background and impetus for the study. This culminates in the presentation of the aims and objectives and the research question that guided the study. Finally the context in which the study took place is discussed.

1.1 Overview of the thesis

This thesis consists of eight chapters. This first chapter outlines the background of the study. In doing so, it explores the researcher's personal story and experiences of incivility and provides insights into the Indonesian higher education system. This is followed by the presentation of the aims, objectives and research questions that guided the study. To provide context, the final part of the chapter offers an overview of relevant aspects of Indonesia and its culture.

Chapter two builds on chapter 1 section 1.2 by evaluating literature relevant to this area of research. Using a systematic approach, the chapter reviews both quantitative and qualitative studies that have investigated incivility in nursing education settings. Gaps of within previous studies are identified and recommendations for future research are proposed. The chapter concludes with a description of the framework adopted for this study.

Chapter three describes the research methodology and methods. It explains why the decision was taken to adopt case study methodology. Details of the recruitment and sampling process, both purposive and theoretical, are

explained. The chapter concludes by describing, the ethical concerns and processes underpinning the study, including: ethical approval; obtaining participants consent and how confidentiality and data protection were achieved.

Chapters four and five outline the findings of the study in a format similar to that suggested by Yin (2014; 2009). These chapters present the 'within-case analysis' findings which describe the results of two units of analysis referred to as private and public universities.

Chapter six outlines the results of the multiple-case study analysis (Yin, 2014; 2009). This chapter further compares and contrasts the findings of the two units of analysis and uses Eisenhardt's (1989) approach of building inductive theory from case study research.

Chapter seven provides an in-depth discussion of the study, including interpretation and explanation of the findings. In doing so it addresses the research question, and critically evaluates the study by comparing it to previous works in this area. Based on the findings, a model for managing incivility in Indonesian nursing education is proposed. Chapter seven concludes the thesis by identifying the limitations of the study, implications for nursing education and practice, and offering recommendations for further research. This discussion aims to enable nurse educators and practitioners, in complex organisations, to promote civility in nursing education settings. The thesis ends with a personal reflexive account.

1.2 Background to the study

The background of this study will be described into five sections: the growing problem of incivility in higher education, definition of incivility, categories of incivility, an overview of previous investigations of incivility in nursing education as well as a personal stody of the researcher.

1.2.1 The growing problem of uncivil behaviour in higher education

Incivility in higher education (HE) is not new (Twale and De Luca 2008). However, it has become a growing concern amongst academics (Alexander-Snow, 2004; Connely, 2009; Rowland, 2009; Bjorklund and Rehling, 2010; Knepp, 2012), to the extent that it is now acknowledged as a global issue (Nilson and Jackson, 2004). Given that civility is the cornerstone of professionalism (Paik and Broedel-Zaugg, 2006), it is incumbent on educators of future health care professionals, such as nurse educators, to be concerned about and address the issue (Ballard, Hagan, Twonsend, Ballard and Armbruster, 2015). However, despite the claims that incivility is a growing issue in HE, there have been difficulties in defining what the term actually means.

1.2.2 Defining Uncivil behaviour

Feldmann (2001) adopt a broad approach describing incivility in the classroom as:

"…any action that interferes with a harmonious and cooperative learning atmosphere in the classroom" (p. 137).

Whereas Phillips and Smith (2003) focus on the intentional behaviour of students which are aimed at disrupting the teaching and learning

environment. Berger (2000) defines incivility as any "speech or action that is disrespectful or rude" (p. 446). Ferris (2002) describes incivility as the lack of decorum, good manners, deportment and politeness. While some definitions focus on students, others include educators. For example, Galbraith (2008) proposes that incivility occurs when the rules of conduct are broken by students or teachers.

An additional issue in defining incivility is that it is socially and culturally determined. It is, therefore, context bound (Connelly, 2009; Moffat, 2001). Alexander-Snow (2004) has defined incivility as a violation of behavioural norms, which are socially constructed and vary from setting to setting. Holm (2014) argues that incivility may manifest itself in the form of a social process. In other words, perceptions of what constitutes incivility can vary according to social groups, social interactions and locations. Hence, incivility will be perceived differently by, for example, people in the United States of America (USA) to that of people from Indonesia. As highlighted later in this chapter and subsequent chapters, these cultural differences have been an essential impetus for this study.

An important point to make is that incivility can be both intentional and unintentional (Clark, 2013; Thomas, 2013). Consequently, perpetrators are not always aware that their behaviour adversely affects other people. However, as discussed later in this section, uncivil behaviour has been found to negatively affect a person's physical and emotional state, and professional relationships. Within nursing, it also has the potential to impact negatively on patients' safety through, for example, poor care delivery (Longo and Hain, 2014; Longo, 2010; Luparell, 2007).

It is apparent that finding a definition that embraces all the aspects discussed above has proven to be elusive (Bjorklund and Rehling 2010).

Moreover, the definitions that exist are very broad and as such open to interpretation. Thus, for some authors, uncivil behaviour can encompass behaviour that many academics and students may not find disruptive, such as acting bored or disinterested, fidgeting, (Bjorklund and a Rehling 2010) failing to take notes in a lecture and dominating discussions (see table 1) (Rowland and Srisukho 2009). Hence 'What one faculty member may experience as problematic in a classroom may not bother another' (Bjorklund and Rehling, 2010, p.17).

Table 1.1: Descriptions of Uncivil Student Behaviour

Description of Uncivil Behaviour		**Author(s)**
Yawning Nose blowing Nodding or smiling in response to others' comments Continuing to talk after being asked to stop Attending class under the influence of alcohol or drugs Allowing a mobile phone to ring Conversing loudly with others Nonverbally showing disrespect for others Swearing Sleeping in class Making disparaging remarks Arriving late and/or leaving early Text messaging	Packing up books before class is over Using a palm pilot, iPod or computer for non-class activities Getting up during class, leaving and returning Nonverbally indicating dissatisfaction with an assignment, activity or grade Fidgeting that distracts others Doing homework for other classes Displaying inattentive posture or facial expressions Questioning the value of an assignment or activity Reading non-class material Discarding trash after class has begun Eating and drinking	Bjorklund and Rehling, (2010)
Late arrivals or early departures from class Using mobile phones and pagers during class	Inattention wearing inappropriate attire	Feldmann (2001)
Acting bored or apathetic Disapproving groans Sleeping in class Chewing gum in class Sarcastic remarks or gestures Not paying attention in class Reluctance to answer direct questions Eating in class Using mobile phones during class Talking in class	Arriving late and leaving early Missing lectures Cheating in examinations and/ or quizzes Belittling other students Challenging your knowledge or credibility in class Harassing comments Hostile verbal attacks or challenges Vulgarity Threats of physical harm	Royce (2000)

It can be argued that the labeling of such behaviors as being uncivil appears arbitrary and could, therefore, be open to various interpretations. Nevertheless, there is a consensus in the literature, that such behaviours are associated with incivility (Connelly 2009; Knepp 2012; Morrisette 2001 Clark, 2006; Alexander-Snow, 2004; Tiberius and Flak, 1999; Boice, 1996). There is, however, less of a consensus over the terms used to describe such behaviour (Felblinger, 2008).

1.2.3 Categories of Incivility

Within the higher education context incivility is usually categorised into groups. These categories do, however, vary. For example, Fieldman (2001) categorised incivility into annoyances, classroom terrorism, intimidation and threats of violence; Conelly (2009) grouped uncivil behaviours into less serious and more serious; and Clark (2009, 2010) divided incivility into disruptive and threatening behaviours. A comparison between these categories (Clark, 2009, 2010; Conelly, 2009; Feldman, 2001) can be seen in appendix 1.

Hunt and Marini, (2012), Clark, (2008a), Randle, (2003), Lashley and de Meneses, (2001) have provided different terms referring to unacceptable behaviour, including uncivil behaviour, disruptive behaviour, vertical violence, horizontal violence and bullying. One factor that may account for this is the lack of consensus on what constitutes incivility. Some researchers have described a range of student behaviour from 'mild to highly aggressive' (Suplee, Lachman, Siebert and Anselmi, 2008). To help clarify the issue, Clark (2011) has developed a continuum (figure 1) which proposes that incivility can be manifested in many forms. Clark (2011) describes a range of behaviours ranging from disruptive to threatening behaviour. Disruptive

behaviour includes non-verbal behaviours, such as 'eye-rolling and sarcastic comments'. At the other end of the continuum tthreatening behaviour includes acts of 'physical violence and tragedy' (Clark, 2011, p. 14). An example of a tragic event is that of a resentful student nurse who murdered three nurse educators and subsequently killed himself at the University of Arizona USA (Hall, 2004; Robertson, 2012).

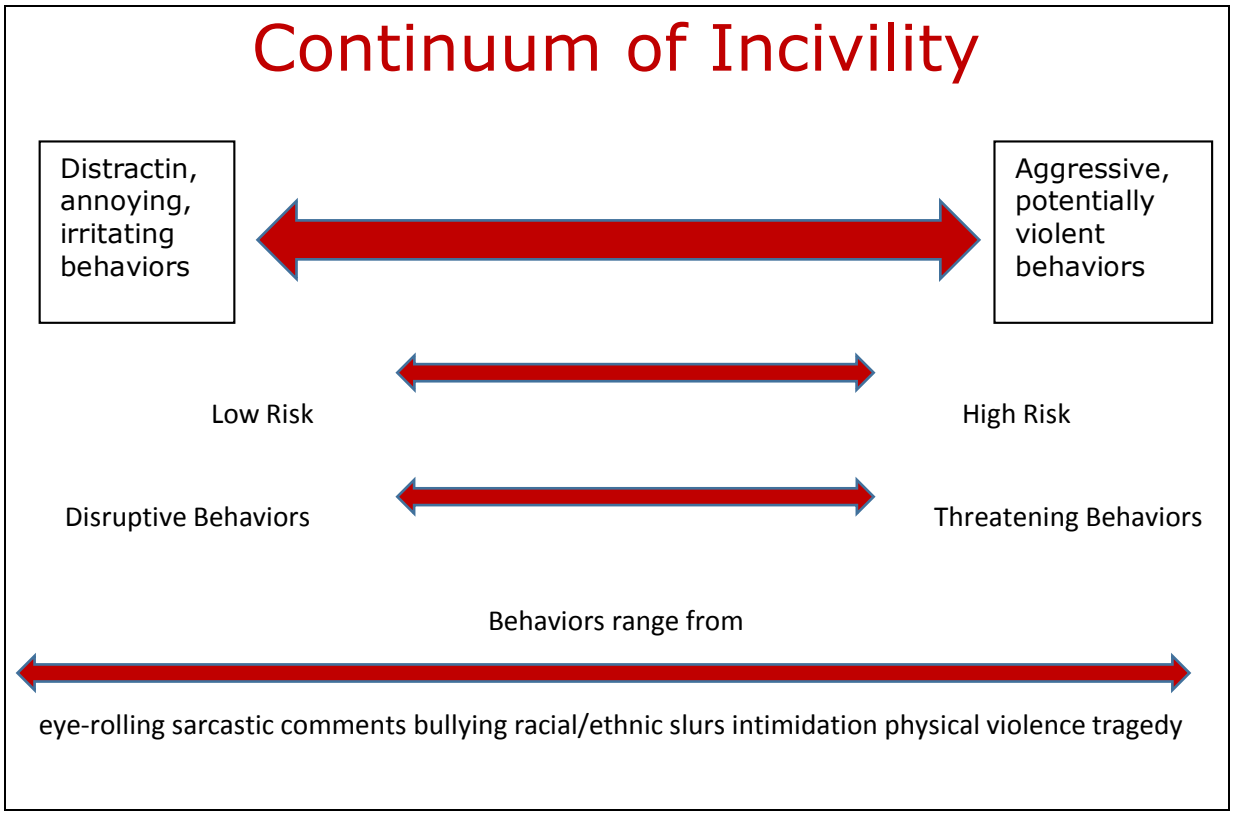


Figure 1-1: Continuum of incivility (Clark, 2011)

Although Clark's continuum offers a useful clarification, it fails to include growing concerns over academic misconducts, such as plagiarism and cheating in examinations, which are also considered as uncivil behaviours within HE (Osinski, 2003).

But as illustrated in the continuum, Clark does include bullying as part of incivility. Hunt and Marini (2012) explain the linke between incivility and bullying. For them the connection between incivility and bullying involves

the 'form' and 'function' of the two behaviours (p.367). The form demonstrates 'how' the behaviour may be conducted, such as 'overtly/covertly' or 'directly/indirectly'. The function demonstrates 'why' the behaviour may be conducted, such as 'reactive/unintentionally' or 'proactive/intentionally'. In other words, incivility includes covert or indirect and unintentional behaviour. On the other hand, bullying involves overt or direct and intentional behaviours. Therefore, bullying is recognized as being a part of the incivility continuum (Clark, 2011).

It is evident that a range of terms are used to describe incivility in the education setting. For the purpose of this study, the terms incivility and uncivil behaviour will be employed interchangeably to capture the range of behaviours that have come to constitute uncivil behaviour.

1.2.4 An overview of previous investigations of incivility in nursing education

This section introduces the extent and nature of incivility within nurse education and will subsequently be developed further in chapter 2. The levels of incivility within nurse education have been reported to be a moderate to a serious problem (Beck, 2009 Clark, 2008a Clark and Springer, 2007a). They occur in a range of teaching and learning contexts, including classrooms, clinical practice areas, and web-based learning forums (Beck, 2009; Clark, 2008a; Clark and Springer, 2007a). Clark (2006), and Clark and Springer (2007a, 2007b) have described incivility from the perspectives of both students and academic staff (tables 1.2 and 1.3). The majority of these behaviours are consistent with those identified in section 1.2.2 and include lateness for class, disruptive chatter/talking, cheating, and explicitly offending academic staff. Whereas uncivil behaviour by academic staff

includes: making negative comments about students, expressing disinterest towards subjects and the students, cancelling class/lectures without prior notice, being late for class and being unprepared for class.

Table 1.2: Uncivil Students' behaviours as identified by faculty (from Clark and Springer, 2007)

Descriptions of Uncivil Student Behaviour
Disrupting others by talking in class
Making negative remarks/disrespectful comments toward faculty
Leaving early or arriving late
Using mobile phones
Sleeping/not paying attention
Bringing children to class
Wearing immodest attire
Coming to class unprepared

Table 1.3: Uncivil Faculty behaviours as Identified by students (from Clark and Springer, 2007)

Description of Uncivil Faculty Behaviours
Making condescending remarks
Using poor teaching style or method
Using poor communication skills
Acting superior and arrogant
Criticizing students in front of peers
Threatening to fail students

Globally there has been a proliferation of studies investigating incivility in nursing, such as in the USA (Clark, 2008d, Lashley and de Meneses , 2001; Luparell, 2007), in the United Kingdom (UK) (Randle, 2003; Thomas, 2013), in the Peoples' Republic of China (PRC) (Clark, Juan, Allerton, et al., 2012; Clark, Otterness, Jun et al., 2010) and Canada (Clarke, Kane, Rajacich et al., 2012), with authors describing the occurrences of incivility in clinical practice areas (Randle, 2003; Thomas, 2013) as well as in classrooms (Clark, 2008d, Lashley and de Meneses, 2001; Luparell, 2007).

Lashley and de Meneses (2001) examined uncivil behaviour in nursing education in the USA and the correlation between uncivil behaviour and demographic variables. The result of the study revealed that undesirable behaviours included yelling or verbal abuse directed towards academic staff or peers, rude behaviour to staff members such as making sarcastic remarks and demonstrating threatening behaviour including offensive physical contact with staff. Statistically, such behaviour is significantly associated with some demographic variables such as the types of institution (public institution, non-religious schools and with a student body of 200 (Lashley and de Meneses, 2001). As a result of their findings, Lashley and de Meneses (2001) called for a national forum to discuss the strategies for managing incivility in nursing education.

The effects of incivility in the classroom are not transient but have been found to have far-reaching consequences for victims of uncivil behaviour including members of faculty and students. With victims reporting effects such aslack of confidence, sleep disorder, feelings of powerlessness and stress (Clark, 2008d; Luparell, 2007). But although most studies have reported adverse reactions a study by Thomas (2013) found that incivility in clinical practice can have a positive effect on students by their resilience.

Acts of uncivil behaviour within nursing education are not confined to academics and students. For example, a UK study that took place in clinical practice (Randle, 2003) described how registered nurses demonstrated their feelings of superiority toward students and patients within the practice setting. Randle reported that "…some of the nurses with whom they[students] worked had used their positions and power to bully 'subordinates' and intentionally humiliate, belittle or isolate patients" (2013, p. 397-398). This study also identified that the abuse of power by nurses

could result in low self-esteem in students (Randle, 2003). Not only did this study reveal bullying of students by the qualified nurses, the students also witnessed the nurses bullying patients.

Clarke et al. (2012) investigated incivility within a Canadian practice setting and also revealed a culture of bullying. The study found that the most frequent form of bullying was the undervaluing of students' efforts (60.24%). The most common perpetrators were clinical instructors (30.22%) followed by staff nurses (25.49%). The study also revealed how student's experiences of such a behaviour became a significant factor influencing their decision to leave nursing (Clarke et al., 2012).

In a non-Western context, Clark et al. (2010) expanded their study of incivility in nursing education by investigating the issue in the PRC. Interestingly the results were broadly similar to the research reported in the USA (Clark, 2008a). Consistent with the discussion above, respondents in the PRC had varying perceptions of incivility with some respondents considering incivility to be a moderate problem while others felt it was not a problem. Conversely, incivility in the USA was perceived as a moderate to a serious problem.

In the PRC the top three uncivil student behaviours, reported by students and academics were: (1) cheating in examinations and tests; (2) the use of mobile phones or pagers during class, and (3) engaging in distracting conversations. The authors further claimed that this study represented the perceptions of the Chinese population because the respondents were 91.6% Han Chinese students, despite the fact that the study was conducted at only one university. Another study that took place in the PRC (Clark, Juan, Allerton, et al., 2012) identified that a major contributing factor to uncivil

behaviours of both students and faculty members was their demanding workload and 'moodiness'.

1.2.5 A personal story

The researcher's interest in this subject arose from concerns expressed by nursing students, university lecturers, clinical educators and administrative staffs. These concerns focus on academic interactions that are sometimes hostile and a belief that poor interactions could possibly result in adverse emotional outcomes, such as anger, frustration and stress. As a result, the researcher explored some terms related to these issues and became interested in incivility or uncivil behaviour in nursing education, and subsequently undertook a small scale workplace study (Eka, Sitompul and Solely, 2013). The study was a descriptive study conducted at a private university in Indonesia between 2010 and 2011 (Eka, Sitompul and Solely, 2013). The respondents consisted of students (N=96 or 74.4%) and academic staff (N=8 or 72.3%). The study identified that incivility in the nursing academic environment is a problem. However, opinions varied and were dependent on personal perspectives. For the students, incivility was considered a moderate problem; however, for academic staff, it was a serious one. The respondents reported incivility that related to: (1) disrespect others, (2) work overload, and (3) miscommunication. The respondents also shared their personal opinions on how to address incivility in the academic environment, which were: (1) the need for counselling sessions, (2) developing rules and sanctions related to incivility (3) respecting each other and (4) good communication within the teaching and learning process.

In order to understand these perceptions and the nature of incivility within Indonesia it is important to know something about its culture and its education system.

1.3 The extent of uncivil behaviour in the Indonesian education system

Indonesia is a developing country, comprised of a sprawling archipelago with diverse ethnicities and socio-economic backgrounds as well as six religions that are accorded official recognition (Mandryk, 2010). Habibie (2012; p. 10), a former Indonesian president, stated that culture, religion or beliefs influence the behaviour and characters of the people of Indonesia. (Further explanation concerning Indonesia as the context of this study can be found in section 1.9).

Given the remarkably pluralistic nature of the Indonesian society, its social relations are relatively tranquil. However, issues of ethnicity and religions are sensitive, and these issues along with economic inequality are considered the main causes of conflicts in the country (Chowdhury and Rammohan, 2006; Rahmawati, 2001). Some examples of moderate-intensity racial, religious and socio-economic conflicts include those that occurred in the regions of Maluku, Aceh, Papua, Poso and Sampit between 1950 and 2001 (Purnomo and Septina, 2004). Significantly, ethnicity, religion and socio-economic status (SES) have influenced the social dynamic of the citizens in Indonesia. These factors intersect all areas of life, including the social transactions that occur in the universities where this study took place.

1.4 Incivility in the Indonesian education system

Many of the previously mentioned problems of incivility (see section 1.2), including plagiarism (Adiningrum and Kutieleh, 2011), bullying (Lai, Ye and Chang, 2008) and cheating in examinations (Rangkuti, 2011), are endemic to the Indonesian education system. Adiningrum and Kutieleh (2011) revealed that most students in higher education in Indonesia lacked awareness of the concept of plagiarism, which goes some way to explaining why Indonesians give little priority to ownership issues (Adiningrum and Kutieleh, 2011).

In terms of bullying, Lai et al. (2008) studied five types of bullying in middle school students in Asian-Pacific countries including Indonesia. Most of the Indonesian students claimed to have experienced bullying at school, such as 'being made fun of or being called names' (female 33.65 and male 38.4%). Interestingly, the study also revealed that students who experienced bullying complained more about their teachers demonstrating a poor attitude and their inability to engender good academic standards (Lai et al., 2008). Rangkuti (2011) identified the occurrence of cheating among accounting students at a private university in Jakarta. The study found that cheating by students' occurred both within and outside the classroom, for example, cheating during examinations and plagiarism in an essay paper.

1.5 Incivility in Indonesian nursing education

As identified in section 1.2, nursing is not immune to incivility and there is a growing body of studies on the topic. However, most incivility studies in nursing and other HE programmes/disciplines have been conducted in Western countries. Consequently, there is a paucity of empirical studies

exploring uncivil behaviour in Asian countries generally, including in Indonesia. In addition, the findings of the studies that have been conducted in the West may not be transferable to the Indonesian context. One of the main reasons for this is the cultural differences that exist between the West and Indonesia.

There has been great deal of literature that have explored the physical and emotional impact of uncivil behaviour (Luparell, 2007; Zhou, Yan, Che and Meier, 2015). There is, however, a relative paucity of studies that have investigated factors that are implicated in uncivil behaviour, particularly the role that ethnicity, religious faith and SES may have (Anthony and Yastik, 2011; Beck, 2009; Marchiondo, et al., 2010). Yet there is evidence that these factors appear to contribute to uncivil behaviour in nursing education in Indonesia. For instance, a study revealed that religion is an important aspect of the academic environment in Indonesia (Sutantoputri and Watt, 2013). The authors claimed that religion might be one predictor of motivational goals in higher education. This also suggests that students' religious backgrounds could influence their behaviour, civil or uncivil, when pursuing their degrees. But while there is some evidence that a correlation may exist between religious beliefs and uncivil behaviour, no studies have investigated how multiple factors, namely, ethnicity, religious faith and social-economic status (SES) are implicated in displays of uncivil behaviour within the Indonesian context and in particular in nurse education.

Uncivil behaviour in nursing education is probably a microcosm of uncivil behaviour problems in general (Beck, 2009) including in the Indonesian society. If these problems could be managed, the incidence of uncivil behaviour may be minimised in Indonesian nursing education. As with any other part of the world, nursing students in Indonesia are not only expected

to display civil behaviour in the classroom but also in clinical settings. These expectations are implicit within the Indonesian student nurses' conduct of practice, which is similar to the Code of Practice that governs registered nurses in Indonesia (Indonesian National Nurses Association/INNA, 2015).

1.6 Aim and objectives

The aim of the study was to explore how nursing students and nurse academics perceived uncivil behaviour based on their ethnicity, religious faith and socio-economic backgrounds.

The objectives of this study were:

1. to compare nursing students' and academic staff members' perceptions of uncivil behaviour in nursing education at private and public universities in relation to ethnicity, religious faith and socio-economic backgrounds;

2. to develop a model in order to provide an educational framework, which includes techniques and strategies for teaching and learning that will help in the management of incivility in nursing education and is congruent with Indonesian culture.

1.7 Research questions

The research questions of the study were:

1. How do nursing students and academic staff perceive behaviour as uncivil with regard to their ethnicity, religious faith and socio-economic backgrounds in the institutions where the study was conducted?

2. What future directions could be instigated for the promotion of civil behaviour in nursing education that is culturally congruent with Indonesian context?

1.8 Significance of the study

Those involved in nursing education, such as nurse educators, student nurses and clinical nurses, who encounter incivility have been found to experience negative emotional and physical consequences, such as stress-induced headaches, sleep disorders, and emotional distress (Longo, 2010; Luparell, 2007; Schaeffer, 2013). Because of the potential negative impacts of incivility on victims of it and the paucity of research on the topic within the Indonesian context, makes it is essential to explore incivility in Indonesia nursing education.

Accordingly, this study will provide new insights which have been used to inform a new framework for managing incivility in nursing education in the Indonesian context. The conceptual framework will clarify the concepts, illustrate the interrelationship between concepts, and describe incivility in nursing education (linkage of the classroom, skills laboratory and clinical practice area) perceived by both students and academic staff based on their ethnicity, religious faith and SES backgrounds.

1.9 Indonesia as the context

As identified in section 1.2, perceptions of what constitutes incivility are socially determined and as such are context bound. This section, therefore, seeks to provide insights into Indonesian culture. This is followed by a discussion on the structure of nurse education in Indonesia.

To understand Indonesia as the context, it is crucial to identify Indonesia's location by discussing the physical features as well as human activities that could influence the distribution of population, resources and social, political and economic activities.

As a nation, Indonesia has been influenced by a number of countries including India, China, Persia, Portugal, Holland and Great Britain (Taylor, 2003). The major influence of these countries has been through the blending of these cultures and religions into the Indonesian society. To understand these influences, the history of Indonesia is briefly presented here.

1.9.1 A brief history of the development of Indonesia

The history of Indonesia can be divided into four periods: the Hindu-Buddhist Kingdom period, Islam period, Colonial period, and Independence period (Laksito, 2007; Taylor, 2003). It seems that each of the periods began with the country being invaded and subsequent oppression by conquering armies. Indeed, it has been suggested that the issue of oppressive behaviour continues to influence the contemporary Indonesian society (Nilan, Demartoto and Broom, 2013), despite Indonesia gaining independence on the 17 August 1945. The most crucial fact related to oppressive behaviour was when anti-government demonstrations became riots in Jakarta and other cities in 1998 due to the financial crisis as well as the domination of Suharto's power (the second president who ruled for more than 30 years). Suharto consistently suppressed Indonesian people using his military power especially for social issues, separatism and religious extremism (BBC News, 2000).

Another important issue that needs to be understood regarding the root of incivility in Indonesia is the fact that Indonesia is made up of diverse ethnic

groups which are spread across the country, as described in the following geographical characteristics. Indonesia consists of approximately 17,508 islands (6,000 inhabited) with five major islands: Sumatera in the west; Java in the south; Kalimantan straddling the equator; Sulawesi; and Papua bordering Papua New Guinea in the east (figure 1) (Asianinfo, 2010). Indonesia is divided administratively into 34 provinces (Statistics Indonesia, 2015). Each province is further subdivided into regencies and cities in which there is a total of 413 regencies and 98 cities (Statistics Indonesia, 2015).

Courtesy of worldatlas

Figure 2-2: Map of Indonesia

The population of Indonesia is approximately 236.7 million, consisting of diverse cultures and hundreds of ethnic groups, each with its own language (Statistics Indonesia, 2013). There are 1,331 categories of ethnic, sub-ethnic and sub-sub-ethnic groups based on the survey in the year 2010 (Ananta, Arifin, Hasbullah et al., 2013). Each ethnic group in Indonesia has

its own unique characteristics (positive and negative), which might further lead to social friction if they live in close proximity (Badaruddin, 2013).

As highlighted in section 1.3, factors such as religion can play an important part in how incivility is perceived. Six religions are officially recognised in Indonesia: Islam, Hinduism, Buddhism, Confucianism, Catholicism and Protestant (Mandryx, 2010; Ananta, et al., 2013). Additionally, religious faiths are influenced by mystical traditions or animism in some parts of Indonesia. This tradition was an early belief system, which widely existed before the influence of foreign religious influences came to Indonesia (Mandyx, 2010). Table 1.4 shows the ethnic categories of Indonesia in relation to the official religions as well as languages spoken at home (Ananta et al., 2013).

The major religion of Indonesia is Islam (87.54%). Although Islam is a dominant religion, the state's rule is not based on Shari'a (Islamic law) as in other Muslim countries, such as Saudi Arabia and Malaysia. Instead, Pancasila is the underlying philosophy of Indonesia which accommodates the diversity of the population regarding ethnicity and religious backgrounds (Siswoyo, 2013; Adiningrum and Kutieleh, 2011). Pancasila originated from two old Javanese words (or Sanskrit), 'pañca' meaning 'five', and 'sīla' meaning 'principles' (Embassy of Indonesia in London United Kingdom, 2016).

The ideology of Pancasila further influences the daily life of Indonesian people (Siswoyo, 2013; Adiningrum and Kutieleh, 2011; Siri, 2010; Novera, 2004). For example, from the first principle of Pancasila, belief in one supreme God, there is a practice of living in harmony as well as mutual assistance in the Indonesian society (Adiningrum and Kutieleh, 2011; Novera, 2004). The ideology also reflects Indonesia's plural society with

differing ethnic groups and faiths. Despite the positive values of the state ideology, many conflicts related to differences of ethnicities and religions still occur in Indonesia (Badaruddin, 2013; Siswoyo, 2013).

1.9.2 The socio-economic status of Indonesia

Uncivil behaviour may also be linked to socio-economic growth (Nilan, Demartoto, and Broom, 2013). Nilan et al. (2013) stated that poverty, unemployment and financial stress trigger violence, especially among Indonesian men. Regarding socio-economic growth, Indonesia is currently the 18th largest economy in the world (Indonesia-investment, 2015). Most of Indonesia's exports consist of commodities from plantations such as palm oil, coal and rubber (Indonesia-investment, 2015). Due to the improvement of the economic condition, the poverty rate has declined between 2005 and 2013. However, the gap between the rich and the poor has widened in recent years (Indonesia-investment, 2015).

Table 1.4: The ethnicity categories of Indonesia in relate to their official religions as well as language spoken at home

Rank	Ethnic Group	Year 2010		Religions (%)							Language spoken at home (%)		
		N (000)	%	Muslims	Protestants	Catholics	Hindus	Buddhists	Confucians	Others	Indonesian	Own language	Others
1	Javanese	94,843	40.06	97.17	1.59	0.97	0.16	0.10	0.00	0.01	16.33	77.36	6.32
2	Sundanese	36,705	15.51	99.41	0.35	0.14	0.01	0.07	0.01	0.01	13.31	83.70	2.99
3	Malay	8,754	3.70	98.77	0.71	0.26	0.01	0.23	0.01	0.00	18.95	76.23	4.82
4	Batak	8,467	3.58	44.17	49.56	6.07	0.02	0.11	0.00	0.07	52.56	43.11	4.33
5	Madurese	7,179	3.03	99.88	0.08	0.03	0.01	0.01	0.00	0.00	3.30	91.12	5.58
6	Betawi	6,808	2.88	97.15	1.62	0.61	0.02	0.58	0.03	0.00	72.57	25.41	2.02
7	Minangkabau	6,463	2.73	99.72	0.18	0.08	0.00	0.02	0.00	0.00	23.87	71.19	4.94
8	Buginese	6,415	2.71	98.99	0.46	0.09	0.41	0.01	0.00	0.04	32.15	59.14	8.71
9	Bantenese	4,642	1.96	99.83	0.08	0.03	0.00	0.06	0.00	0.01	10.32	33.13	56.54
10	Banjarese	4,127	1.74	99.55	0.30	0.08	0.02	0.03	0.00	0.01	10.85	86.13	3.02
11	Balinese	3,925	1.66	3.24	0.92	0.34	95.22	0.26	0.00	0.01	6.29	92.69	1.02
12	Acehnese	3,404	1.44	99.85	0.10	0.02	0.00	0.03	0.00	0.00	14.67	84.17	1.16
13	Dayak	3,220	1.36	31.58	30.18	32.50	0.38	0.54	0.02	4.79	14.11	61.62	24.28
14	Sasak	3,175	1.34	99.33	0.12	0.06	0.14	0.34	0.00	0.01	4.45	93.94	1.62
15	Chinese	2,833	1.20	4.65	27.04	15.76	0.13	49.06	3.32	0.04	60.49	24.07	15.44
16	Others	35,769	15.11	64.48	24.11	10.67	0.18	0.20	0.03	0.33	22.66	31.59	45.75
	Total	236,728	100.00	87.54	6.96	2.91	1.69	0.71	0.05	0.13	19.95	67.58	12.47

1.9.3 Education and health status in Indonesia

In the area of education, Indonesia has also made some major improvements (Statistics Indonesia, 2015). The literacy rate of the population aged 10 and older increased from 87.26% to 94.54% (1994-2013) (Statistics Indonesia, 2015). Additionally, from 1994 to 2013, the proportion of people aged 15 and older who never attended school declined (13.79 to 5.77%) while the number of high school graduates increased from 16.53 to 31.41% (Statistics Indonesia, 2015). An important point to make here is that the diverse social-economic and education backgrounds of the Indonesian people may also influence their antisocial behaviour (Piotroska et al., 2015) as indicated by many conflicts in Indonesia, that were caused by diverse economic status (Badaruddin, 2013).

Concerning health, the people of Indonesia have enjoyed a growth in positive health outcomes in recent years (WHO, 2015; Indonesia-Ministry of Health, 2014). For instance, the average life expectancy in Indonesia increased from 69 to 69.87 years old between 2008 and 2012. Concerning the mortality rate, the under-fives mortality rate decreased from 84 to 29 per 1000 live births in 1990 to 2012, while the maternal mortality rate also decreased from 430 to 190 per 100,000 live births. In 2013 the most common causes of death in children under five were prematurity (19%) and acute respiratory infections (16%). Additionally, stroke was the most common cause of death in adults, killing 328.5 thousand people (21.2%) in 2012 (WHO, 2015). These health trends become a crucial challenge for educating professional health care providers including nurses (Hennesy, Hicks, Hilan and Kawonal, 2006).

The overall nurse to population ratio in Indonesia is 116.1 per 100,000 people (Ministry of Health Indonesia, 2014). The highest nurse to population ratios was in West Papua (116.1), Maluku (305.2) and North Maluku (280.1) per 100,000 people. In contrast, the lowest nurse to population ratios was in North Sumatera (65.7), West Java (68.2), and Banten (68.4) per 100,000 people. The different proportions of nurses throughout Indonesia provide evidence for the need of more nurses (Hennesy et al., 2006).

1.10 Nursing Education in Indonesia

The development of nursing in Indonesia cannot be separated from its history. As explained in the previous section (1.9), nursing in Indonesia began to develop in the Colonial Period and has continued to grow (Kusnanto, 2004; Simamora, 2009). During the colonial period, there was no formal education for health care providers (Kusnanto, 2004; Simamora, 2009). In 1819, the Netherlands established a general hospital which became the first hospital in Indonesia. This hospital, whose name was then changed to Cipto Mangunkusumo (CM) hospital in 1912, has continued to be developed and is now the main referred hospital (Kusnanto, 2004; Simamora, 2009). Eventually, many other hospitals were also developed by missionaries (Catholics and Protestants) such as Sint Carolus and Cikini Hospitals in Jakarta, Santo Borromeus Hospital in Bandung and Sint Elisabeth Hospital in Semarang.

In 1906, the first nursing school was established by the Cikini Hospital and followed by the CM hospital in 1912. The nursing education was conducted at a senior high school level and based on the Dutch system. Nurse education was still based on that system in the transition period from the Colonial to the Independence Period. After that, many nursing schools were established.

However, there was no significant innovation that prepared nursing to develop into a profession (Kusnanto, 2004; Simamora, 2009).

It is noted that nursing in Indonesia began with Christianity initiatives. However, this has changed due to the influence of Islam, which is the dominant religion in Indonesia. Subsequently many Islamic nursing education institutions have evolved to influence the development of nursing in Indonesia (e.g. Jakarta, Semarang, Surabaya, Pontianak, Banjarmasin) (AINEC, 2016). Nuances of Islam can be seen in nursing institutions such as Islamic greetings at the beginning of a class and the wearing of the hijab (headdress) by female students and educators (Utomo, Utomo, McDonald and Hull, 2015).

In 1962, an academy of nursing was established by CM hospital (Kusnanto, 2004). Nevertheless nurse education continued to be separate from the higher education sector. This type of nursing academy was similar to those in other nursing schools which were established by some hospitals in many cities in Indonesia (Kusnanto, 2004; Simamora, 2009).

Finally, in 1983, nursing organisations held a series of national workshops aimed at promoting nursing as a profession (INNA, 2015; Kusnanto, 2004; Simamora, 2009). In 1983, a nursing diploma was also developed (Kusnanto, 2004). In 1985, one public university (University of Indonesia or UI) established a nursing study program under the Faculty of Medicine in Jakarta (Java Island) (Kusnanto, 2004; Simamora, 2009). In 1995 the faculty of nursing was established (Kusnanto, 2004; Simamora, 2009). In the same year, many nursing programs, under Faculties of Medicine were developed by some public universities both on Java and outside of Java, such as in Sumatera and Sulawesi. However, previous studies mentioned that nursing education in Indonesia was mainly at the level of senior high school

while medical education was at the level of university education (Hennessy, et al., 2006; Shield and Hartati, 2003). It seems that the positions of doctors and nurses are unequal based on their education levels. Thus, it may lead to a situation where doctors might assume power over nurses which can further lead to the occurrence of incivility (Clark, 2008d).

Nursing education eventually developed into a Master's program. The first master's program was developed by UI in 1999. A nursing specialisation was also developed between 2003 and 2005 (Kusnanto, 2004; Simamora, 2009). This development of the master's degree in nursing was further followed by other nursing education institutions in Indonesia. Then, in 2008 UI established the first doctoral program in nursing in Indonesia (Kusnanto, 2004; Simamora, 2009).

Currently nursing education in Indonesia includes diploma, undergraduate and postgraduate (master and doctoral) levels (INNA, 2016). The curriculum in the nursing program refers to the national curriculum that was developed by the Association of Indonesian Nurse Education Centre (AINEC). However, the quality of curriculum implementation is not monitored efectively, thus the quality of nursing education differs greatly between institutions (Lock, 2011). Moreover, Lock (2011) and Hennessy et al. (2006) claimed that there was a lack of function regarding the professional body and registration of nurses. The authors further stated that the standardization of nursing curricula and accreditation has not yet been mandated for all types of nursing programs (Lock, 2011; Hennessy et al., 2006). Consequently, there is uncertainty as to whether the graduating nurses have met a general minimum standard of nursing knowledge or skill as well as the minimum requirement to practice safely (Lock, 2011; Hennessy et al., 2006). However, an independent accreditation institution for higher education in health sciences (LAM-PTKes Indonesia) was established in 2011 in

Indonesia. It is hoped that the accreditation institution can promote a culture of continuous quality improvement (LAM-PTKes Indonesia, 2016).

It is further noted that the image of nurses in Indonesia is poor. Sommers, Tarihoran and Sembel (2015) examined the image of Indonesian nurses in Karawaci area in West Java. Most of the participants were female (65.7%) with an average age of 33.9 years, bachelor degree holder (46.9%) and Chinese ethnic background (45.5%). The study revealed that nurses do not meet the participants' expectations in areas of 'careerist' and 'angels of mercy' (Tzeng, 2006, p.757). In terms of careerist, nurses have been found to lack the knowledge, intelligence, and professionalism required for contemporary practice. In terms of being 'angels of mercy', nurses lack self-sacrifice, moral, and respectable. This study also recommended that it is important for nursing education to highlight compassion, competence, knowledge and professionalism in nursing care especially for nursing students as future nurses (Sommers et al., 2015).

It can be seen that there is a challenge for nurse educators to improve the image of nursing in Indonesia. Therefore, nurse educators need to be proactive in identifying motivations and limitations to learning and in developing strategies that promote teaching and learning in nursing education. As already identified previous studies have shown that incivility has an adverse impact on the teaching-learning process (e.g. Longo, 2010; Luparell, 2007; Schaeffer, 2013) and that contexts may influence incivility occurrences (Anthony and Yastik, 2011; Beck, 2009; Nilan, et al. 2013; Marchiondo, et al., 2010). Thereby, raising the question of how nursing students and academic staff perceive behaviour as uncivil in their contexts (ethnicity, religious faiths, socio-economic status/SES). This study provides further insights into these two important factors (incivility and context) in nursing education, especially in Indonesian context.

CHAPTER 2: Literature Review

Chapter 1 highlighted the concerns over the growth of incivility. This chapter seeks to identify factors that have contributed to this growth. It critically analyzes the concept of incivility in higher and nursing education and evaluates the efficacy of conceptual models of incivility. This is followed by a systematic review of the incivility literature in order to identify gaps in existing studies and to provide directions for future research.

2.1 Contributing factors to the growth of incivility in higher and nursing education

In section 1.2, reference was made to the growth, nature and extent of uncivil behavior within higher education. This section seeks to identify factors that may explain the reasons for this growth.

2.1.1 Pedagogical approaches and their implications for incivility.

Vandeveer (2009) defines the learning and teaching process as a meaningful, dignified and respectful interaction involving teachers and students which takes place in various settings, such as the classroom, laboratory, clinical practice area and online-learning forums (Clark, 2006). However the continuing growth of incivility suggests that Vandveer's definition is increasingly becoming a thing of the past. One factor that may have contributed to this situation is the shift from a teacher-centered, behavioural approach to a more student-centered, andragogical approach to learning and teaching.

Behavioural pedagogy

For decades, teacher-centered approaches to learning and teaching dominated education. One reason for this was the use of behavioral objectives, which provided the basis for planning because they provided an explicit guide to teachers as to what to teach (Vandeveer, 2009). Teacher-centered pedagogy stems from the behavioural school of psychology and is based on the work of prominent behavioural psychologists, such as Pavlov's concept of conditioned reflexes, Thorndike's law and effect, and Skinner's operant conditioning (Ashworth, 2014; Quinn and Hughes, 2007; Vandeveer, 2009). In the teacher-centered approach, students are the passive recipients of knowledge, which is transmitted by teachers. Hence, the primary role of the teachers is to give information. In terms of incivility the important point is that when the teachers are controlling and managing the classroom, it is more likely that the classroom remains orderly (Knepp, 2012). Thus some authors advocate behavioral approaches to teaching and learning (Feldman 2001; Dzubak 2007)

But although behaviourism dominated early education theory (Chambers, Thiekötter, and Chambers, 2013), it was later challenged by educational psychologists who began to reject the concept that the locus of learning was external to individuals.

Rogers (1969), an ardent critic of behaviorism, considers it undemocratic. Rogers takes the view that an individual (i.e. a student) is a free and active agent responsible for their own destiny. Hence, critics of behaviorism believe that it is morally wrong to refuse the student's responsibility and freedom in the learning process by molding their behavior to suit the ends of someone else (Gerrish, 1990). Consequently, behaviorism has been described as 'a process [of] indoctrination rather than education' (Kelly, 2009; p.46).

In making this comment, Kelly and other opponents of behaviorism raised fundamental questions over the nature of education itself. A primary concern of education is the process of intellectual and cognitive growth, and crucially not the body of knowledge or the behavioral changes but the process of development that it brings about (Blenkin and Kelly, 1981). Thus, the central premise of education is the development and growth of intellectual capacities rather than the acquisition of knowledge and behavior modification.

Behaviorism in nursing education

Nurse education had used behavioral objectives for some time. However, as a result of the criticisms of the approach, it also began to consider the intrinsic value of individuals and the ethics of forcing nursing students into a 'mold' and excluding those who demonstrated individuality in the learning process (Hollingworth, 1986). Consequently, student-centered/andragogy approach became the preferred pedagogy.

2.1.2 Andragogy and incivility

Andragogy is a term used to describe the teaching and learning of adults (Knowles, Holton III and Swanson, 2005; Quinn and Hughes, 2007; Vandeveer, 2009). A number of assumptions related to adult learners include knowing why they learn, being responsible for their own learning, being prepared for their learning readiness and their rich previous learning experiences (Knowles et al., 2005; Quinn and Hughes, 2007).

According to Morrissette (2001), this valuing of students coupled with the collaborative learning environment that characterises andragogy leads to the reduced levels of student incivility in the classroom. However, adult learners who lack experience might be reluctant to establish their own learning goals and to participate in learning (Vandeveer, 2009). Some authors (e.g.

Bjorklund and Rehling, 2010; Feldmann, 2001; Royce, 2000) reported that students who did not involve or engage in the teaching learning process were perceived as displaying uncivil behaviour through, for example, not paying attention or inattention in class, reluctance to answer direct questions and using computer or mobile phone for non-class activities.

2.1.3 Other student- and teacher-factors that contribute to incivility in the classroom

Knepp (2012) categorises other contributory factors to incivility into three areas: student-related causes and contributors; institution-related causes and contributors; and faculty-related causes and contributors.

The first of these, student-related causes and contributors, includes greater students' expectations and a sense of entitlement. In relation to expectations, Alberts, Hazen and Theobald (2010; p. 440) identify a new generation of students which they refer to as the 'Millennial Generation'. According to Alberts et al these students present unique challenges to faculty because they have experienced a regular diet of instant gratification entertainment, which has led to them having a reduced attention span and ability to multitask, thereby making it difficult to keep them engaged during lectures.

The second factor included in Knepp's classification is a sense of entitlement held by 'Millennial Generation' students. This is thought to lead to students putting minimum effort into their courses, whilest faculty see themselves as being responsible for students' learning; students are increasingly becoming passive. This point appears to be at odds with contemporary andragogical approaches to education.

The second factor in institution-related causes and contributors relates not to students' characteristics, but to a paradigm shift which has taken place within general and higher education in the last 20 years. To this end, it is argued that universities and nurse education have seen the growth in the diversity of students accessing them (Bednarz et al 2010). This diversity brings with it an array of students' attitudes and expectations of learning and the academic environment. In addition, many students have not experienced the courtesies expected at the university in other parts of the education system and are, therefore, unaware that their behaviour may be seen as uncivil (Knepp, 2012).

The third category, as identified by Knepp, focuses on members of the faculty as the source of uncivil behaviour. Given that faculty members have been found to be vulnerable to the effects of students' incivility ranging from rudeness to physical assault (see sections 1.2 and 1.3), it is ironic that the faculty members may have a major role to play in the growth of incivility. But according to Knepp (2012), this is the case and is the result of: (i) the increased use of inexperienced teachers, such as graduate teaching assistants, and (ii) certain demographic or personal characteristics of teachers including gender (women are more likely to be victims of uncivil behavior), age, ethnicity, and status of teachers.

However, Kuhlenschmidt and Layne (1999) argue that uncivil behaviour in the classroom has nothing to do with teachers. Instead, they warn that jumping to conclusions about the source and nature of the problem is a recipe for failure (Kuhlenschmidt and Layne 1999, p.46). Moreover, they suggest that '*... becoming irritated or highly emotional may lead to you [faculty members] to react without understanding the situation*' (Kuhlenschmidt and Layne 1999, p.46). Furthermore, they suggest that

there is a tendency for faculty members to personalise the behaviour and look to themselves as being the cause.

However, it seems that Kuhlenschmidt and Layne are alone in taking this position with an increasing body of research pointing to faculty incivility as being a provocation of incivility in students as well as being a major source of students' stress (Del Prato, Bankert, Grust and Joseph, 2011). For example in a study of factors that contribute to incivility in a South African School of Nursing, Vink and Adejumo (2015) found that one of the major contributors was the attitude and behavior of the educators themselves. Participants in the study felt that the diversity of students they interacted with on a daily basis increased their work load which led to them being abrupt and being perceived as unapproachable by students.

However, to suggest that workload alone is responsible for such displays of incivility underestimates the complexity of the processes involved. The real concern is the lack of demonstration of respect by faculty members to students (Cooper, Walker, Askew et al., 2011). Members of the faculty who do demonstrate positive respectful behaviors are more likely to engender and encourage the display of similar behaviors in their students (Ibrahim and Qalawa, 2016). One way of understanding and explaining this phenomenon is through models of behaviour.

2.2 Theories of learned behaviour

A number of learning theories have been proposed as a way of explaining why people behave the way they do. These theories may offer some explanations of how and why some individuals are engaged in uncivil behaviours.

2.2.1 The psychodynamic approach

One prominent theory of behavior is the psychodynamic approach. The main assumption of this approach is that an individual's behaviour is the result of unconscious motives which are shaped by the person's biological drive and early experiences. In other words, inner determinants are responsible for our behavior. It is, therefore, frequently referred to as a deterministic approach (Sammons, n.d.). Sigmund Freud is considered to be the founder of this branch of psychology (McLeod, 2007). Although contemporaries of Freud, such as Carl Jung, Alfred Adler and Erikson, emphasized different issues in human development and experience in which all of these theories emphasize factors that motivate behavior (McLeod, 2007).

Advocates of the psychodynamic approach assert that its strength is in the way it acknowledges the complexity of human behavior. However, Bandura criticizes the theories of behaviour that look for explanations within the individual both on conceptual and empirical grounds (Bandura, 1971). A major criticism is that the analysis of human behavior is unscientific. The reason is that the concepts central to the psychodynamic theory are subjective and very difficult to test. Another objection to determinism is that it is reductionist and as such oversimplifies what Bandura (1971, p.1) refers to as '*…the tremendous complexity of human responsiveness.*' Such concerns coupled with developments in learning theories began to shift the emphasis from inner determinants to the investigation of external influences known as behavioural psychology.

2.2.2 Behaviorism and learned behaviour

As discussed in section 2.1.1, the behavioural school of psychology focuses on how behavior results from external environmental stimuli. Hence, advocates of behaviourism believe that the root cause of behavior is not found within an individual but in environmental forces. The behaviourist approach is, therefore, an example of environmental determinism.

However, behavioural explanations for learned behaviour have been criticised for reducing complex behavior to a simple stimulus response model. While it may have some value in explaining aspects of animal behaviour, it has far less relevance to human behaviour which has multiple determinates and where the ability to make choices (free will) is evident. It is these criticisms that led Bandura (1971, 1977) to develop his theory of social learning.

2.2.3 Social learning theory

In his theory of social learning, Bandura (1977) argues that behaviour is not the result of 'inner forces' such as needs or drives or external forces, but is the result of observation and learning through imitation. According to Bandura, people learn in a social context by observing, imitating, and modeling the behavior of others. Social learning (also known as 'observational learning') is thought to be an efficient and powerful form of learning. Sources of observational learning include family members, community, and the media. For instance, children can learn aggressive behaviour from family members or care providers such as nurseries (Hong and Espelage, 2012). Community sources include schools, where aggressive behavior might be the cultural norm (Leach, 2003). Media sources include television, video games, movies, and the internet which offer a more aggressive representative modeling (Anderson and Bushman, 2001;

Huesmann, Moise-Titus, Podolski and Eron, 2003; Williams and Guerra, 2007). Moreover, individuals who have been exposed to aggressive behaviour for a long period of time and been rewarded for showing aggression are more likely to repeat the aggressive behaviour (Bandura, 1978).

2.3 Social learning theory applied to incivility

More recent studies also suggest that individuals can learn others' uncivil behaviour (Altmiller, 2012; Luparell, 2011; Walrafen, Brewer, and Mulvenon, 2012). Altmiller (2012) studied incivility in nursing education from the students' perspective using focus group methodology involving 20 nursing students from a state university and three private universities in the Mid-Atlantic States, the USA. In this study, students reported that academic staff commented negatively about students, belittled and disrespected students. Moreover, the study also revealed that students who observed such behaviour were more likely to adopt the same uncivil behaviour displayed by academic staff (Altmiller, 2012). However, as Altmiller's study used a convenience sample, the study may not truly reflect the broader student population.

Nevertheless, Luparell (2011) supports Altmiller's (2012) findings. Luparell (2011) suggests that those students who are victims or observe displays of uncivil behaviour by academic staff and nurses in the clinical setting are more likely to adopt the same behaviour. Luparell further identifies that if students perceive that the attitude of disrespect to others was regarded as a "norm" in nursing, it could prompt them to perpetuate this negative behaviour even after graduation, thereby potentially developing a culture of incivility within the practice setting.

Further, support for the role that social learning theory plays in the transmission of uncivil behaviour comes from a study by Walrafen et al. (2012). Walrafen et al. used a mixed-method design to identify horizontal violence among nurses in a healthcare organization. Using Bandura's social learning theory, Walrafen et al. explained that nurses may replicate the behaviour of other nurses, such as those engaged in 'back-stabbing', disrespecting colleagues and bickering among peers, as a way of being accepted by their colleagues (Walrafen et al., 2012).

2.4 Social Exchange Theory applied to incivility

Cropanzano and Mitchell (2005) argued that one of the most influential concepts for understanding organisational behaviour is social exchange theory (SET). Previous authors (Cropanzano and Mitchell, 2005; Emerson, 1976) highlight that the SET emerged from many disciplines including sociology (e.g. Blau), social psychology (e.g. Homans, Thibaut and Kelly), anthropology (e.g. Sahlins) and behavioural psychology (e.g. Skinner, Bandura).

Homans defines SET as an approach to describe social behaviour regarding actions exchanged between two or more individuals that result in rewards and punishments (Homans, 1961; Emerson, 1976; Cook and Rice, 2001). In addition, SET proposes that interpersonal relations are led by a norm of reciprocity (Gouldner, 1960). This also means that people would mutually acknowledge and repay kindness with kindness in their interactions (Gouldner, 1960). Within the education setting, this norm would be demonstrated by academics and students being reciprocal in displaying helpful actions. However, social relationships may also be characterised by negative reciprocity in which incidents of hostile action by academic staff

prompt students to reciprocate the treatment they receive (Taylor, et al., 2012).

The SET has been used in previous studies of incivility including: uncivil behaviour in the workplace (Andersson and Pearson, 1999; Taylor et al., 2012) and in nursing education (Beck, 2009). Deriving from social exchange theory and reciprocal aggression, Andersson and Pearson (1999) revealed an increasing and mutual nature of incivility using a "tit-for-tat" pattern. A study by Taylor et al. (2012) further revealed that affective commitment in social exchange relationship was the mediator between workplace incivility and individuals' performance.

Both Andersson and Pearson, (1999) and Taylor et al., (2012) utilised the principle of SET namely reciprocity rules. The reciprocity rules are the most crucial principle of the SET as well as the most applied principle when studying behaviour in organisations (Cropanzano and Mitchell, 2005; Taylor et al., 2012). Both papers (Andersson and Pearson, 1999; Taylor et al., 2012) also argued that incivility is a dynamic social interaction involving the exchange of negative reciprocity behaviour.

Beck's (2009) study of incivility in nursing education applied the concept of emotions in social exchange proposed by Lawler and Thye (1999). The authors proposed that the emotional elements of social exchange are also essential when studying social interactions between two or more people (Lawler and Thye, 1999). Emotions are intrinsic in social interactions, influencing relationships as well as producing bias information or destructive cognitive capacity (Lawler and Thye, 1999) which could have major consequences for learning (Beck, 2009). Positive emotions occur when the interactions are successful whereas negative emotions occur when the interactions fail (Lawler, 2001). Moreover, a number of studies also revealed

that negative emotions were felt by people involved in incivility incidences (Beck, 2009; Clark, 2008a, 2008b, 2008c, 2008d; Luparell, 2008).

It is noted that incivility could be perceived as a negative exchange of social behaviour in which incivility can occur in nursing education. The emotional component in the social exchange could further impact on the destructive cognitive capability which might influence individuals' learning process in higher education.

2.5 Incivility in nursing education

Chapter 1 (section 1.2.4) presented a brief introductory discussion on incivility in nursing education. This section builds on this by further discussing occurrences of incivility in nursing education.

As discussed in the previous section (1.2.1), incivility has increased in higher education. In general, nursing education has also experienced a rise in uncivil behaviour in both students and academic staff (Clark, 2006; Clark and Springer, 2007a, 2007b; Lashley and de Meneses, 2001; Luparel, 2007). In their study Lashley and de Meneses (2001) contacted nursing directors from 409 nursing programs, from across the USA, inquiring about the extent and nature of students' disruptive behaviour in their programs and how they managed it. Some nursing directors (43%) reported a variety of problematic student behaviour including: acts of academic dishonesty, rudeness and lateness for class sessions (Lashley and de Meneses, 2001).

Lashley and de Meneses's study (2001) triggered other researchers to further explore incivility in nursing education. Luparell (2003) investigated incidences of student incivility as experienced by 21 faculty members from across the USA. Respondents reported 33 instances of uncivil behaviour by students. It was noted that despite there being relatively few male nurses

in the study almost 44% of the disruptive behaviour was experienced by male nurse educators.

In another study, Luparell (2004) explored academic staff's experiences of uncivil student behaviour using a qualitative design. In her study, Luparrell observed that there were increasing incidents of unprofessional behaviour demonstrated by students including dishonesty, disrespectful and threatening behaviour (Luparell, 2004). Randle (2003) conducted her study using grounded theory design involving 56 students in interviews at the beginning and 39 students participated at the end of one nursing program in the UK. It was found that bullying was a common practice which adversely affected students' self-esteem. Kolanko et al (2006) believed that bullying is a form of incivility and discussed its excessive occurrence in her study.

Clark (2006) explored incivility in her doctoral thesis and developed the Incivility Nursing Education questionnaire (INE) to measure incivility in nursing education. Clark recommended that both quantitative and qualitative data are needed in order for a deep understanding of acts of incivility is to be obtained. Beck (2009) further developed the INE questionnaire and added the behaviour of students, academic staff and nurses in clinical settings. The INE is now the most utilised and valid instrument to measure incivility in nursing education (Gallo, 2012).

In a study of the literature, Suplee et al. (2008) reported that many nurse educators encountered and witnessed incivility in the classroom setting on a daily basis as well as in the clinical setting, and on-line learning forums. Thereby, it is shown that incivility is not confined to the classroom but permeates to a range of teaching and learning settings. In their study, Cooper et al. (2009) observed that bullying was increasing in both classroom and clinical settings. Clark (2009) supported Suplee et al (2008), in reporting

that uncivil student behaviour in online learning forums includes sending inappropriate e-mails to other students, or academic staff, and plagiarism.

Clark and Kenaley (2010) were concerned about the negative impact that incivility could have on the faculty-student relationship and subsequently provided suggestions for empowering students to reduce uncivil behaviour in nursing education. Clark, et al. (2012) expanded the study in a Chinese context at one university in the PRC. This study also confirmed that incivility occurred in nursing education in PRC with overload and moodiness as the cause. A preliminary study by Eka et al. (2013) at one nursing program in Indonesia observed that incivility occurred in Indonesian nursing education. This study recommended that further research needed to be undertaken to explore incivility in nursing education in the Indonesian context, bearing in mind that Indonesian people have diverse backgrounds such as ethnicity, religion, SES which frequently influence acts of incivility (Clark, 2008a).

What all these globally diverse studies highlight is the extent that incivility exists in nursing education settings. Previous studies have further confirmed that incivility in nursing education settings remains a problematic issue.

Various forms of incivility in nursing education have been revealed from previous studies such as those conducted by Lashley and de Meneses (2001), Randle (2003), Luparell 2004), Clark (2008a, 2008b), Beck (2009), Cooper et al. (2009), Thomas and Burk (2009), Clark et al. (2010), Clark, Juan, Allerton, et al. (2012) Clark, Werth and Ahten (2012), Altmiller (2012), Hunt and Marini (2012), Amos (2013) and Thomas (2015). These various forms of incivility in nursing education were illustrated in the classroom, clinical practice settings and online learning environment.

In a national survey among nurse directors (n=409), all the respondents reported that lateness to class, not paying attention in class and poor class

attendance as disruptive student behaviour in nursing programs (Lashley and de Meneses's; 2001). In a grounded theory study by Randle (2003, students reported that nurses in clinical settings bullied student nurses and patients. Luparell (2004) applied critical incident technique to explore academic staffs experiences of uncivil student behaviour and found that students engaged in acts of incivility including being disrespectful, confrontational displaying threatening behaviour and committing academic misconduct.

Clark (2008a) conducted a quantitative study and used Incivility Nursing Education (INE) questionnaire to investigate the problem of uncivil behaviour in nursing education from the perspective of academic staff and students in the USA. In this study, 194 faculty members (38%), 306 nursing students (60.7%) and 4 anonymous respondents from 41 states were recruited. The study identified that the most frequent acts of uncivil behaviour committed by students were: arriving late for class; holding distracting conversations and being unprepared for sessions. Whereas the most frequent uncivil behaviour committed by academic staff included: ineffective teaching methods; arriving late for scheduled activities; deviating from the syllabus, and changing class assignments. However, although the sample was recruited from 41 different states the study used convenience sampling.Subsequently the potential risk of bias and sampling error associated with this methodology makes generalization of the results challenging. Nevertheless several other studies (Clark and Springer, 2010; Clark et al., 2010); Clark, Juan, Allerton et al., 2012; Eka, et al., 2013; Suplee et al., 2008) have identified similar concerns, indicating uncivil acts which occur in nursing education settings among both staff and student nurses.

Beck (2009) examined students', academic staff and nurses' uncivil behaviour as perceived by two groups of students (i.e new and graduating students). A modified INE survey questionnaire (Clark, Farnworth and Landrum, 2009) was used in Beck's (2009) study which investigated 20 nursing programs in the USA. This study revealed uncivil behaviour among academic staff, students and nurses in the classroom and clinical practice sites. The study also reported that there was no statistically significant difference between first years and final year students' perceptions of uncivil behaviour. However, first year students felt that uncivil behaviour was more likely to occur in the classroom; in contrast, the final year students thought that uncivil behaviour occurred more often in the clinical practice setting. This result might be related to the fact that final year/graduating students had more experience to compare what happens in the classroom setting and clinical setting. Moreover, graduating students spent more time in clinical units than in the classroom setting. The most common theme between incivility conducted by the academic staff, students and nurses was 'disregarding others'.

Cooper et al. (2009) investigated final year students' perceptions of bullying by academic staff in 20 nursing schools in the USA. The students reported that bullying by academic staff took various forms including: unrealistic workload; belittling students and being rude and unfriendly towards students. Thomas and Burk (2009) explored 221 junior nursing students' experiences of violence in the clinical setting in a public state university in the South-eastern USA. The study revealed two themes: 'pejorative, unfair treatment of the students themselves, and violation of patient rights' (p. 228).

Clark et al. (2012) investigated incivility in an online learning environment and developed an instrument named the Online Learning Environment

(IOLE). Participants in this study consisted of 19 academic staff and 152 students. Almost half of the students reported that incivility is a mild problem (44.5%), while a few students reported that it is a moderate problem (6.6%). Clark et al., 2012) further reported that both academic staff and students perceived that students were more likely to be involved in uncivil behaviour in online learning settings than are academic staff. Almost all the participants (83.3% academic staff and 87.5% students) identified racial, ethnic, sexual, and religious slurs' as uncivil student behaviour in the online learning setting. Whereas belittling comments toward students was the most likely form of uncivil behaviour demonstrated by faculty members (Clark et al., 2012).

In a qualitative study, Altmiller (2012) investigated nursing students' perceptions of their own uncivil behaviour. The study identified nine themes of uncivil student behaviour:

> "(1) unprofessional behaviour, (2) poor communication techniques, (3) power gradient, (4) inequality, (5) loss of control over one's world, (6) stressful clinical environment, (7) authority failure, (8) difficult peer behaviours, and (9) students' view of faculty perceptions" (p. 16).

In addition, there were similarities regarding students' uncivil behaviour between the students' in the study and academic staffs' perspectives in the literatures, for example, lack of respect and rude behaviour (Altmiller, 2012).

Amos (2013) investigated uncivil academic staff behaviour from the perspectives of academic staff. This study was a non-experimental design which used the Uncivil Workplace Behaviour Questionnaire (Marthin and Hine 2005).Two hundred and fifty seven academic staff from community

colleges in North Carolina took part in the study. Amos concluded that workplace incivility is congruent with Bandura's social learning theory (1977) and the incivility spiral described by Andersson and Pearson (1999). This study also revealed that most of the demographic factors did not relate to perceived uncivil faculty behaviour. However, there were four exceptions: hostility and full-time employment, hostility and salary range, privacy invasion and ethnicity, and uncivil behaviours and the number of years of full-time teaching (Amos, 2013).

Hunt and Marini (2012), in their mixed method study, reported that indirect incivility, such as a nurse talking about other nurses behind their back ('back biting'), commonly occurred in the practice setting. Instances of clinical incivility have led to Hunt and Marini to suggest that nurse educators help students recognise different types of incivility (i.e direct and indirect incivility) in clinical practice setting as a way of creating a more conducive and safe learning environments.

2.5.1 Incivility in relation to unprofessional behaviour

Nursing is known to be a caring profession. The profession also demonstrates professional behaviour as described in the Nurses' code of ethics (ICN, 2015). Therefore, the potential of nurse educators, student nurses and registered nurses engaging in unprofessional behaviour is concerning.

Miller, Adams and Beck (1993) suggest that professionalism may be described in terms of its characteristics and recognisable professional behaviour, although Ghadirian, Salsali and Cheraghi (2014) argue that professionalism in nursing is always changing due to the development of the nursing profession and the values of society. One definition from the medical perspective argues that professionalism is:

> ‘demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism.’ (Arnold and Stern, 2006, p.19)

It is fundamental to have knowledge and skills regarding clinical competence, communication and ethical-legal aspects of the profession in which knowledge and skills should be applied alongside its principles (Arnold and Stern, 2006). Excellence means committing to and understanding professional competence, ethical principles, values, legal restrictions and communication skills beyond common standards. Humanism includes respect to others, compassion, empathy and self-integrity (Arnold and Stern, 2006). Meanwhile, aaccountability involves responsibility, self-management and addressing self-interest conflicts. Lastly, altruism requires considering the interests of others rather than focusing solely on one’s own (Arnold and Stern, 2006).

A study in nursing by Akhtar-Danesh, Baumann, Kolotylo et al. (2011) described professionalism from the perspectives of student nurses and academic staff members in Canada using Q-methodology. The four main factors of professionalism identified were ‘humanist, portrayers, facilitators and regulators’ (p.8). Humanist provided professional values of regard for others, of individual integrity and of protecting patients’ safety. Portrayer meant providing appropriate image, attire and expressions (e.g. not gossiping). Facilitators involved policies/ethics, personal belief and values including being open-minded, confidence and patient. Lastly, regulators demonstrated sharing, acceptance and implementation of the standards (Akhtar-Danesh, et al., 2011).

Based on the above descriptions of a professional, it is obvious that incivility is not consistent with professionalism. For example, incivility includes communication issues such as holding distracting conversations, disregarding others and verbal violence. These incidences are in contrast to professional characteristics such as humanist and portrayer. In regard to classroom incivility such as being unprepared for class sessions, ineffective teaching methods, arriving late for scheduled activities, deviating from the syllabus, and changing class assignments are also contrary to principles that underpin professionalism.

2.5.2 Effects of incivility on nursing education

Occurrences of incivility in nursing education can further produce negative consequences such as emotional and physical harm to those subjected to it (Clarke, et al., 2012; Longo, 2010; Luparell, 2007; Randle, 2003). Academic staff have reported incidences such as sleep disorder, anxiety, and depression as a result of being exposed to incidences of classroom uncivil behaviour (Kolanko, et al., 2006; Luparell, 2007). Students have also reported having suffered emotional trauma, anxiety, depression, gastro-intestinal distress and low-self-esteem (Randle, 2003; Clark and Springer, 2007a; Clark, 2008d). Nurses also experienced lack of self-esteem and self-confidence, anxiety, mistrust, frustration as well as poor professional relationships (Randle, 2003; Rosenstein and O'Daniel, 2008).

In the clinical setting, Rosenstein and O'Daniel (2002, 2006, 2008) reported that disruptive nurse or physician behaviour triggered negative conditions among nurses or doctors, such as stress and frustration, ineffective communication, teamwork issues, poor information transfer and loss of concentration. These negative conditions might lead to some negative clinical outcomes including poor quality of care, medical errors, adverse

events, patient safety issues and patient mortality (Rosenstein and O'Daniel, 2002, 2006, 2008).

A national survey in the USA conducted by Rosenstein and O'Daniel (2008) indicated that more than 90% of the respondents felt that disruptive behaviour raised feelings of stress and frustration; more than 80% felt that disruptive behaviour triggered a loss of concentration, decreased team work, and worsened information transfer; and more than 90% felt that disruptive behaviors led to poor communication and poor nurse-physician relationships. Leonard, Graham, Bonacum (2004) stated that effective communication and team collaboration play crucial role in patient safety. In other words, poor communication and team working among health care providers could negatively impact on patient safety.

Schaeffer (2013) and Luparel (2011) further argued that students' uncivil behaviourin the academic setting might continue into clinical settings. In other words, a student who is uncivil in the classroom might behave similarly in the clinical setting and the behaviour can negatively impact the patient outcomes such as patient safety issues and patient mortality (Schaeffer, 2013; Luparel, 2011; Rosenstein and O'Daniel, 2008). Student nurses' incivility is worrisome because as registered nurses they are responsible for caring patients in health care settings and this may compromise the provision of quality care to the patients (Beck, 2009).

2.5.3 Incivility Nursing Education Survey Instrument

Some authors (e.g. Schilpzand, de Pater and Erez, 2014) acknowledged that developed incivility instruments facilitated empirical research on incivility, and studies using the instruments have revealed instances, causes, sources and effects of incivility. As discussed above one of many valid and reliable instruments of incivility in nursing education is called INE (Incivility Nursing

Education) survey that describes academic staff and student perceptions of incivility in nursing education (classroom) (Clark, 2008a; Clark et al., 2009; Clark, et al. 2015). The INE survey has been used in many countries with many languages (Clark, 2012), thus, the INE survey was used in the current study.

Clark (2008a) developed the INE survey based on three instruments: the Defining Classroom Incivility (DCI) survey (developed by the Center for Survey Research at the University of Indiana in 2000); the Student Classroom Incivility Measure (SCIM) and the Students Classroom Incivility Measure-Faculty (SCIM-F) (Hanson, 2000). The DCI survey consists of 30 uncivil behaviours which were developed following an extensive literature review by researchers at the University of Indiana (Clark et al., 2009). The SCIM and SCIM-F tools were developed by Hanson (2000) based on a survey in 1986 by Plax, Kearney and Tucker (Hanson, 2000).

The INE survey was first piloted in 2005 at the National League for Nursing Education Summit in the USA (Kolanko et al., 2006). Since this initial pilot study, the INE is recognised as the most commonly utilised measurement used in the investigation of incivility in nursing settings (Gallo, 2012).

The INE survey consists of three sections: 1) a demographic component, 2) a list of uncivil students and academic staff behaviours and 3) four open-ended questions (Clark, 2008a; Clark, et al. 2015). The survey also includes the determination of the frequency of incivility as described in section 2 (Clark, 2008a). Section 3 is a qualitative section to provide suggestions on contributors of incivility and on managing incivility. Clark claimed that the INE survey is the most construct instrument for describing uncivil students' and academic staff' behaviour (Clark et al., 2015). However, the INE survey only covers uncivil behaviour in the classroom settings (Beck, 2009).

Therefore, Beck (2009) saw it is necessary to modify the INE questionnaire and eventually modified the INE survey by adding a number of uncivil behaviour in laboratory skills and clinical practice area.

In this current study, the INE survey was modified by adding categories of the ethnic group, religious background and SES in order to suit the context in Indonesia. Furthermore two valid and reliable instruments were adapted namely the Multigroup Ethnic Identity Measure/MEIM (Phinney, 1999) that identifies ethnic identity, and the Abbreviated Santa Clara Strength of Religious Faith Questionnaire/ASCSRF (Plante and Boccaccini, 1997; Plante, Vallaeys, Sherman et al., 2002) which portrays religious faith or practice. The adaptation of these instruments is mostly in regard with language translation and its readability.

2.6 Conceptual models of incivility-civility

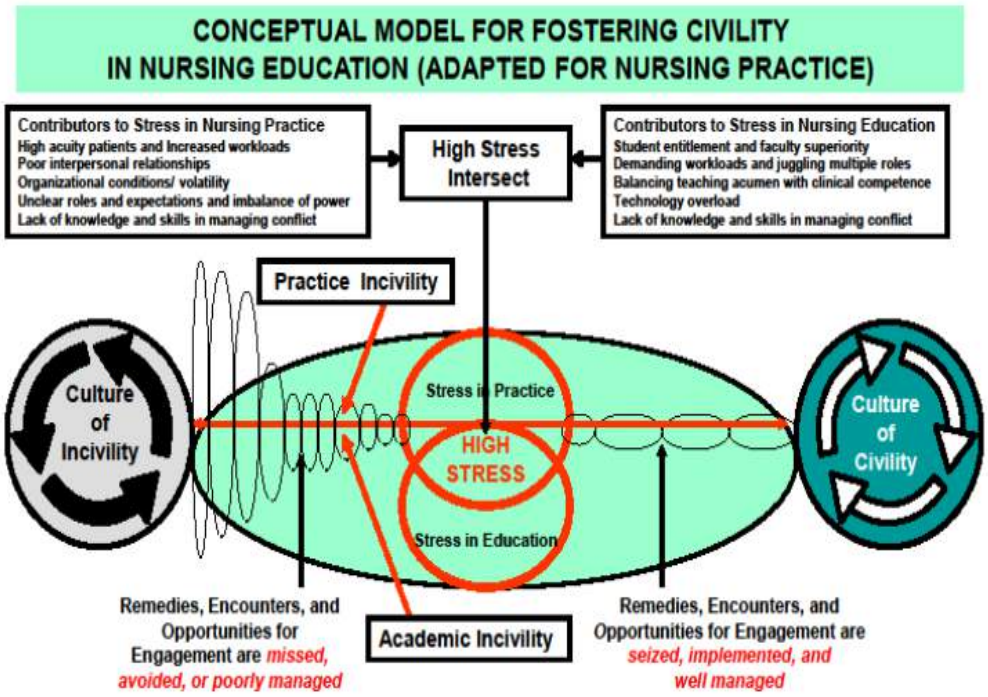
There are several conceptual frameworks suggested in the reviewed literature to study incivility in nursing education, including motivation theory (Daniel, Adams and Smith, 1994), self-esteem theory (Randle, 2003), ethics of caring (McCrink, 2010), the conceptual model for fostering civility in nursing education (Clark and Olender, 2010) and empowerment (Clark and Davis-Kenaley, 2011; Cooper et al., 2011). All these theories could be applied to study uncivil behaviour in nursing environments. However, the model developed by Clark and Olender (2010) was chosen in the current study, since it provides the most comprehensive explanation for managing incivility in nursing education (Beck, 2009; Cicotti, 2012; Vickous, 2015).

In order to fill the gaps in the Clark and Olender's model, another model by Huitt (2003) was further added. These two models were deemed to be adequate to provide a framework for this study in line with the Indonesian

context, although the models were derived from western perspectives. These models are described in the following sections.

2.6.1 The conceptual model for fostering civility in nursing education

The conceptual model for fostering civility in nursing education (Clark and Olender, 2010) provided a basis for empirical studies and presented a new term known as 'the dance of incivility' (Clark, 2008b). Clark (2008b) argued that, similar to dancing, incivility cannot happen through faculty staff or students alone; both of them have to interact. The following figure summarizes the model:



Courtesy of Clark and Olender 2010

Figure 2-1: Conceptual model for fostering civility in nursing education (Clark and Olender, 2010)

The model demonstrates that when the high stress of both faculty staff and students overlaps, the outcome is a combination of increased nervousness and irritability. If the high stress is combined with an attitude of superiority

on the part of faculty staff and an attitude of 'entitlement' on the part of students, this state of affairs may increase the possibility of incivility.

The model also illustrates the opportunity for the academic staff and students to counteract the possibility of conflicts. The conflict will become a culture of incivility if it is poorly managed. Conversely, the conflict will become a culture of civility if it is effectively managed.

In summary, this model demonstrates 'the array of incivility-civility' in nursing education, which explains the interaction between academic staff and students as well as the potential conflicts and suggestions to solve these conflicts.

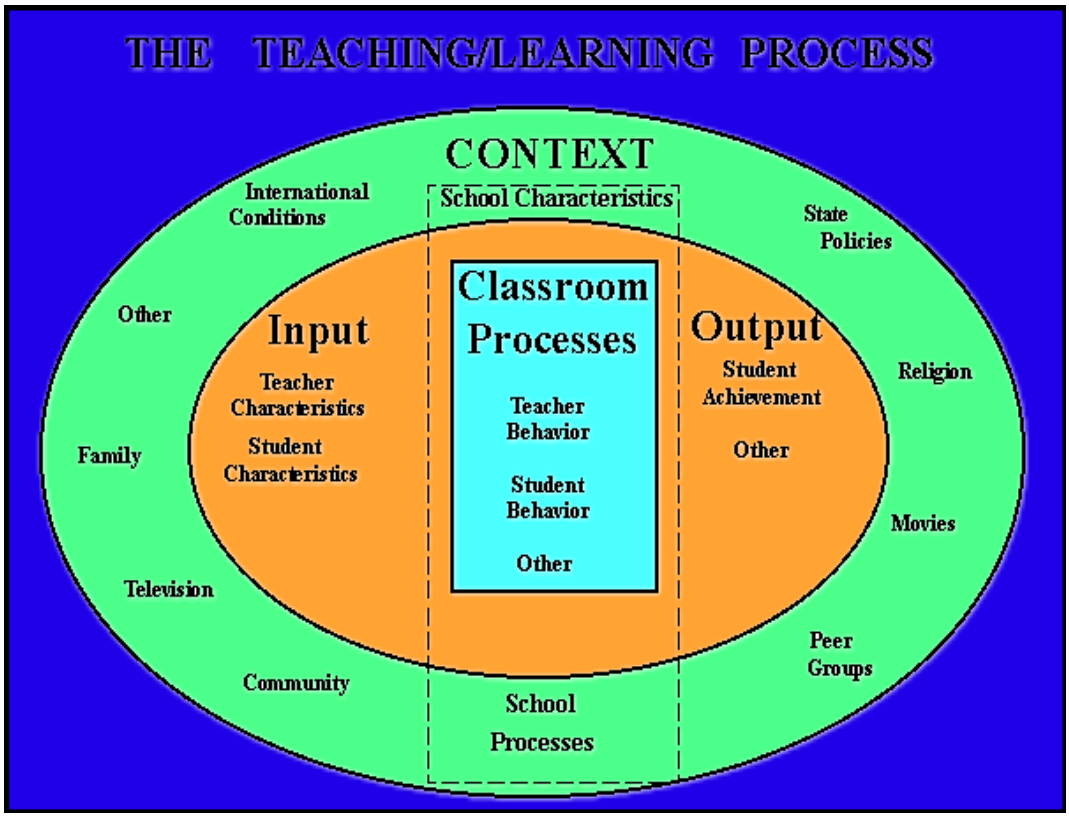
However, the model of Clark and Olender does not appear to address incivility in the Indonesian context, in which ethnicity, religious orientation and SES are prevalent among students and faculty members in nursing education. Therefore, another model is needed to provide an additional focus on ethnicity and religious characteristics of the Indonesian population, which are central to this study (i.e. to investigate the link between incivility, ethnicity, religious orientations and SES and develop an educational framework to guide incivility management in nurse education).

Therefore, this model needs to include more variables related to the incidents of incivility, including school characteristics, school processes and the context, offered by Huitt (2003). Huitt's model, which is also known as the transactional model of teaching learning, is explained below.

2.6.2 The transactional model of teaching and learning

Huitt (2003) proposed a transactional model of teaching and learning which consists of four categories: context, input, process and output (see figure 2.2). The input, process and output are concepts that build the teaching and

learning process. The context consists of external factors that may influence the teaching and learning process. These factors include family/home, community, peer group, culture, policy, religious institutions and the media. Figure 2.2 below illustrates the Huitt's model:



Courtesy of Huitt 2003

Figure 2-2: The transactional model of teaching-learning (Huitt, 2003)

The input consists of the characteristics of the academic staff and students. Academic staff members' characteristics include values, beliefs, knowledge, communication skills and personality. Students' characteristics include age, gender, race/ethnicity and moral development. The attributes of students and academic staff members are intrinsically part of the teaching and learning process, and could influence behaviours, including uncivil behaviour which is the focus of this study.

Huitt's framework shows that the process of students-faculty staff relationships could be influenced by the contextual aspects such as culture (ethnicity), home/family (socio-economic background) and religious institution (religious faiths). A previous literature review by Hong and Espelage (2012) supported the assertion that risk factors within the context of microsystem (e.g. parent-youth relationship, school environment), mesosystem (teacher involvement), exosystem (media and neighbourhood environment) and macrosystem (cultural norm and religion) are associated with bullying in schools. This study (Hong and Espelage, 2012) also revealed that the association between ethnicity, poverty status and religious affiliation is complex and inconsistent.

The three concepts (ethnicity, religious faiths, socio-economic status/SES) will be explained further by drawing on social science perspectives since this current study investigated the research problem in the context of Indonesia nursing education, in which the context could not be separated from Indonesian people as explained in chapter one.

A brief overview of the concept of ethnicity

Given the centrality that ethnicity plays in this study it is important to explore the concept. Fenton (2010) and Dein (2006) argue that race, ethnicity and nation are inter-correlated; thus, it is not easy to differentiate them. Fenton (2010, p. 12) states that "decent and culture communities" are key points for understanding the terms (race, ethnicity and nation) better. 'Race' usually refers to biological/physical or genetic identification (Gunaratnam, 2003; Fenton, 2010). However, Bloch and Solomos (2010) argue that 'race' is not merely biological attributes; it could be constructed rather than naturally present. This term may be related to citizenship, immigration status as well as the marginalisation of socio-economic and

geographic aspects (Bloch and Solomos, 2010). The term 'race' is questioned with regard to its application to the community. Therefore, ethnicity is a preferred term to refer to various backgrounds of people (Gunaratnam, 2003; Fenton, 2010). Also, people will use it variably in different states or areas. For example, people in the USA will use the word 'race' to refer to biological/physical or genetic identification (Gunaratnam, 2003; Fenton, 2010): 'white' or 'black'. On the other hand, people in Malaysia will define 'race' primarily as regards 'political status' and 'culture'.

Fenton (2010) defines ethnicity or ethnic groups as a set of people within a nation state characterised by cultural diversity and symbol. Gunaratnam (2003) states that ethnicity refers to features of culture or religion, kinship and intermarriage. Moreover, Smith (2002) argues that ethnicity is more appropriate if it is defined as "self-elected" or "self-assigned" by someone who is concerned about their origin. Regarding nation, Fenton (2010) mentions that nation usually refers to a country's political shaping.

From the discussion above, the term ethnicity is more suitable to indicate cultural diversity in the community in the Indonesian context. Thus, this study uses the term of ethnicity to refer to diverse people's backgrounds in Indonesia nursing education. Ethnicity in this study is defined as "self-assigned" by individuals to view themselves as regards their "physical appearance" and origin. This study refers to ethnic groups in Indonesia (see section 1.9).

Indonesia consists of various groups, whose biological identification and cultural characteristics are different as explained in chapter one. A previous study by Ananta et al. (2013) explained that the national survey of ethnicity in Indonesia applied open-ended question in which individuals filled in their perceived ethnic group. The authors criticized that this survey only allowed

Indonesian people to choose one ethnic group representing themselves. However, the authors further explained that when the Indonesians were confused about their ethnicity due to their mixed ethnicities of their parents, they were asked questions which were based on their father's line if the society is patrilineal and based on the mother's line if the society is matrilineal. The study of Ananta et al. (2013) developed a new category of ethnicity in Indonesia consisting of 16 categories as described in chapter one.

Several studies argued that culture, race and ethnicity cause incivility issues (Altmiller, 2012; Alexander-Snow, 2003; Thomas, 2003). Culture of conformity to a dominant culture and racial and ethnicity discriminations were perceived as uncivil, which trigger anger (Thomas, 2003). For example, the minority academic staff demonstrates racial bias against white students and vice versa.

Clearly, ethnicity can correlate to students' disturbing behaviour, as described in the Western culture where most are Caucasians. Therefore, it is crucial to study uncivil behaviour in relation to ethnicity in the Indonesian context because of the many differences that exist between it and the Western context/societies.

A brief overview of the concept of religious faiths

Hodge and McGrew (2005, p.13) define religious faiths as "organized beliefs or doctrines, belief in/connection with God, and particularly, practice of spirituality/faith". Edwards, Lapp-Rincker, Magyar-Moe, Rehfeldt, Ryder, Brown and Lopez (2002) argue that religious faith is a belief in a higher power or God that provides meaning and a direction in life. Religious faith is usually demonstrated through rituals like prayers and involvement in religious services (Edwards et. al, 2002). In relation to the Indonesian

context, people in Indonesia believe in one supreme God (see section 1.9-Indonesia as the context) in spite of the various religions. Many activities of Indonesia people are associated with religious activities such as 'sholat' or prayer five times a day for Moslem and daily ritual 'canang sari' by Balinese Hindu people to thank God through praises and prayers.

It is further argued that religious faith plays an important role in the daily life of people, including mental and physical healths (Cummings et al., 2015). Dulin, Hill and Ellingson (2006) state that religious practices/faiths such as prayer and seeking help from the highest power will assist people to handle stress and will support healthy behaviour. In addition, religious practice or religious faiths have been identified as the main variable associated with the attitude towards euthanasia (e.g. Margalith, Musgrave and Goldschmidt, 2003; Broeckaert, et. al, 2009).

Margalith, Musgrave and Goldschmidt (2003) measured religious beliefs/faiths in their study by individual's religious affiliation and perceived degree of religiosity. Their study reported that the main determinant of nursing students' attitudes in Israel toward physician-assisted dying (PAD) was their religious beliefs. More than half of the nursing students in this study (47.3% to 57.3%) disagreed with PAD (Margalith et al., 2003). Broeckaert, et al. (2009) asserted that physicians' attitudes toward euthanasia are influenced by religion and worldview (p-value < 0.05) although those are not the only determining factors.

Religious faiths/practices are further related to substance abuse such as alcohol and drug use (Gnadt, 2006). In his study Gnadt (2006) reported that nursing students who were more religious had lower incidence rates of alcohol use as well as lower numbers exhibiting early risk behaviour. Bradby and Williams (2006) reported that there were some differences in attitudes

related to substance abuse in some religions. The authors reported that Muslims, Sikhs and Hindus consumed less alcohol and fewer cigarettes than Christians (Bradby and Williams, 2006).

A religion study in Indonesia, Gaduh (2012) examined the correlation between religion, trust and religious tolerance in the Indonesian diverse context. The author utilised four sets of secondary national data. The study revealed that religious faith was positively correlated with collaboration attitudes of community in-groups. It also means that Indonesian people trusted their neighbours more than strangers. The study also showed that religious faith was positively correlated with discriminative trust based on religion and ethnic. In other words, the Indonesian people lacked tolerance towards others who have different religion and ethnicity backgrounds than themselves. In this case, most of them were Islam.

Religious faiths might positively or negatively influence individuals' behaviour, especially in the context of Indonesia. For that reason, this study investigates religious faith concerning incivility in Indonesia nursing education. In addition, this study measures religious faith by a self-report of daily practices of faith using the Abbreviated Santa Clara Strength of Religious Faith Questionnaire/ASCSRF (Plante and Boccaccini, 1997; Plante, Vallaeys, Sherman et al., 2002).

An overview of the concept of socio-economic status

Hauser and Warren (1996) argue that socio-economic status (SES) can be indicated by educational background, employment, monthly income and material possessions. Caro and Cortes (2012) support that SES is measured by identifying parents' educational and occupational status, home possessions and financial status. Their study develops an SES measurement and conclude that it is valid and reliable (Caro and Cortes, 2012).

Many studies have been conducted using socio-economic variables that are associated with some behaviours, such as antisocial behaviour (Piotrowska, Stride, Croft and Rowe, 2015) and physical violence (Deveci, Acik and Ayar, 2007; Nilan, Demartoto and Broom, 2013). Additionally, SES is related to academic achievement (Sirin, 2005). In their study Piotrowska et al. (2015) reported the correlation between SES and antisocial behaviour among children and adolescent using meta-analysis study. The study revealed that low SES was significantly correlated to the high level of antisocial behaviour. The correlation between the SES and the antisocial behaviour was stronger when parents or teachers reported the behaviour than self-reporting.

Another SES study examined the association of the exposure to physical violence among school-aged children in Turkey (Deveci, Acik and Ayar, 2007). The SES included the income, education attainment and employment of the respondents' parents. The study showed that children with basic (low) education level parents had a higher risk of exposure to physical violence. Moreover, the risk of violence was also higher among children with unemployed fathers, but lower among those with unemployed mothers.

In the Indonesian context, Nilan, Demartoto and Broom (2013) investigated violence associated with SES among male participants. In this study, 86 men participated from five cities in Indonesia including Jakarta, Solo, Pekanbaru, Mataram and Makassar. The participants were from various ethnic backgrounds. This study reported that unemployment, poverty and financial distress drive violence occurrences (Nilan et al., 2013).

Another study on SES was related to academic achievement (Sirin, 2005). In this study, it was reported that there was a significant correlation between SES and academic achievement (general, maths, verbal and science achievements; $p < 0.001$) based on a meta-analysis. The study further

reported that older students, students from families with two-parents, and greater-achieving students were more likely to report their SES precisely than younger students, students from a single-parent family, and lesser-achieving students (Sirin, 2005). Moreover, the findings suggest that the use of more than two categories (e.g. Likert scale) were more likely to generate a stronger correlation than two categories such as low vs. high SES Sirin (2005).

Apparently, there is evidence of the correlation between the SES and young adults' behaviour. It is for this reason that the current study examines socio-economic background in relation to incivility in nursing education. In addition, the studies above applied the SES variable with some characteristics such as educational achievement, employment status, material deprivation/ amenity index and the income of the respondents' parents. Those characteristics could be applied in Indonesia including education background, income and occupation (Caro and Cortes, 2012). However, the categories would be different due to the dissimilar contexts. For example, income in the Indonesian context is described according to national income category.

2.7 A systematic literature review of incivility in nursing education

A significant number of studies that have investigated workplace incivility have been conducted worldwide in a variety of non-health as well as health care settings (Bartlett, Bartlett and Reio, 2008; Schilpzand, de Pater and Erez, 2014; Wright and Lilian, 2015). For example, Cortina and Magley (2001) examined the instances, victims, perpetrators and impact of incivility in public-sector of federal court employees in the USA; Torkelson, Holm, Backstrom and Schad (2016) identified antecedents of workplace incivility

in the school sector in a Swedish municipality; Bradley, Liddle, Shaw et al. (2015) explored aggressive communication between doctors across three teaching hospitals in England. Studies have also investigated incivility by comparing its incidence across two or more countries. Liu, Chi, Friedman and Tsai (2009) contrasted Taiwan and the United States cultures related to workplace incivility. Yeung (2007) compared six Asian countries regarding the experiences and impacts of incivility in the workplace. A comparative study on six continents was also conducted by Power, Brotheridge, Blenkinsopp et al. (2013) to explore the impact of culture on the acceptability of workplace bullying.

Due to the plethora of incivility studies in the workplace, some authors (e.g. Bartlett et al, 2008; Schilpzand et al., 2014) argue that a comprehensive review on workplace incivility is needed. A comprehensive review on workplace incivility will provide: a strong theoretical framework; strategies to address negative impacts of workplace incivility on organisations and the individual; and develop meaningful research on the incivility (Bartlett et al, 2008; Schilpzand et al., 2014)

Schilpzand et al. (2014) further argue that it is difficult to apply a meta-analysis of workplace incivility since previous studies: used a variety of methods; and differ in time frame and in the type of incivility. Schilpzand and colleagues reviewed 94 empirical papers on workplace incivility in varied settings (e.g. health care, university, and manufacturing) from 2001-2013 using a narrative review. The review revealed three types of incivility: experienced, witnessed and instigated incivility as the foundation of comprehensive models of incivility. In line with Schilpzand's study, Rittenmeyer, Huffman, Hopp et al. (2013) conducted a comprehensive systematic review on lateral/horizontal violence on nursing profession. This review focused on licensed nurses and student nurses in a variety of

settings. The authors (Rittenmeyer et al., 2013) reported that the studies were synthesised using a narrative summary since it was difficult to carry out a meta-analysis of the quantitative papers due to deficiency of data statistically. Hence, Schilpzand et al. (2014) argue that a narrative review will provide valuable-insight for the broad literature on incivility.

Despite some advantages using a narrative review as mentioned before, some authors mention a number of the disadvantages. Dixon-woods, Agarwal, Young et al. (2004) claim that the narrative review tends to lack structure and transparency in the process of synthesise.

Based on the preceding discussion it is apparent that a literature review that is systematic, transparent and accommodates broad literature is needed in order to examine workplace incivility, especially it is noted that there is a need of study regarding incivility in Indonesian nursing education (see sections 1.2.1- 1.2.2 and 2.5). Thus, a systematic search of the literature is needed in order to provide further directions for the study (Aveyard, 2014). Aveyard proposes a simplified approach that provides clear systematic steps and can accommodate varied methods. A detailed discussion of the literature review using the simplified approach is described in three sections: search methods used to identify studies, results of the literature search, and implications of the literature review.

2.7.1 Search methods of the systematic literature review

The purpose of this review is to illustrate how current literature has described incivility in nursing education. The research question for the current review was: "how do students and academic staff perceive incivility in nursing education?"

A number of keywords/terms were used in the search strategy for this study: *incivility, civil, uncivil, uncivil behaviour, civil behaviour, civility, violent, bully, bullying, lateral violence, horizontal violence, oppressive, nursing education*. Searches were conducted in the following databases: CINAHL (Cumulative Index to Nursing and Allied Health Literature), Web of Knowledge (ISI), PsycINFO (Ovid), Medline (Proquest) and ASSIA (Applied Social Sciences Index and Abstracts). The search was refined to include English–language articles and full texts. No date restrictions were applied on the publication date or on the type of study included.

Inclusion criteria

Type of participants: The type of participants included were academic staff members and students in nursing education settings including classroom, clinical laboratory and clinical practice.

Type of studies: Studies were included if they employed quantitative, qualitative and mixed methods. The quantitative design includes all types of quantitative design such as descriptive, survey and cross-sectional study. The qualitative design includes all types of qualitative design such as descriptive qualitative and phenomenology.

The Crowe Critical Appraisal Tool/CCAT (Crow, 2013; Crowe Critical Appraisal Tool/CCAT, 2013) approach was used to appraise the relevant papers (see appendix 2). Figure 2-3 provides a linear description of the search strategy.

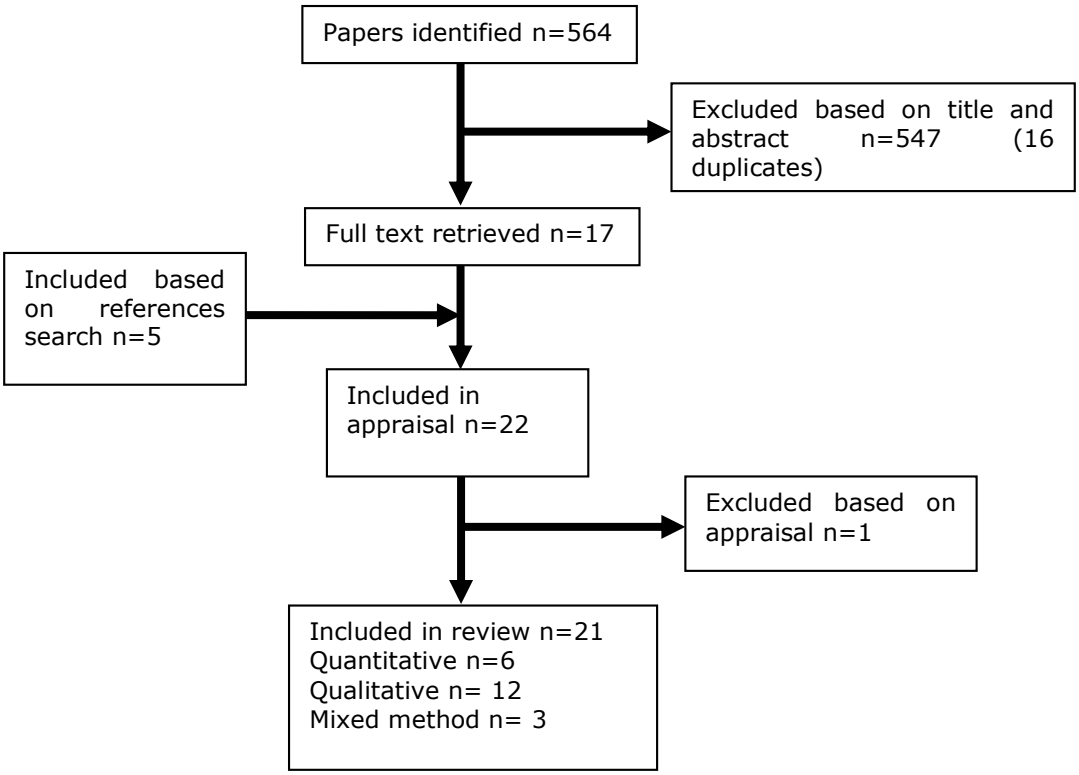


Figure 2-3: Description of the search strategy

A total of 21 studies met the inclusion criteria and formed the body of the review. All studies contained findings from qualitative, quantitative and mixed method investigations of incivility in nursing education, either from educators or students' perspective, or a mixture of both. A brief description of the studies can be seen in appendix 3.

2.7.2 Search results of the literature review

For the quantitative component of this review, six descriptive studies and quantitative results from three mixed-methods studies were summarised and synthesised related to the perceived incivility instances, the seriousness of the issues, and effects of incivility.

For the qualitative component, 12 studies and qualitative results from three mixed-methods studies were included in the review. Five main themes

emerged from the studies including: personal issues, environmental issues, communication and relationship issues, the need for effective implementation of rules and intervention qualitative study. There were one mixed-method and one qualitative studies addressing the effectiveness of interventions.

Based on the previous discussion, the review results will be discussed in two sections: quantitative findings and qualitative findings.

Quantitative findings

Clark (2008a) conducted a survey using a convenience sampling technique among attendees at a national conference in the USA (from 41 states) in order to identify the perceptions of academic staff members and students regarding incivility in nursing education. Clark used the INE/Incivility Nursing Education Survey to measure perceptions of uncivil behaviour. The author observed that the preliminary testing of the INE provided evidence of validity and internal reliability with Cronbach's alphas from 0.85 to 0.96. The author explained that the INE survey requires further testing for the survey to be generalized to a wider context.

Clark (2008a) received a number of valid questionnaires from 194 academic staff (response rate of 38%) and 306 nursing students (response rate of 60.7%). Most respondents were female and Caucasian. Most respondents (academic staff and students) reported that uncivil behaviour was a moderate to a serious problem in nursing education (Clark, 2008a). Both respondents reported some uncivil students' behaviour in the past 12 months, including being late to lectures/sessions, disruptive conversations, being unprepared for learning, leaving the class sessions early and skipping class sessions. Both respondents also reported several academic staff members' uncivil behaviours in the past 12 months, including ineffective

teaching methods, being late for class sessions, syllabus changes, being inflexible, rigid and autocratic as well as ignoring disruptive behaviour (Clark, 2008a).

In the same study (Clark, 2008a) also reported that there were different perceptions of uncivil behaviour among the academic staff and student nurses. Academic staff perceived students' uncivil behaviour in terms of bored and apathetic behaviour ($p < 0.001$) and being unprepared for class sessions ($p < 0.006$) more often than they were cited by students. Students considered their own problematic behaviour to be refusing to answer direct questions, misuse of technology, dominating the conversation ($p < 0.001$), lack of attention ($p < 0.003$) and departing from class sessions early ($p < 0.005$) (Clark, 2008a). Furthermore, academic staff and student nurses had different perceptions of uncivil behaviour. Faculty members reported that academic staff were frequently late and left early during scheduled activities ($p < 0.001$) (Clark, 2008a). Students reported that academic staff refused to allow make-up or remedial examinations, extensions and grade changes ($p < 0.009$) more often than faculty members did (Clark, 2008a).

In a later study Clark et al. (2010) again used the INE Survey to study students' uncivil behaviour from the perceptions of academic staff and students at one university in south-eastern China. In this study, the INE survey was translated into Mandarin Chinese. It was also tested for its validity and reliability using Cronbach's alpha and factor analysis. Questionnaires were distributed to 510 people (comprising 28 academic staff members and 482 students), while completed forms were received from 21 academic staff members (75% response rate) and 392 students (81.3% response rate). All the academic staff respondents were females, and almost all of them were Han Chinese (98.5%). This ethnic group makes up over 90% of China's population. They spoke Mandarin Chinese and their ages

ranged from 24 to 53. Their years of experience in teaching ranged from 1 to 25 years (Clark et al., 2010). The student participants' age ranged from 17 to 23 years old and they were in their first, second and third years of training (Clark et al., 2010). No other demographic data were reported.

Most of the academic staff members reported that uncivil behaviour in the nursing academic environment was not a problem at all (52.4%). On the other hand, the student nurses reported that it was a moderate problem (38.5%) (Clark et al., 2010).

This study (Clark et al., 2010) also reported that there were similarities and differences regarding students' uncivil behaviour between academic staff members and student nurses. The students were identified as being unprepared for learning in class (82.4%), sleeping in class (71.6%), misusing mobile phones during class sessions (69.8%), being bored and apathetic (69.6%), and lacking attention in class (67.7%) more frequently. On the other hand, academic staff members were identified as being unprepared for class (85.0%), sleeping in class while learning (76.2%), acting bored and apathetic (75.0%), disturbing conversations (66.7%), and being late for class (60.0%) as the most frequent cases of students' uncivil behaviour (Clark et al., 2010).

The most frequent uncivil students' behaviours perceived by both respondents were being unprepared for class sessions, sleeping in class while learning and displaying bored and apathetic attitudes. Both respondent groups also reported that there were threatening students' behaviour, such as challenging academic staff members' credibility and disrespecting them (Clark et al., 2010). Student respondents reported that students were challenging academic staff members' credibility (61.7%), disrespecting other students (31.4%), disrespecting academic staff members (22.0%),

being vulgar to other students (17.6%) and being vulgar to academic staff (7.2%) (Clark et al., 2010). Some academic staff members also reported that the academic staff challenge other academic staff members' credibility (38.1%) and disrespect them (14.3%) (Clark et al., 2010).

In a cross-sectional study, Marchiondo, Marchiondo and Lasiter (2010) investigated the effects of academic staff members' uncivil behaviour among senior nursing students using the Nursing Education Environment Survey. The instrument was piloted for its readability and ease of use (Marchiondo, et al., 2010). However, there was no reports regarding the validity and reliability of the instruments. There were 150 participants who were recruited from two public mid-western universities in the USA. Most of the respondents were females (89.5%), Caucasian (86.8%), and aged between 20-22 years.

Participants reported that most of them (88%) had experienced uncivil behaviour from one (40 %) or two (43%) staff members. The students further reported that they experienced uncivil behaviour from academic staff members frequently in the classroom (60%) and clinical settings (50%). The skills laboratory was the least frequent setting for the occurrence of uncivil bahaviour (10%). Additionally, the students expressed that they took both action and no action when experiencing the uncivil behaviour, including 'talking about it with a friend, partner, or spouse,' 'talking to classmates about it,' and simply 'putting up with it' (Marchiondo, et al., 2010, p. 612).

The authors (Marchiondo, et al., 2010) applied multiple regression analysis to determine whether nursing students' satisfaction varied regarding their experiences of academic staff's incivility. Three variables were controlled including age, GPA, and optimism to exclude the possible effects of these variables. The study (Marchiondo, et al., 2010) revealed that students'

dissatisfaction was significantly associated with the experience of academic staff members' uncivil behaviour with a beta of –0.47 ($p < 0.001$, $r2 = 0.22$). They also found that there was no correlation between the experience of faculty members' incivility and student age or self-reported GPA (no report of test analysis result) (Marchiondo, et al., 2010).

Kerber, Jenkins, Woith et al. (2012) conducted an intervention study involving senior nursing students who joined a course of Nurse Leadership Management at one university in the USA. The study aimed to examine the effects of a journal club intervention (Civility Journal Club/CJC) designed to promote civility among student nurses. The study recruited (n=79) senior nursing students consisting of four men and 75 women, with the average age of 23 years; 78 of them were Caucasians and one was (East) Asian (Kerber et al., 2012).

The Nurses' Intervention for Civility Education Questionnaire (NICE-Q) (Kerber et al, 2012) and the Ways of Coping Questionnaire (WCQ) (Folkman and Lazarus, 1998) were the instruments used to assess the outcomes. The NICE-Q was developed by the authors; however, no explanation regarding its validity and reliability was provided. The WCQ (Folkman and Lazarus, 1988) explored the link between stress and coping as well as stress and incivility (0.61 to 0.79 Cronbach's alpha). The CJC intervention was delivered biweekly, with each session lasting approximately 50 minutes.

The authors (Kerber, et al., 2012) reported that the CJC intervention influenced civility among the study participants. The evidence revealed that the student nurses were more aware of civil and uncivil behaviour after completing the intervention (Kerber, et al., 2012). The student nurses in the CJC were also improved regarding their helpfulness to other students (using dependent t-test: mean –1.31; SD 3.16; t –3.33; df 64; p-value 0.001). The

student nurses preferred to use planning in their problem-solving (mean –0.81; SD 2.91; t –2.29; df 67; p-value 0.02).

Even though this was an interventional study, it was not a randomised controlled trial. Thus, there might have been issues of performance bias. Therefore, the findings cannot decisively indicate the effectiveness of the intervention.

A descriptive study by Clarke et al. (2012) aimed to investigate the types, frequency and sources of bullying that was experienced by nursing students during clinical practice in nursing education. The investigators used a bullying questionnaire (Stevenson, 2006). This is a well validated instrument with Cronbach's alpha of 0.86 to 0.93. A total of 674 student nurses (58% response rate) participated in the study. The mean age was 24 years; most of them (83%) were female and Caucasian (Clarke et al., 2012).

This study (Clarke et al., 2012) reported that the majority of the student nurses (88.72%) have experienced at least one instance of bullying. The majority of both male (84.8%) and female (89.2%) students expressed that they had experienced at least one action of bullying. In addition, the experience was more prevalent among the 18-24 (89.5%) age group. There were no significant differences reported regarding bullying by students in terms of the year of study, gender and age group. The student nurses most frequently reported bullying behaviour such as: 'having their efforts undervalued of their efforts (60.24%), being subjected to negative remarks about becoming a nurse (45.25%), feeling that impossible expectations were set for them (43.03%), being victims of hostility (42.14%), being placed under undue pressure to produce work (41.84%), being frozen out, ignored, or excluded (41.54%); and being unjustly criticized (40.36%).' (Clarke et al., 2012, p.272)

There were significant differences regarding the level of bullying based on the bullying source (Chi-square (6) = 45.17, $p < 0.001$, N=598) (Clarke et al., 2012). The perpetrators were clinical instructors (30.22%), staff nurses (25.49%), patients (15%) and patients' families (14%). However, there was no significant relationship between being bullied or not, based on total bullying scores and intentions to leave the nursing program (Clarke et al., 2012). There was a significant association between being self-labelled as bullied or not and intentions to leave the nursing program (Chi-square (1) = 83.39, $p < 0.001$, N = 542) (Clarke et al., 2012).

Beckmann, Cannella and Wantland (2013) examined the prevalence of incivility in the form of bullying among academic staff in nursing programs in three eastern states in the USA. A web version of Negative Acts Questionnaire–Revised (NAQ-R) based on the original NAQ (Einarsen and Raknes, 1997; Mikkelsen and Einarsen, 2001) was used in this study (Beckmann et al., 2013). The NAQ-R was reported to be valid and reliable. A total of 510 academic staff members (26.47% response rate) completed the survey. From the 510 participants, 473 (24.55%) met the inclusion and were included in data analysis. Most of the participants were females (92.6%), Caucasian (88.4%), teaching between 13-21 hours per week (31.7%), and having meetings from 3-4 hours per week (32.8%). This study reported that there were no significant differences in bullying frequency based on race, gender, age, or institution size. Using point–biserial correlation, the study showed that there was a significant correlation between meeting frequency and reports of bullying ($r = 0.18$, $P \leq .001$).

Beckmann et al's (2013) study further reported a number of types of bullying, such as undermining others (n=252), verbal abuse (n=227) and physical abuse (n=15). The following types of bullying were reported mostly by junior academic staff members: undermining others 66% of the 252;

verbal abuse 65% of the 227; physical abuse 66.7% of 15. Additionally, there was a significant association between the rank of the academic staff members and the frequency of negative acts (Chi-square (9) = 123.85, $P \leq 0.001$) (Beckmann et al., 2013). This indicates that administrators and senior academic staff were more likely to be in the bullying group.

Hunt and Marini (2012) conducted a mixed-method study in a Clinical Teacher (CT) orientation program in the USA. The authors (Hunt and Marini, 2012) used Perceptions on Incivility Survey (PICS) to examine the experiences of the participants regarding incivility in clinical practice. They recruited 37 CTs (71% response rate); two were males and 35 were females. Their ages ranged from 25 to 69 years, with nursing experience ranging from 3 to 47 years. The participants reported that they worked in clinical areas such as acute care (51%), maternal/child (30%) and community/public/mental health (19%).

The respondents reported incidences of uncivil behaviour in clinical practice occurred on a weekly basis, with the following means according to practice area: 5.4 (SD 1-15) in acute care, 2.5 (SD 1-5) in maternal/child and 3.6 (SD 1-10) in community/public/mental health (Hunt and Marini, 2012). The qualitative findings of this study are further reported in section of qualitative findings.

Jenkins, Kerber and Woith (2013) conducted research employing a mixed-method (qualitative and quantitative) approach to explore students' dissatisfaction of their colleagues regarding civility, mutual friendship, and teamwork. They used the Ways of Coping Questionnaire (WCQ) (Folkman and Lazarus, 1988) to collect quantitative data. The WCQ is a valid and reliable tool (Cronbach's alpha 0.61 to 0.79) (Jenkins et al., 2013). The qualitative data were collected using the Social Capital Interview (SCI)

developed by the authors (Jenkins et al., 2013). The SCI contained 15 open-ended questions. The authors (Jenkins et al., 2013) also conducted an intervention by applying the CJC (Civility Journal Club) monthly to student leaders. The CJC held a one-hour discussion of a selected article. The student leaders were chosen students who being role models for encouraging civility when encountering other students and academic staff (Jenkins et al., 2013.

The respondents were student nurses at a state university in the mid-west of the USA (Jenkins et al., 2013). The investigators recruited 10 student leaders, aged 20-22 years; eight of whom were females and two were males. All the students identified themselves as Caucasians. The student leaders participated in the CJC intervention and were also researchers. Second, the authors recruited 25 students (junior and senior, with no demographic data reported) (Jenkins et al., 2013).

The same study (Jenkins et al., 2013) reported that students (n=25) applied coping strategies when facing incivility, such as seeking social support (0.1697), planned problem solving (0.1692), and self-controlling (0.1383). Using t-test for applying the WCQ pre- and post-test scores from the 10 student leaders, they found that a number of coping behaviours displayed significant differences, with significance for three items : self-controlling [$t(17) = -2.738$, $p = 0.014$], seeking social support [$t(17) = -2.447$, $p = 0.026$], and positive reappraisal [$t(14) = -5.477$, $p < 0.001$] (Jenkins et al., 2013). However coping behaviour of accepting responsibility was not significant [$t (17) = -5.477$, $p = 0.062$]. The sample size of the study was very small, which limits its generalisability.

Woith, Jenkins and Kerber (2012) used a mixed-method design to examine students' perceptions of academic integrity. They used the Social Capital Survey (SCS) to collect quantitative data and Social Capital Interview (SCI)

to collect qualitative data. Both instruments were developed by the authors (Woith et al., 2012). The authors commented on the content validity of the instruments and claimed they were valid but they failed to report the reliability of the SCS. The authors (Woith et al., 2012) recruited two groups of students at a public university in the USA. The first group comprised of 10 student leaders while the second group consisted of regular students (45 students, with no report of their demographic data). From these students, 15 agreed to participate in the interviews. The SCS findings showed that 27% of the participants were dissatisfied with regard to their colleagues' academic integrity. In addition, there was no difference in the response type between the two groups of students (no report of the statistic test result) (Woith et al., 2012).

From the quantitative findings reported above, several conclusions can be drawn:

1. All of the studies used a survey method (mail and web) to explore the views of academic staff members, or students, or both, with response rates ranging from 26.47% to 100%. Most of the respondents worked in nursing institutions or studied nursing in the USA, Canada or the PRC. The studies concerned one to four faculties of nursing. Most of the respondents were females, Caucasians and were exclusively Chinese-Asian when the studies were conducted in the PRC.

2. The studies found that uncivil behaviour was ubiquitously present, regardless of whether it was perceived to be a problem. It ranged from not being a problem to being a moderate problem according to Clark et al. (2010) and it was perceived to be a moderate to a serious problem according to Clark and Springer (2007). The studies also found that instances of uncivil behaviour occurred very frequently (88% in

Marchiondo et al., 2010; 88.72% in Clarke et al., 2012) during the participants educational experiences.

3. There were a number of statistically significant findings regarding reported uncivil behaviour. Students' experience of uncivil academic staff members' behaviour was significantly related to their dissatisfaction (Marchiondo et. al., 2010). Students' self-labelling concerning incivility as bullying was associated with their intention to leave the nursing program (Clarke et. al., 2012). Academic staff members' reported incivility as bullying was related to their meeting frequency among themselves and their academic rank (Beckmann, et al. 2013).

4. The uncivil behaviours were reported to be insignificantly related to demographic characteristics such as race, gender, age, year of study and institution size (Beckmann et al., 2013; Clarke et. al., 2012; Marchiondo et. al., 2010). However, there were no reports of statistical testing in regard to these findings.

5. Two studies (Jenkins, et al. 2013; Kerber et al., 2012) in one university claimed that CJC program was effective to promote civility in nursing education. However, these studies involved a small number of participants (25-45 students). Larger studies are needed to provide conclusive and definitive evidence regarding CJC influences on students' civil behaviours. Furthermore, these are not randomised controlled studies which can be indicated that the intervention could be not effective.

Qualitative findings

The qualitative findings of the literature review were retrieved from 12 qualitative studies (Anthony and Yastik, 2011; Clark, 2008b; Clark et al., 2010; Clark et al., 2013; Clark, Juan, Allerton et al., 2012; Clark and Springer, 2007b; Del Prato, 2012; Jackson, et al, 2011; Lasiter et al., 2012; Luparell, 2007; Randle, 2003; White, 2011) and three mixed-method studies (Hunt and Marini, 2012; Jenkin, et al., 2013;Woith et al., 2012) . Academic staff members and students provided their opinions regarding uncivil behaviour incidences in nursing education including classroom, skills laboratory and clinical practice. There were four similar themes that emerged from the reports of academic staff members and students, including personal issues, environmental issues, communication and relationship issues, and the need for effective implementation of rules. In addition, there were two intervention qualitative studies from the retrieved studies to promote civility in nursing education.

1) Personal issues

Human beings are unique social individuals. Each individual's unique character can lead to conflict when the individual interacts with others (Lawler and Thye, 1999). Academic staff members reported that being self-centred and intolerant produced uncivil behaviour (Clark, 2008b; Clark and Springer, 2007b; White, 2011). Students were found to: (i) blame others rather than undertake an introspective reflection of incidences of conflict (White, 2011), (ii) demonstrate intolerance by intimidating others through their attitude, remarks and nonverbal behaviour (Clark, 2008b). Academic staff members were also found to have poor personal qualities such as: incompetence, intimidation, and using teaching methods ineffectively (Clark, 2008a; Clark et al., 2012).

The academic staff members also revealed that students' perceptions of themselves as customers could be another reason for their disruptive behaviour (Clark, 2008b; Clark and Springer, 2007b). As paying customers, students felt entitled to act as demanding consumers by, for example, asking for a higher grades for their attendance in the classroom. While others felt that this provoked disruptive behaviours among some of their peers (Clark, 2008b). Furthermore, they reported burnout as a factor associated with (i.e. causing and arising from) incivility in nursing education settings (Clark, 2008b). The students felt overwhelmed regarding their tasks and roles and consequently suffered from exhaustion (Clark, 2008b).

Clark (2008b) also examined factors contributing to incivility in nursing education from members of academic staff (194/38%) who were attending a national meeting in the USA. The study (Clark, 2008b) revealed that 'stress and attitude of superiority' were the factors that contributed to instances of incivility by staff members (Clark, 2008b). The sources of stress included roles and task overloads as well as exposure to incivility. In other words, stress could be the source and the effect of incivility.

Luparell (2007) conducted a qualitative study and interviewed 21 academic staff from six states in the USA to explore how uncivil students' behaviour affects academic staff. This study revealed that academic staff experienced sleep disturbance, low self-esteem, low confidence, emotionally trauma and withdrawal from the school due to encountering uncivil student behaviour.

Similarly, student nurses reported that poor quality of teaching by academic staff promoted uncivil behaviour among students (Clark and Springer, 2007b; Clark et al., 2012). For instance, Clark and Springer (2007b) studied the contributors of incivility among 168 (35.9%) students at one public university in the USA using open-ended questions. Poor teaching style by

academics (n=23) was perceived by students as a key contributor to incivility.

Clark et al. (2012) also examined students' perceptions of the causes of incivility using INE open-ended questions from 367 nursing students (96.2%) in PRC. The students expressed that academics were simply reciting from the textbooks hence they complained that the teaching was boring, humourless and lacked engagement (Clark et al., 2012).

2) Environmental issues

The situational conditions of people can also encourage incidences of incivility (Clark, 2008b; Clark and Springer, 2010). The academic staff members stated that students nowadays are not like the typical students in the past, who were dedicated *students*; rather, they also have roles as parents who should manage their families as well as workers paying (or contributing toward) their own school fees and lifestyle overheads (Clark, 2008b; Clark and Springer, 2010). These conditions make them overwhelmed with their tasks and roles (Clark, 2008b; Clark and Springer, 2010). Thus, high-stress environments (n=9) and a lack of professional-respectful atmosphere (n=10) were reported (Clark and Springer, 2007b) as well as financial pressure (29.7%) and exclusionary behaviour (34%) as contributors of incivility (Clark and Springer, 2010).

Clark and Springer (2010) assessed 126 (73.2%) nurse leaders attending a conference in the USA with regard to their opinions of incivility in nursing education. The nurse leaders stated that academic staff demonstrated exclusionary type behaviour including eliminating others, refusing to listen, refusing to communicate with others openly and gossiping (Clark and Springer, 2010).

Moreover, the costs of incivility includes time loss, financial waste, and the inhibition of the educational process. Incidence reporting of incivility consumes lots of time from documentation until resolution of the problem. It also costs money if the incident becomes very serious (e.g. threatening conditions) when costs for security and attorneys are involved. The cost of educational process includes the decrease of enthusiasm and confidence for performing teaching-learning (Luparell, 2007).

Paradoxically, the students revealed that there were high expectations from nursing schools (Clark, 2008b) and a lack of professional-respectful atmosphere (Clark and Springer, 2007b; Del Prato, 2012). The students felt that the nursing curriculum school was highly demanding and pressured students to complete tasks by any means in order to achieve good grades (Clark, 2008b). Furthermore, it was found that academics sometimes did not perform the traditional role of educators as role models for students (Clark, 2008b; Clark and Springer, 2007b; Del Prato, 2012). This is largely related to the increasing commercialisation of education – just as students see themselves as paying customers and not as deferential seekers of knowledge, staff members see themselves as paid workers and not as vocational figures of intrinsic respect. Thus, the students become disillusioned with the ethics and professionalism of nursing (Clark, 2008b).

The effect of incivility was also related by students to practical issues such as patient safety (Woith, et al., 2012). Moreover, the students expressed the need for academic staff to inform students regarding the reality of incidents of incivility to better prepare students to face it (Anthony and Yastik, 2011).

3) Communication and relationship issues

These were the most common issues that emerged from both academics and student nurses in previous studies (e.g. Clark, 2008b; Clark and Springer, 2007b; Clark and Springer, 2010; Clark et al., 2012; Hunt and Marini, 2012; White, 2011), although they were labelled in different ways. The most common phrases used were verbal communication issues such as 'harsh comments' and 'disturbing conversation'; nonverbal communication issues such as rude behaviour and disrespect others, as well as relationship issues such as superiority and 'feeling of belittled' (Clark, 2008b; Clark and Springer, 2007b; Clark and Springer, 2010; Clark et al., 2012; Hunt and Marini, 2012; White, 2011). It seems that these common phrases emerged from both Western and Eastern perspectives. For example, disregard for others occurred in the USA (Clark, 2008b) and the PRC (Clark et al., 2012), although perceptions of what constitutes such disrespect may differ between cultures.

Most academics also suggested several ways to address incivility related to these issues, including an open discussion and respect for others (Clark, 2008b; Clark and Springer, 2010). The open discussion could be broached at the beginning of the semester by establishing ground rules in the classroom (Clark, 2008b; Clark and Springer, 2010). When academic staff respect students, the students will in turn respect the academic staff members (Clark, 2008b; Clark and Springer, 2010). As part of the open discussion other forms of uncivil behaviour that concern academics could be raised such as the misuse of communication devices, including use of mobile phones and computers for non-learning purposes while in the classroom or laboratory setting, as well as sending inappropriate emails to academic staff members (Clark and Springer, 2007b; White, 2011).

Most of the students reported that poor communication (verbal abuse, harsh comments, gossiping), hostility, exclusionary, feeling of being belittled, acts of superiority and disrespecting others occured in nursing education (Anthony and Yastik, 2011; Clark, 2008b; Clark and Springer, 2007; Clark et al., 2012; Del Prato, 2012; Jackson, Hutchinson, Everett et al., 2011; Lasiter, Marchiondo and Marchiondo, 2012; Randle, 2003). The cycle (or 'dance') of incivility (Clark, 2008b) occurs due to the action and response of the two parties, such as the feeling of superiority among staff members producing the corresponding feeling of belittlement among students. On the other hand, the use of harsh comments by academics could create disrespect among students toward the academic staff (Clark, 2008b). These latent conditions will remain endemic in nursing education if the root causes are not addressed, promoting other negative feelings such as anger and frustration, thereby having long-term, wide-ranging impacts on nursing (and healthcare) generally (Clark, 2008b).

A study which explored students' negative experiences in clinical settings involving 105 students in Australia revealed feelings of intimidation and discrimination related to racial comments. For instance, an Asian student who was studying at one university in Australia reported in regard to her experience in clinical practice (Jackson et al., 2011, p.106):

> 'National abuse between Asian and Aussie because she always says the ''Asian'' do it that way. Also, how many ''international'' students fail the nursing board every year? However, I am the only one ''international and Asian'' in this placement'.

Two studies (Lasiter, et al., 2012; Randle, 2003) further found a number of themes that are exclusively related to the communication and relationship issues. Students stated that uncivil academic staff behaviour occurred in

terms of being talked about in front of other students leading to a feeling of being belittled. (Lasiter et al., 2012; p.123-124). In Randle's (2003) study, students commented that bullying in clinical practice occurred when 'nurses overpower either students or patients' (p.397-398). For example, nurses used their position to bully students as their juniors.

Students in the study also supported an open discussion between people involved to address incivility in nursing education (Clark, 2008b). Such a discussion could foster a feeling equity and team working to solve problems (Clark, 2008b).

4) *The need for effective rules and implementation*

The need for the implementation of effective rules was highlighted by both academics and students in previous studies (Clark, 2008b). Clark (2008b, p.E47) identified that academics were in favour of 'Deans*, directors, faculty, and students agreeing a code of conduct for their respective institutions and then enforcing it fairly and with expedience'* to address incivility in nursing education. In the same study, students made some suggestions as to the nature of the rules that should be implemented which were:

> (1) There should be a policy for students and faculty. The university needs to have a policy in place to address incivility and it needs to be enforced. Respect is very important, especially in nursing. There is too many inappropriate activities that should not be tolerated. Incivility destroys students' self-esteem and hinders our learning;
>
> (2) Set classroom norms the first day and discuss expected behaviours and consequences. Students and faculty need to work together on this.' (Taken from Clark, 2008b, p.E48)

5) Intervention qualitative study

Three interventional studies included a qualitative component (Clark, Ahten and Macy, 2013; Kerber et al., 2012; Jenkins, et al., 2013). A CJC program was conducted in one university to promote students' civility in nursing education. The study recruited 79 senior nursing students (Kerber et al., 2012). In another study, 195 student nurses were recruited including ten student leaders (Jenkins, et al., 2013). Both programs encouraged students to discuss articles regarding incivility during specified times (Kerber et al., 2012; Jenkins, et al., 2013). Both programs were successful in promoting civility (Kerber et al., 2012; Jenkins, et al., 2013). The students involved were more aware helpful, interested in role modelling, and even condemning and challenging the acts of incivility (Kerber et al., 2012; Jenkins, et al., 2013).

Similarly in another study, Clark, Ahten and Macy (2013) applied PBL (Problem Based Learning) intervention to promote students' civility in nursing education. There were 65 senior nursing students in the USA (mentioned not in detail that might be due to confidentiality) involved in the intervention, which provided some scenarios which included incidences of uncivil behaviour in clinical practice. The intervention encouraged students to be more civil. The students' participants expressed that they had learned to recognize and handle the incivility incidence from the scenario (62.8%) (Clark et al., 2013).

Based on the above findings from qualitative studies, the following conclusions can be drawn:

1. There were similarities and differences of academic staff members' and student nurses' opinions of uncivil behaviour in nursing education settings. For instance, only the academic staff members expressed the

concern regarding the misuse of communication devices such as mobile phones and computers (e.g. Clark and Springer, 2007b; White, 2011).

2. The impact of uncivil behaviour can be serious and include physical and psychosocial issues i.e. sleep disorder and distress (Luparell, 2007).
3. There is a dearth of studies that have investigated the effectiveness of the implementation of rules designed to tackle uncivil behaviour in nursing education as well as discrimination related to individuals' backgrounds (e.g. race or ethnicity) (Clark (2008b; Jackson et al., 2011).
4. Three studies applied intervention studies aiming to promote civility in nursing education. The studies applied CJC (Jenkins et al., 2013; Kerber et al., 2012) and PBL (Clark et al., 2013) and the authors concluded that the interventions were effective in promoting students' civility. However, each study was conducted with a small number of respondents (25-65 students) and recruited students in one university. Thus, further research in different settings with a larger sample size is needed.

2.7.3 Implications of the literature review

It appears that previous studies show inconsistent findings on demographic factors and their relationship to incivility in nursing education. Therefore, more research is needed to examine incivility with reference to demographic features. Demographic characteristics such as ethnicity, religious faith and socio-economic status (SES) need to be investigated, because these attributes could affect behaviour in social relationships, including nursing education. Furthermore, they are particularly pertinent in the Indonesian context where ethnic and religious tensions and conflicts overflow into the classroom.

Previous studies of incivility exclusively focussed on examining incivility either in the classroom setting or in clinical practice (Clark, 2008a; Hunt and Marini, 2012); more work is needed to investigate incivility comprehensively in all settings of nursing education, such as the classroom, skills laboratory and clinical practice.

Although many studies used valid and reliable instruments for research, several studies did not report reliability and validity of the instruments used (Gallo, 2012). The INE survey has reported statistics regarding its validity and reliability and has been applied in many countries with many languages (Clark, 2013). Gallo (2012) further mentioned that replication studies using the INE survey may provide rich information on incivility in nursing education regarding its prevalence and evidence based practice for managing the uncivil behaviours. Therefore, a valid and reliable instrument for incivility is used in this study (see section 2.5.4): a revised version of the Incivility in Nursing Education (INE) survey (Beck, 2009; Clark, 2010), which provides questions regarding the uncivil behaviour of students, academic staff members and nurses in nursing education settings, including the classroom, skills laboratory and clinical practice. This instrument is designed to collect both quantitative and qualitative data from the perspectives of academic staff and student nurses.

Findings pertaining to addressing incivility in nursing education further show that most of the strategies are partial-institutional interventions, such as incivility prevention by conducting CJC (Jenkins et al., 2013; Kerber et al., 2012) and PBL (Clark et al., 2013) programs. Therefore, a comprehensive approach to managing incivility in nurse education is warranted. An intervention that addresses the whole organisation rather than individual components of it (here in after called a 'systemic approach') is the best way to address uncivil behaviour incidences, as supported by a strong body of

literature driven by comprehensive systematic reviews (Hodgins, MacCurtain and Mannix-McNamara, 2014; Rogers-Clark, Pearce and Cameron, 2009).

Based on the discussion above, the current study will explore the institutional scope in two different nursing education institutions in Indonesia as case studies. This study contributes to the understanding of the phenomena of incivility in nursing education (a link between classroom, skills laboratory and clinical practice), specifically in the Indonesian context.

The methodology of this study is described in detail in the following chapter, including the rationale for selecting the case study method.

CHAPTER 3: METHODOLOGY

This chapter describes the methodological approach and methods of data collection employed in this study. This study was a case-study design to investigate incivility in nursing education among student nurses, staff members/clinical educator or instructor and nurses in classroom setting, clinical setting and clinical skills laboratory setting. This chapter has eight sections. Section one contains a discussion on research design and explains the paradigm used in this study, the rationale for a case study in pragmatism and multiple-case study design as the research approach. Section two and three describes methods of data collection. The eligibility criteria for entry into the study, the process of identification of study participants included in the survey, interviews and observations. Section four contains the process of obtaining and gaining informed consent from participants. Section five contains the process of recruitment. Section six gives an account of procedures used for data collection. Section seven discusses methods of data analysis by explaining the preparation and analysis of the data. Lastly, section eight clarifies the quality of case study research design.

3.1 Research Design

The research design is the most challenging process in a study; thus, it is crucial to justify the design explicitly (Creswell, 2014). The research design is also the core planning for obtaining answers to the research questions (Polit and Beck, 2012; Shadish, Cook and Campbell, 2002). The current study was conducted in order to answer the following research questions:

1. How do nursing students and academic staff perceive behaviour as uncivil in the context of their ethnicity, religious faith and socio-economic background in the nursing institution?

2. What future directions could be instigated for the promotion of civil behaviour in nursing education that is culturally congruent with Indonesia?

To answer these research questions, the determination of the paradigm of the study is justified to understand in depth the phenomenon that is being investigated. A paradigm or worldview is a researcher's perspective towards the nature of the phenomenon under consideration and the way in which it can be studied (Creswell, 2014). Therefore, it is important to justify which paradigm is used in any studies. There are two main paradigms that are widely used in academic research: positivist and constructivist (Creswell, 2014; Johnson and Onwuegbuzie, 2004; Polit and Beck, 2012).

The research design of this study is discussed in three sections: the paradigm of the study, the rationale for case study design in pragmatism and multiple-case study design as the research approach.

3.1.1 The paradigm of the study

The paradigm of this study is discussed in three sections: the positivist paradigm and its advantages and limitations; the constructivist paradigm and its advantages and limitations; and the pragmatist paradigm and how it offers a more in-depth approach.

Advantages and limitations of the positivist paradigm

The positivist paradigm is based on explanation and truth, verifying a priori hypothesis using evidence collected from observation, quantitative measurements and statistical analysis (Benton and Craib, 2011; Blaikie, 2010; Easterby-Smith, Thorpe, Jackson and Easterby-Smith, 2008). Thus, selecting a positivist paradigm as a stance for investigating the research questions of this study could identify relationships between perceived uncivil behaviour and respondents' backgrounds. However, it could not provide an in-depth understanding of the nature of complex, subjective experiences of uncivil behaviour experiences in nursing education involving interactions between researchers and participants; such issues are best explored using the constructivist paradigm (Creswell, 2014; Polit and Beck, 2012).

Advantages and limitations of the constructivist paradigm

The constructivist paradigm believes that the understanding of reality is developed from subjective meaning, the context of the study and human interactions (Creswell, 2014; Easterby-Smith, Thorpe and Jackson, 2008). This paradigm further provides understanding and description of individuals' experiences of the phenomena, rich detail or in-depth data in naturalistic settings in which the contextual and setting factors relate to the phenomenon of the study (Johnson and Onwuegbuzie, 2004). However, applying a constructivist paradigm could be difficult to test the correlation between concepts using statistical analysis (Creswell, 2014; Johnson and Onwuegbuzie, 2004) which indeed is crucial for answering the questions of this study.

Therefore, to answer the research questions of this study, a combination of both the positivist and constructivist paradigms is needed. This refers to pragmatist paradigm.

The pragmatist paradigm – a deeper approach

A new paradigm in which researchers can combine paradigms in mixed-method studies to answer research questions in a more practical way is called the pragmatist paradigm (Creswell and Clark, 2011; Johnson and Onwuegbuzie, 2004, Johnson, Onwuegbuzie and Turner, 2007). The research questions of this current study are developed by the pragmatic perspective including data collection and analysis. The pragmatic perspective further fitted within the current study's aim to explore uncivil behaviour in Indonesia as perceived by students and academic staff in nursing education based on their ethnicity, religious faith and socio-economic background.

Inquiry of quantitative and qualitative is used to understand academic staff and students' perspective of incivility in nursing education based on their backgrounds. This study is based on the pragmatist assumption that collecting diverse types of data provides the best answer to the research question above (Onwuegbuzie and Leech, 2006). Onwuegbuzie, Johnson and Collins (2009) further mentioned that the pragmatist philosophy supports the use of different combinations of quantitative and qualitative methods to answer research questions.

Creswell and Clark (2011) argue that pragmatism employs many ideas, principally what is deemed the most practical way of achieving the desired goal, utilising various approaches and valuing knowledge of subjective and objective standpoints. Onwuegbuzie et al. (2009) also argue that from a pragmatist's point of view, knowledge is both constructed and based on reality. The knowledge could provide evidence regarding relationships between perceived uncivil behaviour and respondents' background in the

study as well as based on the people's experiences of incivility in nursing education.

The current study uses the pragmatist paradigm to apply a case study using mixed-methods with two considerations: in this worldview, knowledge is both being constructed and based on the experience of the reality of the world (Johnson and Onwuegbuzie, 2004; Onwuegbuzie et al., 2009). The pragmatist paradigm focuses on understanding phenomena using various approaches that could emerge from a variety of data collection and analysis techniques (Creswell and Clark, 2011). Based on these arguments, this paradigm allowed the researcher to gain insight into uncivil behaviour incidences in nursing education by identifying and exploring the respondents' experiences through many different worldviews, methods, analysis, and data collection techniques such as questionnaires, interviews and observations.

3.1.2 The rationale for case study design in pragmatism

Case study design may also be based on either positivism or constructivism (Baxter and Jack, 2008; Scholz and Tietje, 2002; Yin, 2014). Stake (2006) states that case study should approach the research subject from many angles to obtain data which could be examined holistically and analytically; this focus could be achieved by mixed methods. Yin (2014) and Stake (2006) suggest some designs for applying case study using different approaches to collect and analyse data. Stake (2006) proposes a flexible approach while Yin (2009, 2012, 2014) proposes methodological approaches such as replication and logical model (Swan, 2011).

Despite case study design embracing mixed methods, it is evident that Yin tends to favour positivist design while Stake supports the constructivism

approach (Swan, 2011). Yin further recommends using a survey in case study design explicitly, which can be applied either outside or inside the case study design (Yin, 2014). Ihuah and Eaton (2013) also argue that the pragmatic approach allow case study design strategy, which requires many sources of evidence in a research study. Thus, different analytical methods are acceptable such as the thematic analysis and non-parametric statistic for qualitative and quantitative data analyses (Ihuah and Eaton, 2013).

Yin (2009, 2014) further offers some criteria for applying case study design including answering the research questions using 'how' and 'why', examining the phenomena that cannot be separated from its context as well as investigating behaviour that cannot be manipulated by the researcher. In line with this, the case study research methodology was selected as the preferred and most appropriate design for this study due to the aim and research questions of the study.

Specifically, the research design of this study were constructed to answer the 'how' and 'what' questions. Moreover, it is crucial to understand the nature of incivility in nursing education settings. Andersson and Pearson (1999) argue that incivility instance is understood based on contextual factors. In addition, the phenomena related to uncivil behaviour instances also cannot be manipulated or controlled (Andersson and Pearson, 1999). Thus, to understand issues surrounding this topic, it is suggested to study incivility in the natural context. Based on this, a case study approach was considered as the most appropriate method to investigate incivility in nursing education to gain insights on this particular topic and to explore how incivility in nursing education was perceived by academic staff and student nurses within its natural settings such as classroom, skills laboratory and clinical practice.

Following the selection of case study as the research design of this study, it is necessary to choose the type of the design. Yin (2009, 2012, 2014) suggests two types of case study designs: a single case study and multiple-case study. Single case study design is applied to investigate one single case when the case is 'critical or unique or typical or revelatory or longitudinal case' (Yin, 2009, p.47-49). The single case study design consists of holistic and embedded design (Yin, 2009, 2012, 2014). The holistic-single case study may be conducted when examining global nature, whereas the embedded-single case study is applied to examine one case that involves more than one sub-case or sub-unit of analysis (Yin, 2009, 2012, 2014). The multiple-case study design is used to examine two or more cases. It also consists of holistic and embedded design (Yin, 2009 2012, 2014). The multiple-case study-holistic design may be conducted when examining global nature of two or more cases while the embedded design is applied to examine two or more cases with the involvement of sub-cases in each case (Yin, 2009, 2012, 2014).

In contrast, Stake (2006) recommends three types: intrinsic, instrumental and collective research designs. The intrinsic type could be applied when studying an interesting case to understand it better while an instrumental type could be implemented to explore an issue deeply by examining a case or cases (Stake, 2006; Baxter and Jack, 2008). Collective or multiple cases could be applied to study the differences between cases (Stake, 2006; Baxter and Jack, 2008). The collective type is often used interchangeably with the multiple-case study proposed by Yin (Baxter and Jack, 2008).

The multiple-case study (embedded) design is chosen as the design of the current study based on the work of Yin (2009, 2012, 2014). The rationale for using the multiple case study design is the desire to explore uncivil behaviour performance in different environments, which in this study is at

two nursing educational institutions (private and public) that have different characteristics, to strengthen the case study findings. Similar to Yin's study (2009, 2012, 2014), the current study also uses an embedded design which combines quantitative and qualitative data derived from two different groups of participants: academic staff and student nurses (Scholz and Tietje, 2002; Yin, 2014). Thus, based on the strengths of the case study design by Yin and the need for conducting mixed methods in terms of administration of questionnaires, face-to-face interviews and direct observations in this current study, it was decided to apply multiple case study design proposed by Yin (2009, 2012, 2014).

In summary, the current study is a multiple-case study (embedded) design that draws on the pragmatist paradigm to explore uncivil behaviour as perceived by students and faculty staff in nursing education in Indonesia. This study aims to explore the phenomena (uncivil behaviour instances) within its context (nursing education settings). It is assumed that the context is significant to the phenomenon that there might be different realities of uncivil behaviour instances within different settings in nursing education. The multiple case studies are suitable to provide support to examine the uncivil behaviour instances perceived by academic staff and students; integrate the quantitative and qualitative data; and access the natural environment of different nursing education settings such as classrooms, skills laboratory and clinical practice. The knowledge from this study is constructed by identifying, exploring, understanding and analysing uncivil behaviour instances in nursing education settings at two faculties of nursing (FoNs) in Western Indonesia.

3.1.3 Multiple-case study design as the research approach

A multiple-case study (embedded) design is used in this study. This study design is explained by defining 'the case' and the selection of the 'unit of analysis'. This section explains the context of the study, since the case cannot be separated from its context - a main principle of the case study research design. The case study propositions of this study are further identified to limit the scope and enhance the feasibility of the study (Baxter and Jack, 2008).

Defining the case

Yin (2009) states that it is vital to define the 'case' or 'unit of analysis' in a case study design, which guides and determines the scope of the study (p.29). The case could be a person, a process, a system, an organisation or an event (Stake, 2006; Yin, 2009, 2012, 2014).

In this study, the phenomenon under examination is uncivil behaviour in nursing education settings. This is a complex phenomenon in which the boundaries between the phenomenon and the context were ambiguous; thus, in this study, the actual uncivil behaviour instance is viewed as the case. 'The case' of the actual incivility is explored at two FoNs (one private and one public). The two FoNs is viewed as the 'unit of analysis' (Yin, 2009, 2012, 2014).

The decision to choose the two FoNs is based on considerations from experts in case study design (Stake, 2006; Yin, 2009, 2012, 2014). Stake (2006) states that multiple case study requires some 'cases' or 'units of analysis', in general between four to fifteen, whereby the cases can provide adequate data. However, Yin (2009, 2012, 2014) believes that using two or three units

of analysis is suitable for a multiple-case study in which the principle of replication can be applied.

Therefore, given the suggestions by Yin (2009, 2012, 2014) and Stake (2006) as well as the constrained time and funding resources of this study, two units of analysis were selected to address the research questions. The multiple case study (embedded) design is described in Figure 3.1 below.

<table>
<tr><td colspan="2">The Context
National level: Western Indonesia
University level: private vs. public context

Case: Uncivil Behaviour Instances in Nursing Education</td></tr>
<tr><td>Unit of Analysis 1
Faculty of Nursing (private university):
Classroom
Skills laboratory
Clinical settings

Using questionnaires, semi-structured interviews and observation</td><td>Unit of Analysis 2
Faculty of Nursing (public university):
Classroom
Skills laboratory
Clinical settings

Using questionnaires, semi-structured interviews and observation</td></tr>
<tr><td>⬇</td><td>⬇</td></tr>
<tr><td colspan="2">Research Questions
1. How do nursing students and academic staff perceive behaviour as uncivil in the context of their ethnicity, religious faith and socio-economic background in the institutions?
2. What future directions could be instigated for the promotion of civil behaviour in nursing education that is culturally congruent with Indonesian context?</td></tr>
</table>

Figure 3-1: Multiple case study design of the research

The selection of units of analysis in this study is driven by two considerations that relate to the researcher experience and the study literature available. First of all, the researcher selected the private FoN because the researcher have worked at this institution since 2007 and the researcher undertook a preliminary study related to uncivil behaviour in nursing education. Findings from the preliminary study provided evidence of the need for a further in-

depth study to support the civil behaviour culture. Secondly, the researcher chose the public FoN in order to compare the differences and similarities between the two FoNs. This decision is supported by Yin (2009, 2014), who suggests choosing cases that provide contrasting characteristics in order to strengthen findings. Initially the researcher decided that the two FoNs chosen should be from the same island and also be accredited by the Ministry of Higher Education in Indonesia. The differences between the two FoNs included private vs. public, West Java vs. East Java, Christianity-based vs. non-specific religious based. However, the public FoN that the researcher chose declined to grant approval for data collection and therefore the researcher chose another accredited, public FoN that is located on a different island. Differences between the 'units of analyses' remained which include private vs. public, Java vs. Sumatera and Christianity based vs. non-specific religious based.

The challenge concerning the decision to change the 'unit of analyses' of this study provided some advantages. For example, as mentioned before, the new chosen unit analysis (the public FoN) is located on a different island from the private FoN, which means that both units of analysis represent the two major islands of the Indonesian Archipelago (Sumatera and Java). These two major islands also represent the greatest population of Indonesian citizens (Ananta et al., 2013).

The context of the study

As mentioned in chapter one section 1.9, the most crucial features of Indonesia are the multicultural composition of its population, the six official religions of which Indonesians should choose one as their faith, and the disparities of socio-economic status of Indonesian people. Thus, this study

examined incivility in nursing education by considering these features which influence most of the daily activities of people in Indonesia.

The case study propositions

Yin (2009, 2014) suggests that propositions are important elements in the case study design that guide the data collection and discussion (Baxter and Jack, 2008). Baxter and Jack (2008) explain that propositions can be linked with hypotheses in the quantitative study which can be used to predict the possible outcomes of the study. However the authors (Baxter and Jack, 2008, p.552) warn that overwhelmed situation might occur when 'too many propositions that must be returned to when analysing the data and reporting the findings'.

Baxter and Jack (2008) also argue that propositions may emerge from the literature, the experiences of the personal or professional, theories and empirical data. Thus, based on the previous literature study, research findings, social learning theories and the researcher's personal experiences which are described in chapter one and two, the propositions of this study are:

1. Students and academic staff are perceived differently regarding incivility in Indonesian nursing education.
2. Students and academic staff's perceptions of incivility in Indonesian nursing education are influenced by their ethnicity, religious faith and socio-economic background.

3.2 Methods of data collection

The case study-embedded design allows the researcher to explore incivility in different environments at two FoN (private and public) that have different

characteristics, to combine quantitative and qualitative data as well as to collect data from two different perspectives: academic staff and student nurses. Therefore, due to some advantages of the study design, this study collected both quantitative and qualitative data by utilised three data collection strategies: survey, semi-structured individual interviews and direct observations.

3.2.1 Survey

The survey was used to identify perceptions of incivility in nursing education from the opinions of nursing students and academic staff in the context of their ethnicity, religious faith and socio-economic background. Thus, the researcher adapted a number of questionnaires from previous studies (e.g. Beck, 2009; Clark, 2010) and made sure that the questionnaires fitted to the context of this study. The adaptation for the questionnaires is primarily for language translation and restructuring the questions. The survey administration consists of pilot study of questionnaires and main study of the surveys.

Pilot study of the questionnaires

A compiled instrument for the survey was adapted from valid and reliable questionnaires (see appendix six). The questionnaires consisted of: 1) a modified INE questionnaire (Beck, 2009; Clark, 2010) that describes perceived uncivil behaviour in nursing education settings (including in classrooms, skills laboratories and clinical practice); 2) the Multi-group Ethnic Identity Measure/MEIM (Phinney, 1999) that identifies ethnic identity; and 3) the Abbreviated Santa Clara Strength of Religious Faith Questionnaire/ASCSRF (Plante and Boccaccini, 1997; Plante, Vallaeys, Sherman et al., 2002), which portrays religious faith or practice. The

compiled instrument was translated by a translator at the private university into Indonesian and then it was back-translated by an independent professional translator. The researcher and the translator compared the two versions to ensure that each item retained its original meaning. Some Indonesian questions were refined to further improve similarity of meaning with the English version.

After refining the questionnaires, the instruments were piloted in order to test for readability, validity and reliability by administering it to 20 students at the private FoN. The content validity was convincing, since the INE survey has been evaluated by experts (Clark et al., 2009) and was assured by careful translation (Scanlan, 2003). The coefficient of Cronbach value was between 0.830 and 0.993, indicating that the questionnaire has a high degree of internal consistency (Field, 2013). Based on the pilot study, some of the questions in the questionnaire were reworded again to facilitate easy comprehension for Indonesians.

Main study of the surveys

The actual survey was conducted after the pilot study. Data were collected over a seven month period from September 2012 to March 2013. At the private FoN, the respondents were 102 people (96 students and 6 academic staff). At the public FoN, the respondents were 204 people (185 students, 19 academic staff). Moreover, based on the actual surveys, reliability was examined with coefficient alpha for students and academic staff separately and combined. Cronbach's alpha value was between 0.668-0.994 (students n=281), 0.894-0.997 (academic staff n=25), 0.670-0.995 (both n=306). Most of the results of the reliability were above 0.8 which indicating good inter-item reliability (Clark et al., 2010; Field, 2012). Cronbach's alpha for frequency of disturbing faculty behaviours was different between students

and academic staff (students 0.668; academic staff 0.909; both 0.670). This condition might happen because of generational differences regarding perceptions of academic staff behaviours (Clark et al., 2010).

3.2.2 Interviews

Interviews were conducted to gain an in-depth understanding and response related to incivility in nursing education based on respondents' ethnicity, religion and SES (see appendix eight). The purpose of interviews is to explore issues from participants' perspectives, which can include investigating detailed events, thought, intention and feelings (Patton, 2002). Therefore, interviews were seen as appropriate method for the purpose of the case study in order to expand and search in details regarding the phenomena under study (Yin, 2003, 2014). This case study focuses on uncivil behaviour in nursing education and the researcher anticipated that conducting interviews with the participants involved in this would help her to gain insights into the situation. This would then allow an increased understanding of both the respondents' perceptions and of other significant individuals' backgrounds involved in the uncivil behaviour instances.

Three types of interviews include structured, semi-structured and unstructured interviews (Patton, 2002; Polit and Beck, 2012; Yin, 2014). In this study, the researcher used semi-structured interviews or open-ended questions interviews. The rationale for using open-ended questions was to allow her to explore issues and events in considerable detail and other issues outside of the pre-defined interview guide, as well as allowing participants to talk about their experiences in their own words (Patton, 2002). The interview guide was expanded based on previous study by Clark (2006). These factors reflected three broad areas as follows: the perceptions, experiences and reactions in regard to incivility in nursing education.

The interview guide (see appendix 20) consisted of six questions. The first and second questions focused on seeking general information regarding the participants' daily activities in nursing and their interest in nursing. Questions three to sixth explored the participants' perceptions and experiences of incivility in nursing education (classroom, skills laboratory and clinical practice) as well as their reactions when facing the incivility incidences. In addition, the interview method consists of a pilot study of the interviews and main study of the interviews.

Pilot study of the interviews

Before the actual interviews, the researcher conducted a pilot study by interviewing two students at the private FoN. The interviews of the pilot study were transcribed, and then the researcher reported them to the supervisors. After discussing the results of the pilot interviews with the supervisors, the researcher then prepared for producing effective interviews such as providing a comfortable environment or situation, building a good rapport with the interviewee, being a communicative person, and managing the researcher interview's style for accessing more in-depth data. In addition, by conducting the pilot interviews, the researcher felt and become more confidence to conduct interviews with the respondents. The researcher had full belief and hope that the researcher was now ready to collect data for the study using interview method.

Main study of the interviews

Within each case, the researcher interviewed five academic staff and nine students. This was a total of 28 interviews within two units of analysis. The details of interview respondents can be seen in the findings chapters (four and five).

During the semi-structured interviews the researcher interviewed participants from the private FoN in a private room at the academic settings such as counselling room. The researcher interviewed some participants from the public FoN in a private room at the academic settings such as classroom and a small room in the area of the hospital. On the other hand, some participants from the public FoN were interviewed outside the academic settings such as a small room in a private accommodation. Indonesian language was used to interview the participants given that it is the language used in both formal and informal communication in the area. During the interviews the researcher developed a good relationship with my participants throughout the interviews to help them to feel more comfortable. Each interview lasted between 30-60 minutes in duration.

Each interview began by seeking some general information from each participant. The researcher was keen for them to share details about their general daily activities related to nursing. The researcher also encouraged for detailed responses to explore some pertinent issues in more depth (Yin, 2009). During the interviews session, the researcher paid attention to what the participants said and encouraged them to explain and expand on the details of their perceptions and experiences by using phases such as 'please explain more' or 'please give me an example'. All interviews were audio-recorded using a digital recorder (with participants' consent).

The researcher experienced some minor problems when interviewing some participants. For example, it seemed that some participants felt uncertain regarding the definition of incivility. When the researcher asked one academic staff member how he experienced uncivil behaviour in the classroom, the participant asked the researcher to give the definition of incivility and its examples. Thus, the researcher had to ensure that the

researcher describe briefly the definition of incivility in nursing education in the beginning of the interviews phase.

3.2.3 Observations

Direct observation was used to investigate the context within which incivility in nursing education occurs (see appendix seven) (Yin, 2014). Since this study was to explore uncivil behaviour in nursing education, this approach provides an opportunity to observe academic staff, student and nurses' behaviour within their natural environment (Yin, 2014). The observations provide insights into the phenomena which being studied as well as to facilitate contextual meaning in real life events which could be the weaknesses in other methods, such as surveys and interviews (Polit and Beck, 2012; Yin, 2014).

Observation methods include unstructured, participant and structured observations (Paton, 2002; Polit and Beck, 2012; Yin, 2014, 2009). Unstructured observation is conducted when the researcher would like to observe natural phenomena or events without a pre-defined observation guideline, whereas structured observation is conducted when the researcher looks for specific features of phenomena and applies an observational guideline or checklist. Participant observation is conducted when the researcher is directly involved with participants in the study.

However, observations can also have disadvantages. For example, when people become aware that they are being observed, they tend to change their behaviour, as described by Yin (2009). Additionally, researchers may not remember the details of the situation being observed, which might lose the observational data. Thus, in order to maximise the accuracy of observational data, Polit and Beck (2012) suggested that observation

guidelines need to be developed to focus on the aim and to record details immediately. Patton (2002) further recommends that phenomena should be observed and recorded within a period of time such as one hour to maximise data collection efficiency, as well as when specific events are selected, such as class sessions. Moreover, the observer should be conscious of the appropriateness of the presence and be undisruptive in the setting (Polit and Beck, 2012).

In this study, the aim of the observation was to observe the behaviour of academic staff/clinical educators, students and nurses through structured observations in a period of time. The period of time observation focused on the actual academic staff-students or students-nurse or academic staff-nurse interactions in the classroom, skills laboratory and clinical settings. As a result, the researcher observed two academic staff-student interactions (one classroom, one skills laboratory or tutorial class) and two academic staff-student-nurse interactions (ER/Emergency Room and ICU/Intensive Care Unit wards) in each case: eight interactions in a total of two units of analyses. Additionally, the observations method of this study comprised pilot study of the observations and main study of the observations.

Pilot study of the observations

Before the actual observations, the researcher conducted a pilot study of observations by observing two classroom and one skills laboratory at the private FoN and one ward at the private hospital. The observations of the pilot study were written, and then the researcher reported them to the supervisors. From the pilot observations the researcher learnt how to conduct the observations effectively, such as the technique whereby the researcher's position should be at a comfortable distance. The researcher

also felt more confident to observe in the chosen settings and ready to collect data using observation methods.

Main study of the observations

In actual observations, before conducting the observations, the researcher introduced herself as a researcher who would only be collecting data and would not participate in any activities in the settings. The researcher further established good rapport by paying respect, being polite and friendly (Polit and Beck, 2012).

The researcher first asked permission from lecturers before coming into their classrooms or laboratories and from the students when the researcher was coming into their class. The researcher's observations commenced when the class sessions began. The researcher positioned herself at a comfortable distance from which the researcher could see the activities and hear the conversations, yet the researcher had no direct input into their interactions. The researcher observed the academic staff-student interactions, class activities and the content of conversation. The researcher tried to focus on the elements of the behaviour and conversation between the academic staff and the student while in the teaching-learning process. Each observation was around 50-100 minutes in length. The researcher concluded the observations when the class session was terminated and the researcher made sure to thank the students and the academic staff.

In the clinical setting, the observations began after receiving permission from the hospital management, head of the ward, head nurse, nurses and doctors. After gaining the hospital management's letter approval, the researcher brought the letter to the head of the wards and the head nurses. Then, the researcher informed the participants of the study and obtained

verbal permission from the students, clinical educators/lecturers, nurses and doctors prior to the observations.

When the researcher was already inside the chosen ward, the researcher positioned herself at a comfortable distance from the ward activities, such as near the nurse station. From this position, the researcher could see the activities and hear the conversations without interfering directly in their interactions. Similar to the classroom observations, the observations in the ER and ICU wards were conducted to observe behaviours and interactions in regard to the process of teaching and learning.

In each observation, the researcher applied the observational guideline proposed by Polit and Beck (2012) in order to maximise the accuracy of the data and minimise bias. The guideline includes: gathering details relating to the setting physically, the participant, activity and interaction, time, and feeling (emotions felt and expressed) in order to record observational data (see appendix 19). When the researcher wrote the observation field notes, the researcher moved between each guideline to record the details of the interactions.

3.3 Sampling

The sampling of this study will be described in three sections: the participants of survey, interviews and observations. All participants (in surveys and interviews) were identified through purposive sampling strategy. Purposive sampling is 'selecting cases that will most benefit the study' (Polit and Beck, 2012, p.517). There are a number of purposive sampling strategies suggested by several authors (e.g. Patton, 2002; Teddlie and Tashakkori, 2009). In this study, two methods were used for selecting the participants namely: maximum variation sampling and criterion

sampling. These samplings means that when choosing the respondents, the researcher considered the sampling diverse backgrounds (maximum variation sampling) as well as fit to the predetermined criteria (criterion sampling).

3.3.1 Survey participants

Within each FoN, there were two types of respondents: students and academic staff, who were considered as the main subjects in uncivil behaviour incidences in nursing education. The inclusion criteria for survey respondents are described below.

1. An academic staff or faculty member was defined as a lecturer who had been teaching in the FoN for at least one year and who had experience in the teaching and learning processes within the classroom, skills laboratory and in clinical settings (criterion sampling).
2. A student was defined as a person who joined the FoN to get a bachelor's degree and who had been involved (or enrolled) for at least one year in the teaching and learning processes, including in classroom, skills laboratory and in clinical settings (criterion sampling).

However, after conducting a pilot study in the private FoN, the researcher amended the inclusion criteria for the students, as second-year students had not yet practised in the hospital settings. The inclusion criterion for the students was modified as follows: an undergraduate student enrolled in a BSc program in the FoN in year three or four of the academic program, and students in their professional program.

The researcher also included nursing students from upper secondary education (regular class) and nurses with a diploma qualification (conversion class) who intended to upgrade to degree in nursing. However, only the

private FoN approved the inclusion of both types of students as participants for the study. The public FoN disapproved the researcher's request to recruit both types of students, and the researcher was only allowed to collect data from the regular class. The reason given for this was that the school operated a different curriculum between the regular and conversion class.

3.3.2 Interview participants

Participants who took part in the survey were asked to complete a sheet if they wished to further participate in the face-to-face interviews. The students and academic staff who agreed to participate wrote their email address or phone number. Respondents were then chosen according to their characteristics such as ethnicity, religion, religious faith/practice and SES (maximum variation sampling). The researcher also considered the students' program, such as academic or professional, as well as regular class or conversion class for the students (criterion sampling). Furthermore the researcher considered the academic staff's status such as junior (≤5 years' employment) or senior (> 5 years' employment) for the academic staff (criterion sampling). The interviews' respondents of this study consisted of 5 academic staff and 9 students at each FoN. The detailed of the interviews respondents at the private and public FoN can be seen in appendix 21.

3.3.3 Observation participants

The observations were conducted in a chosen classroom and clinical settings (criterion sampling). The classrooms were chosen based on the teaching methods used, to include both lecture/seminar and tutorial/small group teaching formats. In addition, classrooms were chosen with different academic staff at each session in each FoN. Clinical settings were chosen based on their speciality in the hospital settings. As proposed by Hunt and

Marini (2012), the critical care setting is the most likely site for the occurrence of incivility. Thus, the observations of this study were conducted at Emergency Room/ER and Intensive Care Unit/ICU.

The observation aimed to examine the interactions between people involved in clinical settings, in this study included ER and ICU. The participants of the observations were clinical educators or lecturers, students and nurses. However, the researcher also asked other health care providers such as doctors and health care assistants if they were in the locations. As mentioned before (section 3.2.3), the participants in the observations of this study were informed and asked for their permission verbally. This procedure might have led to behavioural distortions in which the participants changed their behaviour because of the known presence of observers (Polit and Beck, 2012). To minimise the behavioural distortions (the Hawthorne Effect), the participants were informed only the purpose of the observation and the study in general.

3.4 Ethical considerations

Ethical approval for this study was obtained from the University of Nottingham Medical School Ethics Committee (F 14082012 OVS SNMP). Approvals of the settings were obtained from two faculties of nursing and two hospitals (private and public) in Indonesia (see appendixes).

When conducting the study, there were guidelines for the protection of respondents' rights including 1) providing detail information to participants about their prospective involvement in the research, 2) preventing any physical or emotional damage to the participants, 3) allowing participants free choice to be involved in the study, and 4) ensuring privacy, confidentiality and anonymity (Polit and Beck, 2012).

During data collection and analyses, the following ethical issues were carefully considered:

1. All participants received informed consent and a full explanation of the research and their potential involvement within it. Each participant was given an information sheet (appendix 13-14), which had been translated into Indonesian language for participants to read. Following this, I obtained and informed consent from the participants (see appendix 15-16).

2. The researcher made sure that any potential physical or emotional damage to the participants was avoided. For example, prior to interviews, the researcher spent a few minutes engaged in conversation with each participant in order to alleviate any potential concerns or anxieties.

3. Participant's right to decide whether or not to take part in the study was respected. The researcher made sure that the participants understood that their participation in this study was voluntary and that they could withdraw from the study at any time without giving any reasons.

4. All information collected from the participants was kept strictly confidential and anonymous. All settings and individuals are anonymised in this thesis. The researcher assigned a code number for each participant, which was subsequently used in the transcripts (e.g. student A, Lecturer X). In addition, the FoNs were assigned a code number (e.g. unit of analysis I and unit of analysis II). The participants' names and the names of units are not identified at any point. Although the researcher's supervisors and the bilingual reviewer reviewed the data, they were not aware whose data they were reviewing. The researcher also ensured that participants were not identifiable within the thesis, including any

subsequent publications or conference presentations. Data were privately, confidentially stored in a password protected personal and or university computer. All data will be destroyed at the completion of the study after 7 years, in accordance with the provisions of the UK Data Protection Act (1998).

Once ethical approval was obtained, the researcher recruited participants for this study. Participants were either students or staff members at both FoNs, who had been at the university for at least one year. The researcher asked the academic staff in the nursing departments to participate in the study. The researcher distributed questionnaires to staff members and asked them to distribute some questionnaires to their nursing students. Academic staff members completed the questionnaires in their own time and provided time during class for students to complete the questionnaires. Consent was implied by completing the survey (see appendix 15-16), and those who did not wish to participate were instructed to return the questionnaires to the staff members or to the researcher. Academic staff and student participation was voluntary.

In the interviews, the respondents were asked for their consent (see appendix 15-16). The researcher explained the purpose and management of the interview, the benefits and risks of participation and the option to withdraw from the study. The respondents had read the written consent and signed it prior to the interview. In direct observation, consent was obtained from the hospitals' management before the observation took place. Moreover, the participants of the observations were asked for their permission verbally.

3.5 Negotiating and recruiting access

The study settings were one private university and one public university. The private university approved my study before the confirmation review and the clinical setting approved my study in October 2012. However, the chosen public university did not approve this study, stating that it was not in their research area.

Due to the 'disapproval' of the public university, the researcher looked for other public universities to grant ethical approval and access for data collection. The researcher found three public universities that were suitable for the study and discussed them with the supervisors. Finally, the researcher decided on one public university that was located in a different province and island from the private university were the researcher had already been granted access.

The researcher contacted the public university and emailed them information related to the study. The public university welcomed the request to collect data at their institution and asked the researcher to send the study's proposal to the Medicine Ethical Committee of their university. The researcher prepared all the requirements and sent the documents to the ethical committee by post.

In early February 2013, the ethical committee of the public university approved the study and asked the researcher to contact the FoN, with whom the researcher discussed the study in more detail.

3.6 Procedures for data collection

Data collection started in the first FoN (unit of analysis I) in October 2012 and finished in the second FoN (unit of analysis II) in March 2013 (see Table 3.4).

Table 3.1: Schedule for data collection

	Unit of Analysis I (Private FoN)	Unit of Analysis II (Public FoN)
Period	October-December 2012	January-March 2013
Methods used	Surveys Interviews Observations	Surveys Interviews Observations

The process for collecting the data in each of the two FoNs was using a similar procedure as well as from varied resources, since this study involved multiple cases and replication (Yin, 2009, 2012, 2014). Yin (2009, 2014) argued that the use of various data collection methods is vital in case study research due to the opportunity to gather data from more than one source, rendering the results of the study more convincing.

This section further explains the procedure of data collection in this study, described by a series of figures (3.2-3.4). Each figure portrays each phase of the data collection process such as surveys and interviews. Each phase is further described in detail by comparing and contrasting the process between the private and the public university. The data collection timeline explains each data collection process within the overall project time schedule.

Figure 3.2 below shows the procedure of data collection in the surveys. The procedures were conducted at the two FoNs using essentially the same procedures. However, when conducting the procedures at public FoN, the Vice Dean accompanied me to introduce me to the students and the

academic staff. This worked to the researcher's advantage as respondents were more welcoming and eager to take part in the study.

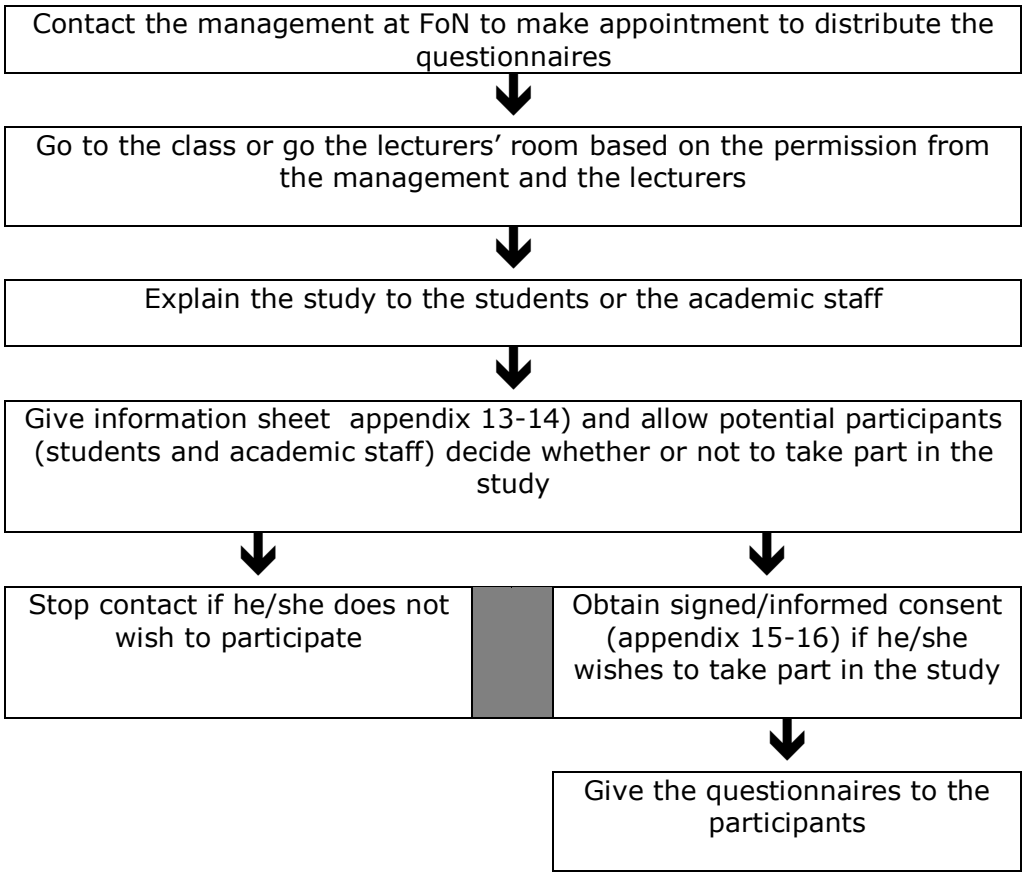


Figure 3-2: The procedure of data collection in the surveys

Figure 3.3 below illustrates the recruitment procedure for interview participants. The interview procedures were a bit different between the private and public FoN. For example, when conducting the interviews, the researcher interviewed the respondents in a counselling room at the private FoN. However, at the public FoN, the rooms were varied such as classroom, a private room in an accommodation setting, and a private room in the hospital. Despite the variety of the rooms for interview sessions at the public FoN, the researcher ensured that the respondents' privacy and confidentiality was respected.

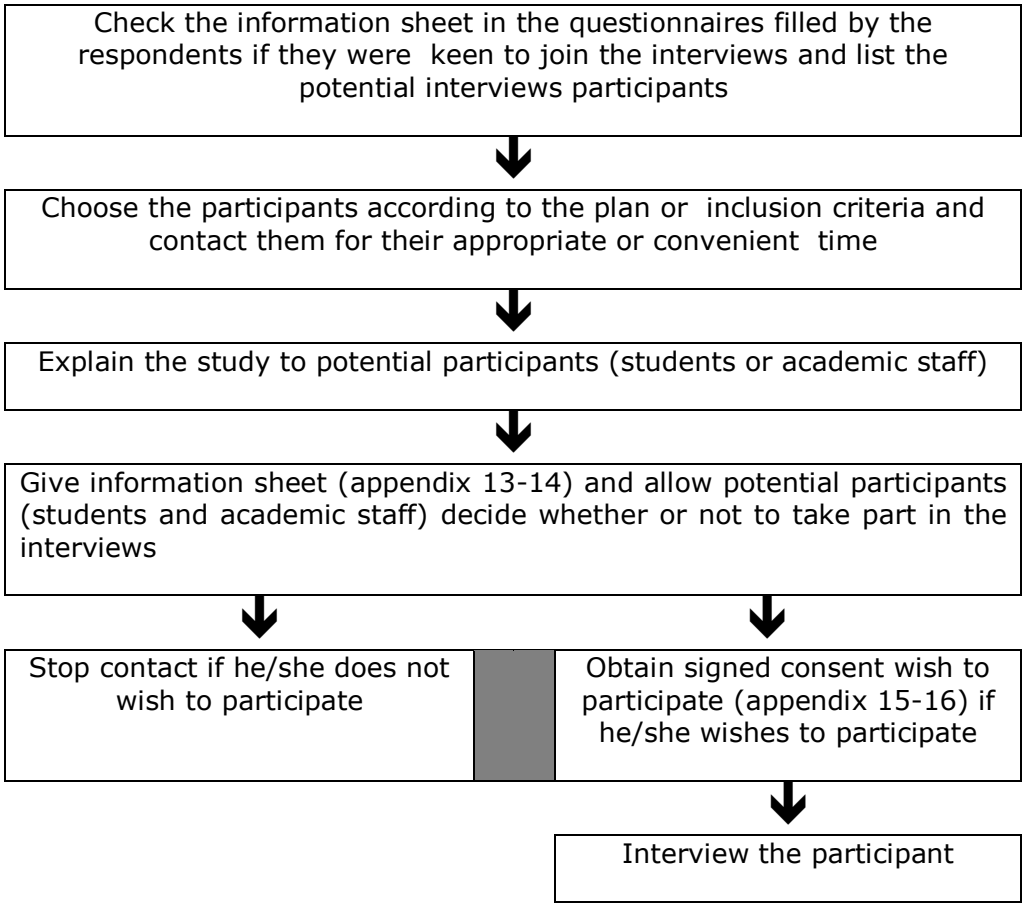
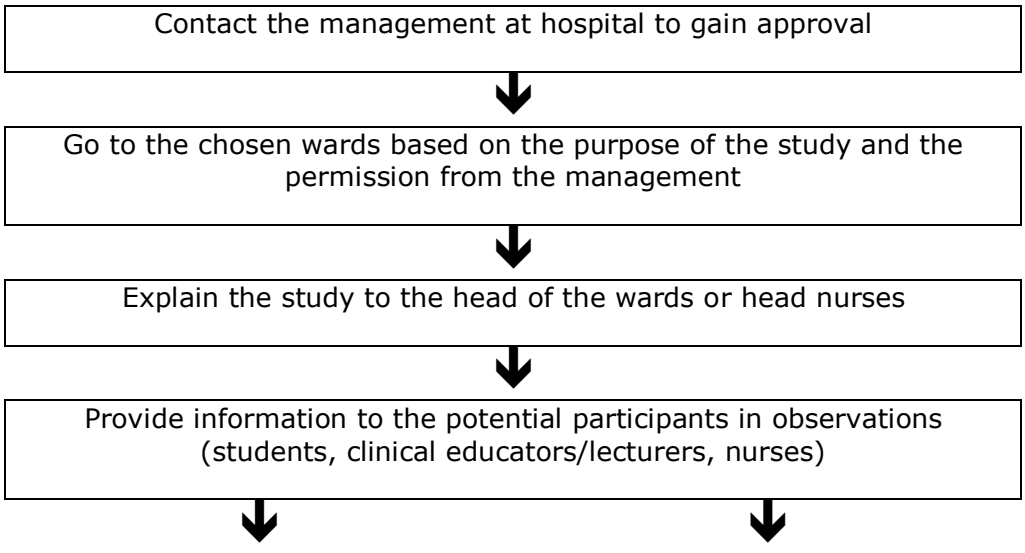


Figure 3-3: The procedure of data collection in the interviews

Figure 3.4 below shows the procedure of data collection in the observations. The procedures were conducted at the two hospitals using essentially the same procedures.



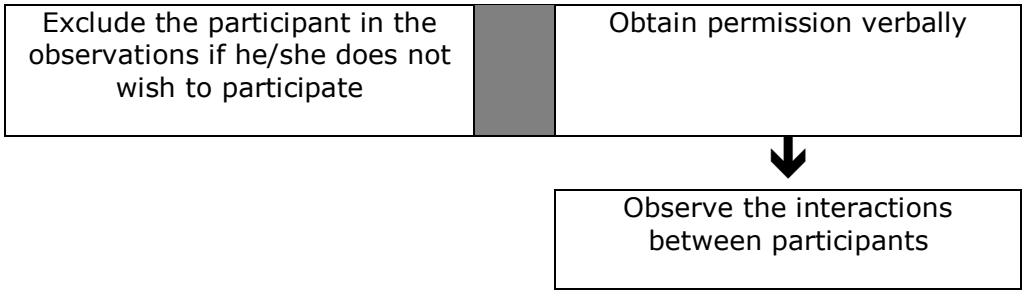


Figure 3-4: The procedure of data collection in the observations

All data (questionnaires, interviews and observations) were collected and recorded in the Indonesian language. The survey data were entered into Microsoft Excel and the interviews were transcribed by listening to the tapes and developing a transcript of each. The transcripts were then typed into Microsoft Word, whilst re-listening to the audiotapes to ensure accuracy. All the questionnaires were transferred onto computer files using a document scanner and were then stored in the folder with password protected.

3.7 Methods of data analysis

This section includes preparing data for analysis and analysing data using case and cross-case analyses.

3.7.1 Preparing data for analysis

This section describes how the data was prepared for analysis and translated from Indonesian to English. After collecting the data through surveys and interviews, a database was prepared in order to collate the data.

Since the interview data was in the Indonesian language, the researcher had to translate the interviews into English language. Twinn (1998) suggested that verbatim transcripts should be analysed in the same language of the interviews recorded, but clearly this is not practical in an academic study

conducted in a second language, wherein supervisory oversight is essential. The example of the translation is in Table 3.2.

Table 3.2: Example of interview translation

Raw data in Indonesian
Kita belum memiliki...persepsi sudah sama. Lalu... komitmen di dalam menjalankan hal itu yang kita memang belum sama. Jadi ketika satu tegas, yang satu lentur, dan ketika yang satu tegas ini dinilai oleh mahasiswa terlalu keras sehingga dengan demikian yang... yang keras ini menjadi sama lenturnya. (Interview/E44)
Raw data when translating word-for-word in English
We don't have… our perception are same. Then… our commitments to run this haven't been same. So if one people acts in distinct way, but the other one acts in flexible, and when one people who acts in distinct is seen by students as something that too harsh, so that she becomes act in flexible way too. (Interview/E44)
Raw data in English after modification
We have not... had similar perceptions yet. Then... commitment in applying it [rules] is still not similar. So, one [lecturer] is strict and another is lenient. When the strict [lecturer] is being evaluated by students, [they complained that the lecturer was] too strict, thus it makes the strict [lecturer] become lenient, therefore this condition creates the reward and punishment implementation is more lenient. (Interview/E44)
Raw data in English after translation check
We [lecturers] have different perceptions and commitments in regard to rules implementation. For example, one lecturer is strict and another lecturer is lenient. In addition, when the strict [lecturer] is being evaluated by students, they complain that the lecturer is too strict. Thus, the strict lecturer becomes lenient. This condition further creates the reward and punishment implementations are more lenient. (Interview/E44)

In order to maintain consistency, the researcher analysed the data in Indonesian and all codes, categories, themes and quotations emerging from these were initially written in Indonesian and then translated into English.

3.7.2 Analysing data

For data analysis in the case study methodology, Yin (2009, 2014) suggests applying a combination of four general strategies and specific analysis techniques such as 'pattern matching, explanation building, time series analysis, logic models and cross-case synthesis' (Yin, 2009; p.126).

In this study, the researcher applied within-case analysis and cross-case analysis (Eisenhardt, 1989; Stake, 2006; Yin, 2014, 2009). Within-case analysis is in-depth exploration of one case for the case familiarisation (Eisenhardt, 1989). Cross-case analysis is examining key findings, similarities and differences across cases (Eisenhardt, 1989). In each FoN the researcher conducted a within-case analysis. The analysis steps included to:

1. Identify and prepare the quantitative and qualitative data.
2. Analyse the quantitative data and the qualitative data independently.
3. Develop the unit of analysis in the database.

The detailed explanation of the case analysis is subsequently discussed. When collecting data, the quantitative data were produced from questionnaires and the qualitative data resulted from open-ended questions in the questionnaires and interviews. The data derived from questionnaires were inputted into Excel documents in which the programs provide flexible table for the raw data. On the other hand, the data derived from open-ended questions and interviews were entered into Word documents.

After identifying and preparing the quantitative findings of the questionnaires, the researcher sent the raw data from Excel into SPSS program after coding. For example, the respondents' religious coding was (1) Islamic, (2) Protestant, (3) Catholic, (4) Hindu, (5) Buddhist and (6) Confucian.

The researcher analysed the data using SPSS version 21 (University oF Nottingham) in two steps: Firstly, the researcher determined the frequency or percentage or mean of the demographic data of the respondents, their ethnicity, ethnic identity, religion, religious faith/practice and SES; secondly, the researcher conducted a comparison or correlation analyses using non-parametric analyses including Mann-Whitney, Kruskal-Wallis and Spearman

(Field, 2013; Polit and Beck, 2012). Mann-Whitney analysis was applied for comparing two independent groups with ordinal (rank) level of measurement. Kruskal-Wallis analysis was applied for comparing more than two groups with ordinal (rank) level of measurement. Spearman analysis was applied for examining relationship between variables.

The comparison or correlation analyses were for:

a. Ethnic identity between students and faculty staff using a nonparametric test (Mann-Whitney).
b. Religious faith/practice between students and faculty staff using a nonparametric test (Mann-Whitney).
c. Perceived disturbing and threatening behaviour of students between students and faculty staff using a nonparametric test (Mann-Whitney).
d. Perceived disturbing and threatening behaviour of faculty staff between students and faculty staff using a nonparametric test (Mann-Whitney).
e. Perceived disturbing and threatening behaviour of nurses between students and faculty staff using a nonparametric test (Mann-Whitney).
f. Perceived disturbing and threatening behaviour of students and respondents' ethnicity/ethnic identity/religion/religious faith/SES using nonparametric tests (Mann-Whitney/Kruskal-Wallis/Spearman).
g. Perceived disturbing and threatening behaviours of faculty staff and respondents' ethnicity/ethnic identity/religion/religious faith/SES using nonparametric tests (Mann-Whitney /Kruskal-Wallis/Spearman).

h. Perceived disturbing and threatening behaviour of nurses and respondents' ethnicity/ethnic identity/religion/religious faith/SES using nonparametric tests (Mann-Whitney /Kruskal-Wallis/Spearman).

Additionally, from the qualitative findings that emerged from the open-ended questions in the survey, interviews and observations, the researcher applied thematic analysis. The thematic analysis steps were applied in each finding. This also means that the researcher did not combine the verbatim data from the three qualitative findings. The thematic analysis' steps (Braun and Clarke, 2006) included:

1) data familiarization,

After the processes of transcribing and translating the data were finished, the researcher become familiar with the raw data through listening and repeated readings. Following this, the researcher wrote notes in the transcripts electronically in word documents to seek the potential key ideas (Braun and Clarke, 2006). This process helped me to develop a general understanding of the data. The open-ended questions findings provided the respondents' opinions on incivility regarding its forms, reasons, and strategies to address as well as the differences of incivilities that occurred in the classroom, skills laboratory and clinical practice. The interview transcripts provided the researcher with details of what academic staff and students experienced on incivility in nursing education settings such as classroom, skills laboratory and clinical practice. The observations data provided information on what the researcher had observed in such settings.

2) Coding,

In this stage, the researcher identified the codes from the key data sets (Braun and Clarke, 2006). The process of coding included that the researcher read through the data, line-by-line, within the paragraphs and then reduced it into one or two words as the codes that were meaningful to me (Patton, 2002). The codes that emerged were directly from the participants' words. The code words were written in the right table of each data. The researcher re-read any data that was not coded to ensure that the the researcher had not missed any crucial information (Braun and Clarke, 2006; Patton, 2002). Then, the researcher developed a list of codes that were emerging. The following is an example of the interviews coding:

Table 3.3: The example of interviews coding

Data extract	**Coding**
I think it's frequent for lecturers to come late, because lecturers' work load here is too much, sometimes they go to many places, moreover to lecturer who is in structural, so they often come late... and then... eee ... they say rudely, maybe some of them do that.	F37. Lateness F38. Overload tasks F39. Harsh comments

3) themes searching,

The researcher continued to the third stage of displaying codes when all data from the findings had been coded. All codes were grouped and classified by considering the meaning behind the words in which the classification was called category.

4) themes reassessing,

Having developed key codes across all the data sets, the initial categories, sub themes and themes began to be developed which represented the relationship between codes across the data sets. The following is an example regarding the process from category into themes of interviews verbatim:

Table 3.4: The example of the process from category, sub-theme and theme

Category	Sub themes	Themes
Self-indiscipline Self-attitude problems Self-management and relationship Personal issues Psychological effects	Personal issues	Personal issues and background influences
Religious practice activities Religious practice effects	Religio-cultural background influences	
Cultural background influences Family-environment influences		
Socio-economic background issues minor social activities	Socio-economic background influences	

5) generating definitions and names of the theme,

After identifying the initial thematic map of codes across the data sets, the researcher proceeded to the next stage, which involved developing and refining the themes. In this stage, a theme was generated by considering the significance behind the codes and the sub-themes. The theme was named and checked by considering the coding, category and sub-theme. Following this, the researcher further reviewed and refined the thematic maps with all data sets until the researcher became satisfied that the themes signified the meaning evident of incivility in nursing education. At this stage, the researcher and the supervisors met regularly to discuss any issues in relation to the coded extracts and to refine the specifics of each theme, which gave clear definitions and names for each theme. On completing the final thematic map, the researcher described the definition of themes in order to discuss the scope and detail of the content of each theme in sentences. An example of a defined theme is presented as follow:

Table 3.5: The example of the definition of the theme

Theme	Definition
Professionalism issues	Problems that occur when people involved in nursing education perform activities with a lack of nursing competency and ineffective communication skills, possibly violating the code of ethics.

6) report producing.

Having defined the themes and subthemes of each case, the researcher was ready to report the findings of each case. The researcher reported the qualitative findings separately between the findings of open-ended questions and interviews-observations findings.

From the two databases or unit of analysis report (see chapters 4 and 5), the researcher conducted a cross-case analysis (Eisenhardt, 1989; Stake, 2006; Yin, 2014, 2009). The steps in a cross-case analysis included:

1. Establishing word-tables based on the two databases and identifying key findings.

   After reporting case analysis for each unit of analysis, the researcher developed some tables that provided the key results from the two units of analyses or databases (Eisenhardt, 1989; Yin, 2014). At first, it was difficult to decide on how to present them appropriately. Finally, the researcher decided to follow suggestions by Eisenhardt (1989) to present the results according to the type of data, such as quantitative and qualitative results. Thus, the researcher reported three sections to present the cross-case analysis including characteristics of unit of analysis, cross-case analysis of quantitative findings and cross-case analysis of qualitative findings (see chapter six).

2. Examining disparities and similarities from each word-table.

   In this stage, the researcher continued to look for the similarities and differences between the units of analysis based on the established

tables (Eisenhardt, 1989; Yin, 2014). The rationale was to explore the possibility of 'unique insights' from different types of data collection, thus, the findings will be 'stronger and better grounded' when the data supported each other (Eisenhardt, 1989; p. 541). However, if the findings contradicted the researcher clarified the evidence by investigating the meaning of the differences deeper (Eisenhardt, 1989).

3. Integrating and interpreting the outcomes based on the research questions.

   In this stage, the researcher made sure that the findings of the cross-case analysis answered the research questions of this study (Creswell and Clark, 2011) as well as developing arguments which supported the data (Yin, 2009, 2014). This also ensured the establishment of a model of incivility for Indonesia nursing education, thus directly achieving one of the objectives of this study (see chapter seven).

Then, from the cross-case analysis steps explained above, the researcher organised the report of the current study. The descriptions of the within-case analysis report can be seen in chapters four and five, while the cross-case analysis report is described in chapter six.

3.8 The quality of case study research design

Maintaining quality is a significant component in any research study (Yin, 2014). Within this study, the researcher complied with certain criteria to meet these across all phases of this study. In the current study , the researcher decided to use Yin's approach to evaluate the quality of a research design (2014, 2009) that focuses on 'construct validity', 'internal validity', 'external validity', and 'reliability'.

3.8.1 Construct validity

This aspect of validity identifies weather the operational measurements are sufficient to the concept being studied (Yin, 2014, 2009). In other words, what the study measure is relevant to the concept being studied.

Since this study only consists of two units of analysis, the possibility to test stability of constructs across units is a bit limited. However, the construct validity is supported by the use of multiple sources of evidence in which the varied sources can include numerous perspectives within and across the data sources (Yin, 2009, 2014). This study responds to these requirements in its sampling of interviewees (academic staff and students) and used multiple data sources including survey, interviews and observations.

3.8.2 Internal validity

This aspect of validity reflects to examine the causal relations (Yin, 2009, 2014). The researcher should be aware of other factors that could affect the investigated factor. Recognition of this problem has led to calls for better documentation of the processes of data collection, the data itself, and the interpretative contribution of the researcher. In this study, the researcher have explained in details data collection process (see section 3.6 procedures for data collection).

3.8.3 External validity

This aspect of validity is concerned with the possibility for generalization of the findings, and the applicability to transfer to other settings (Yin, 2009, 2014). In this study, it is assumed that the two FoNs located in Java and Sumatera are representative of nursing educational institutions in Indonesia. In addition, this study has high participation rate (see section 3.3), and the

fact that Java and Sumatera are the most important socio-economic and cultural islands of Indonesia (Ananta et al., 2013). However, since they are located in the western part of Indonesia, it is impossible to generalise to the nation of Indonesia as a whole.

Yin (2009, 2014) further suggests applying replication logic to support external validity. This study has applied the replication logic since it applies multiple-case study design. The researcher carefully selected the case for predicting similar and different results (see section 3.1.3).

3.8.4 Reliability

Reliability emphasises on the process for maintaining the accuracy and consistency of the study (Polit and Beck, 2012). The study should further be clear on how to code collected data or if questionnaires or interview questions or observations guidance are unclear (Yin, 2009, 2014).

This study addresses these requirements by discussing the research process such as sampling and data collection procedures, and data analysis. Furthermore, this study has explained the instrument test for reliability analysis, as discussed in section 3.2.1.

3.9 Chapter Summary

This study is based on a case study exploring incivility in nursing education from perspective of student nurses, and staff members in classroom setting, clinical setting and clinical skills laboratory setting. The study design included two FoN as the unit of analysis of the study using questionnaires, interviews and observations methods. The questionnaires were adapted from previous valid and reliable questionnaires including INE (Beck, 2009; Clark, 2010), MEIM (Phinney, 1999) and ASCSRF (Plante and

Boccaccini, 1997; Plante, Vallaeys, Sherman et al., 2002). The adaptation of the questionnaires mostly related to the language since the respondents speak Indonesian. The interviews questions were guided by Clark's study (2006) whereas the observations guidance were developed from Polit and Beck (2012).

After questionnaires refinement and interviews trial, the study was conducted by recruiting both academic staff and students at two FoNs based on the inclusion criteria. Moreover, after observations trial, the observations were conducted at the chosen classrooms and hospital wards. The next chapter presents the results of this current study.

CHAPTER 4: WITHIN ANALYSIS FINDINGS - UNIT OF ANALYSIS I

As discussed in the previous chapter, the case of this study is 'the uncivil behaviour instance in nursing education settings'. In addition, the study was conducted at two universities (private and public) in western Indonesia, with a private and a public faculty of nursing (FoN) comprising the units of analysis.

The results of the study will be presented in two chapters (chapter 4 and 5): (1) unit of analysis I for the private university; and (2) unit of analysis II for the public university. In this chapter, the results of the unit of analysis I are presented. The results will be explained in two sections: (1) profile of the unit of analysis I and (2) findings of the unit of analysis I.

4.1 Profile of the unit of analysis I

The unit of analysis I is located in western part of Java Island Indonesia. The population consists mainly of Sundanese, Javanese, and Chinese (Indonesian Ministry of Home Affairs, 2016). Due to industrial development, many newcomers come from others part of Indonesia. Thus, the population becomes a plural society.

The first unit of analysis is at a private university. The university was established in 1994; it is based on Christian religious beliefs with the vision of developing a godly character and glorifying God. The commitment of the university is to achieve this vision through the use of a Liberal Arts curriculum (39 credits). This curriculum is supported by seminars and

workshops organized by the department of academic development in the university.

The unit analysis I of the study is the Faculty of Nursing (FoN), which is part of this private Christian university, established in 2008 and accredited in 2011. The vision of the FoN is to be the preferred higher education institution of nursing in Southeast Asia by the year 2020, and to produce professional nurses who have great integrity, a positive character and an attitude to glorify God, with a competitive advantage in palliative nursing care.

The private FoN renew their vision in the year 2015: 'to be a Christ-centered learning community that will develop competent, professional nurses who are equipped with true knowledge, are guided by faith in Christ, and demonstrate godly character. Nurses equipped as such will be well prepared to meet rapidly changing global healthcare needs, nationally and internationally.'

In addition, the FoN consists of two types of nursing students: students from upper secondary education (regular class) and nurses with a diploma qualification (conversion class) who intend to upgrade their degree in nursing. The FoN further comprises academic and professional programs. The academic program covers seven to eight semesters for regular class and two to three semesters for conversion class to achieve the Academic Degree: Bachelor of Nursing/*Sarjana*. The professional program covers two semesters to obtain a Professional Degree/*Ners*. This professional program covers two semesters of clinical practice in different areas of nursing care, including hospitals and community.

4.2 Findings of the unit of analysis I

Data collection was conducted at the private Christian university FoN using three data collection methods: survey, semi-structured individual interviews and observations. The following sections contains quantitative and qualitative findings of the study.

4.2.1 Quantitative findings

Based on the survey findings, this section contains the results in three parts: 1) demographic data, 2) uncivil behaviour in the nursing academic environment and 3) uncivil behaviour in the context of ethnicity, religious faith and socio-economic background.

Demographic data

The target population of student respondents was 131, consisting of 79 students from the academic program (year 3 and 4) and 52 students from the professional program. The target population of academic staff members was 18. However, because two academics were completing their master's degree, two academic staff had just returned from their master's degree program, five academic staff members had worked less than one year at the private Christian FoN, and two academic staff members were respondents for the pilot study, the total target academic response was seven (7) academic staff.

From the target population, the total number of respondents who completed the questionnaires was 101 (77.09%) students (52 students from the academic program and 49 students from the professional program) and 7 (100%) academic members of staff. However, after the process of data

cleaning, the total number of valid questionnaires was 102 questionnaires completed by 96 (73.28%) students and 6 (86.71%) academic staff.

Five student questionnaires were not included in the analysis because they were: (1) not returned (n=2), (2) not completed (n=2) and (3) because informed consent was not completed (n=1). In addition, one academic staff questionnaire was not returned. Most of the student respondents were females (81.3%), between ages 20-25 (70.8%), Christians (67.7%), Indo-Malay by ethnicity (60.4%) and not working or only being a student (66.7%). Details of the demographic data of the student respondents are shown in Table 4.1.

Table 4.1: Student demographic data

Demographic data				***N***	***%***
Program	Academic program	Regular class		37	38.5
		Conversion class		10	10.4
	Profession program			49	51
	Total			96	100
Gender	Male			17	17.7
	Female			78	81.3
	Not completed			1	1
	Total			96	100
Age	20-25			68	70.8
	26-30			11	11.5
	>30			17	17.7
	Total			96	100
Religion	Moslem			17	17.7
	Christian			65	67.7
	Catholic			13	13.5
	Hinduism			1	1.0
	Total			96	100
Ethnicity	Indo-Malay				60.4
	Sub Indo-Malay	N	%	58	
	Batak	27	46.6		
	Javanese	18	31.1		

Demographic data			*N*	*%*
Manado	5	8.7		
Others	8	13.6		
Chinese			5	5.2
Pacific island people			10	10.4
Mixed-ethnicities			23	24.0
Total			96	100

Student respondents consisted of both students who were not working and students who were working as nurses or HCA (Health Care Assistant) at private hospitals. Students who were working at the hospital were allowed to study for four days at the FoN, and two days working at hospital and one day off. Thus, Tables 4.2-3 show the socio-economic status of each type of student. Table 4.2 shows the socio-economic status of the students who were not working, in relation to their parents' education, employment and income. On the other hand, Table 4.3 shows the socio-economic status of the students who were working, based on their own education, employment and income.

Table 4.2shows that the majority of the students came from a background where fathers have completed a university education and mothers have completed a high school education; both parents work outside the home with an income of 1.5-6 million rupiahs (approx. 100-400 GBP) per month.

Table 4.2: Socio-economic status of the non-working students' respondents

Socio-economic status of the non-working students respondents			***N***	***%***
Father	Education	≤ High school graduate	27	41.5
		University graduate	32	49.1
		Not completed/Deceased	6	9.4
		Total	65	100
	Employment	Private employee	16	25
		Government employee	16	25
		Entrepreneurs	14	21.9
		Others	12	17.2
		Not completed/Deceased	7	11
		Total	65	100
	Income per month	Below regional minimum payment (<1,500,000 rupiahs) or <100 GBP	2	3.1
		1,500,000-6,000,000 rupiahs Or 100-400 GBP	46	70.3
		Above 6,000,000 rupiahs Or 400 GBP	8	12.5
		Not completed/ Deceased	9	14.1
		Total	65	100
Mother	Education	≤ High school graduate	46	70.8
		University graduate	16	24.7
		Not completed/Deceased	3	4.5
		Total	65	100
	Employment	Private employee	8	12.5
		Government employee	10	15.6
		Entrepreneurs	7	10.9
		Others	36	56.3
		Not completed/Deceased	4	4.7
		Total	65	100
	Income per month	Below regional minimum payment (<1,500,000 rupiahs) or <100 GBP	10	15.6
		1,500,000-6,000,000 rupiahs Or 100-400 GBP	23	35.9
		Above 6,000,000 rupiahs Or 400 GBP	4	6.3
		Deceased	1	1.6
		Not completed	27	40.6
		Total	65	100

Table 4.3 further shows that most of the working students completed a university education, worked at a private company and have an income of 1,500,000-6,000,000 rupiahs or approx. 100-400 GBP per month.

Table 4.3: Socio-economic status of the working students' respondents

Socio-economic status of the working student respondents		**N**	**%**
Education	High school graduate	6	19.35
	University graduate	24	77.42
	Not completed	1	3.23
	Total	31	100
Employment	Private employee	28	90.32
	Entrepreneur	1	3.23
	Others	2	6.45
	Total	31	100
Income per month	Below regional minimum payment (<1,500,000 rupiahs) or <100 GBP	2	6.45
	1,500,000-6,000,000 rupiahs p or 100-400 GBP	25	80.65
	Above 6,000,000 rupiahs or above 400 GBP	4	12.90
	Total	31	100

The findings further reveal that the majority of academic staff members (Table 4.4) were: females (83.3%), half of them were aged between 30-40 years all of them were Christians/Catholic (100%) and Indo-Malay (83.3%).

Table 4.4: Demographic data of academic staff

Demographic data of academic staff		N	%
Gender	Male	1	16.7
	Female	5	83.3
	Total	6	100
Age (yrs old)	< 30	1	16.7
	30-40	3	50
	> 40	2	33.3
	Total	6	100
Religion	Moslem	0	0
	Christian/ Catholic	6	100
	Total	6	100
Ethnicity	Indo-Malay	5	83.3
	Chinese	1	16.7
	Total	6	100

Additionally, Table 4.5 shows that most of the academic staff members have worked as lecturers (66.7%) with a working experience of between 6-10 years (50%), and have an income above 6,000,000 rupiahs or approx. above 400 GBP (66.6%) per month.

Table 4.5: Socio-economic status of academic staff

Socio-economic status of academic staff		N	%
Teaching experiences (yrs)	< 5	2	33.3
	6-10	3	50
	11-15	0	0
	16-20	0	0
	> 20	1	16.7
	Total	6	100
Education	Undergraduate	2	33.3
	Postgraduate (master)	3	50
	Postgraduate (doctoral)	1	16.7
	Total	6	100
Employment	Lecturer	4	66.7
	Lecturer assistant/clinical educator	2	33.3
	Total	6	100
Income per month	Below regional minimum payment (<1,500,000 rupiahs) or <100 GBP	0	0
	1,500,000-6,000,000 rupiahs or 100-400 GBP	2	33.4
	Above 6,000,000 rupiahs or above 400 GBP	4	66.6
	Total	6	100

Furthermore, the respondents' religious faith/practice and ethnic identity have been identified further using the ASCSRF/ Abbreviated Santa Clara Strength of Religious Faith Questionnaire (Plante et al., 2002) and the MEIM/ Multigroup Ethnic Identity Measure (Phinney, 1999). The results of both identifications are reported in Tables 4.6-7.

Table 4.6 shows that both academic staff and students described themselves as people who practice their own faith or religion (mean >3). There was no statistically significant difference on religious faith/practice between students and academic staff (p value 0.058).

Table 4.6: Religious faith/practice of the academics' respondents

No	*Religious faith*	*Students*						*Academics*					
		Strongly Disagree n (%)	*Disagree n (%)*	*Agree n (%)*	*Strongly Agree n (%)*	*Mean of 4*	*SD*	*Strongly Disagree n (%)*	*Disagree n (%)*	*Agree n (%)*	*Strongly Agree n (%)*	*Mean of 4*	*SD*
1	I pray daily.	0	5(5.2)	22(22.9)	69(71.9)	3.67	0.574	0	0	0	6(100)	4	0.000
2	I look to my faith as providing meaning and purpose in my life.*	0	1(1.0)	14(14.6)	80(83.3)	3.83	0.404	0	0	0	6(100)	4	0.000
3	I consider myself active in my faith or in the place of worship.	0	21(21.9)	49(51.0)	26(27.1)	3.05	0.701	0	0	3(50)	3(50)	3.5	0.548
4	I enjoy being around others who share my faith.	0	4(4.2)	38(39.6)	54(56.3)	3.52	0.580	0	0	2(33.3)	4(66.7)	3.67	0.516
5	My faith impacts many of my decisions.	0	0	29(30.2)	67(69.8)	3.70	0.462	0	0	0	6(100)	4	0.000

Students' mean rank = 50.14; academic staff mean rank = 73.33; u= 419 z = 1.895 p = 0.058 r = 0.187
*Missing data = 1

Table 4.7: Ethnic identity of the students

No	Statement	STUDENTS					
		Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean of 4	SD
1	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	2(2.1)	39(40.6)	49(51.0)	6(6.3)	2.61	0.639
2	I am active in organizations or social groups that include mostly members of my own ethnic group.	3(3.1)	61(63.5)	25(26.0)	7(7.3)	2.38	0.669
3	I have a clear sense of my ethnic background and what it means for me.	1(1.0)	13(13.5)	66(68.8)	16(16.7)	3.01	0.589
4	I think a lot about how my life will be affected by my ethnic group membership.	4(4.2)	25(26.0)	56(58.3)	11(11.5)	2.77	0.703
5	I am happy that I am a member of the group I belong to.	0	7(7.3)	59(61.5)	30(31.3)	3.24	0.576
6	I have a strong sense of belonging to my own ethnic group.	0	21(21.9)	50(52.1)	25(26.0)	3.04	0.695
7	I understand pretty well what my ethnic group membership means to me.	0	23(24.0)	61(63.5)	12(12.5)	2.89	0.596
8	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	3(3.1)	42(43.8)	43(44.8)	8(8.3)	2.58	0.691
9	I have a lot of pride in my ethnic group.	0	17(17.7)	48(50.0)	31(32.3)	3.15	0.696
10	I participate in cultural practices of my own group, such as special food, music, or customs.	2(2.1)	34(35.4)	48(50.0)	12(12.5)	2.73	0.703
11	I feel a strong attachment towards my own ethnic group.	2(2.1)	32(33.3)	49(51.0)	13(13.5)	2.76	0.707
12	I feel good about my cultural or ethnic background.	0	5(5.2)	58(60.4)	33(34.4)	3.29	0.560

Table 4.8: Ethnic identity of the academic staff

No	Statement	ACADEMIC STAFF					
		Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Mean of 4	SD
1	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	0	1(16.7)	5(83.3)	0	2.83	0.408
2	I am active in organizations or social groups that include mostly members of my own ethnic group.	1(16.7)	2(33.3)	2(33.3)	1(16.7)	2.50	1.049
3	I have a clear sense of my ethnic background and what it means for me.	0	0	5(83.3)	1(16.7)	3.17	0.408
4	I think a lot about how my life will be affected by my ethnic group membership.	0	1(16.7)	5(83.3)	0	2.83	0.408
5	I am happy that I am a member of the group I belong to.	0	1(16.7)	2(33.3)	3(50.0)	3.33	0.816
6	I have a strong sense of belonging to my own ethnic group.	0	1(16.7)	4(66.7)	1(16.7)	3.00	0.632
7	I understand pretty well what my ethnic group membership means to me.	0	0	6(100)	0	3.00	0
8	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	0	2(33.3)	4(66.7)	0	2.67	0.516
9	I have a lot of pride in my ethnic group.	0	0	4(66.7)	2(33.3)	3.33	0.516
10	I participate in cultural practices of my own group, such as special food, music, or customs.	0	2(33.3)	4(66.7)	0	2.67	0.516
11	I feel a strong attachment towards my own ethnic group.	0	1(16.7)	5(83.3)	0	2.83	0.408
12	I feel good about my cultural or ethnic background.	0	1(16.7)	4(66.7)	1(16.7)	3.00	0.632

Tables 4.7 and 4.8 show that most of the students and academic staff felt belonging and proud of their ethnic group (mean > 3) though they were not actively involved with their ethic social group or organisations (mean < 2). There was no significant difference in ethnic identity between students and academic staff (Students mean rank = 51.18; Academics staff mean rank = 56.67; U= 319 z = 0.442 p = 0.659 r = 0.043). Both academic staff and students were similar regarding their ethnic identity. They identified themselves as people who search and affirm their own ethnicity.

Uncivil behaviour in nursing academic environment

Uncivil behaviour in nursing academic environment will be presented in four categories: (a) perceived students' behaviours, (b) perceived academic staff members' behaviours, (c) perceived nurses' behaviours and (d) uncivil behaviour as a problem. In addition, nonparametric test (Mann-Whitney) was used to compare the opinions of perceived uncivil behaviour between students and academic staff.

1) Perceived student behaviours

Perceived students' behaviours derived from the INE survey provided 19 items reflecting students' disruptive behaviours (Table 4.9) and 22 items of students' threatening behaviours (Table 4.10). The survey employed a Likert scale range 1-4 (1=never, 2=sometimes, 3=usually, 4=always).

Table 4.9: Perception of students' disruptive behaviours

Students' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Acting bored or apathetic	2.47	2	0.664	2.5	2	0.837	2.48	2	0.696	2.17	2	0.408
2. Making groans to show disapproval	2.51	2	0.821	2.67	2.5	0.816	2.4	2	0.761	2	2	0.894
3. Making sarcastic remarks or gestures	2.49	2	1.081	3.33	3.5	0.816	1.98	2	0.729	1.83	2	0.753
4. Sleeping in class	2.11	2	0.983	2.33	2	1.033	1.96	2	0.798	1.67	2	0.516
5. Not paying attention in class	2.49	2	0.821	3.5	3.5	0.548	2.39	2	0.789	2.67	2.5	0.816
6. Holding conversations that distract you or others	2.77	3	0.864	3.83	4	0.408	2.44	2	0.834	2.83	3	0.753
7. Refusing to answer direct questions	1.86	2	0.858	2.5	2.5	0.548	1.69	2	0.73	1.83	2	0.753
8. Using a computer to do unrelated classroom work	2.26	2	0.92	3.67	4	0.516	2.24	2	0.855	2.5	2	0.837
9. Using phones or cell phones during class	2.66	3	0.916	3.33	3.5	0.816	2.66	3	0.961	2.33	2	1.033
10. Arriving late for class	2.63	2	0.855	3.17	3	0.753	2.49	2	0.826	2.33	2	0.816
11. Leaving class ahead of schedule	1.99	2	1.061	3.17	3	0.753	1.8	2	0.829	1.67	2	0.516
12. Missing class (not present in class/ being absent)	2.02	2	1.015	2.5	2.5	1.049	1.89	2	0.793	1.5	1.5	0.548
13. Being unprepared for class	2.51	2	0.768	3.5	3.5	0.548	2.53	2	0.739	2.83	2.5	0.983
14. Creating tension by dominating class discussion	2.42	2	1.053	2.5	2.5	0.548	2.02	2	0.894	1.67	2	0.516
15. Cheating on exams or quizzes	2.15	2	1.114	3.33	4	1.033	1.74	2	0.837	1.67	2	0.516
16. Demanding make-up exams, extensions for assignments, grade changes, or other special favours	2.26	2	0.965	3	3	0.632	2.03	2	0.839	2.33	2	1.033
17. Not charting nursing care	2.31	2	0.987	3.33	3.5	0.816	1.88	2	0.684	2	2	0.894
18. Being unprepared for the clinical experience	2.54	2	0.983	3	3	0.632	2.11	2	0.724	2.17	2	0.753
19. Not admitting an error made in patient care	2.39	2	1.155	3	3	0.894	1.6	2	0.657	1.83	2	0.753
Total	2.36	2	0.94	3.06	3	0.74	2.12	2	0.79	2.10	2	0.74
	Students' mean rank = 49.75 Academic staff mean rank = 82.33 U = 473; p = 0.008; z = 2.633; r = 0.261						Students' mean rank = 51.49 Academic staff mean rank = 51.67 U = 289; p = 0.989; z = 0.014; r = 0.0013					

Table 4.10: Perception of students' threatening behaviours

Students' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Taunting or showing disrespect to other students	2.58	3	1.053	2.83	3	0.753	1.92	2	0.66	1.5	1.5	0.548
2. Taunting or showing disrespect to faculty	2.55	3	1.15	3	3	1.095	1.85	2	0.767	1.83	2	0.753
3. Taunting or showing disrespect to nurses	2.43	2	1.131	2.83	3	1.169	1.65	2	0.632	1.5	1.5	0.548
4. Taunting or showing disrespect to patients	2.29	2	1.23	2.83	3.5	1.472	1.5	1	0.681	1.17	1	0.408
5. Challenging faculty staff knowledge or credibility	2.51	3	1.095	2.83	3	1.169	1.69	2	0.685	1.83	2	0.753
6. Challenging nurses knowledge or credibility	2.36	3	1.037	2.5	2.5	1.378	1.6	2	0.64	1.67	1.5	0.816
7. Making harassing comments (racial, ethnic, gender) directed at other students	2.43	2	1.263	2.83	3	1.169	1.56	1	0.678	1.33	1	0.516
8. Making harassing comments (racial, ethnic, gender) directed at faculty staff	2.38	3	1.25	2.83	3	1.169	1.41	1	0.674	1.33	1	0.516
9. Making harassing comments (racial, ethnic, gender) directed at nurses	2.27	2	1.192	2.83	3	1.169	1.34	1	0.538	1.33	1	0.516
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.28	2	1.235	2.83	3	1.169	1.36	1	0.584	1.33	1	0.516
11. Making vulgar comments directed at other students	2.42	2	1.139	3	3	0.894	1.69	2	0.67	1.67	2	0.516
12. Making vulgar comments directed at faculty staff	2.42	2.5	1.295	2.83	3	1.169	1.39	1	0.689	1.33	1	0.516
13. Making vulgar comments directed at nurses	2.39	2	1.276	2.83	3	1.169	1.36	1	0.563	1.5	1.5	0.548
14. Making vulgar comments directed at patients	2.38	2	1.332	2.67	3	1.366	1.23	1	0.448	1.17	1	0.408
15. Sending inappropriate e-mails to other students	2.21	2	1.273	2.5	2.5	1.378	1.05	1	0.224	1.33	1	0.516
16. Sending inappropriate e-mails to faculty staff	2.27	2	1.326	3	3	1.095	1.08	1	0.279	1.67	1	1.033
17. Making threats of physical harm against other students	2.38	2	1.386	2.67	3	1.366	1.15	1	0.461	1	1	0
18. Making threats of physical harm against faculty staff	2.38	2	1.409	2.5	2.5	1.378	1.02	1	0.144	1	1	0
19. Damaging property	2.34	2	1.368	2.5	2.5	1.378	1.19	1	0.49	1	1	0
20. Making statements about having easy access to weapons or sharp objects	2.33	1	1.412	2.67	3	1.506	1.03	1	0.228	1	1	0
21. Neglecting patients in the clinical area	2.46	2.5	1.297	3	3.5	1.265	1.49	1	0.634	1.67	1.5	0.816
22. Charting patients are not completed	2.55	2	1.045	3.17	3.5	1.169	1.74	2	0.605	2.33	2.5	1.211
Total	2.39	2	1.24	2.79	3	1.22	1.42	1	0.54	1.43	1	0.52
	Students' mean rank = 50.87						Students' mean rank = 51.53					
	Academic staff mean rank = 61.58						Academic staff mean rank = 51.00					
	U = 348.5; p = 0.389; z = 0.861; r = 0.085						U = 285; p = 0.966; z = -0.043; r = -0.004					

Table 4.9 shows that there was a statistically significant difference between the students and academic staff (p value 0.008) regarding what was considered as perceived students' disruptive behaviours. For example, the students thought that students *usually* have disturbing conversations (median=3), while the academic staff members felt that this was *always* the case (median=4) (see number 6 Table 4.9).

Table 4.9 shows that there was no significant difference between students and staff experiencing or seeing students' disruptive behaviour in the past 12 months (p value 0.989). Both types of respondents stated that they have experienced or seen students' disruptive behaviour *sometimes* in the past 12 months (Total median=3; Table 4.9).

Table 4.10 shows that there were no statistically significant differences between students and staff experiencing or seeing students' threatening behaviours considered as disruptive in the past 12 months (p value 0.966). The majority of both respondent groups stated that the students' threatening behaviours were considered disruptive *sometimes or usually* (Total median: student= 2 and academic staff=3). However, most of the respondents stated that they had almost *never* experienced or seen the students' threatening behaviour in the past 12 months (Total median=1).

2) Perceived academic staff behaviours

Perceived academic staff behaviours consists of 21 items of disruptive behaviours and 22 items of threatening behaviours as provided in the INE survey. Table 4.11 reveals that there were no significant difference of the perceived academic staff disruptive behaviours that were considered disruptive and had been experienced or seen in the past 12 months between students and academic staff (p value 0.770). For example, most of the

respondents agreed that ineffective teaching methods of the academic staff were considered disruptive *usually* (see number 5; median=3) and it has occurred *sometimes* in the past 12 months (median =2).

Table 4.12 reveals that there were no statistically significant differences of perceived academic staff threatening behaviours that were considered disruptive and have been experienced (p value 0.492) or seen in the past 12 months between students and academic staff (p value 0.285). For example, most of the respondents reported that making vulgar comments directed at students were *usually* considered disruptive (number 11; median =3). On the other hand, most respondents have *never* experienced or seen the academic staff disrespect the nurses (number 3; median=1).

Table 4.11: Perception of academic disruptive behaviours

Academics' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Arriving late for schedule activities	2.55	2	0.84	3	3	0.89	2.12	2	0.51	2	2	0.00
2. Leaving class ahead of schedule	1.93	2	0.90	3	3	0.89	1.69	2	0.65	1.83	2	0.41
3. Cancelling scheduled activities without warning	2.59	3	1.16	3.16	3	0.98	1.78	2	0.69	1.5	1.5	0.54
4. Being unprepared for scheduled activities	2.57	3	1.11	2.83	3	1.17	1.64	2	0.63	1.66	2	0.52
5. Ineffective teaching style/methods	2.85	3	0.99	3	3	0.89	2.13	2	0.67	2	2	0.63
6. Deviating from the course syllabus, changing assignments or test dates	2.60	2	1.22	3	3.5	1.26	1.62	2	0.67	1.83	2	0.41
7. Being inflexible, rigid and authoritarian	2.78	3	1.07	2.66	2.5	0.81	1.93	2	0.75	1.83	2	0.41
8. Punishing the entire class for one student's misbehaviour	2.38	2	1.32	2.66	2.5	1.21	1.17	1	0.40	1	1	0.00
9. Making statements about being disinterested in the subject matter	2.18	2	1.19	2.5	2.5	1.04	1.21	1	0.48	1.33	1	0.52
10. Being distant and cold towards others (unapproachable, reject students opinions)	2.51	3	1.25	2.83	3	1.17	1.43	1	0.64	1.33	1	0.52
11. Refusing or reluctant to answer questions	2.42	2	1.30	2.66	3	1.03	1.30	1	0.56	1.33	1	0.52
12. Subjective grading of students	2.79	3	1.14	2.83	3	1.17	1.92	2	0.86	1.83	2	0.75
13. Making condescending remarks or put downs	2.48	2	1.25	2.83	3	1.17	1.51	1	0.65	1.33	1	0.52
14. Exerting superiority, showing arrogance towards others	2.54	3	1.23	3	3	1.09	1.50	1	0.69	1.33	1	0.82
15. Threatening to fail student for not complying with faculty's demands	2.55	3	1.35	2.83	3	1.17	1.36	1	0.67	1.17	1	0.41
16. Making rude gestures or behaviours towards others	2.43	2	1.42	2.83	3.5	1.47	1.11	1	0.41	1	1	0.00
17. Ignoring disruptive student behaviour	2.59	3	1.15	2.83	3	1.17	1.69	2	0.64	1.83	2	0.75
18. Being unavailable to respond to the students outside of class in office hours	2.40	2	1.28	2.66	3	1.36	1.38	1	0.59	1.33	1	0.82
19. Being unavailable to respond to the students on the patient care unit	2.45	2.5	1.27	2.33	3	1.03	1.32	1	0.57	1.33	1	0.52
20. Being unavailable to respond to the students for practice in the skills laboratory	2.43	2	1.27	2.5	3	1.22	1.29	1	0.57	1.17	1	0.41
21. Taking over from the student when providing patient care	2.32	2	1.13	2.5	2.5	1.37	1.45	1	0.58	1.5	1	0.84
Total	2.49	2	1.18	2.78	3	1.12	1.55	1	0.61	1.50	1	0.49
	Students' mean rank = 51.04 Academic staff mean rank = 58.92 U = 332.5; p = 0.527; z = 0.633; r = 0.062						Students' mean rank = 51.71 Academic staff mean rank = 48.08 U = 267.5; p =0.770; z = -0.292; r=-0.028					

Table 4.12: Perception of academic threatening behaviours

Academics' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Med'n*	*SD*	*Mean*	*Med'n*	*SD*	*Mean*	*Med'n*	*SD*	*Mean*	*Med'n*	*SD*
1. Taunting or showing disrespect to students	2.58	3	1.27	3	3.5	1.26	1.46	1	0.68	1.5	1.5	0.55
2. Taunting or showing disrespect to other faculty staff	2.46	3	1.25	3.17	3.5	1.17	1.29	1	0.50	1.83	2	0.75
3. Taunting or showing disrespect to nurses	2.40	3	1.32	3	3.5	1.26	1.19	1	0.53	1.33	1	0.52
4. Taunting or showing disrespect to patients	2.37	3	1.31	3	3.5	1.26	1.14	1	0.38	1.33	1	0.52
5. Challenging other faculty staff knowledge or credibility	2.37	3	1.31	3.17	3.5	1.17	1.27	1	0.49	1.67	2	0.52
6. Challenging nurses knowledge or credibility	2.35	2	1.22	3	3.5	1.26	1.25	1	0.46	1.67	2	0.52
7. Making harassing comments (racial, ethnic, gender) directed at students	2.46	3	1.33	3	3.5	1.26	1.17	1	0.45	1.17	1	0.41
8. Making harassing comments (racial, ethnic, gender) directed at other faculty staff	2.37	3	1.32	3	3.5	1.26	1.09	1	0.29	1.17	1	0.41
9. Making harassing comments (racial, ethnic, gender) directed at nurses	2.38	3	1.33	3	3.5	1.26	1.10	1	0.31	1.17	1	0.41
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.41	3	1.33	3	3.5	1.26	1.06	1	0.24	1.17	1	0.41
11. Making vulgar comments directed at students	2.60	3	1.31	2.67	3	1.03	1.35	1	0.63	1.5	1.5	0.55
12. Making vulgar comments directed at other faculty	2.42	3	1.33	2.67	3	1.03	1.13	1	0.37	1.33	1	0.52
13. Making vulgar comments directed at nurses	2.45	3	1.33	2.83	3	1.17	1.10	1	0.31	1.17	1	0.41
14. Making vulgar comments directed at patients	2.48	3	1.35	2.83	3	1.17	1.06	1	0.24	1.17	1	0.41
15. Sending inappropriate e-mails to students	2.38	3	1.31	2.67	2.5	1.21	1.07	1	0.26	1.33	1	0.52
16. Sending inappropriate e-mails to other faculty staff	2.30	2	1.26	2.83	3	1.17	1.04	1	0.20	1.5	1	0.84
17. Making threats of physical harm against students	2.48	3	1.38	3	3.5	1.26	1.03	1	0.17	1.17	1	0.41
18. Making threats of physical harm against other faculty staff	2.45	3	1.34	2.83	3	1.17	1.04	1	0.25	1.17	1	0.41
19. Damaging property	2.43	3	1.344	2.67	2.5	1.21	1.06	1	0.28	1.17	1	0.41
20. Making statements about having easy access to weapons	2.47	3	1.34	2.67	2.5	1.21	1.03	1	0.17	1.17	1	0.41
21. Neglecting patients in the clinical area	2.44	2.5	1.33	3	3.5	1.26	1.09	1	0.29	1.33	1	0.52
22. Charting patients are not completed	2.44	2	1.25	3.4	4	0.89	1.21	1	0.41	1.4	1	0.89
Total	2.43	3	1.31	2.93	3	1.19	1.15	1	0.36	1.34	1	0.51
	Students' mean rank = 51.00 Academic staff mean rank = 59.50 U = 336; p = 0.492; z = 0.687; r = 0.048						Students' mean rank = 50.74 Academic staff mean rank = 63.67 U = 361; p =0.285; z = 1.069; r=0.105					

3) Perceived nurse behaviours

Nurses' disruptive behaviours were assessed using 16 items and 20 items reflecting nurses' threatening behaviours from the INE survey. Table 4.13 shows that there were no statistically significant differences regarding perceived nurses' disruptive behaviour as experienced or seen in the past 12 months between students and academic staff (p value 0.792). Both respondents agreed that the nurses' disruptive behaviours were *usually* considered disruptive, for example being inflexible, rigid and authoritarian (number 6; Table 4.13; median=3).

Table 4.14 shows that there were no statistically significant differences regarding perceived nurses' threatening behaviour that was considered as disruptive and had been experienced (p value 0.652) or seen by students in the past 12 months between students and academic staff (p value 0.859). For example, the majority of students and academic staff thought that nurses conducted a number of threatening behaviours *sometimes*, such as neglecting patient in the clinical settings (Table 4.14; number 19; median=3).

Table 4.13: Perception of nurses' disruptive behaviours

Nurses' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Arriving late for work	2.79	3	0.89	2.67	2.50	0.82	2.02	2	0.54	1.83	2.00	0.41
2. Leaving work early	2.58	2	1.08	2.67	2.50	0.82	1.69	2	0.60	1.33	1.00	0.52
3. Being unprepared for patient care	2.76	3	0.99	3.00	3.00	0.89	1.93	2	0.64	1.67	2.00	0.52
4. Refusing to allow students to perform patient care	2.96	3	0.89	3.00	3.50	1.26	2.18	2	0.58	1.50	1.50	0.55
5. Ineffective teaching style/methods	2.82	3	0.93	2.67	2.50	1.21	2.07	2	0.62	1.33	1.00	0.52
6. Being inflexible, rigid and authoritarian	2.97	3	0.98	2.83	3.00	1.17	2.19	2	0.69	1.50	1.50	0.55
7. Making statements about being disinterested in working with students	2.80	3	1.08	2.67	3.00	1.03	1.96	2	0.71	1.33	1.00	0.52
8. Being distant and cold towards others (unapproachable, reject students' opinions)	2.88	3	1.03	2.67	3.00	1.03	2.04	2	0.71	1.33	1.00	0.52
9. Refusing or reluctant to answer questions	2.75	3	1.01	2.67	3.00	1.03	1.87	2	0.62	1.33	1.00	0.52
10. Subjective grading of students	2.99	3	0.96	2.67	3.00	1.03	2.22	2	0.76	1.33	1.00	0.52
11. Making condescending remarks or put downs	2.80	3	1.14	3.17	3.50	0.98	1.86	2	0.72	1.50	1.50	0.55
12. Exerting superiority, showing arrogance towards others	2.76	3	1.21	3.17	3.50	0.98	1.72	2	0.64	1.50	1.00	0.84
13. Threatening to fail student for not complying with nurse's demands	2.58	3	1.31	3.17	3.50	0.98	1.31	1	0.58	1.67	2.00	0.52
14. Making rude gestures or behaviours toward others	2.48	3	1.29	3.00	3.50	1.26	1.38	1	0.58	1.67	2.00	0.52
15. Being unavailable to respond to the students on the patient care unit	2.74	3	1.13	3.00	3.50	1.26	1.77	2	0.62	1.17	1.00	0.41
16. Taking over from the student when providing patient care	2.65	2.5	1.07	2.60	2.00	1.34	1.91	2	0.67	1.20	1.00	0.45
Total	2.77	3	1.06	2.60	3	1.34	1.88	2	0.64	1.20	1	0.45
	Students' mean rank = 50.47						Students' mean rank = 51.69					
	Academic staff mean rank = 67.92						Academic staff mean rank = 48.42					
	U = 385.5; p = 0.161; z = 1.403; r = 0.138						U = 269.5; p =0.792; z = -0.264; r=-0.026					

Table 4.14: Perception of nurses' threatening behaviour

Nurses' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Taunting or showing disrespect to students	2.68	3	1.11	2.69	3	1.12	1.64	2	0.58	1.65	2	0.58
2. Taunting or showing disrespect to faculty	2.54	3	1.19	2.54	3	1.19	1.36	1	0.54	1.37	1	0.54
3. Taunting or showing disrespect to other nurses	2.69	3	1.07	2.69	3	1.07	1.73	2	0.61	1.73	2	0.61
4. Taunting or showing disrespect to patients	2.81	3	1.11	2.81	3	1.11	1.81	2	0.67	1.81	2	0.67
5. Challenging faculty staff knowledge or credibility	2.53	3	1.23	2.53	3	1.23	1.39	1	0.58	1.38	1	0.58
6. Challenging nurses knowledge or credibility	2.62	3	1.19	2.62	3	1.19	1.62	1	0.73	1.62	1	0.72
7. Making harassing comments (racial, ethnic, gender) directed at students	2.69	3	1.27	2.69	3	1.27	1.35	1	0.59	1.35	1	0.59
8. Making harassing comments (racial, ethnic, gender) directed at faculty	2.60	3	1.33	2.60	3	1.33	1.19	1	0.46	1.19	1	0.46
9. Making harassing comments (racial, ethnic, gender) directed at other nurses	2.64	3	1.26	2.64	3	1.26	1.29	1	0.52	1.29	1	0.52
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.73	3	1.24	2.74	3	1.24	1.37	1	0.56	1.37	1	0.56
11. Making vulgar comments directed at students	2.71	3	1.21	2.71	3	1.21	1.44	1	0.52	1.44	1	0.52
12. Making vulgar comments directed at faculty	2.55	3	1.28	2.55	3	1.28	1.21	1	0.48	1.21	1	0.48
13. Making vulgar comments directed at other nurses	2.63	3	1.25	2.63	3	1.25	1.46	1	0.63	1.46	1	0.63
14. Making vulgar comments directed at patients	2.71	3	1.25	2.71	3	1.25	1.48	1	0.65	1.48	1	0.65
15. Making threats of physical harm against students	2.53	3	1.35	2.53	3	1.35	1.10	1	0.31	1.10	1	0.31
16. Making threats of physical harm against faculty	2.54	3	1.33	2.54	3	1.33	1.07	1	0.30	1.07	1	0.30
17. Damaging property	2.48	3	1.32	2.48	3	1.32	1.12	1	0.362	1.12	1	0.36
18. Making statements about having easy access to weapons	2.5	3	1.34	2.50	3	1.34	1.05	1	0.27	1.05	1	0.27
19. Neglecting patients in the clinical area	2.80	3	1.21	2.80	3	1.21	1.66	2	0.66	1.66	2	0.66
20. Charting patients are not completed	2.92	3	1.08	2.93	3	1.08	1.95	2	0.79	1.95	2	0.79
Total	2.65	3.00	1.23	2.65	3.00	1.23	1.41	1	0.54	1.42	1	0.54
	Students' mean rank = 51.17 Academic staff mean rank = 56.75 U = 319.5; p = 0.652; z = 0.652; r = 0.064						Students' mean rank = 51.37 Academic staff mean rank = 53.58 U = 300.5; p =0.859; z = 0.178; r=0.017					

Uncivil behaviour as a problem

The findings of the study demonstrated that some students (49%) and the majority of academic staff (83.3%) stated that uncivil behaviour in nursing education environment was a serious problem, as shown in Table 4.15 below:

Table 4.15: The extent of uncivil behaviour in the nursing academic environment

Question	*Respondents*			
	Students		*Staff*	
To what extent do you think uncivil behaviour in the nursing academic environment is a problem?	*N*	*%*	*N*	*%*
No problem at all	1	1	0	0
Mild problem	7	7.3	0	0
Moderate problem	41	42.7	1	16.7
Serious problem	47	49	5	83.3
I don't know/can't answer	0	0	0	0
Total	96	100	6	100

The survey further illuminates that uncivil behaviour was a problem in the classroom, the skill laboratory and clinical practice. Some of the students (43.8%) and half of the academic staff (50%) thought that student and academic staff were equally likely to engage in uncivil behaviour in the classroom (Table 4.16).

Table 4.16: Perception of uncivil behaviour is a problem in classroom

Question	*Respondents*			
	Students		*Academic*	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	*N*	*%*	*N*	*%*
Academic members are much more likely	4	4.2	1	16.7
Academic members are a little more likely	2	2.1	0	0
About equal	42	43.8	3	50
Students are a little more likely	5	5.2	0	0
Students are much more likely	39	40.6	2	33.3
Don't know	3	3.1	0	0
Total	95	100	6	100

Similarly, Table 4.17 shows that less than half students (40.6%) and almost one third of the academic staff (66.7%) thought student and academic staff were equally likely to engage in uncivil behaviour in the skill laboratory.

Table 4.17: Perception of uncivil behaviour is a problem in skill laboratory

Question	*Respondents*			
	Students		*Academic*	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	*N*	*%*	*N*	*%*
Academic members are much more likely	12	12.5	1	16.7
Academic members are a little more likely	5	5.2	0	0
About equal	39	40.6	4	66.7
Students are a little more likely	2	2.1	0	0
Students are much more likely	31	33.3	1	16.7
Don't know	4	4.2	0	0
Total	96	100	6	100

On the other hand, Table 4.18 shows that few students perceived that nurses were a little more likely to engage in uncivil behaviour in the clinical practice area (37.4%) while none of the academic staff perceived that nurses were more likely to engage in uncivil bahaviour. In addition, half of the academic staff thought that academic members/clinical educators/nurses/students were about equal in taking part of uncivil behaviour in the classroom.

Table 4.18: Perception of uncivil behaviour is a problem in clinical practice

Question	*Respondents*			
	Students		*Academic*	
Based on your experiences or perceptions, do you think that students or academic members/clinical educators or nurses are more likely to engage in uncivil behaviour in clinical practice?	*N*	*%*	*N*	*%*
Academic members/clinical educators are much more likely	9	7.8	1	16.7
Academic members/clinical educators are a little more likely	3	2.6	0	0
Nurses are much more likely	7	6.1	1	16.7
Nurses are a little more likely	43	37.4	0	0
Students are much more likely	6	5.2	1	16.7
Students are a little more likely	13	11.3	0	0
About equal	24	20.9	3	50
Don't know	10	8.7	0	0
Total	115	100	6	100

Furthermore, the survey also identified the settings where most instances of uncivil behaviour occurred in nursing education (Table 4.19).

Table 4.19: Perception of where uncivil behaviour occurs most frequently

Question	*Respondents*			
	Students		*Academic*	
In your opinion, where are uncivil behaviours the most prevalent?	*N*	*%*	*N*	*%*
Traditional classroom	46	47.9	4	66.7
Skill laboratory	6	6.3	0	0
Clinical unit	41	42.1	2	33.3
Total	93	100	6	100

Table 4.19 shows that almost half of the students and almost one third of the academic staff thought that uncivil behaviour most frequently occurred in the traditional classroom. However, they also thought that there were many instances of uncivil behaviour in clinical practice.

Uncivil behaviour in the context of ethnicity, religious faith and socio-economic background

As explained in chapter three (section 3.1.3) regarding the emerge propositions of this study, this section will test the propositions of this study including:

1. Students and academic staff are perceived differently regarding incivility in Indonesia nursing education.

2. Students and academic staff's perceptions of incivility in Indonesia nursing education are influenced by their ethnicity, religious faith and socio-economic background.

Therefore, non-parametric tests (Kruskal-Wallis/Mann-Whitney/Spearman) were used to compare or correlate the uncivil behaviours to respondents' ethnicity/ethnic identity/religion/religious faith/SES. The tables show that there were a number of correlations or differences that were statistically significant, as shown in Tables 4.20-22.

Table 4.20 shows the results of the statistical test with students as respondents. There were four null hypotheses that were rejected according to the students' opinions ($p<0.05$). It appears that the perceived uncivil behaviour relates to respondents' religious backgrounds as well as ethnic identity.

Table 4.20: Results of the significance statistical test with students as respondents

No	*Null hypothesis*	*Statistical test findings*
1	The distribution of perceived students' disruptive behaviour that considered disruptive is the same across categories of religion	H(3)= 9.393; p= 0.025
2	The distribution of perceived students' threatening behaviour considered as disruptive is the same across categories of religion	H(3)= 10.374; p= 0.016 Pairwise comparisons with adjusted p-values: **Islam-catholic** (p= 0.037, r = -0.279) **Christian-catholic** (p= 0.016, r = -0.305)
3	The distribution of perceived academics' disruptive behaviour considered as disruptive is the same across categories of religion	H(3)= 8.080; p= 0.044 Pairwise comparisons with adjusted p-values: **Islam-catholic** (p= 0.035, r = -0.281)
4	There is no significant relationship between the perceived students' threatening behaviour considered as disruptive and ethnic identity	r_s= 0.227; 95% bca ci [0.015, 0.429]; p= 0.026
5	The distribution of perceived academics' threatening behaviour that considered as disruptive is the same across categories of employment background	H(3)=10.151; p value=0.017

Table 4.21 shows the results of the statistical test findings according to the academic staff members' opinions. There were two perceived uncivil behaviours with a significant correlation to ethnic identity and religious faith/ practice of the respondents ($p<0.05$).

Table 4.21: Results of the significance statistical test with academics staff as respondent

No	*Null hypothesis*	*Statistical test findings*
1	There is no significant relationship between the perceived nurses' threatening behaviour considered as disruptive and ethnic identity	τ= 0.828; 95% bca ci [., .]; P= 0.022
2	There is no significant relationship between the perceived students' disruptive behaviour experienced or seen in the past 12 months and religious faith/practice	τ= - 0.856; 95% bca ci [-1.000, 0.645]; P= 0.024

Table 4.22 further showed the findings of the significance statistical test according to the total number of respondents ($p<0.05$). Most of the findings revealed that perceived uncivil behaviours were significantly different based on respondents' religious backgrounds.

Table 4.22: Results of the statistical test with total respondents

No	*Null hypothesis*	*Statistical test findings*
1	The distribution of perceived students' disruptive behaviour considered as disruptive is the same across categories of religion	H(3) = 10.669, p = 0.014 Pairwise comparisons with adjusted p-values: **Islam-catholic** (p= 0.025, r= -0.283)
2	The distribution of perceived students' threatening behaviour considered as disruptive is the same across categories of religion	H(3) = 8.721; p= 0.008 Pairwise comparisons with adjusted p-values: **Islam-catholic** (p= 0.021, r = -0.288) **Christian- catholic** (p= 0.008, r= -0.316)
3	The distribution of perceived students' threatening behaviour experienced or seen in the past 12 months is the same across categories of religion	H(3) = 8.832; p= 0.032 Pairwise comparisons with adjusted p-values: none
4	The distribution of perceived academics' disruptive behaviour considered as disruptive is the same across categories of religion	H(3) = 9.140; p= 0.027 Pairwise comparisons with adjusted p-values: **Islam-catholic** (p= 0.021, r= -0.288)
5	The distribution of perceived academics' threatening behaviour considered as disruptive is the same across categories of religion	H(3) = 7.867; p= 0.049 Pairwise comparisons with adjusted p-values: none
6	There was no significant relationship between the perceived students' threatening behaviour considered as disruptive and ethnic identity	r_s= 0.202; 95% bca ci [0.009, 0.383]; P= 0.041
7	The distribution of perceived academics' threatening behaviour that considered as disruptive is the same across categories of employment background	H(5)=11.260; p value=0.046

Summary of the quantitative findings

It is noted that majority of the respondents were female, Christians, Indo-Malay with Batak as sub-ethnic and in the middle socio-economic status. Both participants (students and academic staff) reported that incivility was a serious problem in nursing education settings; the perpetrators were academic staff, student and nurse. The most places of the occurrence were Incivility mostly occurred in the classroom and clinical practice. There were also some different perception of incivility between students and academic staff such as perceived students' disruptive behaviour. The quantitative findings further revealed that perceived uncivil behaviours were statistically significant based on the participants' religion background.

4.2.2 Qualitative findings

This section will be discussed in two parts: 1) findings from the open-ended questions of the questionnaires and (2) findings from the face-to-face interviews and observations.

Findings from the questionnaires': open-ended questions

One hundred and two (102) participants comprising of six academic staff and 96 students answered the open-ended questions within the INE questionnaires. The questionnaires addressed the types of uncivil behaviour instances in nursing education, reasons for the instances, differences of the instances, as well as suggestions for addressing uncivil behaviour instances in nursing education.

The findings of the open-ended questions of the INE questionnaires are presented in Tables 4.23-4.30. Tables 4.23-4.24 presents the types of uncivil behaviour instances, tables 4.25-4.26 presents the reasons for these

instances, tables 4.27-4.28 presents the differences, and tables 4.29-4.30 presents the suggestions for managing the uncivil behaviour. The findings are presented in themes with illustrative examples that emerged from the narrative findings as well as the individual backgrounds of the respondents.

1) Types of instances

The respondents (academic staff and students) reported that there were many types of uncivil behaviour in nursing education. Table 4.23 shows the academics' opinions regarding ways or types of uncivil behaviour in nursing education. Based on what the academics reported three themes were developed as follows:

Table 4.23: Types of uncivil behaviour perceived by academics in nursing education

Themes	*Illustrative examples*	*Respondents context*
Ineffective communication	(001a) "there were information changes."	Senior lecturer, Batak, Christian
	(002a) "the ways of communication were not polite. Impolite communication: high tone, harsh."	Assistant lecturer, Chinese, Christian
	(006a) "in lab: [the students] felt that the clinical educators responded impolitely to them [when they asked some questions]."	Senior lecturer, Javanese, Catholic
Teaching-learning management issues	(001a) "using laptop, ipad, mobile phone when studying [in the classroom] that was not related to the course"	Senior lecturer, Batak, Christian
	(002a) "[the students] do not comply with the rules regarding appropriate clothes to wear."	Assistant lecturer, Chinese, Christian
	(006a) "in class: [the academics] do not finish the class on time. They come and finish the class not as outlined in the schedule.	Senior lecturer, Javanese, catholic
Professional issues	(004a) "between the academics, they disrespect each other"	Lecturer, Batak, Christian
	(006a) "in the laboratory [skills laboratory]: the clinical educator's responded [the students] in an uneducated way. The students felt that they were answered by the CI impolitely or harshly."	Senior lecturer, Javanese, Christian
	(003a) "in the clinical practice: [students or nurses] were sitting on the bed when conducting a physical examination of the patient."	Assistant lecturer, Batak, Christian

Data from academic staff at a private FoN showed that there were uncivil behaviours in nursing education such as a lack of effective communication, academic misconduct and ineffective management of teaching-learning. The academic staff claimed that there were information changes and impolite communication in nursing education. For example, the academic staff stated that students talked in a harsh tone and responded impolitely. The academic staff also proposed that there was misuse of technology and lack of discipline in nursing education. Lack of discipline refers to poor commitment of people to obey rules in nursing education such as lack of punctuality. The academic staff in this study further stated that there were behaviours that were perceived as uncivil, such as disrespect of others and unprofessional behaviour in nursing education. Moreover, the academic staff provided examples of unprofessional behaviour such as responding to students in an uneducated way and sitting on patients' beds whilst examining them, however, sitting on a patients' bed is not always perceived as improper behaviour. For example, if necessary, a nurse can sit on the bed while assessing the patient. The reason for this is for the nurse to maintain a good posture, or to minimise lower back pain that nurses commonly suffer from, or to promote good rapport with patients.

Table 4.24 shows the students' opinions regarding ways or types of uncivil behaviours in nursing education in terms of three themes they identified. Findings that emerged from students at the private FoN showed that perceived uncivil behaviours in nursing education included verbal and non-verbal issues, misuse of technology and being unprofessional. Students described that there were occurrences of speaking impolitely and poor attitudes of people involved in nursing education. For example, nurses undermined other nurses, and students disrespected academic staff when teaching in the classroom.

The students also stated that there were instances of using technology such as laptops, iPads and mobile phones for things unrelated to classroom work during the class, as well as damaging and making the clinical skills instruments unclean. The students further expressed that superiority such as students' arrogance and unprofessional conduct happened in nursing education. Unprofessional conduct describes improper actions that violate nurses' code of ethics. For example, there was an unwillingness of nurses to work with students in clinical practice.

Table 4.24: Types of uncivil behaviour perceived by students in nursing education

Themes	*Illustrative examples*	*Respondents context*
Communication issues	(003s) "when people talk impolitely, insult others. Usually, the conversation is about race or ethnic issues, in which it is sometimes that they want to make a joke but it is too much [harsh]."	Female, year 3, Islam, mixed: Javanese-Sundanese
	(060s) "students offend others by being sarcastic to the lecturers or nurses. Nurses insult their colleagues behind them. The lecturers were angry towards others lecturers."	Male, profession program, Christian, Batak
	(018s) "most people cannot tolerate when people joke in a racist way."	Male, year 3, Christian, Batak
	(067s) "...impolite attitude toward academics."	Female, professional program, catholic, Chinese
	(089s) "the lecturers respond to students improperly when the students makes a mistake in the skills laboratory or clinical practice. This condition makes the students for feeling of being undermined."	Female, year 4, Christian, Batak
	(045s) "in the class room: the students come late, disrespected other students and lecturers. In the clinical practice: [the nurses] undermined other nurses or students."	Male, profession program, Christian, Batak
	(085s) "the students do not respect the lecturers when teaching. "	Female, year 4, Christian, Papua
Technology or instruments misuse	(015s) "the students neglect the academic staff when teaching by playing an electronic device."	Female, year 3 Christian Batak
	(030s) "in the classroom: the students use laptop/internet that is not related to teaching materials while learning."	Female, year 3 Christian, Manadonese
	(033s) "some students use laptop, mobile phone that are unrelated to classroom work."	Female, profession program, Christian, Javanese

	(020s) "damaging/making dirty the instruments in the skills laboratory"	Female, year 3, Christian, Batak
	(052s) "in the skills laboratory: the students do not follow the procedure that has been taught before by the lecturer."	Female, profession program, Christian, Batak
Professional issues	(008s) "feeling of being more okay than others"	Female, year 3, Christian, Batak
	(072s) "in the [skills] laboratory and clinical practice: the student dominates other students by feeling of being cleverer [than others].	Female, profession program, Christian, mixed: Batak-Nias
	(056s) "subjectivity of the students, academics or nurses"	Female, profession program, Christian, mixed Dayak-Manado-Dayak,
	(066s) "the academic staff pressed on students hardly in the process of dissertation consultation."	Female, profession program, Christian, Ambonese
	(069s) "the nurses do not want the students to be involved in the nurses' works."	Female, profession program, Christian, Manadonese
	(011s) "the academics do not prepare well for teaching in class."	Male, year 3, Christian, Manadonese
	(090s) "in the clinical practice: neglecting patient "	Male, year 4, Christian, Batak
	(062s) "in the clinical practice: the documentation done in the report were different with the actual care provided."	Female, profession program, Christian, Batak

It is noted that the findings that emerged from data by both academic staff and students have similar themes regarding the type of uncivil behaviour, although named in a different way. Both respondents revealed that there were uncivil behaviour instances at the private FoN related to communication issues, unprofessional behaviour and misuse of technology or instruments.

2) Reasons for the instances of uncivil behaviour

The respondents also provided their opinions related to the reasons for the occurrence of uncivil behaviour in nursing education. Table 4.25 contains three themes that emerged from the academics.

Table 4.25: Reasons for uncivil behaviour instances in nursing education according to academic staff

Themes	*Illustrative examples*	*Respondents context*
Communication Barriers	(001a) "communication is poor and unfulfilled someone's expectations in the process."	Senior lecturer, Batak, Christian
	(003a) "...maybe because of the generation differences then the attitude become change too."	Assistant lecturer, Batak, Christian
Personal stress	(002a) "physical: tired, exhausted because of work overload or learning weight."	Assistant lecturer, Chinese, Christian
	(002a) "psychology: [emotional] stress, infective coping..."	Assistant lecturer, Chinese, Christian
Overwhelming responsibilities	(004a) "because of the tasks demand or lots of concerns that have to be fulfilled by both lecturers and students."	Lecturer, Batak, Christian
	(006a) "less optimal of someone's responsibilities to god, their own selves, family and institutions thus cause uncivil behaviour actions."	Senior lecturer, Javanese, Christian

The academics at the private FoN reported their opinions regarding reasons for uncivil behaviour instances in nursing education which included communication issues, stress related issues and abundant responsibilities. Data showed that there was miscommunication and generation gaps as part of the communication barriers. The academic staff also claimed that there were physical stressors, such as tiredness or exhaustion and psychological issues such as being easily angered and ineffective coping mechanisms as the cause of uncivil behaviour occurrences in nursing education. The academic staff further identified that the demanding environment and work overload impedes personal development as well as exacerbating uncivil behaviour instances. A demanding academic environment and challenging responsibilities in nursing education led to a feeling of being overwhelmed. In addition, excessive workload impeded on personal achievement and led to a sense of dysfunction.

Table 4.26 shows three themes that students reported regarding reasons for uncivil behaviour instances in nursing education. Findings from students at the private FoN revealed opinions about why uncivil behaviour occur in

nursing education, including professionalism issues, ineffective communication and background influences. The students provided several examples of professional issues including nurses' superiority or know-it-all attitude, academic staff' ineffective teaching methods and academic staff members' subjective grading.

Table 4.26: Reasons of uncivil behaviour instances according to students

Themes	*Illustrative examples*	*Respondents context*
Professionalism issues	(033s) "the feeling of being more clever and know everything."	Female, profession program, Christian, Javanese
	(041s) "maybe due to the feeling of being cleverer, more knowledgeable, more experienced."	Female, profession program, Christian Batak
	(060s) "because of the feeling of superiority and a lack of ability when dealing with the work overload in a positive way."	Male, profession program, Christian, Batak
	(002s) "the teaching methods and styles of the academics were not effective."	Female, year 3, Islam, Javanese
	(040s) "because there were subjective grading that based on the feeling of being like or dislike toward others."	Female, profession program, Christian, Manadonese
Ineffective communication	(029s) "because the students misperceived the information given by the lecturers ... "	Female, year 3, Christian, mixed Javanese-Padang-Dutch
	(078s) "the communication is ineffective. (here you use full stops at the end of comments, so keep consistent – see box above too"	Female, catholic, Batak, attending profession program
	(033s) "sometimes there are is no respect between students, academic staff and nurses."	Female, profession program, Christian, Javanese
	(090s) "because of a lack of attitude to regard others." (Indentation?)	Male, year 4, Christian, Batak
Personal background influences	(039s) "lack of self-acceptance, destructive angry expression and disappointment, and most of the times staying in an unpleasant environment."	Female, profession program, Christian, mixed Javanese-Batak
	(091s) "because in academic environment, there are students who have their own characters, different attitudes to learn in which these conditions could lead to disturbing behaviour."	Male student, year 4, Christian, mixed Chinese-Sundanese
	(009s) "because maybe there were problems outside the academic environment that could not be solved then cause stress... "	Female, year 3, Christian, Papua
	(067s) "maybe because of the workloads influence the person's emotion as well as their tasks and their people nearby by neglecting them."	Female, profession program, catholic, Chinese
	(088s) "because of the individuals' ethnic-cultural differences that could influence the individuals' attitude and perception... "	Male, year 4, Islam, Sundanese
	(022s) "because students come from different family background in which their family habits and education might influence their attitude in the academic environment."	Female, year 3, Christian, Kupang
	(070s) "someone's characters or personalities that were affected by their family and environment in their daily life."	

	(056s) "maybe the influence of cultural background, life styles, environment and person's character that considered uncivil behaviour as a common thing."	Female, catholic, Javanese
	(084s) "the individuals' environment that provides uncivil behaviour attitude as a common thing could also influence someone to act in uncivil manner."	Female, profession program, Christian, mixed Dayak-Manado-Dayak Female, year 4, Islam, mixed Batak-Sundanese

The student nurses also reported that ineffective communication skills, such as unclear information, leads to misperceptions among students, and disrespect towards others which frequently occurred in nursing education. Some students further stated that individuals' attributes such as uncontrolled emotion, a lack of ability to learn, stress, poor coping skills and workloads influences uncivil behaviour instances in nursing education.

It is noted that there were similar themes that emerged from the opinions of students and academic staff in relation to the reasons for uncivil behaviour instances. The respondents' opinions revealed that the reason for uncivil behaviour at the private FoN was failure of people involved to communicate effectively, personal issues and the effects of working in stressful environments.

3) Differences of uncivil behaviour instances in nursing education

The respondents further described the differences of uncivil behaviour instances in nursing education settings. Table 4.27 shows the academic staff opinions on the differences of uncivil behaviour instances between the classroom, the skill laboratory and clinical practice in the private FoN.

Table 4.27: Differences of uncivil behaviours between classroom, skill laboratory and clinical unit (academics)

Themes	*Illustrative examples*	*Respondents context*
Harassments	(005a) "in the classroom: [the lecturers] threaten the students in front of the public or class. In the skills laboratory: the lecturers dealt with the students harshly. In the clinics: the lecturers were angry with the students in front of the patient."	Senior lecturer, Batak, Christian
Technology or instrument misuse	(001a) "in the classroom: the students pay more attention to the electronic devices such as laptop, iPad, and mobile phone than to the lecturers. In the skills laboratory: disturbing joking and using the instruments for joking or in an improper way."	Senior lecturer, Batak, Christian
Immediate responses of managing uncivil behaviour	(004a) "in the class and clinics [skills] laboratory, the uncivil behaviour can be identified and followed up immediately."	Lecturer, Batak, Christian
Severity of the uncivil behaviour costs	(002a) "in my opinion, basically it is similar, but tends to be dangerous if the uncivil behaviour happen in the clinics because it involves ethical issues and issues of patient safety as well as quality care matters."	Assistant lecturer, Chinese, Christian
	(004a) "uncivil behaviour is risky mainly if it happens in the clinical unit ... "	Lecturer, Batak, Christian

The academic staff at the private FoN provided opinions regarding the differences between uncivil behaviour instances in the classroom, skills laboratory and clinical unit. These included harassments, technology or instrument misuse, immediate response of managing uncivil behaviour, as well as severity of uncivil behaviour consequences. The academic staff provided some examples related to harassment such as threatening the students. In addition, the academic staff stated that the students focus more on their electronic devices than their class activities in classroom and use nursing skill instruments improperly in the laboratory. The academics also reported that people involved in nursing education responded quickly in the classroom and skills laboratory regarding uncivil behaviour instances. Moreover, the academics reported that the effects of uncivil behaviour instances were considered much more unsafe if they occurred in clinical practice.

Table 4.28 shows the students' opinions on the differences of uncivil behaviour instances between the classroom, skills laboratory and clinical practice in the private FoN. The narrative findings by students at the private FoN revealed that there were differences in uncivil behaviour seen in classroom, skills laboratory and clinical units.

Table 4.28: Differences of uncivil behaviours between classroom, skill laboratory and clinical unit (students)

Themes	*Illustrative examples*	*Respondents context*
Form of the uncivil behaviour instances	(024s) "the ways of the uncivil behaviour and usually uncivil [behaviour] happen when person undermine others. "	Male, year 3, Catholic, Timor
	(071s) "in the classroom and laboratory: negligence of the teaching-learning process. In the clinical unit: inappropriate behaviours (bad wording, harsh actions)."	Female, profession program, Catholic, Javanese
	(012s) "if in class maybe it is because of the bored feeling. While in the skills laboratory and clinics maybe it is because of unpreparedness."	Female, year 3, Christian, Manadonese
	(098s) "uncivil behaviour in the classroom stands out more because it might be due to the students' boredom, the ineffective teaching methods, and the length of the learning time."	Female, cc year 2, Christian, Timor
Person involved in uncivil behaviour instances	(033s) "in the classroom, the students tended to be more dominant to show uncivil behaviour than the lectures."	Female, profession program, Christian, Javanese
	(087s) "in the classroom and laboratory, the students behaved more uncivil than the lectures. "	Female, year 4, Christian, Chinese
	(063s) "in the classroom the students are the person who behave uncivil but in the clinical units the students are the victims. "	Female, profession program, catholic, Javanese
	(023s) "maybe if in the classroom or laboratory, uncivil behaviour affect the colleagues, but if in the clinics maybe it influences the patient's family."	Female, conversion class, Islam, mixed Dayak-Banjar
	(070s) "in the clinical unit, the [uncivil] behaviours occurred more between nurses and students than in the classroom or skills laboratory."	Female, profession program, Catholic, mixed Javanese-Dayak
Frequency and variations in uncivil behaviour	(061s) "more often happened in the classroom."	Female, profession program, Christian, Toraja
	(086s) "in the classroom it often occurred."	Female student, year 4, Christian, Papua
	(011s) however, in the clinics it happened frequently because of the workload."	Male student, year 3, Christian, Manadonese
	(043s) "more occur in the clinical units because there were many people from many ethnics backgrounds"	Female, profession program, Islam, Javanese
	(099s) "in the clinics it happened often due lack of students' discipline and no control by the academics."	Female, conversion class, Islam, Batak
	(011s) "in the classroom and skills laboratory, the uncivil behaviours were rarely being seen because the academics staff controlled the situations."	Male student, year 3, Christian, Manadonese
	(008s) "in the laboratory it rarely occurred because lots of individuals working or learning."	Female, year 3, Christian, Batak
	(099s) "in the class the uncivil behaviours were rarely being seen... "	Female, conversion class, Islam, Batak
	(086s)"... while in the clinical unit it does not occur often."	Female student, year 4, Christian, Papua

The differences were the forms of behaviours, the person encountered and frequency of uncivil behaviours. The students reported that uncivil behaviour instances in nursing education were typed as incidents where individuals were undervalued or undermined or harassed. The students also described that most of those individuals involved in the classroom and skills laboratory were academic staff and students. There were also more individuals who were involved in clinical units than in classroom and skills laboratory. The students further identified that in classrooms, students commit instances of uncivil behaviour but in clinics the students are the objects of uncivil behaviour carried out by the academic staff or nurse. This study further revealed that uncivil behaviour may occur in the classroom, skills laboratory and clinical unit either more or less often. The students also reported that behaviours occurred less often in the classroom because the situation is controlled. On the other hand, in the clinical setting it happened more often because the environment is less controlled.

It is noted that both academic staff and students shared similar views about the ways in which uncivil behaviour occurred but used different phrases to describe them. The findings showed that there were differences in uncivil behaviour instances between the settings in nursing education such as the form, the individuals and the effects.

Suggestions for addressing uncivil behaviour instances in nursing education

The respondents provided their opinions on how to manage uncivil behaviour in nursing education. Table 4.29 below shows the academic staff members' suggestions for addressing uncivil behaviour in nursing education in terms of three themes that emerged.

Table 4.29: Academics staff's suggestions for addressing uncivil behaviour instances in nursing education

Themes	*Illustrative examples*	*Respondents context*
Effective communication and relationships	(001a) "the lecturers control the class while teaching and make agreements with students regarding ground rules."	Senior lecturer, Batak, Christian
	(002a) "the nurses should communicate with clinical educator in the campus to have similar perceptions regarding the expectations of the students' competencies."	Assistant lecturer, Chinese, Christian
Presenting self	(004a) "need of a role model from higher position/leaders/academics."	Lecturer, Batak, Christian
	(006a) "apply more regarding self-integration."	Senior lecturer, Javanese, Catholic
Rules implementation	(005a) "all people should follow the rules in the academic environment."	Senior lecturer, Batak, Christian
	(006a) "[the needs for] annual reviews regarding the rules especially on rewards and punishment."	Senior lecturer, Javanese, Catholic

These suggestions from the academic staff are described in terms of three strategies for addressing uncivil behaviour in nursing education, such as building good rapport, developing self-management and implementing the rules properly. The academic staff reported that 'good relationships' are needed to manage uncivil behaviour in nursing education. For example, good communication to address uncivil behaviour in nursing education, controlling the class when teaching and coming to agreements with the students. The academic staff also provided suggestions regarding role modelling and projecting an image of professional integrity by displaying reliable behaviour in nursing education. It was further stated that 'obeying or agreeing to rules' is vital for managing uncivil behaviour in nursing education. For example, the academic staff proposed that people involved in nursing education should follow the established rules and annually review the rewards and punishments in nursing education.

Table 4.30 displays the students' suggestions for addressing uncivil behaviour in nursing education. This id described in terms of three themes that emerged.

Table 4.30: Students' suggestions for addressing uncivil behaviour instances in nursing education

Themes	*Illustrative examples*	*Respondents context*
Presenting self	(003s) "understanding the differences of ethnics; [understanding] the uniqueness of every human that emerge the senses of respects and regards. "	Female, year 3, Islam, mixed Javanese-Sundanese
	(042s) "1.developing tolerant attitude and 2.no attitude of differentiation."	Female, profession program, Christian, Batak
	(056s) "being a good role model without demanding/ judging others."	Female, professional program, Christian, mixed Dayak-Manado-Dayak
	(091s) "as academics provide good examples to students."	Male, year 4, Christian, mixed Chinese-Sundanese
Rules affirmation	(019s) "decision making that tied and have clear consequences."	Male, year 3, Christian, Batak
	(091s) "implement the rules."	Male, year 4, Christian, mixed Chinese-Sundanese
	(091s) "for nurses: working as in standard of procedures."	Male, year 4, Christian, mixed Chinese-Sundanese
Effective communication and relationship	(089s) "need of openness, respects and regards each other, as well as need of evaluation (written) for self- repairmen."	Female, year 4, Christian, Batak
	(011s) "always be assertive when the problems occur."	Male, year 3, Christian, Manadonese
	(088s) "have meetings often between the students, academics and nurses that can create trust relationship and respect others."	Male, year 4, Islam, Sundanese
	(032s) "the need of being strict, being disciplined and being committed on learning together for academics and students to decrease uncivil behaviour with collaboration."	Female, profession program, Christian, Batak

The findings that emerged from students' narratives at the private FoN suggested that the strategies for addressing uncivil behaviour in nursing education include presenting self or role modelling, rules implementation and effective communication. The respondents provided several examples of how to behave properly, such as respecting and understanding others. They also suggested role modelling that displays good behaviour as examples for others to follow so that uncivil behaviour instances in nursing

education are reduced (Clark and Springer, 2010). A number of respondents also provided suggestions regarding the firm implementation of rules, such as implementing rewards and punishments clearly, as well as obeying the rules including following the SOP (Standard of Procedure) in clinical units. The respondents further proposed the need for individual openness for self-evaluation and for assertiveness to deal with the uncivil behaviour instances. In addition, some respondents provided suggestions such as the need for teamwork when facing challenges in nursing education.

It is noted that data provided by academic staff and students show similar themes for addressing uncivil behaviour in nursing education, though labelled differently. The findings demonstrate that role modelling, effective communication and acting in accordance with the rules are required for maintaining civility in nursing education.

Findings from the interviews and observations

Based on the interviews and observations, the findings from both academic staff and students are divided into themes. The themes emerging from the data analysis are presented and supported with academic staff and student verbatim comments and observations data.

Six themes emerged to illustrate uncivil behaviour in nursing education from the academics and students' perspective in the context of their ethnicity, religious faith and socio-economic background. The themes are shown in Table 4.31.

Table 4.31: Themes of the interviews findings

Interviews' Respondents	*Themes*
Academic staff	Professionalism issues Ineffective rule implementations Individuals' character and background influences
Students	Professionalism issues Ineffective rule implementations Individuals' character and background influences

1) Themes emerging from academic staff responses

Three themes emerged, as explained below: (1) professionalism issues, (2) ineffective rule implementations and (3) individuals character and background influences.

Theme 1: Professionalism issues

Academic staff discussed their daily activities inside and outside of the private FoN. The academic staff explained their activities in nursing education that relate to educational activities in classrooms, skill laboratories and clinical units. While talking about their activities in nursing education settings, academic staff described that they encountered a number of unprofessional behaviours perceived as uncivil, and described their reactions when facing them. Their experiences and reactions are explored below.

Professionalism is defined as being: 'demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding', which is held to enable 'excellence, humanism, accountability, and altruism' (Arnold and Stern, 2006, p. 19). In addition, the International Nurses' Code of Conduct defines professional values as those demonstrative of:

> *'respectfulness, responsiveness, compassion, trustworthiness and integrity; foster and maintain a practice culture promoting ethical behaviour and open dialogue; contribute to an ethical organisational environment and challenges unethical practices and settings; support and guide co-workers to advance ethical conduct*' (ICN Code of Ethics for Nurses, 2012, p.2-4).

Professionalism issues therefore refer to problems that occur when people involved in nursing education perform activities with a lack of nursing competency and ineffective communication skills also violating the code of ethics. The theme of 'professionalism issues' was evidenced by teaching-learning issues and communication issues.

Nursing education is a vital place for developing student nurses' professional values. However, academic staff described that there were issues that occurred in the process of teaching and learning in nursing education. An academic experienced the unexpected change of class schedule:

> *'...one time the timetable was not finalised yet. I came to a class in which the students were there [in the classroom] but it seemed that the students who came were not for my course as mentioned in the timetable schedule. Then, we were informed that the schedule has changed*.' (Interview/B62)

She further expressed that she provided minimal supervision for students in the clinical settings:

> '*When students were in clinical placement, they needed a lot of supervision. However, if we evaluate ourselves as clinical educators, we might lack the time to supervise students...*' (Interview/B71)

In the clinical setting, an academic staff identified that nurses were unwilling to provide teaching-learning environments in the clinical units:

> '*There were our colleagues or nurses in the wards… when students came for clinical practice, they did not help. Well, sometimes they even didn't provide chances, chances to do the clinical skills for [the students] to achieve their target [skills competencies]...'* (Interview/C53)

In contrast, the observational findings revealed that there was a teaching-learning session between a head nurse and students in the ICU. This was observed when I was involved in the preparation of a new patient:

> At 11.45 AM I join to observe Ms. Y [head nurse] who is preparing the tools for three new patients, such as ventilators. We discuss a lot regarding the preparation of the tools. The students also ask the head nurse a lot about the tools. For example, one student asks: 'what is the main function of the ventilators?' The head nurse answers, "it substitutes a person's breath functions". (#Observation/ICU52)

The academic staff further reported that communication issues emerged in nursing education. Communication issues concern verbal or nonverbal interactions. An academic staff commented that students were noisy and not paying attention in class:

> *'The students were just being noisy. It might be an ethical problem for instance they do not want to pay attention to their friends who practice their nursing skills.'* (Interview/D49)

Another academic staff witnessed the students make harsh comments but also explained the reason:

> *'They [students] felt that they received unfair treatment so they commented harshly*.' (Interview/C76)

Not only student nurses, but an academic staff also saw that the clinical nurses in the wards acted unprofessionally by acting indifferent towards the students:

> '*They [nurses] do not show that they care to the students.'* (Interview/D61)

While talking about some professional issues as features of uncivil behaviour, the academic staff also provided their opinion on how to deal with uncivil behaviour in nursing education. One explained that the ground rules are clearly established at the beginning of the semester:

> *'At the beginning of the semester, usually I make some agreements with the students regarding ground rules in the classroom. It also means that all students know the consequences when they break the rules.'* (Interview/B47)

It is noted that uncivil behaviour was perpetuated by undesirable professional relationship issues in nursing education, especially between academic staff, nurses and students. It seems that the issues revolved around the university system and personal issues. However, efforts were made to address unprofessional behaviour by establishing mutually agreed rules at the beginning of the semester.

The theme 'professionalism issues' describes perception of how ineffective teaching-learning and poor communication promotes uncivil behaviour instances in nursing education.

Theme 2: Ineffective rule implementation

The academic staff also described that they experienced a lack of accountability for rule implementation in nursing education. Different interpretations and implementations when applying the rules in nursing education escalate uncivil behaviour instances (Clark and Springer, 2007a). The theme was evidenced by varied perceptions of rule implementation, inconsistency of reward and punishment and a lack of discipline.

In regard to varied perceptions of the rule implementation, it is crucial to identify the meaning of perception first. Perception is defined as "a process of interpretation of a present stimulus on the basis of past experience" (Sharma, 2015). The discrepancy of individuals' ability to attain understanding of something influence their behaviour. The academic staff identified that people involved in nursing education have various perceptions regarding the implementation of rules in the teaching-learning process. For instance, an academic stated that there were no similar perceptions and commitment among the academic staff regarding rules implementation:

> *'We [lecturers] have different perceptions and commitments in regard to rules implementation. For example, one lecturer is strict and other lecturer is lenient. In addition, when the strict [lecturer] is being evaluated by students, they complain that the lecturer is too strict. Thus, the strict lecturer becomes lenient. This situation further creates the reward and punishment implementations are more lenient.'* (Interview/E44)

Another academic staff added that similar perceptions of academics and consistent rules are needed to carry out the teaching-learning process in nursing education:

> *'We have to have similar perception, indeed. Second, do not make our own rules, for example in regard to punctuality rules*.' (Interview/B59-60)

The academic staff further reported that there was inconsistency regarding reward and punishment implementations in nursing education. For instance, an academic remarked that there were unclear sanctions of disturbing behaviour instances by stating:

> *'...another thing that makes the instance worse, they [the students] do it because there is no clarity about the sanction, so they thought that it is not a problem, it is still allowed, like that...'* (Interview/A28)

Another academic staff clarified by stating that:

> *'... the consistency and the commitment of the lecturers to apply the reward and punishment is inadequate. This condition makes student to do something unexpectedly.'* (Interview/E44)

> *'Maybe it is part of my weakness, Ma'am, when applying the reward and punishment, especially punishment. I am a person that would be understandable and forgiving, thus I would only advice the student who breaks the rules...'* (Interview/E99)

Lack of willingness to obey the rules was also considered to be a feature of disciplinary problems. An academic supported this by giving an example related to unpunctuality, which is considered to be a disciplinary problem:

> *'I saw students with disciplinary problems. For example, when in clinical practice setting, we have an agreement that the time for coming is at 7.15 a.m. But there were some students who*

> *came late and there were some students who went away [outside the clinical units] while they should be in the clinical practice...'* (Interview/D52)

The findings of the observations further supported the occurrence of students' discipline problems. When the researcher was observing an activity in the skills laboratory, two students arrived late within the first fifteen minutes of the observations:

> Two students come into the skills laboratory at 10.12 AM without greeting, putting their bags then taking a seat. The lecturer keeps explaining about fixation. All the students pay attention enthusiastically. The lecturer asks the students, "Is there any question? No?" The students only keep quiet. Then the lecturer continues her explanation. (#Observation/L28)

It is apparent that the uncivil behaviour continued due to differences in perceptions, accountability and compliance of people involved when applying rules in nursing education. For instance, unpunctuality of students has happened in all settings of nursing education, including in the classroom, skills laboratory and clinical unit.

The theme 'ineffective rules implementation' illustrates how the poor implementations of rules and discrepancies of individuals' perceptions escalate the instance of uncivil behaviour in nursing education.

Theme 3: Individuals' character and background influences

The academic staff further described their activities outside nursing education relating to their personal interests, family backgrounds and environments. The activities included social activities, nursing organization, religious faith and family activities. When explaining their activities, they

associated their social activities with uncivil behaviour occurrences. The theme was evidenced by personality issues and individuals' background influences (ethnicity, religion and socio-economic status).

Academic staff identified that individuals' personality attributes influence uncivil behaviour instances in nursing education. For example, an academic stated:

> *'Maybe the student's character has already been shaped from home. Yes maybe like that. Not only in the skills laboratory and in the clinic, the child's [student's] behaviour is also like that [being uncivil] in the class.'* (Interview/B49)

A senior academic staff supported these thoughts above by giving three examples related to students' personality development issues:

> *'In my opinion, because they [students] are still young, as teenagers they want to explore something in the teaching-learning process, or maybe they also want to see how the lecturers' reactions will be if they do something like this...'* (Interview/C38)

> *'Sometimes there is a student that might not be mentally strong in [their] psyche.'* (Interview/C62)

> *'...students should be mature learners, but they are still teenagers that begin to grow up. They just came into the university world...'* (Interview/C67)

Another senior academic staff expressed that individuals' positive self-concept avert them for trying to behave uncivil, by stating:

'I think her [positive] self-concept can prevent her to act in an uncivil way.' (Interview/E71-72).

It seems that uncivil behaviour is influenced by the individuals' character, including self-concept and maturity. In other words, individuals' character cause uncivil/civil behaviour.

An academic staff member further identified that individual background characteristic, such as ethnic and religious background, as well as socio-economic status, influences the person's behaviour in nursing education. Individuals' background characteristics are briefly defined below:

- Ethnic background refers to family tradition or culture (Fenton, 2010; Gunaratnam, 2003; Smith, 2002).
- Religious practices refer to any personal deeds that relate to the person's belief (Hodge and McGrew, 2005; Edward, et al., 2002).
- Socio-economic status refers to individual or family status, correlated with education, income and employment (Caro and Cortes, 2012; Hauser and Warren, 1996).
- Family is defined as a group of people related by blood or marriage or adoption and commonly living under one roof (Nam, 2004).

The parenting style as part of family tradition may affect the children's behaviour. An academic staff stated that children imitate their parents' behaviour:

'...in my opinion, the most influencing factor is the teaching of the family. The culture of the parents influences their behaviour; we as children are like them [parents].' (Interview/C28).

An academic expressed that any religion create proper personal behaviours:

> *'The religion or faith can make someone behave properly; it's not about what is right or allowed [religious rites and laws], but it's about behaving properly.'* (Interview/E69).

Another academic clarified her belief that academics are people that have been entrusted by God to teach students:

> '*Educators are people who have been entrusted by God to teach them. So it would be better for students to submit to the lecturers' authority, as educators, because they have been trusted by God to guide students for a better life*.' (Interview/A54).

Another academic staff also described that religious values and community norms act as guidance for individuals' behaviour, which can be applied in nursing education:

> *'Christian values are similar to what I believe. Since this is a Christian faculty of nursing, the values of the faculty are similar to my values. The students also have been educated in regard to these values. Thus, this is what we should do to patients, we should provide caring with Christian values. In addition, we should apply values based on the societal norms*.' (Interview/A48).

Similarly, descriptive incidents from observations in the skills laboratory added a portrayal of religious practice in nursing education. Religious practices such as praying were considered to be positive and characterised as good behaviour. The Christian tradition of praying became a feature of the nursing education course since it was part of a Christian-based

university. The researcher observed the conditions of the laboratory at the beginning of the laboratory session:

> I saw the room was divided into two. On the right side, there were four beds and there were a computer and a screen on the left side. I further saw X [assistant lecturer, Christian, Chinese] preparing the clinical skills tools for demonstration in the right part of the first bed. Then, I was looking for a strategic place from which to observe. I was sitting exactly in front of the bed for the skills demonstration. I also went to talk to the students and asked their names one by one. Then the academic [assistant lecturer, Chinese, Christian] said "please submit the task paper". She also asked one student (male) to lead in prayer. The student began to lead the prayer in a Christian way. (#Observation/L21)

In regard to socio-economic factors, these factors of an individual and their parents influence their behaviour in education settings (Proper and Rigg, 2007; van Oort, van Lenthe and Mackenbach, 2005). For example, an academic expressed that students and patients with middle-high socio-economic status are more demanding by stating:

> *'Students from middle-high economic status backgrounds, sometimes they do not want to take care for the patients. It is not because they don't want to do procedures such as cleaning and bathing. Sometimes they might hesitate to do those skills, because they do not do these things at home...'* (Interview/A69).

> *'For example, patients with high economic background don't want to be cared for by students, because they don't want to*

be treated like guinea pigs, so they refuse the students' care...'

(Interview/A74).

It is noted that academic staff in the private FoN described their opinions regarding uncivil behaviour from their own backgrounds. They provided several examples to support the association between individuals' backgrounds and uncivil behaviour.

The theme 'personal issues and contextual influences' demonstrates how character, socio-economic status, ethnic background and religious faith of people in nursing education influences their behaviour either in a good or bad way.

Finally, the findings suggest that professionalism issues, ineffective rule implementation, as well as individuals' personality issues and background influences lead to uncivil behaviour instances.

2) Themes emerging from students responses

Students associated professional relationship issues, ineffective rule implementation and personal issues and background influences with uncivil behaviour. The themes are discussed as follows:

Theme 1: Professionalism issues

When talking about their educational experience in the classroom, skills laboratory and clinical practice, the students identified a number of activities in nursing education settings deemed as uncivil behaviour. These included unprofessional behaviour.

The students expressed that they have seen and experienced a number of behaviours that relate to nursing professionalism. As mentioned before, professionalism issues refer to the challenges of demonstrating clinical and

communication skills as well as of complying with the nurse's code of ethics. The theme was evidenced by teaching-learning problems, communication issues and interaction issues.

Teaching-learning problems in nursing education refer to challenges that occur in the process of teaching-learning. Students identified that they met some challenges in the teaching-learning process. For instance, a student mentioned that the CI (Clinical Instructor) was out of touch with clinical practices:

> *'In fact, CIs are still lacking, Ma'am, in the clinical practice now.'* (Interview/G135)

Other students further commented regarding their experiences when inconsistent information was given by different professionals in different teaching-learning settings. Two students stated that there were misperceptions between academic staff/CIs and students:

> *'When in the teaching-learning process, sometimes the lecturers forget to attune the perceptions between lecturers and students... for example, when students submitted a task, the lecturer said, "Why do you do it like this? What I meant was not like this". Then, the lecturer said "Did I say like this?". So sometimes in the teaching-learning process, it might happen that the perceptions of lecturers and students are different.'* (Interview/K32).

> *'In the skills laboratory, sometimes when we were at the laboratory, there were many different lecturers/CIs teaching a subject with team teaching method. For example, when teaching about injection technique or something about NGT*

> *(Naso Gastric Tube) positioning, the lecturers seem to have different perceptions among themselves. So, uh... sometimes when we [students] are in the class and discussing the subject, some students might say "yesterday, we were taught like this", but other students said "oh, not like that but like this". It looks like that Ma'am, a little bit disturbing. This condition makes us [students] confused.'* (Interview/I67)

Another problem in the teaching-learning process occurred while I was observing in the classroom. One of the activities included the inappropriate use of a mobile phone in a classroom by a student:

> Then I look around, I see one female student is playing with a mobile phone. (#Observation/C7)

The misuse of mobile phones was also observed in the clinical unit. When I was discussing with the students about their experiences in ICU, I saw that one student was playing on a mobile phone:

> At 11.00 AM I stand again near the nurse station and discuss with four students regarding their experiences in this ward. When I am talking with student M, I see student F holding a mobile phone and using it, not for calling but reading something. (#Observation/ICU51)

The unpreparedness of students for learning is also included as one of the teaching-learning issues. When I was observing in the classroom, lots of students did not prepare themselves for learning in the classroom, for example they did not bring their own laptop with SPSS (Statistical Package for the Social Science) installed, which was a prerequisite for the class:

> Mr X says again, OK, you have already learnt regarding qualitative analysis with Ms Y, we will learn now about quantitative analysis. He, then continue says, "Have you all brought a laptop with SPSS software?" And most of the students say, "No". It is seen that the students did not prepare themselves for joining the learning. (#Observation/C5)

Students further stated that they encountered communication issues in nursing education. As communication is an 'interpersonal process' by applying skills of communication either verbal or non-verbal (McCabe and Timmins, 2013); thus, communication issues refer to any problems faced by people involved in nursing education that relate to communicating with others, either in a verbal or non-verbal way. In regard to verbal issues, a student attending a professional program stated that the harsh behaviour of nurses became a habit:

> *'Nurses talk harshly and cruelly... it is already becoming a habit...'* (Interview/F72).

However, another student on the same program gave an example related to patients' harsh attitude by throwing food toward a nurse:

> *'...the nutritionist at the hospital prepared warm food for the patients' dinner. But when the nutritionist served the food in the patients' room, the patient was still sleeping. The nutritionist just put the food on the patient's table. Then, when the patient woke up, the food was already cold. It seemed that the patient was upset, so the patient then threw the food at the nurse. The nurse's uniform was wet and dirty due to the food...'* (Interview/H56).

Interaction issues further happened in nursing education, such as academic-to-student issues, academic-to-nurse issues and nurse-to-student issues. A student remarked that senior nurses displayed a superior attitude towards junior nurses in clinical practice:

> *'In fact, I felt embarrassed to admit that a lot of nurses behaved uncivilly. For example, there is seniority in the nursing world; this condition cannot disappear. Senior nurses tend to be more difficult in regard to change. On the other hand, junior nurses prefer changes. Another example, when junior nurses have planned for patients' nursing care and already applied the care, suddenly the senior nurses interfere in the care and change it without acknowledging the professionalism of the junior nurses.'* (Interview/H63-67).

Another student gave an example related to the poor academic-student relationship during a skills laboratory session:

> *'When conducting nursing skills competency test, an academic interrogated a student, by which the student felt cornered in regard to the questions. It seemed that the student could not do anything. Still, the academic seemed to attack the student by repeatedly asking the student questions. It looked like that the student was insulted due to the academic's behaviour*.' (Interview/N45).

In-line with interaction issues, several observational findings depicted the occurrence of impolite and polite behaviour in nursing education settings. I experienced students disregarding a lecturer when the lecturer came into the classroom:

> At 11.00 AM I and Mr. X enter the classroom and no one of the students greets him. It seems that the students are not ready to attend [class] for learning. There are students still talking and some students are bringing food. (#Observation/C1)

On the other hand, as a lecturer, I felt respected by students when I did my observation in the ER:

> At 07.00 AM I am at ER and I see that two students are in the room. The students are one male-Batak-Christian and one female-Batak-Christian. When they see me, one of the students says to me, "Good morning, Ma'am". I reply, "good morning". Then the female student asks, "What is your purpose for being here, Ma'am?" I answer "I am doing my observation for my study". (#Observation/ER54)

Furthermore, opinions on how to deal with uncivil behaviour were exposed by students. For instance, a student stated that nurses are positive role models:

> '*Nurses are role models for patients. If the nurses are not really good to the patients, how can the nurses be trusted by the patients? The patients will certainly not cooperate.*' (Interview/L83).

It is noted that students identified that professional relationship problems occurred in nursing education. The problems included lack of CI's attendance for supervisions, misperceptions between academics, nurses' superiority, harsh comments by academic staff and the unwillingness of nurses to work with students. The students also proposed that role modelling by nurses is

needed to deal with uncivil behaviour in nursing education, specifically in clinical practice.

The theme 'professionalism issues' describes that teaching-learning problems, communication issues and interaction issues promote uncivil behaviour in nursing education.

Theme 2: Ineffective rule implementation

Students also described that they experienced a lack of effective rule implementation, which they perceived as uncivil behaviour. The theme was evidenced by lack of discipline, inconsistency of reward and punishment and inconsistency of actions when facing uncivil behaviour.

Tardiness is considered to result from a lack of discipline. Lateness is also identified by Altmiller (2008, p.64) as 'disrespectful behaviour'. A student who was attending a professional program commented that some students were late for their class:

> '*… it seemed that at least academic staff members were late for 5 minutes, not too much, but if students have ever been late for half or one hour, indeed*.' (Interview/I55-56)

On the other hand, academic staff were not immune for being late and unprepared for a class as a student commented:

> *'For example, a lecturer already comes late in a class. After coming in class, the teaching materials could not be opened from the flash disc. The reason could be forgetting to copy the lecture onto flash disc. Then the lecturer has to goes back to the office again, to prepare the file and the teaching materials. This situation might be a barrier to learning*.' (Interview/G52).

It appears that both academic staff and students were not punctual. Since the academic staff is a role model for students, it is expected that they should be more committed and accountable.

Students also reported the inconsistency of reward and punishment in the private FoN. A student seemed unsure whether academic staff were lenient or not, which could be a reason for uncivil behavioural instances:

> *'It seems to depend on the students... there are many factors Ma'am, we also do not know. Is it because of less... or because the academics were lenient to us [students]?'* (Interview/L107).

Another student supported this by stating that academic staff members were too tolerant:

> *'... it might be because the lecturers were being tolerant, lots of being tolerant. This made some students to act improperly and behave uncivilly.'* (Interview/J24).

Students further revealed that people involved in nursing education act differently depending on who behaved uncivilly in nursing education, they may reprimand them or do nothing. A male student attending a professional program commented by providing an example of his experience when facing uncivil behaviour in clinical practice:

> *'So for younger [nurses] I dare to reprimand them, but for senior [nurses] I dare not reprimand them*.' (Interview/G90)

It is apparent that the students described that unclear rule implementation occurred in nursing education, including being lenient when implementing rules, being tolerant of others' disturbing behaviour and being uncertain on how to deal with uncivil behaviour in clinical practice. It seems that people

involved in nursing education lacked accountability. This condition corrode the respect for themselves and for others.

The theme 'ineffective rule implementation' explains how improper implementation of the rules lead to uncivil behaviour in nursing education.

Theme 3: Individual characteristics and background influences

The students further described their activities outside nursing education relating to their personal interests, family backgrounds and environments. When discussing their activities such as social organization and religious faith activities, they associated these with uncivil behaviour. The theme was evidenced by individual issues and individual background influences.

The students identified that individual issues or personal attributes affect a person's behaviour. The students also explained personal attributes by providing several examples related to their personal character and self-awareness. Their explanations will be described using quotes.

A student commented that tardiness, being noisy and cheating are influenced by personal character:

> '*If being late and being chatty… the sources of these behaviours are from each person, Ma'am. But if cheating... maybe because the students were not self-confident or afraid, or lacking preparedness, well, everything goes back to their own selves, Ma'am.'* (Interview/I124-125)

Another student reported that some people lacked self-awareness in nursing education. A student provided her opinion related to senior nurses' unawareness in the clinical unit which endanger patient safety:

> *'...the most serious thing is that senior nurses tend to do things wrong. The mistakes they make influences the junior nurses. Thus, there are no positive changes. I have ever asked why they (senior nurses) did not apply nursing care based on theory. They (senior nurses) answered, just like that [not theory-based nursing practice] is enough, not very dangerous...'* (Interview/F82).

The students further identified that an individual's ethnic, religious and socio-economic background influences uncivil behaviour instances in nursing education. Family tradition relating to ethnic background influences the individual in regard to their habits or behaviours, as supported by previous studies (Scott et al., 2010; Scholte et al., 2006). A student attending the profession program expressed that parenting develop individuals' habits:

> *'In my opinion, individuals' habits are due to parenting styles, indeed.'* (Interview/H31)

Additionally, a student remarked that his parents' ethnic background influenced his behaviour:

> *'The specific difference between my parents' ethnic background is when we are eating. Usually if eating in Javanese culture, [we] have to finish [the food]. Additionally, the ways of eating should be polite... cannot be noisy. If in Batak [culture], usually the way of eating is freer, for example either using hands or being noisy as well as either tidy or not while eating the food. It is different between Javanese and Bataknesse, regarding their eating manners.'* (Interview/M6).

Individuals' religious practices also influence their behaviour (Gnadt, 2006). A student stated that conducting uncivil behaviour intentionally is similar to sinning:

> *'The disturbing behaviour, in Hinduism, this [behaviour] can be acknowledged as a sin ma'am, especially when conducting it intentionally, such as insulting others' feelings and hurting others. In Hinduism, we cannot hurt other creatures, including humans.'* (Interview/G100).

Another student revealed that her behaviour improved after she started believing in God:

> '*...before believing in God, it seems that sometimes I could not control myself. But after knowing God, it seems that my emotions have changed... I rarely get angry*.' (Interview/J49)

Individuals' socio-economic status further influences their behaviour (van Oort et al., 2005; Proper and Rigg, 2002). A student expressed that he cares for poor patients more than rich patients because he perceives the former to be in greater need:

> *'But I am aware, actually, my status is categorised as low-middle socio-economic status. But when caring for patients, this condition is a strong basis for me. I promise to myself that I will serve others who are lacking [poor] as good as people who paid [rich]'.'* (Interview/G107-108).

Another student added that the disadvantage status of her family encourages her to have positive behaviour:

> *'... due to my parents' disadvantage [poverty], this situation encourages me to stay on track, indeed. I do not let myself fall [out of track]. My road for the future already exists, in terms of a bright future. It will not suddenly become dark, I hope it will not. Thus, I have to keep behaving properly.'* (Interview/J55)

The same student further commented that patients from middle-to-high socio-economic status are more likely to complain than patients from low socio-economic status:

> *'Usually patients who have more money seem to complain more.'* (Interview/J71).

It is noted that students described the influence of ethnic-religious backgrounds on a person's behaviour in nursing education, such as habits, eating manners, hurting others and controlling emotions. Additionally, the students described that someone's socio-economic status influences their behaviour either in a positive or negative way. This behaviour included caring for patients, behaving properly and complaining to others.

The theme 'personal issues and background influences' demonstrates how individual attributes, family-ethnic background, religious practices and socio-economic status influences behaviours that are perceived as uncivil in nursing education.

Summary of findings from interviews and observations

According to the themes that emerged from the interviews and observations findings, it can be summarised that both academics and students shared similar perceptions, but expressed them differently. Academic staff and students identified that there were uncivil behaviour instances in nursing education that relates to professionalism issues, rule implementation issues,

area and effects of uncivil behaviour as well as personal and background issues. These findings, apart from the background factors, support previous research. The findings regarding background factors are a distinctive feature of this study, providing a new insight into the study of uncivil behaviour in nursing education. The theme 'personal issues and background influences' demonstrates how individual attributes, family-ethnic background, religious practices and socio-economic status influence behaviours that are perceived as uncivil in nursing education.

4.3 Chapter summary

It is clear that both academic staff and student nurses at the private FoN were concerned with incivility that challenged them personally as well as interfering with the teaching-learning process. Many forms of behaviours were viewed by the academic staff and students that included disruptive and threatening behaviours. It is further noticed that though many forms were perceived similarly regarding the behaviours being disruptive or not, occurred frequently or not and have experienced the behaviour in the past 12 months or not, both academic staff and students expressed some of the behaviours differently. For example, the academic staff and students perceived the disruptive student's behaviour significantly different.

Both respondents also stated their opinions regarding the types and reasons of incivility instances, the behavioural differences between the nursing education settings and suggestions on how to deal the uncivil behaviour. Many of their opinions were similar, and yet some of them were different, for instance, only the students mentioned personal background influences as one of the reasons that cause incivility instance.

In depth interviews and direct observations showed that both academic staff and student nurses provided similar themes in which incivility was associated with unprofessional behaviour, rule implementation issues and personal and background issues. Though some of the behaviours were expressed differently, it is evident that both the respondents witnessed incivility and were concerned regarding the issues.

CHAPTER 5: WITHIN ANALYSIS FINDINGS - UNIT OF ANALYSIS II

In this chapter, the results of unit analysis II are presented. The results are explained in two sections: (1) profile of the unit of analysis II; and (2) findings of the unit of analysis II.

5.1 Profile of the unit of analysis II

The unit of analysis II is located in the northern part of Sumatera Island. The population consists mainly of Acehnese, Batak, Minangkabau and Malay peoples (Ananta et al., 2013). Residents with Chinese and South Asian backgrounds together form a small but significant minority (Encyclopedia Britannica, 2016).

The second unit of analysis is at a public university. The university was established in 1952. The unit of analysis II of the study is the FoN, which was established in 1999 as a study program, became a faculty in 2009 and has been accredited. The vision of the FoN is to be the centre of development and learning of nursing sciences with excellence in holistic caring so as to increase the competitive effort regionally, nationally and globally by the year 2020. The FoN consists of five study programs: Masters in Nursing, Bachelors in Nursing, Profession Program, and Diploma IV in Midwifery Educator and Diploma III in Nursing.

The Masters in Nursing program's vision is to become a centre for producing competitive graduate nurses in developing science and technology in nursing based on holistic caring. The program is delivered in four semesters. The undergraduate program enrols students from upper secondary education

(regular class) and nurses with a diploma qualification (conversion class) who intend to upgrade their degree in nursing. Thus, the bachelor program covers eight semesters (regular class) or three semesters (conversion class) to achieve the academic degree (*Sarjana*/ Bachelor of Nursing).

The profession program covers two semesters (regular and conversion class) to obtain the Professional Degree/*Ners*. This professional program further covers two semesters of clinical practices in different areas of nursing care including hospitals and community. The Diploma IV in Midwifery Education produces educators in midwifery field based on holistic care. The Diploma III in Nursing's program covers six semesters to produce vocational nurses based on holistic care.

5.2 Findings of the unit of analysis II

The same data collection techniques explained in chapter four (unit of analysis I) were employed for this case (unit of analysis II): Survey, semi-structured individual interviews and observations were used to collect the data. Therefore, the findings are explained the same way the researcher explained findings in the previous chapter as follows: There are two sections, section one contains quantitative findings and section two contains qualitative analysis of the findings.

5.2.1 Quantitative findings

This section comprises three parts: (1) demographic data, (2) uncivil behaviour in nursing academic environment and (3) uncivil behaviour in the context of ethnicity, religious faith and socio-economic background.

Demographic data

The respondents of this study were students and academics in the undergraduate nursing program. However, there were no conversion class students (diploma nursing students upgrading to degree level) as the public FoN did not give permission to recruit such participants (because the curricula between regular and conversion classes were different).

A total of 262 students were approached, consisting of 202 students of academic programs (years 3 and 4) and 60 students of professional programs. 28 academic staff members were approached.

Of the 262 students 216 consented to participate in the study (82.44%) students (183 students from the academic programs and 33 students from the profession programs). Of the 28 academic staff members 20 (71.42%) academic staff members consented to participate in the study. However, after the process of data cleaning, the valid questionnaires that were included in data analysis were 204 questionnaires completed by 185 (85.64%) students and 19 (95%) academic staff. The reasons for exclusion among student participants were: questionnaire not returned n=1), questionnaires not completed (n=24), and informed consent not completed n=6) One academic questionnaire was not returned.

According to the findings from the survey, the majority of student respondents were: females (88.65%), their age ranged from 20-25 years (100%), just above half of them were Christians (51.35%) and Indo-Malay (100%). The most common sub-ethnic background was Bataknesse (46.6%). The details of the demographic data of the students are shown in Table 5.1 below.

Table 5.1: Student demographic data

Demographic data				*Students*	
				N	*%*
Program	Academic Program			156	84.85
	Profession program			28	15.15
	Total			185	100
Gender	Male			21	11.35
	Female			164	88.65
	Total			185	100
Age	20-25			185	100
	>25			0	0
	Total			185	100
Religion	Moslem			84	45.40
	Christian			95	51.35
	Catholic			6	3.25
	Total			185	100
Ethnicity	Indo-Malay			166	89.72
	Sub Indo-Malay	N	%		
	Batak	85	51.2		
	Minangkabau	11	6.6		
	Aceh	10	6.02		
	Others	19	36.18		
	Mixed ethnicities			18	9.73
	Not completed			1	0.55
	Total			185	100

The majority of the students came from backgrounds where parents have completed a high school education; both parents work outside the home and have income of 1,500,000-6,000,000 rupiahs or 100-400 GBP per month (See table 5.2 below).

Table 5.2: Socio-economic status of student respondents

Socio-economic status of the students respondents			*N*	*%*
Father	Education	≤ High school graduate	108	58.37
		University graduate	73	39.45
		Not completed/Deceased	4	2.18
		Total	185	100
	Employment	Private employee	24	12.97
		Government employee	87	47.03
		Entrepreneurs	34	18.37
		Others	34	18.37
		Not completed/Deceased	6	3.35
		Total	185	100
	Income per month	Below regional minimum payment (<1,500,000 or <100 GBP)	34	18.37
		1,500,000-6,000,000 Or 100-400 GBP	136	73.51
		Above 6,000,000 Or 400 GBP	9	4.86
		Not completed/ Deceased	6	3.26
		Total	185	100
Mother	Education	≤ High school graduate	114	61.62
		University graduate	64	34.59
		Not completed/Deceased	7	3.79
		Total	185	100
	Employment	Private employee	8	4.32
		Government employee	88	47.57
		Entrepreneurs	21	11.35
		Others	58	31.35
		Not completed	10	5.41
		Total	185	100
	Income per month	Below regional minimum payment (<1,500,000 or <100 GBP)	31	16.76
		1,500,000-6,000,000 Or 100-400 GBP	111	59.99
		Above 6,000,000 Or above 301 GBP	2	1.08
		Not completed	41	22.17
		Total	185	100

The findings further reveal that the majority of academic staff were females (78.94%), their age ranged from 30-40 years old (78.95%), Muslims (89.48%) and Indo-Malay (100%) with Batak as the most prevalent group (52.63%). This can be seen in Table 5.3 below.

Table 5.3: Academic staff demographic data

Demographic data				*Academics*	
				N	*%*
Gender	Male			4	21.06
	Female			15	78.94
	Total			19	100
Age	<30			0	0
	30-40			15	78.95
	> 40			4	21.05
	Total			19	100
Religion	Moslem			17	89.48
	Christian/ Catholic			2	10.52
	Total			19	100
Ethnicity	Indo-Malay				
	Sub Indo-Malay	N	%		
	Batak	10	52.63	19	100
	Others	5	26.32		
	Not completed	4	21.05		
	Total			19	100

Additionally, Table 5.4 shows that most of the academic staff have worked as lecturers (100%), just above half of them have 11-15 years of teaching experience and all of them had masters degrees, and just about half of them have an income above 6,000,000 rupiahs or 300 GBP per month (42.11%).

Table 5.4: Socio-economic status of academic staff

Socio-economic status		*N*	*%*
Teaching Experiences *(Year)*	< 5	2	10.53
	6-10	6	31.58
	11-15	10	52.63
	16-20	1	5.26
	Total	19	100
Education	Undergraduate	0	0
	Postgraduate (master)	19	0
	Postgraduate (doctoral)	0	0
	Total	19	100
Employment	Lecturer	19	0
	Lecturer assistant/clinical educator	0	0
	Total	19	100
Income per month	Below regional minimum payment (<1,500,000 or <100 GBP)	0	0
	1,500,000-6,000,000 or 100-400 GBP	10	52.63
	Above 6,000,000 or above 400 GBP	8	42.11
	Not completed	1	5.26
	Total	19	100

Furthermore, the respondents' (both students and academic staff) religious faith/practice and ethnic identity have been identified further using ASCSRF (Plante et al., 2002) and MEIM (Phinney, 1999). The results of both identifications can be seen in Tables 5.5-6.

Table 5.5 shows there was a statistically significant difference of religious faith/practice between students and academic staff (p value 0.001). Both academic staff and students described themselves as people who practice their own faith or religion. However, the religious faith/practice of the academic staff were stronger than that of the students (academic staff mean rank = 145.76 and students mean rank =98.06).

Table 5.5: Religious faith/practice of the students and academic staffrespondents

No	*Religious faith*	*Students*						*Academics*					
		Strongly disagree n (%)	*Disagree n (%)*	*Agree n (%)*	*Strongly agree n (%)*	*Mean of 4*	*SD*	*Strongly disagree n (%)*	*Disagree n (%)*	*Agree n (%)*	*Strongly agree n (%)*	*Mean of 4*	*SD*
1	I pray daily	0	1(0.5)	23(12.4)	161(87)	3.86	0.358	0	0	2(10.5)	17(89.5)	3.89	0.315
2	I look to my faith as providing meaning and purpose in my life.	0	0	17(9.2)	168(90.8)	3.91	0.290	0	0	0	19(100)	4.00	0.000
3	I consider myself active in my faith or in the place of worship	0	26(14.1)	119(64.3)	40(21.6)	3.08	0.594	0	1(5.3)	9(47.4)	9(47.4)	3.42	0.607
4	I enjoy being around others who share my faith.	1(0.5)	7(3.8)	73(39.5)	104(56.2)	3.51	0.600	0	0	2(10.5)	17(89.5)	3.89	0.315
5	My faith impacts many of my decisions.	0	4(2.2)	77(41.6)	104(56.2)	3.54	0.541	0	0	2(10.5)	17(89.5)	3.89	0.315

Students' mean rank = 98.06; academic staff mean rank = 145.76; u= 2,579.5 z = 3.428 p = 0.001 r = 0.24

Table 5.6: Ethnic identity of the students

No	Statement	STUDENTS						
		Strongly Disagree n(%)	Disagree n(%)	Agree n(%)	Strongly Agree n(%)	Not completed	Mean of 4	SD
1	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	2(1.1)	66(35.7)	100(54.1)	17(9.2)	0	2.71	0.642
2	I am active in organizations or social groups that include mostly members of my own ethnic group.	7(3.8)	102(55.1)	58(31.4)	18(9.7)	0	2.47	0.723
3	I have a clear sense of my ethnic background and what it means for me.	1(0.5)	18(9.7)	122(65.9)	44(23.8)	0	3.13	0.585
4	I think a lot about how my life will be affected by my ethnic group membership.	6(3.2)	64(34.6)	98(53)	16(8.6)	1(0.5)	2.67	0.679
5	I am happy that I am a member of the group I belong to.	0	8(4.3)	112(60.5)	64(34.6)	1(0.5)	3.30	0.548
6	I have a strong sense of belonging to my own ethnic group.	0	22(11.9)	115(62.2)	46(24.9)	2(1.1)	3.13	0.597
7	I understand pretty well what my ethnic group membership means to me.	1(0.5)	30(16.2)	123(66.5)	31(16.8)	0	2.99	0.594
8	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	4(2.2)	55(29.7)	97(52.4)	29(15.7)	0	2.82	0.714
9	I have a lot of pride in my ethnic group.	0	15(8.1)	100(54.1)	70(37.8)	0	3.30	0.611
10	I participate in cultural practices of my own group, such as special food, music, or customs.	2(1.1)	54(29.2)	96(51.9)	33(17.8)	0	2.86	0.706
11	I feel a strong attachment towards my own ethnic group.	1(0.5)	40(21.6)	114(61.6)	30(16.2)	0	2.94	0.631
12	I feel good about my cultural or ethnic background.	0	4(2.2)	102(55.1)	79(42.7)	0	3.41	0.535

Table 5.7: Ethnic identity of the academic staff

No	Statement	ACADEMICS					
		Strongly Disagree n(%)	Disagree n(%)	Agree n(%)	Strongly Agree n(%)	Mean of 4	SD
1	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	4(21.1)	4(21.1)	10(52.6)	1(5.3)	2.42	0.902
2	I am active in organizations or social groups that include mostly members of my own ethnic group.	3(15.8)	9(47.4)	7(36.8)	0	2.21	0.713
3	I have a clear sense of my ethnic background and what it means for me.	1(5.3)	2(10.5)	7(36.8)	9(47.4)	3.26	0.872
4	I think a lot about how my life will be affected by my ethnic group membership.	3(15.8)	10(52.6)	6(31.6)	0	2.16	0.688
5	I am happy that I am a member of the group I belong to.	1(5.3)	1(5.3)	12(63.2)	4(26.3)	3.11	0.737
6	I have a strong sense of belonging to my own ethnic group.	1(5.3)	2(10.5)	10(52.6)	6(31.6)	3.11	0.809
7	I understand pretty well what my ethnic group membership means to me.	1(5.3)	4(21.1)	14(73.7)	0	2.68	0.582
8	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	1(5.3)	7(36.8)	10(52.6)	1(5.3)	2.58	0.692
9	I have a lot of pride in my ethnic group.	1(5.3)	1(5.3)	10(52.6)	7(36.8)	3.21	0.787
10	I participate in cultural practices of my own group, such as special food, music, or customs.	2(10.5)	4(21.1)	11(57.9)	2(10.5)	2.68	0.820
11	I feel a strong attachment towards my own ethnic group.	1(5.3)	4(21.1)	12(63.2)	2(10.5)	2.79	0.713
12	I feel good about my cultural or ethnic background.	1(5.3)	1(5.3)	11(57.9)	6(31.6)	3.16	0.765

The findings demonstrate that there was no statistically significant difference of ethnic identity between students and academic staff (Students mean rank = 103.20; Academic staff mean rank = 95.66; U= 1,627.5 z = -0.532 p = 0.595 r = -0.037). Both academic staff and students were similar related to their ethnic identity (cognitive and affective). It also means that the academics and students' ethnic identity have been searched, affirmed, belonged, and committed towards their ethnic groups (Phinney, 1999).

Uncivil behaviour in nursing academic environment

Uncivil behaviour in nursing academic environment will be presented in four categories: (a) perceived students' behaviours, (b) perceived academic staff members' behaviours, (c) perceived nurses' behaviours and (d) uncivil behaviour as a problem. In addition, a nonparametric test (Mann-Whitney) was used to compare the opinions of perceived uncivil behaviour between students and academic staff.

1) Perceived students' behaviours

There are 19 items that reflect students' disruptive behaviours (Table 5.8) and 22 items of students' threatening behaviours (Table 5.9) from the INE survey. The survey employed a Likert scale range 1-4 (1=never, 2=sometimes, 3=usually, 4=always).

Table 5.8 shows that there were no significant differences on perceived students' disruptive behaviours between students and academic staff perceptions (p value 0.432). For example, item number six, both respondents agreed that students *usually* hold conversations that distract others (median=3). On the other hand, there was a significant difference on perceived students' disruptive behaviours between students and academic

staff perceptions that have experienced or seen in the past 12 months (p value 0.029).

For example, students stated that students were *never* to not admitting an error made in patient care in the past 12 months (Table 5.8; number 10; median=1) but the academic staff stated that the students were sometimes did it (median=2).

Table 5.9 shows there were no significant differences of perceived students' threatening between students and academic staff perceptions that both consider disruptive and have experienced or seen in the past 12 months (p value > 0.05). Both respondents agreed that the threatening students' behaviour tended to never happen (Total median=1).

Table 5.8: Perception of students' disruptive behaviours

Students' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Acting bored or apathetic	2.54	2.00	.716	2.39	2.00	.916	2.40	2.00	.693	2.00	2.00	.485
2. Making groans to show disapproval	2.59	2.00	.856	2.33	2.00	.907	2.23	2.00	.689	1.67	2.00	.594
3. Making sarcastic remarks or gestures	2.37	2.00	1.203	2.22	2.00	1.166	1.64	2.00	.704	1.33	1.00	.485
4. Sleeping in class	2.19	2.00	.953	2.11	2.00	1.023	1.82	2.00	.641	1.61	2.00	.502
5. Not paying attention in class	2.39	2.00	.788	2.56	2.50	1.042	2.26	2.00	.652	2.06	2.00	.725
6. Holding conversations that distract you or others	2.94	3.00	.844	3.00	3.00	.907	2.48	2.00	.776	2.28	2.00	.461
7. Refusing to answer direct questions	1.88	2.00	.901	2.11	2.00	1.132	1.61	2.00	.635	1.67	2.00	.767
8. Using a computer to do unrelated classroom work	2.19	2.00	.968	2.33	2.00	1.085	1.83	2.00	.717	1.83	2.00	.707
9. Using phones or cell phones during class	2.66	3.00	.859	2.33	2.00	1.188	2.50	2.00	.753	1.72	2.00	.669
10. Arriving late for class	2.72	3.00	.924	2.50	2.00	.786	2.52	2.00	.841	2.06	2.00	.416
11. Leaving class ahead of schedule	1.98	2.00	1.013	1.78	1.00	1.263	1.58	1.00	.680	1.28	1.00	.461
12. Missing class (not present in class/ being absent)	2.18	2.00	.924	2.28	2.00	.958	1.99	2.00	.663	1.78	2.00	.548
13. Being unprepared for class	2.50	2.00	.767	2.33	2.00	.767	2.42	2.00	.656	2.00	2.00	.686
14. Creating tension by dominating class discussion	2.31	2.00	.942	2.06	2.00	1.056	2.02	2.00	.838	1.67	2.00	.485
15. Cheating on exams or quizzes	2.72	3.00	1.020	2.72	2.00	.895	2.22	2.00	.912	2.06	2.00	.416
16. Demanding make-up exams, extensions for assignments, grade changes, or other special favours	2.20	2.00	.993	2.22	2.00	1.003	1.88	2.00	.783	1.78	2.00	.548
17. Not charting nursing care	2.13	2.00	1.067	2.33	2.00	1.085	1.64	1.00	.774	1.83	2.00	.618
18. Being unprepared for the clinical experience	2.23	2.00	1.017	2.39	2.00	1.037	1.81	2.00	.749	1.89	2.00	.676
19. Not admitting an error made in patient care	2.21	2.00	1.175	2.00	2.00	.970	1.57	1.00	.721	1.65	2.00	.493
Total	2.37	2.21	0.94	2.32	2.03	1.01	2.02	1.84	0.73	1.80	1.89	0.57
	Students' mean rank = 103.01 Academic staff mean rank = 91.61 U = 1,478; p = 0.432; z = -0.786; r = 0.055						Students' mean rank = 104.81 Academic staff mean rank = 73.14 U = 1,145.5; **p = 0.029**; z = -2.185; R = 0.153					

Table 5.9: Perception of students' threatening behaviours

Students' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Taunting or showing disrespect to other students	2.64	2.00	1.044	2.22	2.00	1.060	1.59	1.00	.670	1.28	1.00	.461
2. Taunting or showing disrespect to faculty	2.39	2.00	1.207	1.94	1.00	1.259	1.63	1.00	.751	1.33	1.00	.594
3. Taunting or showing disrespect to nurses	2.46	2.00	1.235	2.00	1.50	1.237	1.44	1.00	.608	1.17	1.00	.383
4. Taunting or showing disrespect to patients	2.44	2.00	1.305	1.78	1.00	1.263	1.56	1.00	.633	1.22	1.00	.428
5. Challenging faculty staff knowledge or credibility	2.37	2.00	1.168	1.89	1.00	1.183	1.59	1.00	.720	1.28	1.00	.461
6. Challenging nurses knowledge or credibility	2.36	2.00	1.156	1.83	1.00	1.150	1.40	1.00	.677	1.17	1.00	.383
7. Making harassing comments (racial, ethnic, gender) directed at other students	2.49	2.00	1.360	1.72	1.00	1.274	1.26	1.00	.559	1.06	1.00	.236
8. Making harassing comments (racial, ethnic, gender) directed at faculty staff	2.35	2.00	1.335	1.78	1.00	1.263	1.23	1.00	.473	1.22	1.00	.428
9. Making harassing comments (racial, ethnic, gender) directed at nurses	2.34	2.00	1.362	1.83	1.00	1.249	1.21	1.00	.457	1.17	1.00	.383
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.35	2.00	1.371	1.78	1.00	1.263	1.58	1.50	.648	1.39	1.00	.502
11. Making vulgar comments directed at other students	2.51	2.00	1.269	1.94	1.50	1.211	1.26	1.00	.521	1.11	1.00	.323
12. Making vulgar comments directed at faculty staff	2.39	2.00	1.344	1.78	1.00	1.263	1.33	1.00	.584	1.22	1.00	.428
13. Making vulgar comments directed at nurses	2.41	2.00	1.327	1.78	1.00	1.263	1.26	1.00	.541	1.17	1.00	.383
14. Making vulgar comments directed at patients	2.37	2.00	1.328	1.72	1.00	1.274	1.11	1.00	.351	1.17	1.00	.383
15. Sending inappropriate e-mails to other students	2.22	2.00	1.323	1.72	1.00	1.274	1.10	1.00	.363	1.00	1.00	0.000
16. Sending inappropriate e-mails to faculty staff	2.22	1.00	1.343	1.67	1.00	1.283	1.10	1.00	.378	1.11	1.00	.323
17. Making threats of physical harm against other students	2.34	2.00	1.389	1.72	1.00	1.274	1.09	1.00	.386	1.11	1.00	.323
18. Making threats of physical harm against faculty staff	2.30	1.00	1.397	1.78	1.00	1.263	1.24	1.00	.569	1.17	1.00	.383
19. Damaging property	2.37	2.00	1.378	1.83	1.00	1.249	1.10	1.00	.397	1.00	1.00	0.000
20. Making statements about having easy access to weapons or sharp objects	2.32	2.00	1.404	1.67	1.00	1.283	1.43	1.00	.716	1.22	1.00	.428
21. Neglecting patients in the clinical area	2.49	2.00	1.382	1.83	1.00	1.249	1.49	1.00	.704	1.72	2.00	.669
22. Charting patients are not completed	2.43	2.00	1.310	2.17	2.00	1.098	1.33	1.02	.56	1.20	1.05	.38
Total	1.95	2.00	.739	1.67	2.00	.485	1.59	1.00	.670	1.28	1.00	.461
	Students' mean rank = 104.41 Academic staff mean rank = 77.28 U = 1,220; p = 0.061; z = -1.873; r = -0.131						Students' mean rank = 104.25 Academic staff mean rank = 78.83 U = 1,248; p = 0.079; z = -1.757; r = -0.123					

2) Perceived academic staff behaviours

Academic staff disruptive behaviours consisted of 21 items (Table 5.10) and 22 items in the surveys for academic threatening behaviours (Table 5.11). Table 5.10 shows that there were statistically significant differences on perceived academic staff disruptive behaviours between students and academic staff (p value 0.003) and have been experienced or seen in the past 12 months (p value 0.001).

Table 5.10 further clarifies that the students thought that academic staff disruptive behaviours tended to be considered disruptive *sometimes* (Total median=2). On the other hand, the academics thought that academic staff disruptive behaviours tended to be *never* considered disruptive (Total median=1). In addition, the students implied that the academic staff disruptive behaviours happened *sometimes* (Total median=2) but the academic staffs implied that the behaviours tended to *never* occur (Total median=1).

Table 5.10: Perception of academic disruptive behaviours

Academics' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Arriving late for schedule activities	2.91	3.00	0.82	2.63	2.00	0.90	2.51	2.00	0.69	2.00	2.00	0.33
2. Leaving class ahead of schedule	2.50	2.00	0.89	2.47	2.00	1.12	2.15	2.00	0.66	1.95	2.00	0.40
3. Cancelling scheduled activities without warning	3.02	3.00	0.98	2.11	2.00	1.20	2.36	2.00	0.76	1.42	1.00	0.61
4. Being unprepared for scheduled activities	2.52	2.00	1.12	1.89	1.00	1.24	1.75	2.00	0.60	1.37	1.00	0.60
5. Ineffective teaching style/methods	2.77	3.00	0.93	2.05	2.00	1.18	2.05	2.00	0.66	1.47	1.00	0.61
6. Deviating from the course syllabus, changing assignments or test dates	2.65	3.00	1.10	1.95	1.00	1.22	1.74	2.00	0.64	1.37	1.00	0.60
7. Being inflexible, rigid and authoritarian	2.70	3.00	1.05	2.26	2.00	1.19	1.97	2.00	0.68	1.79	2.00	0.79
8. Punishing the entire class for one student's misbehaviour	2.36	2.00	1.29	1.89	1.00	1.20	1.35	1.00	0.53	1.32	1.00	0.48
9. Making statements about being disinterested in the subject matter	2.25	2.00	1.16	1.89	1.00	1.33	1.41	1.00	0.53	1.26	1.00	0.73
10. Being distant and cold towards others (unapproachable, reject students opinions)	2.48	2.00	1.16	1.89	1.00	1.24	1.57	2.00	0.60	1.32	1.00	0.58
11. Refusing or reluctant to answer questions	2.30	2.00	1.27	1.74	1.00	1.15	1.24	1.00	0.48	1.21	1.00	0.42
12. Subjective grading of students	2.82	3.00	1.10	1.89	2.00	1.10	1.95	2.00	0.80	1.53	2.00	0.51
13. Making condescending remarks or put downs	2.54	2.00	1.29	1.79	1.00	1.27	1.61	1.00	0.70	1.16	1.00	0.50
14. Exerting superiority, showing arrogance towards others	2.57	2.00	1.16	1.89	1.00	1.24	1.66	2.00	0.67	1.32	1.00	0.58
15. Threatening to fail student for not complying with faculty's demands	2.50	2.00	1.28	1.74	1.00	1.24	1.40	1.00	0.59	1.11	1.00	0.32
16. Making rude gestures or behaviours towards others	2.43	2.00	1.35	1.79	1.00	1.23	1.31	1.00	0.61	1.21	1.00	0.42
17. Ignoring disruptive student behaviour	2.62	2.00	1.03	2.05	2.00	1.27	1.83	2.00	0.65	1.32	1.00	0.48
18. Being unavailable to respond to the students outside of class in office hours	2.49	2.00	1.13	1.68	1.00	1.16	1.68	2.00	0.66	1.37	1.00	0.50
19. Being unavailable to respond to the students on the patient care unit	2.31	2.00	1.22	1.68	1.00	1.25	1.39	1.00	0.60	1.11	1.00	0.32
20. Being unavailable to respond to the students for practice in the skills laboratory	2.36	2.00	1.29	1.68	1.00	1.25	1.36	1.00	0.54	1.11	1.00	0.32
21. Taking over from the student when providing patient care	2.15	2.00	1.24	1.79	1.00	1.03	1.22	1.00	0.44	1.42	1.00	0.51
Total	2.53	2.00	1.14	1.94	1.00	1.19	1.69	2.00	0.62	1.39	1.00	0.50
	Students' mean rank = 106.43 Academic staff mean rank = 64.26 U = 1,031; **p = 0.003**; z = -2.966; R = -0.208						Students' mean rank = 107.98 Academic staff mean rank = 49.16 U = 744; **p =0.0001**; z = -4.141; R=-0.290					

Table 5.11: Perception of academic threatening behaviours

Academics' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Taunting or showing disrespect to students	2.58	2.00	1.24	1.84	1.00	1.12	1.59	1.00	0.70	1.42	1.00	0.61
2. Taunting or showing disrespect to other faculty staff	2.53	2.00	1.18	1.84	1.00	1.21	1.55	1.00	0.62	1.21	1.00	0.42
3. Taunting or showing disrespect to nurses	2.39	2.00	1.30	1.84	1.00	1.26	1.28	1.00	0.48	1.16	1.00	0.50
4. Taunting or showing disrespect to patients	2.39	2.00	1.34	1.74	1.00	1.24	1.18	1.00	0.45	1.05	1.00	0.23
5. Challenging other faculty staff knowledge or credibility	2.41	2.00	1.19	1.84	1.00	1.17	1.49	1.00	0.63	1.26	1.00	0.56
6. Challenging nurses knowledge or credibility	2.42	2.00	1.20	1.84	1.00	1.17	1.41	1.00	0.55	1.21	1.00	0.54
7. Making harassing comments (racial, ethnic, gender) directed at students	2.48	2.00	1.32	1.74	1.00	1.24	1.34	1.00	0.59	1.16	1.00	0.37
8. Making harassing comments (racial, ethnic, gender) directed at other faculty staff	2.38	2.00	1.36	1.74	1.00	1.24	1.17	1.00	0.45	1.16	1.00	0.37
9. Making harassing comments (racial, ethnic, gender) directed at nurses	2.37	2.00	1.38	1.79	1.00	1.27	1.15	1.00	0.40	1.16	1.00	0.50
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.35	2.00	1.39	1.74	1.00	1.24	1.21	1.00	0.42	1.11	1.00	0.32
11. Making vulgar comments directed at students	2.58	2.00	1.20	2.00	1.00	1.25	1.66	2.00	0.67	1.47	1.00	0.61
12. Making vulgar comments directed at other faculty	2.31	2.00	1.31	1.95	1.00	1.27	1.30	1.00	0.55	1.32	1.00	0.58
13. Making vulgar comments directed at nurses	2.35	2.00	1.34	1.79	1.00	1.27	1.26	1.00	0.51	1.16	1.00	0.37
14. Making vulgar comments directed at patients	2.35	2.00	1.35	1.79	1.00	1.27	1.16	1.00	0.39	1.11	1.00	0.32
15. Sending inappropriate e-mails to students	2.25	2.00	1.33	1.74	1.00	1.28	1.10	1.00	0.36	1.00	1.00	0.00
16. Sending inappropriate e-mails to other faculty staff	2.22	2.00	1.32	1.74	1.00	1.28	1.07	1.00	0.26	1.00	1.00	0.00
17. Making threats of physical harm against students	2.34	2.00	1.41	1.79	1.00	1.27	1.09	1.00	0.34	1.05	1.00	0.23
18. Making threats of physical harm against other faculty staff	2.30	1.00	1.40	1.74	1.00	1.28	1.05	1.00	0.27	1.00	1.00	0.00
19. Damaging property	2.29	2.00	1.36	1.74	1.00	1.28	1.14	1.00	0.43	1.00	1.00	0.00
20. Making statements about having easy access to weapons	2.24	1.00	1.39	1.74	1.00	1.28	1.08	1.00	0.31	1.00	1.00	0.00
21. Neglecting patients in the clinical area	2.43	2.00	1.40	1.84	1.00	1.26	1.17	1.00	0.42	1.16	1.00	0.37
22. Charting patients are not completed	2.38	2.00	1.37	1.89	1.00	1.20	1.25	1.00	0.53	1.37	1.00	0.60
Total	2.38	1.91	1.32	1.80	1.00	1.24	1.26	1.05	0.47	1.16	1.00	0.34
	Students' mean rank = 105.78 Academic staff mean rank = 70.55 U = 1,150.5; **p = 0.013**; z = -2.485; R = -0.174						Students' mean rank = 105.84 Academic staff mean rank = 69.95 U = 1,139; **p =0.011**; z = -2.538; r=-0.178					

Table 5.11 shows that there were statistically significant differences of perceived academic staff threatening behaviours that were considered disruptive and have been experienced or seen in the past 12 months (p value <0.05). For example, the students stated that the academic staff made vulgar comments directed at students *sometimes* (Table 5.11; number 11; median=2). In contrast, the academic staff stated d that they *never* tended to make vulgar comments directed at students (median=1).

3) Perceived nurses' behaviours

Nurses' disruptive behaviours are comprised of 16 items (Table 5.12) and 20 items reflecting nurses threatening behaviours (Table 5.13) from the INE survey. Table 5.12 displays there were no statistically significant differences of perceived nurses' disruptive between students and academic staff perceptions that consider disruptive and have seen or experienced in the past 12 months (p value > 0.05). Most of both respondent groups thought that nurses behaved uncivilly that considered disruptive *sometimes* (Total *median=2)*.

Table 5.13 displays that there was a statistically significant difference of perceived threatening nurses' behaviours between students and academic staff that considered disruptive (p value 0.013). The students perceived that the nurses threatening behaviour such as making vulgar comments directed at students was considered disruptive *usually* (number 11; median=3), but the academics staff perceived it *never* disruptive (median=1).

Table 5.12: Perception of nurses' disruptive behaviours

Nurses' disruptive behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Arriving late for work	2.68	2.00	1.08	2.28	2.00	1.02	1.86	2.00	0.69	1.89	2.00	0.58
2. Leaving work early	2.61	2.00	1.13	2.17	2.00	0.99	1.75	2.00	0.68	1.78	2.00	0.65
3. Being unprepared for patient care	2.63	3.00	1.13	2.11	2.00	1.13	1.68	2.00	0.63	1.72	2.00	0.67
4. Refusing to allow students to perform patient care	2.50	2.00	1.18	1.94	2.00	1.00	1.58	1.00	0.65	1.61	2.00	0.61
5. Ineffective teaching style/methods	2.62	2.00	1.12	2.33	2.00	0.97	1.68	2.00	0.68	1.94	2.00	0.73
6. Being inflexible, rigid and authoritarian	2.69	3.00	1.14	2.22	2.00	1.17	1.89	2.00	0.81	1.72	1.50	0.83
7. Making statements about being disinterested in working with students	2.58	3.00	1.19	1.83	1.00	1.10	1.71	2.00	0.78	1.44	1.00	0.62
8. Being distant and cold towards others (unapproachable, reject students' opinions)	2.62	3.00	1.22	1.94	2.00	1.06	1.72	2.00	0.76	1.56	1.50	0.62
9. Refusing or reluctant to answer questions	2.59	2.00	1.14	2.00	2.00	1.14	1.68	2.00	0.70	1.56	1.50	0.62
10. Subjective grading of students	2.70	3.00	1.16	2.22	2.00	1.06	1.76	2.00	0.75	1.78	2.00	0.65
11. Making condescending remarks or put downs	2.68	3.00	1.22	2.06	2.00	1.21	1.69	2.00	0.77	1.50	1.00	0.62
12. Exerting superiority, showing arrogance towards others	2.63	2.00	1.16	2.00	1.50	1.24	1.69	2.00	0.71	1.50	1.00	0.62
13. Threatening to fail student for not complying with nurse's demands	2.50	2.00	1.27	2.00	1.50	1.19	1.46	1.00	0.63	1.44	1.00	0.70
14. Making rude gestures or behaviours toward others	2.53	2.00	1.24	1.94	1.50	1.21	1.49	1.00	0.63	1.33	1.00	0.49
15. Being unavailable to respond to the students on the patient care unit	2.59	2.00	1.20	1.83	1.00	1.10	1.63	2.00	0.69	1.50	1.00	0.62
16. Taking over from the student when providing patient care	2.41	2.00	1.20	2.06	2.00	1.00	1.49	1.00	0.61	1.72	2.00	0.57
Total	2.60	2.00	1.17	2.00	1.78	1.10	1.67	1.00	0.70	1.63	1.00	0.64
	Students' mean rank = 104.68 Academic staff mean rank = 81.24 U = 1,353.5; p = 0.099; z = -1.651; R = -0.116						Students' mean rank = 102.55 Academic staff mean rank = 101.97 U = 1,747.5; p =0.967; z = -0.041; R=-0.003					

Table 5.13: Perception of nurses' threatening behaviours

Nurses' threatening behaviour	*Consider disruptive*						*Have experienced or seen in the past 12 months*					
	Student			*Academic*			*Student*			*Academic*		
	Mean	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*	*Mean*	*Median*	*SD*
1. Taunting or showing disrespect to students	2.66	3.00	1.16	2.00	2.00	1.20	1.74	2.00	0.74	1.53	1.00	0.61
2. Taunting or showing disrespect to faculty	2.50	2.50	1.27	1.89	1.00	1.24	1.42	1.00	0.59	1.26	1.00	0.56
3. Taunting or showing disrespect to other nurses	2.56	3.00	1.18	1.84	1.00	1.21	1.58	2.00	0.63	1.32	1.00	0.48
4. Taunting or showing disrespect to patients	2.57	3.00	1.23	1.95	1.00	1.22	1.62	2.00	0.69	1.42	1.00	0.77
5. Challenging faculty staff knowledge or credibility	2.51	2.50	1.27	1.84	1.00	1.12	1.43	1.00	0.64	1.26	1.00	0.45
6. Challenging nurses knowledge or credibility	2.52	3.00	1.22	1.95	2.00	1.18	1.51	1.00	0.68	1.37	1.00	0.50
7. Making harassing comments (racial, ethnic, gender) directed at students	2.50	2.00	1.30	1.79	1.00	1.23	1.37	1.00	0.60	1.21	1.00	0.42
8. Making harassing comments (racial, ethnic, gender) directed at faculty	2.43	2.00	1.33	1.74	1.00	1.24	1.19	1.00	0.43	1.11	1.00	0.32
9. Making harassing comments (racial, ethnic, gender) directed at other nurses	2.46	2.00	1.35	1.74	1.00	1.24	1.28	1.00	0.56	1.11	1.00	0.32
10. Making harassing comments (racial, ethnic, gender) directed at patients	2.49	2.00	1.35	1.74	1.00	1.15	1.29	1.00	0.53	1.21	1.00	0.42
11. Making vulgar comments directed at students	2.68	3.00	1.18	1.95	1.00	1.22	1.68	2.00	0.72	1.42	1.00	0.61
12. Making vulgar comments directed at faculty	2.44	3.00	1.31	1.89	1.00	1.20	1.29	1.00	0.58	1.26	1.00	0.45
13. Making vulgar comments directed at other nurses	2.45	2.00	1.26	1.84	1.00	1.12	1.40	1.00	0.62	1.37	1.00	0.50
14. Making vulgar comments directed at patients	2.54	3.00	1.22	2.05	2.00	1.22	1.47	1.00	0.68	1.53	1.00	0.84
15. Making threats of physical harm against students	2.39	2.00	1.37	1.68	1.00	1.25	1.15	1.00	0.43	1.05	1.00	0.23
16. Making threats of physical harm against faculty	2.36	2.00	1.38	1.79	1.00	1.36	1.12	1.00	0.37	1.00	1.00	0.00
17. Damaging property	2.37	2.00	1.36	1.74	1.00	1.28	1.14	1.00	0.44	1.00	1.00	0.00
18. Making statements about having easy access to weapons	2.35	2.00	1.40	1.74	1.00	1.28	1.07	1.00	0.32	1.00	1.00	0.00
19. Neglecting patients in the clinical area	2.65	3.00	1.29	1.95	1.00	1.27	1.63	1.00	0.75	1.32	1.00	0.75
20. Charting patients are not completed	2.61	3.00	1.24	2.16	2.00	1.17	1.72	2.00	0.79	1.95	2.00	1.03
Total	2.50	2.50	1.28	1.86	1.00	1.22	1.40	1.00	0.59	1.28	1.00	0.46
	Students' mean rank = 105.75 Academic staff mean rank = 70.82 U = 1,155.5; **p = 0.013**; z = -2.473; R = -0.173						Students' mean rank = 104.44 Academic staff mean rank = 83.61 U = 1,398.5; p =0.139; z = -1.479; R= -0.139					

Table 5.13 further shows that there were no statistically significant differences of perceived threatening nurses' behaviours between students and academic staff that they have experienced or seen in the past 12 months (p value 0.139). Most of these respondents (both students and academic staff) agreed that they almost have never seen or experienced the nurses' threatening behaviour in the past 12 months (Total median=1).

3) Uncivil behaviour as a problem

The findings of the study demonstrated that both students (44.86%) and academic staff (52.6%) stated that uncivil behaviour in nursing education environment was a serious problem, as shown in Table 5.14 below:

Table 5.14: The extent of uncivil behaviour in the nursing academic environment

Question	*Respond respondents*			
	Students		*Academics*	
To what extent do you think uncivil behaviour in the nursing academic environment is a problem?	*N*	*%*	*N*	*%*
No problem at all	2	1.08	1	5.3
Mild problem	21	11.35	4	21.1
Moderate problem	73	39.46	4	21.1
Serious problem	83	44.86	10	52.6
I don't know/can't answer	5	2.7	0	0.0
Not filled	1	0.54	0	0
Total	184	0.54	19	0.0

The survey further illuminates that the uncivil behaviour was a problem in the classroom, skills laboratory and clinical practice. Nearly half of the students (46.49%) and nearly a third of the academics (36.84%) thought that students and academic staff were equally likely to engage in uncivil behaviour in the classroom (Table 5.15).

Table 5.15: Perception of uncivil behaviour is a problem in classroom

Question	*Respond respondents*			
	Students		*Academics*	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	*N*	*%*	*N*	*%*
Academic members are much more likely	21	11.35	1	5.26
Academic members are a little more likely	7	3.78	3	15.79
About equal	86	46.49	7	36.84
Students are a little more likely	9	4.86	1	5.26
Students are much more likely	45	24.32	6	31.58
Don't know	16	8.65	1	5.26
Not filled	1	0.54	0	0.00
Total	185	100	19	100

Similarly, Table 5.16 shows that both students (36.22%) and academic staff (35%) thought students and academic staff were equally likely to engage in uncivil behaviour in the skills laboratory.

Table 5.16: Perception of uncivil behaviour is a problem in skill laboratory

Question	*Respond respondents*			
	Students		*Academics*	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	*N*	*%*	*N*	*%*
Academic members are much more likely	40	21.62	3	15
Academic members are a little more likely	12	6.49	4	20
About equal	67	36.22	7	35
Students are a little more likely	13	7.03	0	0.00
Students are much more likely	31	16.79	5	25
Don't know	21	11.35	1	5
Not filled	1	0.54	0	0.00
Total	185	100	20	100

Table 5.17 shows that most academic staff' perceived that nurses were much more likely to engage in uncivil behaviour in the clinical practice area (42.11%) while less than a third (28.42%) of the students thought that nurses were much more likely to engage in uncivil behaviour. On the contrary nearly a third of the students thought that academic members/clinical educator/nurse/students were about equal (30.53%) while 21% of the academic staff thought that

academic members/clinical educators/nurses were about equal to engage in uncivil behaviour.

Table 5.17: Perception of uncivil behaviour as a problem in clinical practice

Question	*Respond respondents*			
	Students		*Academics*	
Based on your experiences or perceptions, do you think that students or academic members/clinical educator or nurses are more likely to engage in uncivil behaviour in the clinical practice?	*N*	*%*	*N*	*%*
Academic members/clinical educator are much more likely	8	4.21	0	0.00
Academic members/clinical educator are a little more likely	18	9.47	2	10.53
Nurses are much more likely	54	28.42	8	42.11
Nurses are a little more likely	2	1.05	0	0.00
Students are much more likely	18	9.47	4	21.05
Students are a little more likely	6	3.16	0	0.00
About equal	58	30.53	4	21.05
Don't know	25	13.16	1	5.26
Not filled	1	0.53	0	0.00
Total	190	100	19	100

Furthermore, the survey also identified the settings where most instances of uncivil behaviour occurred in nursing education (Table 5.18).

Table 5.18: Perception of where uncivil behaviour occurs most frequently

Question	*Respond of respondents*			
	Students		*Academics*	
In your opinion, where are uncivil behaviours the most prevalent?	*N*	*%*	*N*	*%*
Traditional classroom	77	41.62	8	42.11
Skill laboratory	20	10.81	3	15.79
Clinical unit	77	41.62	8	42.11
Not filled	11	5.95	0	0.00
Total	185	100	19	100

It can be seen that students (41.62%) and academic staff (42.11%) thought the most frequent settings for uncivil behaviour were both in the traditional classroom and clinical practice.

Uncivil behaviour in the context of ethnicity, religious faith and socio-economic background

This section also test the propositions of this study (see chapter three) including:

1. Students and academic staff are perceived differently regarding incivility in Indonesia nursing education.

2. Students and academic staff's perceptions of incivility in Indonesia nursing education are influenced by their ethnicity, religious faith and socio-economic background.

A nonparametric test (Kruskal-Wallis/Mann-Whitney/Spearman) was used to compare or correlate the uncivil behaviours to respondents' ethnicity/ethnic identity/religion/religious faith/SES. The findings revealed that there were a number of correlations that were statistically significant based on each type of respondents. The findings that based on students (Table 5.19) and academic staff (Table 5.20) perceptions can be seen in below:

Table 5.19: Results of the significance statistical test with students as respondent

No	*Null hypothesis*	*Statistical test findings*
1	There is no significant relationship between the perceived students threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.238; 95% bca ci [0.102, 0.373]; p= 0.001
2	There is no significant relationship between the perceived academics disruptive behaviour that considered disruptive and religious faith/practice	r_s= 0.217; 95% bca ci [0.080, 0.357]; p= 0.003
3	There is no significant relationship between the perceived academics threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.205; 95% bca ci [0.054, 0.350]; p= 0.005
4	There is no significant relationship between the perceived nurses' disruptive behaviour that considered disruptive and religious faith/practice	r_s= 0.191; 95% bca ci [0.037, 0.330]; p= 0.009
5	There is no significant relationship between the perceived nurses threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.221; 95% bca ci [0.074, 0.351]; p= 0.002

Table 5.19 shows that there were statistically significant correlations between perceived behaviours and students religions backgrounds/religious faith.

Table 5.20 shows there were statistically significant correlations between perceived behaviours and academic staff SES backgrounds.

Table 5.20: Results of the significance statistical test with academic staff as respondent

No	*Null hypothesis*	*Statistical test findings*
1	The distribution of perceived academic staff members' disruptive behaviour that have experienced or seen in the past 12 months is the same across categories of employment	U= 332 p= 0.047 z= 2.017 r=0.462
2	The distribution of perceived nurses' threatening behaviour that have experienced or seen in the past 12 months	U=32 p=0.047 z=2.072 r=0.475
3	The distribution of perceived nurses' disruptive behaviour that considered disruptive	H(4)=9.826 p=0.043 J=92.5 z=2.075 p=0.038 r=0.476

Additionally, the findings based on total respondents can be seen in Table 5.21.

Table 5.21: Results of the significance statistical test with total respondents

No	*Null hypothesis*	*Statistical test findings*
1	The distribution of perceived students threatening behaviour that considered disruptive is the same across categories of religion	H(3) = 8.708; p= 0.033 Pairwise comparisons with adjusted p-values: none
2	The distribution of perceived academics disruptive behaviour that considered disruptive is the same across categories of religion	H(3) = 8.644; p= 0.034 Pairwise comparisons with adjusted p-values: None
3	The distribution of perceived academics threatening behaviour that considered disruptive is the same across categories of religion	H(3) = 10.222; p= 0.017 Pairwise comparisons with adjusted p-values: none
4	The distribution of perceived nurses threatening behaviour that considered disruptive is the same across categories of religion	H(3) = 9.836; p= 0.020 Pairwise comparisons with adjusted p-values: none
5	There was no significant relationship between the perceived students threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.179; 95% bca ci [0.040, 0.325]; p= 0.011
6	There was no significant relationship between the perceived academics disruptive behaviour that considered disruptive and religious faith/practice	r_s= 0.144; 95% bca ci [-0.001, 0.288]; p= 0.040
7	There was no significant relationship between the perceived academics threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.145; 95% bca ci [-0.011, 0.291]; p= 0.040
8	There was no significant relationship between the perceived nurses' disruptive behaviour that considered disruptive and religious faith/practice	r_s= 0.153; 95% bca ci [0.020, 0.289]; p= 0.029
9	There was no significant relationship between the perceived nurses threatening behaviour that considered disruptive and religious faith/practice	r_s= 0.163; 95% bca ci [0.019, 0.305]; p= 0.020
10	The distribution of perceived academic staff members' disruptive behaviour that considered disruptive is the same across categories of education	H(5)=13.942 p=0.16 J=6,671 z=-1.526 p=0.127 r=-0.106
11	The distribution of perceived academic staff members' disruptive behaviour that have experienced or seen in the past 12 months is the same across categories of education	H(5)=20.879 p=0.001 J=6,0775 z=-2.813 p=0.005 r=-0.196
12	The distribution of perceived academic staff members' threatening behaviour that considered disruptive is the same across categories of education	H(5)=13.263 p=0.021 J=7,260 z=-0.252 p=0.801 r=-0.0176
13	The distribution of perceived academic staff members' threatening behaviour that have experienced or seen in the past 12 months is the same across categories of education	H(5)=11.246 p=0.047 J=6,278.5 z=-2.388 p=0.017 r=-0.167
14	The distribution ofpPerceived nurses' threatening behaviour that considered disruptive is the same across categories of education	H(5)=13.331 p=0.020 J=6,822.5 z=-1.206 p=0.228 r=-0.084

15	The distribution of perceived academic staff members' disruptive behaviour that have experienced or seen in the past 12 months is the same across categories of employment	H(5)=26.455 p=0.0001
16	The distribution of perceived academic staff members' threatening behaviour that have experienced or seen in the past 12 months is the same across categories of employment	H(5)=17.233 p=0.004 J=5,808 z=0.115 p=0.909 r=0.008
17	The distribution of perceived nurses' threatening behaviour that have experienced or seen in the past 12 months is the same across categories of employment	H(5)=12.991 p=0.023 J=6,027 z=0.636 p=0.524 r=0.044
18	The distribution of perceived academic staff members' disruptive behaviour that considered disruptive is the same across categories of income	H(11)=23.627 p=0.014 J=7,931 z=-0.580 p=0.562 r=-0.041
19	The distribution of perceived academic staff members' disruptive behaviour that have experienced or seen in the past 12 months is the same across categories of income	H(11)=27.995 p=0.003 J=7,855 z=-0.741 p=0.459 r=-0.052

Table 5.21 shows that there were statistically significant relations between perceived uncivil behaviour and respondents' religions backgrounds/ religious practices and SES backgrounds.

In summary, most of the respondents were female, Christians, Indo-Malay with Batak as sub-ethnic and with middle socio-economic status. Both participants (students and academic staff) reported that incivility was a serious problem in nursing education settings; the perpetrators were academic staff, students and nurses. Incivility occurred most frequent in the classroom and clinical practice. There were also some different perceptions of incivility between students and academic staff such as perceived academic disruptive and threatening behaviours. The quantitative findings further showed that there were no significant differences of perceived uncivil behaviour based on the participants' background.

5.2.2 Qualitative findings

This section will be discussed in two parts: (1) findings of the questionnaires' open-ended questions (2) findings of the interviews and observations.

Findings of the questionnaires' open-ended questions

Two hundred and four (204) participants comprising of 19 academics and 185 students responded to the open-ended questions within the INE questionnaires. The questionnaires addressed the ways or types of the uncivil behaviour instances, reasons for the instances, differences in the instances, as well as suggestions for addressing uncivil behaviour instances in nursing education.

The findings of the open-ended questions of the INE questionnaires are presented in eight tables Table 5.22-5.29 as shown below. Table 5.22 and 5.23 presents the types of uncivil behaviour instances, Table 5.24 and 5.25 presents the reasons for uncivil behaviour, Table 5.26 and 5.27 presents the differences, finally Table 5.28 and 5.29 presents suggestions for managing uncivil behaviour. Furthermore the findings are presented in terms of themes with their illustrative examples that emerged from the narrative findings including individual backgrounds of the respondents.

1) *Types of uncivil behaviour*

Table 5.22 and table 5.23 indicates the types of uncivil behaviours reported by the respondents (students and academic staff) which occurred in nursing education.

Table 5.22 shows the students' opinions regarding the ways or types of being uncivil in nursing education. Three themes came out from the opinions of the students as follows:

Table 5.22: Types of uncivil behaviour perceived by students in nursing education

Themes	*Illustrative examples*	*Respondents context*
Unprofessional conduct	076s) "in classroom: coming late, talking while in the teaching-learning process, playing mobile phone while in the learning process. In laboratory: being late. In clinical practice: being late, underestimating client's problems"	Female, year 3, Islam, Batak
	(191s) "laboratory and clinical practice: being late"	Male, profession program, Islam, mixed: Malay-Aceh
	(196s) "coming late, changing the schedule or the time for exam at any time, subjective grading, inflexible, rigid, authoritarian, does not want to listen to the students' opinions , neglecting the patients"	Female, profession program, Christian, Batak
	(176s) "in classroom: students often come without preparation, the learning time schedule changed suddenly, did not provide with the teaching materials, teacher being very anxious while teaching. Laboratory: rigid and tense situations created by lecturers thus students were afraid. Nurses: nurses asked students to perform a procedure not suitable with students' competencies"	Female, year 3, Catholic, Batak
	(135s) "disruptive behaviour while learning, talking during the class, talking in the phone, lacking of enthusiasm in teaching, unprepared materials for teaching, too much stories regarding the experiences or daily life"	Female, year 2, Christian, Batak
	(187s) "in classroom: the lecturers were talking impolitely because the students could not answer the questions. Laboratory: the lecturers were angry toward the students who could not apply the skills that being taught by the lecturer correctly	Female, profession program, Islam, Indo-Malay
	(118s) "when [lecturer] asking the students, the students' attitude that answered is indifferently with crossed legs and hands which is as symbol of arrogance"	Female, year 3, Islam, Batak

Themes	*Illustrative examples*	*Respondents context*
Communication and relationship issues	(195s) "... ignoring the patients that was not under their responsibility"	Female, profession program, Christian mixed: Batak-Javanese
	(168s) "neglecting the patients' privacy. Ignoring the patients"	Female, year 2, Islam, Javanese
	(069s) "in classroom: students who sit in the back row were usually not paying attention towards the lecturer. Laboratory: students were making noise when their colleagues were practicing the skills and [the students] did not pay attention. Clinical practices: the lecturer sometimes reprimanded the students, who were wrong in front of the patients and family. The nurses usually talkedharshly during the provision of health education"	Female, year 2, Christian, Batak
	(185s) "in classroom: students made negative comments towards one another .; The lecturer's method of teaching were not suitable with students' interest." "Laboratory: sometimes the lecturer talked inappropriately if the students did not answer questions such as 'stupid'. Clinical practices: clinical instructors often underestimated students or did not believe on bachelor students capability in public university because they [clinical instructors] believe that the students only were clever in theory"	Female, profession program, Christian, Batak
Teaching-learning management issues	(039s) "using communication tools while in learning process"	Female, year 2, Christian, Batak
	(208s) "in classroom/laboratory: cheating in exams, playing mobile phone while learning"	Female, profession program, Islam, Aceh
	(019s) "sleeping in class, being noisy, using mobile phone while learning, lecturer/students were late	Female, year 2, Christian, Nias
	(027s) students were talking, using mobile phone while in learning process	Female, year 2, Islam, Minangkabau
	(046s) did not pay attention to the lecturer while teaching	Female, year 2, Islam, Aceh
	(056s) cheating, disruptive by talking to other colleagues, using mobile phone, chatting with other colleagues	Female, year 2, Christian, Batak
	(063s) lecturer: rearrange the schedule/ change it/ do not come on time, ineffective teaching method	Female, year 2, Islam, mixed: Batak-Javanese
	(192s) [lecturer] administered the exams at any time they wanted, giving subjective grading, inflexible, do not want to listen students opinions	Female, profession program, Christian, Indo-Malay

The academics revealed three themes on ways or types of uncivil behaviour in nursing education including teaching-learning process issues, ineffective

communication and professional issues. The themes are illustrated in the Table 5.23.

Table 5.233: Types of uncivil behaviour perceived by academics in nursing education

Themes	*Illustrative examples*	*Respondents context*
Teaching-learning process issues	(016a) "in classroom: being late when coming to the classroom"	Lecturer, Batak, Islam
	(015a) "clinical practice: not on time as the schedule"	Lecturer, Malay, Islam
	(002a) "in classroom: being late, cheating, using mobile phone while learning... ... "	Lecturer, Javanese, Islam
	(007a) "examples in classroom: students eating candy while the academics teaching, using mobile phone...	Lecturer, Batak, Islam
Ineffective communication	(003a) "saying harsh words and being inappropriate to the students" . "Show inappropriate behaviour [students] in the clinical area"	Lecturer, Batak, Islam
	(010a) "directly rebuking students while talking, insinuating students who were sleepy"	Lecturer, Batak, Islam
	(013a) "spontaneous strong voice, bulging eyes, suddenly shook off the hands when [students] did wrong procedure"	Lecturer, Batak, Catholic
	(004a) inappropriate response to students when answering [the question], for example laughing at the student if the answer is not correct	Lecturer, Malay, Islam
Professional issues	(006a) "in classroom: underestimating students, perceiving students to be stupid, being subjective. Both in laboratory and clinical practice.	Lecturer, Batak, Islam
	(011a) "... students did not bring materials for clinical practice, schedule changed without information from the clinical practice coordinator, the experts did not come on time according to the scheduled time without clear reasons"	Lecturer, Batak, Islam
	(007a) "in laboratory: not wearing the lab coat"	Lecturer, Batak, Islam
	(019a) "in clinical practice: did not make introduction reports, being late in submitting the report, wearing uniform outside the clinical units (e.g. To the mall, outside the campus)	Lecturer, Sundanese, Islam
	(009a) "not giving opportunity to clarify the problems/issues"	Lecturer, Christian, Batak

Three similar themes emerged from the respondents regarding the types of uncivil behaviour in nursing education. The themes included teaching-learning management issues, communication and relationship issues and unprofessional conduct. The respondents identified problems of teaching-learning process at the public FoN such as being late, eating, cheating, ineffective teaching method, subjective grading and misuse of mobile phone occurred in nursing education.

Additionally, harsh comments and inappropriate conduct were considered as verbal and non-verbal communication issues.

Professional issues included underestimating others, being subjective and neglecting the patients. The respondents reported that some types of uncivil behaviour occur in all settings (classroom, skills laboratory and clinical practice), such as being late.

It seems that there is a link between the settings including the classroom, skills laboratory and clinical unit. For example, if someone is usually late arriving to the classroom, this habit also happened in the skills laboratory and clinical unit. In other words, some types of uncivil behaviours that occur in the classroom further occur in others settings.

2) Reasons for the uncivil behaviour instances

The respondents also provided opinions related to the reasons why uncivil behaviour occurred in nursing education (Table 5.24-25). Table 5.24 shows three themes that emerged from students' response regarding reasons for uncivil behaviour instances in nursing education.

Table 5.24: Reasons of uncivil behaviour instances in nursing education (students)

Themes	*Illustrative examples*	*Respondents context*
Personal and contextual factors/ influences	(056s) "because there was no awareness or sensitivity of their roles and behaviours"	
	(079s) "my opinion, because every individual that is involved in it [nursing education] do not have high awareness"	Female, year 2, Christian, Batak
	(181s) "lack of awareness and responsibilities"	Female, year 3, Christian, Nias
	(039s) ""in my opinion, it can happen because of socio-economic background". "Besides, ethnicity and religion that initially developed and accepted in the family"	Female, profession program, Christian, Batak
	(195s) "because of differences in socioeconomic status"	Female, year 2, Christian, Batak
	(106s) "uncivil behaviour occurred in academic environment because of many factors, one thing that I understand, every person has different ways to respond or act toward something, that most dominant is personal characters that made or influenced by [their] backgrounds including religion, social, culture and economics"	Female, profession program, Christian, mixed: Batak-Javanese
	(173s) "because the values that learned in campus and the faith values learned from their own religions, have not been implemented in every aspect of [their] life. [it is called] lack of integrity"	Female, year 3, Islam, mixed: Banjar-Palembang
	(180s) "because human beings do not recognise their God anymore and do not implement what should be done according their religions' teaching. Then, the norms that are developing in the community, [they] are not suited with the individual anymore because a lot of influences from the foreign norms and culture."	Female, year 3, Christian, Batak
	(052s) "the most common cause is because of the religious' differences"	Female, year 3, Islam, Minangkabau
		Female, year 2, Christian, Batak
Professionalism issues	(183s) "uncivil behaviour can happen in the environment because of lack of respect poor attitude and due to the fact that there are many ethnicities, customs and cultures"	Female, profession program, Christian, Batak
	(067s) "uncivil behaviour occurred in academic environment usually because the academics were arrogant, want to show that they are superior and underestimating the students. Thus, sometimes the students miss behaved because they wanted to satisfy their ego towards the academics that insulted them..."	Female, year 2, Christian, Batak
	(208s) ""students uncivil behaviour can occur due to lack of confidences with their capabilities, lack of preparedness, personal characters, lack of discipline, etc."	Female, profession program, Islam, Aceh

Themes	*Illustrative examples*	*Respondents context*
Rules implementation issues	(194s) "in my opinion, the uncivil behaviour occurred because there were no strict rules and sanctions in the academic settings"	Female, profession program, Christian, Batak
	(112s) "because there were no clear rules and accurate sanctions"	Female, year 3, Islam, Batak
	(065s) "because there were no strict rules related to this [uncivil behaviour]"	Male, year 2, Christian, Batak
	(036s) "no firm regulations"	Female, year 2, Islam, Javanese

Table 5.25 shows three themes that emerged from academic staff's response.

Table 5.25: Reasons for uncivil behaviour instances in nursing education (academics)

Themes	*Illustrative examples*	*Respondents context*
Professionalism issues	(018a) "inharmonious relationships in academic environment"	Lecturer, mixed: Aceh-Minangkabau, Islam
	(001a) "ineffective communication"	Lecturer, Maduranese, Islam
	(004a) "nurses professionalism values have not been adopted totally"	Lecturer, Malay, Islam
	(009a) "because academics or nurses perceived students as subordinates who do not have power to avoid or refuse the power of academics or nurses"	Lecturer, Batak, Christian
Individual and contextual factors	(005a) "factors of individual characteristics can influence uncivil behaviour". "Individual faith/belief of each person including academics or students	Lecturer, Batak, Islam
	(009a) "because of academics or nurses' characters that cannot be controlled by lecturers or nurses"	Lecturer, Batak, Christian
	(007a) "can begin from: wrong family environment, culture in wrong environment... ... "	Lecturer, Javanese, Islam
Ineffective rules implementation	(005a) "the factors of rules clearness when implementing education program"	Lecturer, Batak, Islam
	(013a) "students behaviour that do not follow the rules of academics/campus"	Lecturer, Batak, Catholic

The data presented in tables 5.24 and 5.25 shows that the respondents (students and academic staff) provided similar opinions regarding the causes of uncivil behaviour instances. The following themes emerged during data analysis: professionalism issues, individual and background factors, and

ineffective implementation of rules. The respondent's stated that people involved in nursing education behaved unprofessionally. This was evidenced by showing attitude of superiority and disrespect to others. There was poor implementation of the rules including noncompliance and a lack of clarity about the rules. Another cause of uncivil behaviour was related to individual and background factors such as a lack of awareness as well as differences of individuals' ethnicity, religion and socio-economic status which influence the individuals' behaviour.

3) Differences of uncivil behaviour instances in nursing education settings

The respondents further described differences between uncivil behaviour instances in nursing education settings. Table 5.26 shows the students' opinions on the differences of uncivil behaviours instances between classroom, skill laboratory and clinical practice in the private FoN.

Table 5.26: Differences of uncivil behaviours between classroom, skill laboratory and clinical unit (students)

Themes	*Illustrative examples*	*Respondents context*
Scopes of uncivil behaviour	(069s) "uncivil behaviour occurred more dominantly in classroom, maybe due to large number of students in the classroom making it difficult for the lecturer to control the group. In the laboratory, uncivil behaviour occurred less frequent students come in small groups which is easier for the lecturer to control.	Female, year 2, Christian, Batak
	(205s) "in my opinion, uncivil behaviour in classroom [occurred] as responses of the students towards an uninterested class, such as sleeping, chatting and playing mobile phone while learning. On the other hand, in clinical unit, it occurs as responses of students towards nurses' behaviour that perceived students as inferior"	Female, profession program, Christian, Batak
	(106s) "uncivil behaviour in classroom were limited to the small problems that showed personal/students characters as well as in laboratory; but in clinical unit, the uncivil behaviour showed are more complex and danger"	Female, year 3, Islam, mixed: Banjar-Palembang
	(200s) "uncivil behaviour felt heavier if it happens in clinical practice"	Female, profession program, Islam, Indo-Malay-deli

Forms of uncivil behaviours	(105s) "the differences between classroom and skills laboratory: in the classroom, there was more on students lateness and schedule changes; while in the skills laboratory it was more about verbal abuse (said stupid students, less skills) and asked students to stand during the process of practice"	Female, year 3, Islam, Minangkabau
	(207s) " in the wards, it is often talking with harsh words or high intonation. In the clinical unit, using harsh words and also insulting words, underestimating education institution and hitting or pinching"	Male, profession program, Islam, Batak
	(092s) "there was no difference between uncivil behaviour which occurred in the classroom and that which occurred in the laboratory, but in the clinics I do not know because I have never been there"	Female, year 3, Christian, Batak Female, year 3, Catholic, Batak
	(176s) "in my opinion, uncivil behaviour that were seen in the classroom, in the skills laboratory and in clinical units were similar because all commonly [occurred] based on negative emotions"	
	(186s) "no difference, the only difference was the cause of the uncivil behaviour"	Female, profession program, Islam, Indo-Malay
	(085s) "for me, the noncompliance of the rules are similar, no differences."	Male, year 3, Christian, Nias
Person who involved in uncivil behaviour	(178s) "the differences of uncivil behaviour between classroom, skills laboratory and clinical unit might be on the person who did it. The uncivil behaviour in classroom and skills laboratory are mainly done by the students while in clinics, the uncivil behaviour are mainly done by the CI in the hospital"	Female, year 3, Islam, mixed: Javanese-Bugis
	(187s) "in classroom usually the precipitating factors of the emerging uncivil behaviour by students is the lecturer. So, the lecturer was usually the first person who did the uncivil behaviour. In the laboratory, it was usually because of lack of students' concentration when the lecturer demonstrated the skills. In the clinics: it usually happened because of high workload demands from thepatients and their families.	Female, profession rogram, Islam, Indo-Malay
	(134s) "the differences canonly be explained in terms of the subjects who suffered or were affected by the uncivil behaviour: In the classroom: students and/or academics. In the laboratory: students only. In the clinics: students, and/or academics".	Female, year 2, Christian, Batak

Table 5.27 shows the academic staff's opinions on the differences between uncivil behaviours instances between classroom, skill laboratory and clinical practice in the public FoN.

Table 5.27: Differences of uncivil behaviours between classroom, skill laboratory and clinical unit (academic staff)

Themes	*Illustrative examples*	*Respondents context*
Areas of uncivil behaviour occurrences	(003a) "it is similar, just the settings that are different"	Lecturer, Batak, Islam
	(016a) "uncivil behaviours were often seen in clinical units than in classroom and skills laboratory"	Lecturer, Batak, Islam
	(002a) "if in classroom and skills laboratory, it [uncivil behaviour] directly can be seen and addressed, [but] if in clinics, it is more difficult"	Lecturer, Javanese, Islam
	(001a) "situation of the environment that is conducive in each setting"	Lecturer, Maduranese, Islam
Forms of uncivil behaviours	(007a) "In classroom: students were noisy though lecturer was angry in classroom. In skills laboratory: students did not attempt to practice demonstrations . Untidiness of female hair. In clinics: communication between students and patients was not good. (006a) "actually, it is similar, the only difference is the people involved. In the laboratory, it happens between students and academics staff. In the clinics, it is uncivil behaviour towards patients"	Lecturer, Batak, Islam Lecturer, Javanese, Islam
	(013a) "commonly, there were none [no differences], usually in attitude, behaviour, words and psychomotor mostly while doing the procedure quickly/correctly"	Lecturer, Batak, Catholic
	(011a) "in my opinion, there were no differences. The problems were similar. In the clinics, usually uncivil [behaviour] that occur [such as] being late without reasons, did not make task or nursing care [report], submitted nursing care reporst were not on time"	Lecturer, Batak, Islam
Persons involved in uncivil behaviour	(015a) "the most clear difference [seen] was that in the clinical unit it involved a lot of persons such as nurses, CI, lecturer, patients, doctors, students and others health care professions"	Lecturer, Malay, Islam
	(017a) "in clinics, it mostly[happens] in the nursing field because the students are new comers in the settings thus they have less sense of belonging... ... ."	Lecturer, mixed: Betawi-Minang, Islam Lecturer, Sundanese, Islam
	(019a) "basically, it is similar, uncivil behaviour that occured in classroom will be repeated in the laboratory or clinics. There is therefore aneed for continuous monitoring"	

Tables 5.26-5.27 show that the respondents (academic staff and students) described there were differences between uncivil behaviour instances in nursing education. The following themes emerged: forms of uncivil behaviour, areas of uncivil behaviour and people involved in the uncivil behaviour instances. The

forms included harsh comments and undermined others. The uncivil behaviours happened most commonly in the classroom and clinical setting. Uncivil behaviour was more dangerous if happened in the clinical unit. The people involved in each setting included student nurses and nurse educators who were in the classroom and skills laboratory. In the clinical units, the people involved included student nurses, nurse educators, nurses and patients.

It is noted that both respondents provided similar opinions in some issues for example, both respondent groups perceived that people in nursing education tended not to comply with the rules. On the other hand, the respondents perceived differently regarding the cause of the uncivil behaviour.

4) *Suggestions for addressing uncivil behaviour instances in nursing education*

The respondents provided their opinions on how to manage uncivil behaviour in nursing education. Table 5.28-29 presents the respondents' suggestions regarding managing uncivil behaviour in nursing education. The findings are presented in form of three themes which emerged: effective communication and relationship, effective rules implementation and presenting self. Effective communication and relationship consist of respecting others, dealing with others to solve the problem and being responsive. Implementation of the rules effectively included applying the rules firmly and being accountable. Presenting self-comprised of self-control, open mindedness and being a role model.

Table 5.28: Students' suggestions for addressing uncivil behaviour instances in nursing education

Themes	*Illustrative examples*	*Respondents context*
Effective rules implementation	(194s) "obey rules and norms in academic environment and respect each other"	Female, profession program, Christian, Batak
	(082s) "determined rules, provide sanctions toward people who disobey the rules"	Female, year 3, Christian, Batak
	(111s) "based on strong religiosity, besides the available rules that have to be adopted in the environment that might decrease the uncivil behaviour occurrences"	Female, year 3, Christian, Batak
	(001s) "knowing their own rights and obligations and obeying the agreed' rules"	Female, year 2, Islam, Aceh
Effective communication and relationship	(024s) "appreciate and respect each other. We must know as nurses that an individual is a unique person, thus the understanding about it should be developed within ourselves"	Female, year 2, Christian, Batak
	(073s) "understanding each other"	Female, year 2, Islam, Javanese
	(185s) "socialisation/ being close to each other , being role model for students and respecting each other. Not always being angry or making unpleasant facial expressions."	Female, profession program, Christian, Batak
	(192s) "flexible attitude, listen to reasons or opinions of students, provide discussions for solving the problems, being open to students "	Female, profession program, Christian, Indo-Malay
	(076s) "for students and lecturers, they should maintain a good communication and responsive towards what is essential for avoiding misunderstandings. Between lectures and students, they should have good communication, the lecturers should understand what is needed (what the students want) and the teaching process should be effective and not boring"	Female, year 3, Islam, Batak
Presenting self	(176s) "the lecturers should behave professionally in all things, being more open and give opportunity for students to express their opinions as well as create pleasant teaching and learning enviromment"	Female, year 3, catholic, Batak
	(205s) "every person should conduct their roles, and lecturers have obligations to work based on the standards established. "	Female, profession program, Christian, Batak
	(197s) "realise that a nurse should have a soft soul, altruistic and realise that there is no one who want to be treated badly including ourselves"	Female, profession program, Islam, Aceh
	(203s) "controlling own self and maintaining [good] attitude"	Female, profession program, Islam, mixed: Minangkabau-Batak

Table 5.28 displays the students' suggestions for addressing uncivil behaviour in nursing education. Table 5.29 displays the academic staff's suggestions for addressing uncivil behaviour in nursing education.

Table 5.29: *Academics' suggestions for addressing uncivil behaviour instances in nursing education*

Themes	*Illustrative examples*	*Respondents context*
Effective communication and relationship	(005a) "reprimand the person involved "	Lecturer, Batak, Islam
	(004a) "applying caring in learning process such as being respect"	Lecturer, Malay, Islam
	(013a) discussing to solve/deal with the problem	Lecturer, Batak, Catholic
Effective rules implementation	(002a) "there are discipline or contract agreements before the learning"	Lecturer, Javanese, Islam
	(009a) "understanding rights and obligations" "Apply ethical principles"	Lecturer, Batak, Christian
	(016a) "determine therules and apply the rules, provided "	Lecturer, Batak, Islam
Presenting self	(011a) "students: prepare themselves before learning/practice if the materials have been given minimum one week before the class/laboratory so the students can learn at home and do not coming late. Lecturers: make their own notes regarding time schedule and can manage their time well/ have good time management, updated teaching materials, applying teaching methods in variety ways"	Lecturer, Batak, Islam
	(007a) "have to understand their own behaviour first..." "...Avoid negative behaviour that is inappropriate with culture and environment, socialise to students and nurses for applying good attitude"	Lecturer, Javanese, Islam
	(008a) "giving good examples to the students"	Lecturer, Batak, Islam
	(010a)"understanding uncivil behaviour correctly, socialising to all"	Lecturer, Batak, Islam

The findings from this study regarding the suggestions for addressing uncivil behaviour in nursing education are effective communication, relationship and rule implementation and role-modelling.

It is noted that the respondents reported that there were uncivil behaviour instances at a public FoN that relates to communication issues, unprofessional

behaviour and teaching-leaning process issues. Tables 5.21-5.28 show the similarities and differences in the responses of the uncivil behaviour.

The reasons why the uncivil behaviour occurred included the failure of people involved in nursing education to behave professionally and to implement the rules effectively as well as individual and background influences. The differences between uncivil behaviour instances between classroom, skills laboratory and clinical unit included the features, the areas and the person involved. In addition, the respondents stated that presenting self properly, effective communication and acting in accordance with the rules are required for maintaining civility in nursing education.

Findings of the interviews and observations

This section contains findings from the interviews and observations. In this section three themes that emerged from the findings which illustrates uncivil behaviour in nursing education from the academics and students' perspective in the context of their ethnicity, religious faith and socio-economic background as well as from the observations findings. The findings are presented in table 5.30 below.

Table 5.30: Themes from the interviews and observation findings

Interviews' Respondents	*Themes*
Academic Staff	Professionalism issues
	Ineffective rules implementations
	Personal issues and background influences
Students	Professionalism issues
	Ineffective rules implementations
	Personal issues and background influences

1) Themes emerging from academic staff responses

Three themes emerged from the perspectives of academic staff: (1) professionalism issues, (2) ineffective rules implementations, and (3) individuals' character and background influences.

Theme 1: Professionalism issues

Academic staff members recalled incidents around professional issues related to uncivil behaviour. They recounted issues involving students, nurse educators and nurses' professional behaviours in the context of clinical competencies, communication skills as well as ethical and legal matters. Narrated professional issues included communication, relationships and teaching-learning process.

Communication issues such as harsh comments appeared commonly in the nursing education settings, as a junior academic staff member commented:

> '*Harsh talking [by the lecturer], it is almost, almost common in the campus, even in the skills laboratory...*' (Interviews/BB35)

He also confessed that he was once rude to the students due to their dishonesty in the classroom:

> *'I checked the students' attendance list again, there were students who signed it but they were not present... I was very angry and unintentionally said harsh words... for me those words were harsh since I have never treated students like that...'* (Interviews/BB41-43)

The rudeness of other academic staff in the office was further reported by a student directly to the dean of the school, as described by a senior academic staff member:

> *'[When] a lecturer was eating [a student came]. She [the lecturer] said, "wait a moment I am eating", but she did not. The lecturer rebuked the student and asked her to go outside. Therefore [finally], the student complained to [the school dean]... here, the dean can receive the phone text directly [from the students] and [we provide] a suggestion box. So, we [dean and vice dean] held a meeting, then we reprimanded the head of the department [the lecturer].'* (Interviews/CC37-38).

In contrast, the students were disruptive by talking during the lectures in the classroom:

> The students are being noisy again and the level of noise is disturbing. Some students are talking to their friends and some others students seem that they want their friends to be quiet by uttering a sound, "shush".... (#Observation/C40-43)

The observation showed that uncivil behaviour commonly occurred in the classroom. The occurrence of this phenomenon is interesting since the academic staff and the students were aware of my presence as researcher observing them.

Other academic staff members supported this, providing some evidence of communication issues in the clinical area. Nurses' uncivil behaviours included acting and talking harshly to the students, patients and their families:

'... For example when the nurse asks the students to move their position, the nurse says, "There! There!" [pointing at the place harshly], the language is just like that. Or by saying "do not disturb me", like that.' (Interview/EE80).

'Sometimes the nurses also communicate badly such as harsh talking, to the family of the patient.. The causes of nurses' performing badly are multiple factors. Sometimes the patients are also naughty [stubborn], their families too, [thus] the nurses finally talk with high intonation... especially people from Batak ethnic background...' (Interview/CC95).

The patients and the nurses were confrontational to each other and these were perceived as uncivil behaviour:

'There is a lot of harsh talking [by nurses]... then... the patients are also like that... ' (Interview/BB72-73).

It is apparent that the academics' opinions on harsh comments are related to people's culture, specifically the Batak culture, which is the prevailing tradition in their community. It seems that poor communication, such as harsh comments are perceived as a common mode of communication that is accepted by the community. Uncivil behaviour is one of the perceptions that is what is acceptable- one culture is unacceptable in another culture. However, such negative features do not necessarily equate with an effective learning. Some students, despite exhibiting uncivil behaviour may still perform well academically.

The academic staff further identified that there were unsuccessful professional relationships not founded on 'trust, respect and professional intimacy' (CRNBC's Standards of Practice, 2013) that should underpin nursing education. In reality, several students show a lack of respect to the lecturer in the classroom by not paying attention while learning:

> After answering the students' questions, the lecturer explains again regarding the relationship between human and environment. When the lecturer is explaining, I look around the room and see two female students are sitting in the back row and chatting. Besides, there are students that either making notes or only listening. (#Observation/C26-27)

However, such negative features do not necessarily equate with an effective learning. Some students, despite exhibiting uncivil behaviour may still perform well academically.

Though respect and disrespect are perceived differently in every community, there are some basic rules in the classroom, including listening actively and attentively as well as not interrupting one another. The academic staff and students have to work together to establish the ground rules in their class from the beginning.

There were also 'grey areas' in professional boundaries between doctors and nurses' jobs; this condition produce poor relationships between the two professions:

> *'When the nurses want to do the task, the nurses hindered it because it is doctors' task... they [doctors] seemed to say "this is*

our working area"… In the maternity ward there are many cases like that.' (Interview/EE82).

Nurses' act of superiority in the clinical unit is also featured as a relationship issue. Two academic staff reflected upon their experiences while they were student nurses. They expressed that they faced nurses who exhibited the act of superiority in the hospital where they worked. However, these academics recalled that they responded to them by challenging them that their behaviours were offensive:

'Well, it felt that when I go to the hospital for clinical practice, I see nurses' superiority complex. However, maybe this condition made me survive as a student nurse because I considered it as a challenge.' (Interview/EE16).

'When I had a clinical placement in the hospital, a lot of work was imposed upon the employees [nurses], take this and that. In my early practice, I felt that, Why are the nurses like this?' (Interview/AA11)

Another academic witnessed nurses' poor attitude such as ordering students to do things unrelated to nursing skills:

'We can see ourselves that... when we were supervising [students] in the [hospital], sometimes they [students] were asked [by nurses] to buy something, deliver this and that... uh... actually students have already been informed about this, but maybe not all the lecturers informed them… Personally I always say [to the

students] that they have to think critically, they have to say it pleasantly, that it is not their [students] job.' (Interview/CC81).

In fact, students routinely undertake non-nursing activities:

> Then I look around the room, one female student nurse (from other university) is sweeping and mopping the room and then discussing the schedule with a nurse. (#Observation/ICU15)

Though the descriptions from the above observation provide some activities of a student from other FoN, it is evident that they are given non-nursing activities in the ward.

The teaching and learning process is an important phase for developing professionalism in nursing. It will be effective if there are good relationships between academics, students and a good learning environment. However, the academic staff members also claimed that they experience some problems while they are engaging in the teaching-learning process. The problems included misinformation, tardiness and misuse of mobile phones. An academic complained regarding misinformation relating to his class schedule:

> *'The department [administration] also did not inform me [that the schedule was changed]. So [I just found out] my schedule moved forward.'* (Interview/BB81)

And some students were late to the clinical unit:

> *'Sometimes I come [to the hospital] ... I do not inform the students when the time [for supervision] is... very often I see some students are late...'* (Interview/DD28)

A student played with her mobile phone while her colleague was explaining the topic in the tutorial room:

> Then my attention moves to X [student, female] because she is holding a mobile phone. Suddenly, the academic says to her, "Put your mobile phone away!" (#Observation/T23)

It appears that the lecturer in the tutorial room responded properly regarding the misuse of mobile phone by the student. In contrast, other lecturers responded improperly:

> At 9.00 the lecturer is explaining about stress and appraisal. I begin to look around again and I see that one female student is holding a mobile phone and reading it intently. Suddenly, a mobile phone then rings in front of my seat, two rows in front of me; the voice is loud enough to make others laugh. The lecturer only smiles and says, "There is someone who has a new phone." (#Observation/C28)

Evaluation is also crucial in the teaching-learning process which aims to provide educational quality assurance at four level of higher education including educator, program, institution and external quality monitoring (Quinn and Hughes, 2007). Two academic staff commented that there were no lecturers' evaluations or the use of soft skills evaluation for students, as the following comments explain:

> *'In the bachelor's program, evaluations for the academic staff have just begun, [but] I have never seen it. For the master's program,*

because I am [teaching], though only a few times, once for example, the students directly evaluated me.' (Interview/AA76).

'If in the skills laboratory, the evaluation forms are still lacking in regard to soft skills evaluations, we only evaluate one soft skill evaluation, it is therapeutic communication. The soft skills evaluation is needed indeed... it is needed actually... yes... even more for nurses...' (Interview/DD57-58).

One academic staff member further expressed his experiences regarding students' threatening behaviour in the academic setting when a male student challenged the academic due to his failure in an exam:

'I have experienced that [there was] a male student who brought a knife, indeed. At that time the [student] did not pass [an exam], it was not that we did not want to make him pass, but he was not capable ... unable to achieve the pass standard, so he failed.' (Interview/BB15-16).

The theme 'professionalism issues' explains how unprofessional conduct such as harsh comments, feelings or assumptions of superiority and misbehaviour are perceived as uncivil behaviour instances.

Theme 2: Ineffective rules implementation

Academic staff expressed concerns about a lack of an effective strategy to implement institutional rules. The most common concerns included varying perceptions of rules implementation and poor implementation thereof.

Evidence shows that academic staff members have different opinions regarding the academic rules in nursing education. One academic staff claimed that the school does not have rules regarding tardiness or lateness allowances, and she opposed the agreement allowances for 15 minutes lateness in her class:

> *'Generally, from the institution, there is no lateness rule. But I think if the lecturer is a disciplined person, allowing 15 minutes for tardiness is a very long time... if it is 15 minutes... meanwhile the class session is only 100 minutes.'* (Interview/DD21).

In contrast, there is a guidebook for students, as mentioned by another academic staff member:

> *'There is an academic guide book; it states that 15-30 minutes is for lateness allowances...'* (Interview/CC24)

There were also various implementations of punctuality rules at the public FoN in which the lecturer decides the rules:

> *'The students cannot be allowed to be late, indeed, but the rules are managed by each lecturer, each department. It is the coordinator of the course or the lecturer who manages it. The lateness tolerance is ten minutes [commonly], or even more. There are some lecturers, if they are already is in the classroom, they do not allow the students to come in [the classroom].'* (Interview/EE56-57)

> *'Actually, it [the punctuality rule] depends on the lecturer... there is no common rule...'* (Interview/BB47).

In regard to lateness allowances, the academic staff members applied many different consequences. For example, one academic seemed to manage students' lack of punctuality in the classroom according to his own individual style:

> *'If it's me, I just let them [the students] come in. However, if they come in impolitely, like yesterday, a student was late and impolitely in a non-verbal way, then I asked the student come in [the classroom] correctly [properly].'* (Interview/AA24).

Another academic staff acted differently:

> *'... but sometimes there were lecturers that implemented it [time allowed for tardiness] differently, and I think it was not fair, but uh... it might be not reported ... from the student report ... she said that there was a lecturer, [when the student was] one minute [late], [the lecturer] did not allow the student to enter the class. It was not fair for the student. It is written in the academic rule book regarding the time allowed for tardiness; it is 15-30 minutes...'* (Interview/CC25).

An extreme punishment implementation occurred whereby a senior lecturer punished a student physically due to her incomplete assignment, as a junior lecturer testified:

> *'There are some lecturers that treat students extremely too... for example there was a lecturer who punished a student by asking the student to go down [squat]... since the classroom was on the third floor and that time the student just came back from the night*

shift in the hospital, indeed... then the student was asked [by the lecturer] to walking squatting until the ground floor... [the student] was grounded because she did not complete her clinical tasks. Finally [the student] fainted and then the incident was in a students' magazine here [or published]. The lecturer was called [by the dean]. This lecturer's character is like that [a strict person], maybe her intention was good... the purpose might be good, the punishment seemed have good purposes, but it [the punishment] was too much.' (Interview/BB21-23)

It is noted that from the descriptions of the above interviews, there was an incidence of physical assault. This condition is unacceptable since the incidence is included as high risk and threatening behaviour (Clark and Athen, 2011).

There were also inadequate rules in hospital, which promote uncivil behaviour there:

'So, there are uncivil behaviour instances in regard to the patients, and their family. These conditions might happen because of the inadequate rules also...' (Interview/CC91)

Additionally, though a senior lecturer observed that the academic rules are crucial to prevent uncivil behaviour:

'The task of the leader and institution is to make the rules, thus, the uncivil behaviour could be prevented.' (Interview/CC44).

Ultimately, individual awareness is required for students to comply with the rules and for staff members to maintain a disciplined learning environment:

'There is an x-banner standard about how to groom [at the school] but sometimes the students wear inappropriate clothes...' (Interview/BB107)

The theme 'ineffective rules implementation' explains how people involved in nursing education conduct the rules poorly, which lead to uncivil behaviour instances in nursing education settings. Moreover, there is inconsistency among academics' opinions regarding the availability of a guidebook of academic rules at the public FoN.

Theme 3: Individuals' character and background influences

Academic staff members further described their activities outside nursing education which relates to their personal interests and family/environment life. They claimed that individuals' character and background factors such as ethnicity, religion and socio-economic status influences individuals' behaviours, either to be more civil or uncivil.

One academic asserted that people in her community (people of Batak background) give the impression of being harsh, but they are actually friendly:

'Because it is basically that the characters of people in the community in here, though they seem to be harsh, the fact is they are nice.' (Interview/EE84)

As a Batak person, a senior academic realised that she is a disciplined person and most of the students recognised her as a harsh lecturer:

'So, students do not like lecturers who are disciplined. They might say that we are fussy and fierce... for me I do not care what the

students say. They should be disciplined, indeed... Because what if the nurses are not disciplined... so I am recognised as a harsh lecturer... but I do not care...' (Interview/DD67-68).

The same senior academic staff justified that she is a frankly speaking person: '*My character is like that [frankly speaking]'* (Interview/DD71) and she further compared herself to others who have a different ethnic background:

'It is me as a real Batak, I am a person that is to the point [when talking], indeed (laugh) maybe there are people who have the characteristics... [when they talk]... they expressed it more pleasantly...' (Interview/DD86)

A senior academic (Javanese) perceived that the Batak people are harsher than people of her ethnic background:

'But in here, if I see... the people' culture is like that, they are [more harsh], indeed.' (Interview/EE88)

It seems that people's general way of talking and their manner are perceived differently, especially if they have different cultural or ethnic backgrounds. Moreover, sometimes people tend to talk with their own ethnic language when with others of the same background. This condition unintentionally occur in the professional working area, where it is perceived as unprofessional behaviour by other people with different ethnic backgrounds.

When I observed in the ER, one participant reported a doctor-nurse interaction using Batak dialect:

> I also hear a discussion between a doctor and a nurse using Batak language. They seem to be discussing the admission of the new patient. (#Observation/ER16)

In addition to using their own local languages with people of the same linguistic background, people in nursing education tended to greet others using their religious language. Religious greetings (Christian and Muslim) were noted in the classroom and tutorial room:

> At 8.00 AM I see only some of students in the classroom; suddenly two students (male and female) come into the classroom and say loudly, 'shalom' [this Hebrew greeting is sometimes used by Christian believers in Indonesia to great each other] (#Observation/C5)

> Mr X says, 'Assalam Mualaikum' [this Arabic greeting is sometimes used by Muslim believers in Indonesia to great each other], good morning and best wishes, I am sorry I am late'. (#Observation/C16)

> At 9.07 I come into the tutorial room with one academic (Aceh, Muslim) and she says to the students, 'Assalam-Mualaikum, good morning'. And all the students reply, some of them say 'Walaikumsalam' and some students say 'good morning'. (#Observation/T3)

A senior academic further declared that the common norms in the community emerge from religious values:

'... the norm is from the religion... so as a common norm, the behaviour should be to help each other, respect others, be polite...' (Interview/AA54)

However, a junior academic stated that there is no relationship between individuals' religious values and their behaviour:

'If religion… I have not yet [or] I cannot see that they [religion] clearly influence the behaviour, indeed...' (Interview/BB105).

Community/social norms is "an expected idea of how to behave in a particular social group or culture" (McLeod, 2008, p.1). Thus, it can be said that the individuals' environments such as family, community and campus settings also influence individuals' behaviour or character. A number of academic staff members supported this, as explained in the following comments:

'It is their environment that has not supported them to produce good characters [or] positive characters.' (Interview/EE90).

'And I also see that some lecturers who come from Java, when they came here... could change indeed. People said that Javanese people tend to be gentle, but when they are here [in this city] I see that they become harsher than Batak people, it is my opinion. Yet I really do not know why they become like that. Sometimes we cannot generalise the ethnic characteristics... uh... just like that... sometimes there are harsh attitudes... or behaviours that might be in other places unaccepted, but here it becomes [normal]... it is usually [common] here...' (Interview/BB11).

> *'It is [based] on the rules in the family environment and these are [transferred] to the campus environment, indeed. However, [it is also the responsibility of] the campus environment to organize the students [to behave properly]...'* (Interview/CC20).

Another academic staff member also identified that the students with high economic status wear improper clothes occasionally:

> *'Students with high socio-economic status sometimes disturb us due to their clothing. Sometimes we can see, for example they wear different clothes. In here there are no uniform rules, the students have freedom, though there is an x-banner poster that explains how to groom, but sometimes there is inappropriate grooming [dress, i.e. revealing or tight clothing] that is different from our expectations...'* (Interview/BB106).

It seems that uncivil behaviour occured in nursing education due to individuals' characters and backgrounds. The finding of individuals' background influences is unique to this study because other studies have not reported these influences on uncivil behaviour instances in nursing education.

The theme 'personal issues and background influences' demonstrates how individuals' characteristics, socio-economic status, ethnic background and religious faith influences their behaviour, either positively or negatively. The behaviours included being harsh and frank speaking, improper attire, greeting others in a religious way and using local dialect or language in the professional area.

2) *Themes emerging from students' responses*

The findings from students' interviews in the public FoN revealed three themes: 1) professionalism issues; 2) ineffective rules implementation; and 3) individual characteristics and background influences.

Theme 1: Professionalism issues

Students perceived that nurses, nurse educators and student nurses behave unprofessionally. They further provided explanations in regard to communication issues, relationship issues and teaching-learning management problems.

Communication issues such as talking using a loud voice were perceived as uncivil behaviour. . A student nurse in professional program stated that nurses communicate harshly toward students and patients, the following section illustrates improper communication including an example of proper communication.

> *'... From the way [nurses'] communication, it seems [not good]... [for example] "Sister, get this there" [with high intonation], it seems uh... not nice to be heard, if it is heard by people, why do the nurses [talk] like this?... [the nurses should talk like this] "Sis please take this..." [with a lower intonation]. The [nurses'] communication was less good, Ma'am. So, I often see the nurses [perform poor communication] to the students... However, the nurses perform bad communication to the patients when managing difficult patient encounters, indeed... but [this incidence is] rare...'* (Interview/LL40-41).

Another student in the professional program echoed similar statements:

> *'The most [uncivil nurses' behaviour]... according to my friends' complaints; is poor communication of the nurses. Sometimes [the nurses do not communicate properly], not all nurses. There are good nurses that are polite.'* (Interview/MM59).

The narrative of nurses being rude or impolite is spread by students in the professional program to students in the academic program. A third-year student in the academic program narrated:

> *'... from a senior [student nurse] in the profession program, he said that the nurses liked to label the student nurse... he told me like this, we [student nurses] already labelled us impolitely by (nurses)...'* (Interview/KK77).

It seems that nurses are perceived as people who behave unprofessionally by student nurses. This condition lead the students in an academic program to be worried and afraid to join the professional program. On the other hand, this is a challenge by which the student nurses are preparing themselves to face nurses' disruptive behaviour.

A third year student who had a bad experience regarding a lecturers' attitude mentioned that she and her classmates had been waiting for a lecturer for three hours, then they finally decided to go home. Nevertheless, they later had to face that lecturer, who was angry with them:

> *'We [students] had already gone home... already three hours. The lecturer might not come again. However, the lecturer came and the lecturer was really angry and said "why do you not wait?"...'* (Interview/HH25).

Being angry seems to be a common emotional expression by lecturers towards the students. Being angry and using abusive and harsh words like 'stupid' is also prevalent according to the students in nursing education, as a student in year three mentioned: 'The harsh word was "stupid"' (Interview/JJ24). Remembering her experience of harsh comments from a lecturer in front of her peers, the student reported feelings of: 'Being embarrassed and feeling hatred' (Interview/JJ30). Another student in year three who was also offended by a lecturer said that: 'The lecturers should be friendly to the students' (Interview/KK99). A student expressed her feeling when her peer were disruptive in class by talking during a teaching session:

> One student seems to be bothered by her colleague [disturbing talking] and says "just be quiet first" to her friend with an upset face. Then the student begins to explain her opinions. (#Observation/T34)

Moreover, two students from Aceh and Padang (ethnicities) felt that their perceptions differ from those of Batak people regarding the way they talk:

> *'Maybe it is because I am not a Batak. It might be the way they talk, using that intonation, the Batak people were used to it. I am not a Batak, so I do not understand. Maybe ethnicity could influence a little. So, in my opinion, I did not get used to hearing it. My peers might get used to it [high intonation].'* (Interview/MM48).

> *'... I am from Padang, so if I heard about 'Kau' [you] when I came first here, it felt that the word 'Kau' [you] is harsh, but now I say that word, indeed...'* (Interview/JJ32-33).

Human relationship issues describe the problems that occur while people interact with each other in the nursing education. For example, a student attending a professional program stated that most of the students felt stressed due to being intimidated by the academic staff:

> *'It feels like being pressured because of the lecturers. There is one lecturer for example, she is like what [laughing], a little bit scary. So, if we want to meet her, we felt like under pressure first, like that. Just like that.'* (Interview/MM37).

Surprisingly, some students seem to be scared when facing a senior lecturer in the clinical unit:

> It is seen that the lecturer cannot manage her emotion. I see a student who looks pale and confused. Then two students come. They will also be evaluated today by the lecturer. They seem a little bit afraid when approaching the lecturer. (#Observation/ICU28-29)

The academics' harsh behaviour seemed to be internalised by the students, as a student in year three commented:

> *'Maybe from seeing like that the lecturer is harsh, the student is also harsh. When the lecturer is harsh, the students might think "why I am not?" So there are these instances [uncivil behaviour].'* (Interview/GG49).

Being abandoned by the clinical educator in the clinical settings is also perceived as uncivil behaviour (Thomas, 2014). A student in a professional program

complained that most of the times students lacked supervision from the clinical educator:

> *'There are clinical educators in the hospital but they are useless, they have never supervised.'* (Interview/LL37).

The student also testified that some nurses in the hospital undermined the students:

> *'There are people [nurses] who ask why the students from the public university cannot do that [nursing skills], indeed... uh... so many pressures like that. Then [other opinion] of the nurse [said], "ah, the students only know about [the nursing] theory".'* (Interview/LL33).

As a consequence, the same student expressed her feelings emotionally regarding the nurses' uncivil behaviour by stating:

> *'The most frequent uncivil behaviour is from the nurses toward the students, so it seems that... we are being 'di jajah' [oppressed] by our own profession...'* (Interview/LL38).

It appears that some academic staff and nurses abused their power over the students (Clark, 2008b). These happen due to exposure to abuse power relationship in their education. In other words, the academic staff and nurses adopt a culture of bullying in the nursing scope due to unchecked constant exposure (Randle, 2003).

Teaching-learning management problems refer to the issues faced by people involved in nursing education regarding the teaching-learning process. There

were unexpected schedule changes by academic staff in campus settings, as stated in the following comments:

> *'The problems related to the schedule of the lecturers sometimes are a little bit hard on us. For example, the schedule for the skills laboratory is today but the lecturer cannot come, so when we try to find another day, sometimes the lecturer also cannot come, indeed. To manage the schedule sometimes it is difficult.'* (Interview/MM35).

> *'Sometimes also they [the lecturers], uh, changed schedule and who determine the replacement's day, us [students]. So we have already been given syllabus with the schedule but, the schedule, what it is for, maybe the syllabus is just for example of the learning materials. Uh... with the time schedule which does not have free time, we have to uh... "find the unoccupied schedule, this and this" like the lecturer said, in fact, uh... from 1 PM uh... from 8 AM until 1 PM is the time for class and then the skills laboratory session... so we have difficulty like that, Ma'am.'* (Interview/HH33-34).

Though it seems a small problem, one changed teaching session will impact other teaching sessions. The commitment of academic staff members is required to comply with the schedule. On the other hand, another academic staff member in the same teaching team take the place of the session if any urgent matters emerged.

Academic staff members should be the gatekeepers of ground rules in nursing education, especially in the classroom, in which they should monitor

compliance. However, some of them ignore disturbing students' behaviour in the classroom:

> It is seen that there are students who talk by themselves (in three areas), then a student who went outside and come in again. Besides, the students seem to be restless and begin to chat (some of the students). However, the lecturer is still explaining using slides about coping. (#Observation/C36)

It appears that there is no code of conduct for learning in the classroom. Thus, the academic staff and students might not know about their behavioural expectations in the teaching and learning process. Establishing a code of conduct to be referred to instances when the rules are being broken would be very useful.

A highly achieving student in year three also complained that there were different academic staff member's opinions related to nursing courses, stating:

> *'Sometimes the materials are subjective Ma'am. For example, this book is different, and then sometimes the lecturers' opinions also are different. Even more when learning the nursing care, indeed. So nursing care is subjective, Ma'am. [I] read in this [book], [it] is also different. Later in the lectures' slides, [they] are different again. The other lectures said differently again. Ouch! It makes me dizzy.'* (Interview/KK46).

Though it is a responsibility of students to further explore the resources for learning, it is also an academic staff's responsibility to provide clear explanation regarding learning materials.

In contrast, there were a number of disturbing students' behaviours, such as displaying lack of attention and refusing to answer direct questions that aimed to him/her:

> I see one male student who from the beginning of the class session does not make any notes, just being quiet (do nothing). I do not know if he is listening or not, but he is signing the attendance book (#Observation/C30)

> Then the lecturer says, "Who is the person next to X [a female student]?" The student answers, "Y, Ma'am". The lecturer then says, "Come on, you answer [the question] because from the beginning you did not talk." But Y says nothing. (#Observation/T27)

It seems that there are some individual and personal issues among students that prevent their full engagement in class, such as being shy, medical problems or being too bored to muster interest. Thus, it is the academic staff role to facilitate teaching and learning process by providing effective teaching tailored to learner needs. However, students are also expected to pay attention and to engage in the learning session, as this is the fundamental basis of any educational context.

The theme 'professionalism issues' describes how teaching-learning process, relationships and communication issues are included as unprofessional behaviours, which are also perceived as uncivil behaviour by the students. Thus, understanding the academic ground rules and nurse professional attributes are important as basis for professional behaviour as expected in the nursing

profession. These understandings would further minimise the instances of uncivil behaviours as well as its impact.

Theme 2: Ineffective rules implementation

Lack of effective rules implementation as well as poor rules implementations were also perceived as uncivil behaviours by students. A student in year three was concerned that the academic staff members made their own rules:

> *'Sometimes the lecturers make their own rules. They allow students for 10 minutes lateness…it is the lecturers' rules.'* (Interview/HH27).

Two other third-year students commented about disciplinary action by academics:

> *'Some of the lecturers are a little bit disciplined. But some lecturers are not [they ignore the rules], indeed.'* (Interview/II29).

> *'Actually, sometimes it [the rule of tardiness] is firm…'* (Interview/GG31).

Another student further conveyed her disagreement regarding a lecturer's response when facing students' disruptive behaviour:

> *'Actually it is not [appropriate], there is another method [than rebuking] that is more... more understandable by the students, there is another method according to my opinion.'* (Interview/JJ36).

In contrast, the hospital responded positively by establishing a new rule in the clinical practice due to the relationship issues between the nurses and the student nurses. The issues relate to nurses' attitude of superiority and disrespect towards students. Similar narrative followed from other students attending diploma program and a bachelor program. A third-year student in the bachelor's program reflected:

> *'I heard from my colleagues in diploma program... they are already in the placement. They said that nurses treated them just like... nurses were always angry to them. [For example] a nurse said, "You've never done anything right, it is useless that you are from a public university, you are not good [competent]. You are not good in practice, only theory". Most of the students were just silent [when facing the nurse]. However, one of them felt offended and then directly answered the nurse, by which the nurse felt disrespected. Thus, there was a confrontation between the nurse and the student until the head nurse heard about the incident. And they [student nurses] said that after the incidence [of uncivil behaviour], the hospital made the rules... the students and the nurses should maintain [their] manners [properly].'* (Interview/HH55-59).

The theme 'ineffective rules implementation' describes how poor rule implementations lead to uncivil behaviour in the nursing education. The poor rule implementations include making one's own rules and disregarding the rules. However, it seems that the hospital established a new rule of manners to maintain good relationships between the students and the nurses in the hospital due to incivility issues.

Theme 3: Individual characteristics and background influences

The students further described that individual characteristics and background influences individuals' behaviour to be either civil or uncivil in nursing education. Individual characteristics refer to the attributes of people involved in nursing education that influence their behaviour. A third-year student commented that academic staff members who were moody would also engage in poor teaching practices in the classroom:

> *'The problems of the lecturers during the learning [process] in the classroom is that the lecturers sometimes are moody, indeed. Sometimes they are in good mood for teaching in class, sometimes they are not. So, for example, if they are not in good mood, they teach the way they want to. Yes, they only read the slides until they finish, and when there is no question, they leave.'* (Interview/GG33).

Two students attending the professional program explained that personal problems were the reason for disruptive students' behaviours:

> *'The [uncivil behaviour] that I found, most of them are because of personal problems. So, the person already had problems with the lecturer. Sometimes there was pressure/stress [also].'* (Interview/NN45).

> *'There were [some students] who have that kind of character. For example, there is a male [student], I do not know why, sometimes he sits here, he does not want to sit on the chair. Then he talks, talks and talks. In other time, he just sits in the back row to chat.*

But there is [a time] that maybe he has problem, so he is just being quiet...' (Interview/JJ44).

A student in year three voiced her feelings regarding her personality:

'Sometimes I feel that I have a personality disorder because I cannot get along with others.' (Interview/KK90).

The same student also stated that she felt she was routinely insulted by the academics in the campus settings, but she has accepted it:

'Actually Ma'am, [I feel] insulted, insulted Ma'am, I also do not realise what is the problem, I feel that I am easy to be close to the lecturers indeed and I feel that for anything what the lecturers asked [me to do], I always say yes. However, it is OK for my self-introspection.' (Interview/KK117).

In contrast, a student in the professional program responded negatively regarding nurses' uncivil behaviour in the hospital: *'... At least I just mocked them [nurses]. I was upset... indeed.'* (Interview/LL34-35)

As a consequence of uncivil behaviour, feelings of being offended linger for a very long time, as a student in year four pointed out that:

'The angriest feeling is from the words which hurt the most, so it [angry feeling] will occur maybe in two years and [will make me] always think that "This Ms X has insulted me".' (Interview/FF81)

Individuals' background issues describe the problems related to ethnicity, religion and socio-economic status that influences their behaviour in nursing education. The students identified that the individuals' ethnic and religious

background influences their behaviour. A third year student commented that her religious activities influences her behaviour:

> *'The most influential for me is maybe because I allocate more of my time for the religious organisations, so the most influential recently is religious activities, actually.'* (Interview/HH19)

Another student in year four added by comparing students' behaviour due to their religion and ethnicity:

> *'It is not that I differentiate between Islam and Christian, but maybe Muslim's are more calm, maybe because they are Javanese too, thus what they say is pleasantly, "I am sorry Ma'am, this is not my competency". On the other hand, there is a senior student who is Christian and Batak, who directly [frankly] says, "Sorry Ma'am, this is not my competency, I don't practice here for this", like that.'* (Interview/FF65)

Similarly, religious practices occurred in the ICU:

> The nurses on the afternoon shift are three female nurses; two are wearing hijab and one is not. (#Observation/ICU2)

The family environment as a support system for individuals also influences individuals' behaviour. A student confessed that her impoliteness when speaking was influenced by her home environment:

> *'For example, I am a little bit impolite, or [my] ways of talking are not good enough, it is because of my home environment, Ma'am, the people there lack education… my grandfather only graduated*

from elementary school but he was a successful entrepreneur Ma'am, so people respected him.' (Interview/KK66).

Another student attending a professional program realised that her family influenced her to choose nursing:

'The one who is interested here [nursing] is my mother, she asked my brother to go to medical school, but he said, "what if I have not finished if I do not want to and will not graduate ever Mom?" He said like that. Thus, finally she asked me. Uh... when joining the examination for entering university I chose nursing as the third choice, the safe choice. Actually, I would prefer management or accountancy school.' (Interview/LL15).

With regards to socio-economic background issues, individuals' socio-economic status also affects their behaviour in nursing education. A student in year three claimed that her parents' education background influences her social life:

'With my parents' education background, which they have achieved, it might influence their social status, indeed. My parents associate with... automatically with their background, with the colleagues that are at their level [or] above them. It influences us [the children]. We are educated on how to have good socialisation [social skills], indeed.' (Interview/HH70).

Another student on the professional program commented that patients' education background influences patients' perception of nurses' behaviour:

'If a patient's family did not report nurses' uncivil behaviour, maybe because of their low education background. The [patient

and family] thought that it is a common thing that they are cared for [by nurses]... Usually the person [nurses] said, "I already cared for the patient like this, so give us your money", so like that, maybe like that...' (Interview/NN56).

It can be concluded that individuals' background affects their behaviour. For example, a higher education background is associated with improved socialisation within the community, whereas inappropriate attitudes and behaviour are associated with lower educational backgrounds. Thus, it can be assumed that low education promotes negative behaviour.

The theme 'individual characteristics and background influences' demonstrates how individuals' character, ethnic background, religious faith and family or environment as well as socio-economic status influences people's behaviours in nursing education. Problems related to personal characteristics included being moody and even disclosures of personality disorders. The personal background influences included belief in a specific religion, parenting and a high or low educational background.

Summary of the interviews and observations findings

In summary, three similar themes emerged from academic staff and students at the public FoN that portrayed uncivil behaviour in nursing education. The respondents described that there were uncivil behavioural instances in nursing education such as unprofessional conduct, poor communication skills and poor rule implementation. The findings of this study support previous research regarding uncivil behaviour in nursing education, though conceptualised differently.

There is further possibility of individual backgrounds such as ethnicity, religion and socio-economic status influencing the occurrence of uncivil behaviour in nursing education. These conditions occur since the people involved in this study cannot separate their daily activities from their ethnicity/family background, belief and status. The findings regarding the effects of individual backgrounds on uncivil behaviour provide a new insight of the study including ethnic, religious faith and socio-economic backgrounds.

5.3 Chapter summary

It is clear that both academic staff and student nurses at the public FoN were concerned with incivility that challenged them personally and interfered with the teaching-learning process. Many forms of behaviours were viewed by the academic staff and students that included disruptive and threatening behaviours. It is further noted that though many forms were perceived similarly regarding the behaviours being disruptive or not, occurred frequently or not and have experienced the behaviour in the past 12 months or not, both academic staff and students expressed some of the behaviours differently. For example, the academic staff and students perceived the disruptive student's behaviour differently.

Both respondents also wrote their opinions regarding the types and the reasons of incivility instances, the behaviours' differences between the nursing education settings and the suggestions on how to deal the uncivil behaviour. Many of their opinions were similar, and yet some of them were different, for instance, only the students mentioned personal background influences as one of the reasons that cause incivility instance.

In depth interviews showed that both academic staff and student nurses further provided similar themes in which incivility associated with unprofessional behaviour, rule implementation issues and personal and backgrounds issues. These themes were also supported by the observations findings. Though some of the behaviours were expressed differently, it is evident that both the respondents witnessed incivility as well as concerned regarding the issues.

Chapter 6: CROSS-CASE ANALYSIS OF FINDINGS

This chapter describes cross-case analysis of two units of analysis in which the within-case analysis of each unit has been described in the two previous chapters (four and five). The cross-case analysis of this study is explained based on three steps which include: (1) establishing a number of Word-tables from the findings of the two units of analysis; (2) identifying the key findings as well as the disparities and similarities of the findings; and (3) integrating and interpreting the findings by answering the research questions of this study (Stake, 2006; Yin, 2009).

The cross-case analysis of the findings are presented in three sections. Section one describes the characteristics of units of analysis, section two contains the cross-case analysis of quantitative findings and section three contains the cross analysis of qualitative findings.

6.1 Characteristics of units of analysis

Table 6.1 reports that the two units of analysis have different characteristics other than their status as private or public FoNs. The differences included the location, the religious vs. non-religious institutional orientation and the programs offered. The crucial difference of the two FoNs was in the implementations of the curriculum programs. For example, in the academic program at the private FoN, the students had clinical placements from year two (academic program). On the other hand, the students at the public FoN had

clinical placements only when they were in the professional program (after finishing academic program).

Table 6.1: Characteristics of unit of analysis

Characteristic		Private FoN	Public FoN
Location	Java Island	√	
	Sumatera Island		√
Value	Christian based university	√	
	Non-specific religion based university		√
Program	Master in Nursing,		√
	Bachelor in Nursing	√	√
	Ners professions	√	√
	Diploma IV in Midwifery Educator		√
	Diploma III in Nursing.		√
Program selected for respondents	Academic programs: • Regular class	√	√
	Academic programs: • Conversion class	√	
	Profession programs • Regular class	√	√
	Profession programs • Conversion class	√	
Curriculum	Academic program: 3.5-4 year clinical practice laboratory in skills laboratory and hospital since year two	√ √	√
	Academic program: clinical practice only in skills laboratory, not in hospital		√
	Profession program: 1 year, with one year clinical practice in eight areas of nursing: medical surgical, paediatric, maternity, critical care, management, family and community, geriatric and mental health.	√	√

This study recruited students and academic staff members involved in the bachelor programs (academic and professional). In addition, this study recruited diploma nurses who intended to pursue their bachelor degree (only at

the private FoN). Table 6.2 below describes the characteristics of each type of respondents at the two FoNs. The table shows that most of the respondents at both FoNs had similar characteristics regarding their gender, age and ethnic backgrounds. Most of the respondents (academic staff and students) were Indo-Malay, with Batak as the most common sub-ethnic background.

The majority of the academic staff at both FoNs were females and aged between 30-40 years old. In regard to religion, all the academic staff were Christians/Catholic at the private FoN, while most were Muslims at the public FoN. Additionally, the academic staff at the public FoN had more working experiences than at the private FoN, however, most of the academic staff at both FoNs had similar monthly income.

The majority of the students at both FoNs were females, aged between 20-25 years old, and identified as Christians. Most of the students had parents who work outside the home and had similar income. Most male parents of students at the private FoN graduated with a university degree and their female parents had a high school education. In contrast, most parents at the public FoN completed a high school education.

Table 6.2: Respondent characteristics

Characteristic	Private FoN		Public FoN	
	Academic staff	Students	Academic staff	Students
Gender	Female (83.3%)	Female (78%)	Female (78.94%)	Female (88.65%)
Age	30-40 years old (50%)	20-25 years old (70.8%)	30-40 years old (78.95%)	20-25 years old (100%)
Religion	Christian/Catholic (100%)	Christian (67.7%)	Islam (89.48%)	Christian (51.35%)
Ethnicity	Indo-Malay (83.3%) with Batak as the most common sub-ethnic background (80%)	Indo-Malay (58%) with Batak as the most common sub-ethnic background (46.6%)	Indo-Malay (100%), with Batak as the most common sub-ethnic background (52.63%)	Indo-Malay (100%) with Batak as the most common sub-ethnic background (46.6%)
Socio-economic status	Have worked as lecturer (66.7%) with working experiences between 6-10 years (50%), have monthly income above 6,000,000 rupiahs/ 300 GBP (66.6%)	Fathers have completed an undergraduate education (40.6%) and mothers have completed a high school education (50.6%), both parents work outside the home (father 89%); mother 49.23%) and have an income of 1,500,000-3,000,000 rupiahs (750-150 GBP) per month (father 34.4%; mother 21.9%)	Have worked as lecturer (100%) with working experiences between 11-15 years (52.63%), have monthly income above 6,000,000 rupiahs/ 300 GBP (42.22%).	Parents have completed a high school education (father 49.19%; mother 49.19%); both parents work outside the home (father 85.4%; mother 78.91%) and have an income of 1,500,000-3,000,000 rupiahs (750-150 GBP) per month (father 43.78%; mother 39.46)
Ethnic identity	There was no statistically significant difference between students and academic staff regarding their ethnic identity Students' mean rank = 51.18; Academics mean rank = 56.67; U= 319 z = 0.442 p = 0.659 r = 0.04		There was no statistically significant difference between students and academic staff regarding their ethnic identity Students' mean rank = 103.20; Academics mean rank = 95.66; U= 1,627.5 z = -0.532 p = 0.595 r = -0.037	
Religious faith/practice	There was no statistically significant difference between students and academic staff regarding their religious faith/practice Students' mean rank = 50.14; Academics mean rank = 73.33; U= 419 z = 1.895 p = 0.058 r = 0.187		There was a statistically significant difference between students and academic staff regarding their religious faith/practice Students' mean rank = 98.06; Academics mean rank = 145.76; U= 2,579.5 z = 3.428 p = 0.001 r = 0.24	

Both respondents at the two FoNs had similar ethnic identity, and they actively searched and affirmed their ethnicities. In regard to religious faith, the academic staff and students at the private FoN had similar religious faith , unlike in the public FoN, where the academic staff members reported stronger religious faith than the students (regardless of religious affiliation).

Previous research on uncivil behaviour adopted a perspective relating to Western values, with a majority of Caucasian respondents of varying ages (notably not the typical college age range of 18-22 years old) (Gallo, 2012). In this study, the respondents were located in Indonesia, which is highly heterogeneous ethnically, religiously and in terms of SES.

In order to offer unique insight to uncivil behaviour in nursing education, the primary research question of this study is: 'How do nursing students and academic staff perceive behaviours as uncivil in the context of their ethnicity, religious faith and socio-economic background in the case study institutions?' This study has answered this question, and the findings are presented using a tactic as proposed by Eisenhardt (1989) to provide good cross-case comparison. Following Eisenhardt (1989), the cross-case analysis data are divided into two data sources including quantitative and qualitative findings.

6.2 Cross-case analysis of quantitative findings

Based on the findings of this study in previous chapters (chapters four and five), this section consists of the cross-case analysis of the findings in three parts as follows: (1) uncivil behaviour as a problem; (2) perceived uncivil behaviour; and (3) uncivil behaviour findings in the context of ethnic, religion and socio-economic backgrounds.

6.2.1 Uncivil behaviour as a problem

Most of the respondents at the two FoNs perceived that uncivil behaviour was a serious problem in nursing education and people who engaged in uncivil behaviour in the classroom and skills laboratory were students and academic staff (see table 6.3 below). In addition, most of the academic staff at the private FoN and most of the students at the public FoN thought that academic staff, students and nurses were equally guilty of uncivil behaviour in the clinical placements (see item number four on table 6.3). In contrast, most of the students at the private FoN thought that nurses were a little more likely and most of the academic staff at the public FoN thought that nurses were more likely to engage in uncivil behaviour in clinical practices.

The respondents also provided opinions regarding the most prevalent settings of uncivil behaviour incidences. Most of the respondents thought that the classrooms and the clinical practices were more prevalent than the skills laboratories (see item number five on table 6.3).

Table 6.3: Cross-case analysis of uncivil behaviour as a problem finding

No	Uncivil behaviour as a problem	Private FoN	Public FoN
1	The extent of uncivil behaviour in the nursing education	Uncivil behaviour in nursing education environment was a serious problem (students 49%; academic staff 83.3%)	Uncivil behaviour in nursing education environment was a serious problem (students 44.86%; academic staff 52.6%)
2	Person who engage in uncivil behaviour in classroom	Student and academic staff were equally likely to engage in uncivil behaviour in the classroom (students 43.8%; academic staff 50%)	Student and academic were equally likely to engage in uncivil behaviour in the classroom (students 46.49%; academic staff 36.84%)
3	Person who engage in uncivil behaviour in skills laboratory	Student and academic staff were equally likely to engage in uncivil behaviour in the skill laboratory. (students 40.6%; academic staff 66.7%)	Student and academic staff were equally likely to engage in uncivil behaviour in the skill laboratory. (students 36.22%; academic staff, 35%)
4	Person who engage in uncivil behaviour in clinical practice	Students' perceived that nurses were a little more likely to engage in uncivil behaviour in the clinical practice area (37.4%) than academic staff and students. Academic staff thought that academic members/clinical educator/nurse/students were about equal (50%) in taking part of uncivil behaviour in the classroom.	Students thought that academic members/clinical educator/nurse/students were about equal (30.53%). Academic staff perceived that nurses were much more likely to engage in uncivil behaviour in the clinical practice area (42.11%).
5	The setting of uncivil behaviour occurrence most occurred	Students (47.9%) and academic staff (66.7%) thought that uncivil behaviour most frequently occurred in the traditional classroom. However, they also thought that there were many incidences of uncivil behaviour in the clinical practice (students 42.1%; academic staff 33.3%).	Students (41.62%) and academic staff (42.11%) thought the most occurred setting of uncivil behaviour was both in the traditional classroom and clinical practice. However, they further thought that there were a lot of incidences of uncivil behaviour in the clinical practice. (students 41.62%; academic staff 42.11%).

6.2.2 Perceived uncivil behaviour

This study further revealed that there were different perceptions of uncivil behaviour between the academic staff and students at both FoNs. The findings are presented in table 6.4 below.

Table 6.4: Cross-case analysis of uncivil behaviour

Uncivil behaviour	Significant different between students and academic staff perceptions	
	Private FoN	Public FoN
1.Students' disruptive behaviour that considered disruptive	√	
2.Students' disruptive behaviour that have experienced or seen in the past 12 months		√
3.Students' threatening behaviour that considered disruptive		
4.Students' threatening behaviour that have experienced or seen in the past 12 months		
5.Academic staff members' disruptive behaviour that considered disruptive		√
6.Academic staff members' disruptive behaviour that have experienced or seen in the past 12 months		√
7.Academic staff members' threatening behaviour that considered disruptive		√
8.Academic staff members' threatening behaviour that have experienced or seen in the past 12 months		√
9.Nurses' disruptive behaviour that considered disruptive		
10.Nurses' disruptive behaviour that have experienced or seen in the past 12 months		
11.Nurses' threatening behaviour that considered disruptive		√
12.Nurses' threatening behaviour that have experienced or seen in the past 12 months		

Table 6.4 shows that the academic staff and students at the public FoN had different perceptions of uncivil behaviour than the academic staff and students at the private FoN. Most of the different perceptions at the public FoN were related to academic staff members' uncivil behaviour (Items 5-8). It seems that the academic staff perceived uncivil academic staff behaviour differently from students at the public FoN.

Moreover, since Indonesian consists of various ethnicities, religious and socio-economic/SES backgrounds, it is important to relate the perceptions to such backgrounds. The descriptions of the relationship between perceived uncivil

behaviour and such respondents' backgrounds will be discussed in the following section.

6.2.3 Uncivil behaviour in the context of ethnicity, religion and socio-economic backgrounds

Table 6.5 below shows that most of the perceived uncivil behaviours were similar based on the respondents' ethnic background. This condition can be predicted since most of the ethnic identities of the respondents were similar. In contrast, since the religious backgrounds of the respondents were different, a number of the findings show that uncivil behaviour were perceived in the context of the respondents' religions and religious faith/practice (Table 6.6). For example, the findings at both FoNs revealed that there were statistically significant differences of perceived uncivil behaviours such as students and academic staff threatening behaviours as well as academic staff disruptive behaviours based on the respondents' religions backgrounds (see item three, five, seven Table 6.6).

Additionally, there were no differences of perceived uncivil behaviour based on students' religious faith/practice at the private FoN; in contrast, there were statistically significant differences of perceived uncivil behaviour such as academic staff and nurses' threatening behaviour based on students' religious faith/practice at the public FoN (see item seven and eleven Table 6.6).

Table 6.5: Cross-case analysis of uncivil behaviour findings in the context of ethnic backgrounds

Uncivil behaviour	***Significant different/relationship based on ethnic background***											
	Private FoN						***Public FoN***					
	Ethnic background			***Ethnic identity***			***Ethnic background***			***Ethnic identity***		
	S	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*
1.Students' disruptive behaviour that considered disruptive												
2.Students' disruptive behaviour that have experienced or seen in the past 12 months												
3.Students' threatening behaviour that considered disruptive				√		√						
4.Students' threatening behaviour that have experienced or seen in the past 12 months												
5.Academic staff members' disruptive behaviour that considered disruptive												
6.Academic staff members' disruptive behaviour that have experienced or seen in the past 12 months												
7.Academic staff members' threatening behaviour that considered disruptive												
8.Academic staff members' threatening behaviour that have experienced or seen in the past 12 months												
9.Nurses' disruptive behaviour that considered disruptive												
10.Nurses' disruptive behaviour that have experienced or seen in the past 12 months												
11.Nurses' threatening behaviour that considered disruptive					√							
12.Nurses' threatening behaviour that have experienced or seen in the past 12 months												

Key: S: Students; A: Academic Staff; T:Total respondents

Table 6.6: Cross-case analysis of uncivil behaviour findings in the context of religious backgrounds

Uncivil behaviour	***Significant different/relationship based on religious background***											
	Private FoN						***Public FoN***					
	Religion			***Religious faith/practice***			***Religion***			***Religious faith/practice***		
	S	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*
1. Students' disruptive behaviour that considered disruptive												
2. Students' disruptive behaviour that have experienced or seen in the past 12 months					√							
3. Students' threatening behaviour that considered disruptive	√		√						√	√		√
4. Students' threatening behaviour that have experienced or seen in the past 12 months												
5. Academic staff members' disruptive behaviour that considered disruptive	√		√						√	√		√
6. Academic staff members' disruptive behaviour that have experienced or seen in the past 12 months												
7. Academic staff members' threatening behaviour that considered disruptive			√						√	√		√
8. Academic staff members' threatening behaviour that have experienced or seen in the past 12 months												
9. Nurses' disruptive behaviour that considered disruptive										√		√
10. Nurses' disruptive behaviour that have experienced or seen in the past 12 months												
11. Nurses' threatening behaviour that considered disruptive									√	√		√
12. Nurses' threatening behaviour that have experienced or seen in the past 12 months												

Key: S: Students; A: Academic Staff; T:Total respondents

Table 6.7 further describes the perceived uncivil behaviour based on the respondents' SES backgrounds. It is apparent that most of the perceived uncivil behaviour were similar based on the respondents' SES backgrounds at both FoNs. Though there were a number of perceptions that were statistically significant, especially at the public FoN, when the perceptions were analysed at follow-up, the result showed no significant difference. For example, academic staff members' disruptive behaviours were statistically different (p value 0.014) based on respondents' income in the first statistical test, however at follow-up the results were not significant (p value 0.562) (see section 5.2.1 point 3).

It is noted that the students at the private FoN perceived differently regarding academic staff members' threatening behaviours that considered disruptive based on their parents' employment. In contrast, the students at the public FoN their perceptions were similar based on their parents' employment. This was so probably because most of the parents of the students at the public FoN had similar employment status (government employee: father 47.03%, mother 47.57%).

Table 6.7: Cross-case analysis of uncivil behaviour findings in the context of socio-economic backgrounds

Uncivil behaviour	***Significant different/relationship based on socio-economic background***																	
	Education			***Private FoN Employment***			***Income***			***Education***			***Public FoN Employment***			***Income***		
	S	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*	*S*	*A*	*T*
1.Students' disruptive behaviour that considered disruptive																		
2.Students' disruptive behaviour that have experienced or seen in the past 12 months																		
3.Students' threatening behaviour that considered disruptive																		
4.Students' threatening behaviour that have experienced or seen in the past 12 months																		
5.Academic staff members' disruptive behaviour that considered disruptive												√						√
6.Academic staff members' disruptive behaviour that have experienced or seen in the past 12 months												√		√	√			√
7.Academic staff members' threatening behaviour that considered disruptive				√								√						
8.Academic staff members' threatening behaviour that have experienced or seen in the past 12 months												√			√			
9.Nurses' disruptive behaviour that considered disruptive																	√	
10.Nurses' disruptive behaviour that have experienced or seen in the past 12 months																		
11.Nurses' threatening behaviour that considered disruptive												√						
12.Nurses' threatening behaviour that have experienced or seen in the past 12 months														√	√			

Key: S: Students; A: Academic Staff; T:Total respondents;

Furthermore, the academic staff at the private FoN had similar perceptions regarding their experiences of the academic staff members' disruptive behaviours in the past 12 months based on their employment status. In contrast, academic staff at the public FoN perceived the behaviours differently. The academic staff at the public FoN also perceived nurses' threatening behaviours in the past 12 months differently based on their employment status. Further to that there were different perceptions between junior and senior academic staff at the public FoN regarding uncivil behaviour of academic staff and nurses.

In summary, the cross-case analysis of the quantitative findings have answered the main research question 'How do nursing students and academic staff perceive behaviours as uncivil in the context of their ethnicity, religious faith and socio-economic background in the case study institutions?' including: (1) students and academic staff at the private FoN perceived differently regarding students disruptive behaviour; (2) students and academic staff at the public FoN perceived differently regarding uncivil behaviour in which most of them included academic staff members' uncivil behaviour; (3) there were three main similar findings at both faculties which included that there were different perceptions based on the respondents' religious backgrounds in regard to students' threatening behaviours, academic staff threatening behaviours and academic staff disruptive behaviours.

6.3 Cross-case analysis of qualitative findings

According to the findings of the current study presented in chapters four and five, this section consists of cross-case analysis as follows: (1) open-ended questions findings and (2) findings from the interviews and observations.

6.3.3 Findings from open-ended questions

Table 6.8 below shows that the respondents at the two faculties provided opinions regarding the type and the reasons of the uncivil behaviour incidences, the differences between the settings of the incidences and the suggestions for managing the incidences. In regard to the types of the uncivil behaviour, three themes emerged from the data which included unprofessional behaviour, ineffective communication and teaching-learning process issues.

Table 6.8: Cross-case analysis of open-ended questions findings

Question	***Themes***	***Private FON***		***Public FON***	
		Academic staff	***Students***	***Academic staff***	***Students***
Types of the uncivil behaviour incidences	Communication issues	√	√	√	√
	Relationship issues				√
	Teaching-Learning management issues	√		√	√
	Professional issues	√	√	√	√
	Technology or instruments misuse		√		
Reasons of the uncivil behaviour incidences	Ineffective communication	√	√		
	Professionalism issues	√	√	√	√
	Individual and contextual factors	√	√	√	√
	Ineffective rules implementation			√	√
Differences of uncivil behaviours between classroom, skill laboratory and clinical unit	Form of the uncivil behaviour incidences	√	√	√	√
	Person involved in uncivil behaviour incidences	√	√	√	√
	Areas or scopes of uncivil behaviour	√	√	√	√
Suggestions for managing the uncivil behaviour	Effective communication and relationships	√	√	√	√
	Effective rules implementation	√	√	√	√
	Presenting self	√	√	√	√

Unprofessional behaviours occurred among academic staff, students and nurses in nursing education settings. For example, the academic staff undermined students, awarded unjustified grade and disrespected other academic staff members. The students were late and came unprepared for a class and showing the altitude of superiority towards other students. The nurses' unprofessional behaviours included neglecting patients, refusing to work with students and recording the patients' chart information inaccurately/poor documentation.

The academic staff, students and nurses also did not communicate to others properly by making harassing comments, talking impolitely and insulting others. The teaching-learning process issues further occurred in nursing education settings which included cheating in examination, sleeping in the class while learning and disturbing other students by talking while in class. Interestingly, students at the private FoN mainly reported that the misuse of instruments or technology as types of uncivil behaviour incidences during teaching-learning process. A student at the private FoN stated '*In the classroom, the students use laptop/internet that is not related to teaching materials while learning*' (Open-ended question/030s).

Table 6.8 above also reports the themes that emerged regarding the reasons of the uncivil behaviour incidences, which included: professionalism issues, communication issues, rules implementation issues and individual and background influences. Professionalism issues were stated by most of the respondents except the academic staff at the private FoN. Despite identifying professionalism issues as one of the reasons, the academic staff at the private FoN mentioned overwhelming responsibilities as a contributing factor to uncivil behaviour. Therefore overwhelming responsibilities can also be part of the

theme 'professionalism issues'. An academic staff at the private FoN commented that '*Because of the tasks demand or lots of concerns that have to be fulfilled by both lecturers and students'* (Open-ended question/004a).

In addition, only respondents at the private FoN mentioned communication issues as one of the reasons for the occurrence of uncivil behaviour. On the other hand, only respondents at the public FoN reported ineffective rules and implementations as one of the reasons for the occurrence of uncivil behaviour. It appears that there were a few different concerns in each FoN regarding the reasons for the uncivil behaviour incidences.

The individual and background factors were also stated as one of the reasons for the occurrence of uncivil behaviour incidences. Interestingly, the academic staff at the private FoN pointed out specifically on personal stress: *'Psychology: [emotional] stress, ineffective coping... '* (Open-ended question/002a), can be considered as one of the individual factors.

The study showed that there were differences of uncivil behaviour between the classroom, skills laboratories and clinical units. The differences were related to the (1) form of the uncivil behaviour, (2) the person involved, (3) the areas and scope of the uncivil behaviour. Interestingly, it seemed that all the respondents supported the three themes above, there were some differences in the use of these different terms by the academic staff at the private FoN. For example, harassment and misuse of technology can be under the theme of forms of uncivil behaviour. In addition, immediate response for managing uncivil behaviour can be under the theme of the person engaged in incivility.

This study further revealed that there were three main themes such as role modelling, effective rules implementations and effective communication and

relationship as strategies for managing uncivil behaviour in nursing education (see table 6.8 above).

Role modelling means providing good examples. Role modelling was expected from academic staff and nurses in nursing education, for example an academic staff member mentioned: *'Need of a role model from higher position/leaders/academics'* (Open-ended question/004a). Not only for academic staff and nurses, role modelling was also expected from every person involved in nursing education as a student stated '*Controlling own self and maintaining [good] attitude'* (Open-ended question/203s). Moreover, for role modelling, it is important to *'understand the differences of ethnics; [understand] the uniqueness of every human that emerge the senses of respects and regards'* (Open-ended question/003s) as a student further clarified.

Effective rule implementation is also needed for maintaining civility in nursing education. For example, an academic staff member supported by stating: '*All people should follow the rules in academics environment*' (Open-ended question/005a). Additionally, a student expressed that not only effective rule implementation is needed to maintain the civility but also strong religious values. The student further stated *'Based on strong religiosity [is also needed], not only [based on] the available rules...'* (Open-ended question/111s).

Effective communication and relationships are also important to manage uncivil behaviour in nursing education. Not only for managing such behaviour but also preventing the occurrences of the uncivil behaviour. One example of effective communication can be the establishment of ground rules, as an academic staff suggested: '*The lecturers control the class while teaching and make agreements*

with students regarding ground rules' (Open-ended question/001a). Below are some examples regarding effective relationships encouraging respect for others and self-introspection. One student stated a need for '*openness, respect and regard for each other, as well as need for [written] evaluation for self-improvement*' (Open-ended question/089s).

6.3.4 Findings from the interviews and observations

A number of respondents further provided their views on uncivil behaviour in nursing education through face-to-face interviews with eight students and five academic staff in each FoN. Based on the interviews at the two FoNs, three similar themes emerged from the respondents: professionalism issues, ineffective rule implementations and individuals' character and background influences (see table 6.9 below).

Table 6.9: Cross-case analysis of interview and observation findings

Theme	Sub theme	Private FoN		Public FoN	
		Academic staff	Student	Academic staff	Student
Professionalism issues	Communication issues	√	√	V	V
	Relationship issues		√	V	V
	Teaching-learning management problems	√	√	V	V
Ineffective rule implementations	Varied perceptions of rules implementation	√		√	
	Poor rules implementation			√	V
	Lack of discipline	√	√		
	Inconsistency of rewards-punishments	√	√		
	Lack of effective rules				√
	Inconsistency of actions when facing uncivil behaviour		**√**		
Individuals' character and background influences.	Individual issues	**√**	**√**	**√**	**√**
	Individuals backgrounds influences	**√**	**√**	**√**	**√**

Professionalism issues

The respondents described their opinions in regard to uncivil behaviour in nursing education. Both academic staff and students at the two FoNs explained uncivil behaviour related to nursing as a profession. The respondents provided a number of behaviours that were categorised as professional issues. These issues were articulated at two FoNs mentioned as a key of uncivil behaviour instances nursing education. The instances of professional issues in nursing education related to ineffective communication and relationship as well as teaching and learning process issues.

Ineffective communication, such as disruptive talking while in the classroom and harassing comments by people involved in nursing education, were stated by respondents at both FoNs. The respondents at the public FoN perceived that making harsh comments is common behaviour in their community. For example, an academic staff member mentioned: *'[There are] a lot of hash talking [by nurses]... then... the patients also like that... maybe it [harsh talking] is the culture in this city indeed'* (Interview/BB72-73).

In addition, poor rapport between students-academic staff-nurses happened at both FoNs, such as disrespectful or undermining behaviours. The respondents at the public FoN also reported that the academic staff members' uncivil behaviour, such as harsh behaviour, was adopted by students:

> *'Maybe from seeing that the lecturer is harsh, the student also becomes harsh. When the lecturer is harsh, the student might think "why I am not?" So there are these incidences [uncivil behaviour]'* (Interview/GG49).

In regard to the teaching-learning process issues, it seems that the academic staff and the students supported each other when describing the incidences of uncivil behaviour related to teaching-learning process issues. For example, both academic staff and students at the private FoN stated that supervision of students by CI in the clinical settings was not adequate. For example, an academic staff stated *'Maybe if we evaluate ourselves as [clinical educators], we will discover that we do not provide enough supervision [to the students]...'* (Interview/B71). A student supported this: *'because in fact... the CI is still lacking, Ma'am, in the clinical practice'* (Interview/G135).

Likewise, the study at the public FoN reported that there were unexpected changes in class schedule in their school. For example, an academic expressed *'The department [administration] also does not inform me [that the schedule has changed]. So [I just realised that] my schedule dates have been adjusted forward'* (Interview/BB81). A student further noted:

> *'The problems related to the schedule of the lecturers sometimes are a little bit hard on us. For example, the schedule for the skills laboratory is today but the lecturer cannot come, so when we try to find another day, sometimes the lecturer also cannot come, indeed. To manage the schedule sometimes is difficult'* (Interview/MM35).

Ineffective rule implementation

Professionalism is also related to ethical and legal understanding (Arnold and Stern, 2006). In nursing education, there are rules or policies that guide education system in the classroom, skills laboratory or clinical placement.

However, it seems that there were ineffective rules implementations in both FoNs.

Ineffective rules implementation in nursing education was also recognised as a key factor of uncivil behaviour incidences. The respondents at both FoNs reported various perceptions on poor implementations of rules. The academic staff at both FoNs reported that they applied the rules inconsistently and they realised regarding this condition. For example, an academic staff stated:

> *'We [lecturers] have different perceptions and commitments in regard to rule implementation. For example, one lecturer is strict and other lecturer is lenient'* (Interview/E44).

The students at both FoNs also expressed that there were inconsistent reward and punishment in nursing education which possibly influences the incidences of uncivil behaviour in their school. For example, a student at the public FoN stated *'Sometimes the lecturers also make their own rules. They allow students for 10 minutes lateness…it is the lecturers' rules' (Interview/HH27).*On the other hand, an academic staff punished a student severely at the public FoN by giving a physical punishment (walking squatting from the third to ground floor). This affected the student emotionally and physically.

Individuals' character and background influences

The daily life of people involved in nursing education in Indonesia was influenced by their backgrounds, and their own cultural characteristics which also influenced civility in their behaviour. 'Characters of person involved in nursing education and their ethnic backgrounds' were also acknowledged as key factors of incivility in nursing education. Indonesia consists of people with multi

ethnicities, diverse SES and religious backgrounds. Furthermore, Indonesia is a collectivist society in which the value of group such as family and ethnic group is very important (Hofstede, Hofstede and Minkov, 2010).

The study at both FoNs revealed that personal characters contributes to the incidences of uncivil behaviour in nursing education such as mood, personal maturity and stress. These individual characteristics promoted the use of ineffective teaching methods among academic staff and disturbing behaviour among students. A student expressed that:

> *'The problems of the lecturers during the learning [process] in the classroom is that the lecturers sometimes are moody, indeed. Sometimes they are in good mood for teaching, sometimes they are not. So, for example, if they are not in good mood, they teach the way they want to. Yes…. they only read the slides until they finish, and when there is no question, they leave'* (Interview/GG33).

Personal background also factors also influenced the uncivil behaviour incidences, including parenting with traditions from a particular ethnic background, religious values of the family or environment and socio-economic status of the parents. These factors appeared to influence either proper or improper behaviour of the person involved in the family or environment. One academic felt that students' behaviour was determined by 'the teaching of the family'.

The respondents at both FoNs further expressed their religious values explicitly through the interviews. For example, an academic staff at the private FoN expressed that *'Lecturers are people who have been trusted by God to teach*

them (the students)' (Interview/A54). A student at the public FoN supported this:

> *'It is not that I am trying to differentiate between Islam and Christian, but maybe Muslim's are more calm, maybe because they are Javanese too, what they say is pleasant, "I am sorry Ma'am, this is not my competency". On the other hand, there is a senior student who is Christian and Batak, who directly [frankly] says, "Sorry Ma'am, this is not my competency, I don't practice here for this", like that'* (Interview/FF65).

In summary, the cross-case analysis of the qualitative findings has answered the main research question 'How do nursing students and academic staff perceive behaviours as uncivil in the context of their ethnicity, religious faith and socio-economic background in the case study institutions?' including:

1) There were similarities and differences regarding perceived uncivil behaviour between students and academic staff at both FoNs. It seems that most of the differences were mainly related to different terms used by the respondents. There was a difference regarding the reason for uncivil behaviour between the two FoNs. The private FoN concerns centred on ineffective communication while as the public FoN attributed it to ineffective rule implementation.
2) There were different perceptions of uncivil behaviour that related to the respondents backgrounds at both FoNs. It was reported that individuals' ethnicity, socio-economic and religious backgrounds influences individuals' perception of uncivil behaviour in nursing education in Indonesia.

6.4 Chapter summary

It is evident that there were similarities and differences between two units of analysis (private and public faculties of nursing) including the characteristics and the study's findings (quantitative and qualitative). The most crucial different characteristic was the implementation of the programme regarding clinical placements.

In regard to quantitative findings, the respondents at both units of analysis agreed that incivility was a serious problem which occurred more frequent in the classroom. The respondents also reported that students and academic staff as the perpetrators in the classroom and skills laboratory as well as students, academic staff and nurses as perpetrators in the clinical practice settings. However, it seems that uncivil behaviours were perceived more differently between the students and academic staff at the public faculty of nursing than the private one.

This study also revealed that uncivil behaviour related to respondents' backgrounds. Most uncivil behaviours were perceived similarly based on the respondents' ethnic background. On the other hand, some uncivil behaviours were perceived differently based on the respondents' religious backgrounds. Moreover, based on the respondents' SES backgrounds at both sites, most of the perceived uncivil behaviour were similar.

In regard to qualitative findings, the respondents at both settings revealed a number of similar themes. The themes related to type of incivility included communication and professional issues. The reasons of incivility included professional issues and individuals' backgrounds. In addition, the respondents

at the private site were more concerns on ineffective communication, on the other hand, the respondents at the public site more concerns on ineffective rules implementation.

In depth interviews and direct observations further revealed that the respondents at two sites reported similar themes: professionalism issues, ineffective rule implementations and individuals' character and background influences. However, it appears that the respondents provided varied sub-themes under ineffective rule implementation.

CHAPTER 7: DISCUSSION

7.1 Introduction

The aim of this study was to increase understanding of the nature and factors that predispose to acts of uncivil behaviour from the perspective of nursing students and academic staff in the context of their ethnicity, religious faith and socio-economic background in Indonesian nursing education. The secondary aims were to: 1) compare nursing students' and academic staff members' uncivil behaviour perception in nursing education in private and public universities in relation to ethnicity, religious faith and socio-economic background; 2) develop a model to provide an educational framework of the techniques and strategies for teaching and learning and managing civility in nursing education that is congruent with Indonesian culture.

This chapter contains a discussion of the main study findings and compares them with those of other international research literature that have investigated incivility in higher or nursing education. The chapter goes on to discuss the methodological strengths and limitations of this study and identifies its implications for nursing education and practice, culminating in proposals for further research on the topic.

7.2 Discussion of the study findings

The study comprehensively explored the uncivil behaviour of students, academic staff members and clinical nurses in Indonesia as perceived by

academic staff and students in nursing education settings. The two-unit analysis employed in this study were highly efficient in yielding substantive quantitative and qualitative findings (chapters 4, 5 and 6).

The findings make a significant contribution to knowledge and understanding of incivility, in nursing education in 3 ways. Firstly the study is unique because to the best of my knowledge, it is the first of its kind undertaken in nurse education within Indonesia. Secondly it has investigated the role that three, previously unexplored factors: ethnicity; religion and socio-economic, play in the manifestation of incivility in nursing education. Thirdly it has led to the development of a new explanatory model of incivility that is applicable to the Indonesian context.

The model, which is presented in Figure 7.1, has been developed by assimilating the study findings namely academic staff and student nurses' beliefs of what constitutes instances of incivility and civility in Indonesian nursing education and in doing making it congruent with the Indonesian context. These insights have been used to build on the research and theories of other researchers in this area, namely those proposed by Clark and Olender (2010) and Huitt (2003) and have subsequently led to the development of the new model.

Given the model has built on previous international studies it proposed that it is not only culturally congruent with Indonesia but also has the potential for wider application across the globe, including the strategies for managing incivility: effective communication and relationships, role modelling and effective rules' implementation.

Although the model builds on the work of Clark and Olender (2010) and Huitt (2003), it also seeks to offer new insights into the nature of incivility in nursing.

This has been achieved by addressing the deficiencies contained within the models developed by Clark and Olender (2010) and Huitt (2003) through (1) involvement of nurses supporting students within clinical practice; (2) the occurrences of combined academic-practice incivility; (3) investigating the relationship between classroom behaviour, skills laboratory behaviour and clinical practice behaviour; (4) the contributing factors of incivility that relates to Indonesia context; and (5) the strategies for managing incivility or promoting civility that are congruent with the Indonesian context or culture.

Another factor that distinguishes this model from that of Clark and Olender's (2010) model is that whereas the model illustrates how to foster civility in nursing education, it does not present the contextual factors that influence the nurse education process, which this study has found to be a crucial element in Indonesian nursing education. Due to this gap, the Huitt's transactional model of teaching-learning process provided context as one of the concepts that could impact the education process (Huitt, 2003). Therefore, the transactional model by Huitt complemented the civility model to provide an illustration of the nursing education process in the Indonesian context, despite the fact that it emerged from (and was originally devised for) Western cultural contexts.

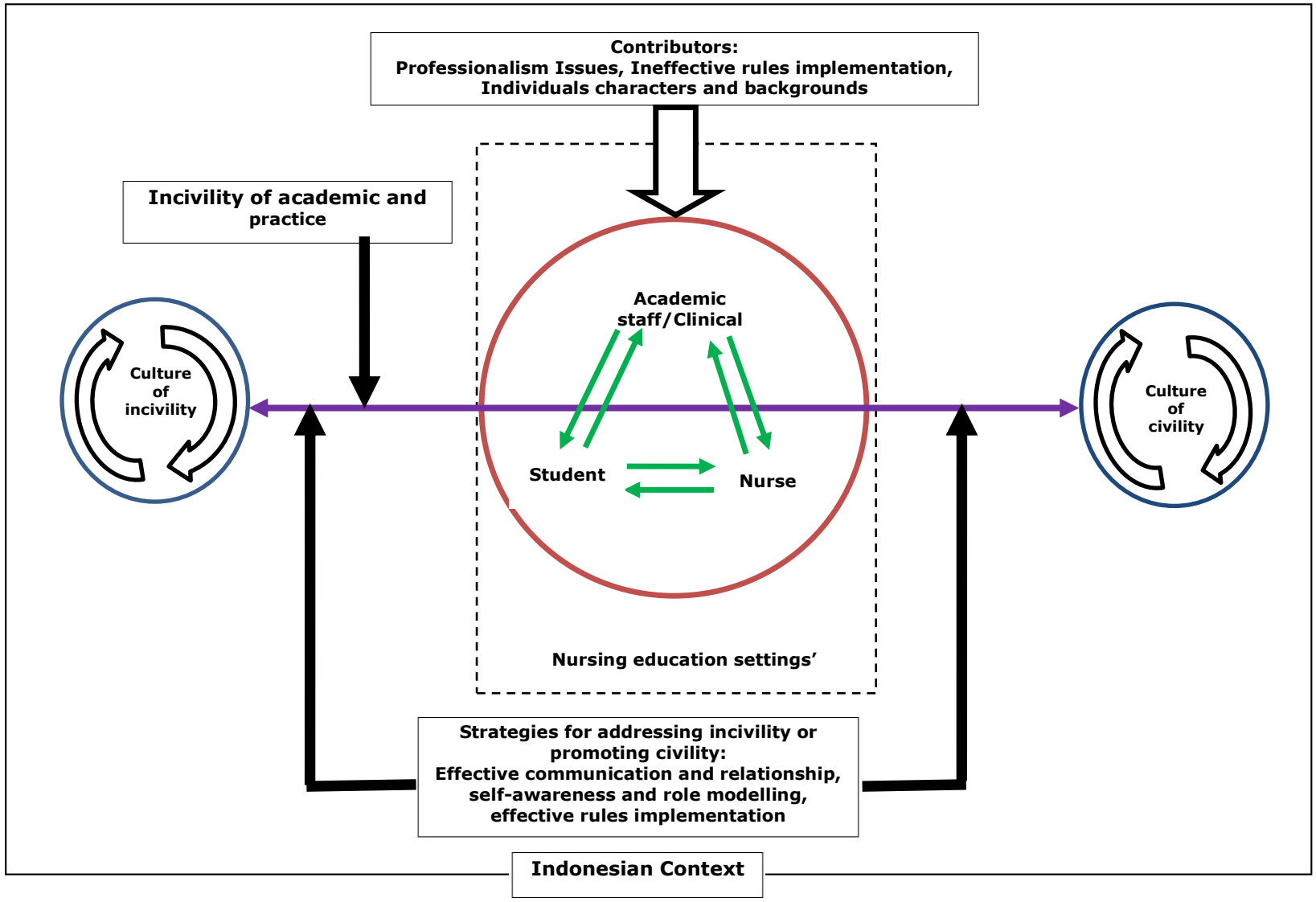


Figure 7-1: A model for promoting civility in Indonesian nursing education developed from Clark and Olender (2010) and Huitt (2003)

The model has also drawn on social exchange theory (SET) (section 2.4) to help understand some of the complex relationships that exist between actors of interactions (academic staff, students and nurses) and the impact of settings (classroom, skills laboratory and clinical practice) on interactions as well as contributing factors of incivility and strategies for addressing incivility or promoting civility in nursing education.

Accordingly, the SET will explain the interactions within an explanatory model for promoting civility in Indonesia nursing education. The SET will further aid to understand the contributing factors of incivility as well as the strategies for managing incivility that emerge from the findings of this study.

The model's components consists of: the interactions between actors, the culture of civility-incivility, the academic-practice incivility, the contributing factors of the interactions, the strategies for managing incivility or promoting civility and the new insight of the emerging model.

a) The interactions between actors

Originally, Clark and Olender's (2010) model illustrated the interaction between the academic staff members and students. This current study added nurses as people who are involved in nursing education specifically in clinical practice.

As can be seen at the centre of the model (Figure 7.1), the findings of this study revealed that there were interpersonal relationships between academic staff members, nursing students and nurses in nursing education settings. The relationships emergent during teaching-learning processes can be thought of as social exchanges whereby individuals look for social

relations that tend to produce favorable expected outcomes or rewards (Blau, 1964; Homans, 1961).

Thus, in this case, the academic staff, students and nurses expect that their interaction will produce benefits for them. For example academic staff expect the students to listen and pay attention when learning, whereas the students expect the academic staff to adopt effective teaching methods in the classroom. This brings benefits to both camps, enabling the academic staff to achieve the learning aims whilst the students gain information and knowledge. However, the situation becomes costly when people do not do what others' expect. For example, when the students do not pay attention and engage in unrelated conversation among themselves, the academic staff members feel distressed.

Moreover, the power and position of the person involved in the interaction could also affect the social exchange process (Lawler and Thye, 1999). For example, students are perceived as people involved in the interaction with low power and low social position (Clark, 2008b; Randle, 2003), whereas in the social exchange process, people with low power positions experience negative emotions; on the other hand, people with high power positions experience positive emotions (Lawler and Thye, 1999). This is supported by previous studies indicating that students felt undermined due to perceived academic staff and nurses' hierarchical position in nursing education settings (e.g. Clark, 2008b, 2008d; Randle, 2003).

As this study demonstrated, the people involved in the interactions depend on the educational setting. For instance, in the classroom, the interaction could be between academic staff and students; in the skills laboratory, between CE/Clinical Educator or CI/Clinical Instructor and student; in the clinical practice between student-nurse or academic staff/CE-nurse or CE-

student in the clinical setting. Andersson and Pearson (1999, p.457) argued that 'interpersonal and situational factors involved in the exchange of incivilities'. This also means that the interactions are influenced by the setting where the interactions take place.

Still at the centre of the model (Figure 7.1), the figure displays that the interrelationships between academic staff-student-nurse occur in the settings of nursing education, in which the school has its own characteristics and process. Thus, the school's characteristics and process should also be considered in the teaching-learning process (Huitt, 2003). In this study, nursing education consisted of the public and private FoNs in two different areas. Therefore, the characteristic of each FoN was different. For instance, the private FoN was part of a Christian-based university. Thus, the Christian values of the FoN penetrated into their teaching-learning process, such as praying in a Christian way and applying Christian principles while teaching. Therefore, it is expected that civil behaviour could occur in such conditions.

However, though the public FoN is part of non-specific religious value university, the religious values of the stakeholders involved there could not be separated from daily activities, such as Islamic greetings (since most of the people involved in the public FoN were Muslims). In addition, there were a number of female students wearing hijab, which showed that they were practicing their beliefs as Muslim women (Al-Islam, 2014). This condition further supports the previous expectation that civil behaviour should be the culture of the nursing schools due to the implementation of individuals' belief.

In regard to the school process, this study showed that there were different educational processes applied by the two FoNs (see section 6.1). For example, students at the private FoN had clinical placements in the second

year of the academic program. On the other hand, the students at the public FON had clinical placements when they were in their professional program. Thus, this condition could impact on the students' achievements at the two FoNs. There could be differences in students' professional behaviours between the two FoNs because of differences in clinical experiences in health care settings. Hence, these differences in experiences could explain the contrasting versions about students' achievement.

b) The culture of civility-incivility

The double-sided arrow in the middle of Figure 7.1 illustrates a continuum of opportunity for academic staff, students and clinical nurses in relation to the possibility of conflicts: the left direction leads to a culture of incivility if they have managed the conflicts poorly, while the right direction leads to a culture of civility if they have managed the conflicts effectively. In short, when the persons involved communicate and engage effectively, a culture of civility is promoted.

The culture of civility or incivility is developed from the set of shared behaviours between people involved in society units such as nursing education. In nursing education, the academic staff-student-nurse engagements aim to produce a conducive learning environment. The culture of civility occurs when opportunities for effective engagement contribute to the interactions (Clark, 2008b). When academic staff and student-nurse work together to solve conflict, the possibility for the 'interaction or exchange' is increased, which promotes a civil learning environment (Clark, 2008b). Moreover, if academic staff andstudent-nurse interactions are characterized by effective communication and active engagement, a culture of civility emerges (Clark, 2008b). Applying effective communication and dealing with conflict in a courteous manner is conducive to a civil

environment (Clark, 2008b). In contrast, a culture of incivility will occur when opportunities for resolving conflict is neglected, avoided, or inadequately managed; eventually this cultivates a culture of incivility (Clark, 2008b).

It is noted that individuals engaged in exchange relationships sometimes feel good or bad due to the exchange or interaction (Lawler and Thye, 1999). The reason is that emotions are part of the interaction. Moreover, mutual interdependence produces joint activities which lead to the stimulation of positive/negative emotions. These emotions will be transposed to and expressed in the social unit, creating stronger/weaker individual-communal connection, and grasping more/less group collaboration and conformity (Lawler and Thye, 1999). In short, individuals' emotions (positive or negative) emerge in interactions and influence their outcomes, resulting in adequate or inadequate collaboration as well as a culture of civility or incivility.

c) Academic-practice incivility

The model (Figure 7.1) also identified that there were academic and practice incivilities (left side of the figure). The current study supported both types of incivilities. Academic incivility included sleeping during class sessions were in progress, talking/making noise, not paying attention in the classroom, and cheating in exams (Beck, 2009; Clark, 2010). The practice incivility included charting patient care that is not done, unprepared for clinical practice and not admitting an error made in patient care (Beck, 2009; Clark, 2010). The current study also revealed that combined academic-practice incivility might occur in the skills laboratory despite its fewer occurrences due to firm rules in this setting. The incivility incidences in the skills laboratory included tardiness, harassing comments and misuse of clinical

skills instruments (e.g. misappropriation of drugs, equipment and supplies). These uncivil behaviours could also occur either in the classroom or clinical practice. Thus, these findings also showed that there was a relationship between classroom behaviour, skills laboratory behaviour and clinical practice behaviour. This finding reflects previous authors who suggest that there is a relationship between such behaviours (Kolanko et al., 2006; Lashley and de Meneses, 2001; Luparell, 2011). However, these authors are not basing their claims empirical findings.

d) Contributing factors in the interactions

The model further portrays the contributing factors of interactions in nursing education in Indonesia. Based on the findings of this study, three factors that contributed to interactions in nursing education included professional issues, ineffective rules implementation and individuals' characters and background.

The professional issues contributed to the interaction among people involved in nursing education including ineffective communication, poor relationships and ineffective teaching and learning (e.g. disruptive talking and harassing comments while in class, poor rapport between students, academic staff and nurses by demonstrating disrespectful or undermining behaviours and lack of supervision by CI in the clinical settings).

Being professional means displaying acceptable behaviour by following norms or principles (Akhtar-Danesh et al., 2011; Arnold and Stern, 2006), in this case, nursing education norms or nurse professional norms. In regard to emotions, Lawler and Thye (1999) argue that emotions are part of the normative context, in this case, nursing education. There is a 'script' of appropriate behaviour in a certain situation (Lawler and Thye, 1999). Therefore, people involved in nursing education should display emotions as

expected in nursing education settings such as classroom, skills laboratory and clinical practice. For example, academic staff members are expected to express their emotions professionally even when they face disrespect (i.e. a violation of conceptual professional norms) from student nurses in the classroom.

Ineffective rules implementation further contributes to interpersonal relationships in nursing education settings. For example, academic staff members have varied degrees of stringency in the implementation of rules and they applied reward and punishment inconsistently. Rules are perceived as standard norms in nursing education that should be obeyed by people involved in the related environments, such as classroom and skills laboratory. In addition, rules and norms are the guideline of exchange processes and adopted by people involved in the process (Cropanzano and Mitchell, 2005; Emerson, 1976). SET reciprocity rules are considered as standards of how individuals should behave, and individuals who adhere to the norms are obliged to behave mutually (Lawler and Thye, 1999). However, not all people value reciprocity to the same extent and it is argued that cultural and individual differences influence this value (Lawler and Thye, 1999). Additionally, the different values of reciprocity between people involved in the interactions will lead to conflicts (Lawler and Thye, 1999).

Individuals' characteristics also contributed to the interpersonal relationship, such as personality and personal maturity, as well as background factors such as ethnicity, religion and SES. Huitt (2003) further argued that academic staff and student characteristics are qualities that they bring prior to their interactions in the learning process (e.g. from home and school). These characteristics could impact further in the teaching-learning process. The academic staff members' characteristics included values, belief, knowledge, communication skills and efficacy. The students' characteristics

included personality, age, gender, race/ethnicity and religious practices. The current study confirmed Huitt's model in that there was a relationship between individuals' characteristics (such as personality and ethnicity) and their behaviour, such as their perceived uncivil behaviour in nursing education. Andersson and Pearson (1999) further proposed that individuals who have certain characteristics such as a 'hot temperament' escalate incidences of incivility. The 'hot temperament' refers to the mood and consequent behaviour of individuals who are impulsive or who lack self-regulatory capacity (Andersson and Pearson, 1999). This also means that impulsive people will influence others to react mutually, which could lead to the negative exchange and exacerbation of uncivil behaviour.

It is argued that emotion is the outcome of a cognitive judgment and individuals' moods impact on individuals' social judgments (Lawler and Thye, 1999). That is why an individual who is considered to have moody characteristics might have biased perceptions regarding others' behaviour, which might be interpreted as incivility (Andersson and Pearson, 1999). Meanwhile, the person who performs the behaviour might perceive his/her behaviour to be acceptable or civil (Andersson and Pearson, 1999).

The current study further provides a new understanding that the contributory factors of incivility are congruent with the Indonesian context or culture such as individuals' backgrounds that influence daily life of people in Indonesia (Adiningrum and Kutieleh, 2011). This also means that individuals' ethnicity, religion and socio-economic status backgrounds affect the behaviour of people in the country, which consequently impacts on their interactions. For example, people's religion shapes their moral values. Rahim and Rahiem (2012) mentioned that moral education in Indonesia is integrated with religious and citizenship education. In other words, people of Indonesia learn to socialise with others from their religious holy book and

Pancasila, from which sources Indonesians construct their moral worldview (Rahim and Rahiem, 2012).

As discussed in section 1.6, Indonesia is very culturally diverse and this has major implications for understanding and managing incivility. A good example of this is the multiplicity of religions and religious practices that exist in Indonesia, which are reflected in people's values. For example, people with a Batak ethnic background have values of *hamoraon, hagabeon*, and *hasangapon* ('prosperity, happiness and honour'), thus these values are drawn upon by Batak people in their efforts to work hard and gain success (Badaruddin, 2013). However, it seems that the Batak's people do not consider others when they are trying to achieve their success, thus many people with different ethnic backgrounds (particularly those whose cultures place more stress on social harmony, such as the Javanese) dislike their behaviour (Badaruddin, 2013).

The important point is that people's perceptions of incivility are the result of exposure to religious and ethnic discourses and experiences (Chambers et al., 2011). Hence, each culturally diverse group is likely to define aspects of incivility differently. These values are therefore likely to manifest themselves in behaviour. For example, amongst many Indonesians, direct eye contact is considered inappropriate, particularly when addressing people older than oneself (Seob, 2009; Setyanto, 2014). In regard to personal space, all Indonesians traditionally tend to touch others as part of a greeting, for example on the hand or shoulder (Setyanto, 2014); however, touching the head of another person is a great taboo (Seob, 2009), and Muslims tend to refrain from touching members of the opposite sex, with the exception of family members (Al-Islam, 2015).

In relation to this study, these values are likely to impact on nursing students perceptions of what constitutes civil and uncivil behaviour within a range of learning environments. This has major implications for the development of strategy for managing incivility and promotion of civility within the Indonesian context. If it is to succeed, a strategy will need to be congruent with Indonesian culture including ethnic and religious backgrounds. In other words, when communicating and interacting within nurse education settings, academic staff and others involved in the delivery of the curriculum need to be aware and understand different individuals' backgrounds.

d) Strategies for managing incivility or promoting civility

Figure 7.1 further shows that the findings of this study provide scope for developing strategies for managing incivility or promoting civility culture. As mentioned in section 7.1.5, the strategies include effective communication and relationship, self-awareness and role modelling, and effective rules implementation. These strategies align with previous studies suggesting mechanisms for managing the behaviour (e.g. Clark and Springer, 2010; Decker and Shellenbarger, 2012). However, the current study provides a new understanding that the strategies for managing incivility should be congruent with the Indonesian context or culture, as discussed previously (see p.320).

7.3 Comparison with other studies

This section will compare the results of this study with other studies. The comparison will be discussed in four sub-sections: 1) the perceptions of academic staff and students regarding incivility in nursing education; 2) the actors of incivility in nursing education; 3) the settings of incivility in nursing

education; 3) the contributors of incivility in nursing education; and 4) the strategies for addressing incivility or promoting civility.

7.3.1 The perceptions of academic staff and students regarding incivility in nursing education

Uncivil behaviour has been perceived differently by people involved in nursing education, as mentioned in previous studies. For example, most respondents (academic staff and students) at one FoN in the USA perceived that uncivil behaviour was a moderate to serious problem in nursing education (Clark, 2008a). On the other hand, most of the academic staff at one FON in the People's Republic of China reported that uncivil behaviour was not a problem at all (Clark et al., 2010). Whereas, the student nurses reported that it was not a problem at all to a moderate problem (Clark et al., 2010). It seems that uncivil behaviour could be perceived differently due to personal and context concerns.

The current study assessed perceptions of academic staff and students at two FoNs in Western Indonesia. Most of the academic staff and students perceived incivility as being a serious issue in nursing education. This is in contrast to Clark et al. (2010). The current study's findings raise serious concerns and therefore call for action to address the incivility incidences. More respondents perceived uncivil behaviour as a mild problem and not a problem in the public FoN (students 12.43%; academic staff 26.4%) than respondents at the private FoN (students 8.3%; academic staff 0). This may be due to various interpretations regarding incidences of uncivil behaviour at the public FoN. In other words, people involved in the public FoN might perceive that the behaviour was a common occurrence in the academic setting or even in the community. Academic staff demonstrated this when they stated 'Harsh talking [by the lecturer], it is almost, almost common in

the campus, even in the skills laboratory...' (Interviews/BB35). This finding calls for further exploration of how and who constructs behaviours as uncivil.

Uncivil behaviour is perceived differently by different people. This is because our perceptions of uncivil behaviour are determined by a number of factors including people's context or personal experiences, values and beliefs (Clark, 2013; Robertson, 2012). Perpetrators may perceive to it be normal, while recipients may perceive it to uncivil. The concept (and perception) of uncivil behaviour is socially constructed and subject to expansion and development (Lawler and Thye, 1999; Moffat, 2001).

There is also the danger that what are considered to be acts of fun and harmless gestures in students' lives are captured and constructed as uncivil behaviours under academic scrutiny by those in powerful positions. For example, sarcasm, swearing, racial insults, teasing and the use of an inappropriate voice tone. However, the literature in this area is unequivocal that certain behaviours are uncivil (Altmiller, 2012; Clark and Springer, 2007b; Lashley and de Meneses, 2001; Thomas and Burk, 2009) as identified in chapter two (section 2.5).

7.3.2 The actors of incivility incidences in nursing education

In this study, when providing their opinion on who engages in incivility, the respondents proposed that both academic staff and students were the perpetrators of uncivil behaviour in the classroom as well as in the skills laboratory. A student commented regarding students uncivil behaviour 'in classroom: students often come without preparation, the learning time schedule changed suddenly, did not provide with the teaching materials, teaching with tense situations' (Female, year 3, Catholic, Batak; Open-ended question/176s). In addition, an academic staff commented regarding

academic staff uncivil behaviour 'in classroom: underestimating students, perceiving students to be stupid, being subjective' (Lecturer, Batak, Islam; Open-ended question/006a).

It seemed that academic staff and students at both FoNs realised that teacher-student interaction is crucial to achieve the learning goals. As supported by a previous study in Indonesia, teacher-student interpersonal interaction influenced students' outcomes (Fraser, Aldridge and Soerjaningsih, 2010). This previous study showed that when the statistically significant ($p<0.05$) teacher's behaviour was perceived as dissatisfied, admonishing and strict, it was negatively related to student course achievement scores. On the other hand, the helpful/friendly and understanding behaviour of the teacher was statistically significant ($p<0.01$), it was positively related to student course achievement scores. In other words, to achieve the teaching-learning goals, there is a need for positive interactions between academic staff and student nurse including supportive behaviour and respecting others. These behaviours are also perceived as civil behaviour.

Moreover, there were differences of opinions among respondents when reporting the perpetrators of uncivil behaviour in clinical practice. Half of the academic staff (50%) at the private FoN and one third of the students (30.53%) at the public FoN reported that students or academic staff/clinical educator or nurses were equally responsible for uncivil behaviour incidence in clinical practice. In contrast, less than half of the academic staff (42.11%) at the public FoN reported that clinical nurses were more likely to engage in uncivil behaviour. In addition, over one third of the students (37.4%) at the private FoN reported that nurses were a little more likely to display uncivil behaviour in clinical practice. The different responses might be due to the respondents' lived experience, especially in the clinical settings. For

example, the students at the private FoN have practiced in clinical placement during the second-fourth year of their training in the academic program and the profession program. The academic program covers from seven to eight semesters to achieve the academic degree. The profession program covers two semesters that consist of clinical practice in the health care settings to obtain a professional degree. In contrast, students at the public FoN have clinical placements only when attending the professional program. In addition, the academic staff members at the public FoN have more working experience than the academic staff at the private FoN. Therefore, it could be said that academic staff at the public FoN have more exposure in clinical practice settings than academic staff at the private FoN.

Despite different opinions in regard to the perpetrators of incivility in the current study, a previous study (Clarke et al., 2012) revealed that the most perpetrators in clinical practice were clinical instructors (30.22%) and staff nurses (25.49%), Thus, Clarke's study supported the opinion of the academic staff at the public FoN and students at the private FoN in the current study.

7.3.3 The impact of settings on incivility in nursing education

A previous study by Marchiondo et al. (2010) reported the perspectives of senior nursing students' that the most prevalent places of uncivil academic staff behaviour were in the classroom and clinical settings, whereas it was least frequent in the skills laboratory. The current study confirmed the previous studies findings in which the respondents (academic staff and students) perceived that the classroom was the most prevalent place of incivility incidences compared to the skills laboratory and clinical practice (Beck, 2009). This may be because of the unawareness of ground rules in

the classroom or policies in clinical practice (Longo, 2010; Suplee et al, 2008).

Furthermore, inconsistencies in teaching and learning styles adopted by teachers and the varied nature of classroom activities may have contributed to such conceptions (Clark, 2013; Boice, 1996). For example, a teacher should be capable to provide an educational approach that is congruent with students' learning style in which each student could have different learning style such as visual or aural learning (Clark, 2013).

Further research is required to establish if classroom dynamics and teachers' personalities might be factors influencing such perceptions about uncivil behaviours. Boice (1996) argued that the main contributor of classroom incivility could be academic staff members' unfriendly attitudes, particularly at the beginning of courses. The academic staff unfriendly attitudes could de-motivate students, resulting in a lack of engagement and involvement in the learning process Boice (1996).

The skills laboratory had the lowest prevalence of uncivil behaviour incidences. This might be due to the rules and procedures that govern practice in this area (Beck, 2009). The emphasis on safety factors may also act as a deterrent. Moreover, a student stated that 'If in laboratory, uncivil behaviour occurred less frequent because the lecturers are in good control in the room since there is only a small number of students' (Female, year 2, Christian, Batak; Open-ended question/069s).

In addition, the clinical unit was perceived as a place for uncivil behaviour to occur after the classroom. The reason could be work environment stress (Altmiller, 2008; Clark and Springer, 2007b), which could be a causative factor in creating the conditions for uncivil behaviour to occur. A student further stated 'in the clinics [incivility] happened more frequently because

of the workload' (Male student, year 3, Christian, Manadonese; Open- ended question/011s). On the other hand, uncivil behaviour could be used as stress relievers as Hoover and Sherrell (2010) identify that taking out our stress on others such as 'lashing out, angry outbursts and physical violence' are a number of unhealthy strategies for managing stress in which such behaviours may only reduce stress in the short term.

This current study also revealed that there were differences of uncivil behaviours between the classroom, skills laboratory and clinical practice from both academic staff and students' perspectives at two FoNs. There were three themes which emerged in regard to the differences including forms of the behaviour, persons involved as well as areas and scope of the behaviour. For example, in the classroom, the uncivil behaviour included disturbing talking and tardiness by students. In the skills laboratory, the uncivil behaviour included verbal abuse by academic staff. Lastly, in the clinical practice, nurses acted with an air of superiority; the consequences of this poor healthcare professional interaction could include negative patient safety issues (Rosenstein and O'Daniel, 2008).

A previous study (Beck, 2009) is in line with the current study's findings regarding the area and scope of the behaviour. Although there were no statistically significant differences between first- and third-year students regarding incivility occurrences in classroom and clinical settings, the first year students perceived that the uncivil behaviours were more likely to occur in the classroom; in contrast, final year students perceived that uncivil behaviour occurred often in the clinical practice (Beck, 2009). This result might be related to the reality that the graduating students spent more time in clinical units as well as being in a position to compare what constitutes professional or unprofessional behaviour in the context of civility as

experienced students who have acquired a greater degree of professionalism (Beck, 2009).

There were different perceptions between academic staff and student nurses regarding uncivil behaviour of student, academic staff and nurses in nursing education. The academic staff and students at the private FoN perceived students' uncivil behaviours differently ($p<0.05$). In addition, the academic staff and students at the public FoN perceived uncivil behaviour of students, academic staff and nurses' differently ($p<0.05$). Most of the differences in perceptions between academic staff and students at the public FoN were related to academic staff's uncivil behaviour. For example, academic staff behaviour that were perceived as uncivil by the students included arriving late for scheduled activities, leaving class ahead of schedule, cancelling scheduled activities without warning. However, academic staff felt that such incidences were rare

It seems that the most frequent incidences of incivility at both FoNs were attributed to the differences in perceptions between the academic staff and students. Thus, a common or agreed upon way of interpreting behaviour is required to avoid the current ambiguity of the meaning of incivility in nursing education between academic staff members and student nurses (Clark and Springer, 2010).

7.3.4 The contributing factors of incivility in nursing education

This study also showed that there were a number of factors that contributed to uncivil behaviour incidences in nursing education. These factors included professional issues, individuals' characters and background, and ineffective rules implementation.

1) Professional issues

Professional issues comprised ineffectiveness of communication and relationships, the teaching-learning process and rules implementation. As mentioned in chapter two (section 2.5.1), incivility is related to professional issues in which incivility against nursing professionalism principles such as 'humanist, portrayers, facilitators and regulators' (Akhtar-Danesh, Baumann, Kolotylo et al., 2011, p.8). Thus, ineffective communication and relationships are in contrast to humanist and portrayer principles in which both principles believe that appropriate expressions are crucial as a professional. The teaching-learning process and rules implementation issues also opposed excellence and accountability principles in which these principles believe that a professional should commit to professional competence and ethical principles as well as responsible for their profession.

Ineffective teaching and learning processes could further occur either in the educational or clinical settings. When alluding to ineffective teaching and learning processes, the respondents at both FoNs reported that there was a lack of clinical instructors in clinical practice, with the result that the students were unsupervised while they practiced. As an academic stated 'maybe if we evaluate ourselves as [clinical educators], we are not always available to supervise our students the students]...' (Interview/B71). A student also supported this: 'because in fact... the CI [Clinical Instructor] is still lacking, Ma'am, in the clinical practice' (Interview/G135). Moreover, another student criticised 'There are clinical educators in the hospital but they are useless, they have never supervised' (Interview/LL37).

Being without clinical instructors in the clinical practice was perceived as 'professional abandonment', which is also identified as 'unintentional incivility' (Thomas, 2013, p.151). Thomas (2013) described how student nurses felt unnoticed, alone and ignorant of what to do in clinical settings, especially without their mentor. Clinical supervision is crucial to facilitate the

learning in clinical practice by supporting, guiding and conducting adequate evaluations (Papastavrou, Lambrinou, Tsangari et al., 2010). Such roles of clinical instructors will support a conducive learning environment especially in clinical settings (Emanuel and Pryce-Miller, 2013).

Additionally, the respondents at both FoNs reported that unexpected changes in class or clinical schedule occurred in the educational settings. This could occur as a result of lack of preparation at management level in the settings. In this case, the management level is a team of individuals who have daily responsibilities of managing nursing education such as adjusting time-tables. Thus, commitment and good management skills are required at the managerial level in educational settings (Quinn and Hughes, 2007) in order to minimise the incidence of uncivil behaviour.

Good communication and relationships are paramount in nursing (McCabe and Timmins, 2013). However, the respondents at both FoNs revealed that people involved in nursing education failed to communicate and interact effectively, which might cause anger, stress and frustration for the people involved. A student uttered her feelings emotionally regarding the clinical nurses' uncivil behaviour by commenting: 'The most frequent uncivil behaviour is from the nurses toward the students, so it seems that... we are being 'di jajah' [oppressed] by our own profession...' (Interview/LL38)

The respondents at the public FoN further stated that speaking harshly was part of the common communication of people in the community. As an academic staff member mentioned: '... maybe it [harsh talking] is the culture in this city indeed' (Interview/BB72-73). McCabe and Timmins (2013) argued that intonation and pitch of voice as well as accent of the person are important in communication especially in nursing. For example, when a nurse speaks with a loud and high-pitched voice to a patient, the

patient could perceive that the nurse demonstrates an irritating and inconsiderate behaviour.

Moreover, the public FoN is located in the area where most of the people originated as Batak people with 44.75% of city population in 2010 (Statistics Indonesia, 2015), who are stereotyped as 'emotional and quick-tempered' (Jaspars and Warnaen, 2010, p.349) especially Batak with sub-ethnic Batak Toba (Badaruddin, 2013). A senior academic staff (Batak ethnic) justified that she is a frankly speaking person: 'My character is like that [frankly speaking]' (Interview/DD71) and further stated that:'It is me as a real Batak, I am a person that is to the point [when talking], indeed (laugh) maybe there are people who have the characteristics... [when they talk]... they expressed it more pleasantly...' (Interview/DD86)

Moreover, a senior academic (Javanese) perceived that the Batak people are harsher than people of her ethnic background: 'But in here... the people' culture [behaviour] is like that, they are [harsher], indeed.' (Interview/EE88).

These characteristics might also be assumed by people living in the neighbourhood of the public FoN and working in the settings. A student stated that: 'It is not that I differentiate between Islam and Christian, but maybe Muslim people are more calm, maybe because they are Javanese too, thus what they say is pleasant, "I am sorry Ma'am, this is not my competency". On the other hand, there is a senior student who is Christian and Batak, who directly [frankly] says, "Sorry Ma'am, this is not my competency, I don't practice here for this", like that.' (Interview/FF65).

Bodenhausen and Richeson (2010, p.345) argued that such stereotyping, prejudice and discrimination are 'interlocking phenomena' which may cause unconscious bias and misperceptions in regard to a person or group.

Stereotyping is an underlying set of assumptions or beliefs about individuals or groups that give rise to prejudice, an 'affective response' toward the stereotyped subject (Bodenhausen and Richeson; 2010). Active discrimination is the fullest realisation of the antipathetic treatment that arises from stereotyping and prejudice. The authors further argued that cognitive appraisals enhance affective reactions that shape intentions and behaviour (Bodenhausen and Richeson; 2010). To avert misunderstanding and wrong assumptions based on stereotyping, Sully and Dallas (2010) call for greater understanding of cross-cultural communication for effective relationship in multi-ethnic and cultural context.

2) Individuals' characters and backgrounds

Individuals' characteristics included being moody and stressed as well as personal immaturity. The characters of people involved in nursing education were important, and it was clear that people should have better self-awareness and value clarification to understand the impact of personal attributes in cross-cultural interactions. As mentioned in the findings' chapter (section 2.5.3.2), one student stated that 'sometimes I feel that I have a personality disorder because I cannot get along with others, indeed' (Interview/KK90). This finding is supported by a previous study, which revealed that the current students' attributes such as a lack of social relationship skills and kindness as well as disrespectful and selfish behaviours could be the reason for incidences of incivility (Hernandez and Fister, 2001). The authors further stated that the college students were influenced by socio-political and technological issues in which the growth of being person who depend on computer and social media lead to incapability in social relationship with colleagues and academic staff members. Indonesia consists of people with various ethnicities, religions and SES backgrounds (Mandryx, 2010), and such backgrounds could not be separated from their

daily lives (Adiningrum and Kutieleh, 2011). Thus, it is apparent that individuals' background such as ethnicity, religion and SES backgrounds could influence uncivil behaviour in Indonesian nursing education. This calls for further exploration of how to manage the incivility in nursing education based on this special context.

In regard to the individuals' backgrounds, this study revealed that the academic staff and students at both FoNs have similar ethnic identities. They identified themselves as people who searched and affirmed their own ethnicity (Phinney, 1992). This also means that the respondents explored their self-identification regarding ethnic background as well as committed to the social activities of their ethnicity. Both FoNs displayed similar findings, which may be because most of the respondents shared similar ethnicities (i.e. Indo-Malay/Batak). Moreover, the respondents at the private FoN consisted of five main categories of ethnicities that represented the majority of all ethnicities in Indonesia. On the other hand, the respondents at the public FoN only represented two main categories (Indo-Malay and mixed ethnicities). Since the respondents represent the most numerous ethnicities in Indonesia, it could be said that most Indonesian people tend to judge others in terms of their own ethnicity.

Since most respondents in this study were similar in terms of ethnic background (Batak) and ethnic identity (p value >0.05), most of the perceived uncivil behaviours were also similar ($p > 0.05$) at both FoNs. There were only differences in regard to perceived students' threatening behaviour based on students' ethnic identity; and perceived nurses' threatening behaviour based on academic staff members' ethnic identity at the private FoN ($p < 0.05$).

The similar perceptions of the respondents might occur since the respondents lived in a city which the people come from many ethnicities. Thus, there might be acculturation among the people involved at both FoN. For example, an academic staff stated: 'And I also see that some lecturers who come from Java, when they came here... could change indeed. People said that Javanese people tend to be gentle, but when they are here [in this city] I see that they become harsher than Batak people, it is my opinion. Yet I really do not know why they become like that. Sometimes we cannot generalise the ethnic characteristics... uh... just like that... sometimes there are harsh attitudes... or behaviours that might be in other places unaccepted, but here it becomes [normal]... it is usually [common] here...' (Interview/BB11).

This process of adopting others culture could impact on individuals' ethnic identity in which they could perceive differently regarding the behaviours regardless of their similar ethnicity backgrounds (Berry, 2005; McCabe and Timmins, 2013).

In regard to religious faith/practice, several authors argued that there was a relationship between religious practice and behaviour (Gaduh, 2012; Margalith, Musgrave and Goldschmidt, 2003; Broeckaert, et. al, 2009; Gnadt, 2006; Bradby and Williams, 2006). In the current study, most of the academic staff and students at the private FoN had similar religious faith/practice regardless of their religions. They described themselves as people who practice their own faith though they have different religious backgrounds. The academic staff and students at the public FoN also identified themselves as people who practice their own faith. However, it appeared that there were differences in religious practices between the academic staff and students at the public FoN ($p < 0.05$). The academics staff members' faith/practices perceived themselves as people who practice

more their faith than the students. This factor could be attributed to the fact that the academic staff at the public FoN could be intolerant of students' uncivil behaviour because such behaviours may go against their religious beliefs and values, as an academic mentioned: '... the norm is from the religion... so as a common norm, the behaviour should be to help each other, respect others, be polite...' (Interview/AA54).

There were also statistically significant differences of perceived uncivil behaviour based on respondents' religious backgrounds at both FoNs ($p<0.05$). For example, perceived academic staff members' disruptive and threatening behaviour were perceived differently based on respondents' religious backgrounds. However follow-up analyses showed that there were only two significant findings including students' threatening behaviour and academic staff members' disruptive behaviour, which only occur at the private FoN. In other words, it is apparent that people involved (academic staff and students) in the private FoN had different perceptions of uncivil behaviour, such as students' threatening behaviour and academic staff members' disruptive behaviour based on their religious backgrounds (Christian, Islam and Catholic). These findings call for the private FoN to consider individuals' religious background when planning strategies to prevent or manage incivility. Although there were no differences of perceptions of incivility based on respondents' backgrounds at the public FoN, it is necessary to consider religious background because it is integral to the Indonesian way of life (Adiningrum and Kutieleh, 2011). This also means that religion shapes personal identity and moral values of Indonesia people (Adiningrum and Kutieleh, 2011; Novera, 2004).

Furthermore, it is interesting that religious background was a factor that could influence people's attitude in nursing education, as an academic stated that 'The religion or faith can make someone behave properly; it's not about

what is right or allowed [religious rites and laws], but it's about behaving properly' (Interview/E69). In addition, a student mentioned that:

'The disturbing behaviour, in Hinduism, this [behaviour] can be acknowledged as a sin ma'am, especially when conducting it intentionally, such as insulting others' feelings and hurting others. In Hinduism, we cannot hurt other creatures, including humans' (Interview/G100).

Every religion has an ethical system based on teaching people to be 'good' and to promote in-group harmony (Wilkinson, 2008), thus every religion has similar moral beliefs. For example, Christians and Catholics believe that people should love their neighbour as themselves (Mark 12 verse 31) similarly Muslims also value this belief (Al Hujarat 49 verse 10-11). However, religion also tend to be associated with prejudiced behaviours and attitudes (Dhanani and Donley, 2011). Additionally, the private FoN is a religiously oriented education institution; this could be a factor that it is associated with the lack of religious tolerance in the Indonesia context, as argued by a previous study in Indonesia (Gaduh, 2012). Therefore, it could be speculated that the respondents' religious background might influence how they perceive uncivil behaviour. Some people judge others from their religious worldview point, causing differences in perceptions about uncivil behaviours.

The respondents' socio-economic status (SES) and backgrounds in the current study were considered in relation to respondents' perceptions of uncivil behaviour in nursing education. A meta-analysis study by Piotrowska et al. (2015) supported that low SES was significantly related to high level of antisocial behaviour. The SES backgrounds considered in this study were employment, income and education (Piotrowska et al. 2015; Sirin, 2005). The students' SES backgrounds in this study were measured from their

parents' SES, including employment, monthly income and educational background. Most of the students at both FoNs had parents who work outside the home and had similar income. Additionally, most parents at the public FoN completed a high school education with job as government employees (father 47.03%, mother 47.57%). In contrast, most fathers at the private FoN graduated with university degrees and mothers had a high school education (father's job: private 25%; government 25%; mother's job: others 56.3% with most of them as housewives/77.8%). This could be the reason why students' perceptions of academic staff members' threatening behaviour were different and were based on the nature of the parents' employment, especially at the private FoN. This also means that an individuals' values can be influenced by their parents. A student stated: 'with my parents' education background, which they have achieved, it might influence their social status, indeed. My parents associate with... automatically with their background, with the colleagues that are at their level [or] above them. It influences us [the children]. We are educated on how to have good socialisation [social skills], indeed.' (Interview/HH70).

In regard to SES, the academic staff at the public FoN had more work experiences than those at the private FoN but most of the academic staff at both FoNs had a similar monthly income. The study further showed that the academic staff at the public FoN perceived differently regarding the experiences of academic staff members' disruptive behaviours and nurses' threatening behaviours in the past 12 months based on their employment status. In other words, there were differences in perceptions between junior and senior academic staff at the public FoN in regard to uncivil behaviour of academic staff and nurses. One of the reasons for these differences could be the generation gap between the junior and senior academic staff as supported by a previous study (Leiter, Price and Laschinger, 2010). The

authors compared two generation cohorts: Generation X (born 1961-1981) and Baby Boomers (born 1943-1960). The Generation X nurses reported that there was lack of civility in the workplace than the Baby Boomers did.

3) Ineffective implementation of rules

In regard to rules implementation, academic staff at both FoNs implemented the rules inconsistently, for example in applying the tardiness policy, reward and punishment. These differences might cause students to ignore rules and tolerate incivility incidences. Previous studies reported that students' uncivil behaviour persists when uncivil behaviours are managed poorly (Clark, 2008b; Luparell, 2005). An academic member of staff stated 'we [lecturers] have different perceptions and commitments in regard to rules implementation. For example, one lecturer is strict and another lecturer is lenient' (Interview/E44). A student further stated 'sometimes the lecturers also make their own rules. They allow students for 10 minutes lateness…it is the lecturers' rules' (Interview/HH27).

Moreover, the most surprising incidence was when a senior lecturer punished a student physically due to her submitting an incomplete assignment. A junior lecturer clarified: 'there are some lecturers that treat students extremely... for example there was a lecturer who punished a student by asking the student to go down [squat]... until the ground floor... [the student] was punished because she did not complete her clinical tasks. Finally [the student] fainted…' (Interview/BB21-23).

There is a need to come up with a standard for punishment to avoid giving extreme punishments to students. Students, academic staff and clinical nurses to be oriented so that they are all familiar with the standards. They will also have to understand the type of behaviour expected from them and

the type of punishment they will receive or give if they behave contrary to the expectations.

7.3.5 The strategies for addressing incivility or promoting civility

In the current study, the respondents suggested that role modelling, effective rules' implementation and effective communication and relationships for addressing uncivil behaviour in nursing education are required.

1) Role modelling

The respondents provided several examples of how to behave properly, such as respecting and understanding others, and role modelling that displays good behavioural examples to others as ways of reducing uncivil behavioural incidences in nursing education (Clark and Springer, 2010). It is interesting that the respondents also proposed to honour others by considering others' ethnic backgrounds. One student considered that it is necessary to 'understand the differences of ethnicities; [understand] the uniqueness of every human that emerge the senses of respects and regards' (Open ended question/003s) to enhance civility in nursing education. These suggestions could be considered to develop strategies for managing incivility in Indonesian nursing education. Despite the fact that there might be a cultural change from collectivist to individualist (Mangundjaya, 2013), Indonesia is a collectivist society in which the value of group such as family and ethnic group is foremost important (Hofstede, Hofstede and Minkov, 2010).

This further calls for better education processes in the classroom that foster and promote harmonious relationships between various ethnic groups. Students could be helped to develop cultural competence to increase tolerance and respect for students of other ethnicities and culture

(Chambers, Thompson and Narayanasamy 2011; Narayanasamy 2006). Such an approach would modify behaviour to be appropriate and acceptable and consequently bring about better social and cultural cohesion.

2) Effective rules' implementation

A number of respondents also provided suggestions regarding the implementation of rules, such as rewarding and giving punishments consistently as well as obeying the rules, including conducting SOP/Standard of Procedure in clinical units. As an academic staff member stated, 'the task of the leader and institution is to make the rules, thus, the uncivil behaviour could be prevented' (Interview/CC44). A student further mentioned that rules should be enforced by 'sanctions' on offenders in order to manage incivility in nursing education. This is consistent with Skinner's learning theory commonly known as 'operant conditioning' (Quinn and Hughes, 2007). This learning theory states that reinforced individual behaviour tends to be repeated or strengthened. In contrast, behaviour which is not reinforced tends to be extinguished or weakened. The current study's findings is consistent with previous research in that it is crucial to establish effective policies, regulations and ground rules to prevent and combat uncivil behaviour incidences (Longo, 2010; Suplee et al., 2008). Longo (2010) further suggested that special policies and regulations are required to address the incidences effectively, such as developing a code of conduct to define and manage civil or uncivil behaviours.

3) Effective communication and relationships

The respondents further implied the need for individuals' openness for self-evaluation and assertiveness to deal with the uncivil behavioural incidences. In addition, some respondents recommended 'team work' when facing challenges in nursing education. For example, a student suggested that to

address incivility, it should be 'having meetings often between the students, academics and nurses that can create trust relationship and respects others' (Open ended question/088s). These suggestions are consistent with previous research that several strategies for addressing incivility in nursing education included promotion of good communication strategies between nursing students and clinical educators, collaborative support among nurses, nursing schools and students (Decker and Shellenbarger, 2012) as well as providing transparent discussions, and encouraging activities that included 'counselling, coaching and mentoring' (Clark and Springer, 2010, p.324). Jenkins et al. (2013) further reported that nursing students at one FoN in the USA, have applied coping behaviours when facing incivility such as looking for social support, planned problem solving, and self-controlling.

7.4 Methodological strengths and limitations

This study originated from my experiences as a nurse lecturer in Indonesia and the awareness that there was a need for research to understand incivility in nursing education in Indonesia. As a lecturer, in one of the units of analysis, I am required responsible to teach a range of topics in different kinds environments, examine students and supervise them in clinical practice. From the outset, I was cognisant of the possibility of my roles and position to influence my feelings, especially when interviewing my own students. The students as the respondents may also have provided opinions tailored to suit me as their lecturer (i.e. providing what they believe to be desirable responses) rather than reflecting the empirical truth.

However, since the participants were from two different nursing schools, one of which was totally unrelated to me personally, this could serve as a means to confirm the findings in my school. In addition, continuous reports and

discussions with my supervisors provided an opportunity to offset any potential biases (see section 3.7.2).

A strength of the study is that I was born and grew up in Indonesia. I am, therefore, very aware of the importance of contexts such as religion, ethnic background and socio-economic status in influencing people's behaviour. Understanding all this was important to enable me to identify and thoroughly understand the context. Moreover, my previous experience as a nursing student meant that I have personally been exposed to incivility in nursing education settings.

This study assumed that the two FoNs are representatives of nursing educational institutions in the western part of Indonesia in general; however, they may not be truly representative of the entire population. Despite the high participation rate, and the fact that Java and Sumatera are the most important socio-economic and cultural islands of west Indonesia, the myriad cultures and environments pose a fundamental problem to any researcher in any Indonesian institutions, thus, it is impossible to generalise with any certainty. However, the study was as a success in terms of geographical diversity and representativeness; moreover, five main Indonesian ethnicities were included in the current study. Although four of the six officially recognised Indonesian religions were included, the participants were predominantly Christian, Catholic and Muslim, with only one Hindu.

This study applied a multiple-case (embedded) study at two FoNs and used similar data collection methods. However, there were a few differences in the data collection implementation between the two FoNs. Firstly, the participants of this study consisted of regular students – who were fresh high school graduates nursing students (in academic and professional programs) from both FoNs, but diploma-graduate nursing students seeking their

bachelor's certification were only recruited from the private FoN. This was because the public FoN did not grant permission to collect data from this group, which could limit the evidence from the clinical settings. However, the student respondents joining the profession program at the public FoN could compensate for this limitation, since the professional program students also provided evidence from clinical settings as they had practiced for at least a year in various clinical placements.

Secondly, when conducting interviews with respondents at the public FoN, there were some students who were interviewed outside the faculty buildings. This situation provided both advantages and disadvantage for the study. The advantage was the students felt more comfortable since they were talking about their experiences in their school, which were often unpleasant. The disadvantage was the practical limitation of the poor sound quality of audio recordings of those interviews.

Multiple-case study as a research design is still being debated, and several authors doubt that the case study can be a useful research method (Yin, 2014). As a way to address this concern, the study has applied two main research principles. The multiple-case study was the most appropriate design to answer the research questions of this study (Creswell and Clark, 2011). This study followed a methodological framework advocated by Yin (2009; 2014) by: (i) including a well-defined phenomenon of interest (ii) providing clearly articulated boundaries within a specific context (iii) operating within a well-structured analytical strategy. In addition, it is still a concern about whether this study could be generalised or not due to the challenges of truly representing various societies in Indonesia. Therefore, further work addressing this limitation is required to be conducted in other Indonesian nursing educational settings.

7.5 Implication for nursing education and practice

This study has identified key issues in relation to incivility in nursing education in Indonesia. The findings of this study provide new perspectives regarding incivility instances in nursing education. To my knowledge, the concept of incivility is new in Indonesian nursing education.

Much needs to be done on incivility/civility studies in Indonesia nursing education in which could provide evidences as a whole. This study offers a model for promoting civility in Indonesian nursing education. This study also provides the strategies for managing incivility or promoting civility that are congruent with the Indonesian context and culture.

7.6 Implication for further research

This study has established that context offers a unique perspective, which is crucial for a comprehensive understanding of incivility in nursing education. It has also presented a model for promoting civility in Indonesian nursing education. However, there are enormous opportunities for further research on the subject in Indonesia.

This study concentrated on the west part of Indonesia. It is further noted that the main findings of the study are commonly applicable across the country. However further research is required to confirm the applicability of these findings for the rest of the country. Studies are needed among nurses, patients and others health providers to further understand the contemporary notion of incivility in nursing education settings specifically in clinical practice.

This study has also identified several areas of further research in related subjects within nursing education that impact on the understanding of

incivility. For example, much research is needed to demonstrate the importance of gender and generation gaps in Indonesian nursing education.

The findings of this study have been presented in several international conferences between 2013 and 2014. In June 2013, an oral presentation on the overview of the study at RCN Education Forum International Conference and Exhibition at Glasgow UK and a poster presentation regarding a pilot study of the incivility study was also presented at the 3rd European Transcultural Nursing Association (ETNA) International Conference, Hagoshrim Israel.

In 2014, three oral presentations on study's findings regarding uncivil behaviour in nursing education which included:(1) the RCN 2014 Annual International Nursing Research Conference, at Glasgow UK; (2) the 5th International Nurse Education Conference Noordwijkerhout, The Netherland and (3) the 25th International Networking for Healthcare Education Conference, NET2014 Conference at Cambridge, UK. The presentations were received very well. Several participants from these conferences supported and commented for the new perspective of the findings of this study that offers an important and unique understanding of incivility in nursing education globally. Moreover, a paper based on the quantitative findings of this study was also accepted for publication in Journal (Nursing Education in Practice-see appendix 22).

7.7 Summary of recommendations

The findings of this study showed that there were instances of uncivil behaviour in Indonesian nursing education in which the perpetrators were nurse educators, student nurses and clinical practice nurses. This study focused on uncivil behaviour at two faculties of nursing in the west part of

Indonesia. Further study is necessary to determine the widespread of the issue. Studies conducted in nursing programs in other parts of Indonesia would help define the extent of incivility in nursing education. Research studies involving students and academic staff in other disciplines than nursing would further provide a foundation for comparison of incivility in the Indonesia's higher educational system.

Previous studies have proposed strategies for addressing incivility, however there is sparse published literature on the interventions available to deal with incivility that cover nursing education settings entirely. For example, strategies have been suggested to prevent uncivil behaviour in nursing education for academic staff or nurse leaders which included self-evaluation and development, establishment of policies and ground rules, role modelling, open discussion and supervision (Clark and Springer, 2010; Luparell, 2005; Suplee et al., 2008). Similarly, Longo (2010) proposed developing policies and procedures and providing good communication and "zero tolerance policies" to promote civility in working area (p.6). Decker and Shellenbarger (2012) further recommended several strategies to support healthy learning environment in clinical settings including effective communication and collaboration between nurses, nursing school and students, nurses' empowerment, as well as preparation and orientation for students to enter clinical practice.

Strategies and suggestions on how to promote effective relationships between different ethnic groups included providing education processess in the classroom that develop cultural competence for students (Chambers, Thompson and Narayanasamy, 2011). There is evidence that increasing students' cultural competence helps the student to honour and respect those of other ethnicities and cultures (Narayanasamy, 2006).

The findings of this study provides further areas that require exploration of uncivil behaviour in nursing education. In accordance with the aim of this study, the perceptions and experiences of academic staff members and students regarding uncivil behaviour in nursing education settings was explored by applying a number of methods such as survey and interviews. Regardless of its limitations, the methods have provided an in-depth understanding regarding uncivil behaviour in Indonesian nursing education, with the glaring omission of asking clinical practice nurses involved in nursing education (i.e. practical placements) about their opinions and experiences of the phenomenon of uncivil behaviour; it is highly advisable that future research addresses this gap to provide a rich source of complementary data for comparative purposes.

Finally, it is noted that organisational strategies to promote civility that involve all levels (Clark; 2013; Leiter et al., 2011; Osatuke et al., 2009) of nursing education, including student nurses, nurse educators, nurse administrators and clinical nurses, all of whom could offer valuable perspectives on this phenomenon.

7.8 Conclusions

This study adds to the emerging literature acknowledging that uncivil behaviour in nursing education is a vital problem that needs to be prevented and addressed. It provides new insights that perceived uncivil behaviour might differ according to the individuals' backgrounds in the Indonesian context. It indicates that there are different perceptions of uncivil behaviour based on people's religious beliefs and values. The evidence also suggests that it is crucial to respect others by understanding their ethnic backgrounds in order to manage uncivil behaviour in nursing education. In regard to SES backgrounds, the finding show that such backgrounds could impact on

perceived uncivil behaviour in nursing education such as employment status of the students' parents as well as the length experiences of being a nurse educator.

This study further provides a new model based on adaptation from previous models (Clark and Olender, 2010) and Huitt (2003) in which social exchange theory help to explain the model. This new model offers a number of new insights in regard to incivility in nursing education including context as contributor, nurses' involvement in the professionalisation of nursing students and evidence of relationship between the settings in relation to uncivil behaviour instances. Although some aspects of the findings of this study align to previous studies, this study provides new understandings for managing such behaviours in a contextually sensitive way, which is crucial for providing an approach to promote civility in nursing education, especially in Indonesia.

This thesis concludes with the advice of Benjamin Franklin indicating the practical importance of civility in life:

'Be civil to all; sociable to many; familiar with few; friend to one; enemy to none.'

It is hoped that people can apply this advice regardless of their background such as ethnicity religion, socio-economic status, culture or occupation.

7.9 Personal reflective account

The completion of a PhD study is both challenging and an amazing journey. This journey transformed my personal and professional life as well as my research experience. Truthfully, I doubted my commitment and ability to stay on this journey many times.

It is apparent that each year of a PhD study has its own difficulties as well as periods of ease. The difficulties of my first year were made worse by my responses to the issues. Specifically for my confirmation review issue, I should have managed the researcher response to fit an academic. In retrospect, I would handle some experiences differently concerning issues in the first year of my PhD journey. For instance, I should have accepted the feedback from the internal assessors constructively. As a previous reflection by Roche (2000) argued, learning to maintain a positive attitude is vital in a PhD journey.

In the second year, I faced challenges with more appropriate responses than the first year. I learned how to manage emotional responses to the issues. I also realised that I have supervisors and colleagues who always helped me in any situation, especially relating to my PhD work.

The third year brought more intellectual challenges. I needed more time to devote to the qualitative data analysis since I did not have experience in qualitative research. However the support I received from my supervisors and colleagues was vital (Batchelor and Di Napoli, 2006; Roche, 2000). Additionally, attending short courses and seminars improved my knowledge, skills and attitude. I felt more confident and independent in my PhD study.

Due to many challenges I faced and the support I received in the previous years, I felt that I became more mature and composed to handle a number issues in the fourth year. Despite the fact that English is not my first language, I learned how to write in English more effectively and to an acceptable academic standard.

Having a 'theme' throughout the researcher journey was also a good defense mechanism. The 'theme' as written in the Bible is in Isaiah 41 verse 10: 'So

do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand.'

Previous reflections provided similar opinions in which they provided themselves with a 'metaphor' for their journey (Batchelor and Di Napoli, 2006; Roche, 2000). Roche (2000) mentioned that she learned to love and respect her thesis as a child. This situation encouraged her to nurture her thesis like a parent who always supports her child through maturity. Likewise, Batchelor and Di Napoli (2006) stated that the journey of a PhD study could be perceived as 'the voyage' (p.13) or 'learning-as-travel' (p.17). The journey may lead one to face some experiences including being stuck, meeting conflict and finding new knowledge which could be the source of strength to reach the destination.

It can be seen that pursuing a PhD study means one will encounter both academic and non-academic issues. For example, an academic issue is lack of knowledge regarding research methodology. The non-academic issues include lack of skills regarding adaptation as well as managing criticism. However, both of these challenges were minimised since there were many people who provided support throughout the journey. In addition, joining relevant courses was crucial and valuable for this journey to improve my knowledge, attitude and skills in research. Despite the challenges in pursuing a PhD study, it is was wonderful journey for my personal and career development which has been a good preparation for my future career plans.

REFERENCES

Adams, D. and Miller, B.K. 2001. Professionalism in nursing behaviours of Nurse Practitioners. **Journal of Professional Nursing**, 17(4), pp.203-210.

Adiningrum and Kutieleh, T.S. and Kutieleh, S. 2011. How different are we? Understanding and managing plagiarism between east and west. **Journal of Academic Language and Learning**, 5(2), pp.A88-A98.

Aebersold, M., Tschannen, D. and Sculli, G. 2013. Improving nursing students' communication skills using Crew resource management strategies. **Journal of Nursing Education**, 52 (3), pp.126-130.

AINEC. 2015. AINEC Members. [Online] Available at: http://aipni-ainec.com/id/anggota_list.

Akhtar-Danesh, N., Baumann, A., Kolotylo, C., Lawlor, Y., Tompkins, C. and Lee, R. 2011. Perceptions of professionalism among nursing faculty and nursing students. **Western Journal of Nursing Research**, 35(2), pp.248–271.

Alberts, H. C., Hazen, H. D., and Theobald, R. B. (2010). Classroom incivilities: The challenge of interactions between college students and instructors in the US. **Journal of Geography in Higher Education**, 34, 439-462.

Alexander-Snow, M., 2004. Dynamics of gender, ethnicity and race in understanding classroom incivility. **New Directions for Teaching and Learning**, 99, pp.21-31.

Al-Islam. 2014. The Qur'an and Hijab. [Online.] Available at: http://www.al-islam.org/hijab-muslim-womens-dress-islamic-or-cultural-sayyid-muhammad-rizvi/quran-and-hijab. [Accessed 7 December 2014].

Alidina, K. 2013. Professionalism in post-licensure nurses in developed countries. **Journal of Nursing Education and Practice**, 3 (5), pp.128-137.

Altmiller, G., 2012. Student perceptions of incivility in nursing education: Implication for educators. **Nursing Education Perspective**, 33 (1), pp.15-20.

Ananta, A., Arifin, E. N., Hasbullah, M. S., Handayani, N. B., & Pramono, A. .2013. Changing Ethnic Composition: Indonesia, 2000-2010. **Paper presented at the XXVII IUSSP International Population Conference**, 26 – 31 August 2013, Busan, Korea. [Online] Available at: http://www.iussp.org/sites/default/files/event_call_for_papers/IUSSP%20Ethnicity%20Indonesia%20Poster%20Section%20G%202708%202013%20revised.pdf.

Ananta, A., Arifin, E.N., Hasbullah, M. S., Handayani, N.B. and Pramono, A. 2014. A New Classification of Indonesia's Ethnic Groups (Based on the 2010 Population Census). **Institute of Southeast Asian Studies working paper series.** [Online] Available at: www.iseas.edu.sg

Anderson, C. A. & Bushman, B. J. (2001) Effects of Violent Video Games on Aggressive Behavior, Aggressive Cognition, Aggressive Affect, Physiological Arousal, and Prosocial Behavior: A Meta-Analytic Review of the Scientific Literature. **Psychological Science**, 12(5), pp.353-9.

Andersson, L.M. and Pearson, C.M. 1999. Tit for Tat? The Spiraling Effect of Incivility in the Workplace. **The Academy of Management Review**, 24(3), pp. 452-471

Anthony, M. and Yastik, J., 2011. Nursing students' experiences with incivility in clinical education. **Journal of Nursing Education**, 50(3), pp.140-144.

Asianinfo, 2010. Indonesia's geography. [Online] Available at: http://www.asianinfo.org/asianinfo/indonesia/pro-geography.htm

Australian museum. 2015. Indonesian emblem. [Online] Available at: http://australianmuseum.net.au/image/indonesian-emblem-e74743

Arnold, L. and Stern, D.T.2006. **What is medical professionalism**. Oxford University Press, USA.

Ashworth, F., Brennan, G., Egan, K., Hamilton, R. and Sáenz, O. 2014. Learning Theories and Higher Education. Level3, Issue 2, June 2004. [Online] Available at: http://arrow.dit.ie/cgi/viewcontent.cgi?article=1003&context=engschleart

Aveyard, H. and Sharp, P. 2014. **Doing a Literature Review in Health and Social Care** (3rd edition). Open University Press.

Badaruddin, 2013. Map of conflict regarding ethnicity, religion,race and between group in plural community in North Sumatera. [Translation writer's own] [Online] Available at: http://spe.dbp.gov.my/bhn/2013/Seminar%20Pelbagai%20Kaum/Hasil%20Seminar/kertas%20kerja%20Prof%20Badaruddin.pdf

Baldwin, A., Mills, J., Birks, M. and Buddena, L.2013. Role modeling in undergraduate nursing education: An integrative literature review. **Nurse Education Today**. [Online] Available at: http://dx.doi.org/10.1016/j.nedt.2013.12.007

Bandura, A.1971. Social Learning Theory. [Online] Available at: http://www.esludwig.com/uploads/2/6/1/0/26105457/bandura_sociallearningtheory.pdf

Bandura, A.1977. Self-efficacy: Toward a unifying theory of behavioral change. **Psychological Review**, 84(2), 191-215.

Bandura, A.1978.Social Cognitive Theory. [Online] Available at: https://www.uky.edu/~eushe2/Bandura/Bandura1989ACD.pdf

Bartkowski, J.P., Xu, X., Levin, M.L. 2008. Religion and child development: Evidence from the Early Childhood Longitudinal Study. **Social Science Research**, 37, pp.18–36.

Baxter, P. And Jack, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. **The Qualitative Report**, 13(4), p.544-559. [Online] Available at: http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf

Beck, J. W., 2009. **Deconstructing student perceptions of incivility in the nursing education triad.** PhD Dissertation Louisiana State University. [Online]. Available at: http://etd.lsu.edu/docs/available/etd-10312009-095845/unrestricted/JWBeck_diss.pdf. [Accessed 23 February 2012].

Beckmann, C.A., Cannella, B.L and Wantland, D. (2013) Faculty perception of bullying in school of nursing. **Journal of Professional Nursing**, 29(5), pp. 287-294.

Benton, T. and Craib, I. 2011. **Philosophy od social science: the philosophical foundations of social thought**, 2nd ed. Palgrave Maacmillan.

Berger, B. A. 2000. Incivility. **American Journal of Pharmaceutical Education**, 64, pp.445-450.

Berry, J.W. 2005. Acculturation: Living successfully in two cultures. **International Journal of Intercultural Relations**, 29, p. 697–712

Bjorklund, W. L., & Rehling, D. L. 2010. Student perceptions of classroom incivility. **College Teaching**, 58, pp.15–18.

Blaikie, N.2010. **Designing social research**, 2nd ed. Polity Press.

Blau, P.M. 1964. **Exchange and Power in Social Life***.* New York: Wiley.

Blenkin, G.M. and Kelly, A.V.1981. The primary curriculum. London: Harper & Row.

Blichfeldt, B.S. and Andersen, J.R. 2006. Creating a Wider Audience for Action Research: Learning from Case-Study Research. **Journal of Research Practice***,* 2(1), Article D2.

Bloch, A. and Solomos, J. Eds.2010. **Race and ethnicity in the 21st century**. England: Palgrave MacMillan.

Bodenhausen, G.V. and Richeson, J.A. 2010. Prejudice, stereotyping and discrimination. In Baumeister, R.F. and Finkel, F.J. (ed.) **Advance social psychology: The state of science**. Oxford University Press

Boice, B. 1996. Classroom incivilities. **Research in Higher Education**, 37(4), pp.453-486.

Ballard, R.W., Hagan, J.L., Townsend, J.A., Ballard, M.B. and Armbruster, P.C. 2015. Perceptions of Uncivil Student Behavior in Dental Education. **Journal of Dental Education**, 79(1), pp.38-46.

Bradby, H. and Williams, R. 2006. Is religion or culture the key feature in changes in substance use after leaving school? Young Punjabis and a Comparison Group in Glasgow. **Ethnicity and Health**, 11(3): pp.307-324.

Braun, V., & Clarke, V. 2006. Using thematic analysis in psychology. **Qualitative Research in Psychology**, *3*, p. 77–101. doi:10.1191/1478088706qp063oa

Encyclopedia Britannica. 2016. Sumatera Island. [Online] Avalilable at: https://www.britannica.com/place/Sumatra

Broeckaert B, Gielen J, Van Iersel T, Van den Branden S. 2009. Palliative Care Physicians' Religious / World View and Attitude Towards Euthanasia: A Quantitative Study Among Flemish Palliative Care Physicians. **Indian Journal of Palliative Care**, 15(1): pp.41-50.

Çelebioğlue, A., Akpinar, R.B., Küçükoğlu, S. and Engin, R., 2010. Violence experienced by Turkish nursing students in clinical settings: Their emotion behaviors. **Nursing Education Today**, 30, pp.687-691.

Caro, D. & Cortes, D., 2012. Measuring family socioeconomic status: An illustation using data from PIRLS 2006. *IERI Monograph Series: Issues and Methodologies in Large-Scale Assessments,* 5, pp. 9-33.

Chambers, D., Thompson, S., and Narayanasamy, A., 2011. Engendering cultural responsive care: a reflective model for nurse education. **Journal of Education and Practice**, 3(1), pp.70-81.

Chambers, D., Thiekötter, T. and Chambers, L. 2013. Preparing student nurses for contemporary practice: The case for discovery learning. **Journal of Nursing Education and Practice**, 3(9), pp.106-113

Chun-Heung, L. and French, P. 1997. Education in the practicum: a study of the ward learning climate in Hong Kong . **Journal of Advanced Nursing**, 26, p. 455–462

Chowdhury, S. and Rammohan, A., 2006. **Ethnicity and conflict in Indonesia** [online] Available at: https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=ACE10&paper_id=202 [Accessed 7 August 2012]

Clark, C. M., 2006. **Incivility in nursing education: Students perception of uncivil faculty behaviour in the academic environment**. Phd Dissertaton University of Idaho.

Clark, C.M. 2008a. Faculty and student assessment of and experience with incivility in nursing education. **Journal of Nursing Education**, 47 (10): pp.458-465.

Clark, C.M. 2008b. The dance of incivility in nursing education as described by nursing faculty and students. **Advances in Nursing Science**, 31(4), pp.E37-E54.

Clark, C.M. 2008c. Student voices on faculty incivility in nursing education: A conceptual model. **Nursing Education Perspectives**, September/October 2008, Vol. 29, No. 5, pp.284- 289

Clark, C.M.2008d. Student perspectives on faculty incivility in nursing education: An application for the concept of Rankism. **Nursing Outlook**, 56, pp.4-8.

Clark, C.M. 2011. **Continuum of incivility**. [Online] Available at: http://hs.boisestate.edu/civilitymatters/docs/Clark-Continuum-of-Incivility-revised-2014.pdf

Clark, C.M., 2013. **Creating and sustaining civility in nursing education**. Sigma Theta Tau International, Indianapolis USA.

Clark, C.M., Ahten, S.M. and Macy, R. 2013. Using problem based learning scenarios to prepare nursing students to address incivility. **Clinical Simulation in Nursing**, 9, pp.e75-e83

Clark, C.M and Carnosso, J., 2008. Civility: A concept analysis. **The Journal of Theory Construction and Testing**, 12 (1), pp.11-15.

Clark, C. M., & Davis-Kenaley, B. L. 2011. Faculty empowerment of students to foster civility in nursing education: A merging of two conceptual models. **Nursing Outlook**, 59(3), pp.158-165.

Clark, C.M., Farnworth, J. and Landrum, R.E., 2009. Development and description of the incivility in nursing education (INE) survey. **The Journal of Theory Construction and Testing**, 13(1), pp.7-15.

Clark, C.M., Juan, C.M., Allerton, W., Otterness, N.S., Jun, W.Y. and Wei, F. (2012). Faculty and student perceptions of academic incivility in the people's Republic of China. **Journal of Cultural Diversity**, 19(3), pp.85-93.

Clark, C. M. and Olender, L. (2010). **Conceptual model for fostering civility in nursing education (adapted for nursing practice).** [Online]. Available at: http://hs.boisestate.edu/civilitymatters/docs/Conceptual%20Model%20to%20Foster%20Civility%20in%20Nursing%20Education%20and%20Practice%20Dec%202011.pdf. [Accessed 20 January 2010].

Clark, C.M., Otterness, N.S., Jun, W. Y., Allerton, B.W., Juan, C. M., Black, M. and Wei, F., 2010. Descriptive study of student incivility in the people's Republic of China. **Journal of Cultural Diversity**,17(4), pp.136-143.

Clark,C.M. and Springer, P.J. 2007a. Incivility in nursing education: A descriptive study of definitions and prevalence. **Journal of Nursing Education**, January 2007, 46(1), pp.7-14.

Clark,C.M. and Springer, P.J. 2007b. Thoughts on incivility: Student and faculty perceptions of uncivil behavior in nursing education. **Nursing Education Perspective**, 28(2), pp.93-97.

Clark, C.M. and Springer, P.J. 2010. Academic nurse leaders' role in fostering a culture of civility in nursing education. **Journal of Nursing Education**, 49(6), pp.319-325

Clarke, C.M, Kane, D.J., Rajacich, D.L. and Lafreniere, K.D. 2012. Bullying in undergraduate clinical nursing education. **Journal of Nursing Education**, 51(5), pp.269-276.

CRNBC's/College of Registered Nurses of British Columbia Standards of Practice. 2013. **Practice Standard**. [Online]. Available at: https://www.crnbc.ca/Standards/Lists/StandardResources/432NurseClientRelationshipsPracStd.pdf [Accessed 17 November 2014].

Connelly, R. 2009.Introducing a culture of civility in first-year college classes. **The Journal of General Education**, 58 (1), pp. 2-8.

Cook, K.S. and Rice, E.R.W. 2001. Exchange and power: Issues of structure and agency. In Jonathan H. Turner (ed.). **Handbook of sociological theory**. New York: Springer.

Cooper, J.R.M., Walker, J., Askew, R., Robinson, J.C. and McNair M. (2011) Students' perceptions of bullying behaviours by nursing faculty. **Issues in Educational Research**, 21(1), pp.1-18.

Creswell, J. W. and Clark, V.L.P. 2011. **Designing and conducting mixed methods research**. 2nd ed. SAGE Publication, Inc.

Creswell, J.W. 2014. **Research design: qualitative, quantitative, and mixed methods approaches**. 4th ed. International student edition. SAGE Publication, Inc.

Crowe, M. 2013. **Crowe Critical Appraisal Tool (CCAT) User Guide**.[Online]. Available at: http://www.conchra.com.au/docs/CCAT_User_Guide_v1.4.pdf [Accessed 3 October 2014].

Crowe Critical Appraisal Tool/CCAT. 2013. **Form (v1.4)**. [Online]. Available at: http://www.conchra.com.au/docs/CCAT_Form_v1.4.pdf [Accessed 3 October 2014].

Cropanzano, R. and Mitchell, M.S. 2005. Social Exchange Theory: An Interdisciplinary Review. **Journal of Management***,* 31, p.874-900. DOI: 10.1177/0149206305279602

Daniel, L.G., Adams, B.N. and Smith, N.M., 1994. Academic misconduct among nursing students: A multivariate investigation. **Journal of Professional Nursing**, 10(5), pp.278-288.

Decker, J.L and Shellenbarger, T. 2012. Strategies for nursing faculty to promote a healthy work environment for nursing students. **Teaching and Learning in Nursing**, 7, pp.56-61.

Dein, S. 2006. Race, culture and ethnicity in minority research: A critical discussion. **Journal of Cultural Diversity**, 13(2): pp. 68-75.

Del Prato, D. 2012. Students' voices: The lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. **Nurse Education Today**, doi: 10.1016/j.nedt.2012.05.030.

Del Prato, D., Bankert, E., Grust, P. and Joseph, J. (2011) Transforming Nursing Education: A Review of Stressors and Strategies That Support Students' Professional Socialization. **Advances in Medical Education and Practice**, 6, 109-116. http://dx.doi.org/10.2147/AMEP.S18359

Deveci, S. E., Acik, Y. and Ayar, A. 2007. A survey of rate of victimization and attitudes towards physical violence among school-aged children in Turkey. **Child: care, health and development,** 34(1): pp. 25–31

Dhanani, L. and Donley, A., 2011. How religiosity affects perceptions of the homeless. **The University of Central Florida Undergraduate Research Journal**, 4(2), pp.52-61

Dulin, P.L., Hill, R.D. and Ellingson, K. 2006. Relationships Among Religious Factors, Social Support and Alcohol Abuse in a Western U.S. College Student Sample. A letter to editor. **Journal of Alcohol and Drug Education** 50 (1): pp.5-14.

Dzubak, C.M. 2007.**Classroom Decorum: What's Happening and Does it Matter?** [Online] Available at: http://www.myatp.org/wp-content/uploads/2015/04/Synergy-Vol-2-Dzubak1.pdf

Easterby-Smith, M., Thorpe, R., Jackson, P. R., & Easterby-Smith, M.. 2008. *Management research: an introduction*. Los Angeles, SAGE.

Edwards, L., Lapp-Rincker, R.H., Magyar-Moe, J.L., Rehfeldt, J.D., Ryder, J.A., Brown, J.C., and Lopez, S.J. 2002. A Positive Relationship Between Religious Faith and Forgiveness: Faith in the Absence of Data? **Pastoral Psychology**, 50(3), pp.147-152.

Eka, N., Sitompul, R. and Houghty, G.S., 2013. Incivility in Tangerang nursing education scope. **Nursing Current Journal** 1(1), 15-24. [Translation writer's own]. [Online]. Available at: http://dspace.library.uph.edu:8080/handle/123456789/2304

Eisenhardt, K.M.1989. Building Theories From Case Study Research. **The Academy of Management Review***,* 14 (4), p.532-550.

Emanuel V, Pryce-Miller M. 2013. Creating supportive environments for students. **Nursing Times***,* 109(37), p.18-20.

Embassy of Indonesia-Washington DC, n.d. **National symbols**. [Online] Available at: http://www.embassyofindonesia.org/wordpress/?page_id=603

Emerson, R.M. 1976. Social Exchange Theory. **Annual Review of Sociology**, 2, p. 335-362.

Felblinger, D.M. 2008. Incivility and bullying in the workplace and nurses' shame responses. **The Journal of Obstetric, Gynecologic, & Neonatal Nursing,** *37, p. 234-242.* DOI: 10.1111/j.1552-6909.2008.00227

Feldman, L. J. 2001. Classroom civility is another of our instructor responsibilities. **College Teaching**, 49, pp.137-140.

Fenton, S. 2010. **Ethnicity**. 2nd ed. UK: Polity Press.

Ferriss, A. (2002). Studying and measuring civility. A framework, trends, and scale. **Sociological Inquiry**, 72, pp.376-392.

Field, A., 2013. **Discovering Statistics using IBM SPSS Statistics**. 4th Ed. SAGE Publications Ltd.

Finfgeld-Connett, D. (2006) Meta-synthesis of caring in nursing. **Journal of Clinical Nursing**. Journal compilation 2007 Blackwell Publishing Ltd: pp. 197-204.

Foa, E.B. and Foa, U.G. 2012. Resource Theory of Social Exchange. K. Törnblom and A. Kazemi (eds.), **Handbook of Social Resource Theory: Theoretical Extensions***,* 15. *Empirical Insights, and Social Applications*, Critical Issues in Social Justice, DOI 10.1007/978-1-4614-4175-5_2, © Springer Science+Business Media New York 2012

Fraser, B.J., Aldridge, J.M and Soerjaningsih, W. 2010. Instructor-student interpersonal interaction and student outcomes at the university level in Indonesia. **The Open Education Journal,** 3, pp.21-23

Ghadirian, F., Salsali, M. and Cheraghi, M.A. 2014. Nursing professionalism: An evolutionary concept analysis. **Iran Journal of Nursing and Midwifery Research**, 19(1), pp.1-10

Gaduh, A., 2012. **Uniter or Divider? Religion and Social Cooperation: Evidence from Indonesia**. [Online] Available at: http://ssrn.com/abstract=1991484 or http://dx.doi.org/10.2139/ssrn.1991484 [Accessed 10 August 2014]

Galbraith, M. W. (2008). College teaching: Developing perspective through dialogue. Malabar, FL: Krieger Publishing Co.

Gallo, V.J., 2012. Incivility in nursing education: a review of the literature. **Teaching and Learning in Nursing,** 7, pp.62-66.

Gerris, C.A. 1990. Purposes, values and objectives in adult education--the post-basic perspective. **Nurse Education Today**, 10(2), pp.118-24.

Gnadt, B. 2006. Religiousness, Current Substance Use, and Early Risk Indicators for Substance Abuse in Nursing Students. **Journal of Addictions Nursing**, 17: pp.151–158.

Gouldner, A.W. 1960. The Norm of Reciprocity: A Preliminary Statement. **American Sociological Review**, 25(2), p. 161-178.

Gunaratnam, Y. 2003. **Researching 'race' and ethnicity: Methods, knowledge and power.** London: Sage Publications.

Habibie, B.J., 2012.**Thoughts on a modern civil society: The Indonesian case**. [online] Available at: http://www.scribd.com/doc/98277705/Thoughts-on-a-Modern-Civil-Society-The-Indonesian-Case [Accessed 7 August 2012]

Hall, J. M. 2004. Dispelling desperation in nursing education. **Nursing Outlook**, 52, pp.147-154.

Hauser, R.M. and Warren, J.R. 1996. Socioeconomic indexes for occupations: A review, update and critique. Center for Demography and Ecology University of Wisconsin-Madison, **CDE Working Paper** No. 96-01

Health and Care Professions Council/HCPC. 2014. **Professionalism in health care professionals**. Publication code: MORROW11

(amended May 2014). http://www.hpcuk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf [Accessed 17 November 2014].

Hennessy, D.,Hicks, C., Hilan, A. and Kawonal, Y. 2006.The training and development needs of nurses in Indonesia: paper 3 of 3. **Human Resources for Health***,* 4(10).

Hernandez, T.J. and Fister, D.L. 2001. Dealing with disruptive and emotional college students: A systems model. **Journal of College Counseling**, 4, pp.49-62.

Hodge, D. R. and McGrew, C. C. 2005. Clarifying the distinctions and connections between spirituality and religion. **Journal of the North American Association of Christians in Social Work**, Social Work & Christianity 32 (1): 1-21.

Hodgins , M., MacCurtain, S. and Mannix-McNamara, P. 2014. Workplace bullying and incivility: a systematic review of interventions. **International Journal of Workplace Health Management**, 7(1), pp.54 - 72

Hofstede, G. & Hofstede, G. J. and Minkov, M., 2010. **Cultures and Organizations: Software of the mind: Intercultural cooperation and its importance for survival**. 3rd Ed, McGraw-Hill USA.

Hollingworth, B.1986. Human values and the training of teachers. Higher Education Quarterly, 40(3), pp.314–322.

Holm, K. 2014. Workplace incivility as a social process: How witnessing incivility relates to uncivil conduct, well-being, job satisfaction and stress. **Unpublished master's thesis**, Lund University, Lund, Sweden.

Homans, G. L. 1961. **Social Behavior: Its Elementary Forms***.* New York: Harcourtm Brace Jovanovich

Hong, J.S. and Espelage, D.L. 2012. A review of research on bullying and peer victimization in school: An ecological system analysis. Aggression and Violent Behavior, 17, pp. 311–322.

Hoover, R. and Sherrell, C.N. 2010. **Coping with Stress [brochure and video].** Western Kentucky University Top SCHOLAR® [Online] Available at: http://digitalcommons.wku.edu/cgi/viewcontent.cgi?article=1008&context=cns_apps

Huesmann, R., Moise-Titus, J. Podolski, C. and Eron, L.D. 2003.Longitudinal Relations Between Children's Exposure to TV Violence and Their Aggressive and Violent Behavior in Young Adulthood: 1977–1992. Developmental Psychology, 39(2), pp. 201–221.

Hunt, C. and Marini, Z.A. 2012. Incivility in the practice environment: A perspective from clinical nursing teachers. **Nurse Education in Practice**, doi:10.1016/j.nepr.2012.05.001.

Huitt, W. 2003. **A transactional model of the teaching/learning process**. [online] Available at: <http://teach.valdosta.edu/WHuitt/col/process/class.html> [Accessed 25 January 2010]

Ibrahim, S.A.E. and Qalawa, S.A. 2016. Factors affecting nursing students' incivility: As perceived by students and faculty staff. **Nurse Education Today***, 36, pp.118-123.*

Ihuah, P.W. and Eaton, D. 2013. The Pragmatic Research Approach: A Framework for Sustainable Management of Public Housing Estates in Nigeria. **Journal of US-China Public Administration**, 10(10), p.933-944

Indonesian Ministry of Home Affairs. 2016. Jawa Barat [West Java]. Available at: http://www.kemendagri.go.id/pages/profil-daerah/provinsi/detail/32/jawa-barat

Indonesian National Nurses Association/INNA, 2014. **Nursing Code of Ethics**, [online], [Translation writer's own] Available: http://www.inna-ppni.or.id/index.php/kode-etik [Accessed 8 September 2014]

Indonesian National Nurses Association/INNA. 2014. **Indonesia Nursing Education**. [online] Available at: http://www.inna-ppni.or.id/index.php?option=com_content&view=article&id=13&Itemid=16 [Accessed 1 June 2014]

Indonesia-investment. 2015. **Indonesia-Investment**. [Online] Available at: http://www.indonesia-investments.com/

International Council of Nurses (ICN).2006. **The ICN Code of Ethics for Nurses**. [online] Available at: http://www.icn.ch/images/stories/documents/about/icncode_english.pdf [Accessed 11 February 2012]

Jackson, D., Hutchinson, M., Everett, B., Mannix, J., Peters, K., Weaver, R. and Salamonson, Y. 2011. Struggling for legitimacy: nursing students' stories of organizational aggression, resilience and resistance. **Nursing Inquiry**, 18(2), pp.102–110.

Jaspars, J.M.F., and Warnaen, S. 2010. Intergroup relations, ethnic identity and self-evaluation in Indonesia. **Social identity and intergroup relations**. Tajfel, H.Ed. Cambridge University Press.

Jenkins, S.D., Kerber, C.S. and Woith, W.M. 2013. An intervention to promote civility among nursing students. **Nursing Education Research**, 34(2), pp.95-100.

Johnson, R. B. and Onwuegbuzie, A. J. 2004. Mix methods research: A research paradigm whose time has come. **Educational Researcher**, 33(7), p. 14–26.

Johnson, R.B., Onwuegbuzie, A.J. and Turner, L.A. 2007. Toward a Definition of Mixed Methods Research. **Journal of Mixed Methods Research***,* 1, 112

Karim, 2001 Karim K. 2001. Assessing the strengths and weaknesses of action research. **Nursing Standard,**15(26), p. 33-35.

Kelly, A.V. 2009. The curriculum: Theory and practice. 6th ed. Sage London.

Keeling, J. and Templeman, J. 2012. An exploratory study: Student nurses' perceptions of professionalism. **Nurse Education in Practice**, 13, pp.18-22.

Kerber, C., Jenkins, S., Woith, W. and Kim, M. 2012. Journal clubs: A strategy to tech civility to nursing students. **Journal of Nursing Education**, 51(5), pp. 277-282.

Knepp, K. A. F. 2012. Understanding student and faculty incivility in higher education. **The Journal of Effective Teaching**, 12 (1), pp.32-45.

Knowles, M.S., Holton III, E.F. and Swanson, R.A. 2005. The adult learner. 6th ed. Elsevier Inc.

Koch, J., Everett, B. and Philips, J. 2014. Is there a relationship between the diversity characteristics of nursing students and their clinical placement experiences? A literature review. **Collegian** , [Online] Available at: http://dx.doi.org/10.1016/j.colegn.2014.03.007

Kolanko, K.M., Clark, C., Heinrich, K.T., Olive, D., Serembus, J.F., and Sifford, K.S. 2006. Academic dishonesty, bullying, incivility, and violence: Difficult challenges facing nurse educators. **Nursing Education Perspectives**, 27(1), pp.35-43.

Kuhlenschmidt, S.L. and Layne, L.E. 1999. Strategies for dealing with difficult behavior. **New Directions for Teaching and Learning,** 77, pp. 45–57

Kusnanto, 2004. Introduction of profession and national nursing practice. EGC Publisher. [Translation writer's own]

Lai, S., Ye, R. and Chang, K., 2008. Bullying in middle schools: An Asian-Pacific regional study. **Asian Pacific Education Review**, 9(4), pp.393-405.

Laksito, K. 2007. **Indonesia**. [Online] Available at: www.ic.keio.ac.jp/en/download/jjwbgsp/2007/2_Indonesia.pdf

Lashley, F.R. & de Meneses, M., 2001. Student civility in nursing programs: A national survey. **Journal of Professional Nursing**, 17(2), pp.81-86.

Lasiter, S., Marchiondo, L. and Marchiondo, K. 2012. Student naratives of faculty incivility. **Nursing Outlook**, 60, pp.121-126.

LAM-PTKes Indonesia. 2016. **Orientasi Strategis LAM-PTKes**. Retrieved from http://lamptkes.org/

Lawler, E.J. 2001. An Affect Theory of Social Exchange. **The American Journal of Sociology**, 107(2). p. 321-352.

Lawler, E.J. and Thye, S.R .1999. Bringging emotions into social exchange theory. **Annual Review Sociology***, 25, p.217-244.*

Leach, F. 2003. Learning to be Violent: The role of the school in developing adolescent gendered behaviour, **Compare: A Journal of Comparative and International Education**, 33(3), pp.385-400, DOI: 10.1080/03057920302587

Leiter, M.P., Price, S.L. and Laschinger, H.K.S. 2010. Generational differences in distress, attitudes and incivility among nurses. **Journal of Nursing Management**, pp.1-11.

Leiter, M.P., Day, A. and Oore, D.G. 2011. Getting better and staying better: Assessing civility, incivility, distress, and job attitudes one year after a civility intervention. **Journal of Occupational Health Psychology**, 17(4), pp.425–434.

Lock, L.R. 2011. Selecting examinable nursing core competencies: a Delphi project. **International Nursing Review**, 58, pp.347–353

Longo, J. 2007. Horizontal violence among nursing student. **Archives of Psychiatric Nursing**, 21(3), pp. 177–178

Longo, J. 2010. Combating disruptive behaviors: Strategies to promote a healthy work environment. **The Online Journal of Issues in Nursing**, 15 (1), Manuscript 5. doi: 10.3912/OJIN.Vol15No01Man05.

Longo, J. and Hain, D. 2014. Bullying: A hidden threat to patient safety. **Nephrology Nursing Journal***, 41*(2), pp. 193-199.

Luparell, S. 2005. Why and how we should address student incivility in nursing program. In: Oerman, M.H. (Ed.) and Heinrich K.T. (associate Ed.) **Strategies for teaching, assessment and program planning. Annual review of nursing education**, vol. 3, 2005. New York: Springer Publishing Company.

Luparell, S., 2007. The effects of student incivility on nursing faculty. **Journal of Nursing Education**, 46 (1), pp.15-19.

Luparell, S. 2011. Incivility in nursing: The connection between academia and clinical settings. **Critical Care Nurse**, 31(2), pp.92-95.

Mabuda, B.T., Potgieter, E., and Alberts, U.U. 2008. Student nurses' experiences during clinical practice in the Limpopo Province. **Curationis,** 31(1), p.19-27.

Mandryk, J., 2010. **Operation world: The definitive prayer guide to every nation**. Biblica Publising USA.

Mangundjaya, W.L.H., 2013. Is there cultural change in the national cultures of Indoneisa? *In. Steering the cultural dynamic.* **Proceedings 20th International Congress of the International Association for Cross-Cultural Psychology**. The University of Melbourne Australia, 7-10 July 2010. (pp. 59-68) http://iaccp.org/drupal/sites/default/files/melbourne_pdf/Melbourne%20Proceedings.pdf#page=59 [Accessed 17 November 2014].

Marchiondo, K.M, Marchiondo, L.A., and Lasiter S., 2010. Faculty incivility: Effects on program satisfaction on BSN students. **Journal of Nursing Education**, 49 (11), pp.608-614.

Margalith, I., Musgrave, C.F. and Goldschmidt, L. 2003. Physician-Assisted Dying: Are Education and Religious Beliefs Related to Nursing Students' Attitudes? **Journal of Nursing Education** 42(2): pp.91-96.

McCabe, C. and Timmins, F.2013. **Communication skills for nursing practice**. 2nd ed. Palgrave Macmillan.

McCrink, A. 2010. Academic misconduct in nursing students: Behaviors, attitudes, rationalizations, and cultural identity. **Journal of Nursing Education** ,49 (11), pp.653-659.

McLeod, S. 2007. Social Roles. [Online] Available at: http://www.simplypsychology.org/social-roles.html

Meeker, B.F.1971. Decisions and Exchange. **American Sociological Review**, 36(3), p. 485-495

Merriam-Webster. n.d. **'Family' definition** [Online] Available at: http://www.merriam-webster.com/dictionary/family [Accessed 11 June 2014]

Miller, B.K. 1988. A model for professionalism in nursing. **Today's OR Nurse**, 19(9), pp.18-23.

Miller BK, Adams V, Beck L. 1993. A behavioural inventory for professionalism in nursing. **Journal of Professional Nursing**, 9(5), pp.290-295.

Ministry of Health- Indonesia, 2014. Indonesia health profile year 2013. Health Ministry of Republic of Indonesia. [Translation writer's own].

Moffat, R.C.L. 2001.Incivility as a barometer of societal decay. **Florida Philosophical Review**. 1 (1), p. 63-75.

Morrissette, P. 2001. Reducing incivility in the university/college classroom. **International Electronic Journal for Leadership in Learning**, 5 (4). [Online] Available at: <http://iejll.synergiesprairies.ca/iejll/index.php/ijll/article/view/497/159>

Nam, C.B. 2004. The Concept of the Family: Demographic and Genealogical Perspectives. Sociation Today, 2(2). Available at: http://www.ncsociology.org/sociationtoday/v22/family.htm

Narayanasamy, A., 2006. **Spiritual care and transcultural care research**. Quay, London.

Nilan, P., Demartoto, A., and Broom, A. 2013. Masculinity, Violence and Socioeconomic Status in Indonesia. **Culture, Society and Masculinities**, 5(1), pp. 3–20.

Nilson, L.B., and Jackson, N.S. 2004. Combating classroom misconduct (incivility) with Bills of Rights. Paper presented at the International Consortium for Educational Development, Ottawa, Ontario, Canada.

Novera, I.A. 2004. Indonesian Postgraduate Students studying in Australia: An Examination of their Academic, Social and Cultural Experiences. **International Education Journal***, 5(4), p 475-487.* [Online] Available at: http://iej.cjb.net

Olive, D., 2006. **Nursing student incivility: The experience of nursing faculty**. Phd Dissertation Widener University.

Onwuegbuzie, A.J. and Leech, N.L. 2006. Linking Research Questions to Mixed Methods Data Analysis Procedures. The Qualitative Report, 11(3), pp. 474-498.

Onwuegbuzie, A.J., Johnson, R.B. and Collins, K.Mt. 2009. Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. **International Journal of Multiple Research Approaches**, 3(2), pp.

Osatuke, K., Moore, S.C., Ward, C., Dyrenforth, S.R. and Belton, L. 2009. Civility, Respect, Engagement in the Workforce (CREW): Nationwide organization developmentIIintervention at Veterans Health Administration. **Journal of Applied Behavioral Science**, 45, pp.384-410. DOI: 10.1177/0021886309335067

Osatuke, K., Leiter, M., Belton, L., Moore, S.C., Dyrenforth, S.R. and Ramsel, D. 2013. Civility, Respect and Engagement at the Workplace (CREW): A National Organization Development Program at the Department of Veterans Affairs. **Journal of Management Policies and Practices**, 1(2), pp.25-34.

Osinski, K. 2003. Faculty forum. Due process rights of nursing students in cases of misconduct. **Journal Nurse Educator**, 42(2). Pp.55–58.

Paik, C. and Broedel-Zaugg, K. 2006. Pharmacy students' opinions on civility and preferences regarding professors. **American Journal of Pharmaceutical Education**, 70(4), pp.1-9.

Papastavrou, E., Lambrinou, E., Tsangari, H., Saarikoski, Leino-Kilpi, M.H. 2010. Student nurses experience of learning in the clinical environment. **Nurse Education in Practice,** 10, p. 176–182

Papp, I., Markkanen, M. and von Bonsdorff, M. 2003. Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences. **Nurse Education Today**, 23, p.262–268

Patton, M.Q. 2002. **Qualitative research and evaluation methods**. 3rd edition. USA: Sage publications.

Philips, T. and Smith, P. 2003. Everyday incivility: Towards a benchmark. **Sociological Review**, 51, pp.85-108.

Phinney, J., 1992. The multigroup ethnic identity measure: A new scale for use with adolescents and young adults from diverse groups. **Journal of Adolescent Research** ,7, pp.156-176.

Piotrowska, P.J., Stride, C.B., Croft, S.E., and Rowe, R. 2015. Socioeconomic status and antisocial behaviour among children and adolescents: A systematic review and meta-analysis. **Clinical Psychology Review,** 35, p. 47–55

Plante, T.G., & Boccaccini, M. 1997. The Santa Clara strength of religious faith Questionnaire. **Pastoral Psychology,** 45, p.375-387

Plante, T.G., Vallaeys, C., Sherman, A.C., & Wallston, K.A. 2002. The development of a brief version of the Santa Clara Strength of Religious Faith Questionnaire. **Pastoral Psychology**, 50, 359-368.

Polit, D. F. and Beck, C. T. 2012. **Nursing research: Generating and assessing evidence for nursing practice** / Denise F. Polit, Cheryl Tatano Beck. 9th ed., Wolters Kluwer/Lippincott Williams & Wilkins.

Portal National Republic Indonesia. 2010. Geografi Indonesia (Geography of Indonesia). [Translation writer's own] [Online] Available at: http://www.indonesia.go.id/in/sekilas-indonesia/geografi-indonesia

Portal National Republic Indonesia. 2010. Lambang Negara (Country Emblem). [Translation writer's own] [Online] Available at: http://www.indonesia.go.id/in/sekilas-indonesia/lambang-dan-bentuk-negara/lambang-negara

Propper, C. and Rigg, J.A. 2007. Socio-economic status and child behaviour: evidence from a contemporary UK cohort.CASEpapers, CASE/125. Centre for Analysis of Social Exclusion, London School of Economics and Political Science, London, UK.

Purnomo, J. and Septina, S., 2004. **Managing conflict through consciousness: raising a lesson from Indonesia**. [online] Vibro News Release. Available at: http://www.ired.org/modules/infodoc/cache/files/pdf/anglais/doc_e640.pdf [Accessed 7 August 2014]

Quinn, F.M. & Hughes, S.J. 2007. **Quinn's principles and practice of nurse education**. UK: Nelson Thornes Ltd.Malesevic, 2004;

Rahim, H. and Rahiem, M.D.H. 2012. The Use of Stories as Moral Education for Young Children. International Journal of Social Science and Humanity, 2(6), pp. 454-458. Available at: www.ijssh.org/papers/144-A00019.pdf

Rahmawati, A. 2001. From people to people: Indonesia's ethnic and religious conflict and its resolution. **Asialink Seminar Melbourne**.18 October [online]. Available at: http://www.asialink.unimelb.edu.au/archived/events/past/past_events_public/from_people_to_people_indonesias_ethnic_and_religious_conflicts_and_its_resolution [Accessed 7 August 2012]

Randle, J., 2003. Bullying in the nursing profession. **Journal of Advance Nursing**, 43(40), pp.395-401.

Rangkuti, A. A., 2011. Academic cheating behaviour of accounting students: A case study in Jakarta State University. In *Educational integrity: Culture and values.* ***Proceedings 5th Asia Pacific Conference on Educational Integrity*****. The University of Western Australia**, 26-28 September. (pp. 105-109). Available at: http://www.apcei.catl.uwa.edu.au/procs/rangkuti.pdf. [Accessed 17 November 2014].

Rittenmeyer, L., Huffman, D., Hopp, L. and Block, M. 2013. A comprehensive systematic review on the experience of lateral/horizontal violence in the profession of nursing. **JBI Library of Systematic Reviews**, 11(11), pp.362-468.

Robertson, J.E. 2012. Can't we all just get along? A primer on student incivility in nursing education. **Nursing Education Perspective**, 33(1), pp. 21-26.

Rogers, C.1969. **Freedom to Learn: A View of What Education Might Become**. 1st ed. Columbus, Ohio: Charles Merill.

Rogers-Clark, C., Pearce, S. and Cameron, M. 2009. Management of disruptive behaviour within nursing work environments: a comprehensive systematic review of the evidence. **JBI Library of Systematic Reviews**, 7(15), pp.615-678.

Rosenstein, A.H. and O'Daniel, M. 2008. A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety. *The Joint* **Commission Journal on Quality and Patient Safety***,* 34(8), pp.464-471

Rowland, M. L. and Srisukho, K. 2009. Dental Students and Faculty Perceptions of Incivility in the Classroom. **Journal of Dental Education**, 73 (1), pp.115-122.

Royce, A.P. 2000. A survey on academic incivility at Indiana University: Preliminary report. Bloomington: Centre for survey research, Indiana University.

Salamonson, Y. and Andrew, S. 2006. Academic performance in nursing student: influence of part time employment, age and ethnicity. **Issues and Innovation in Nursing Education**, Journal Compilation, Blackwell Publishing Ltd, pp.342-349.

Sammons, A. n.d. The social learning approach. [Online] Available at: psychlotron.org.uk.

Scanlan, C. L. 2003. **Reliability and validity of a student scale for assessing the quality of Internet-based distance learning**. [online]. Available at: http://www.westga.edu/~distance/ojdla/fall63/scanlan63.htm [Accessed 7 December 2014].

Schaeffer, A. 2013. The effects of incivility on nursing education. **Open Journal of Nursing**, 2013, 3, 178-181 OJN http://dx.doi.org/10.4236/ojn.2013.32023. Available at: http://www.scirp.org/journal/ojn/

Scott, S., Doolan, M., Beckett, C., Harry, S., Cartwright, S and the HCA team. 2012. **How is parenting style related to child antisocial behaviour? Preliminary findings from the Helping Children Achieve Study**. [Online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197732/DFE-RR185a.pdf [Accessed 8 February 2014].

Scholte, R.H.J., Engels, R.C.M.E., de Kemp, R.A.T., Harakeh, Z., and Overbeek, G. 2006. Differential Parental Treatment, Sibling Relationships and Delinquency in Adolescence. **Journal Youth Adolescence**, 36, pp.661–671.

Scholz, R.W. and Tietje, O.2002. **Embedded case study methods: Integrating quantitative and qualitative knowledge**. USA: Sage publications.

Seob, K.G. 2009. **Komunikasi antara budaya Korea dan Indonesia: Kajian tentang Perilaku Masyarakat Korea dan Jawa**. [Online] Available at: elisa1.ugm.ac.id/.../komunikasi%20antarbudaya.doc

Setyanto, A. 2014. **Intercultural language competence: Mastery of culture are absolute for learning a language.** [Translation writer's own] [Online] Available at: http://fib.ub.ac.id/wrp-con/uploads/Intercultural-Language-Competence.pdf

Shadish, W. R., Cook, T. D., & Campbell, D. T. 2002. **Experimental and quasi-experimental designs for generalized causal inference**. Boston: Houghton Mifflin.

Shaw, K. and Timmons, S. 2010. Exploring how nursing uniforms influences self image and professional identity. **Nursing Times**, 106(10), pp.21-23.

Sharma, N. 2015. Medical students' perceptions of the situational judgment test: a mixed methods study. British Journal of Hospital Medicine, 76(4), pp.234-8.

Shek, DTL. 2004. Family processes and developmental outcomes in Chinese adolescents. **Hongkong Journal Paediatric (new series)**, 9, p.316-324.

Smith, K. 2002. Some Critical Observations on the Use of the Concept of Èthnicity' in Modood et al., Ethnic Minorities in Britain. **Sociology** 36: pp. 399-417

Simamora, R.H. 2009. Teaching book in nursing. EGC Publisher. [Translation writer's own]

Sinha, J.W., Cnaan, R.A., and Gelles, R.W. Adolescent Risk Behaviors and Religion: Findings from a National Study. **Journal of Adolescence**, 30(2), 231-249. http://dx.doi.org/10.1016/j.adolescence.2006.02.005

Siri, T.A. 2010. **Pancasila as way of life in the context of liquid modernity: Sociological and ethical analysis**. [Online] Available at: oikonomia.it/old/pages/2010/2010_ottobre/avvenimenti_2.htm

Sirin, S. R. 2005. Socioeconomic Status and Academic Achievement: A Meta-Analytic Review of Research. **Review of Educational Research** 75 (3):pp. 417–453.

Siswoyo, D. 2013. Philosophy of Education in Indonesia: Theory and Thoughts of Institutionalized State (PANCASILA). **Asian Social Science**, 9(12), p. 136-143.

Smith, K. 2002. Some Critical Observations on the Use of the Concept of Èthnicity' in Modood et al., Ethnic Minorities in Britain. **Sociology**, 36, p. 399-417

Stake, R.E. 1995. **The art of case study research**. Sage publications.

Stake, R.E., 2006. **Multiple case study analysis**. The Guilford press, New York.

Statistics Indonesia (Badan Pusat Statistik—BPS), National Population and Family Planning Board (BKKBN), and Kementerian Kesehatan (Kemenkes—MOH), and ICF International. 2013. *Indonesia Demographic and Health Survey 2012*. Jakarta, Indonesia: BPS, BKKBN, Kemenkes, and ICF International.

Statistics Indonesia (Badan Pusat Statistik—BPS). 2015. **Government**. [Online] Available at: http://www.bps.go.id/Subjek/view/id/101#subjekViewTab3|accordion-daftar-subjek1

Statistics Indonesia (Badan Pusat Statistik—BPS). 2015. **Education**. [Online] Available at: http://www.bps.go.id/Subjek/view/id/28#subjekViewTab3|accordion-daftar-subjek1

Sommers, C., Tarihoran, D., and Sembel, S. 2015. **The image of Indonesian nurses as perceived by nursing and non-nursing community in Lippo Karawaci**. . Paper presented at The 3rd International Conference: 'Culturally Sensitive Intervention in the Delivery of Health Care Professional to Encounter Globalization Era' April 15 - 16 2015 in Bandung Indonesia.

Sully, P. and Dallas, J. 2010. **Essential communication skills for nursing and midwifery**. 2nd ed. Mosby Elsevier.

Suplee, P.D., Lachman, V.D., Siebert B., and Anselmi, K.K., 2008. Managing nursing student incivility in the classroom, clinical setting, and on-line. **Journal of Nursing Law**, 12 (2), pp.68-77.

Sutantoputri, N.W. and Watt, H.M.G. 2013. Attribution and Motivation: Gender, Ethnicity, and Religion Differences among Indonesian University Students. **International Journal of Higher Education**, 2 (1), pp.12-21.

Swan N. 2011. Researching sustainable development of the rural poor in India. **The Electronic Journal of Business Research Methods,** 9(2), p.185 – 194

Taylor, S.G., Bedeian, H.D., and Kluemper, D.H. 2012. Linking workplace incivility to citizenship performance: The combined effects of affective commitment and conscientiousness. **Journal of Organizational Behavior**. 33, p. 878–893

Taylor, J.G. 2003. **Indonesia: Peoples and histories**. New Haven and London: Yale University press.

Teddlie, C. and Tashakkori, A. 2009. **Foundations of mixed methods research**. Thousand Oaks, CA: Sage publications.

The world fact book. 2015. **Indonesia**. [Online] Available at: https://www.cia.gov/library/publications/the-world-factbook/geos/id.html (Accessed 17 March 2015)

Thomas, G. 2011. **How to do your Case Study: A Guide for Students and Researchers**. London: SAGE publication.

Thomas, J. A. 2013. **Finessing Incivility: How student nurses respond to issues concerning their status and learning during practice: A grounded theory.** Phd Dissertaton Edge Hill University.

Thomas, S.P., & Burk, R. 2009. Junior nursing students' experiences of vertical violence during clinical rotations. **Nursing Outlook** ,57, pp.226-231

Tiberius, R.G. and Flak, E., 1999. Incivility in dyadic teaching and learning. **New Directions for Teaching and Learning**, 77, pp.3-12.

Twale, DJ and DeLuca, BM. 2008. Faculty Incivility: The Rise of the Academic Bully Culture and What to Do About it. San Francisco, CA: Jossey-Bass.

Twinn, S.1997. An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. **Journal of Advanced Nursing**, 26, p.418–423

Tzeng, H.M. 2006. Testing a conceptual model of the image of nursing in Taiwan. **International Journal of Nursing Studies**, 43, pp.755–765.

Utomo, Utomo, McDonald and Hull. 2015. **Who wears the Hijab? Predictors of Veiling in Greater Jakarta**. Paper presented at Session 93 – Population and Geopolitics, Population Association of America Annual Meeting, San Diego, April 20 – May 2, 2015.

Vandeveer, M.2009. From teaching to learning: Theoretical foundations. In D.M. Billings and J.A. Halstead. (Eds.). Teaching in nursing: A guide for faculty (3rd ed.. pp. 189-226). St Louis, MO: Saunders.

van Oort, FV, van Lenthe, F.J. and Mackenbach, J.P. 2005. Material, psychosocial, and behavioural factors in the explanation of educational inequalities in mortality in the Netherlands. Journal Epidemiology Community Health, 59(3), pp.214-220.

Vink, H. and Adejumo, O.2015. Factors contributing to incivility amongst students at a South African nursing school. Curationis, 38(1), doi: 10.4102/curationis.v38i1.1464.

Walrafen, N., Brewer, M.K. and Mulvenon, C. 2012. Sadly caught up in the moment: An exploration of horizontal violence. Nursing Economics, 30(1), pp.6-12.

Wass, V., Roberts, C., Hoogenboom, R., Jones, R. And Vleuten, C.V. 2003. Effect of ethnicity on performance in a final objective structured clinical examination: qualitative and quantitative study. **BMJ**, 326, pp.800-803.

White, S.J. 2011. Student nurses harassing academics. **Nurse Education Today**, 33, pp.41-45.

WHO/World Health Organisation. 2015. **Indonesia: WHO statistical profile**. [Online] Available at: http://www.who.int/countries/idn/en/

Wilkinson, P. 2008. **Eyewitness companions: Religions**. Dorling Kindersley Limited.

Williams, K.R. and Guerra, N.G.2007. Prevalence and predictors of internet bullying. **The Journal of Adolescent Health,** 41(6 Suppl 1):S14-21.

Williamson, M.M. 2011. **Nurse educators' lived experiences with student incivility**. Phd Dissertaton University of Alabama. [Online].Available at: http://acumen.lib.ua.edu/content/u0015/0000001/0000638/u0015_0000001_0000638.pdf [Accessed 11 July 2014].

Woith, W.M., Jenkins, S.D. and Kerber, C.S.2012. Perceptions of academic integrity among nursing students. **Nursing Forum**, 47(4), pp.253-259.

Wynd, C.A. 2003. Current factors contributing to professionalism in nursing. **Journal of Professional Nursing**, 19 (5), pp.251-261.

Yin, R. K., 2009. **Case study research: Design and methods**. 4th ed. SAGE Publication, Inc.

Yin, R. K., 2012. **Application of case study research**. 4th ed. SAGE Publication, Inc.

Yin, R. K., 2014. **Case study research: Design and methods**. 5th ed. SAGE Publication, Inc.

Zhou, Z.E., Yan, Y., Che X.X. and Meier, L.L. 2015.Effect of workplace incivility on end-of-work negative effect: examiningindiviual and organizational moderators in a daily dairy study. **Journal of Occupational Health Psychology**, 20(1), pp.117-30.

APPENDICES

Appendix one: A comparison of incivility categories

Feldmann Category	Conelly Category	INE Category	INE Survey (Beck, 2009; Clark, 2010)		
			Students Behaviours	Faculty Behaviours	Nurses Behaviours
Annoyances and Classroom Terrorism	Less serious	Disruptive Behaviours	○ Acting bored or apathetic ○ Making groaning to show disapproval ○ Making sarcastic remarks or gestures ○ Sleeping in class ○ Not paying attention in class ○ Holding conversations that distract you or other students ○ Refusing to answer direct questions that aimed to him/her. ○ Using a computer to do unrelated classroom work ○ Using phones or cell phones during class ○ Arriving late for class ○ Leaving class ahead of schedule ○ Cutting class (not present in class/ being absent) ○ Being unprepared for class ○ Creating tension by dominating class discussion ○ Cheating on exams or quizzes ○ Demanding make-up exams, ○ extensions for assignments, grade changes, or other special favours ○ Not charting nursing care ○ Being unprepared for the clinical experience ○ Not admitting an error made in patient care	○ Arriving late for schedule activities ○ Leaving class ahead of schedule ○ Cancelling scheduled activities without warning ○ Being unprepared for scheduled activities ○ Ineffective teaching style/methods ○ Being inflexible, rigid and authoritarian ○ Punishing the entire class for one student's misbehaviour ○ Making statements about being disinterested in the subject matter ○ Being distant and cold towards others (unapproachable, reject students opinions) ○ Refusing or reluctant to answer questions ○ Subjective grading of students ○ Making condescending remarks or put downs ○ Exerting superiority, showing arrogance towards others ○ Threatening to fail student for not complying to faculty's demands ○ Making rude gestures or behaviours toward others ○ Ignoring disruptive student behaviours ○ Being unavailable to respond the students outside of class in office hours ○ Being unavailable to respond to the students on the patient care unit	○ Arriving late for work ○ Leaving work early ○ Being unprepared for patient care ○ Refusing to allow students to perform patient care ○ Ineffective teaching style/methods ○ Being inflexible, rigid and authoritarian ○ Making statements about being disinterested in working with students ○ Being distant and cold towards others (unapproachable, reject ○ students opinions) ○ Refusing or reluctant to answer questions ○ Subjective grading of students ○ Making condescending remarks or put downs ○ Exerting superiority, showing arrogance towards others ○ Threatening to fail student for not complying to nurse's demands ○ Making rude gestures or behaviours toward others ○ Being unavailable to respond to the students on the patient care unit

Feldmann Category	Conelly Category	INE Category	INE Survey (Beck, 2009; Clark, 2010)		
			Students Behaviours	Faculty Behaviours	Nurses Behaviours
				○ Being unavailable to respond to the students for practice in the skills laboratory ○ Taking over for the student when providing patient care	○ Taking over for the student when providing patient care
Intimidation and Threaten violence	More Serious	Threatening Behaviours	○ Taunting or showing disrespect to other students ○ Taunting or showing disrespect to faculty ○ Taunting or showing disrespect to nurses ○ Taunting or showing disrespect to patients ○ Challenging faculty staff knowledge or credibility ○ Challenging nurses knowledge or credibility ○ Making harassing comments (racial, ethnic, gender) directed at other students ○ Making harassing comments (racial, ethnic, gender) directed at faculty staff ○ Making harassing comments (racial, ethnic, gender) directed at nurses ○ Making harassing comments (racial, ethnic, gender) directed at patients ○ Making vulgar comments directed at other students ○ Making vulgar comments directed at faculty staff ○ Making vulgar comments directed at nurses ○ Making vulgar comments directed at patients ○ Sending inappropriate e-mails to other students ○ Sending inappropriate e-mails to faculty staff ○ Making threats of physical harm against other students	○ Taunting or showing disrespect to students ○ Taunting or showing disrespect to other faculty staff ○ Taunting or showing disrespect to nurses ○ Taunting or showing disrespect to patients ○ Challenging other faculty staff knowledge or credibility ○ Challenging nurses knowledge or credibility ○ Making harassing comments (racial, ethnic, gender) directed at students ○ Making harassing comments (racial, ethnic, gender) directed at other faculty staff ○ Making harassing comments (racial, ethnic, gender) directed at nurses ○ Making harassing comments (racial, ethnic, gender) directed at patients ○ Making vulgar comments directed at students ○ Making vulgar comments directed at other faculty ○ Making vulgar comments directed at nurses ○ Making vulgar comments directed at patients ○ Sending Inappropriate e-mails to students ○ Sending Inappropriate e-mails to other faculty staff ○ Making threats of physical harm against students	○ Taunting or showing disrespect to students ○ Taunting or showing disrespect to faculty ○ Taunting or showing disrespect to other nurses ○ Taunting or showing disrespect to patients ○ Challenging faculty staff knowledge or credibility ○ Challenging nurses knowledge or credibility ○ Making harassing comments (racial, ethnic, gender) directed at students ○ Making harassing comments (racial, ethnic, gender) directed at faculty ○ Making harassing comments (racial, ethnic, gender) directed at other nurses ○ Making harassing comments (racial, ethnic, gender) directed at patients ○ Making vulgar comments directed at students ○ Making vulgar comments directed at faculty ○ Making vulgar comments directed at other nurses ○ Making vulgar comments directed at patients ○ Making threats of physical harm against students

Feldmann Category	Conelly Category	INE Category	INE Survey (Beck, 2009; Clark, 2010)		
			Students Behaviours	Faculty Behaviours	Nurses Behaviours
			○ Making threats of physical harm against faculty staff ○ Damaging property ○ Making statements about having easy access to weapons or sharp objects ○ Neglecting patients in the clinical area ○ Charting patient are not completed	○ Making threats of physical harm against other faculty staff ○ Damaging property ○ Making statements about having easy access to weapons ○ Neglecting patients in the clinical area ○ Charting patient are not completed	○ Making threats of physical harm against faculty ○ Damaging property ○ Making statements about having easy access to weapons ○ Neglecting patients in the clinical area ○ Charting patient are not completed

Appendix two: Crowe Critical Appraisal Tool (CCAT) Form

Crowe Critical Appraisal Tool (CCAT) Form (v1.4)

Reference | Reviewer

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

Citation

	Year

Research design (add if not listed)

❑ Not research		Article | Editorial | Report | Opinion | Guideline | Pamphlet | ...
❑ Historical		...
❑ Qualitative		Narrative | Phenomenology | Ethnography | Grounded theory | Narrative case study | ...
❑ Descriptive, Exploratory, Observational		A. Cross-sectional | Longitudinal | Retrospective | Prospective | Correlational | Predictive | ...
		B. Cohort | Case-control | Survey | Developmental | Normative | Case study | ...
Experimental	❑ True experiment	Pre-test/post-test control group | Solomon four-group | Post-test only control group | Randomised two-factor | Placebo controlled trial | ...
	❑ Quasi-experiment	Post-test only | Non-equivalent control group | Counter balanced *(cross-over)* | Multiple time series | Separate sample pre-test post-test [no Control] [Control] | ...
	❑ Single system	One-shot experimental *(case study)* | Simple time series | One group pre-test/post-test | Interactive | Multiple baseline | Within subjects *(Equivalent time, repeated measures, multiple treatment)* | ...
❑ Mixed Methods		Action research | Sequential | Concurrent | Transformative | ...
❑ Synthesis		Systematic review | Critical review | Thematic synthesis | Meta-ethnography | Narrative synthesis | ...
❑ Other		...

Variables and analysis

Intervention(s), Treatment(s), Exposure(s)	Outcome(s), Output(s), Predictor(s), Measure(s)	Data analysis method(s)

Sampling

Total size	Group 1	Group 2	Group 3	Group 4	Control
Population, sample, setting					

Data collection (add if not listed)

Audit/Review	a) Primary | Secondary | ... b) Authoritative | Partisan | Antagonist | ... c) Literature | Systematic | ...	Interview	a) Formal | Informal | ... b) Structured | Semi-structured | Unstructured | ... c) One-on-one | Group | Multiple | Self-administered | ...
Observation	a) Participant | Non-participant | ... b) Structured | Semi-structured | Unstructured | ... c) Covert | Candid | ...	Testing	a) Standardised | Norm-ref | Criterion-ref | Ipsative | ... b) Objective | Subjective | ... c) One-on-one | Group | Self-administered | ...

Scores

Preliminaries		Design		Data Collection		Results		Total [/40]	
Introduction		Sampling		Ethical Matters		Discussion		Total [%]	

General notes

Appendix two: Crowe Critical Appraisal Tool (CCAT) Form

Appraise research on the merits of the research design used, not against other research designs.

Category Item	Item descriptors [☑ Present; ☒ Absent; ■ Not applicable]	Description [Important information for each item]	Score [0–5]
1. Preliminaries			
Title	1. Includes study aims ❑ and design ❑		
Abstract (assess last)	1. Key information ❑ 2. Balanced ❑ and informative ❑		
Text (assess last)	1. Sufficient detail others could reproduce ❑ 2. Clear/concise writing ❑, table(s) ❑, diagram(s) ❑, figure(s) ❑		
		Preliminaries [/5]	
2. Introduction			
Background	1. Summary of current knowledge ❑ 2. Specific problem(s) addressed ❑ and reason(s) for addressing ❑		
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ❑ 2. Secondary question(s) ❑		
	Is it worth continuing?	**Introduction [/5]**	
3. Design			
Research design	1. Research design(s) chosen ❑ and why ❑ 2. Suitability of research design(s) ❑		
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ❑ and why ❑ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ❑ for each group ❑ 3. Intervention(s)/treatment(s)/exposure(s) valid ❑ and reliable ❑		
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ❑ and why ❑ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ❑ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ❑ and reliable ❑		
Bias, etc	1. Potential bias ❑, confounding variables ❑, effect modifiers ❑, interactions ❑ 2. Sequence generation ❑, group allocation ❑, group balance ❑, and by whom ❑ 3. Equivalent treatment of participants/cases/groups ❑		
	Is it worth continuing?	**Design [/5]**	
4. Sampling			
Sampling method	1. Sampling method(s) chosen ❑ and why ❑ 2. Suitability of sampling method ❑		
Sample size	1. Sample size ❑, how chosen ❑, and why ❑ 2. Suitability of sample size ❑		
Sampling protocol	1. Target/actual/sample population(s): description ❑ and suitability ❑ 2. Participants/cases/groups: inclusion ❑ and exclusion ❑ criteria 3. Recruitment of participants/cases/groups ❑		
	Is it worth continuing?	**Sampling [/5]**	
5. Data collection			
Collection method	1. Collection method(s) chosen ❑ and why ❑ 2. Suitability of collection method(s) ❑		
Collection protocol	1. Include date(s) ❑, location(s) ❑, setting(s) ❑, personnel ❑, materials ❑, processes ❑ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ❑ 3. Manage non-participation ❑, withdrawal ❑, incomplete/lost data ❑		
	Is it worth continuing?	**Data collection [/5]**	
6. Ethical matters			
Participant ethics	1. Informed consent ❑, equity ❑ 2. Privacy ❑, confidentiality/anonymity ❑		
Researcher ethics	1. Ethical approval ❑, funding ❑, conflict(s) of interest ❑ 2. Subjectivities ❑, relationship(s) with participants/cases ❑		
	Is it worth continuing?	**Ethical matters [/5]**	
7. Results			
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ❑ and why ❑ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ❑ and why ❑ 3. Suitability of analysis/integration/interpretation method(s) ❑		
Essential analysis	1. Flow of participants/cases/groups through each stage of research ❑ 2. Demographic and other characteristics of participants/cases/groups ❑ 3. Analyse raw data ❑, response rate ❑, non-participation/withdrawal/incomplete/lost data ❑		
Outcome, Output, Predictor analysis	1. Summary of results ❑ and precision ❑ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ❑, unexpected results ❑, problems/failures ❑ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ❑		
		Results [/5]	
8. Discussion			
Interpretation	1. Interpretation of results in the context of current evidence ❑ and objectives ❑ 2. Draw inferences consistent with the strength of the data ❑ 3. Consideration of alternative explanations for observed results ❑ 4. Account for bias ❑, confounding/effect modifiers/interactions/imprecision ❑		
Generalisation	1. Consideration of overall practical usefulness of the study ❑ 2. Description of generalisability (external validity) of the study ❑		
Concluding remarks	1. Highlight study's particular strengths ❑ 2. Suggest steps that may improve future results (e.g. limitations) ❑ 3. Suggest further studies ❑		
		Discussion [/5]	
9. Total			
Total score	1. Add all scores for categories 1–8		
		Total [/40]	

Crowe Critical Appraisal Tool (CCAT) :: Version 1.4 (19 November 2013) :: Michael Crowe (michael.crowe@my.jcu.edu.au) Page 2 of 2

Appendix three: Literature Review –Data extraction- Quantitative

NO	Author	Concept and aim/s of the study	Study Design and Instrument	Sample characteristic	Major Findings and suggestions for further study	Strengths and limitations	Score of 40 (%)
1	Clark, C.M. and Springer, P.J. (2007a) Incivility in nursing education: A descriptive study of definitions and prevalence. Journal of Nursing Education, January 2007, Vol. 46, No. 1, p. 7-14	Incivility • What behaviours do nursing students and faculty perceive as uncivil in the academic environment? • Do nursing students and faculty perceive the same behaviors as uncivil? • Is there a relationship between age and perceptions of incivility? • To what extent do students and faculty perceive incivility as a problem in nursing education?	Survey INE, no information for its validity and reliability	Population: A public university in USA, 36 nursing faculties and 467 nursing students; Sample: 32 faculties (88.9%), 324 students (69.4%)	Findings: A number of uncivil behaviours that perceived differently between academic staff and student nurses: • Students acting apathetic or bored ($p < 0.01$). • Students making disapproving groans ($p < 0.01$). • Students sleeping in class ($p < 0.01$). • Students arriving late to class ($p < 0.05$). • Students leaving class early ($p < 0.05$). • Faculty cancelling class without warning ($p < 0.05$). • Faculty delivering fast-paced, non-involving lectures ($p < 0.05$). No statistically significant differences between faculty and students' perceptions based on age. Suggestions: Understanding of incivility, its effects, and ways to prevent and intervene the uncivil behaviours.	This study developed a questionnaire that accommodate both academic staff and students perceptions of incivility. This study limitations include: a. No explanation of ethical approval, only setting approval b. Pilot study explanations are not complete.	30 (75%)
2	Clark, C.M. (2008a) Faculty and student assessment of and experience with incivility in nursing education.	Incivility This study assessed perceptions of nursing faculty and student uncivil behaviours in a	Mixed methods design but only present the quantitative part INE; valid and reliable with Cronbach Alpha ranges 0.85-0.96	A convenience sample from attendees at two national meeting. Sample: 194 faculties (38%),	Findings: The majority of the academic staff and students perceived incivility as a moderate and serious problem in nursing education. Both groups viewed many uncivil student behaviours in the same way. Suggestions:	The questionnaire is valid and reliable however there is no explanation regarding the statistical analysis that used in the study.	35 (88%)

NO	Author	Concept and aim/s of the study	Study Design and Instrument	Sample characteristic	Major Findings and suggestions for further study	Strengths and limitations	Score of 40 (%)
	Journal of Nursing Education, October 2008, Vol. 47, No. 10, p. 458-465	national convenience sample.		306 nursing students (60.7%) and 4 respondents anonym from 41 states in USA.	Determine whether there are differences in perceptions of incivility related to race and ethnicity, generation, and gender. To study the potential effect of academic incivility on the practice setting.		
3	Clark, C.M., Otterness, N.S., Jun, W. Y., Allerton, B.W., Juan, C. M., Black, M. And Wei, F. (2010) Descriptive study of student incivility in the people's Republic of China. Journal of Cultural Diversity, Vol. 17, No. 4, pp. 136-143.	Incivility • To what extent do nursing students and faculty perceive student incivility to be a problem? • What student behaviors are considered to be uncivil by nursing faculty and students? • What is the perceived frequency of uncivil student behaviors? • How often have threatening behaviors happened to nursing students and faculty?	Quantitative INE, valid and reliable Cronbach Alpha (both respondents) ranges 0.494-0.916	Population: 510 (faculty 28, student 482) Sample: faculty staff 21 (75%), students 392 (81.3%) PRC	Findings: Top three uncivil student behaviours reported by students and faculties : cheating on exams and quizzes, using cell phones and pagers during class, holding distracting conversations Suggestions: Measure the use and implication of uncivil behaviour and linking the impact of student incivility on patient care in the practice setting	This study applied a valid and reliable questionnaire. The explanation regarding the instrument is comprehensive. However, there is no explanation regarding ethical approval, only settings approval is described.	36 (90%)
4	Marchiondo, K.M, Marchiondo, L.A., and Lasiter S. (2010) Faculty incivility: Effects on program	Incivility • What percentage of senior nursing students in BSN programs report experiencing faculty incivility?	Descriptive study Instrument: Nursing Education Environment Survey. Content validity and clarity by two	152 (100%) senior nursing students from two public Midwestern universities in USA	Findings: Faculty incivility is higher in classroom and clinical setting than laboratory, office and online communication. Student dissatisfaction with the nursing program varied significantly as a function of experiences of faculty incivility ($p < 0.001$).	The study developed a valid and reliable questionnaire from two questionnaires (Workplace Incivility Scale by Cortina et al., 2001 and Incivility in Nursing	33 (83%)

NO	Author	Concept and aim/s of the study	Study Design and Instrument	Sample characteristic	Major Findings and suggestions for further study	Strengths and limitations	Score of 40 (%)
	satisfaction on BSN students. Journal of Nursing Education, Vol.49, No. 11, pp. 608-614	• What is the relationship between faculty incivility and nursing students' ratings of program satisfaction? • In what educational settings does perceived incivility toward nursing students occur? • How do nursing students respond to perceived faculty incivility?	experienced nurse researcher; pilot tested with 35 students for its use and readability.		No correlation between experience of faculty incivility and student age or self-reported GPA. Suggestions: Clarify role of gender, ethnicity or race that may influence in students experiences of faculty incivility	Education Survey by Clark & Springer, 2007a, 2007b). However, the study lacked of explanation regarding method analysis and table of the results.	

NO	Author	Concept and aim/s of the study	Study Design and Instrument	Sample characteristic	Major Findings and suggestions for further study	Strengths and limitations	Score of 40 (%)
5	Kerber, C., Jenkins, S., Woith, W. and Kim, M. (2012) Journal clubs: A strategy to teach civility to nursing students. Journal of Nursing Education, 51(5), p. 277-282.	Civility Aim: to test a journal club intervention designed to foster student civility. • Will participation in a CJC facilitate change in students' awareness of civil behavior? • Will participation in a CJC facilitate change in students' attitudes concerning civility? • Will participation in a CJC facilitate change in students' coping behavior concerning civility?	Mixed method design but only present the *quantitative part* NICE questionnaire Cronbach Alpha ranges 0.68-0.79 (pretest) and 0.70-0.86 (posttest) WCQ Cronbach Alpha ranges 0.61-0.76 (pretest) and 0.62-0.75 (posttest) Intervention: biweekly journal clubs sessions	At one university USA. Sample: 79 senior nursing students.	Findings: Using of journal clubs raise awareness, promote civility and helpfulness. Developing coping skills: distancing (escape-avoidance), seeking social support, planful problem solving and positive reappraisal. Suggestions: Studies of faculty staff related to incivility and the influence of faculty incivility on nursing students	One of rare articles regarding intervention for incivility. This study is explained clearly with two valid and reliable questionnaires. However, using convenience sample without randomization and no explanation regarding themes for the qualitative findings.	37 (93%)
6	Clarke, C.M, Kane, D.J., Rajacich, D.L. and Lafreniere, K.D. (2012) Bullying in undergraduate clinical nursing education. Journal of Nursing Education, 51(5), p. 269-276.	Bullying • What are the types, frequencies and sources of bullying behavior experienced by nursing students? • What are the relationships between demographic characteristics	Descriptive quantitative study Questionnaire bullying by Stevenson, Stevenson, Randle, & Grayling (2006) with Cronbach's alpha coefficients ranging from 0.86 to 0.93	Four campus in Canada, population: 1,162 nursing students; sample: 674 nursing students	Findings: There were no statistically significant differences in rates of reported bullying by year of study, gender or age group. The most reported bullying: • undervaluing of their efforts (60.24%) • being told negative remarks about becoming a nurse (first-year students,25.74%; second-year students, 51.6%; third-year students, 56.67%; fourth-year students, 53.52%).	This study applied a valid and reliable questionnaire. This study also explained the respondents comments in the discussion section (qualitative data), however, there was no explanation regarding the data collection method.	37 (93%)

NO	Author	Concept and aim/s of the study	Study Design and Instrument	Sample characteristic	Major Findings and suggestions for further study	Strengths and limitations	Score of 40 (%)
		and the frequency of bullying behaviors experienced by nursing students? • Do experiences of bullying behaviors influence nursing students' intentions to leave their nursing program?			Clinical instructors (30.22%) were identified as the greatest source of bullying behaviors in the practice setting, followed by staff nurses (25.49%). Fourth-year students tended, on average, to report the greatest amount of bullying behaviors in the clinical practice than others students. Suggestions: Develop tool of bullying measurement in nursing education. Define bullying and measure the phenomenon. Establish what nursing students perceived as bullying behaviors.		
7	Beckmann, C.A., Cannella, B.L and Wantland, D. (2013) Faculty perception of bullying in school of nursing. Journal of Professional Nursing, 29(5), pp 287-294.	Bullying Aim: To determine the prevalence of bullying among faculty members in schools or colleges of nursing in three eastern states of the United States. For purposes of this study, bullying is defined as repeatedly harassing, offending, socially excluding someone or negatively affecting someone's work tasks (p.289).	Descriptive cross sectional study NAQ-R questionnaire that based on NAQ (Einarsen & Raknes, 1997; Mikkelsen & Einarsen, 2001). Cronbach alpha 0.88	Three universities USA, Sample: 473 full time faculty member	Findings: Significant correlation between meeting frequency and the report of bullying ($r = 0.18$, $P \leq .001$). Administrators and senior faculty were more likely than expected to be the perpetrators of bullying including physical abuse, verbal abuse and devaluing acts. Suggestions: • Relationship between geographical location and the prevalence of bullying. • Relationship between bullying of faculty and leadership qualities.	This study discussed comprehensively regarding the phenomena, method, results, discussion and limitation. However, this study lacked respondents. (Population 1,926 faculties; 519 responded, respondents that meet criteria 473).	38 (95%)

Appendix four: Literature Review –Data extraction- Qualitative

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
1	Clark,C.M. and Springer, P.J .(2010) Academic nurse leaders' role in fostering a culture of civility in nursing education. Journal of Nursing Education, 49(6), p. 319-325.	Civility • What do you perceive to be the biggest stressors for nursing students? • What uncivil behaviors do you see nursing students displaying? • What do you perceive to be the biggest stressors for nursing faculty? • What uncivil behaviors do you see nursing faculty displaying? • What is the role of nursing leadership in addressing incivility?	Qualitative Content analysis Open-ended survey (Reviewed by content experts)	Nurse leader attending a conference 126 of 172 (73.2%) in USA. Deans, chairs, and directors from 128 associate and bachelor degree nursing programs, 42 private colleges, 70 community colleges, and 16 state colleges and universities.	Findings: Five major themes regarding the biggest stressors for nursing students were juggling multiple roles related to work, academic, and family responsibilities; financial pressures; time-management challenges; lack of faculty support and incivility; and mental health issues. The major theme regarding students uncivil behaviour included in-class disruptions such as students making rude comments, using technology in disruptive ways, interrupting others and engaging in side conversations, arriving late and leaving early, and sleeping in class. The biggest stressor for nursing faculty included multiple work demands, problematic students, salary inequities, and faculty-to-faculty incivility. Themes related to faculty incivility included two major categories: uncivil faculty behaviours toward faculty and administrators, and uncivil faculty behaviours toward students. The majority of respondents believed that nurse leaders	This study provided new perspectives regarding academic nurse leaders' perception on incivility issues. However, this study applied a convenience sample though the study explained the respondents came from many nursing educations with high response rate. It is needed of further study with more respondents.	38 (95%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
					have a responsibility to create a culture of civility and respect in nursing education. Suggestions: Survey incivility in nursing education including clinical settings from the perspectives of faculty members and students.		
2	Luparell, S. (2007) The effects of student incivility on nursing faculty. Journal of Nursing Education, 46 (1), p. 15-19	Incivility To detail more fully how uncivil encounters with students affect nursing faculty.	Qualitative CIT (Critical Incident Technique) Interview	21 faculty members from six states in USA	Findings: The short-term and long-term consequences of the uncivil encounters described by faculty members related to time, money, productivity, and well-being were significant and included physical and emotional reactions, decreased self-esteem, loss of confidence in their teaching abilities, significant time expenditures, and negative effects on the educational process. Suggestions: The influence of gender, the target and the perpetrator, experience as an educator, and professional background. Explore what the consequences for the nursing workforce might be if students who behave uncivilly toward faculty are permitted to join the profession.	This study provided a valuable insight regarding the effects of incivility in nursing education. However, it needs more respondents to be generalised.	36 (90%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
3	White, S.J. (2011) Student nurses harassing academics. Nurse Education Today, 33, p. 41-45.	Harassment and bullying • To identify the means by which faculty working within Post-1992 Universities in England are being subjected to harassment by undergraduate students • To establish the explanations regarding the context of the harassment and whether any tactic is prominent.	Qualitative Attribution theory Semi structured interview	12 academic staff in universities in England	Findings: Three main themes: verbal and task attack, personal attack, communication devices used to harass Suggestions: Not mentioned regarding future study	This study recognised their limitation regarding small respondents and methodology limitation. However, this study provided a new perspective regarding harassment in nursing education settings.	34 (85%)
4	Jackson, D., Hutchinson, M., Everett, B., Mannix, J., Peters, K., Weaver, R. and Salamonson, Y. (2011) Struggling for legitimacy: nursing students' stories of organisational aggression, resilience and resistance. Nursing Inquiry, 18(2), p. 102–110	Violence and interpersonal conflict To explore students' experiences of negative behaviours in the clinical environment to identify strategies they used to manage and resist such behaviours.	Qualitative Content analysis Open-ended survey	105 nursing students in a large university in Australia	Findings: Three main themes: • Confronted by contradiction: students as others • Organisational aggression as a legitimating device • Resisting 'othering': securing a legitimacy identity as a student Suggestions: The perspectives and experiences of clinical facilitators during students' clinical placements.	This study provided an insight regarding students' resistance and resilience when facing negative behaviours in the clinical settings. However, this study was conducted only in one university with 45.45% response rate.	35 (88%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
5	Clark, C.M., Ahten, S.M. and Macy, R. (2013) Using problem based learning scenarios to prepare nursing students to address incivility. Clinical Simulation in Nursing, 9, e75-e83	Incivility To develop a design for nursing faculty who are developing content for a senior-level leadership course as preparation for entry into practice. It used Kirkpatrick's model of evaluation to assess student reaction and learning after a problem-based scenario.	Qualitative PBL scenario and Kirkpatrick's model for evaluation	65 senior nursing students at a university in USA With most of them were women and white (90.77%).	Findings: The scenario is preferred by the students and they claimed for being prepared to facing incivility in the working settings. Suggestions: Students perceptions and knowledge of incivility in nursing education and clinical settings; conflict management strategies and promote assertive communication.	This study promoted civility in nursing education settings by using a PBL scenario which was perceived by the students as an effective method to prepare themselves facing incivility in the working settings. However, this study needs further larger study to support the evidences.	38 (95%)
6	Del Prato, D. (2012) Students' voices: The lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. Nurse Education Today, doi: 10.1016/j.nedt.2012.05.030.	Incivility To investigate the student's lived experience in nursing education.	Interpretive phenomenology Interview	13 participants with 5 participants in the second interview. Total interviews From the 13 participants, 9 Female & 4 Male; 2 women of colour, others white.	Findings: Faculty incivility: verbally abusive and demeaning experiences, favoritisms and subjective evaluation, rigid expectations for perfection and time management, targeting and weeding out practice. Suggestions: Faculty staff experiences regarding responding stressful in the teaching and learning setting	This study applied a rigorous study which provided a new perspectives regarding students' experiences in clinical placement. Yet, this study needed further larger study with diverse respondents to support the findings.	39 (98%)
7	Anthony, M. and Yastik, J. (2011) Nursing students' experiences with incivility in clinical education. Journal of Nursing Education, 50(3), p. 140-144.	Incivility • To explore the experiences of nursing students as targets of workplace	Qualitative descriptive study FGD (Focus Group Discussions)	21 participants: 18 Female, 3 Male; most age 20-25 (11 people) and 17 people white (80.9%)	Findings: Three themes of perceived uncivil behaviour: exclusionary, hostile or rude, dismissive. Positive experiences: nurses initiated to interact with	This study enhanced an understanding of incivility in clinical practice that have experienced by nursing students. However, it is needed of larger scale of study to support the findings.	36 (90%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
		incivility in clinical education. • To describe the students' perceptions of specific uncivil and favorable behaviors of nurses, and to examine how they think schools of nursing should address workplace incivility in clinical nursing education.	Semi-structured interviews		students and being included in patient care. Addressing incivility: being warned regarding the possibility of the incivility encounter in clinical practice, good communication and well respected instructor. Suggestions: Influence of gender, age, type of unit level of student on incivility. Intervention to help students develop skills to effectively cope with incivility.		
8	Lasiter, S., Marchiondo, L. and Marchiondo, K. (2012) Student narratives of faculty incivility. Nurs Outlook, 60, p. 121-126.	Incivility • To find the percentage of senior BSN nursing students who had experienced faculty incivility during their education. • In what educational settings did perceived incivility most often occur? • How nursing students responded to perceived incivility?	Qualitative study using narrative or written method	94 students from two Midwestern public universities.	Findings: 4 themes: in front of someone, talked to others about me, it made me feel stupid, I felt belittled. Suggestions: a prospective or longitudinal approach	This study was part of a survey study using a questionnaire to identify nursing workplace incivility in the same settings. It could be better to report the both findings (quantitative and qualitative) to get whole descriptions regarding the instances of incivility.	36 (90%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
		• The relationship between faculty incivility and nursing students' ratings of program satisfaction.					
9	Randle, J. (2003) Bullying in the nursing profession. Journal of Advance Nursing, 43(40), P. 395-401.	Bullying To discuss one major theme emerging from qualitative data in a larger mixed methods study of self esteem in a cohort preregistration nursing students in England.	Qualitative study Interview	56 students in one nursing programme, become 39 at the end.	Findings: Nurse power over student and nurse power over patient. Having power over someone became integral to their self-esteem. Student's witness and being bullied of nurses and bully patient. Suggestions: Suggestion for radical social structural change. Bullying can be understood by recognise its origin of historical and social structure.	This study provides new perspective regarding bullying in the clinical settings. The authors has explained that the respondents knew her as the researcher. And it might be that the researcher has managed the issues. However, there was no explanation on the paper how the researcher managed that issue.	40 (100%)
10	Clark, C.M. and Springer, P.J. (2007b) Thoughts on incivility: Student and faculty perceptions of uncivil behavior in nursing education. Nursing Education Perspective, 28 (2), p. 93-97	Incivility/ Uncivil behaviour • How do nursing students and nurse faculty contribute to incivility in nursing education? ○ What are some of the causes of incivility in nursing education?	Qualitative Interpretive qualitative method Open ended survey	Population : a metropolitan public university, 36 nursing faculty and 467 nursing students; sample: 15 faculties (41.6%), 168 (35.9%) students USA	Findings: Six themes; 1)disruption by students: a) in-class disruption b) outclass disruption; 2) uncivil faculty behaviors: Eleven themes of causes of incivility such as high-stress environment of nursing education, faculty arrogance, and a lack of immediacy in addressing incivility when it occurs.	The authors developed a questionnaire of incivility from some previous questionnaires to provide a suitable questionnaire for nursing education settings. However, this study only asked permission from the settings. It is needed of IRB approval. Moreover, the study lacked respondents in	34 (85%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
		○ What remedies might be effective in preventing or reducing incivility in nursing education?			Possible remedies: setting forth standards and norms, strengthening university policies and support for faculty, and enforcing campus codes of conduct Suggestions: • The nature of incivility and its impact on the educational process and on the profession as a whole. • The relationships between student and faculty perceptions of incivility and ways to effectively address the problem. • Whether there are gender differences in ways that faculty and students experience incivility; • How civility experienced by students or perpetrated by students — affects patients	which the response rate below 50%.	
11	Clark, C.M., Juan, C.M., Allerton, W., Otterness, N.S., Jun, W.Y. and Wei, F. (2012). Faculty and student perceptions of academic incivility in the people's Republic of China. Journal of Cultural Diversity, 19(3), p.85-93.	Incivility To examine nursing faculty and student perceptions of the factors that contribute to incivility in nursing education, the types of uncivil behaviors each group exhibits, and remedies for prevention and intervention.	Qualitative Content analysis INE-open ended questions	At one nursing college, the qualitative portion of the study drawn from 382 of 413 faculty and student participants (92.5%) who responded to the open-ended questions included on the survey.	Findings: Both academic staff and students identified a lack of mutual respect, poor communication, generational and environmental factors, and poor quality of students and faculty as influencing this reciprocal interaction. Suggestions to address incivility: a comprehensive university response encompassing educational program, policies and procedures for dealing with incivility and responding	This study provides new understanding of incivility in nursing education especially in Asian. Though the response rate was high, it is needed of larger scale of study to support the findings since the study was conducted in one university.	38 (95%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
					effectively and fairly, improving communication, encourage personal responsibility, improve teaching methods, show forgiveness and tolerance, improve the quality of faculty and student, allow student more flexibility to select majors, schedules and course. Suggestions: Study the link between behaviour in academic and clinical practice. Effective strategy to manage incivility.		
12	Clark, C. (2008b) The dance of incivility in nursing education as described by nursing faculty and students. Advances in Nursing Science, 31(4), p. E37-E54.	Incivility To examine nursing faculty and student perceptions of the factors that contribute to incivility in nursing education, the types of uncivil behaviors each group exhibits, and remedies for prevention and intervention.	qualitative INE-open ended questions	A convenience sample from attendees at two national meeting, sample: 194 faculties (38%), 306 nursing students (60.7%) and 4 respondents anonym from 41 states in USA	Findings: A conceptual model: describe stress, attitude and lack of effective communication and intentional engagement may contribute the "dance" of incivility in nursing education. Suggestions: Efficacy of the conceptual model for fostering civility in nursing education. Understanding the dynamics of faculty and students to develop strategies for removing blame. Determine the best practices for policy development and implementation. Understand the role of stress, its precursors and its potential relationship to incivility.	This study revealed a new conceptual model to explain incivility instances in nursing education using valid and reliable questionnaires. Though the study claimed the respondents came from 41 states in the USA, the response rate was low (<50%).	39 (98%)

NO	Author	Concept And Aim/s	Study Design and Instrument (method)	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
					Potential link between incivility in nursing education and its impact on practice. Compare and contrast faculty and student perceptions of the same uncivil incident.		

Appendix five: Literature Review –Data extraction- Mixed Method

NO	Author	Concept and aim/s of the study	Study design and Instrument	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
1	Hunt, C. and Marini, Z.A. (2012) Incivility in the practice environment: A perspective from clinical nursing teachers.	Incivility/ Civility Develop a conceptual framework to capture the complex and multi-layered aspects of in/civility	Mixed method PICS (perceptions on Incivility Survey); valid and reliable with Cronbach Alpha 0.72-0.86	37 clinical teacher consist of 2 Male and 35 female (71% response rate). The respondents consist of 51% acute area, 30% maternal/child and 19% community/ mental health.	Quantitative findings: The majority of the participants reported their area of practice as acute care (51%), followed by maternal/child (30%), and community/public/mental health (19%). The biggest mean number of uncivil behaviour per week 5.4 at Acute Care. Qualitative findings: Civility was identified as "calm and safe" (acute care), "sharing information" (maternal/child health) and "kindness and dignity" (community/public/mental health). Incivility was described as "hurtful and disruptive" (acute care), "opinion of others not heard" (maternal/child health) and "impolite" (community/public/mental health). This study contributes new insights to understanding civility/incivility in clinical settings. Suggestions: Explore relationship between incivility, health care team functioning and inter-professional collaboration. Intervention for specific type of incivility to promote civil learning and working setting. Examine participants who currently experience incivility.	This study examined bullying using a new valid and reliable questionnaire, thus it is needed of broader participants to provide significant evidence regarding incivility in clinical settings.	33 (83%)

NO	Author	Concept and aim/s of the study	Study design and Instrument	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
2	Jenkins, S.D., Kerber, C.S. and Woith, W.M. (2013) An intervention to promote civility among nursing students. Nursing Education Research, 34(2), p.95-100.	Civility/Social capital • What are pre-licensure nursing students' perceptions of incivility? • How do pre-licensure students describe incivility to each other and faculty? • Can efforts to build social capital among the learning community improve students' awareness of academic incivility and effect personal change?	Mixed method WCQ (The ways of Coping Questionnaire) valid and reliable with Cronbach alpha 0.61-0.79 SCI (Social Capital Interview), 15 open ended questions Journal entries of student leaders	At one university With population 190 student nurses 10 student leaders 25 junior and senior students	Findings: Quantitative findings: Results were significant for three of the scales: self-controlling [$t(17) = -2.738, p = 0.014$], seeking social support [$t(17)=-2.447$, $p = 0.026$], and positive reappraisal [$t(14)=-5.477$, $p < .001$]. Near significance was reached for accepting responsibility [$t(17) = -5.477$, $p = 0.062$]; this finding might have reached significance with a larger sample. Qualitative findings: Interviews revealed five themes related to civility: respect, equality, caring, building relationships, and working together. Description of incivility: students' incivility to students was described into four categories: rude or demeaning behaviour, refusing to help others, taking advantage of others, and gossip. Students' incivility to nursing faculty was described by some participants as acts of overt hostility toward faculty, especially during exam reviews. Journaling revealed personal change as the major theme with subthemes include awareness, acceptance, refusal to participate, desire to help, and taking the lead. Suggestions: Define uncivil behaviours, policies development, expectations of the	This study provided an intervention study to promote civility. However, this study needs further study to strengthen their results due to their small respondents.	30 (75%)

NO	Author	Concept and aim/s of the study	Study design and Instrument	Sample characteristics	Major Findings and suggestions for further study	Strengths and limitations	Score
					prevalent settings, and explore the consequences of uncivil behaviours.		
3	Woith, W.M., Jenkins, S.D., and Kerber, C.S. (2012) Perceptions of academic integrity among nursing students. Nursing Forum, 47(4), p.253-259.	Academic integrity • How do nursing students define academic integrity? • What examples of academic integrity would nursing students offer? • What examples of academic dishonesty would nursing students offer? • Why is academic integrity among nursing students important?	Mixed method Social Capital Survey that reviewed by expert nurse educators for content validity. Social Capital Interview-derived from the study's research questions.	Senior students (n = 25) for both survey and interviews. Most students are Caucasian females in their early 20s, from north-central Illinois	Findings: Quantitative findings: Twenty-seven percent (27%) of participants were not satisfied with their peers' academic integrity. Qualitative findings: Three themes: characteristics of students with academic integrity, patient safety outcomes, and professional outcomes. Suggestions: Describe students' ideas for eliminating dishonesty and to develop interventions to promote academic integrity Reframe the approach to managing academic integrity by linking it with civility	This study provides a new perspective regarding academic integrity that relate to nursing professionalism and patients outcomes. However, this study need a valid and reliable questionnaire with more respondents.	33 (83%)

Appendix six: University of Nottingham Ethical approval letter

Direct line/e-mail
+44 (0) 115 8231063
Louise.Sabir@nottingham.ac.uk

The University of Nottingham
Faculty of Medicine and Health Sciences

Medical School Research Ethics Committee
Division of Therapeutics & Molecular Medicine
D Floor, South Block
Queen's Medical Centre
Nottingham
NG7 2UH

Tel: +44 (0) 115 8231063
Fax: +44 (0) 115 8231059

15th August 2012

Ni Gusti Ayu Eka
PhD Student
c/o Dr Aru Narayanasamy
School of Nursing, Midwifery & Physiotherapy
The Medical School
QMC Campus
Nottingham University Hospitals
NG7 2UH

Dear Ni Gusti

Ethics Reference No: F14082012 OVS SNMP
Study Title: Incivility in Indonesia Nursing Education: A Case Study
Lead Investigator: Ni Gusti Ayu Eka, PhD student, Nursing, School of Nursing Midwifery and Physiotherapy.
Chief Investigators: Dr Aru Narayanasamy, Associate Professor, Dr Derek Chambers, Associate Professor, School of Nursing Midwifery and Physiotherapy.
Duration of Study: 07/12-07/13 1yr No of Subjects: 300

Thank you for submitting the above application which was considered at the Medical School Research Ethics Committee at its meeting on 14th August 2012. The following documents were reviewed:

- Application form dated 27/06/2012
- Protocol version dated 27/06/2012
- Information sheet for students 27/06/2012
- Information sheet for Faculty Staff 27/06/2012
- Healthy Volunteer's Consent Form 27/06/2012
- Letter of support from Dr Fransiska Maria, Acting Dean of Faculty of Nursing & Allied Health Science, Universitas Pelita Harapan Karawaci, 22 May 2012
- Appendix E Modified Incivility in Nursing, Education (INE)Survey (Clark ©2004, revised 2010 and Beck © 2009)
- Sample letter

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are sought for each overseas project in accordance with all local laws, and that the host organisation involved also gives their permission where applicable.

The Committee did suggest for advice only that on the questionnaire that you had a detachable page at the beginning or end which subjects can complete if they are

Appendix six: University of Nottingham Ethical approval letter(s)

interested in joining the interview which can be returned separately – this will ensure the questionnaire is completely anonymous.

Yours sincerely

Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

Appendix seven: Unit of Analysis I approval letter(s)

UPH
UNIVERSITAS PELITA HARAPAN

FACULTY OF NURSING AND ALLIED HEALTH SCIENCES

Karawaci, 22 May 2012
088/FoN-UPH/V/Ext/2012

University of Nottingham Medical School Ethics Committee

Faculty of Medicine and Health Sciences
University of Nottingham
Medical School
Queen's Medical Centre
Nottingham, NG7 2UH

RE: Ni Gusti Ayu Eka
Dr. Aru Narayanasamy (Supervisor 1)
Dr. Derek Chambers (Supervisor 2)
"Incivility in Indonesia Nursing Education: A Case Study"

To: UoNMSEC

This letter is to convey that we have reviewed the proposed research study being conducted by Ni Gusti Ayu Eka intended to conduct research at School of Nursing, Universitas Pelita Harapan, Tangerang Indonesia and find that **"Incivility in Indonesia Nursing Education: A Case Study"** acceptable. We give permission for the above investigators to conduct research at this site. If you have any questions regarding site permission, please contact: fransiska.susilasumiartiningsih@uph.edu.

Sincerely,

Dr. Fransiska Maria S.,S.Kp., M.Pd
Acting Dean of Faculty of Nursing & Allied Health Science
Universitas Pelita Harapan
Jl.Boulevard Sudirman,Karawaci-Tangerang
Indonesia 15811
Ph:+6221 54210130 Ext: 3402
Fax: +6221 54203459

Jl. Jenderal Sudirman Boulevard No. 15, Lippo Karawaci, Tangerang 15811, INDONESIA Telp. (021) 54210130 - 31, Fax. (021) 54203459 Web: http://www.uph.edu

Appendix seven: Unit of Analysis I approval letter(s)

UNIVERSITAS PELITA HARAPAN

Karawaci, 3rd August, 2015

No : 079/FoN-UPH/VIII/Ext/2015
Re : Confirmation Letter

To:
Joanne Lymn
Director of Learning & Teaching/PhD Programme Director
Faculty of Medicine & Health Sciences
The University of Nottingham

With regard,

Based the proposed study entitled 'Incivility in Indonesia Nursing Education: A case study' and the previous letter regarding research permission (088/FoN-UPH/V/Ext/2012), we would like to confirm that it has been given permission to Ni Gusti Ayu Eka to conduct the research at the Faculty of Nursing Universitas Pelita Harapan by collecting data using survey, interviews and observation (Interaction between academic staff/clinical educator and students).

Regards,

Yakobus Siswadi
Chair of Ethical Committee

Cc:
1. File

Faculty of Nursing and Allied Health Sciences

Appendix eight: Private Hospital Approval Letter(s)

Siloam Hospitals
LIPPO VILLAGE

No. : 092/SHLV-HA/II/13
Lippo Village, 27 Februari 2013

Kepada Yth:
Dr. Fr. Maria Susila S., S.Kp., Dra., M.Pd.
Dekan Fakultas Keperawatan
Universitas Pelita Harapan

Perihal: Ijin Penelitian

Dengan hormat,

Dengan ini kami sampaikan bahwa kami telah menerima surat Dokter no. 024/FoN-UPH/II/Ext/2013 perihal Ijin Penelitian.

Sehubungan dengan hal tersebut, kami bersedia menerima dosen Fakultas Ilmu Keperawatan Universitas Pelita Harapan atas nama :

Nama : Ibu Ni Gusti Ayu Eka. M.Kes. (Ph. D *Candidate*)
Tanggal : Kamis, 28 Maret 2013 di ICU RSUS
Jumat, 1 April 2013, di UGD RSUS

mengambil data penelitian untuk mengobservasi kegiatan mahasiswa praktik profesi (nama mahasiswa terlampir) di Siloam Hospitals Lippo Village

Demikian kami sampaikan, terima kasih atas perhatian dan kerjasamanya.

Hormat kami,

DR. dr. Andry, MM., MH.Kes.
Chief Executive Officer

Cc. : Ibu Suhartini Sri Agustin, S.Pd., MM.

Siloam Hospitals Lippo Village
Jl. Siloam No. 6, Lippo Village 1600, Tangerang 15811
T: +62-21 546-0055 F: +62-21 546-0921
www.siloamhospitals.com
Akreditasi DepKes RI No. YM.01.10/III/693/08
Indonesia's First Internationally Accredited Hospital

Appendix eight: Private Hospital Approval Letter(s)-translation

No:92
Lippo Village 27 February 2013

To
Dr F. Maria
Dean of Faculty of Nursing

With regards

With this we would like convey that we have already got your letter no 24. Based on that letter, we would like to receive:
Name: Ni GUsti Ayu
Date: 28 March and 1 April 2013
For collecting data to observe students activities in their profession practice (the name attached) at Siloam Hospital.

Accordingly we convey. Thank you for your attention and collaboration.

With regards

CEO

Appendix eight: Private Hospital Approval Letter(s)

No. 004/SIH-CEOO/VIII/15 3 August 2015

To:
Mrs. Christine Sommers, MN, RN, CNE
Executive Dean
Faculty of Nursing
University of Pelita Harapan

Dear Mrs. Sommers,

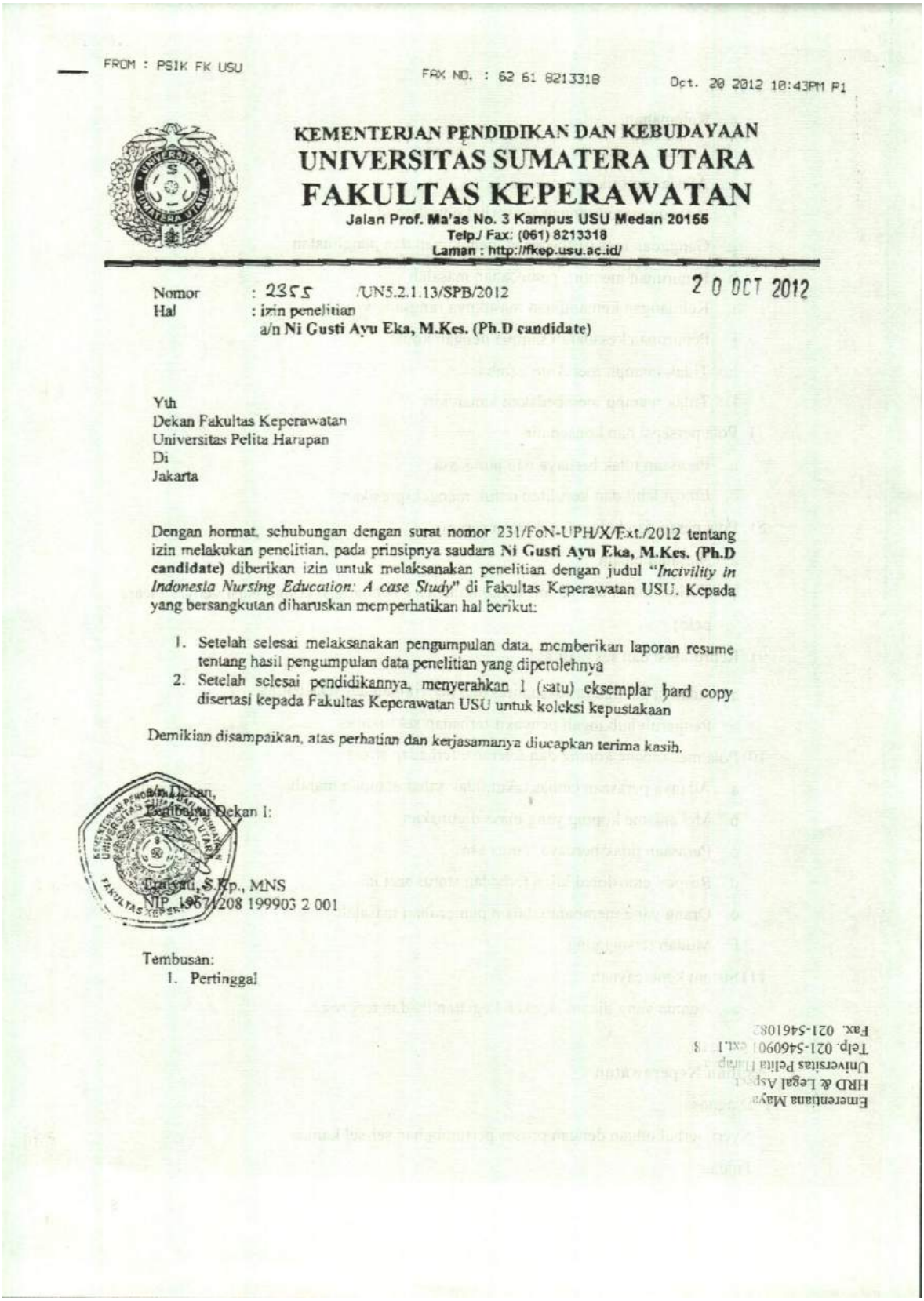
Based on the proposed study with the following title: "*Incivility in Indonesia Nursing Education: A case study*", and our previous letter attached no. 092/SHLV-HA/II/13 regarding research permission, we would like to confirm that we have given permission to Mrs. Ni Gusti Ayu Eka for observing students-academic staff-nurses interactions at Siloam General Hospital (RSU Siloam) on March 28th 2013 at ICU and April 1st 2013 at ER.

Thank you for your attention and collaboration.

Best regards,

Dr. dr. Andry, MM, MHKes
Managing Director
Siloam Hospitals Group

Appendix nine: Unit of Analysis II approval letter(s)



FROM : PSIK FK USU FAX NO. : 62 61 8213318 Oct. 20 2012 10:43PM P1

KEMENTERIAN PENDIDIKAN DAN KEBUDAYAAN
UNIVERSITAS SUMATERA UTARA
FAKULTAS KEPERAWATAN
Jalan Prof. Ma'as No. 3 Kampus USU Medan 20155
Telp./ Fax: (061) 8213318
Laman : http://fkep.usu.ac.id/

Nomor : 2355 /UN5.2.1.13/SPB/2012 20 OCT 2012
Hal : izin penelitian
a/n Ni Gusti Ayu Eka, M.Kes. (Ph.D candidate)

Yth
Dekan Fakultas Keperawatan
Universitas Pelita Harapan
Di
Jakarta

Dengan hormat, schubungan dengan surat nomor 231/FoN-UPH/X/Ext./2012 tentang izin melakukan penelitian, pada prinsipnya saudara **Ni Gusti Ayu Eka, M.Kes. (Ph.D candidate)** diberikan izin untuk melaksanakan penelitian dengan judul "*Incivility in Indonesia Nursing Education: A case Study*" di Fakultas Keperawatan USU. Kepada yang bersangkutan diharuskan memperhatikan hal berikut:

1. Setelah selesai melaksanakan pengumpulan data, memberikan laporan resume tentang hasil pengumpulan data penelitian yang diperolehnya
2. Setelah selesai pendidikannya, menyerahkan 1 (satu) eksemplar hard copy disertasi kepada Fakultas Keperawatan USU untuk koleksi kepustakaan

Demikian disampaikan, atas perhatian dan kerjasamanya diucapkan terima kasih.

Pembantu Dekan I:

Erniyati, S.Kp., MNS
NIP. 19674208 199903 2 001

Tembusan:
1. Pertinggal

Appendix nine: Unit of Analysis II approval letter(s)-translation

No: 2355/UNS.2.1.13/SPB/2012
About: Research approval for Ni Gusti Ayu Eka

To:
Dean of Faculty of Nursing
Universitas Pelita Harapan
In Jakarta

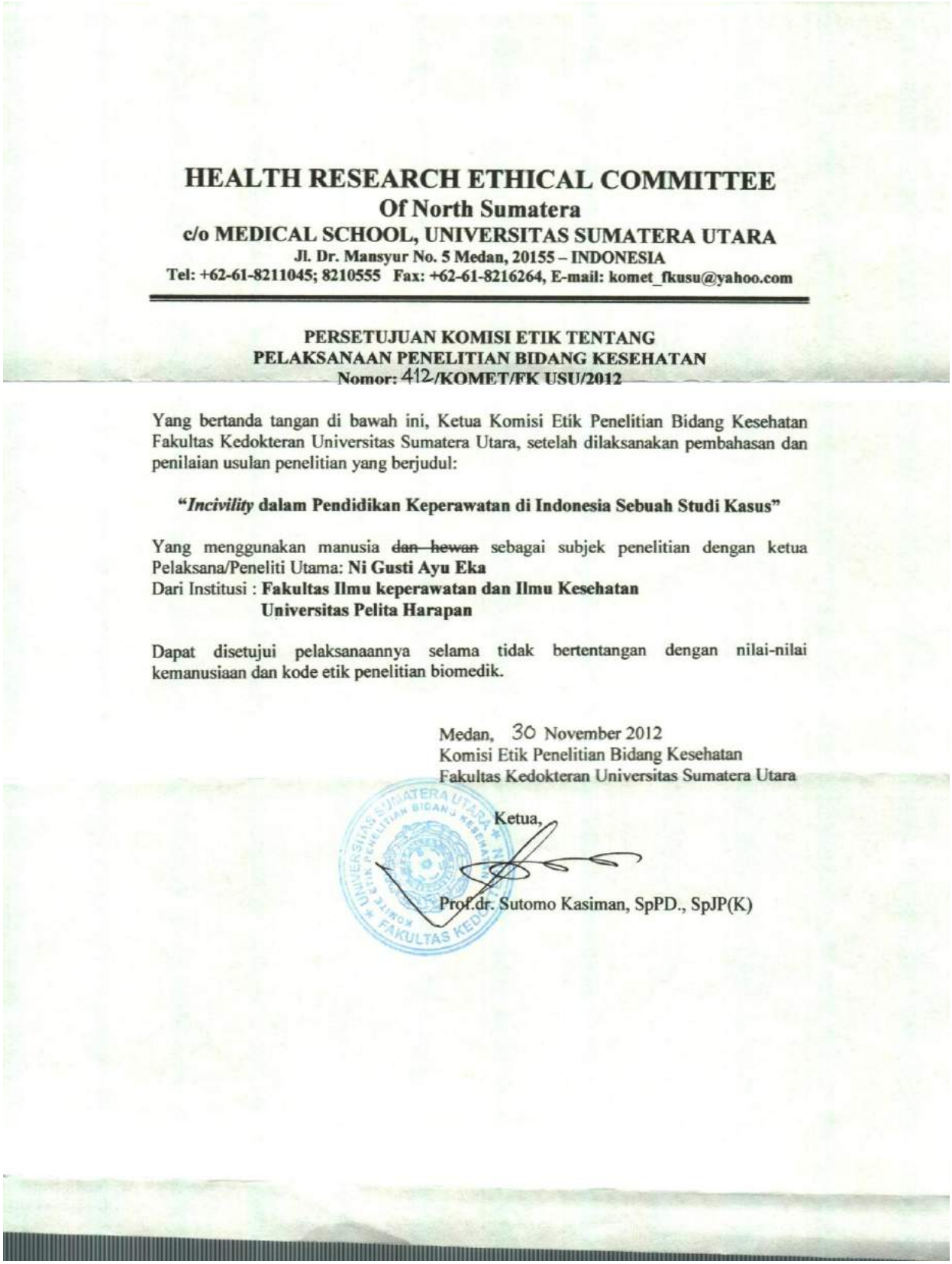
With regard, in relate to a letter number 231/FoN-UPH/X/Ext/2012 regarding permission to cinduct a research, in principle, Ni Gusti Ayu has ben granted permission to conduct her research : Incivility in Indonesia Nursing Education: A case study" at Faculty of Nursing Unviersitas Sumatera Utara (USU). For the researcher should consider as follow:

1. After finishing data collection, provide summary report of the findings
2. After finishing her study, provide one hardcopy of the thesis to the Faculty of Nursing Unviersitas Sumatera Utara (USU) for library collection.

Thank you for your attaention and collaboration.

Vice Dean I

Appendix ten: Univeristas Sumatera Utara Ethical approval letter(s)



HEALTH RESEARCH ETHICAL COMMITTEE
Of North Sumatera
c/o MEDICAL SCHOOL, UNIVERSITAS SUMATERA UTARA
Jl. Dr. Mansyur No. 5 Medan, 20155 – INDONESIA
Tel: +62-61-8211045; 8210555 Fax: +62-61-8216264, E-mail: komet_fkusu@yahoo.com

PERSETUJUAN KOMISI ETIK TENTANG
PELAKSANAAN PENELITIAN BIDANG KESEHATAN
Nomor: 412/KOMET/FK USU/2012

Yang bertanda tangan di bawah ini, Ketua Komisi Etik Penelitian Bidang Kesehatan Fakultas Kedokteran Universitas Sumatera Utara, setelah dilaksanakan pembahasan dan penilaian usulan penelitian yang berjudul:

"*Incivility* dalam Pendidikan Keperawatan di Indonesia Sebuah Studi Kasus"

Yang menggunakan manusia ~~dan hewan~~ sebagai subjek penelitian dengan ketua Pelaksana/Peneliti Utama: **Ni Gusti Ayu Eka**
Dari Institusi : **Fakultas Ilmu keperawatan dan Ilmu Kesehatan**
Universitas Pelita Harapan

Dapat disetujui pelaksanaannya selama tidak bertentangan dengan nilai-nilai kemanusiaan dan kode etik penelitian biomedik.

Medan, 30 November 2012
Komisi Etik Penelitian Bidang Kesehatan
Fakultas Kedokteran Universitas Sumatera Utara

Ketua,

Prof.dr. Sutomo Kasiman, SpPD., SpJP(K)

Appendix ten: Univeristas Sumatera Utara Ethical approval letter(s)-translation

Comitte Ethic Approval regarding research implementioan in health scope
No:412/KOMET/FK USU/2012

I who signed below, Chair of Committee Ethic of Health sciences research Faculty of Medicine Universitas Sumatera Utara, after discussing anf evaluating a proposed research with tittle:

"Incivility in Nursing education: A case study"

Using human as research subyek with principal investigator: Ni Gusti Ayu Eka
From institution: Faculty of Nursing and Allied Health Sciences Universitas Pelita Harapan

It can be approved for its implementation as long as not contradicting to human values and code of ethic biomedic research.

Medan 30 November 2012
Ethical Committeee Health sciences research
Faculty of Medicine Universitas Sumatera Utara

Chair

Appendix eleven: Public Hospital approval letter(s)

KEMENTERIAN KESEHATAN RI
DIREKTORAT JENDERAL BINA UPAYA KESEHATAN
RUMAH SAKIT UMUM PUSAT
H. ADAM MALIK

Jl.Bunga Lau No. 17
Medan 20136

Telp. (061) 8360381
8360405

Nomor : LB.02.03.II.4. 5942 Medan, 30 Maret 2013
Lampiran : -
Perihal : Rekomendasi Hasil Penelitian
Sdr. Ni Gusti Ayu Eka (Dosen Fak.Keperawatan-UPH)

Kepada Yth :
Direktur Utama
RSUP H.Adam Malik Medan
Di -
Tempat

Sehubungan hasil penelitian mahasiswa / peneliti :

Nama : NI GUSTI AYU EKA
Institusi : Fakultas Keperawatan Universitas Pelita Harapan – Tangerang
Judul : ***" Incivility in Nursing Education : A Report for Adam Malik Hospital Medan "***

Yang telah diseminarkan pada hari / tanggal : Rabu, 20 Maret 2013 dan dihadiri oleh Bidang Keperawatan, Bidang Diklit, Instalasi DikLat, para clinical instructure dari Rindu B, IGD dan IPI serta unit kerja terkait, didapatkan bahwa :

1. *Incivility* (perlakuan yang mengancam/mengganggu) cukup sering terjadi selama pendidikan keperawatan termasuk di lahan praktek klinis keperawatan di rumah sakit
2. Belum ada kesamaan persepsi tentang etika perawat selama melakukan praktek klinis keperawatan di rumah sakit antara institusi pendidikan dan RSUP H.Adam Malik

Sehubungan dengan itu kami rekomendasikan :

1. **untuk meminta Bidang DikLit dan Instalasi DikLat agar terlebih dahulu menyamakan persepsi dengan institusi pendidikan tentang Etika Perawat sebelum mahasiswanya mengikuti praktek klinis di RSUP H.Adam Malik Medan.**
2. **Mengadakan pertemuan rutin antara Fakultas Keperawatan dan RSUP H.Adam Malik untuk mengevaluasi pelaksanaan PKL mahasiswa keperawatan di RSUP H. Adam Malik.**

Demikian disampaikan, atas perhatiannya diucapkan terima kasih.

Diketahui,
Direktur SDM dan Pendidikan

Dr.Purnamawaty, MARS
NIP 19570331 198501 2 001

Kepala Instalasi Litbang,

Drs. Palas Tarigan, Apt
NIP 19530515 198902 1 001

Tembusan :
1. Direktur Pelayanan Medik dan Keperawatan RSUP H.Adam Malik Medan
2. Kepala Bidang DikLit RSUP H. Adam Malik Medan
3. Pertinggal

Appendix eleven: Public Hospital approval letter(s)-translation

No : I.B.02.03.II.4.5442
Attachment : -
About : Recommendation of research result
Ni Gusti Ayu Eka (lecturer of faculty of Nursing UPH)

To:
Main Director
Adam Malik Hospital

Based on the result of student/ researcher:
Name : Ni Gusti Ayu Eka
Institution : Faculty of Nursing Universitas Pelita Harapan – Tangerang
Title : Incivility in Nursing Education: A report for Adam Malik Hospital Medan

Who has been presented on Wednesday 20 March 2013 and been attended by Nursing Department, Division of Education and Research, clinical instructors from wards Rndu B, ER, ICU and all working unit that involved, the result was:

1. Incivility (disturbing behaviour) is often happen in nursing education include clinical nursing practice in the hospital
2. There were no similar perception regarding nursing ethics when clinical placement in the hospital between education institution and Adam Malik Hospital

Therefore, we recommended that:

1. For division of education and research and division education and training to achieve similar perception with education institution about nursing ethics before the students come for clinical placement at Adam Malik Hospital
2. To held a regular meeting between faculty of nursing and Adam Malik Hospital to evaluate clinical placement of nursing students at Adam Malik Hospital

Thank you for your attention.

Director of human resources and education
Head of research and development

Appendix eleven: Public Hospital approval letter(s)

KEMENTERIAN KESEHATAN RI
DIREKTORAT JENDERAL BINA UPAYA KESEHATAN
RUMAH SAKIT UMUM PUSAT
H. ADAM MALIK

Jl. Bunga Lau No. 17 Medan Tuntungan Km. 12 Kotak Pos 246
Telp. (061) 8364581 - 8360143 - 8360051 Fax. 8360255
MEDAN - 20136

SURAT KETERANGAN

Nomor : LB.02.03.II.4. 5463

Yang bertanda-tangan di bawah ini :

N a m a	: dr. Purnamawati, MARS.
N I P	: 19570331 198501 2 001
Jabatan	: Direktur SDM dan Pendidikan RSUP H. Adam Malik
Alamat	: Jl. Bunga Lau No. 17 Medan

Dengan ini menerangkan bahwa mahasiswa/peneliti :

N a m a	: Ni Gusti Ayu Eka
Institusi	: Fakultas Keperawatan Universitas Pelita Harapan - Tangerang
Judul	: *"Incivility in Nursing Education : A Report for Adam Malik Hospital Medan"*

bahwa benar telah selesai melaksanakan penelitian di lingkungan RSUP H. Adam Malik sesuai prosedur dan ketentuan penelitian yang berlaku di RSUP H. Adam Malik Medan.

Demikian surat keterangan ini dibuat sesuai dengan sebenarnya, untuk dapat dipergunakan seperlunya.

Medan, 2 April 2013
Direktur SDM dan Pendidikan

RSUP.H.ADAM MALIK

dr. Purnamawati, MARS.
NIP. 19570331 198501 2 001

Appendix eleven: Public Hospital approval letter(s)

Letter of explanation
No: LB.02.03.II.4. 5463

I am who signed below:

Name	: dr. Purnamawati, MARS
No of employment	: 19570331 198501 2 001
Position	: Director of human resources and education Adam Malik Hospital
Address	: Bunga Lau street no 17 Medan

With this explain that the student/ researcher:

Name	: Ni Gusti Ayu Eka
Institution	: Faculty of Nursing Universitas Pelita Harapan-Tangerang
Title	: Incivility in Nursing education: A report for Adam Malik Hospital Medan

It is true that she has finished her research at Adam Malik Hospital based on the procedure and provision of research that apply/valid at Adam Malik Hospital.

Accordingly, this explanation letter has been made with actual condition for being used as needed.

Medan 2 April 2013
Director of human resources and education

Dr. Purnamawati MARS

Appendix eleven: Public Hospital approval letter(s)

RSUP. H.Adam Malik Medan.	Prosedur Penyelenggaraan Penelitian Ekternal di Instalasi Litbang RSUP. H.Adam Malik		
	No. Dokumen OT.02.01.11.1/3747/12	No. Revisi 0	Halaman 1/1
PROTAP Penelitian & Pengembangan	Tanggal Terbit 27-06-2012	Ditetapkan Direktur Utama, Dr. Azwan Hakmi Lubis, Sp.A, M.Kes NIP. 195309241980121001	
Pengertian	Suatu kegiatan penanganan penelitian yang oleh pihak luar di rumah sakit.		
Tujuan	Sebagai Acuan penanganan dan penyelesaian penelitian ekternal di rumah sakit.		
Kebijakan	Tentang Penelitian dan Pengembangan di RSUP. H. Adam Malik Medan.		
Prosedur	- Peneliti/Institusi mengirimkan surat permohonan penelitian serta proposal penelitian kepada Direktur Utama RSUP.H.Adam Malik. - Direktur Utama menerima serta membuat disposisi kepada Direktur SDM & Pendidikan untuk di proses. - Direktur SDM & Pendidikan membuat disposisi kepada Kabag. Diklit untuk diproses selanjutnya. - Kabag. Diklit memberi disposisi kepada Ka. Instalasi Litbang untuk diproses. - Ka. Instalasi menugaskan kepada Waka dan kapokja untuk mempelajari dan memproses surat permohonan penelitian tsb. - Kapokja menerima dan melakukan persiapan penyelesaian surat sesuai dengan disposisi Ka. Instalasi, setelah membaca isi proposal serta mendiskusikannya dengan peneliti. - Kapokja akan bekerjasama dengan TU menyiapkan surat-surat yang diperlukan. - Ka. Instalasi akan memberikan surat pengantar ke unit kerja tempat dilaksanakannya penelitian sesuai dengan proposal. - Staf Instalasi Litbang akan mengantar peneliti ke unit kerja tempat penelitian. - Peneliti melakukan penelitian di unit kerja sesuai dengan proposal penelitiannya. - Hasil penelitian yang dianggap perlu akan diseminarkan terlebih dahulu. - Ka. Instalasi Litbang akan menyampaikan laporan tentang selesainya penyelenggaraan penelitian yang dilakukan oleh peneliti ke Direktur SDM & Pendidikan melalui Kabag. Diklit. - Instalasi Litbang akan membuat laporan hasil penelitian yang dianggap perlu untuk meningkatkan pelayanan di rumah sakit. - Peneliti menyerahkan 2 eksemplar hasil penelitian yang sudah dijilid kepada Instalasi Litbang.		
Unit Terkait	- Instalasi Litbang - Kabag. Diklit - Unit kerja tempat penelitian - Direktur SDM & Pendidikan		

Appendix eleven: Public Hospital approval letter(s)

<table>
<tr><td>Adam Malik Hospital Medan</td><td colspan="3">Procedure of external research conduct at "Litbang" Adam Malik Hospital</td></tr>
<tr><td></td><td>Document no.</td><td>Revision no.</td><td>Page 171</td></tr>
<tr><td>Procedure Research and development</td><td>Date</td><td colspan="2">Main director</td></tr>
<tr><td>Definition</td><td colspan="3">An activity for research management by external people of hospital</td></tr>
<tr><td>Aim</td><td colspan="3">As a reference for management and finishing external researcher of hospital</td></tr>
<tr><td>Policy</td><td colspan="3">About research and development at Adam Malik Hospital</td></tr>
<tr><td>Procedure</td><td colspan="3">- Reseacher/institution send a request research letter with research proposal to main director Adam Malik hospital
- The main director accept and make a letter to head department of education and research for further process
- The head department of education and research give a letter to head of research and development to be processed
- The head of research and development instruct to head and vice of working team to study and process the request letter
- The head of working team accept and prepare for finishing the letter based on head of research and development after read the proposal and discuss with the researcher
- The head of working team work together with administration team for preparing the needed letter
- The head of research and development will give a letter to the unit for research setting based on the proposal
- The staff of research and development will accompany the researcher to the research settings
- The researcher conduct their research in the settings based on the proposal
- The result of the study which is needed will be presenting first
- The head of research and development will send the report of the research implementation which has been done by the researcher to director of human resources and education through head department of education and research
- The team of research and development will make a report for the result of the study (when needed) for promoting services at hospital
- The researcher provide two results of the the study to the team of research and development</td></tr>
<tr><td>Unit which involved</td><td colspan="3">- Team/ Division of research and development
- Head department of education and research
- Working unit of the settings for research
- Director of human resources and education</td></tr>
</table>

Appendix twelve: Head Nurse approval letter(s)

Kepada pihak yang berkepentingan
To Whom it may concern

Saya, kepala ruangan ICU, dengan ini menyatakan kembali secara tulisan bahwa saya mengijinkan kegiatan di ruangan ICU digunakan dalam penelitian yang dilakukan oleh Ni Gusti Ayu Eka yang pada saat itu melakukan observasi terhadap interaksi mahasiswa-dosen/clinical educator-perawat yang sedang bertugas atau praktik klinik di rungan ICU pada tanggal 28 Maret 2013.

I, the head nurse of ICU, hereby would like to confirm in written that I have given permission to Ni Gusti Ayu Eka to do her study in the ICU, in which at that time she was observing students-academic staff/clinical educator-nurses interactions who worked or had a placement at ICU on 28th March 2013.

Hormat saya,
Regards,

Kepala ruangan ICU RSUS: Nita Setianingrum
(Nama dan tandatangan)
Head Nurse of ICU RSUS (Name and sign)

Mengetahui:
Acknowledge by:
Koordinator perawat RSUS: Ch. C. Sri Budi Rahayu
(Nama dan tandatangan)
Nursing coordinator RSUS (Name and sign)

Appendix twelve: Head Nurse approval letter(s)

Kepada pihak yang berkepentingan

To Whom it may concern

Saya, kepala ruangan Unit Gawat Darurat (UGD), dengan ini menyatakan kembali secara tulisan bahwa saya mengijinkan kegiatan di ruangan UGD digunakan dalam penelitian yang dilakukan oleh Ni Gusti Ayu Eka yang pada saat itu melakukan observasi terhadap interaksi mahasiswa-dosen/clinical educator-perawat yang sedang bertugas atau praktik klinik di rungan UGD pada tanggal 1 April 2013.

I, the head nurse of Emergency Room (ER), hereby would like to confirm in written that I have given permission to Ni Gusti Ayu Eka to do her study at ER, in which at that time she was observing students-academic staff/clinical educator nurses interactions who worked or had a placement at ER on 1 April 2013.

Hormat saya,

Regards,

Kepala ruangan UGD RSUS: Ari Yuliany

(Nama dan tandatangan)

Head Nurse of ER RSUS (Name and sign)

Mengetahui:

Acknowledge by:

Koordinator perawat RSUS: CH. C. Sri Budi Rahayu

(Nama dan tandatangan)

Nursing coordinator RSUS (Name and sign)

Appendix twelve: Head Nurse approval letter(s)

Kepada pihak yang berkepentingan
To Whom it may concern

Saya, kepala ruangan ICU, dengan ini menyatakan kembali secara tulisan bahwa saya mengijinkan kegiatan di ruangan ICU digunakan dalam penelitian yang dilakukan oleh Ni Gusti Ayu Eka yang pada saat itu melakukan observasi terhadap interaksi mahasiswa-dosen/clinical educator-perawat yang sedang bertugas atau praktik klinik di rungan ICU pada tanggal 6 Maret 2013.

I, the head nurse of ICU, hereby would like to confirm in written that I have given permission to Ni Gusti Ayu Eka to do her study in the ICU, in which at that time she was observing students-academic staff/clinical educator-nurses interactions who worked or had a placementat ICU on 6th March 2013.

Hormat saya,
Regards,

Kepala ruangan ICU RS Adam Malik : Rosma Tenny Purba
(Nama dan tanda tangan)
Head Nurse of ICU Adam Malik Hospital (Name and sign)

Appendix twelve: Head Nurse approval letter(s)

Kepada pihak yang berkepentingan
To Whom it may concern

Saya, kepala ruangan Unit Gaat Darurat (UGD), dengan ini menyatakan kembali secara tulisan bahwa saya mengijinkan kegiatan di ruangan UGD digunakan dalam penelitian yang dilakukan oleh Ni Gusti Ayu Eka yang pada saat itu melakukan observasi terhadap interaksi mahasiswa-dosen/clinical educator-perawat yang sedang bertugas atau praktik klinik di rungan ER pada tanggal 8 Maret 2013.

I, the head nurse of Emergency Room (ER), hereby would like to confirm in written that I have given permission to Ni Gusti Ayu Eka to do her study at ER, in which at that time she was observing students-academic staff/clinical educator-nurses interactions who worked or had a placement at ER on 8th March 2013.

Hormat saya,
Regards,

Kepala ruangan UGD RS Adam Malik : Jemmi Ferawati. Ners MKep .
(Nama dan tanda tangan)
Head Nurse of ER Adam Malik Hospital (Name and sign)

Appendix thirteen: Participant information sheets – Academic Staff

Title of Project: Incivility in Indonesia Nursing Education: A Case Study

Name of Investigators*:*
Ni Gusti Ayu Eka, Postgraduate student (PhD in Nursing Studies), School of Nursing, University of Nottingham
Academic supervisors:
Dr Aru Narayanasamy, Associate Professor of Nurse Education (Diversity teaching and learning), School od Nursing, University of Nottingham
Dr Derek Chambers, Associate Professor, School of Nursing, University of Nottingham

Information Sheet for Academic Staff

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

Background: In recent times, incivility (the impoliteness of speaking and action) has become an issue in nursing education. This study will be conducted at two nursing education institutions in Indonesia. The Faculty of Nursing University of Pelita Harapan (FoN UPH) Tangerang (near Jakarta) is an accredited private university which is based on Christian principles. Contrastingly, the Faculty of Nursing Airlangga University (FoN UNAIR) Surabaya is an accredited public university. Both universities are located in two major cities of Indonesia which has over 750 distinct ethnicities with Indo-Malay (94.3%) as the dominant ethnic group. It also has six officially-recognised religious faiths and a wide disparity of socio economic backgrounds. The socio-economic status of this country is low middle-income with 13.67% of the population living below the poverty line (World Bank, 2012).
Clearly, students and faculties' behaviour may be influenced by their ethnic, religion and socio-economic background. These factors may influence their behaviour in the teaching and learning process.
A preliminary study (Eka, Sitompul and Solely, 2011) about uncivil behaviour as defined by Clark (2009) showed that uncivil student behaviours include cheating in exams or tests and holding conversations that distract themselves or other students. Conversely, uncivil faculty staff behaviour includes cancelling scheduled activities without notice and utilising ineffective teaching styles or methods.
Aim: To explore incivility as perceived by students and faculty staff in Indonesian nursing education based on ethnicity, religious faith and socio economic background.
The duration of the study: 1 year

What does the study involve?

1. The questionnaires will be distributed to students year 2, 3 and 4 as well as faculty staff (minimum one year participated in nursing education). In addition, there is a request for participating in interviews in the questionnaire sheets. Therefore, the students and faculty staff who agreed will write their email address.
2. The respondents will be chosen regarding their variety of characteristics (ethnicity, religious practices and socio-economic background). The chosen respondents will be asked for interviews sessions. However, the interviews will be held after the researchers applied direct observations in class-room settings.

Why have you been chosen?

You have choosen because you are a faculty staff either at FoN UPH or FoN USU that have been involved or worked for minimum one year.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

You have to fill the questionnaire related to incivility in nursing education and write down your email address if you would like to involve in interview.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results will enhance current understanding on incivility in Indonesia nursing education. The results will be published in journal articles and conferences and will be written as a doctoral thesis. No names and addresses or any personal identifying details will be used for publishing the results.

Who is organising and funding the research?

The Directoral General of Higher Education of Indonesia is funding this study. This is being undertaken as a partial fulfillment for an educational qualification at the University of Nottingham, UK (PhD).

Who has reviewed the study?

This study has been reviewed by the ethics committee of the faculty of medicine and health sciences, University of Nottingham, UK, the ethics committee of the faculty of medicine Unversitas Sumatera Utara and the ethics committee of the faculty of nursing and allied health sciences Universitas Pelita Harapan.

Contact for Further Information

Ni Gusti Ayu Eka

Faculty of Nursing and Allied Health Science
Universitas Pelita Harapan
Jl.Boulevard Sudirman, Karawaci-Tangerang
Indonesia 15811
Ph:+6221 54210130
Fax: +6221 54203459

Email: ntxnn3@nottingham.ac.uk

Thank you for reading this.

Appendix fourteen: Participant information sheets – Student

Title of Project: Incivility in Indonesia Nursing Education: A Case Study

Name of Investigators*:*
Ni Gusti Ayu Eka, Postgraduate student (PhD in Nursing Studies), School of Nursing, University of Nottingham
Academic supervisors:
Dr Aru Narayanasamy, Associate Professor of Nurse Education (Diversity teaching and learning), School od Nursing, University of Nottingham
Dr Derek Chambers, Associate Professor, School of Nursing, University of Nottingham

Information Sheet for Students

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

Background: In recent times, incivility (the impoliteness of speaking and action) has become an issue in nursing education. This study will be conducted at two nursing education institutions in Indonesia. The Faculty of Nursing University of Pelita Harapan (FoN UPH) Tangerang (near Jakarta) is an accredited private university which is based on Christian principles. Contrastingly, the Faculty of Nursing Airlangga University (FoN UNAIR) Surabaya is an accredited public university. Both universities are located in two major cities of Indonesia which has over 750 distinct ethnicities with Indo-Malay (94.3%) as the dominant ethnic group. It also has six officially-recognised religious faiths and a wide disparity of socio economic backgrounds. The socio-economic status of this country is low middle-income with 13.67% of the population living below the poverty line (World Bank, 2012).
Clearly, students and faculties' behaviour may be influenced by their ethnic, religion and socio-economic background. These factors may influence their behaviour in the teaching and learning process.
A preliminary study (Eka, Sitompul and Solely, 2011) about uncivil behaviour as defined by Clark (2009) showed that uncivil student behaviours include cheating in exams or tests and holding conversations that distract themselves or other students. Conversely, uncivil faculty staff behaviour includes cancelling scheduled activities without notice and utilising ineffective teaching styles or methods.
Aim: To explore incivility as perceived by students and faculty staff in Indonesian nursing education based on ethnicity, religious faith and socio economic background.
The duration of the study: 1 year

What does the study involve?

1. The questionnaires will be distributed to students year 2, 3 and 4 as well as faculty staff (minimum one year participated in nursing education). In addition, there is a request for participating in interviews in the questionnaire sheets. Therefore, the students and faculty staff who agreed will write their email address.
2. The respondents will be chosen regarding their variety of characteristics (ethnicity, religious practices and socio-economic background). The chosen respondents will be asked for interviews sessions. However, the interviews will be held after the researchers applied direct observations in class-room settings.

Why have you been chosen?

You have choosen because you are a nursing student either at FoN UPH or FoN USU that have been participated for minimum one year.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

You have to fill the questionnaire related to incivility in nursing education and write down your email address if you would like to involve in interview.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results will enhance current understanding on incivility in Indonesia nursing education. The results will be published in journal articles and conferences and will be written as a doctoral thesis. No names and addresses or any personal identifying details will be used for publishing the results.

Who is organising and funding the research?

The Directoral General of Higher Education of Indonesia is funding this study. This is being undertaken as a partial fulfillment for an educational qualification at the University of Nottingham, UK (PhD).

Who has reviewed the study?

This study has been reviewed by the ethics committee of the faculty of medicine and health sciences, University of Nottingham, UK, the ethics committee of the faculty of medicine Unversitas Sumatera Utara and the ethics committee of the faculty of nursing and allied health sciences Universitas Pelita Harapan.

Contact for Further Information

Ni Gusti Ayu Eka

Faculty of Nursing and Allied Health Science
Universitas Pelita Harapan
Jl.Boulevard Sudirman, Karawaci-Tangerang
Indonesia 15811
Ph:+6221 54210130
Fax: +6221 54203459

Email: ntxnn3@nottingham.ac.uk

Thank you for reading this.

Appendix fifteen: Healthy Volunteer's consent form

The University of Nottingham

Title of Project: **Incivility in Indonesia Nursing Education: A Case Study**

Name of Investigators: Ni Gusti Ayu Eka
Academic Supervisors: Dr Aru Narayanasamy, Dr Derek Chambers

Healthy Volunteer's Consent Form

Please read this form and sign (√) it once the above named or their designated representative, has explained fully the aims and procedures of the study to you

• I voluntarily agree to take part in this study.	
• I confirm that I have been given a full explanation by the above named and that I have read and understand the information sheet given to me which is attached.	
• I have been given the opportunity to ask questions and discuss the study with one of the above investigators or their deputies on all aspects of the study and have understood the advice and information given as a result.	
• I agree to comply with the reasonable instructions of the supervising investigator and will notify him immediately of any unexpected unusual symptoms or deterioration of health.	
• I understand that my personal details will not be included in the results and publication or any other output from the research.	
• I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 7 years after the results of this study have been published.	
• I understand that I can ask for further instructions or explanations at any time.	
• I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing.	

Name: .....

Signature: ..... **Date:** .....

I confirm that I have fully explained the purpose of the study and what is involved to:

.....

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: ..... **Date:** .....

Investigators Name:.....

Study Volunteer Number

Appendix sixteen: Partisipant consent form

Participant Consent Form
Formulir Persetujuan

Incivility in Indonesia nursing education: A case study
Incivility dalam Pendidikan Keperawatan di Indonesia: Sebuah Studi Kasus

Dear Participant:
Kepada Paritispan:

This form gives me final authorization to use material from your interview in my research. Drafts of the result of the interview have been presented to you for your review, correction, or modification.

Formulir ini memberikan saya otoritas akhir untuk menggunakan bahan dari hasil wawancara untuk penelitian saya. Rancangan hasil wawancara telah dikirimkan kepada anda untuk direview, dikoreksi, atau dimodifikasi.

I, _____, hereby grant the right to use information from recordings and or notes taken in interviews of me, to Ni Gusti Ayu Eka, and as presented to me as a draft copy. I understand that the interview records will be kept by the interviewer, and that the information contained in the interviews may be used for the study.

Saya, _____, dengan ini memberikan hak untuk menggunakan informasi dari rekaman dan atau catatan yang diambil dalam wawancara saya kepada Ni Gusti Ayu Eka dan telah dikirimkan kepada saya draft kopiannya. Saya mengerti rekaman interview akan disimpan pewawancara, dan informasi dalam interview akan digunakan untuk penelitian

_____ Date:_____
Signature of Interviewee
Tanda Tangan Responden

Appendix seventeen: Questionnaire of the study –English version

Volunteer Study Number ☐

Questionnaire
Modified Incivility in Nursing Education (INE) Survey
(Clark © 2004, revised 2010 and Beck © 2009)

"Incivility in nursing education is defined as rude or disruptive behaviors which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations" (Clark, Farnworth and Landrum, 2009, p.7*).*
The nursing academic environment is defined as any location of the teaching and learning process, including the class room, clinical practice and on-line teaching *(Clark, 2006).*

1. Please indicate (✓) your status at your college/university:

○ Faculty ○ Student

2. Please indicate (✓) your gender:

○ Male ○ Female

3. In what year were you born?

☐☐☐☐

4. If you are *a faculty member*, how many years have you taught at the university and/or college level?

☐☐

5. If you are *a student*, please indicate (✓) your current program level:

○ ETP/Regular year _____

○ CC/ Extention year _____

○ Professions year _____

6. Please indicate (✓) whether your university is:

○ Private ○ Public

7. Please indicate (✓) your religion:

○ Moslem
○ Christian
○ Catholic
○ Hinduism
○ Buddhism
○ Confucianism
○ Other: _____

8. In terms of *ethnic group* (Mandryk, 2010), I consider myself to be (circle and mention):

a. Indo-Malay :_____
(such as Javanese, Sunda, Madura, Batak, Minangkabau, Banjar, Bali, Bugis, Aceh, Malay, Betawi, Makassar, Sasak, Deli, Riau, Dayak)

b. Chinese : _____
(Indonesia with Chinese in heritage)

c. Pacific Island peoples: _____
(such as peoples in New Guinea cluster, in West Timor, Halmahera and Papua)

d. Mixed (Parents are from two different ethnicities)

e. Others :_____
(such as Arab, Indian, European, US mixed race)

My father's ethnicity is: _____

My mother's ethnicity is: _____

9. Religious Faith**/**Practice
(Abbreviated Santa Clara Strength of Religious Faith Questionnaire/ASCSRFQ by Plante, et al., 2002)
Use the numbers below (***please circle***) to indicate how much you agree or disagree with each statement.

No	Religious Faith	Strongly Disagree	Disagree	Agree	Strongly Agree
1	I pray daily	**1**	**2**	**3**	**4**
2	I look to my faith as providing meaning and purpose in my life.	**1**	**2**	**3**	**4**
3	I consider myself active in my faith or in the place of worship	**1**	**2**	**3**	**4**
4	I enjoy being around others who share my faith.	**1**	**2**	**3**	**4**
5	My faith impacts many of my decisions.	**1**	**2**	**3**	**4**

10. The Multigroup Ethnic Identity Measure/MEIM (Phinney, 1999)
Use the numbers below (***please circle***) to indicate how much you agree or disagree with each statement.

No	Statement	Strongly disagree	Disagree	Agree	Strongly agree
1	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	**1**	**2**	**3**	**4**
2	I am active in organizations or social groups that include mostly members of my own ethnic group.	**1**	**2**	**3**	**4**
3	I have a clear sense of my ethnic background and what it means for me.	**1**	**2**	**3**	**4**
4	I think a lot about how my life will be affected by my ethnic group membership.	**1**	**2**	**3**	**4**
5	I am happy that I am a member of the group I belong to.	**1**	**2**	**3**	**4**
6	I have a strong sense of belonging to my own ethnic group.	**1**	**2**	**3**	**4**
7	I understand pretty well what my ethnic group membership means to me.	**1**	**2**	**3**	**4**
8	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	**1**	**2**	**3**	**4**
9	I have a lot of pride in my ethnic group.	**1**	**2**	**3**	**4**
10	I participate in cultural practices of my own group, such as special food, music, or customs.	**1**	**2**	**3**	**4**
11	I feel a strong attachment towards my own ethnic group.	**1**	**2**	**3**	**4**
12	I feel good about my cultural or ethnic background.	**1**	**2**	**3**	**4**

11. Socio-economic Status

Please ***circle*** your father's and mother's education, employment and income if you are a <u>student that has not work yet</u>; or ***circle*** under student who <u>has worked</u>; or ***circle*** under faculty if you are a <u>faculty staff</u>.

NO	**Socio-Economic Status**	**STUDENT who has not worked yet**		**STUDENT who has worked**	**FACULTY**
		Father	***Mother***		
1	Education	a. Primary School b. Junior School c. High School d. Diploma e. Undergraduate f. Postgraduate (Master) g. Postgraduate (Doctoral)	a. Primary School b. Junior School c. High School d. Diploma e. Undergraduate f. Postgraduate(Master) g. Postgraduate (Doctoral)	a. Primary School b. Junior School c. High School d. Diploma e. Undergraduate f. Postgraduate (Master) g. Postgraduate (Doctoral)	a. Primary School b. Junior School c. High School d. Diploma e. Undergraduate f. Postgraduate (Master) Postgraduate (Doctoral)
2	Employment	a. Private employee b. Government employee c. Entrepreneurs d. Other: ________________	a. Private employee b. Government employee c. Entrepreneurs d. Other: ________________	A nurse in ward or speciality: ________________	a. Assistant Lecturer/Clinical Educator b. Other: ________________
3	Income per month	a. Below regional minimum payment (<1,500,000) b. 1,500,000-3,000,000 c. 3,000,001-4,500,000 d. 4,500,001-6,000,000 e. Above 6,000,000	a. Below regional minimum payment (<1,500,000) b. 1,500,000-3,000,000 c. 3,000,001-4,500,000 d. 4,500,001-6,000,000 e. Above 6,000,000	a. Below regional minimum payment (<1,500,000) b. 1,500,000-3,000,000 c. 3,000,001-4,500,000 d. 4,500,001-6,000,000 e. Above 6,000,000	a. Below regional minimum payment (<1,500,000) b. 1,500,000-3,000,000 c. 3,000,001-4,500,000 d. 4,500,001-6,000,000 e. Above 6,000,000

12. Listed are some **STUDENT** behaviours you may have experienced or seen in the nursing academic environment. Please **circle** regarding the level of "disruption" **and** how often each behaviour occurred over the past 12 months.

Students …	**Do you consider this behaviour disruptive?**				**How often have you experienced or seen this in the past 12 months?**			
	Never	***Sometimes***	***Usually***	***Always***	***Never***	***Sometimes***	***Usually***	***Always***
Acting bored or apathetic	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making groaning to show disapproval	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making sarcastic remarks or gestures	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sleeping in class	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Not paying attention in class	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Holding conversations that distract you or other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Refusing to answer direct questions that aimed to him/her.	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Using a computer to do unrelated classroom work	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Using phones or cell phones during class	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Arriving late for class	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Leaving class ahead of schedule	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Cutting class (not present in class/ being absent)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unprepared for class	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Creating tension by dominating class discussion	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Cheating on exams or quizzes	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Demanding make-up exams, extensions for assignments, grade changes, or other special favours	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Not charting nursing care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unprepared for the clinical experience	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Not admitting an error made in patient care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

13. Listed below are some **STUDENT** behaviours that may be considered **threatening**. Please **circle** whether this behaviour has happened to you or someone you know within the nursing academic environment in the past 12 months.

Students…	**Do you consider this behaviour threatening?**				**How often have you experienced or seen this in the past 12 months?**			
	Never	***Sometimes***		***Usually Always***	***Never***	***Sometimes***		***Usually Always***
Taunting or showing disrespect to other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging faculty staff knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging nurses knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sending inappropriate e-mails to other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sending inappropriate e-mails to faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against other students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Damaging property	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making statements about having easy access to weapons or sharp objects	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Neglecting patients in the clinical area	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Charting patient are not completed	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

14. Listed are some **FACULTY** behaviours you may have experienced or seen in the nursing academic environment. Please **circle** regarding the level of "disruption" **and** how often each behaviour occurred over the past 12 months.

Faculty …	**Do you consider this behaviour disruptive?**				**How often have you experienced or seen this in the past 12 months?**			
	Never	***Sometimes***		***Usually Always***	***Never***	***Sometimes***		***Usually Always***
Arriving late for schedule activities	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Leaving class ahead of schedule	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Cancelling scheduled activities without warning	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unprepared for scheduled activities	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Ineffective teaching style/methods	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being inflexible, rigid and authoritarian	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Punishing the entire class for one student's misbehaviour	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making statements about being disinterested in the subject matter	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being distant and cold towards others (unapproachable, reject students opinions)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Refusing or reluctant to answer questions	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Subjective grading of students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making condescending remarks or put downs	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Exerting superiority, showing arrogance towards others	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Threatening to fail student for not complying to faculty's demands	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making rude gestures or behaviours toward others	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Ignoring disruptive student behaviours	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unavailable to respond the students outside of class in office hours	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unavailable to respond to the students on the patient care unit	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unavailable to respond to the students for practice in the skills laboratory	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taking over for the student when providing patient care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

15. Listed below are some **FACULTY** behaviours that may be considered **threatening**. Please **circle** whether this behaviour has happened to you or someone you know within the nursing academic environment in the past 12 months.

Faculty……..	**Do you consider this behaviour threatening?**				**How often have you experienced or seen this in the past 12 months?**			
	Never		***Sometimes***	***Usually Always***	***Never***		***Sometimes***	***Usually Always***
Taunting or showing disrespect to students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to other faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging other faculty staff knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging nurses knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at other faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at other faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sending Inappropriate e-mails to students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sending Inappropriate e-mails to other faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against other faculty staff	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Damaging property	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making statements about having easy access to weapons	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Neglecting patients in the clinical area	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Charting patient are not completed	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

16. Listed are some **NURSES** behaviours you may have experienced or seen in the nursing academic environment. Please **circle** regarding the level of "disruption" **and** how often each behaviour occurred over the past 12 months.

Nurses …	**Do you consider this behaviour disruptive?**				**How often have you experienced or seen this in the past 12 months?**			
	Never	***Sometimes***	***Usually***	***Always***	***Never***	***Sometimes***	***Usually***	***Always***
Arriving late for work	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Leaving work early	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unprepared for patient care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Refusing to allow students to perform patient care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Ineffective teaching style/methods	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being inflexible, rigid and Authoritarian	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making statements about being disinterested in working with students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being distant and cold towards others (unapproachable, reject students opinions)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Refusing or reluctant to answer questions	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Subjective grading of students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making condescending remarks or put downs	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Exerting superiority, showing arrogance towards others	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Threatening to fail student for not complying to nurse's demands	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making rude gestures or behaviours toward others	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Being unavailable to respond to the students on the patient care unit	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taking over for the student when providing patient care	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

17. Listed below are some **NURSES** behaviours that may be considered **threatening**. Please **circle** whether this behaviour has happened to you or someone you know within the nursing academic environment in the past 12 months.

Nurses……..	**Do you consider this behaviour threatening?**				**How often have you experienced or seen this in the past 12 months?**			
	Never	***Sometimes***	***Usually***	***Always***	***Never***	***Sometimes***	***Usually***	***Always***
Taunting or showing disrespect to students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to other nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Taunting or showing disrespect to patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging faculty staff knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Challenging nurses knowledge or credibility	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at other nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making harassing comments (racial, ethnic, gender) directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at other nurses	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making vulgar comments directed at patients	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against students	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making threats of physical harm against faculty	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Damaging property	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Making statements about having easy access to weapons	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Neglecting patients in the clinical area	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Charting patient are not completed	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

18. To what extent do you think incivility in the nursing academic environment is a problem? **Please check (✓)**

○ No problem at all
○ Mild problem
○ Moderate problem
○ Serious problem
○ I don't know/can't answer

19. Based on your experiences or perceptions, do you think that students or faculty members are more likely to engage in uncivil behaviour in the class-room? **Please check (✓)**

○ Faculty members are much more likely
○ Faculty members are a little more likely
○ About equal
○ Students are a little more likely
○ Students are much more likely
○ Don't know

20. Based on your experiences or perceptions, do you think that students or faculty members are more likely to engage in uncivil behaviour in the skills laboratory? **Please check (✓)**

○ Faculty members/clinical educator are much more likely
○ Faculty members/clinical educator are a little more likely
○ About equal
○ Students are a little more likely
○ Students are much more likely
○ Don't know

21. Based on your experiences or perceptions, do you think that students or faculty members/clinical educator or nurses are more likely to engage in uncivil behaviour in the clinical practice? (**<u>If possible, fill in more than one</u>**) **Please check (✓)**

○ Faculty members/clinical educator are much more likely
○ Faculty members/clinical educator are a little more likely
○ Nurses are much more likely
○ Nurses are a little more likely
○ Students are much more likely
○ Students are a little more likely
○ About equal
○ Don't know

22. In your opinion, **WHY (reasons)** do you think incivility occurs in academic environment?

23. Give examples of uncivil behaviours that occurs in academic environment (classroom, skills laboratory and clinical practice)

24. Please describe **HOW** students, faculty members, nurses and the university/college should address incivility in the academic environment.

25. What are the **differences** in the uncivil behaviours seen in the traditional classroom, skills laboratory and the clinical unit?

26. In your opinion, where are uncivil behaviours the **most prevalent**?
Please check (✓)

○ Traditional Classroom ○ Skills laboratory ○ Clinical Unit

Thank You so much for Your Participation

INE Survey used with permission from Dr. Cynthia Clark, Professor, Boise State University (email: cclark@boisestate.edu) and Dr. Jennifer Wibbenmeyer Beck, Dean and Associate Professor, School of Nursing, Our Lady of the Lake College, LA (email: jbeck@ololcollege.edu)

Note:
I am interested in joining the ***interview*** regarding incivility in nursing education, please contact me by email:_____
or mobile phone:_____

Volunteer Study Number ☐

Appendix eighteen: Questionnaire of the study –Indonesian version

Kuesioner
Modified Incivility in Nursing Education (INE) Survey
(Clark © 2004, revised 2010 and Beck © 2009)

"Perilaku *incivility* dalam pendidikan keperawatan didefinisikan sebagai perilaku yang kasar atau mengganggu yang terkadang menimbulkan tekanan psikologis atau fisiologis pada orang yang terlibat dan jika tidak ditindaklanjuti bisa berkembang menjadi situasi yang membahayakan" (Clark, Farnworth and Landrum, 2009, p.7*)*.
Lingkungan pendidikan keperawatan didefinisikan sebagai lokasi proses pengajaran dan pembelajaran, termasuk ruang kelas, praktik klinik dan pengajaran *on-line* (Clark, 2006).

"Incivility in nursing education is defined as rude or disruptive behaviors which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations" (Clark, Farnworth and Landrum, 2009, p.7).
The nursing academic environment is defined as any location of the teaching and learning process, including the class room, clinical practice and on-line teaching (Clark, 2006).

1. Mohon beri tanda **(v)** pada status Anda di universitas:
   ○ Staf Pengajar ○ Mahasiswa

2. Mohon beri tanda **(v)** pada jenis kelamin Anda:
   ○ Laki-laki ○ Perempuan

3. Tahun Anda lahir:
   □□□□

4. Jika Anda seorang STAF PENGAJAR, berapa tahun Anda telah mengajar di tingkat universitas?
   □□

5. Jika Anda seorang MAHASISWA, mohon beri tanda **(v)** pada tingkat program Anda:
   ○ ETP/reguler Tahun _____
   ○ CC/ekstensi Tahun _____
   ○ Profesi Tahun _____

6. Mohon beri tanda **(v)** pada jenis universitas Anda:
   ○ Swasta ○ Negeri

7. Mohon beri tanda **(v)** pada Agama Anda:
   ○ Islam
   ○ Kristen
   ○ Katolik
   ○ Hindu
   ○ Budha
   ○ Konghucu
   ○ Lainnya: _____

8. Dalam terminologi kelompok etnis (Mandryk, 2010), saya termasuk dalam kelompok etnis (**lingkari dan sebutkan**):

a. Indo-Malay :_____
(seperti: Javanese, Sunda, Madura, Batak, Minangkabau, Banjar, Bali, Bugis, Aceh, Malay, Betawi, Makassar, Sasak, Deli, Riau, Dayak)

b. Chinese : _____
(Indonesia dengan keturunan etnis Tionghoa)

c. Pacific Island peoples: _____
(seperti orang-orang di New Guinea cluster, Timor, Halmahera and Papua)

d. Mixed/campuran (Orang tua dari dua etnik yang berbeda)

e. Lainnya:_____
(seperti Arab, Indian, European, US mixed race)

Asal etnis ayah saya : _____

Asal etnis ibu saya : _____

9. Kepercayaan/Praktik Keagamaan
(*Abbreviated Santa Clara Strength of Religious Faith Questionnaire*/ASCSRFQ by Plante, et al., 2002)
Gunakan angka dibawah ini (**Lingkari**) untuk menunjukkan seberapa besar Anda setuju atau tidak setuju dengan setiap pernyataan berikut.

No	Iman/Praktik Keagamaan	Sangat tidak setuju	Tidak setuju	Setuju	Sangat setuju
1	Saya berdoa setiap hari.	**1**	**2**	**3**	**4**
2	Saya mengganggap agama/kepercayaan saya sebagai pemberi arti dan tujuan di dalam hidup saya.	**1**	**2**	**3**	**4**
3	Saya menganggap diri saya aktif dalam kegiatan keagamaan atau di tempat ibadah saya.	**1**	**2**	**3**	**4**
4	Saya merasa senang berada disekitar orang-orang yang seiman.	**1**	**2**	**3**	**4**
5	Iman kepercayaan saya berdampak banyak pada keputusan-keputusan saya	**1**	**2**	**3**	**4**

10. Pengukuran identitas etnis multi kelompok
(*The Multigroup Ethnic Identity Measure*/MEIM) (Phinney, 1999)
Gunakan angka dibawah ini (**Lingkari**) untuk menunjukkan seberapa besar Anda setuju atau tidak setuju dengan setiap pernyataan.

No	Pernyataan	Sangat tidak setuju	Tidak setuju	Setuju	Sangat setuju
1	Saya menghabiskan waktu untuk mencoba mencari lebih banyak informasi tentang kelompok etnis saya, seperti sejarahnya, tradisi dan adat istiadat.	**1**	**2**	**3**	**4**
2	Saya aktif dalam organisasi atau kelompok sosial yang sebagian besar anggotanya berasal dari kelompok etnis saya.	**1**	**2**	**3**	**4**
3	Saya memiliki kejelasan tentang latar belakang etnis saya dan apa artinya bagi saya.	**1**	**2**	**3**	**4**
4	Saya banyak memikirkan tentang bagaimana hidup saya akan dipengaruhi oleh keanggotaan terhadap kelompok etnis saya.	**1**	**2**	**3**	**4**
5	Saya merasa bahagia bahwa saya termasuk anggota kelompok etnis saya	**1**	**2**	**3**	**4**
6	Saya mempunyai rasa memiliki yang kuat terhadap kelompok etnis saya.	**1**	**2**	**3**	**4**
7	Saya sangat memahami apa arti keanggotaan di kelompok etnis saya terhadap diri saya	**1**	**2**	**3**	**4**
8	Dalam rangka belajar lebih banyak lagi tentang latar belakang etnis saya, saya telah sering membicarakan latar belakang etnis saya kepada orang lain	**1**	**2**	**3**	**4**
9	Saya memiliki rasa kebanggaan yang besar terhadap kelompok etnis saya	**1**	**2**	**3**	**4**

10	Saya berpartisipasi dalam kegiatan kebudayaan dari kelompok etnis saya, seperti makanan khusus, musik atau adat	**1**	**2**	**3**	**4**
11	Saya merasa memiliki keterikatan yang kuat terhadap kelompok etnis saya	**1**	**2**	**3**	**4**
12	Saya merasa bahagia dengan latar belakang kebudayaan atau etnis saya	**1**	**2**	**3**	**4**

11. Status Sosio-Ekonomi

Mohon **lingkari** pada pendidikan, pekerjaan dan pendapatan ayah dan ibu jika Anda adalah seorang **mahasiswa yang belum bekerja**; atau lingkari dibawah **mahasiswa yang sudah bekerja** jika Anda seorang mahasiswa yang sudah bekerja; atau lingkari dibawah staf pengajar jika Anda seorang **staf pengajar**.

NO	**Status Sosio-Ekonomi**	**MAHASISWA yang belum bekerja**		**MAHASISWA yang sudah bekerja**	**STAF PENGAJAR**
		Ayah	**Ibu**		
1	Pendidikan	a. Sekolah Dasar (SD) b. Sekolah Menengah Pertama (SMP) c. Sekolah Menengah Atas (SMA) d. Sarjana e. Pasca Sarjana (Master) f. Pasca Sarjana (Doktoral)	a. Sekolah Dasar (SD) b. Sekolah Menengah Pertama (SMP) c. Sekolah Menengah Atas (SMA) d. Sarjana e. Pasca Sarjana (Master) a. Pasca Sarjana (Doktoral)	a. Sekolah Dasar (SD) b. Sekolah Menengah Pertama (SMP) c. Sekolah Menengah Atas (SMA) d. Sarjana e. Pasca Sarjana (Master) f. Pasca Sarjana (Doktoral)	a. Sekolah Dasar (SD) b. Sekolah Menengah Pertama (SMP) c. Sekolah Menengah Atas (SMA) d. Sarjana e. Pasca Sarjana (Master) f. Pasca Sarjana (Doktoral)
2	Pekerjaan	a. Karyawan Swasta b. Pegawai Negeri c. Pengusaha/*Entrepreneurs* d. Lainnya, sebutkan: _________________	a. Karyawan Swasta b. Pegawai Negeri c. Pengusaha/*Entrepreneurs* d. Lainnya, sebutkan: _________________	a. Karyawan Swasta b. Pegawai Negeri c. Pengusaha/Entrepreneurs d. Lainnya, sebutkan: _________________	a. Pengajar *b.* Asisten Pengajar/*Clinical Educator* c. Lainnya, sebutkan: _________________
3	Penghasilan per bulan	a. Dibawah upah minimum regional/ UMR (< Rp. 1.500.000) b. Rp. 1.500.000-3.000.000 c. Rp. 3.000.001-4.500.000 d. Rp. 4.500.001-6.000.000 e. Diatas Rp. 6,000,000	a. Dibawah upah minimum regional/ UMR (< Rp. 1.500.000) b. Rp. 1.500.000-3.000.000 c. Rp. 3.000.001-4.500.000 d. Rp. 4.500.001-6.000.000 e. Diatas Rp. 6,000,000	a. Dibawah upah minimum regional/ UMR (< Rp. 1.500.000) b. Rp. 1.500.000-3.000.000 c. Rp. 3.000.001-4.500.000 d. Rp. 4.500.001-6.000.000 e. Diatas Rp. 6,000,000	f. Dibawah upah minimum regional/ UMR (< Rp. 1.500.000) g. Rp. 1.500.000-3.000.000 h. Rp. 3.000.001-4.500.000 i. Rp. 4.500.001-6.000.000 j. Diatas Rp. 6,000,000

12. Daftar berikut merupakan beberapa perilaku **MAHASISWA** yang dapat Anda alami atau lihat dalam lingkungan pendidikan keperawatan. Mohon **lingkari** berkenaan dengan tingkat '**gangguan**' **dan** seberapa sering setiap perilaku terjadi selama 12 bulan terakhir.

MAHASISWA	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**				**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**			
	Tidak Pernah		**Kadang[2]**	**Biasanya Selalu**	**Tidak Pernah**		**Kadang[2]**	**Biasanya Selalu**
Menunjukkan sikap bosan atau tidak antusias	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat suara menggerutu sebagai pernyataan ketidaksetujuan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menyampaikan kata-kata kasar atau gerak tubuh yang tidak sopan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidur di kelas	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak memperhatikan di kelas	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Bercakap-cakap yang mengganggu Anda dan mahasiswa lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menolak untuk menjawab pertanyaan yang langsung ditujukan kepadanya	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menggunakan komputer untuk tujuan yang tidak berhubungan dengan kelas tersebut	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menggunakan telepon atau Hp saat kelas berlangsung	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Datang terlambat	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Meninggalkan kelas lebih awal dari jadwal yang telah ditentukan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membolos (tidak hadir dalam pelajaran)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak mempersiapkan diri untuk belajar di kelas	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menciptakan ketegangan dengan mendominasi kegiatan diskusi di kelas	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menyontek saat ujian atau kuis	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menuntut adanya ujian susulan, perpanjangan waktu untuk tugas, perubahan nilai atau perlakuan khusus lainnya	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

Tidak melakukan pencatatan asuhan keperawatan	**1 2 3 4**	**1 2 3 4**
Tidak mempersiapkan diri untuk pengalaman praktik	**1 2 3 4**	**1 2 3 4**
Tidak mengakui kesalahan yang dibuat dalam perawatan pasien	**1 2 3 4**	**1 2 3 4**

13. Daftar berikut ini merupakan perilaku **MAHASISWA** yang bisa dianggap ***mengancam/membahayakan***. Mohon **lingkari** apakah perilaku ini pernah terjadi pada Anda atau seseorang yang Anda kenal dalam lingkungan pendidikan keperawatan selama 12 bulan terakhir.

MAHASISWA	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**	**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**
	Tidak Pernah 1 Kadang[2] 2 Biasanya 3 Selalu 4	**Tidak Pernah 1 Kadang[2] 2 Biasanya 3 Selalu 4**
Sikap yang mengejek atau tidak menghormati mahasiswa lain	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau tidak menghormati staf pengajar	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau tidak menghormati perawat	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau tidak menghormati pasien	**1 2 3 4**	**1 2 3 4**
Bersikap yang menantang pengetahuan atau kredibilitas staf pengajar	**1 2 3 4**	**1 2 3 4**
Bersikap yang menantang pengetahuan atau kredibilitas perawat	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada mahasiswa lain	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada staf pengajar	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) perawat	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) pasien	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang kasar kepada mahasiswa lain	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang kasar kepada staf pengajar	**1 2 3 4**	**1 2 3 4**
Membuat komentar langsung yang kasar kepada perawat	**1 2 3 4**	**1 2 3 4**

Membuat komentar langsung yang kasar kepada pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengirim email yang tidak pantas/sesuai kepada mahasiswa lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengirim email yang tidak pantas/sesuai kepada staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap mahasiswa lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Merusak barang-barang	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat pernyataan tentang kemudahan mendapatkan senjata api atau benda tajam	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Melalaikan pasien di dalam area klinik	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mencatat perawatan pasien tidak lengkap	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

14. Daftar berikut ini perilaku **STAF PENGAJAR** yang Anda alami atau lihat di lingkungan pendidikan keperawatan. Mohon **lingkari** berkenaan dengan tingkat "**gangguan**" **dan** seberapa sering setiap perilaku terjad dalam 12 bulan terakhir.

STAF PENGAJAR	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**				**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**			
	Tidak Pernah		**Kadang[2]**	**Biasanya Selalu**	**Tidak Pernah**		**Kadang[2]**	**Biasanya Selalu**
Terlambat masuk kelas	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Meninggalkan kelas lebih awal dari jadwal yang telah ditentukan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membatalkan aktivitas terjadwal tanpa pemberitahuan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak mempersiapkan diri untuk aktivitas yang terjadwal	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Metode/gaya pengajaran yang tidak efektif	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menyimpang dari silabus mata ajar, merubah penugasan atau tanggal ujian	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak fleksibel, kaku dan otoriter	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menghukum seluruh kelas oleh karena satu orang mahasiswa yang melakukan perilaku tidak baik	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat pernyataan tentang ketidaktertarikan dalam materi pelajaran	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menjaga jarak dan bersikap dingin terhadap orang lain (tidak dapat	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

didekati, menolak pendapat mahasiswa)		
Menolak atau enggan untuk menjawab pertanyaan	**1 2 3 4**	**1 2 3 4**
Memberikan nilai secara subyektif atas mahasiswa	**1 2 3 4**	**1 2 3 4**
Meremehkan orang lain	**1 2 3 4**	**1 2 3 4**
Meninggikan diri sendiri, bersikap angkuh terhadap orang lain	**1 2 3 4**	**1 2 3 4**
Mengancam mahasiswa untuk mengagalkan mahasiswa (tidak lulus) apabila tidak melakukan permintaan staf pengajar	**1 2 3 4**	**1 2 3 4**
Berperilaku kasar terhadap orang lain	**1 2 3 4**	**1 2 3 4**
Mengabaikan perilaku mahasiswa yang mengganggu	**1 2 3 4**	**1 2 3 4**
Tidak bersedia menanggapi mahasiswa di luar jam kelas yang masih di dalam jam kerja	**1 2 3 4**	**1 2 3 4**
Tidak bersedia menanggapi mahasiswa saat berada di unit perawatan pasien	**1 2 3 4**	**1 2 3 4**
Tidak bersedia menanggapi mahasiswa dalam praktik laboratorium keterampilan	**1 2 3 4**	**1 2 3 4**
Mengambil alih pekerjaan mahasiswa saat melakukan perawatan pasien	**1 2 3 4**	**1 2 3 4**

15. Daftar berikut ini merupakan perilaku **STAF PENGAJAR** yang bisa dianggap ***mengancam/membahayakan***. Mohon **lingkari** apakah perilaku ini pernah terjadi pada Anda atau seseorang yang Anda kenal dalam lingkungan pendidikan keperawatan selama 12 bulan terakhir.

STAF PENGAJAR	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**	**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**
	Tidak Pernah 1 Kadang[2] 2 3 Biasanya Selalu 4	**Tidak Pernah 1 Kadang[2] 2 3 Biasanya Selalu 4**
Sikap yang mengejek atau terlihat tidak menghormati mahasiswa	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau terlihat tidak menghormati staf pengajar lain	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau tidak menghormati perawat	**1 2 3 4**	**1 2 3 4**
Sikap yang mengejek atau tidak menghormati pasien	**1 2 3 4**	**1 2 3 4**
Sikap yang menantang pengetahuan atau kredibilitas staf pengajar lain	**1 2 3 4**	**1 2 3 4**
Sikap yang menantang pengetahuan atau kredibilitas perawat	**1 2 3 4**	**1 2 3 4**

Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada staf pengajar lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada perawat	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada staf pengajar lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada perawat	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengirim e-mail yang tidak pantas/sesuai kepada mahasiswa lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengirim e-mail yang tidak pantas/sesuai kepada staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap staf pengajar lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Merusak barang-barang	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat pernyataan tentang kemudahan mendapatkan senjata api atau benda tajam.	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Melalaikan pasien di dalam area klinik	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mencatat perawatan pasien tidak lengkap	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

16. Daftar berikut ini perilaku **PERAWAT** yang Anda alami atau lihat di lingkungan pendidikan keperawatan. Mohon **lingkari** berkenaan dengan tingkat "**gangguan**" **dan** seberapa sering setiap perilaku terjad dalam 12 bulan terakhir

PERAWAT	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**				**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**			
	Tidak Pernah		**Kadang[2]**	**Biasanya Selalu**	**Tidak Pernah**		**Kadang[2]**	**Biasanya Selalu**
Datang terlambat saat masuk kerja	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Meninggalkan pekerjaan lebih awal	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak mempersiapkan diri untuk perawatan pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menolak untuk memperbolehkan mahasiswa melakukan perawatan pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Metode/ gaya pengajaran yang tidak efektif	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak fleksibel, kaku dan otoriter	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat pernyataan tentang ketidaktertarikan untuk bekerja dengan mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menjaga jarak dan bersikap dingin terhadap orang lain (tidak dapat didekati, menolak pendapat mahasiswa/staf pengajar)	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Menolak atau tidak mau menjawab pertanyaan	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Memberikan penilaian secara subyektif atas mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Meremehkan orang lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Meninggikan diri sendiri, bersikap angkuh terhadap orang lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengancam mahasiswa untuk mengagalkan mahasiswa (tidak lulus) apabila tidak melakukan permintaan perawat	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Berperilaku kasar terhadap orang lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Tidak bersedia menanggapi mahasiswa saat berada di unit perawatan pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mengambil alih pekerjaan mahasiswa saat melakukan perawatan pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

17. Daftar berikut ini merupakan perilaku **PERAWAT** yang bisa dianggap ***mengancam/membahayakan***. Mohon **lingkari** apakah perilaku ini pernah terjadi pada Anda atau seseorang yang Anda kenal dalam lingkungan pendidikan keperawatan selama 12 bulan terakhir.

PERAWAT	**Apakah Anda mempertimbangkan perilaku ini mengganggu?**				**Seberapa sering setiap perilaku terjadi selama 12 bulan terakhir**			
	Tidak Pernah		**Kadang[2]**	**Biasanya Selalu**	**Tidak Pernah**		**Kadang[2]**	**Biasanya Selalu**
Sikap yang mengejek atau tidak menghormati mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sikap yang mengejek atau tidak menghormati staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sikap yang mengejek atau tidak menghormati perawat lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sikap yang mengejek atau tidak menghormati pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sikap yang menantang pengetahuan atau kredibilitas staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Sikap yang menantang pengetahuan atau kredibilitas perawat lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada perawat lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang melecehkan (ras, etnik, gender) kepada pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada perawat lain	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat komentar langsung yang kasar kepada pasien	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap mahasiswa	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat ancaman kekerasan fisik terhadap staf pengajar	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Merusak barang-barang	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Membuat pernyataan tentang kemudahan mendapatkan senjata api atau benda tajam.	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Melalaikan pasien dalam area klinik	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mencatat perawatan pasien tidak lengkap	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**

18. Menurut Anda, sejauh mana tindakan *incivility* dalam lingkungan akademik keperawatan merupakan sebuah masalah? **Mohon beri tanda (v)**
    - ○ Sama sekali bukan masalah
    - ○ Masalah ringan
    - ○ Cukup menjadi masalah (*moderate*)
    - ○ Masalah serius
    - ○ Saya tidak tahu/tidak dapat menjawab

19. Berdasarkan pengalaman atau persepsi Anda, bagaimana pendapat Anda tentang kemungkinan mahasiswa atau staf pengajar (pengajar/pembimbing klinik/perawat) untuk terlibat dalam perilaku *uncivil* di dalam **ruang kelas**? **Mohon beri tanda (v)**
    - ○ Anggota staf pengajar lebih besar kemungkinannya
    - ○ Anggota staf pengajar lebih kecil kemungkinannya
    - ○ Sama saja antara staf pengajar dan mahasiswa
    - ○ Mahasiswa lebih kecil kemungkinannya
    - ○ Mahasiswa lebih besar kemungkinannya
    - ○ Tidak Tahu

20. Berdasarkan pengalaman atau persepsi Anda, bagaimana pendapat anda tentang kemungkinan mahasiswa atau staf pengajar (pengajar/pembimbing klinik/perawat) untuk terlibat dalam perilaku *uncivil* di dalam **laboratorium keterampilan**?
    Mohon beri tanda (v)
    - ○ Anggota staf pengajar/ *clinical educator* lebih besar kemungkinannya
    - ○ Anggota staf pengajar/ *clinical educator* lebih kecil kemungkinannya
    - ○ Sama saja antara staf pengajar / *clinical educator* dan mahasiswa
    - ○ Mahasiswa lebih kecil kemungkinannya
    - ○ Mahasiswa lebih besar kemungkinannya
    - ○ Tidak Tahu

21. Berdasarkan pengalaman atau persepsi Anda, bagaimana pendapat anda tentang kemungkinan mahasiswa atau staf pengajar/*clinical educator* atau perawat lebih mungkin terlibat dalam perilaku *uncivil* di **praktik klinik**? **Mohon beri tanda (v)** (**Jika mungkin, pilih lebih dari satu**)

    - ○ Anggota staf pengajar/ *clinical educator* lebih kecil kemungkinannya
    - ○ Anggota staf pengajar/ *clinical educator* lebih besar kemungkinannya
    - ○ Perawat lebih kecil kemungkinannya
    - ○ Perawat lebih besar kemungkinannya
    - ○ Mahasiswa lebih kecil kemungkinannya
    - ○ Mahasiswa lebih besar kemungkinannya
    - ○ Sama saja
    - ○ Tidak Tahu

22. Menurut pendapat Anda, **mengapa** (alasannya) Anda pikir *incivility* terjadi di lingkungan akademik?

23. Berikan **<u>contoh</u>** perilaku *uncivil* yang terjadi di lingkungan akademik (**ruang kelas, laboratorium keterampilan dan praktik klinik**)?

24. Tolong deskripsikan bagaimana mahasiswa, anggota staf pengajar, perawat dan universtas seharusnya **mengatasi** incivility dalam lingkungan akademik

25. Apa **perbedaan** perilaku *uncivil* yang terlihat dalam ruang kelas, laboratorium keterampilan dan di unit klinik?

26. Menurut pendapat Anda, dimana perilaku *uncivil* **paling sering terjadi**?
Mohon beri tanda (v)

○ Ruang kelas tradisional ○ Laboratorium Keterampilan ○ Unit Klinik

Terima Kasih Banyak untuk partisipasi Anda

Kuesioner ini (INE Survey) digunakan atas ijin Dr. Cynthia Clark, Profesor, Boise State University (email: cclark@boisestate.edu) dan Dr. Jennifer Wibbenmeyer Beck, Dekan and Asosiat Profesor, School of Nursing, Our Lady of the Lake College, LA (email: jbeck@ololcollege.edu)

Note:
Saya tertarik untuk ikut serta dalam **interview** berkenaan dengan *incivility* di pendidikan keperawatan, tolong hubungi saya dengan:
e-mail:_____
atau telepon genggam:_____

Nomor studi volunter

Appendix nineteen: Observation guideline

Observation Guideline

Date :
Observer name :
Setting :
Forms of observation: Field notes
Time:
Aspects that will be observed (Polit, D.F., & Beck, C.T., 2006):

1. *Physical Setting*-"dimana". Dimana aktivitas ini diadakan?
   (Physical Setting- Where. Where is the activity?)
2. Partisipan-"siapa". Siapa yang hadir? Apa karakteristik mereka? Apa peran mereka? Apa yang membuat partisipan ini berkumpul bersama.
   (Participant-Who. Who is present? What are their characteristics? What are their roles?)
3. Aktivitas-"apa". Apa yang sedang terjadi? Apa yang dilakukan partisipan? Bagaimana partisipan berinteraksi satu dengan lainnya. Metode apa yang digunakan partisipan untuk berkomunikasi, dan seberapa sering mereka melakukan hal tersebut.
   (Activities- What. What is going on? What are the participants doing? How participants interact each other? What method that is using for communications and how often they do that?)
4. Frekuensi dan Durasi-"kapan". Kapan aktivitas dimulai dan berakhir? Apakah aktivitas tersebut berkelanjutan? Seberapa sering hal tersebut terjadi?
   (Frequency and duration- When. When the activitybegin and ended? Are their activities will be continue? How often such activities occur?)
5. Proses-"bagaimana". Bagaimana pengaturan aktivitas/kegiatan? Bagaimana cara partisipan berinteraksi dan berkomunikasi?
   (Process- How. How the arrangement of the activities? How the activities interact and communicate?
6. Hasil-"mengapa". Mengapa aktivitas/kegiatan ini terjadi? Atau mengapa tindakan/perilaku ini terjadi?
   (Result- Why. Why the activities occurred? Or why the actions/ behaviour occurred?)

Appendix twenty: Semi-structured interview guideline

Semi-structured Interview Guideline

Date	:
Interviewee	:
Sign	:
Year in school	:
DOB	:
Gender	:
University	:
Interviewer	:
Sign	:

Interview Questions:

1. Tolong ceritakan tentang kegiatan sehari-hari Anda di fakultas keperawatan (*Tell me about your typical day in nursing school*)
2. Tolong ceritakan tentang ketertarikan Anda dalam keperawatan (*Tell me about your interest in nursing*)
3. Tolong gambarkan secara rinci pengalaman Anda mengenai perilaku uncivil di ruang kelas (dengan teman/mahasiswa Anda dan staf pengajar) (*Please described in detail your experience regarding uncivil behaviour in classroom ; with your friends and faculty staff*)
4. Bagaimana Anda bereaksi saat itu (melihat/mengalami perilaku uncivil) (*How did you react on that time?*)
5. Tolong gambarkan secara rinci pengalaman Anda mengenai perilaku uncivil di praktik klinis (dengan teman/mahasiswa, staf pengajar, perawat dan pasien) (*Please described in detail your experience regarding uncivil behaviour in clinical practice ;with your friends, faculty staff, nurses and patients*)
6. Bagaimana Anda bereaksi saat itu (melihat/mengalami perilaku uncivil) (*How did you react on that time?)*

Note:

Appendix twenty one: Interview respondents at the private FoN

Respondents	*Initial/ Gender*	*Backgrounds*		
		Ethnicity	*Religion/ religious faith (mean of 4)*	*Socio-economic status*
Academics	A/f	Chinese	Christian/ 3.6	Clinical educator/undergraduate/income 4,500,001-6,000,000 rupiahs or 300-400 GBP
	B/f	Batak	Christian/ 3.6	Clinical educator/undergraduate/income 3,000,001-4,500,000 rupiahs or 200-300 GBP
	C/f	Batak	Christian/ 3.8	Lecturer/master degree/ income above 6,000,000 rupiahs or 400 GBP
	D/m	Batak	Christian/ 4	Lecturer/ master degree/ income above 6,000,000 rupiahs or 400 GBP
	E/f	Javanese	Catholic/ 4	Lecturer/ doctoral degree/income above 6,000,000 rupiahs or 400 GBP
Students	F/f	Batak	Christian/2.4	Father: undergraduate degree, government employee, income 3,000,001-4,500,000 rupiahs or 200-300 GBP; mother: undergraduate degree, government employee, income 3,000,001-4,500,000 rupiahs or 200-300 GBP
	G/m	Balinese	Hindu/ 3.6	Private employee (nurse)/diploma degree/ above 6,000,000 rupiahs or 400 GBP
	H/f	Javanese	Catholic/ 3.8	Private employee (nurse)/diploma degree/ 1,500,000 – 3,000,000 rupiahs or 100-200 GBP
	I/f	Mixed (manadonese-chinese japan)	Christian/ 2.8	Father: high school degree, entrepreneur, income above 6,000,000 or 400 GBP; mother: high school degree, housewife
	J/f	Chinese	Christian/ 3.6	Father: elementary school degree, private employee, income 3,000,001-4,500,000 rupiahs or 200-300 GBP; mother: elementary school degree, housewife.
	K/f	Mixed (east java-betawi)	Islam/ 3.2	Father: high school degree, entrepreneur, income 3,000,001-4,500,000 rupiahs or 200-300 GBP; mother: high school degree, entrepreneur, income 3,000,001-4,500,000 rupiahs or 200-300 GBP
	L/f	Papua	Christian/ 3.8	Father: undergraduate degree, government employee, income 1,500,000 – 3,000,000 rupiahs or 100-200 GBP; mother: elementary school degree, housewife.
	M/m	Mixed (Batak-Javanese)	Christian/ 3	Private employee (hca), high school degree, income 1,500,000 – 3,000,000 rupiahs or 100-200 GBP.
	N/f	Javanese	Islam/3.6	Private employee (lab analyst), high school degree, income 1,500,000 – 3,000,000 rupiahs or 100-200 GBP.

Appendix twenty one: Interview respondents at the public FoN

Respondents	*Initial/ Gender*	*Backgrounds*		
		Ethnicity	*Religion/ religious faith (mean of 4)*	*Socio-economic status*
Academics	AA/m	Batak	Christian/ 3.6	Lecturer/ master degree/ income above 6,000,000 rupiahs
	BB/m	Malay	Islam/ 3.6	Lecturer/ master degree/ income above 6,000,000 rupiahs
	CC/f	Batak (Karo)	Islam/3.8	Lecturer/master degree/ income above 6,000,000 rupiahs
	DD/f	Batak (Toba)	Islam/4	Lecturer/ master degree/ income above 6,000,000 rupiahs
	EE/f	Javanese	Islam/3.6	Lecturer/ master degree/ income above 6,000,000 rupiahs
Students	FF/f	Batak	Christian/3.6	Father: undergraduate degree, government employee, income 1,500,000-3,000,000; mother: undergraduate degree, government employee, income 1,500,000-3,000,000
	GG/m	Mixed (Javanese-Aceh/Gayo)	Islam / 3.8	Father: junior school degree, entrepreneur, income 1,500,000-3,000,000; mother: high school degree, entrepreneur, income 1,500,000-3,000,000
	HH/f	Batak	Catholic/ 3.8	Father: high school degree, government employee, income 1,500,000-3,000,000; mother: high school degree, government employee, income 1,500,000-3,000,000
	II/m	Batak	Christian/ 3	Father: junior school degree, farmer, 1,500,000-3,000,000; mother: high school degree, farmer, income 1,500,000-3,000,000
	JJ/f	Minangkabau	Islam / 3.8	Semester eight student; private teacher, income under 1,500,000
	KK/f	Minangkabau	Islam/ 3.4	Father: high school degree, entrepreneur, income under 1,500,000; mother: high school degree, private employee, under 1,500,000
	LL/f	Batak (Mixed sub-Batakness Karo -Toba)	Christian/ 3.2	Father: undergraduate degree, private employee, income 1,500,000 – 3,000,000; mother: high school degree, housewife.
	MM/f	Aceh	Islam /3.2	Father: high school degree, retirement, income 1,500,000-3,000,000; mother: high school degree, housewife
	NN/m	Batak (Mandailing)	Islam/3.6	Father: undergraduate degree, private employee, income 1,500,000 – 3,000,000; mother: high school degree, private employee, income 1,500,000 – 3,000,000

Appendix twenty two:
Published Article-Perceived Uncivil Behaviour in Indonesian Nursing Education

Nurse Education in Practice 20 (2016) 99–108

Contents lists available at ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/nepr

Perceived uncivil behaviour in Indonesian nursing education

Ni Gusti Ayu Eka [a, b, *], Derek Chambers [b], Aru Narayanasamy [b]

[a] Faculty of Nursing Universitas Pelita Harapan, Indonesia
[b] Faculty of Health Science University of Nottingham, UK

ARTICLE INFO

Article history:
Received 9 October 2014
Received in revised form
14 June 2016
Accepted 28 July 2016

Keywords:
Uncivil behaviour
Nursing education
Indonesia

ABSTRACT

Uncivil behaviour is a phenomenon that has attracted a growing number of investigations, particularly in Western based nurse education. Unlike the West, uncivil behaviour is a relatively new field of study to Indonesia. However, with the incidence of incivility becoming a growing problem within Indonesian nurse education it is one that warrants investigation. This study investigated; the construct of uncivil behaviour and how it is perceived by students and faculty within the Indonesia context. The impact that socio economic status may play in its manifestation is also explored. The study was conducted in two faculties of nursing in the west of Indonesia. Findings suggest that religion is strongly implicated in the way that uncivil behaviour is perceived.

1. Introduction

Indonesia is a developing country that has more than 700 ethnicities and diverse socio-economic backgrounds and has six officially recognised religions (Mandryk, 2010). Although its diversity enriches the country it has been argued that its multiple ethnicities and religions, coupled with economic factors, have led to conflicts (Chowdhury and Rammohan, 2006; Rahmawati, 2001). These factors have led to moderate-intensity conflicts such as those that occurred in the regions of Maluku, Aceh, Papua, Poso and Sampit (Purnomo and Septina, 2004).

Habibie (2012; p.10) a former Indonesian president, proposed that *"culture, religion or beliefs influence the behaviour and character of humans"* in Indonesia Significantly, ethnicity, religion and socio-economic status (SES) have influenced the social dynamic of the citizens in Indonesia. These factors intersect in all aspects of life, including the social transactions that occur in the Indonesian Higher Education system such as the universities where this study took place.

As with many other countries (Nilson and Jackson, 2004) one of the main challenges currently facing Indonesia's Higher Education system is the growing incidence of uncivil behaviour in the learning environment particularly: academic plagiarism (Adiningrum, 2011), cheating in examinations (Rangkuti, 2011) and bullying (Lai et al., 2008; Rangkuti, 2011). All of which have been described, along with a host of other behaviours, as uncivil behaviour (Clark, 2006; Alexander-Snow, 2004; Tiberius and Flak, 1999). However, most incivility studies, including those in nursing education, have been conducted in Western countries which are culturally very different to Indonesia. Consequently their findings have been difficult to apply to the Indonesian context. In addition those investigations that have been undertaken have tended to focus on the manifestation of uncivil behaviour (Luparell, 2007) with relatively little attention being given to the factors that may influence such behaviour including ethnicity, religious faith and socio-economic status (Anthony and Yastik, 2011; Beck, 2009; Marchiondo et al., 2010). Yet all of these factors appear to contribute to uncivil behaviour in nursing education in Indonesia. For instance, Sutantoputri and Watt (2013) found that religion plays an important aspect of the academic environment in Indonesia to the extent that it might be one predictor of motivational goals in higher education. Thus Sutantoputri and Watt (2013) suggest that a students' religious background could influence the lengths they will go to in order to attain high marks in their degree in the form of plagiarism. Such behaviour could, therefore, encompass both uncivil as well as civil behaviour.

The few studies that have investigated the role that ethnicity, religious faith and SES play in uncivil behaviour have found a correlation between them (Abbotts et al., 2004; Altmiller, 2012; Alexander-Snow, 2004; Ellison et al., 1996; Chaux et al., 2009; Due

This paper was presented at NETNEP 2014.

* Corresponding author. Faculty of Nursing Universitas Pelita Harapan, UK.
E-mail addresses: gusti.eka@uph.edu (N.G.A. Eka), derek.chambers@nottingham.ac.uk (D. Chambers), aru.narayanasamy@nottingham.ac.uk (A. Narayanasamy).

http://dx.doi.org/10.1016/j.nepr.2016.07.007
1471-5953/

et al., 2009; Thomas, 2003). But again the relationship between these factors and incivility have not been fully explored or developed within the Indonesia context and particularly not in nursing education.

Uncivil behaviour in nursing education is probably a microcosm of uncivil behaviour problems in Indonesian society generally. If these problems could be managed, uncivil behaviour may be minimised. Hence, there is a need for more empirical studies exploring uncivil behaviours in Asian countries generally including Indonesia.

2. Indonesia's professional body requirements

Within Indonesia Registered nurses are required to follow the Indonesian Nursing Code of Practice (Indonesian National Nurses Association/INNA, 2014). As future registrants, students of nursing are expected to follow the student nurses' conduct of practice which has similarities with the Nurses' Code of Practice. As such they are expected to display civil behaviour in both the classroom and clinical placements.

3. Review of the literature

3.1. Defining the term uncivil behaviour

As identified above the term uncivil behaviour has been used to describe a set of behaviours deemed to be unacceptable within an education setting and have raised growing concerns in nursing education settings globally (Hunt and Marini, 2012; Eka, Sitompul and Solely, 2013; Clark and Springer, 2010; Clark et al., 2010; Marchiondo et al., 2010; Randle, 2003; Lashley and de Meneses, 2001).

Forms that uncivil behaviour can take vary and include inappropriate communication, professional relationship issues, self-management issues, and general lack of regard for others (Altmiller, 2012; Clark and Springer, 2007b; Lashley and de Meneses, 2001; Thomas and Burk, 2009). Uncivil behaviour can encompass some behaviours (Table 1) that many academics and students may not find disruptive, such as acting bored or disinterested, fidgeting (Bjorklund and a Rehling, 2010), failing to take notes in a lecture and dominating discussions (Rowland and Srisukho, 2009).

Within nursing, these forms of uncivil behaviour are not confined to the classroom but have also been found to be present within other learning environments such as skills laboratories and clinical practice. The impact that uncivil behaviour has on those subjected to them can be severe with victims experiencing psychological symptoms such as emotional stress, physical attack or both (Longo, 2010; Luparell, 2007).

Within the literature, uncivil behaviour is also known as incivility, disturbing behaviour, lateral or horizontal violence and bullying (e.g. Hunt and Marini, 2012; Clark, 2008; Randle, 2003; Lashley and de Meneses, 2001). Within nurse education, incivility has been defined as 'rude or disruptive behaviours which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations' (Clark et al., 2009, p.7).

For this study, the terms uncivil behaviour and incivility are used interchangeably to describe all forms of unacceptable behaviour within the learning context. But in doing so, it is acknowledged that differing forms of uncivil behaviour will require different strategies to address them. Moreover the main concern of this study was to explore students and faculty perceptions of incivility, it was, therefore, felt important not to limit the behaviours that constitute it to those in the literature.

3.2. The role of demography in uncivil behaviour

Previous studies have endeavored to identify the factors that may contribute to incivility in the classroom. Beckmann et al. (2013), Clarke et al. (2012) and Marchiondo et al. (2010) suggest that race, gender, age, year of study and institution size are not significantly related to uncivil behaviour. Support for these findings come from a study undertaken by the Incivility in Nursed Education (Gallo, 2012), which also found that no significant correlations existed between incivility and demographic characteristics. This is further supported by Daniel et al. (1994) and Clark and Springer (2007a, 2007b). Daniel et al. (1994) reported that age, marital status, application to learning and the cognitive ability of students were not related to academic misconduct.

Studies that have investigated perceptions of uncivil behaviour have produced conflicting results. For example Clark and Springer (2007a, 2007b) found that younger and older respondents' perceptions of uncivil behaviour were similar at a public university in the north-western United States. However, other studies have found the converse to be true (Robertson, 2012). For example, a study by Leiter et al. (2010) compared two generations: Generation X (born 1961–1981) and 'baby boomers' (born 1943–1960). The Generation X nurses reported a greater incidence of uncivil behaviour in the workplace than the 'baby boomers'. Incivility included 'disrespectful, rude or condescending behaviour' (p. 974).

These inconsistencies have raised important questions about the role that demographic factors play in the manifestation and perceptions of uncivil behaviour and there has subsequently been a call from nurse authors to further investigate the relationship (Anthony and Yastik, 2011; Beck, 2009; Marchiondo et al., 2010; Olive, 2006). Given the growing incidence of phenomena in nurse education, it is important to determine to what extent demography plays in uncivil behaviour if it is to be understood and better managed.

Thus the research question that guided this study was "How do Indonesian nursing students and faculty perceive uncivil behaviour in the context of their ethnicity, religious faith and socio-economic backgrounds?"

The proposition developed for the study is: "There are different perceptions of uncivil behaviours between academic staff and students based on their ethnicity, religious beliefs and socio-economic status".

4. Methods

A case study methodology was selected to achieve the aims of the study in order to provide an in-depth understanding of the phenomena (Yin, 2009; Stake, 2006). The study was conducted as part of an ongoing doctoral program Ethical approval for the study was obtained from the university's Institutional Review Board and the faculties of nursing in which the study took place.

Nursing students and academic staff at two Faculties of Nursing (one private and one public university) in the western part of Indonesia took part in the study. The private faculty of nursing is a part of private Christian university, whilst the public faculty of nursing is a part of non-specific religion based university. The private universities recruit two types of nursing students: students from upper secondary education ('regular' cohorts) and nurses with a diploma qualification (conversion cohorts) who intend to upgrade their nursing diploma to a degree in nursing. Both faculties of nursing deliver academic and professional programs. The academic program covers seven to eight semesters for the 'regular cohorts' and two to three semesters for the conversion cohorts to achieve the Academic Degree: Bachelor of Nursing/*Sarjana*. The professional program covers two semesters to obtain a Professional

Degree/*Ners*. This professional program covers two semesters of clinical practice in different areas of nursing care, including hospitals and community.

Participants of the study were recruited using purposive sampling. Student' participants respondents were third and fourth year students in the academic program and professional programs. Third and fourth year students were chosen for their experience of clinical placement areas. However, owing to the curricula between 'regular' and conversion classes being different at the public faculty of nursing no conversion students (diploma nursing students who pursue their bachelor degree) were included in the study.

Faculty participants were required to have a minimum of one year experience as a nurse educator (lecturer/assistant lecturer/clinical) within their respective faculty in order to ensure they had an adequate level of experience in the setting.

Data collection was carried out using a survey and semi-structured interviews. However, only the results of the survey are being reported in this paper.

Three questionnaires were used in the survey including:

1) A modified Incivility in Nursing Education/INE questionnaire (Clark et al., 2009; Beck, 2009) that describes perceived uncivil behaviour in nursing education settings including classrooms, skills laboratories and clinical practices;
2) The Multigroup Ethnic Identity Measure/MEIM (Phinney, 1992) that identifies ethnicity identity;
3) Abbreviated Santa Clara Strength of Religious Faith Questionnaire/ASCSRF (Plante and Boccaccini, 2002) that portrays religious faith or practice.

The questionnaires were chosen for their applicability to the study and because they had already been tested for validity and reliability. However, as the questionnaires were originally developed for English speaking respondents they had to be translated into Indonesian to accommodate language differences.

The translation was undertaken by an Indonesian faculty member from the private university who is fluent in English. The translated version of the questionnaire was then checked for accuracy by an independent party. The author and the translator met to compare the two versions and to ensure that each item retained its original meaning. This resulted in some questions being refined to further improve similarity of meaning between the Indonesian and original English versions.

After refining the questionnaire, a pilot study was conducted to test its readability, validity and reliability by giving the questionnaire to 20 students. The content validity was convincing since the INE survey had been evaluated by experts (Clark et al., 2009) and was assured by careful translation (Scanlan, 2003). The coefficient Cronbach value is between 0.830 and 0.993, giving the questionnaire a high degree of internal consistency (Field, 2013). Based on the pilot study, some of the questions were reworded again to improve their understanding by Indonesians. The final questionnaire consisted of 156 questions with 4 of them being open ended and 152 being closed questions.

Data were collected over an eight month period from September 2012 to April 2013. At the private faculty of nursing, the respondents that agreed to be respondents were 108 (101 students, 7 Academic staff), yet the total number of valid questionnaires was 102 respondents that consisted of 96 students (73.28% of response rate) and 6 academic staff (86.71% of response rate). At the public faculty of nursing, the respondents that agreed to be respondents were 236 (216 students, 20 Academic staff), but the total number of valid questionnaires was 204 questionnaires that consisted of 185 students (85.64% of response rate) and 19 academics (95% of response rate) at the public faculty of nursing. In total there were 306 responses to the survey (private faculty of nursing 102 and public faculty of nursing 204).

Moreover, one of the data collectors of this study was a lecturer at the same university as participants in one faculty of nursing in which this role might influence the lecturer feelings, especially when interviewing her own students as the respondents. The students as the respondents may also provide opinions tailored to suit the lecturer (i.e. providing what they believe to be desirable responses) rather than reflecting the empirical truth. However, since the participants were from two different nursing schools, one of which was totally unrelated to the lecturer personally, this could

Table 1
Descriptions of uncivil student behaviour.

Description of uncivil behaviour		Author(s)
Yawning	Packing up books before class is over	Bjorklund and Rehling (2010)
Nose blowing	Using a palm pilot, iPod or computer for non-class activities	
Nodding or smiling in response to others' comments	Getting up during class, leaving and returning Nonverbally indicating	
Continuing to talk after being asked to stop Attending class under the influence of alcohol or drugs	dissatisfaction with an assignment, activity or grade	
	Fidgeting that distracts others	
Allowing a mobile phone to ring	Doing homework for other classes	
Conversing loudly with others	Displaying inattentive posture or facial expressions	
Nonverbally showing disrespect for others	Questioning the value of an assignment or activity	
Swearing	Reading non-class material	
Sleeping in class	Discarding trash after class has begun	
Making disparaging remarks	Eating and drinking	
Arriving late and/or leaving early		
Text messaging		
Late arrivals or early departures from class	Inattention	Feldmann (2001)
Using mobile phones and pagers during class	wearing inappropriate attire	
Acting bored or apathetic	Arriving late and leaving early	Royce (2000)
Disapproving groans	Missing lectures	
Sleeping in class	Cheating in examinations and/or quizzes	
Chewing gum in class	Belittling other students	
Sarcastic remarks or gestures	Challenging your knowledge or credibility in class	
Not paying attention in class	Harassing comments	
Reluctance to answer direct questions	Hostile verbal attacks or challenges	
Eating in class	Vulgarity	
Using mobile phones during class	Threats of physical harm	
Talking in class		

have minimised the bias that might otherwise have influenced the study. In addition, continuous reports and discussion among the researchers provided an opportunity to offset any potential biases and to promote neutral objectivity.

Data from the survey were analysed using descriptive and non-parametric statistical analysis (IBM SPSS Statistics 21-University of Nottingham). A thematic analysis was applied to the analysis of the open-ended questions (Braun and Clark, 2006). Only data collection from the survey is reported in this paper since the study is still progressing.

5. Results

The data elicited from both students and academic staff from the private and public faculty of nursing were compared in order to understand the similarities and the differences regarding uncivil behaviour between the two institutions.

Table 2 describes that most of the academic staff at the private faculty of nursing are female (5 of 6), age range 31–35 years old (2 of 6) and above 40 (2 of 6), Christian (5 of 6), Indo Malay (5 of 6), and have between 6 and 10 years (3 of 6), have a monthly income above 6,000,000 rupiahs (300 GBP) (4 of 6). Characteristics of the academic respondents at the public faculty of nursing are female (15 of 19), age range 36–40 years old (10 of 19), Islam (17 of 19), Indo Malay (19 of 19), have worked as lecturer with working experiences between 11 and 15 years (10 of 19), have monthly income above 6,000,000 rupiahs/300 GBP (8 of 19).

Table 3 identifies that the majority of students at the private faculty of nursing are female (78%), with an age range of 20–25 years old (68%), Christian (65%), Indo Malay (58%) with Bataknese as the most sub-ethnic background. Their fathers had completed an undergraduate education and mothers have a high school education, both parents' work and have an income each of 1,500,000–3,000,000 rupiahs per month (75–150 GBP). Most of the students at the public faculty of nursing are female (88.65%), age range 20–25 years old (100%), Christian (51.35%), Indo Malay (89.72%) with Bataknese as the most sub-ethnic background, parents have completed a high school education, both parents work and have an income each of 1,500,000–3,000,000 rupiahs per month (75–150 GBP).

The findings (see Table 4) suggest that incivility is a serious problem in both educational settings as identified by 5 of the 6 academic staff and 49% of the students at the private faculty of nursing; 10 of the 19 academic staff and 44.86% of the students at the public faculty of nursing. The respondents at both faculty of nursing further agree that academic staff and students are more likely to engage in uncivil behaviour in both the classroom (Table 5) and skills laboratory (Table 6).

Moreover, Table 7 shows that there are different opinions between academic staff and students regarding who is more likely to engage in uncivil behaviour in clinical practice. The majority of the academic staff at the private faculty of nursing state that students, academic staff/clinical educators and practitioners are equally likely to engage in uncivil behaviour in the clinical practice. In contrast, most of the students felt that practitioners are more likely to do so. The majority of the academic staff at the public faculty of nursing state that nurses are much more likely to engage in incivility in clinical practice. Whereas most of the students asserted that students, academic staff/clinical educators, and practitioners were equally likely to do so. Respondents from both faculties of nursing further agree that the incidence of uncivil behaviour is more prevalent in the classroom as compared to the clinical practice and the skills laboratory (Table 8).

The ethnic identities and religious practice data were further analysed using Mann Whitney *U* test. Table 9 shows that there are no statistically significant differences in ethnic identity between students and academic staff ($p > 0.05$) at either faculty of nursing. Table 6 also demonstrates that there is no statistically significant difference in the religious faith/practices between students and academic staff ($p > 0.05$) at the private faculty of nursing. In contrast, there is a statistically significant difference of religious faith/practice between students and academic staff ($p < 0.05$).

The data analysis using Kruskall Wallis test revealed that there are three similar differences in respondents' perceptions of uncivil behaviour at both faculties of nursing (Table 10). First, there is a significant difference regarding perceived students threatening behaviour that is considered disruptive ($p < 0.05$) based on respondents' religions. Second, there is a significant difference in what faculty members perceive as being disruptive behaviour ($p < 0.05$) based on respondents' religions. Third, there is a significant difference regarding perceived academics' threatening behaviour that is considered disruptive ($p < 0.05$) based on respondents' religions (see Table 10).

Follow up analyses (Field, 2013) revealed that religious backgrounds including Islam, Christian, and Catholic is a determining factor in the ways in which students perceive and consider disruptive and threating behaviour at the private faculty of nursing. This finding was replicated amongst academics' at the private faculty of nursing.

The respondents also provide suggestions of the ways uncivil behaviour can be addressed in nursing education. Three themes emerged including: promoting effective communication and relationships; presenting self professionally and the implementation of rules designed to limit uncivil behaviour. These themes are presented with illustrative examples from the academic staff and students at both faculties of nursing (Table 11).

6. Discussion

This study assesses perceptions of academic staff and students at two faculties of nursing in Western Indonesia. Most of the academic staff and student participants at the two faculties of nursing perceive incivility as being a serious issue which warrants urgent action. However, more respondents perceive uncivil behaviour as a mild problem at the private faculty of nursing whilst respondents from the public faculty of nursing do not see it has a problem. This may be due to the lack of awareness regarding the incidences of uncivil behaviour at the public faculty of nursing. In other words, people involved at the public faculty of nursing might perceive that the behaviour is a common occurrence in the academic setting or even in the community. This calls for further exploration of how constructs behaviours as uncivil and who conducts the behaviours uncivilly.

The reasons why uncivil behaviour is perceived differently by different people maybe because our perceptions of uncivil behaviour are determined by a number of factors including people's context or personal experiences, values and beliefs (Clark, 2013; Robertson, 2012). Perpetrators may perceive it be normal, while recipients may perceive it as uncivil. The concept (and perception) of uncivil behaviour is, therefore, socially constructed and subject to expansion and development (Lawler and Thye, 1999; Moffat, 2001).

There is also the danger that what are considered to be acts of 'fun' and harmless gestures by students' are construed as uncivil behaviour when they occur in an academic setting. For example, sarcasm, teasing and the use of an inappropriate voice tone. However, the literature in this area is unequivocal that certain behaviours are considered uncivil (Altmiller, 2012; Clark and Springer, 2007b; Lashley and de Meneses, 2001; Thomas and Burk, 2009).

When providing their opinion on who engages in incivility, the

respondents propose that both academic staff and students are the perpetrators of uncivil behaviours in the classroom as well as in the skills laboratory. The engagement of uncivil behaviours between students and academic staff could lead to poor interactions between them. This suggestion is supported by a previous Indonesian study by Fraser et al. (2010). This study showed that when a teachers behaviour was perceived as being admonishing and strict, it was negatively related to student course achievement scores ($p < 0.05$). On the other hand, the helpful/friendly and understanding behaviour of the teacher was positively related to student course achievement scores ($p < 0.01$). In other words, to achieve the learning goals, positive interactions between academic staff and student are needed such as supportive behaviour and respecting others. These behaviours are also considered to be civil behaviour.

Interestingly, there were differences of opinion among respondents when reporting the perpetrators of uncivil behaviour in clinical practice. The majority of academic staff (50%) at the private faculty of nursing and the majority of students (30.53%) at the public faculty of nursing reported that students or academic staff/clinical educator or nurses were equally responsible for incidences of uncivil behaviour in clinical practice. In contrast, the majority of academic staff (42.11%) at the public faculty of nursing reported that clinical nurses were much more likely to engage in uncivil behaviour. In addition, the majority of students (37.4%) at the private faculty of nursing reported that nurses were slightly more likely to display uncivil behaviour in clinical practice. The different responses might be due to the respondents' lived experience, especially in the clinical settings. For example, students at the private faculty of nursing have experience clinical placements during the second year of their academic and professional program. The academic program is spread over seven to eight semesters in order to achieve the Academic Degree. The professional program covers two semesters that consist of clinical practice in the health care settings to obtain a Professional Degree. In contrast, students at the public faculty of nursing have clinical placements only when attending the professional program. In addition, the academic staff members at the public faculty of nursing have more working experience than the academic staff at the private faculty of nursing. Therefore, it could be said that academic staff at the public faculty of nursing have exposure more in clinical practice settings than academic staff at the private faculty of nursing.

Despite different opinions of the perpetrators of incivility in this study, a previous study (Clarke et al., 2012) identified that the most perpetrators in clinical practice were clinical instructors (30.22%) and staff nurses (25.49%), Thus, Clarke's study supported the opinions of the academic staff at the public faculty of nursing and students at the private faculty of nursing in this study.

The respondents (academic staff and students) further perceive that the classroom is the most prevalent place of incivility incidences compared to the skills laboratory and clinical practice. This might be due to them being unawareness of the existence of ground rules in the classroom or policies in clinical practice (Longo, 2010; Suplee et al., 2008). Furthermore, inconsistencies in teaching and learning styles adopted by teachers and the varied nature of classroom activities may have contributed to such conceptions (Clark, 2013; Boice, 1996). For example, a teacher should be capable of adopting an educational approach that is congruent with a range of students' learning styles (Clark, 2013).

Further research is required to establish if classroom dynamics and teachers personalities might be factors influencing such perceptions of uncivil behaviour. Boice (1996) argued that the main contributor of classroom incivility could be academic staff members' unfriendly attitudes, particularly at the beginning of courses. An academics unfriendly attitude could serve to demotivate students, resulting in a lack of engagement and involvement in the learning process (Boice, 1996).

In contrast, the skills laboratory is the least prevalent place of incidences of incivility. This situation could occur due to skills laboratory having a clear set of rules or procedures (Beck, 2009). After the classroom the next most likely place for uncivil behaviour to occur was the clinical unit way. One reason that might explain this could be work environment stress (Altmiller, 2012; Clark and Springer, 2007b). On the other hand, uncivil behaviour could be used as a way of relieving stress. As Hoover and Sherrell (2010) identify taking out our stress on others such as 'lashing out, angry outbursts and physical violence' one of many unhealthy strategies used for managing stress even though such behaviours may only reduce stress in the short term.

In regard to the respondents' backgrounds, most of the academic staff and students at both faculties of nursing have similar ethnic identities (Tables 2 and 3). They identify themselves as people who search and affirm their own ethnicity. Both faculties of nursing display similar findings, which may be because most of the respondents share similar ethnicities in both faculties of nursing (Indo Malay/Bataknese). It is further noted that the respondents at the private faculty of nursing are comprised of diverse ethnicities. The respondents at the private faculty of nursing consist of the five main ethnic categories found in Indonesia. The respondents at the

Table 2
Comparisons of academic staff' demographic data between the private and public FoN.

Type of faculty of nursing	Gender (n)	Age ranges in year (n)	Religion (n)	Ethnicity (n)	Length of experiences in year (n)	Monthly income (n)
Private	Female (5) Male (1)	26–30 (1) 31–35 (2) 36–40 (1) >40 (2)	Christian (5) Catholic (1)	Indo Malay (5) Chinese (1)	<5 (2) 6–10 (3) 11–15 (0) 16–20 (0) >20 (1)	1,500,000–3,000,000 (0) /75–150 GBP 3,000,001–4,500,000 rupiahs/201–300 GBP (1) 4,500,001–6,000,000 rupiahs/301–400 GBP (1) 6,000,000 rupiahs /300 GBP (4)
Public	Female (15) Male (4)	26–30 (0) 31–35 (5) 36–40 (10) >40 (4)	Christian (1) Catholic (1) Islam (17)	Indo Malay (19)	<5 (2) 6–10 (6) 11–15 (10) 16–20 (1) >20 (0)	1,500,000–3,000,000 (2) /75–150 GBP 3,000,001–4,500,000 rupiahs/201–300 GBP (5) 4,500,001–6,000,000 rupiahs/301–400 GBP (3) 6,000,000 rupiahs /300 GBP (8) Not completed (1)

Table 3
Comparisons of students' demographic data between the private and public FoN.

Type of faculty of nursing	Gender (n/%)	Age ranges in year (n/%)	Religion (n/%)	Ethnicity (n/%)	Parents' education backgrounds (n/%)	Parents employment (n/%)	Parents' monthly income (n/%)
Private	Female (78/81.3%) Male (17/17.7%) Not completed (1)	20–25 (68/70.8%) 26–30 (11/11.5%) 31–35 (13/13.5%) 36–40 (4/4.2%)	Islam (17/17.7%) Christian (65/67.7%) Catholic (13 13.5%) Hinduism (1/1.0%)	Indo Malay (58/60.4%) Chinese (5/5.2%) Pacific Island people (10/10.4%) Mixed-ethnicities (23/24%)	Fathers: Primary school (4/6.3%) Junior school (2/1.6%) High school (21/32.8%) Undergraduate (26/40.6%) Postgraduate (master) (5/7.8%) Diploma (1/1.6%) Deceased (6/9.4%) Mothers: Primary school (8/12.5%) Junior school (5/7.8%) High school (33/51.6%) Undergraduate (13/20.3%) Postgraduate (master) (3/4.7%) Deceased (1/1.6%) Not completed (2/1.6%)	Fathers: Private employee (16/25%) Government employee (16/25%) Entrepreneurs (14/21.9%) Others (12/17.2%) Deceased (6/9.4%) Not completed (1/1.6%) Mothers: Private employee (8/12.5%) Government employee (10/15.6%) Entrepreneurs (7/10.9%) Others (36/56.3%) Deceased (1/1.6%) Not completed (3/3.1%)	Fathers: <1,500,000 rupiahs) or <100 GBP (2/3.1%) 1,500,000–3,000,000 rupiahs Or 100–200 GBP (23/34.4%) 3,000,001–4,500,000 rupiahs Or 201–300 GBP (14/21.9%) 4,500,001–6,000,000 rupiahs Or 301–400 GBP (9/14.1%) Above 6,000,000 rupiahs Or 400 GBP (8/12.5%) Deceased (6/9.4%) Not completed (3/4.7%) Mothers: <1,500,000 rupiahs) or <100 GBP (10/15.6%) 1,500,000–3,000,000 rupiahs Or 100–200 GBP (14/21.9%) 3,000,001–4,500,000 rupiahs Or 201–300 GBP (7/10.9%) 4,500,001–6,000,000 rupiahs Or 301–400 GBP (2/3.1%) Above 6,000,000 rupiahs Or 400 GBP (4/6.3%) Deceased (1/1.6%) Not completed (27/40.6%)
Public	Female (164/88.65%) Male (21/11.35%)	20–25 (100%)	Christian (95/51.35%) Catholic (6/3.25%) Islam (84/45.4%)	Indo Malay (166/89.72%) Mixed-ethnicities (18/9.73) Not completed (1/0.55%)	Fathers: Primary school (4/2.162%) Junior school (13/7.02%) High school (91/49.19%) Diploma (4/2.162%) Undergraduate (64/34.59%) Postgraduate/master (5/2.70%) Deceased (1/0.54%) Not completed (3/1.63%) Mothers Primary school (13/7.02%) Junior school (10/5.40%) High school (91/49.19%) Diploma (1/0.54%) Undergraduate (62/33.51%) Postgraduate/master (1/0.54%) Deceased (2/1.08%) Not completed (5/2.72%)	Fathers Private employee (24/12.97%) Government employee (87/47.03%) Entrepreneurs (34/18.37%) Others (34/18.37%) Deceased (1/0.55%) Not completed (5/2.8%) Mothers Private employee (8/4.32%) Government employee (88/47.57%) Entrepreneurs (21/11.35%) Others (58/31.35%) Not completed (10/5.41%)	Fathers <1,500,000 or <75 GBP (34/18.37%) 1,500,000–3,000,000 Or 75–150 GBP (81/43.78%) 3,000,001–4,500,000 Or 151–230 GBP (37/20%) 4,500,001–6,000,000 Or 231–300 GBP (18/9.73%) Above 6,000,000 Or above 301 GBP (9/4.86%) Not completed (6/3.26%) Mothers <1,500,000 or <75 GBP (31/16.76%) 1,500,000–3,000,000 Or 75–150 GBP (73/39.46%) 3,000,001–4,500,000 Or 151–230 GBP (30/16.21%) 4,500,001–6,000,000 Or 231–300 GBP (8/4.32%) Above 6,000,000 Or above 301 GBP (2/1.08%) Not completed (41/22.17%)

Table 4
The extent of uncivil behaviour in the nursing academic environment.

Question	Respondents							
	Private FoN				Public FoN			
	Students		Academic staff		Students		Academic staff	
To what extent do you think uncivil behaviour in the nursing academic environment is a problem?	N	%	N	%	N	%	N	%
No problem at all	1	1	0	0	2	1.08	1	5.3
Mild problem	7	7.3	0	0	21	11.35	4	21.1
Moderate problem	41	42.7	1	16.7	73	39.46	4	21.1
Serious problem	47	49	5	83.3	83	44.86	10	52.6
I don't know/can't answer	0	0	0	0	5	2.7	0	0.0
Not filled	0	0	0	0	1	0.54	0	0
Total	96	100	6	100	184	0.54	19	0.0

Table 5
Perception of uncivil behaviour is a problem in classroom.

Question	Respondents							
	Students		Academic staff		Students		Academic staff	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	N	%	N	%	N	%	N	%
Academic members are much more likely	4	4.2	1	16.7	21	11.35	1	5.26
Academic members are a little more likely	2	2.1	0	0	7	3.78	3	15.79
About equal	42	43.8	3	50	86	46.49	7	36.84
Students are a little more likely	5	5.2	0	0	9	4.86	1	5.26
Students are much more likely	39	40.6	2	33.3	45	24.32	6	31.58
Don't know	3	3.1	0	0	16	8.65	1	5.26
Not filled	0	0	0	0	1	0.54	0	0.00
Total	95	100	6	100	185	100	19	100

Table 6
Perception of uncivil behaviour is a problem in skill laboratory.

Question	Respondents							
	Students		Academic staff		Students		Academic staff	
Based on your experiences or perceptions, do you think that students or academic members are more likely to engage in uncivil behaviour in the classroom?	N	%	N	%	N	%	N	%
Academic members are much more likely	12	12.5	1	16.7	40	21.62	3	15
Academic members are a little more likely	5	5.2	0	0	12	6.49	4	20
About equal	39	40.6	4	66.7	67	36.22	7	35
Students are a little more likely	2	2.1	0	0	13	7.03	0	0.00
Students are much more likely	31	33.3	1	16.7	31	16.79	5	25
Don't know	4	4.2	0	0	21	11.35	1	5
Not filled	0	0	0	0	1	0.54	0	0.00
Total	96	100	6	100	185	100	20	100

Table 7
Perception of uncivil behaviour is a problem in clinical practice.

Question	Respondents							
	Students		Academic staff		Students		Academic staff	
Based on your experiences or perceptions, do you think that students or academic members/clinical educators or nurses are more likely to engage in uncivil behaviour in clinical practice?	N	%	N	%	N	%	N	%
Academic members/clinical educators are much more likely	9	7.8	1	16.7	8	4.21	0	0.00
Academic members/clinical educators are a little more likely	3	2.6	0	0	18	9.47	2	10.53
Nurses are much more likely	7	6.1	1	16.7	54	28.42	8	42.11
Nurses are a little more likely	43	37.4	0	0	2	1.05	0	0.00
Students are much more likely	6	5.2	1	16.7	18	9.47	4	21.05
Students are a little more likely	13	11.3	0	0	6	3.16	0	0.00
About equal	24	20.9	3	50	58	30.53	4	21.05
Don't know	10	8.7	0	0	25	13.16	1	5.26
Not filled	0	0	0	0	1	0.53	0	0.00
Total	115	100	6	100	190	100	19	100

public faculty of nursing only represent two main categories.

The academic staff and students at the private faculty of nursing have similar religious faith/practices. They described themselves as people who practice their own faith or religion. The academic staff and students at the public faculty of nursing also identify themselves as people who practice their religion. However, it appears that there is different religious faith/practice between the academic staff and students at the public faculty of nursing ($p < 0.05$). The academics staff's faith/practices are stronger than the students regardless of their religion. This could lead to a condition in which the academic staff at the public faculty of nursing are more sensitive to students' disturbing behaviour since they might believe that it goes against their religious values.

The results of the Kruskall Wallis test of the study (Table 9) show that there are significant differences of perceived uncivil behaviour based on respondents' religious backgrounds ($p < 0.05$). However, the follow up analyses revealed that there are only two significant findings which only occur at the private faculty of nursing. It is evident that those involved (academic staff and students) in the private faculty of nursing have different perceptions of uncivil behaviour, such as students' threatening behaviour and academic disruptive behaviour based on their religious backgrounds (Christian, Islam and Catholic). Given that religions attempt to teach people to be good (Wilkinson, 2008), it would suggest that all religions should have similar moral beliefs. However, religion also tend to be associated with prejudiced behaviour and attitudes

Table 8
Perception of where uncivil behaviour occurs most frequently.

Question	Respondents							
	Students		Academic staff		Students		Academic staff	
In your opinion, where are uncivil behaviours the most prevalent?	N	%	N	%	N	%	N	%
Traditional classroom	46	47.9	4	66.7	77	41.62	8	42.11
Skill laboratory	6	6.3	0	0	20	10.81	3	15.79
Clinical unit	41	42.1	2	33.3	77	41.62	8	42.11
Not filled	0	0	0	0	11	5.95	0	0.00
Total	93	100	6	100	185	100	19	100

Table 9
Statistical test results of ethnic identity and religious faith.

Variable	Faculty of nursing	Academic staff mean rank	Students mean rank	Mann Whitney U standardized test statistic	Z	p-value	r
Ethnic identity	Private	56.67	51.18	319	0.442	0.659	0.043
	Public	95.66	103.20	1627.5	−0.532	0.595	−0.0416
Religious faith/practice	Private	73.33	50.14	419	1.895	0.058	0.187
	Public	145.76	98.06	2579.5	3.428	0.001	0.240

Table 10
Similar significant statistical test results between the private and public faculties of nursing.

Null hypothesis	Faculty of nursing	Kruskall-Wallis test	Follow-up analysis
The distribution of perceived students threatening behaviour that considered disruptive is the same across categories of religion	Private	$H(3) = 8.721$; $p = 0.008$	Pairwise comparisons with adjusted p-values: Islam-Catholic ($p = 0.021$, $r = -0.288$) Christian- Catholic ($p = 0.008$, $r = -0.316$)
	Public	$H(3) = 8.708$; $p = 0.033$	Step-down follow up analysis: Islam-Catholic-Christian ($p = 0.078$) Catholic-Christian-Hinduism ($p = 0.272$)
The distribution of perceived academics disruptive behaviour that considered disruptive is the same across categories of religion	Private	$H(3) = 9.140$; $p = 0.027$	Pairwise comparisons with adjusted p-values: Islam-Catholic ($p = 0.021$, $r = -0.288$)
	Public	$H(3) = 8.644$; $p = 0.034$	Step-down follow up analysis: Islam-Catholic ($p = 0.855$) Christian-Hinduism ($p = 0.657$)
perceived academics threatening behaviour that considered disruptive is the same across categories of religion	Private	$H(3) = 7.867$; $p = 0.049$	Step-down follow up analysis: Islam-Christian ($p = 0.709$) Catholic-Hinduism ($p = 0.965$)
	Public	$H(3) = 10.222$; $p = 0.017$	Step-down follow up analysis: Islam-Catholic ($p = 0.988$) Catholic-Christian-Hinduism ($p = 0.305$)

(Dhanani and Donley, 2011). Additionally, the private faculty of nursing is an education institution based on Christian perspectives. Gaduh (2012) stated that a religious community could be a factor that associates with the lacking of religious tolerance in Indonesia context (Gaduh, 2012). Therefore, it can be said that the respondents' religious background might influence how they perceive uncivil behaviour. Some people judge others from their religious worldview hence the reason for differences in perceptions about uncivil behaviours.

The findings further suggest that effective communication and relationships, role modelling and implementation of rules for addressing uncivil behaviour in nursing education is required if the problem is to be addressed. Respondents provided several examples of how to behave properly, such as respecting and understanding others, and suggested role modelling that demonstrates examples of acceptable behaviour (Clark and Springer, 2010). It is interesting that the respondents also propose to respect others by understanding other ethnicities. This calls for better education processes in the classroom which foster and promote harmonious relationships between various ethnic groups. Students could be helped to develop cultural competence to increase tolerance and respect for students of other ethnicities and culture (Chambers et al., 2011; Narayanasamy, 2006). Such approaches would help modify behaviour so that it is more appropriate and acceptable.

A number of respondents also suggested a system of reward and punishment and the inclusion of Standards of Procedure in clinical units. This study's findings confirm previous research in that it is essential to establish effective policies, regulations and ground rules to prevent and combat uncivil behaviour incidences (Longo, 2010; Suplee et al., 2008).

Table 11
Suggestions for addressing uncivil behaviour in nursing education.

Themes	Respondent	Illustrative examples of private FoN	Illustrative examples of public FoN
Effective communication and relationships	Academic Staff	(001A) "The lecturers should control the class while teaching and make agreements with students regarding ground rules." (002A) "The nurses should communicate to Clinical Educator in the campus to have similar perceptions regarding the expectations of the students' competencies."	(005A) "Reprimand the person involved pleasantly" (004A) "Applying caring in the learning process such as being respect" (013A) Discussing/dealing to solve the problem
	Students	(089S) "Need of openness, respects and regards each other, as well as need of evaluation (written) for self- evaluation." (011S) "Always assertive when the problems occur." (088S) "Held meeting often between the students, academics and nurses in which this meeting can produce trust relationship and respects others."	(024S) "Appreciate and respect each other. We must know as nurses that individual is a unique person, thus the understanding about it should be developed within ourselves" (073S) "Understanding each other"
Presenting self	Academic Staff	(004A) "Need of a role model from higher management/leaders/ academics." (006A) "Self- integration."	(008A) "Providing good examples to the students" (010A)"Understanding incivility correctly"
	Students	(003S) "Understanding the differences of ethnics; [understanding] the uniqueness of every human that could emerge the senses of respects and regards. " (042S) "Developing tolerant attitude and no attitude of differentiate." (056S) "Try for being a good role model without demanding/judging others."	(176S) "The lecturers behave professionally in all things, being more self-opened and give opportunity for students to express their opinions as well as create pleasant teaching situations, relax but right on the target" (205S) "Every person behaves as their roles"
Rules implementation	Academic Staff	(005A) "All people should follow the rules in academics environment." (006A) "[the needs of] annual reviews regarding the rules especially on rewards and punishment."	002A) "There should be a discipline or contract agreement before the learning [in the beginning of semester]" (009A) "Understanding [their own] rights and obligations" "Apply the ethical principles" (016A) "Determine, apply and provide the rules"
	Students	(091S) "Implement the rules." (091S) "For nurses: working as in the SOP [Standard of Procedures]."	(194S) "Obey the rules and norms in the academic environment and respects each other" (082S) "Determined rules, provided punishments toward person who disobey the rules"

7. Implications and new insights

Previous research has suggested some methods for addressing uncivil behaviour. However, this information remains limited, especially for the Indonesian context. This study has added to the growing body of the literature that has investigated incivility in three main ways identified.

First, it has identified the need to promote awareness of incivility amongst students and academic staff. Second, it has highlighted to consider the role that a person's religious background may play in acts of incivility within the learning environment. Thirdly, it has identified the need to understand and respect others. All three areas need to be considered if strategies for addressing uncivil behaviour in nursing education are to be effective.

8. Limitations

One limitation of this study is that despite the participation rate being high it was not possible to represent all of the ethnic groups and religions of Indonesia. Nevertheless with five of the main ethnic groups and four religions taking part in the study it has provided some useful insights into the role both play in incivility in nursed education in Indonesia.

9. Conclusion

This study supports the emerging literature that uncivil behaviour in nursing education is a problem that needs to be prevented and addressed. It provides new insights into how perceptions of uncivil behaviour might differ according to an individuals' social context. It indicates that there are different perceptions of uncivil behaviour based on people's religions.

Acknowledgement

This study is supported by Directorate General of Higher Education Indonesia that is also known as DIKTI. The authors would also like to thank people at the private and public FoN as well as the private and public hospitals in the west part of Indonesia for their permission to undertake this research. Thanks also to all academic staff and students who agreed to participate in the study and provided their valuable opinions regarding uncivil behaviour in nursing education as well as a number of colleagues who helped in data collections and reviewed this article.

References

Abbotts, J.E., Williams, R.G., Sweeting, H.N., West, P.B., 2004. Is going to church good or bad for you? Denomination, attendance and mental health of children in West Scotland. Soc. Sci. Med. 58 (3), 645–656.
Adiningrum, T.S., 2011. How different are we? Understanding and managing plagiarism between east and west. J. Acad. Lang. Learn. 5 (2), A88–A98.
Alexander-Snow, M., 2004. Dynamics of gender, ethnicity and race in understanding classroom incivility. New Dir. Teach. Learn. 99, 21–31.
Altmiller, G., 2012. Student perceptions of incivility in nursing education: implication for educators. Nurs. Educ. Perspect. 33 (1), 15–20.
Anthony, M., Yastik, J., 2011. Nursing students' experiences with incivility in clinical education. J. Nurs. Educ. 50 (3), 140–144.
Beck, J.W., 2009. Deconstructing Student Perceptions of Incivility in the Nursing Education Triad. PhD Dissertation Louisiana State University [online]. Available at: http://etd.lsu.edu/docs/available/etd-10312009-095845/unrestricted/JWBeck_diss.pdf.
Beckmann, C.A., Cannella, B.L., Wantland, D., 2013. Faculty perception of bullying in school of nursing. J. Prof. Nurs. 29 (5), 287–294.
Bjorklund, W.L., Rehling, D.L., 2010. Student perceptions of classroom incivility. College Teach. 58, 15–18.
Boice, B., 1996. Classroom incivilities. Res. High. Edu. 37 (4), 453–486.
Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3 (2), 77–101.
Chambers, D., Thompson, S., Narayanasamy, A., 2011. Engendering cultural responsive care: a reflective model for nurse education. J. Educ. Pract. 3 (1), 70–81.
Chaux, E., Molano, A., Podlesky, P., 2009. Socio-economic, socio-political and socio-emotional variables explaining school bullying: a country-wide multilevel

analysis. Aggress. Behav. 35, 520–529.
Chowdhury, S., Rammohan, A., 2006. Ethnicity and Conflict in Indonesia [online] Available at: https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=ACE10&paper_id=202 [Accessed 7 August 2012].
Clark, C.M., 2006. Incivility in Nursing Education: Students Perception of Uncivil Faculty Behaviour in the Academic Environment (Phd Dissertaton University of Idaho).
Clark, C.M., 2013. Creating and Sustaining Civility in Nursing Education. Sigma Theta Tau International, Indianapolis USA.
Clark, C.M., Springer, P.J., 2007a. Incivility in nursing education: a descriptive study of definitions and prevalence. J. Nurs. Educ. 46 (1), 7–14. January 2007.
Clark, C.M., Springer, P.J., 2007b. Thoughts on incivility: student and faculty perceptions of uncivil behavior in nursing education. Nurs. Educ. Perspect. 28 (2), 93–97.
Clark, C.M., Carnosso, J., 2008. Civility: a concept analysis. J. Theory Constr. Test. 12 (1), 11–15.
Clark, C.M., Farnworth, J., Landrum, R.E., 2009. Development and description of the incivility in nursing education (INE) survey. J. Theory Constr. Test. 13 (1), 7–15.
Clark, C.M., Otterness, N.S., Jun, W.Y., Allerton, B.W., Juan, C.M., Black, M., Wei, F., 2010. Descriptive study of student incivility in the people's Republic of China. J. Cult. Divers. 17 (4), 136–143.
Clark, C.M., Springer, P.J., 2010. Academic nurse leaders' role in fostering a culture of civility in nursing education. J. Nurs. Educ. 49 (6), 319–325.
Clarke, C.M., Kane, D.J., Rajacich, D.L., Lafreniere, K.D., 2012. Bullying in undergraduate clinical nursing education. J. Nurs. Edu. 51 (5), 269–276.
Daniel, L.G., Adams, B.N., Smith, N.M., 1994. Academic misconduct among nursing students: a multivariate investigation. J. Prof. Nurs. 10 (5), 278–288.
Dhanani, L., Donley, A., 2011. How religiosity affects perceptions of the homeless. Univ. Central Fla. Undergrad. Res. J. 4 (2), 52–61.
Due, P., Merlo, J., Harel-Fisch, Y., Damsgaard, M.T., Holstein, B.E., Hetland, J., Currie, C., Gabhainn, S.N., de Matos, G., Lynch, J., 2009. Socioeconomic inequality in exposure to bullying during adolescence: a comparative, cross-sectional, multilevel study in 35 countries. Am. J. Public Health 99 (5), 907–914.
Eka, N., Sitompul, R., Houghty, G.S., 2013. Incivility in Tangerang nursing education scope. Nurs. Curr. J. 1 (1), 15–24 [Translation writer's own] Available at: http://dspace.library.uph.edu:8080/handle/123456789/2304.
Ellison, C.G., Bartkowski, J.P., Segal, M.L., 1996. Conservative Protestantism and the parental use of corporal punishment. Soc. Forces 74, 1003–1028.
Feldman, L.J., 2001. Classroom civility is another of our instructor responsibilities. College Teach. 49, 137–140.
Field, A., 2013. Discovering Statistics Using IBM SPSS Statistics, fourth ed. SAGE Publications Ltd.
Fraser, B.J., Aldridge, J.M., Soerjaningsih, W., 2010. Instructor-student interpersonal interaction and student outcomes at the university level in Indonesia. Open Educ. J. 3, 21–23.
Gaduh, A., 2012. Uniter or Divider? Religion and Social Cooperation: Evidence from Indonesia. [online] Available at: SSRN: http://ssrn.com/abstract=1991484 or http://dx.doi.org/10.2139/ssrn.1991484 [Accessed 10 August 2014].
Gallo, V.J., 2012. Incivility in nursing education: a review of the literature. Teach. Learn. Nurs. 7, 62–66.
Habibie, B.J., 2012. Thoughts on a Modern Civil Society: the Indonesian Case [online] Available at: http://www.scribd.com/doc/98277705/Thoughts-on-a-Modern-Civil-Society-The-Indonesian-Case [Accessed 7 August 2012].
Hoover, R., Sherrell, C.N., 2010. Coping with Stress [brochure and video]. Retrieved from. http://digitalcommons.wku.edu/cgi/viewcontent.cgi?article=1008&context=cns_apps.
Hunt, C., Marini, Z.A., 2012. Incivility in the practice environment: a perspective from clinical nursing teachers. Nurse Educ. Pract. http://dx.doi.org/10.1016/j.nepr.2012.05.001.
Indonesian National Nurses Association/INNA, 2014. Nursing Code of Ethics [online]. [Translation writer's own] Available: http://www.inna-ppni.or.id/index.php/kode-etik [08 September 2014].
Lai, S., Ye, R., Chang, K., 2008. Bullying in middle schools: an Asian-Pacific regional study. Asian Pac. Educ. Rev. 9 (4), 393–405.
Lashley, F.R., de Meneses, M., 2001. Student civility in nursing programs: a national survey. J. Prof. Nurs. 17 (2), 81–86.
Lawler, Edward J., Thye, Shane R., 1999. Bringing emotions into social exchange theory. Annu. Rev. Sociol 25, 217–244.
Leiter, M.P., Price, S.L., Laschinger, H.K.S., 2010. Generational differences in distress, attitudes and incivility among nurses. J. Nurs. Manag 1–11.
Longo, J., 2010. Combating disruptive behaviors: Strategies to promote a healthy work environment. OJIN: Online J. Issues Nurs. 15 (1) http://dx.doi.org/10.3912/OJIN.Vol15No01Man05. Manuscript 5.
Luparell, S., 2007. The effects of student incivility on nursing faculty. J. Nurs. Educ. 46 (1), 15–19.
Mandryk, J., 2010. Operation World: the Definitive Prayer Guide to Every Nation. Biblica Publising USA.
Marchiondo, K.M., Marchiondo, L.A., Lasiter, S., 2010. Faculty incivility: effects on program satisfaction on BSN students. J. Nurs. Educ. 49 (11), 608–614.
Moffat, R.C.L., 2001. Incivility as a barometer of societal decay. Fla. Philos. Rev. 1 (1). Retrieved from. http://www.cah.ucf.edu/philosophy/fpr/journals/volume1/issue1/moffat.html.
Narayanasamy, A., 2006. Spiritual Care and Transcultural Care Research. Quay, London.
Nilson, L.B., Jackson, N.S. 2004, June. Combating classroom misconduct (incivility) with bills of rights. Paper presented at the meeting of the International Consortium for Educational Development, Ottawa, Ontario, Canada.
Olive, D., 2006. Nursing Student Incivility: the Experience of Nursing Faculty. Phd Dissertation. Widener University.
Phinney, J., 1992. The multigroup ethnic identity measure: a new scale for use with adolescents and young adults from diverse groups. J. Adolesc. Res. 7, 156–176.
Plante, T.G., Boccaccini, M., 1997. The Santa Clara strength of religious faith Questionnaire. Pastor. Psychol. 45, 375–387.
Purnomo, J., Septina, S., 2004. Managing Conflict through Consciousness: Raising a Lesson from Indonesia [online] Vibro News Release. Available at: http://www.ired.org/modules/infodoc/cache/files/pdf/anglais/doc_e640.pdf [Accessed 7 August 2014].
Rahmawati, A., 2001. From people to people: Indonesia's ethnic and religious conflict and its resolution. Asialink Seminar Melbourne.18 October [online]. Available at: http://www.asialink.unimelb.edu.au/archived/events/past/past_events_public/from_people_to_people_indonesias_ethnic_and_religious_conflicts_and_its_resolution [Accessed 7 August 2012].
Randle, J., 2003. Bullying in the nursing profession. J. Adv. Nurs. 43 (40), 395–401.
Rangkuti, A.A., 2011. Academic cheating behaviour of accounting students: a case study in Jakarta State University. In: Educational Integrity: Culture and Values. Proceedings 5th Asia Pacific Conference on Educational Integrity. The University of Western Australia, pp. 105–109, 26-28 September Available at: http://www.apcei.catl.uwa.edu.au/procs/rangkuti.pdf.
Robertson, J.E., 2012. Can't we all just get along? A primer on student incivility in nursing education. Nurs. Educ. Perspect. 33 (1), 21–26.
Rowland, M.L., Srisukho, K., 2009. Dental students' and faculty members' perceptions of incivility in the classroom. J. Dent. Educ 73, 119–126.
Royce, A.P., 2000. A survey of academic incivility at Indiana University: Preliminary report. Bloomington. In: Center for Survey Research, Indiana University. http://spea.iupui.edu/documents/Incivility%20at%20IU.pdf.
Scanlan, C.L., 2003. Reliability and Validity of a Student Scale for Assessing the Quality of Internet-based Distance Learning [online]. Available at: http://www.westga.edu/%7edistance/ojdla/fall63/scanlan63.htm.
Stake, R.E., 2006. Multiple Case Study Analysis. The Guilford press, New York.
Suplee, P.D., Lachman, V.D., Siebert, B., Anselmi, K.K., 2008. Managing nursing student incivility in the classroom, clinical setting, and on-line. J. Nurs. Law 12 (2), 68–77.
Sutantoputri, N.W., Watt, H.M.G., 2013. Attribution and motivation: gender, ethnicity, and religion differences among Indonesian university students. Int. J. High. Educ. 2 (1), 12–21.
Thomas, S.P., 2003. Horizontal hostility: Nurses against themselves: How to resolve this threat to retention. Am. J. Nurs. 103, 87–91.
Thomas, S.P., Burk, R., 2009. Junior nursing students' experiences of vertical violence during clinical rotations. Nurs. Outlook 57, 226–231.
Tiberius, R.G., Flak, E., 1999. Incivility in dyadic teaching and learning. New Dir. Teach. Learn. 77, 3–12.
Wilkinson, P., 2008. Eyewitness Companions: Religions. Dorling Kindersley Limited.
Yin, R.K., 2009. Case Study Research: Design and Methods, fourth ed. SAGE Publication, Inc.