



Manifestations of Uncivil Behaviors in Clinical Settings: Perspectives of Students, Faculty Members, Nurses, and Clinical Managers

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Abstract

Background: The increasing incidence of uncivil behaviors in nursing education has become a major global concern, particularly in clinical learning environments where professional interactions are essential. Although previous studies have documented various forms of incivility, less attention has been given to distinguishing incivility from related phenomena, such as stress responses, role ambiguity, and structural challenges.

Objectives: This study aimed to explore and clarify manifestations of uncivil behavior in clinical nursing education.

Methods: A qualitative exploratory design was used. Participants comprised nursing students, faculty members, administrators, and healthcare staff at Shahid Beheshti University of Medical Sciences in Tehran, Iran. Purposive and snowball sampling techniques were used to ensure diverse perspectives. Data were collected over 5 months through semistructured interviews with 27 participants, and sampling continued until data saturation was reached. Conventional content analysis, supported by MAXQDA 2020 software, guided the analysis. Reflexivity was maintained throughout data collection and analysis.

Results: Uncivil behaviors were categorized into 4 main groups: student-related, faculty-related, healthcare staff-related, and organizational behaviors. The findings indicated that incivility is a multidimensional phenomenon shaped by interactions across these groups. Importantly, not all identified behaviors constituted incivility in a strict sense; some reflected stress responses, role ambiguity, or organizational constraints. Incivility was characterized by violations of professional respect and interpersonal norms, whereas contextual factors were interpreted as underlying conditions influencing these behaviors.

Conclusions: Uncivil behaviors in clinical nursing education arise from complex interactions among students, faculty members, healthcare staff, and organizational systems. The findings distinguish incivility from related phenomena, such as stress responses, role ambiguity, and structural constraints, clarifying that not all negative behaviors constitute incivility per se. Incivility was specifically characterized by violations of professional respect and interpersonal norms, whereas contextual factors served as underlying conditions. Addressing incivility therefore requires multilevel interventions that target both interpersonal behaviors and systemic organizational factors to promote respectful and effective clinical learning environments.

Keywords: Uncivil Behavior, Universities, Hospitals, Clinical Settings

1. Background

In contemporary organizations, maintaining respectful and professional interactions is a fundamental component of effective functioning and social responsibility. However, despite increased

attention to ethical and professional standards, uncivil behaviors continue to be reported across educational and workplace settings (1, 2). Incivility has emerged as a global concern, particularly in educational and healthcare environments, where interpersonal

interactions play a central role in learning and professional development (3, 4).

Over the past decade, research has increasingly highlighted the prevalence of uncivil behaviors among students, faculty members, and healthcare staff, as well as their negative effects on learning outcomes, psychological well-being, and organizational climate (5-7). One of the most widely cited conceptualizations defines incivility as low-intensity deviant behavior with ambiguous intent to harm, characterized by violations of norms of mutual respect in the workplace (8). This definition emphasizes that incivility is not necessarily overt aggression but may manifest as subtle forms of disrespect, disregard, or exclusion.

In nursing education, incivility has been identified as a significant challenge affecting both academic and clinical learning environments. Studies have shown that nursing students frequently encounter behaviors such as disrespect, exclusion, ineffective communication, and lack of support during clinical training (9, 10). These experiences contribute to stress, reduced professional confidence, and impaired professional identity development (11).

Importantly, incivility in clinical settings is not limited to student behavior. Faculty members, clinical instructors, and healthcare staff may also contribute to uncivil interactions through ineffective teaching practices, unfair treatment, hierarchical communication, and lack of interprofessional collaboration (12). Such behaviors may function as part of a hidden curriculum, shaping professional norms beyond formal instruction (12). Recent evidence suggests that uncivil behaviors are closely linked to broader organizational and structural factors, including workload pressures, unclear role expectations, and hierarchical power dynamics (13, 14). These conditions may create environments in which uncivil behaviors are normalized rather than recognized as deviations from professional standards.

Despite growing international evidence, limited qualitative research has examined how these behaviors are experienced in specific clinical nursing education contexts, particularly in Iran. In Iran, research on incivility remains limited, and most studies have examined antecedents and consequences of discourteous behaviors in governmental and industrial organizations. Within educational settings, research has been relatively sparse and has predominantly focused

on academic environments, with limited attention to clinical and healthcare settings. In the few existing national studies, research has primarily focused on government organizations, industries, or academic fields using quantitative approaches, whereas the specific manifestations of incivility in nursing clinical education have remained largely undefined.

In this study, uncivil behavior is conceptualized as low-intensity behavior that violates norms of respect, dignity, and professional interaction within clinical education settings. Importantly, not all negative or dysfunctional behaviors observed in clinical environments are considered incivility. Behaviors arising from structural constraints, workload pressures, role ambiguity, or emotional stress responses were distinguished from incivility during data analysis and interpreted as contextual or contributing factors rather than core manifestations of the construct.

2. Objectives

This study aimed to examine the manifestations of uncivil behaviors in clinical environments. Using a qualitative exploratory approach, the study sought to answer the following questions:

- 1) What are the manifestations of students' uncivil behaviors in clinical settings?
- 2) What are the manifestations of faculty members' uncivil behaviors in clinical settings?
- 3) What are the manifestations of healthcare staff's uncivil behaviors in clinical settings?
- 4) What are the manifestations of organizational uncivil behaviors in clinical settings?

3. Methods

3.1. Study Design

This study employed a qualitative descriptive-exploratory design to comprehensively explore manifestations of uncivil behaviors in clinical nursing education. Given the limited contextualized evidence on academic and clinical incivility within Iran's nursing education system, a qualitative approach was considered appropriate for capturing participants' lived experiences and interpretations without imposing predefined theoretical frameworks.

3.2. Study Setting

The research was conducted in the clinical education environments of teaching hospitals affiliated with Tehran University of Medical Sciences, Iran University of Medical Sciences, and Shahid Beheshti University of Medical Sciences. These hospitals serve as major clinical training sites for undergraduate nursing students and represent diverse clinical wards and organizational structures within the Iranian healthcare system.

3.3. Participants and Sampling

Participants included undergraduate nursing students in their seventh and eighth semesters who were actively engaged in clinical internships, as well as faculty members, academic administrators, head nurses, and clinical supervisors involved in nursing education. Purposive sampling was initially used to recruit participants with direct experience in clinical education and a willingness to share their perspectives. This was followed by snowball sampling to identify additional participants based on emerging concepts during analysis. Maximum variation sampling was applied to ensure diversity in age, gender, institutional affiliation, and clinical settings.

Sampling continued until data saturation was achieved, defined as the point at which no new categories emerged. In total, 27 participants were included: 18 nursing students, 5 faculty members and academic administrators, and 4 head nurses and clinical supervisors. Some participants also held managerial roles, such as Vice Dean for Education, Department Head, or Clinical Supervisor.

The larger number of student participants reflects their continuous presence in clinical environments and direct exposure to uncivil behaviors. Faculty members and healthcare personnel were included to provide complementary perspectives from educational and clinical management roles. The inclusion of multiple stakeholder groups enabled comparisons across roles and contributed to the depth and credibility of the findings.

3.4. Data Collection

Data were collected over a 5-month period from February 2024 to July 2024 using in-depth, semistructured interviews. After informed consent was obtained, interview times and locations were arranged according to participants' preferences. Most interviews were conducted during clinical rotations in educational

classrooms or ward rest areas to ensure convenience and comfort.

Interviews began with broad, open-ended questions such as, "Can you describe your experience of clinical nursing education?" and "How would you evaluate behaviors in the clinical environment?" Follow-up probing questions, such as "Can you explain further?" and "Can you give an example?", were used to deepen understanding and clarify meanings. As data collection progressed, interviews became more focused on emerging categories to enrich and refine the findings. At the end of each interview, participants were asked whether they wished to discuss any additional issues.

Interviews lasted between 30 and 60 minutes, with an average duration of approximately 45 minutes. All interviews were audio-recorded using the researcher's mobile device with participants' permission and transcribed verbatim shortly after completion. Field notes were documented before, during, and after the interviews to capture nonverbal cues, contextual observations, and the researcher's reflections.

3.5. Researcher Characteristics and Reflexivity

All interviews were conducted by the first author, a PhD candidate in nursing at Shahid Beheshti University of Medical Sciences, who had received formal training in qualitative research methods, including semistructured interviewing and conventional content analysis. The researcher also had prior experience conducting qualitative interviews, which facilitated effective communication and in-depth exploration of participants' experiences. No prior personal or professional relationship existed between the researcher and the participants before recruitment.

At the beginning of each interview, the researcher introduced the study objectives, ensured confidentiality, and emphasized voluntary participation to establish rapport and encourage open and honest responses. Given the researcher's academic background in nursing, it is acknowledged that pre-existing assumptions regarding uncivil behaviors in clinical settings could have influenced the research process. To address this, reflexivity was actively maintained throughout the study. Reflective field notes were recorded after each interview to capture personal impressions, potential biases, and contextual factors that might shape data generation and interpretation. During data analysis, these reflections were continuously examined and

discussed with the research team. Regular peer debriefing sessions with supervisors experienced in qualitative research were conducted to ensure that coding and category development remained grounded in participants' perspectives. This process helped enhance the credibility and confirmability of the findings.

3.6. Data Analysis

Data analysis was conducted concurrently with data collection using conventional content analysis, following the 5-step approach proposed by Graneheim and Lundman (2004). This inductive method allowed categories and themes to emerge directly from the data without imposing prior assumptions. The analysis process involved: 1) transcribing interviews verbatim and repeatedly reading transcripts to achieve an overall understanding; 2) identifying meaning units related to uncivil behaviors in clinical education; 3) condensing meaning units and assigning initial codes; 4) grouping similar codes into subcategories through constant comparison; and 5) abstracting subcategories into broader categories that captured the underlying meanings.

Following these steps, particular attention was given to the processes of condensation, abstraction, and categorization to ensure analytical coherence. Meaning units were condensed while preserving their core meaning and labeled with initial codes closely reflecting participants' expressions. Similar codes were continuously compared and grouped based on conceptual similarities and differences. Subcategories were formed by clustering related codes that represented shared underlying concepts. To avoid excessive fragmentation, overlapping codes were merged, whereas distinct codes were retained.

The transition from subcategories to broader categories involved a higher level of abstraction, in which subcategories were examined in relation to one another to identify overarching patterns. The final 4-category structure was developed by organizing subcategories according to the source and direction of uncivil behaviors: students, faculty members, healthcare staff, and the organization. This structure ensured internal coherence and clear conceptual boundaries between categories.

Constant comparison was applied throughout the analysis, both within and across interviews and

stakeholder groups. Initial coding was performed using MAXQDA software, and subsequent refinement and organization of categories were completed using Microsoft Word. Data analysis began with the first interview and continuously informed subsequent data collection, allowing emerging concepts to guide later interviews.

3.7. Coding Process and Research Team Consensus

Coding and category development were conducted through an iterative and collaborative process. Initial codes and preliminary categories were reviewed by the supervising professor, and full transcripts of 2 interviews with detailed coding were examined by consulting professors. Regular discussions were held within the research team to compare interpretations, resolve discrepancies, and reach consensus on code meanings and category boundaries. Categories were finalized only after agreement was achieved among team members, ensuring analytical rigor and coherence.

3.8. Trustworthiness

Study rigor was ensured using the criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement in the research field, in-depth interviews, maximum variation sampling, and member checking, whereby participants reviewed and confirmed interpretations of their statements. Dependability was supported by documenting all stages of data collection and analysis and by maintaining consistency in interview topics across participants.

Confirmability was achieved through peer debriefing with faculty members experienced in qualitative research and by maintaining an audit trail of transcripts, codes, categories, and analytic decisions. Reflexivity was practiced throughout the study, with the researcher consciously setting aside personal assumptions to remain attentive to participants' perspectives. Transferability was addressed by providing detailed descriptions of the study context, participants, and research process, allowing readers to assess the applicability of the findings to similar settings.

3.9. Ethical Considerations

Ethical approval for the study was obtained from the Ethics Committee of Shahid Beheshti University of

Medical Sciences (approval No. IR.SBMU.PHARMACY.REC.1402.185). Participation was voluntary, and written informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained throughout the research process.

4. Results

The findings of this study were derived from 27 interviews, including 18 nursing students in their seventh and eighth semesters, 5 faculty members from Tehran, Iran, and Shahid Beheshti University of Medical Sciences, 2 nursing supervisors, and 2 head nurses. The mean age of the participants was 31.14 years. Among the participants, 33.3% were male and 66.6% were female. Additional demographic characteristics are presented in Table 1.

Table 1. Demographic Characteristics of Participants

Characteristics	No.
Roles	
Nursing students	18
Faculty members	5
Nursing supervisors	2
Head nurses	2
Gender	
Female	18
Male	9
Age (y)	
Mean [range]	31.14 [21 - 62]
Marital status	
Single	17
Married	10
Education level	
Undergraduate nursing students	18
Bachelor's degree in nursing	2
Master's degree in nursing	1
Assistant professor	2
Work experience (y)	
None (students)	14
<1	4
1 - 10	3
> 10	6
Administrative role	
Yes	7
No	20

4.1. Research Question 1: Manifestations of Uncivil Behaviors Among Students in Clinical Settings

Data analysis identified 3 subcategories related to manifestations of uncivil behaviors among nursing students in clinical environments: uncivil behavior toward faculty members, uncivil behavior toward the organization, and uncivil behavior toward oneself. The manifestations of uncivil behaviors among students in clinical settings are summarized in Table 2.

To enhance clarity and readability, detailed behavioral codes and extended lists of manifestations were transferred to Table S1 in the Supplementary File, whereas the main text provides an analytically condensed and interpretive summary of the findings.

4.1.1. Overall Pattern of Uncivil Behaviors and Levels of Disruption

Qualitative analysis indicated that uncivil behaviors among nursing students during clinical education constitute a heterogeneous phenomenon encompassing a wide spectrum of actions with varying intensity, visibility, and effects on the clinical learning environment. Participants described these behaviors as ranging from subtle violations of professional etiquette to more overt forms of disruption and unprofessional conduct.

A central pattern in participants' accounts was that incivility is not limited to interpersonal rudeness or breaches of courtesy. Rather, participants consistently emphasized that behaviors affecting patient safety, learning engagement, and professional responsibility are perceived as particularly disruptive in clinical settings. Examples included concealing clinical errors, performing routine-based care without critical thinking, and disengagement from learning activities. These accounts, grounded in participants' clinical experiences, were repeatedly described as undermining both educational quality and patient safety.

A prominent pattern across interviews was passive disengagement. Participants described situations in which students were physically present in clinical settings but mentally detached from learning processes. This pattern was characterized by minimal participation, lack of curiosity, and superficial involvement in patient care. Rather than overt misconduct, participants referred to this pattern as "silent withdrawal" from learning. This theme emerged consistently across narratives and was described as a major barrier to clinical learning and professional development.

Table 2. Manifestations of Uncivil Behaviors Among Students in Clinical Settings

Themes	Representative Behaviors / Examples
Toward faculty members	Disrespect, rudeness, mocking instructors, ignoring instructions, excessive arguing, and refusing to communicate. Quote: "Some students refuse to perform assigned tasks unless constantly supervised, disrupting workflow and learning."
Toward the organization	Cheating, absenteeism, breaking rules, ignoring safety, lack of cooperation with staff, and evading responsibilities. Quote: "Students sometimes skip clinical placements without notice and ignore safety protocols."
Toward self	Overdependence on faculty, lack of motivation, low confidence, emotional overreactions, and following inappropriate role models. Quote: "Students often over-rely on faculty and show low engagement in learning."

In addition, normalization of unprofessional behaviors was identified as an important cross-cutting pattern. Participants reported that behaviors such as academic dishonesty, covering peers' absenteeism, and avoidance of responsibility were frequently observed within peer groups and gradually became accepted as routine practice. From participants' perspective, this normalization was shaped by peer culture within clinical environments and reinforced through repeated exposure rather than formal instruction. This interpretation reflects how participants made sense of weakening professional boundaries in their educational context.

4.1.2. Manifestations of Uncivil Behaviors Toward Faculty Members

Participants described uncivil behaviors directed toward faculty members as occurring along a continuum from subtle disrespect to overt confrontation. Subtle forms included failure to greet, informal or inappropriate language, excessive mobile phone use during clinical instruction, and failure to observe expected professional etiquette, such as punctuality and attentiveness. These behaviors were described as part of everyday clinical interactions and were consistently attributed to student conduct in participants' narratives.

More explicit forms of incivility included resistance to instructions, arguing with instructors, inappropriate joking in clinical settings, and refusal to complete assigned tasks. Participants described these behaviors as disruptive to the educational process because they weakened instructional structure and challenged instructor authority within clinical settings.

In some cases, participants recounted episodes of confrontational interactions between students and faculty members, including raised voices or disrespectful disagreement with feedback. Although reported less frequently, these incidents were

consistently described as emotionally distressing for instructors and disruptive to the learning environment.

4.1.3. Manifestations of Uncivil Behaviors Toward the Organization

Participants described uncivil behaviors toward the organization primarily as violations of professional and institutional expectations. These included academic dishonesty, absenteeism from clinical placements, concealment of clinical mistakes, and avoidance of assigned responsibilities. These accounts were based on participants' direct observations in clinical training environments.

Participants also highlighted behaviors that, in their view, had direct implications for patient care, including insufficient attention to safety protocols, limited engagement in clinical tasks, and inappropriate communication with patients. Participants consistently interpreted these behaviors as breaches of professional responsibility in clinical practice.

In addition, disregard for institutional regulations, such as dress codes, attendance policies, and hierarchical structures, was frequently mentioned. Participants described these behaviors as reflecting limited internalization of professional norms within clinical education settings.

4.1.4. Manifestations of Uncivil Behaviors Toward Self

Participants described self-directed behaviors as including low motivation, reduced engagement in learning, emotional instability, and overdependence on instructors. These accounts reflected students who, according to participants, relied heavily on faculty members for clinical decision-making and demonstrated limited initiative in practice.

Emotional reactivity in clinical situations was another frequently reported pattern. Participants described episodes of frustration, withdrawal from

tasks, and difficulty coping with stress in patient care environments. These reactions were interpreted as contributing to reduced participation in clinical responsibilities.

Participants also emphasized limited active engagement in learning and minimal effort to understand clinical procedures. These behaviors were described as constraining students' professional development and limiting the emergence of independent clinical judgment.

4.1.5. Interconnection of Behavioral Domains

Across interviews, participants consistently indicated that uncivil behaviors across self, faculty, and organizational domains are interconnected rather than isolated. For example, reduced motivation and disengagement at the individual level were described as being associated with noncompliance with organizational expectations and diminished respect toward faculty members.

Participants also linked these behaviors to broader contextual influences, including institutional practices and clinical learning environments. Weak or inconsistent role modeling and structural limitations were described as factors that may contribute to reinforcing such behavioral patterns. These interpretations were explicitly derived from participants' explanations of their clinical experiences rather than externally imposed by the authors.

4.1.6. Analytical Summary

Overall, participants described uncivil behaviors in clinical nursing education as extending beyond overt interpersonal misconduct to include broader patterns of disengagement, weakened professional responsibility, and normalization of unprofessional conduct. While overtly disrespectful behaviors were viewed as disruptive to the educational atmosphere, participants more frequently emphasized subtle forms of disengagement and noncompliance as pervasive challenges in clinical learning environments.

These findings, grounded in participants' accounts, suggest that uncivil behaviors should be understood as emerging from interactions among individual, relational, and contextual factors within clinical education settings.

4.2. Research Question 2: Manifestations of Uncivil Behaviors Among Faculty Members and Clinical Instructors in Clinical Settings

Data analysis identified 3 subcategories related to manifestations of uncivil behaviors by faculty members and clinical instructors in clinical environments: uncivil behavior toward students, uncivil behavior toward colleagues, and uncivil behavior toward the organization. The manifestations of uncivil behaviors by faculty members and clinical instructors are presented in [Table 3](#).

To enhance clarity and readability, detailed behavioral codes and extended lists of manifestations were transferred to Table S1 in the Supplementary File, whereas the main text provides an analytically condensed and interpretive summary of the findings.

4.2.1. Uncivil Behaviors Toward Students

Analysis of participants' accounts indicated that uncivil behaviors by faculty members and clinical instructors toward students are multidimensional and extend beyond isolated interpersonal incidents. These behaviors were described as embedded within educational, relational, and organizational practices in clinical teaching environments.

A dominant pattern in participants' narratives was educational inefficiency and a lack of structured clinical guidance. Participants described situations in which clinical teaching was perceived as insufficiently organized and weakly connected to clinical practice. According to participants, students were often not adequately guided in the ethical, legal, and communication aspects of care, and opportunities for hands-on learning were limited. These accounts reflected a perceived gap between theoretical instruction and clinical application, which participants associated with confusion, increased dependence on instructors, and reduced development of professional autonomy.

Another pattern described by participants was behavioral inconsistency in faculty-student interactions. Participants reported variability in instructors' communication styles and behavioral responses across clinical contexts. These inconsistencies were described as creating ambiguity for students regarding expectations and appropriate professional conduct. Some participants recounted experiences of instructors perceived as overly controlling or

Table 3. Manifestations of Uncivil Behaviors Among Faculty Members and Clinical Instructors in Clinical Settings

Themes	Representative Behaviors/Examples
Toward students	Educational and behavioral inefficiency, micromanagement, neglecting clinical teaching, unfair grading, public humiliation, exploitation, and inconsistent support. Quote: "Faculty sometimes ignore students' concerns or inconsistencies in teaching, creating tension in clinical training."
Toward colleagues	Unprofessional or unethical conduct, undermining peers, favoritism, disrespect in the presence of students, conflicts, and jealousy. Quote: "Some faculty undermine peers or show favoritism, affecting professional relationships."
Toward the organization	Neglecting institutional responsibilities, ignoring clinical supervision, lack of support for school policies, and inadequate engagement in professional development. Quote: "Faculty may neglect clinical supervision or fail to support institutional policies."

insufficiently supportive, which they associated with reduced motivation and engagement in clinical learning.

Participants also described harassing and psychologically distressing interactions. These included instances of humiliation in front of peers or patients, excessive criticism, and punitive or authority-driven communication styles. According to participants, such experiences were associated with emotional distress and reduced confidence among students. In some accounts, participants interpreted certain practices as positioning students more as task performers than learners, particularly when clinical tasks were assigned without explicit educational explanation.

Although less frequently reported, overtly aggressive or authoritarian behaviors were also described. These included verbal aggression, exclusion from participation in clinical activities, and highly hierarchical communication styles. Participants linked these experiences to diminished psychological safety within clinical learning environments.

A further theme was a perceived lack of trust in students' capabilities. Participants reported that students often felt their clinical judgments were undervalued and their perspectives insufficiently considered. Responsibility for clinical issues was frequently attributed to students without consideration of contextual or systemic factors, as described by participants. This perceived lack of trust was associated with feelings of insecurity and reduced engagement in learning activities.

Participants also highlighted managerial and supervisory inefficiencies as shaping the clinical learning environment. These included limited structured supervision, inconsistent instructor presence, and a lack of clear learning objectives during clinical placements. According to participants, these conditions resulted in fewer opportunities for feedback

and unclear expectations regarding clinical performance.

Another recurring pattern was limited instructional engagement, in which participants described instructors who were present in clinical settings but provided minimal active teaching, feedback, or supervision. These accounts reflected a perception of reduced educational involvement, which participants associated with diminished learning opportunities.

Finally, participants reported perceived unfair practices, including inconsistent evaluation, unequal treatment of students, and favoritism. These experiences were described as undermining fairness and transparency within the educational environment.

4.2.2. Uncivil Behaviors Toward Colleagues

Participants described uncivil behaviors among faculty members toward colleagues as an important, yet often less visible, dimension of the clinical educational environment. These behaviors were primarily reported as occurring in professional interactions and, in some cases, in the presence of students.

Participants reported unethical interpersonal behaviors, including criticizing colleagues in front of students, questioning their teaching competence, and engaging in comparative judgments regarding academic performance. These accounts were described as reflecting broader relational tensions within academic environments.

In addition, participants described unprofessional interactions among colleagues, including breaches of communication norms, avoidance of respectful dialogue, and selective acknowledgment of contributions. Even subtle behaviors, such as omission of recognition, were described by participants as relationally significant and as affecting collegial trust.

4.2.3. Uncivil Behaviors Toward the Organization

Participants' accounts indicated that uncivil behaviors toward the organization were embedded within both academic and clinical institutional contexts.

Within the academic environment, participants described issues such as inconsistent professional communication, weak adherence to hierarchical and administrative structures, and limited engagement in educational development activities. These accounts reflected participants' perceptions of variability in organizational professionalism and role clarity.

Within clinical hospital settings, participants described concerns regarding instructors' limited familiarity with clinical workflows and insufficient verification of students' clinical procedures. According to participants, these conditions were perceived as affecting the quality of clinical teaching and increasing reliance on clinical staff for supervision. Participants also noted that insufficient practical experience among some instructors may influence the effectiveness of clinical education delivery.

4.2.4. Analytical Summary

Overall, participants' accounts suggest that uncivil behaviors among faculty members are not isolated events but are embedded within broader educational and organizational contexts. These behaviors were described as simultaneously affecting students' learning experiences, collegial relationships, and institutional functioning.

Across narratives, participants emphasized that inconsistencies between expected educational roles and actual instructional practices contributed to tensions within clinical education environments. These accounts reflected perceived role complexity among faculty members, who were described as simultaneously fulfilling educational, evaluative, and organizational responsibilities.

From an interpretive perspective, the data suggest that clinical education may also transmit implicit norms of interaction and hierarchy through everyday practices. Participants' accounts indicate that students may learn not only formal clinical content but also unspoken behavioral norms within clinical environments. This interpretation is derived from participants' descriptions of repeated exposure to observed behaviors across clinical settings.

4.3. Research Question 3: Manifestations of Uncivil Behaviors Among Healthcare Staff in Clinical Settings

Data analysis identified 3 subcategories related to manifestations of uncivil behaviors by healthcare staff: uncivil behavior toward students, uncivil behavior toward faculty members, and uncivil behavior toward colleagues. These findings are summarized in [Table 4](#).

To enhance clarity and readability, detailed behavioral codes and extended lists of manifestations were transferred to Table S1 in the Supplementary File, whereas the main text provides an analytically condensed and interpretive summary of the findings.

4.3.1. Uncivil Behaviors Toward Students

The analysis indicated that uncivil behaviors by healthcare staff toward nursing students are pervasive and multifaceted, reflecting both interpersonal dynamics and structural pressures within clinical environments. These behaviors were described not as isolated incidents but as part of a broader pattern of interaction shaping students' clinical experiences.

A dominant pattern in participants' accounts was the perception of students as functional labor rather than learners. Participants consistently described situations in which students were assigned tasks primarily for service delivery rather than educational purposes. Based on participants' descriptions of clinical workload allocation, this instrumental use of students limited learning opportunities and contributed to feelings of marginalization and exclusion.

Another prominent theme was unfair and inconsistent treatment. Students reported variability in expectations, differential responses to mistakes, and assignment of responsibilities beyond their defined role. These accounts suggest that perceived inconsistency in clinical supervision contributed to a sense of inequity and unpredictability in the learning environment.

In addition, rejecting and exclusionary behaviors were frequently reported. Students described being denied opportunities to participate in clinical activities, excluded from patient care processes such as handovers, or positioned as passive observers rather than active learners. From participants' perspectives, such exclusion reduced opportunities for skill acquisition and weakened their sense of belonging within the clinical team.

Table 4. Manifestations of Uncivil Behaviors Among Healthcare Staff in Clinical Settings

Themes	Representative Behaviors/Examples
Toward students	Harassment, bullying, unfair treatment, neglect of learning needs, exclusion from clinical activities, aggression, and inappropriate authority. Quote: "Students often feel humiliated, overburdened, or ignored by healthcare staff during clinical training."
Toward faculty members	Rejecting cooperation, denying access to resources, disrespectful communication, and discriminatory treatment between nursing and medical faculty. Quote: "Some staff ignore faculty instructions or fail to address them properly, impacting clinical education."
Toward colleagues	Unethical, unprofessional, or unfair behaviors, including favoritism, gossiping, lack of respect, and bullying among staff. Quote: "Staff may undermine peers, favor certain colleagues, or display disrespect in front of others."

Participants also described overtly aggressive or intimidating behaviors, including harsh verbal communication, humiliation in front of others, and authoritarian interactions. Participants linked these experiences to feelings of emotional unsafety and reduced willingness to engage in clinical learning activities.

4.3.2. Uncivil Behaviors Toward Colleagues

The findings indicated that uncivil behaviors among healthcare staff toward colleagues contribute substantially to the overall clinical climate and are also observed by students, thereby shaping informal learning about professional conduct.

A key pattern was hierarchical and horizontal tension within nursing teams. Participants described situations in which senior staff exerted control over less experienced colleagues through the allocation of demanding shifts and unequal workload distribution. These descriptions reflect participants' perceptions of power asymmetries within clinical units, experienced as structural rather than individual phenomena.

Unprofessional interpersonal interactions among colleagues were also evident, including lack of mutual respect, jealousy, and differential valuation of professional input depending on hierarchical status. Participants noted that nursing contributions were sometimes disregarded in favor of physicians' opinions. These observations were interpreted by participants as reinforcing existing professional hierarchies.

In addition, unethical relational behaviors, such as gossiping and inconsistent interpersonal conduct, were frequently reported. Participants indicated that witnessing these interactions contributed to mistrust and emotional tension within the clinical environment.

4.3.3. Uncivil Behaviors Toward Faculty Members and the Organization

Uncivil behaviors directed toward faculty members were primarily expressed as professional disregard and structural exclusion. Participants described situations in which academic staff were not afforded appropriate recognition or access to resources for educational activities. These accounts were based on observed interactions in clinical settings in which faculty status was not consistently acknowledged.

At the organizational level, patterns of exclusion and marginalization were also evident, including restricted access to facilities and unequal support for educational activities. Participants interpreted these conditions as reflecting structural imbalances between academic and clinical systems.

4.3.4. Underlying Structural and Contextual Factors

The findings suggest that uncivil behaviors in clinical environments are embedded within structural and organizational conditions reported by participants. A central issue identified in the accounts was the tension between service delivery demands and educational objectives. Participants frequently described situations in which clinical workload priorities overshadowed educational goals.

Additionally, hierarchical structures within clinical settings were repeatedly described as shaping patterns of interaction among staff, faculty members, and students. These hierarchical dynamics were presented in participant narratives as influencing communication patterns and limiting collaborative learning opportunities.

4.3.5. Analytical Summary and Implications

Overall, the findings demonstrate that uncivil behaviors toward students, colleagues, and faculty members are interconnected and reflect broader cultural and structural characteristics of clinical education environments.

Table 5. Manifestations of Organizational Incivility in Clinical Settings

Theme	Representative Behaviors/Examples
School administrators toward students	Inefficiencies in education, behavior, management, and operations; for example, abrupt schedule changes, lack of compensatory courses, inadequate supervision, overcrowded clinical groups, and neglecting students' concerns.
School administrators toward faculty members	Managerial and behavioral inefficiencies; for example, lack of support, favoritism toward students, forced silence, poor conflict resolution, and unjust administrative interventions.
Hospital administrators	Discriminatory treatment of nursing faculty and students; for example, privileging physicians, inequitable allocation of resources, inadequate facilities and rest areas, and poor collaboration with nursing schools.
University administrators	Failure to promote the nursing profession; for example, appointing inefficient managers, lack of resources and funding, inadequate human resource allocation, and limited welfare facilities compared with other universities.

From an interpretive perspective, these patterns suggest that instrumental treatment of students, hierarchical pressures, and organizational exclusion collectively contribute to a learning environment characterized by emotional strain and weakened professional identity formation. These interpretations are grounded in participants' accounts and extend them to suggest that addressing uncivil behaviors requires structural reform, clarification of educational roles, and the development of collaborative interprofessional cultures.

4.4. Research Question 4: Manifestations of Organizational Uncivil Behaviors in Clinical Settings

Data analysis identified 4 subcategories of organizational incivility: uncivil behavior by school administrators toward students, uncivil behavior by school administrators toward faculty members, uncivil behavior by hospital administrators, and uncivil behavior by university administrators. These findings are presented in Table 5.

To enhance clarity and readability, detailed behavioral codes and extended lists of manifestations were transferred to Table S1 in the Supplementary File, whereas the main text provides an analytically condensed and interpretive summary of the findings.

4.4.1. Organizational Incivility Toward Students

The analysis revealed that organizational incivility toward nursing students is primarily expressed through structural, managerial, and symbolic practices shaping the overall clinical learning environment. These behaviors were described as extending beyond individual managerial decisions to reflect broader institutional priorities and value systems, as indicated in participants' accounts of their clinical experiences.

A central finding was the presence of structural and educational inefficiencies that disrupted the continuity and coherence of clinical education. Participants described frequent schedule changes, unclear definitions of student roles, insufficient clinical exposure in key specialty areas, and a lack of preparatory orientation before clinical placements. Based on participants' reports, such instability created uncertainty and reduced their ability to plan and engage effectively in learning activities.

Another prominent theme was behavioral inefficiency within administrative systems, reflected in the devaluation of students' concerns, a lack of advocacy for student rights, and restrictive control over student participation. In some cases, students reported feeling silenced or discouraged from expressing concerns, contributing to perceptions of marginalization and lack of agency. These experiences, as reported by participants, reflected a perceived pattern in which students were positioned as passive recipients rather than active participants in education.

Managerial inefficiency was also consistently reported, including insufficient supervision, overcrowded clinical groups, inconsistent instructor presence, and a lack of structured educational planning. Clinical placements were frequently described as observational rather than participatory. Participants indicated that this limited their opportunities for skill development and reduced the educational value of clinical training.

Operational inefficiency further compounded these challenges. Participants highlighted the lack of structured orientation programs, fragmented curriculum implementation, and repetitive or nonpurposeful clinical assignments. From participants' perspective, these conditions created ambiguity

regarding expectations and contributed to a sense of disorganization in clinical education.

Collectively, these patterns suggest that organizational incivility toward students is embedded in systemic shortcomings affecting both the structure and delivery of clinical education.

4.4.2. Organizational Incivility Toward Faculty Members

Organizational incivility toward faculty members was primarily reflected in inadequate institutional support, weak recognition of academic roles, and limited structural authority within clinical settings. Participants described situations in which faculty members were held accountable for clinical conflicts without adequate institutional backing or recognition of contextual constraints.

Managerial inefficiency in this domain included a lack of understanding of clinical teaching challenges, inconsistent administrative support, and an absence of clear mechanisms for conflict resolution. Faculty members reported feeling unsupported in disputes involving students and clinical staff. These accounts suggest that they were often positioned as the default source of responsibility regardless of the contextual factors described in their narratives.

Behavioral inefficiency was also evident in institutional responses that limited faculty autonomy and imposed excessive administrative responsibilities. Participants interpreted these conditions as undermining their professional authority and weakening academic identity within clinical environments.

4.4.3. Organizational Incivility Within Hospital Systems

Within hospital settings, organizational incivility was primarily manifested through structural inequalities, professional hierarchies, and unequal distribution of resources between professional groups. Participants emphasized that clinical environments were predominantly physician-centered, with nursing roles often lacking formal recognition or institutional visibility. This characterization was based on participants' descriptions of their clinical workplace experiences.

Discriminatory patterns were evident in access to facilities, allocation of resources, and professional recognition. Nursing students and faculty members

frequently experienced limited access to basic amenities compared with other professional groups. Participants reported that these disparities contributed to feelings of exclusion and reinforced perceived hierarchical divisions.

Furthermore, limited collaboration between hospitals and nursing schools was highlighted as a barrier to effective clinical education. From participants' perspective, weak coordination between systems reduced continuity of educational processes and contributed to fragmentation.

4.4.4. Organizational Incivility Within University Administration

At the university level, organizational incivility was associated with inadequate resource allocation, insufficient support for nursing education, and limited investment in infrastructure and professional development. Participants emphasized that fundamental needs, such as staffing and facilities, were not adequately addressed, directly affecting clinical training.

Beyond resource limitations, participants described a broader structural imbalance between institutional priorities and educational needs. These descriptions were interpreted by participants as making it more challenging to maintain ethical and professional standards in practice.

4.4.5. Analytical Integration

Overall, the findings demonstrate that organizational incivility in clinical nursing education is a systemic phenomenon rooted in structural inequality, managerial inefficiency, and institutional prioritization of service over education, as reflected in participants' narratives across settings.

A key insight emerging from participants' accounts is that organizational incivility operates through both material and symbolic mechanisms. Material mechanisms include resource allocation, staffing, and infrastructure, whereas symbolic mechanisms involve recognition, visibility, and professional legitimacy. These interpretations are derived from participants' descriptions of how such conditions were experienced in clinical environments.

Together, these mechanisms shape perceptions of value, belonging, and respect within clinical

environments.

4.4.6. Implications for Organizational Reform

Addressing organizational incivility requires systemic interventions rather than isolated administrative adjustments. Priority areas include restructuring clinical education planning, improving coordination between academic and clinical institutions, and ensuring equitable access to resources across professional groups.

Strengthening institutional recognition of nursing education, clarifying role expectations, and improving supervision systems are also essential to enhance the quality of clinical learning environments. Finally, fostering integrated educational-clinical governance structures may contribute to reducing fragmentation and improving organizational coherence.

5. Discussion

The present study provides a comprehensive understanding of uncivil behaviors in clinical nursing education by demonstrating that such behaviors are not isolated interpersonal incidents but emerge from interactions among individual, relational, and organizational processes. Across students, faculty members, healthcare staff, and organizational structures, incivility was found to operate as a multidimensional, mutually reinforcing phenomenon embedded within the clinical learning environment (15). A key finding is that uncivil behaviors exist on a continuum ranging from overt disrespect and exclusion to subtle disengagement, withdrawal, and the normalization of unprofessional conduct.

Importantly, not all observed behaviors represented incivility per se. Some reflected stress responses, role ambiguity, or structural inefficiencies. During analysis, incivility was therefore defined strictly as behavior that violates interpersonal respect, dignity, and professional norms, whereas contextual factors were treated as antecedents rather than incivility itself (16).

5.1. Student-Related Findings

Within the student-related findings, instrumental treatment and exclusion were identified as clear forms of incivility. However, disengagement, reduced motivation, and dependence were interpreted as stress-related responses to unclear expectations and

educational instability. This distinction aligns with evidence showing that clinical stress and ambiguous learning environments influence student engagement and adaptation (13). This separation was essential to avoid conflating the behavioral outcomes of incivility with incivility itself.

5.2. Faculty-Related Incivility

Faculty-related incivility was identified as a central driver of the broader cycle. Direct disrespect and unfair treatment contributed to the erosion of trust, while inconsistent teaching practices and limited engagement further intensified perceptions of incivility. Previous studies emphasize that fairness, competence, and respectful communication are essential for maintaining civility in education (17). Importantly, some behaviors reflected workload or institutional constraints rather than intentional disrespect; however, their interpersonal expression still shaped student perceptions (18). This finding highlights the need to distinguish structural burden from its behavioral manifestations.

5.3. Healthcare Staff and Hierarchy

At the healthcare staff level, hierarchical and physician-centered structures strongly influenced interaction patterns. Many exclusionary behaviors were rooted in institutionalized power asymmetries rather than individual intent. Nevertheless, these behaviors were experienced as incivility because of their effects on dignity and inclusion.

5.4. Organizational Level

Organizational inefficiencies, such as poor coordination, a lack of resources, and a weak educational structure, created conditions that facilitated stress and ambiguity. These factors are better understood as antecedents of incivility rather than incivility itself (13). Thus, the organizational system functions as a contextual layer shaping the emergence and expression of uncivil behaviors.

5.5. Integrated Model

Overall, the findings support a cyclical and interactive model of incivility in which behaviors are reproduced through reciprocal interactions among students, faculty members, staff, and organizational

systems. This cycle is influenced by structural conditions such as leadership style, resource allocation, and cultural hierarchy. Importantly, incivility should be understood as embedded within broader systems of power and structure rather than as isolated interpersonal events.

5.6. Conclusions

This study demonstrates that uncivil behaviors in clinical nursing education arise from a complex interplay between interpersonal interactions and organizational structures. Incivility was observed across students, faculty members, healthcare staff, and institutional systems, but its manifestations varied in intensity and form, ranging from overt disrespect to subtle exclusion and disengagement.

A key contribution of this study is the clarification of conceptual boundaries between incivility and related phenomena. Not all observed behaviors represented incivility in its strict sense. Some reflected stress responses, role ambiguity, or structural constraints rather than intentional violations of professional norms. In the analytic process, incivility was defined specifically as behavior involving violations of professional respect, dignity, and interpersonal norms, whereas contextual and systemic factors were interpreted as underlying conditions that shape or facilitate these behaviors.

The findings indicate that uncivil behaviors are sustained through a cyclical and mutually reinforcing process involving individuals and institutions. Hierarchical clinical structures, limited educational resources, inconsistent instructional practices, and weak organizational support systems collectively contribute to an environment in which incivility can emerge and persist.

To address this issue effectively, interventions must move beyond individual-level behavioral correction and focus on systemic reform. Such interventions include improving role clarity in clinical education, strengthening faculty development, enhancing interprofessional collaboration, and addressing structural inequalities between professional groups. Equally important is the need to improve organizational support systems that reduce ambiguity, workload imbalance, and educational fragmentation.

By integrating individual, relational, and organizational perspectives, this study contributes to a

more nuanced understanding of incivility in clinical nursing education and provides a foundation for developing multilevel interventions aimed at fostering respectful, equitable, and effective learning environments.

Supplementary Material

Supplementary material(s) is available [here](#) [To read supplementary materials, please refer to the journal website and open PDF/HTML].

Footnotes

AI Use Disclosure: The authors declare that no generative AI tools were used in the creation of this article.

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