

Incivility of Nurses in Uganda: Causes and Skills Needed to Cultivate Civility

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Abstract

The research was undertaken to establish the causes of incivility and skills needed for cultivating civility among practising nurses. Workplace incivility is a common phenomenon. Unfortunately, not much is known about it in Uganda's health sectors and this motivated this research. A qualitative approach was used and a total of 195 respondents were interviewed to establish their experiences with nurses in public and private hospitals around Kampala. The qualitative data was thematically analysed. Incivility was found to be higher in the public than in the private hospitals, and with diverse causes. The lowest rates were in the Christian-founded not-for-profit facility. Interpersonal skills were found to be most needed to cultivate civility. Nursing administrators are instrumental to cultivating civility. They and other stakeholders are, however, cautioned that all these take commitment and careful planning if better outcomes are to be realised from the nurses and the health sector in general.

Keywords: incivility, nurses, health sector, Uganda.

1. Introduction

Workplace incivility is defined as low-intensity deviant behaviour with ambiguous intent to harm the target and violates workplace norms of mutual respect (Andersson and Pearson, 1999). Uncivil behaviour is generally characterised by rudeness, discourtesy and a display of lack of regard for others. Incivility is conceptually distinct from physical aggression and violence because there is no direct intention to harm, and it does not include overt physical threats to others (Cortina, *et al.*, 2001; Pearson, *et al.*, 2000).

Emerging evidence suggests that nurses' incivility has significant implications for nurses, patients and health care organisations. For example, new research suggests that victims of nurse-on-nurse incivility are more likely to report that they intend to quit their jobs or leave nursing altogether. Additionally, poor communication and unprofessional relationships among health care workers in general have a direct impact on patients' outcomes and safety (Susan, 2011). Incivility in health care can lead to unsafe working conditions, poor patient care, and increased medical costs (Clark and Olender, 2011).

In Uganda, cases of incivility among nurses may be many but no prior empirical study has been undertaken to establish the causes and skills needed to mitigate it.

2. Problem statement

Uganda has made progress in improving the health of its population (NDP 2010/11-2014/15)¹. However, apart from the widespread institutional and structural problems, the researchers believe that the delivery of health services may be hampered by factors related to incivility at the workplace. Inculcating civility has long been proposed for implementation in the public service of the Republic of Uganda,² but it appears that not much has been done in the enforcement of this policy. To-date, a spot check in any of the health units may reveal the absence of positive virtues. Instead, negative virtues are common. For example, grand corruption and abuse of office in the case of the Global Fund scam (Bouchard *et al.*, 2012; Cohen, 2008; Kelly, 2009). These shortcomings are not confined to public health care facilities but apply to other health service providers. Hence, the state, the market and the not-for-profit hospitals are examined in this current research.

3. Purpose of the study

Lessons from the health sector will be used to improve service delivery in other social sectors. The research posed and answered these key questions: 'In your opinion, what are the causes of nurses' incivility in Uganda's clinical setting?' 'What are the essential skills needed to prepare nurses to foster civility in practice?'

4. Theory and literature review

This section covers the theory causes and strategies to address incivility in clinical settings.

¹ NDP (National Development Plan) is Uganda government's five year development plan that replaced the PEAP (Poverty Alleviation Action Plan).

² National Planning Authority: Proposed Strategies for Transforming Public Service Delivery in Uganda, March 2005.

4.1 Theory of incivility

The work of Brad and Jia (2008) presents the core concepts and theoretical notions that demonstrate the constructs that are believed to explain the occurrence of incivility, such as social systems and interactions (Scott, 1977; Hodson, 2001), management philosophy (Lim and Cortina, 2005), and organisational culture, amongst others.

Brad and Jia's (2008) incivility theory presents the core concepts and theoretical notions that demonstrate the eight constructs that are believed to explain the occurrence of incivility, such as social systems and interactions, co-worker beliefs, mental disorders, and moral maturity. Other elements, such as management philosophy and organisational culture, have an indirect effect on incivility. The psychological contract element of the theory assists in understanding why one individual may consider an act uncivil while another individual may not. The theory states that incivility leads to undesirable organisational performance. In fact, the negative impact of uncivil behaviour on individual employees and their organisation has been documented by a number of researchers on organisational management and organisational and social psychology (Cortina, 2008; Cortina *et al.*, 2001; Hornstein, 1996; Lim and Cortina, 2005; Lutgen-Sandvik, 2003; Pearson *et al.*, 2000; Pearson and Porath, 2004, 2005).

4.2 Causes of incivility

A plethora of antecedents for uncivil behaviour have been suggested, one of which is stressful working conditions (Sara *et al.*, 2011). Hewlett and Luce (2006), for example, assert that there are extreme jobs that are characteristically more stressful than others due to unpredictable workflow, tight deadlines, and consistently long hours. Workplace stressors may be related to a lack of autonomy, interpersonal conflict, overwhelming job demands, and anything else a person perceives as stressful (Spector & Fox, 2005). These stressors lead to an appraisal of the situation, which in turn creates a psychological or behaviour reaction that may be counterproductive in nature (Lazarus and Folamkn, 1984). Related to stress, job burnt out has also been found to be a cause of incivility (Halbesleben & Buckley, 2004). The primary drivers of burnt out are excessive workload, and conflicts of personal values with organisational values (Leiter & Shaughnessy, 2006, Leiter *et al.*, 2010). It has also been observed that poor relationships with colleagues and supervisors have been identified to aggravate both exhaustion and cynicism (Leiter & Maslach, 1988; Shaufeli *et al.*, 2009), leading to acts of incivility. Yet a strong sense of collegiality plays powerful role in models of organisational culture (Schein, 1992). The causes for Uganda should fall within these practical experiences.

4.3 Strategies to address incivility in clinical settings

There are many strategies in the literature to address incivility. One of them is having an institutional policy that governs incivility (Suplee *et al.*, 2008). Once the policy document is ready, it should be effectively enforced, made accessible to all and the consequences of committing the stated offences clearly stipulated (Dunphy *et al.*, 2008).

According to Clark and Olender (2011), other strategies in practice to enhance civility include: conducting joint meetings to develop a shared vision and culture of civility; establishing codes of conduct and policies with clearly expected behaviours; and providing ongoing education, amongst others. The faculty have the moral and ethical obligation to prepare nurses who are safe and competent to serve and uphold professional standards of conduct (Dunphy *et al.*, 2008). In addition, faculty should act as role models by demonstrating professional behaviour and decorum as well as setting a positive example for trainees (Clark and Springer, 2007). Other remedies include creating a culture of civility through communication and working together (Clark, 2008). Though the literature review may not be exhaustive, what is evidently lacking in the literature is skills development. This is the focus of the current research.

5. Methods

This section covers design and approaches, data collection, measures and analysis.

5.1 Design and approaches

The study was exploratory and explanatory and conducted with approval from the relevant institutions and ethical bodies. It purposively collected data from three hospitals represented as A, B and C. A is a public hospital, B is a private Christian-founded not-for-profit hospital and C is a purely private-for-profit hospital. The respondents were the patients who were admitted to these hospitals and had interacted with the nurses for at least two weeks. They were, therefore, conveniently selected from the above hospitals in the order of 87 (45%), 58(30%) and 50(25%) respectively. This number included actual respondents and proxy respondents, i.e. caretakers who spoke on behalf of critically ill patients or minors. Patients were thought to give a more reliable account of the nurses' incivility than the nurses themselves.

The tool, including the demographic component, was modified from tools used in other previous incivility studies on nurses, namely the Perceptions on Incivility Survey (PICS) (Hunt and Marini, 2012); the

Nursing Incivility Scale (NIS), which measures source-specific incivility (co-workers [nurses], supervisors, physicians, patients/visitors, and the general environment); the Work Limitations Questionnaire (WLQ) (Smokler and Malecha, 2011); and the tools designed by Clark and Olender (2011).

5.2 Data collection

Field data were collected through an interviewer-administered questionnaire by three trained research assistants and this lasted three months (September-November 2012). The contact point was the nurse on duty who first identified the patients who had been in hospital for more than two weeks. Such patients were approached and interviewed on condition that they accepted to participate.

5.3 Measures and analysis

The qualitative narrative was coded and textual analysis was used to manually analyse the respondents' narrative responses on the two key questions. Key words or phrases were quantified by the researchers; and inferences were made about their meanings and categorised on strategies for mitigating incivility. These were done independently by the two investigators. Consensus with the two investigators using the Multidimensional In/Civility Identification model (MIIM) was 96 per cent. Disagreement on the 4 per cent of the narratives by theme was resolved by discussion between the two investigators.

6. Findings

In terms of occupation, 19 per cent of the respondents were self-employed, 20 per cent were salary earners and 61 per cent were neither employed nor salary earners. The commonest diagnosis was malaria, which constituted 26 per cent of the diseases. Analysis by gender indicated that 30 per cent of the respondents were male. When the respondents were asked the extent to which they thought incivility in nursing practice was a problem in Uganda, 44 per cent reported it was a serious problem, 19 per cent indicated it was a moderate problem, 26 per cent noted it was a mild problem and 11 per cent indicated it was not a problem.

The qualitative analysis also revealed important issues regarding incivility. The first question asked was: 'In your opinion, what are the causes of nurses' incivility in Uganda's clinical setting?' The respondents named 14 causes indicated here inform of frequency and percentage: Personality problem of nurse, 100 (51%); Unresolved family problem, 66 (34%); Corruption, 15 (7%); Stress/fatigue, 185 (95%); Poor pay, 134 (67%); Poor work environment, 100(51%) Administrative incompetence, 20(10%); Lack of motivation/low morale, 55 (28%); Poor facilities, 68(34%); Poor communication with bosses,67 (34%). Others are: Poverty among patients, 60(31%); Poor time management, 11(6%); Poor communication between nurses and patients, 30 (15%); Physical and social status of nurse, 12 (6%).

On the question 'What are the essential skills needed to prepare nurses to foster civility in practice?', the following were the key skills mentioned by respondents identified frequency and percentage: Communication skills,80 (41%); Learning skills,48(25%); Counselling skills,27 (14%); Coping skills,79 (40%); Teamwork skills,62(32%); Leadership skills,35(18%); Listening skills,44(22%); Interactional/interpersonal skills,109 (56%); Conflict-resolution skills,23 (12%); Judgement/problem-solving skills/decision-making skills, 69 (35%).

In respect of both sets of questions, any item mentioned by less than 10 respondents was not analysed.

Some of the issues that emerged showed some marked differences among the participating institutions. For example, whereas 80 per cent of the respondents in Hospital A mentioned 'stress' as the cause of incivility among nurses, the same factor was mentioned by 29 per cent and by 70 per cent in Hospital B and Hospital C respectively. Poor pay was also mentioned as the cause of incivility by 94 per cent of the respondents in Hospital A, 34 per cent of those in Hospital B and 76 per cent of those in Hospital C. Poor facilities were mentioned as a cause of incivility of nurses by 42 per cent, 12 per cent, and 48 per cent by the respondents in Hospitals A, B and C respectively. Poverty among the patients was mentioned as the cause of nurses' incivility by 46 per cent, 5 per cent and 34 per cent of the respondents in Hospitals A, B, and C respectively. A similar pattern of responses was observed on the other variables. Corruption was mentioned only by respondents in Hospital A (17%). Other causes of incivility that could be worth noting, though mentioned by fewer than 10 per cent of the respondents, were: tribalism (Hospital B); a decline in the role of churches in inculcating good morals (Hospital B); and excessive enforcement of rules and regulations (Hospital C). In terms of the skills required, training in customer care was mentioned only by respondents in Hospital (C).

Other qualitative analysis established the public hospital studied has more pronounced evidence of incivility, followed by the private-for-profit hospital and the least evidence is found in the Christian-founded not-for-profit hospital.

7. Discussion

The applicability of Brad and Jia (2008) and others' workplace incivility framework is supported by findings of

this research. The dynamics of nurses' incivility operate within the organisational context and in the context of social systems and interactions, most of which result in stress. What is evident is that incivility exists, to a large extent, among practising nurses in Uganda. The findings are generally consistent with the empirical and theoretical evidence already mentioned elsewhere.

The causes of incivility in Uganda's clinical setting are not different from those theorised by Brad and Jia (2008) and other researchers. The causes are indeed more complex, involving the administrators, patients, nurses and the greater context of the hospital setting. It is no doubt that the key skills required are interactional and communication related. It is obvious that the administrators are part and parcel of these interpersonal and communication loops. However, it should be born in mind that the work of researchers such as Suplee *et al.*, (2000); Dunply *et al.*, (2008); Clark (2008), Clark and Olender (2011) and Pearson and Porath (2005) point to other strategies of dealing with incivility, besides skills development.

The differences observed among the participating hospitals with respect to experience of incivility are all sources of interest. It is clear that the public hospital studied has more pronounced experience of incivility, followed by the private-for-profit hospital and the least is found in the Christian-founded not-for-profit hospital. This would suggest that perhaps religious values play a big role in cultivating the virtues of civility. This appears to support the conclusion of a recent faith and nursing symposium that religion continues to be a potent force in many contexts, including health care.¹ However, further studies need to be conducted to determine how and to what extent religion influences the behaviour of practicing nurses. It may be the case that the faith-based hospitals pay their staff more than public hospitals do or that they provide an environment that is conducive for the nurses to work in, hence less incivility in the faith-based hospitals.

Despite all that has been presented, the study has its limitations- by seeking only the perceptions of the patients on nurses' incivility and focusing on skills development as the only strategy of cultivating civility. The study also selected only health units within Kampala city, thus perhaps missing salient issues on incivility that could have emerged from rural hospitals. Future research should be carried out with perceptions triangulated from the nurses, administration and patients using a geographical mix of hospitals.

8. Conclusions

It can be concluded that, incivility among the nurses is rife in Uganda's health units. The data from the three hospitals included in this study now provide scientific evidence of incivility in the health sector in Uganda. Incivility is pronounced in the public sector hospital, followed by the private-for-profit facility and least in the not-for-profit Christian-founded health facility. More studies are also needed in this direction in order to establish the facts about the disproportionate incivility scores in the hospitals. However, these findings are consistent with findings from elsewhere (Brandson *et al.*, 2010) that third sector organisations are carriers of civil values. Our findings do offer some explanations for the nurses' behaviour which members of the public have complained about and which needs to be addressed by those in positions of responsibility. The skills needed to inculcate civility are important for both public and private health institutions in Uganda which desire to improve the performance of the health sector in the country. The causes however are more complex and could require a multi-pronged approach involving multiple stakeholders if incivility is to be effectively tackled. Nursing administrators, both in the clinical and training institutions should take cognisance of these requisite skills that could make nurses civil. Mitigation of stress triggers is critical. The administrators should as well be part of any intervention strategy aimed at skills development to cultivate civility in the entire hospital setting, including looking at broader approaches for interventions in the context of the clinical settings. However, it should also be noted that fostering civility takes careful planning, courage and commitment to change, as well as resources and the involvement of a wider spectrum of stakeholders. The ball is always in the court of Nursing administrators as well as those in decision-making positions, whether in the private or public sector. This should be true not only for Uganda's context but in all clinical settings, especially in sub-Saharan African counties.

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