Nurse Educator

Fostering Civility in Learning Conversations

Introducing the PAAIL Communication Strategy

Cynthia M. Clark, PhD, RN, ANEF, FAAN; and Mary K. Fey, PhD, RN, CHSE-A, ANEF

ABSTRACT

Background: Civility, psychological safety, and effective stress management are essential for meaningful learning conversations.

Problem: Incivility triggers fear and humiliation, impairs clinical judgment and learning, reduces psychological safety, and increases cognitive load. These factors converge to make learners less likely to incorporate feedback, speak up when there is a problem, and discuss practice errors and patient safety issues.

Approach: The authors combined the Basic Assumption and the PAAIL (Preview, Advocacy1, Advocacy2, Inquiry, and Listen) conversational strategy to help surface (rather than obscure) both educators' and learners' thinking. The synergy of these 2 strategies allows educators to identify individual learning needs and develop the learners' clinical judgment skills. This process improves learning by reducing incivility and cognitive load, improving psychological safety, and strengthening clinical judgment skills.

Conclusion: This conversational strategy can minimize stress and anxiety in learners and optimize learning.

Keywords: civility, communication, learning, nursing students, patient safety

Cite this article as: Clark CM, Fey MK. Fostering civility in learning conversations: introducing the PAAIL communication strategy. *Nurse Educ.* 2019; doi: 10.1097/NNE.0000000000000731

Nursing care is an inherently emotional endeavor. Guided by constructs such as caring and empathy, emotions are a constant element in the delivery of professional nursing care. Emotion, long thought of as distinct from cognition, is increasingly being recognized as inseparable from cognitive processes such as problem solving and decision making.[1] If emotion and cognition are seen as separate and distinct, educators run the risk of allowing negative emotion to harmfully impact both learning and performance.[1-3] Incivility can activate negative emotions and is unfortunately prevalent in nursing education.[4-8] The negative emotional impact of incivility can be corrosive to the goal of every nurse educator: developing nurses who are capable of clinical problem solving, protecting patient safety, and advocating for optimal patient care.

Incivility is defined as a range of behaviors from lower-intensity acts of aggression such as arm-crossing, eye rolling, or refusing to listen and walking away to more overt behaviors such as making disparaging remarks, belittling, or intentionally excluding and marginalizing others.[9-11] Incivility also includes failing to take action when actions are warranted, such as withholding important information about a patient's care, failing to intervene on another's behalf, or refusing to assist a colleague.[9,12] These actions and inactions may result in psychological or physiological distress for the people involved.[9]

In nursing and health care, harm from disrespect (incivility) has been identified as the next frontier in patient safety efforts and is associated with higher risk of physical harm, a worse patient experience, and a lower likelihood of perceiving care as high quality and seeking care again in the same facility.[13] Exposure to acts of incivility may result in a lack of psychological safety. This lack of psychological safety impairs thinking and decreases willingness to discuss errors or speak up about potential or actual problems.[14]

This article offers strategies that allow nurse educators to remain civil when offering constructive feedback and efficiently identify the real learning needs that underlie performance. The authors propose that a fundamental paradigm shift in how nursing faculty view their students, coupled with a specific conversation strategy, has the power to alter the intellectual discourse in nursing education in a way that benefits the teacher-learner relationship. In addition, the authors present a method for learning conversations that decreases cognitive load and stress levels, fosters civility and psychological safety, and improves learning outcomes and

Author Affiliations: Strategic Nursing Advisor (Dr Clark), ATI Nursing Education, Boise, Idaho; Associate Director (Dr Fey), Institute for Medical Simulation, Center for Medical Simulation, Boston, Massachusetts.

The authors declare no conflicts of interest.

Correspondence: Dr Clark, ATI Nursing Education, 279 E Danskin Dr, Boise, ID 83716 (cindy.clark@atitesting.com).

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.nurseeducatoronline.com).

Accepted for publication: June 25, 2019

Published ahead of print: September 5, 2019

DOI: 10.1097/NNE.0000000000000731

patient care. To address these critical issues, the authors provide nurse educators with an evidence-based approach to prevent incivility, improve the teacher-learner relationship, and create a safe space for learning.

Civility, Incivility, and Stress

Over the past 2 decades, the body of science related to civility and incivility in nursing education has continued to expand. Studies have examined both the manifestations of nursing faculty incivility and the impact of incivility on nursing students. Faculty behaviors that have been identified as uncivil include displaying an attitude of superiority, rigidity and refusal to change, misusing power, and a disregard for students' previous work and academic experience.[6,8,15] Other uncivil faculty behaviors included students being made to feel stupid and belittling them in front of others.[7] Del Prato[5] found similar results when exploring students' "lived experiences" (their qualitative perceptions of interacting with faculty) with faculty incivility.[5] Del Prato[5] found that faculty incivility comprised 4 interrelated experiences: verbally abusive and demeaning experiences, favoritism and subjective evaluation, rigid expectations for perfection, and targeting and weeding-out practices.

Several studies revealed that stress plays a significant role in the display of uncivil behaviors in nursing education," often resulting in physical and psychological symptoms for the individuals involved.[6,8,15] Demanding workloads, juggling multiple roles, competing in a high-stakes academic environment, and experiencing incivility by faculty, other students, and nurses in practice contributed to increased levels of student stress. The impact of these behaviors on students can be significant both personally and in their view of the nursing profession.

Students have reported the personal impact of faculty incivility to be feelings of powerlessness, anger, psychological trauma, and disillusionment with both faculty and the nursing profession.[4,5,8,16] Students feel they are unable to learn in these negative environments, which rob them of their self-confidence.[4] Similarly, Rawlins[17] concluded that incivility between and among nursing faculty and students may result in disruption in the learning environment along with diminished health and well-being. Students are often reluctant to speak up about the incivility because they fear being failed in a course or terminated from the nursing program altogether. Rawlins'[17] study reported that they chose instead to adopt a *save yourself attitude* and go into *survival mode*, doing whatever has to be done to get through the program.

Incivility interferes with the brain's ability to problem solve in conditions that are perceived as threatening. Porath et al[18] found that incivility disrupts working memory, which in turn negatively impacts learning, performance, and creativity. They also found that "a workplace that has a climate of incivility may impair creativity and performance because incivility robs people of cognitive resources, disrupts working memory, and ultimately hijacks performance."[18(p259)]

Cognitive Load and Working Memory

Cognitive load theory and an understanding of working memory provide an important framework for the understanding of learning situations. This theory posits 3 types of cognitive load: intrinsic, extraneous, and germane.[19] Tasks with high intrinsic load have many interacting elements that must be processed simultaneously. Because of the number of interacting elements, these problems are complex and difficult to understand by their nature.[20] For example, directing a cardiac resuscitation would have high intrinsic cognitive load compared with simply doing chest compressions. Extraneous load refers to cognitive demands that are not relevant to the learning goals. It is often imposed by instructional design or delivery features such as providing incomplete information to complete a task. When learners integrate the elements of intrinsic load with information stored in long-term memory to create new cognitive schema, it is referred to as germane cognitive load. All of these types of cognitive load are additive and place demands on working memory.[20-22]

Humans have 2 memory systems: long-term and working (ie, short-term) memory. Long-term memory has unlimited capacity to store learned patterns and retrieve them when faced with the same or similar situations in the future. Working memory, on the other hand, processes and organizes new information. It is limited in the amount of information it can process at any given time.[20] Long-term memory is at work when we complete routine tasks with little cognitive effort. Imagine the usual drive home from work, which is accomplished with little concentrated effort; in fact, we can listen to music or have a conversation with a passenger. Driving in a new city, however, is very different—we have to concentrate. This is because in nonroutine situations our working memory is highly active—perceiving data, processing information, making judgments, and evaluating progress. Working memory is our ability to "keep multiple balls in the air" at the same time, as we interpret data and make decisions.[20,22] Similarly, in novel learning situations, students are limited in the amount of incoming data they can attend to and process.

A source of extraneous cognitive load that is often not taken into consideration is negative emotion. Emotions modulate what we pay attention to, how we interpret data from the environment, and our ability to make judgments.[1,23] High levels of negative emotions, such as stress and anxiety, can be considered extraneous cognitive load when not directly connected to learning outcomes. In this context, the impact on working memory is significant. Because of the additive effects of the 3 types of cognitive load, the learner must allocate some working memory to dealing with a perceived threat, robbing valuable cognitive resources from other important tasks or goals.

Psychological Safety

Psychological safety in work teams is a construct used in organizational behavior literature.[24] Edmondson and Lei[25] define a psychologically safe learning environment as one

in which individuals believe that they will not be embarrassed or humiliated for any mistakes they might make. Psychological safety has been shown to improve teamwork and patient outcomes in health care.[24-27] Importantly, for educators, when learners feel psychologically safe, they are more willing to admit when they do not know something, ask questions, and seek feedback. Learners in these types of environments develop a learning orientation and are more willing to strive to reach their next developmental level.[27]

Strategies for Learning Conversations

Nurse educators have a primary responsibility to guide students' progression throughout the nursing program. This includes monitoring progress, coaching performance, giving feedback, and building a learner's ability to self-reflect during learning experiences and conversations. Feedback and learning conversations can create anxiety for learners; this anxiety has the potential to interfere with their ability to fully process and respond to input from faculty. Feedback is more likely to be heard and, more importantly, incorporated, when learners perceive that the feedback is positive, allows for reflection, and is given with the intent to help them improve.[28] Yet, feedback given in response to performance errors is not always viewed as positive. The way the educator approaches this difficult terrain of giving direct feedback while maintaining a psychologically safe learning environment can significantly influence its outcome.[29] As described by Carl Rogers,[30] positive regard and empathy are key to creating an environment that encourages growth and integration. Many educational approaches that embrace a constructivist, active learning approach have adopted Rogers' tenets, as have educational theorists such as Knowles et al,[31] Kolb,[32] and Heim.[33]

The Basic Assumption[34] is a philosophical belief based on positive regard for the learner that lays the groundwork for improved communication between and among faculty and learners. It has the potential to prevent and address incivility, decrease stress and cognitive load, and foster psychological safety. The Basic Assumption states: "We believe that everyone participating in activities here is intelligent, capable, cares about doing their best, and wants to improve."[34]

This powerful belief, once genuinely incorporated into one's teaching philosophy, allows the educator to view learners as sincerely trying their best. It is the pathway to a learning conversation that is curious, is respectful, and encourages self-reflection on the part of the learner. In this environment, learners can share their thought processes without fear of humiliation or embarrassment. Having this window into the learner's thinking allows the educator to teach to specific learning needs, co-constructing meaning with the learner.[35] For many educators, this is a significant shift in philosophy and when embraced and assimilated forms a foundation to support meaningful learning conversations between teachers and learners. The converse is also true: when the Basic Assumption is not incorporated, and when learners feel disrespected and fearful, they tend to either "shut down" or experience cognitive overload as they deal with the extraneous cognitive load caused by feeling the need to defend themselves against a perceived threat. Defending against a threat robs learners of essential emotional and cognitive resources necessary for learning and performance.[36] The strength of this approach is that it allows the faculty member to address the core dilemmas of providing direct feedback to learners with high regard, curiosity, and respect. Importantly, the Basic Assumption is not something learners must earn; it is the starting place for the teacher-learner relationship and begins with the teacher (R. Simon, personal oral communication, October 15, 2015).

A conversational strategy that may be paired with the Basic Assumption includes Previewing (framing) the conversation, coupled with the Advocacy-Inquiry questioning technique. Advocacy, in this context, refers to educators describing the action they observed (Advocacy1) and explicitly sharing why they are concerned about the action (Advocacy2). The Inquiry question that follows is an open-ended invitation to learners to share their perspective. Following the question, it is most important for the educator to carefully Listen to the students' reflection on their thoughts (Preview, Advocacy1, Advocacy2, Inquiry, and Listen [PAAIL]).[37] The PAAIL strategy is displayed in Table 1. The acronym PAAIL is a helpful way to remember the components of the conversational strategy.

Conceptual Model for Civil Conversations

Exposure to incivility, experiencing prolonged levels of heightened stress, feeling psychologically unsafe, and being cognitively overloaded can occur individually or in combination to negatively impact learning and performance. The authors introduce a conceptual model (Figure, Supplemental Digital Content, http://links.lww.com/NE/A681) to illustrate the interactivity and impact of these experiences on learning and performance.

The conceptual model for civil conversations begins with educators holding the Basic Assumption about the learner, followed by using the PAAIL communication strategy to foster a safe learning environment. By doing so, civility, cognitive balance, psychological safety, and effective coping are strengthened, which leads to a meaningful learning experience and ultimately safe patient care.

Table 1. PAAIL Strategy

Preview: "I'd like to talk to you about _____."
Advocacy (part 1): "I saw (or heard, or noticed…) _____."
Advocacy (part 2): "I am concerned because _____."
Inquiry: "I wonder what was on your mind at the time?"
Listen: Students describe how their working memory was perceiving events, data, and/or information; how they were interpreting it; the decision made to act (or not); and what outcome they were trying to achieve. Based on this information, the educator can target the specific flaws in thinking that lead to errors or substandard practice.

This model represents a multidirectional relationship with no consistent starting point. In other words, regardless of the point of entry, these detrimental processes can start a cascade of events leading to impaired learning and unsafe patient care. For example, an educator may display uncivil behaviors such as eye rolling or making demeaning comments about a learner's performance, which in turn elevates learner stress levels and constricts cognitive processing, psychological safety, and the ability to cope effectively. Further, incivility triggers reactions in the brain that make task completion and problem solving much more difficult[18] and contributes to decreased learner motivation, engagement, and performance.[38]

In addition to being an outcome of incivility, stress may also be a precursor to incivility. Uncivil encounters between faculty and learners are more likely to occur when stress levels are heightened.[8,15] When an individual experiences stress or a threat stemming from an uncivil act, it constricts cognitive processing and takes up working memory, which, in turn, can degrade performance. Therefore, the ability to focus on a task and perform skills (such as those required by nurses and other members of the health care team) is diminished.

Application for Educators

For an exemplar, the authors use a situation in which a nursing student listens to the patient's lungs anteriorly, but not posteriorly, during the physical assessment. Helpful tips for the use of each element of PAAIL are found in Table 2.

Another exemplar illustrates a nonroutine patient care situation where the nursing student needs to administer an intravenous diuretic medication to a patient who requires increasing amounts of supplemental oxygen. Understanding that this procedure will require the student to minimize extraneous cognitive load while preparing and administering the medication, the instructor reviews information about the process prior to entering the medication preparation area. In Table 3, the instructor incorporates the principles of cognitive load while using the Basic Assumption.

Once in the patient's room, the student checks the medication and the patient's identification and informs the patient of the plan, but forgets to check the patient's blood pressure. The Table in Supplemental Digital Content, http://links.lww.com/NE/A682, displays the instructor and student exchange. On leaving the room, the instructor returns to the Basic Assumption by internally reminding themselves that the student is an intelligent, capable nursing student who somehow forgot an important safety check before giving a medication. The instructor uses PAAIL to give clear feedback on performance and to help the student self-reflect. Based on this self-reflection, the instructor more clearly understands flaws in thinking that may have led to the error.

Conclusions

Coaching, mentoring, giving feedback, and guiding reflection on practice are integral to the teacher-learner relationship in nursing education. To optimize the gains for nursing students, attention to creating a psychologically safe environment in which learning can happen is key. Lack of respect for the learner, especially when expressed as uncivil behavior, negatively impacts the learner's working memory and makes it much more difficult to attend to and process information for the purpose of learning. To achieve this, the authors recommend 2 critical strategies. The first is to hold the learners in high regard while also holding them to high standards by incorporating the Basic Assumption into one's teaching philosophy. The second is to use the conversational strategy of PAAIL to give clear and direct feedback on performance and spark the level of learner self-reflection that gives instructors insight into the learner's thought processes. These insights allow educators to teach to specific learning needs, enhance the learners' clinical judgment, and subsequently improve practice.

Incorporating civility into one's teaching approach can have important learning benefits. Minimizing stress and anxiety allows working memory to more fully perceive and interpret data for the purpose of decision making and learning. This can be accomplished while still giving students

Table 2. Helpful Tips for Using Each Element of PAAIL

Element	Strong Example	Weak Example	Uncivil Example
Preview	I'd like to talk to you about your respiratory assessment on Mr Smith.	I'd like to talk about physical assessment (too vague).	No preview at all, or "Your physical assessment skills are terrible."
Advocacy1 I saw	I saw that you listened to Mr Smith's breath sounds in the front of his chest, but I didn't see you listen in the back (stating objective data).	You were rushing through that respiratory assessment and didn't do a thorough job (this is making an inference).	I guess you think doing half of an assessment is good enough.
Advocacy2 I think	I'm concerned that by not listening in all fields, you may miss findings like crackles in the bases	You should always do the entire respiratory assessment (too general).	I guess you don't care about thoroughness
Inquiry	Can you please walk me through what was on your mind as you were performing the respiratory assessment?	What would you do differently next time? (Does not seek to understand what was driving the current decision).	What on earth are you thinking?? Or Lecturing "ad nauseum."

Table 3. Instructor Incorporates Principles of Cognitive Load With Basic Assumption

Nursing instructor to student:
I realize that this is a new situation for you and one that is potentially high risk for the patient. I know that you are going to do your best to be sure that the medication is administered safely. I want you to stop at any time to ask questions or verify that your thinking and plan are on target. First, let's go over the information about the drug, the "5 rights" of medication administration, and a step-by-step review of what you're going to do. Then we'll draw up and administer the drug together. How does that sound? What questions do you have?

direct feedback about their performance. Use of the Basic Assumption, coupled with PAAIL, provides a pathway to more meaningful and fruitful learning conversations.

References

1. Pessoa L. A network model of the emotional brain. *Trends Cogn Sci*. 2017;21(5):357-371.
2. Damasio AR. *Descartes' Error: Emotion, Rationality and the Human Brain*. New York, NY: Penquin Putnam; 1994.
3. Pessoa L. On the relationship between emotion and cognition. *Nat Rev Neurosci*. 2008;9(2):148-158.
4. Mott J. Undergraduate nursing student experiences with faculty bullies. *Nurs Educ*. 2014;39(3):143-148.
5. Del Prato D. Students' voices: the lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. *Nurs Educ Today*. 2013;33(3):286-290.
6. Altmiller G. Student perceptions of incivility in nursing education: implications for educators. *Nurs Educ Perspect*. 2012;33(1):15-20.
7. Lasiter S, Marchiondo L, Marchiondo K. Student narratives on faculty incivility. *Nurs Outlook*. 2012;60(3):121-126.
8. Clark CM. The dance of incivility in nursing education as described by nursing faculty and students. *Adv Nurs Sci*. 2008;31(4):E37-E54.
9. Clark CM. *Creating and Sustaining Civility in Nursing Education*. 2nd ed. Indianapolis, IN: Sigma Theta Tau International Publishing; 2017.
10. Clark CM. An evidence-based approach to integrate civility, professionalism, and ethical practice into nursing curricula. *Nurs Educ*. 2017;42(3):120-126.
11. Porath C, Pearson C. The price of incivility. *Harv Bus Rev*. 2013; 91(1-2):114-121, 146.
12. American Nurses Association. Position statement: incivility, bullying, and workplace violence. 2015. Available at https://www.nursingworld.org/practice-policy/nursingexcellence/official-position-statements/id/incivility-bullying-and-workplace-violence/. Accessed May 10, 2019.
13. Sokol-Hessner L, Folcarelli PH, Annas CL, et alPractice of Respect Delphi Study Group. A road map for advancing the practice of respect in health care: the results of an interdisciplinary modified Delphi consensus study. *Jt Comm J Qual Patient Saf*. 2018;44(8):463-476.
14. Porath CL. *Mastering Civility: A Manifesto for the Workplace*. New York, NY: Grand Central Publishers; 2016.
15. Clark CM, Juan CM, Allerton BW, Otterness NS, Jun WY, Wei F. Faculty and student perceptions of academic incivility in the People's Republic of China. *J Cult Divers*. 2012;19(3):85-93.
16. Clark CM. On faculty incivility in nursing education: a conceptual model. *Nurs Educ Perspect*. 2008;29(5):284-289.
17. Rawlins L. Faculty and student incivility in undergraduate nursing education: an integrative review. *J Nurs Educ*. 2017;56(12): 709-716.
18. Porath CL, Foulk T, Erez A. How incivility hijacks performance: it robs cognitive resources, increases dysfunctional behavior, and infects team dynamics and functioning. *Organ Dyn*. 2015;44: 258-265.
19. Sweller J. Cognitive load theory, learning difficulty, and instructional design. *Learn Instr*. 1994;4(4):295-312.
20. Van Merriënboer JJ, Sweller J. Cognitive load theory in health professional education: design principles and strategies. *Med Educ*. 2010; 44(1):85-93.
21. Josephsen J. Cognitive load theory and nursing simulation: an integrative review. *Clin Simul Nurs*. 2015;11(5):259-267.
22. Meguerdichian M, Walker K, Bajaj K. Working memory is limited: improving knowledge transfer by optimising simulation through cognitive load theory. *BMJ STEL*. 2016;2(4):131-138.
23. LeBlanc VR, McConnell MM, Monteiro SD. Predictable chaos: a review of the effects of emotions on attention, memory and decision making. *Adv Health Sci Educ*. 2015;20(1):265-282.
24. Edmondson A. Psychological safety and learning behavior in work teams. *Adm Sci Q*. 1999;44(2):350-383.
25. Edmondson AC, Lei Z. Psychological safety: the history, renaissance, and future of an interpersonal construct. *Annu Rev Organ Psych*. 2014;1(1):23-43.
26. Dweck C. *Mindset: Changing the Way You Think to Fulfil Your Potential*. Updated ed. New York, NY: Random House; 2016.
27. Edmondson AC. *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth*. Hoboken, NJ: Wiley; 2019.
28. Sargeant J, Lockyer JM, Mann K, et al. The R2C2 model in residency education: how does it foster coaching and promote feedback use? *Acad Med*. 2018;93(7):1055-1063.
29. Rudolph JW, Raemer DB, Simon R. Establishing a safe container for learning in simulation: the role of the presimulation briefing. *Simul Healthc*. 2014;9(6):339-349.
30. Rogers CR. The necessary and sufficient conditions of therapeutic personality change. *J Consult Psychol*. 1957;21(2):95-103.
31. Knowles MS, Holton E, Swanson R. *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*. 5th ed. Houston, TX: Gulf Publishing Company; 1998.
32. Kolb DA. *Experience as the Source of Learning and Development*. Upper Saddle River, NJ: Prentice Hall; 1984.
33. Heim C. Tutorial facilitation in the humanities based on the tenets of Carl Rogers. *High Educ*. 2012;63(3):289-298.
34. Center for Medical Simulation. *Basic Assumption* [class handout]. Boston, MA: Center for Medical Simulation; 2004.
35. SG Forneris, MK Fey, eds. *Critical Conversations: The NLN Guide for Teaching Thinking*. Washington, DC: National League for Nursing; 2018.
36. Rudolph JW, Simon R, Raemer DB, Eppich WJ. Debriefing as formative assessment: closing performance gaps in medical education. *Acad Emerg Med*. 2008;15(11):1010-1016.
37. Center for Medical Simulation. *PAAIL [class handout]*. Boston, MA: Center for Medical Simulation; 2016.
38. Clark CM, Davis Kenaley BL. Faculty empowerment of students to foster civility in nursing education: a merging of two conceptual models. *Nurs Outlook*. 2011;59(3):158-165.