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"You can't escape it": Bullying experiences of New Zealand nursing students on clinical placement

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ABSTRACT

Background: Bullying in nursing is not a new phenomenon and nursing students are not exempt from its effects, however there is limited literature that deals directly with bullying of nursing students within the clinical environment in New Zealand. Quality clinical placements are vital to facilitate the link between theory and practice whilst working in complex healthcare settings.

Aim: The purpose of this article is to present the experiences described by nursing students regarding the nature and extent of bullying during clinical placements.

Design: This study employed a cross-sectional survey design using an electronic survey in which this paper focuses on the textual data provided by nursing students from across New Zealand. Data was analysed by coding and grouping into themes.

Results: There were numerous uncivil behaviours students were subject to during clinical placements. The consequences of these behaviours had physical, psychological and financial implications for students, with some suggestions that they choose to leave the nursing profession.

Conclusions: Predominantly the practice setting is clearly not nurturing enough for nursing students; a situation unlikely to change in the near future. Hence academic institutions must be proactive in developing students' ability to address incivility in these environments and to educate their own staff on how to recognise and respond to bullying in the clinical arena.

1. Introduction

Undergraduate nursing education consists of theory and practice, with the practice component providing students with the opportunity to apply theoretical knowledge from the classroom to the practice setting. Within New Zealand (NZ) clinical practice experiences for undergraduate nursing students consists of a minimum of 1100 hours as stipulated by the New Zealand Nursing Council, which is approximately one-third of the total hours within the Bachelor of Nursing degree. Quality clinical placements provide the link between theory and the practical application and are essential to develop professional attributes and competence (Ford et al., 2016). However the clinical practice environment can be complicated and at times a hostile place for students, which can affect their ability to learn (Birks et al., 2017b; Hakojarvi et al., 2014). Bullying by and between nurses in the clinical setting is a widely acknowledged concern internationally (Birks et al., 2017c; Blackwood et al., 2017; Hakojarvi et al., 2014; Hartin et al., 2018; Logan and Michael Malone, 2018; Tee et al., 2016). Unfortunately nursing students often witness and/or encounter episodes of bullying within the clinical setting.

Bullying has been defined by Hewett (2010) as "aggressive behaviour towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence, such as verbal abuse, incivility and intimidation" (p.10). The term bullying can be used interchangeably with words such as harassment, incivility and horizontal or vertical violence (Courtney-Pratt et al., 2018; Seibel, 2014). Vertical violence occurs when there is a power imbalance between the victim and the perpetrator, such as the nursing student and preceptor, or new graduate nurse and senior nurse. Beyond its more overt forms, behaviours that constitute bullying can include excessive criticism, non-verbal gestures, withholding information, intimidation and exclusion (Courtney-Pratt et al., 2018; Sanner-Stiehr and Ward-Smith, 2017).

Historically the associated of nursing being an oppressed group, in which a predominately female group, who were subordinate to medicine, and existed in a hierarchical nature has led to bullying behaviours,

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because they were unable to address their own oppression (Courtney-Pratt et al., 2018; Thomas and Burk, 2009). Increased pressure, limited resources and an organisational culture within healthcare that is not proactive in preventing or dealing with bullying allows it to persist (Blackwood et al., 2017; Huntington et al., 2011). Bullying is said to be so entrenched in nursing that it results in students leaving the profession (Clarke et al., 2012). Students may not only be subject to bullying but may also witness its occurrence with fellow students and between other nurses. It has also been suggested that bullying persists because it originates in undergraduate nursing education (Seibel, 2014) and is therefore socialised into graduates from their first exposure to the profession.

Bullying of nursing students during their clinical placements is being recognised increasingly within the international literature (Birks, Budden et al., 2017; Hakojarvi et al., 2014; Smith et al., 2016; Tee et al., 2016). Bullying of students does not just occur in the clinical setting, it has also been identified by academics within educational institutions (Courtney-Pratt et al., 2018; Rawlins, 2017; Seibel, 2014). Students can also be perpetrators of bullying to other students, both face to face and through social media (Clark et al., 2012; Cooper and Curzio, 2012).

The consequences of bullying of students in the clinical environment are profound. Students who have been bullied reported the loss of learning opportunities, being unable to meet learning objectives and of losing motivation (Birks et al., 2017b; Budden et al., 2017; Hakojarvi et al., 2014; Smith et al., 2016). Students also questioned whether they wanted to continue with their nursing degree (Hakojarvi et al., 2014). Bullying has additionally been found to affect students' physical and mental well-being, with problems such as loss of sleep, frustration, feelings of anxiety and depression, headaches and gastrointestinal problems (Birks, Budden et al., 2017; Bowllan, 2015; Rawlins, 2017; Seibel, 2014). Witnessing bullying has also negative consequences for nursing students, including heightened levels of stress and low self-confidence (Lutgen-Sandvik et al., 2007).

Nursing students are particularly vulnerable to being bullied for a number of reasons. Firstly they are often younger, lack experience and are unaware of the cultural norms within the healthcare environment (Tee et al., 2016). There has been a number of reasons proposed as to why bullying occurs with students. Sadly, it is often seen to be a “rite of passage”, reflecting that it is ingrained in the culture of the profession (Birks, Budden et al., 2017; Smith et al., 2016).

Given the complex and seemingly inevitable nature of bullying within nursing, it is important to understand nursing students' experiences of bullying during clinical placement. There is limited literature from NZ that has explored nursing students experiences whilst on clinical placement. This paper presents the experiences described by nursing students that were derived from a larger study investigating the nature and extent of bullying amongst this vulnerable group.

2. Methods

This study employed a cross-sectional survey design using an electronic survey. The target population was all students enrolled in a Bachelor of Nursing undergraduate degree in New Zealand. The study used the *Student Experience of Bullying During Clinical Placement* (SEBDCP) survey which was developed by Budden et al., based on early work by Hewett (2010) in her study of undergraduate nursing students in South Africa. The survey had been used in studies of Australian (Birks, Budden et al., 2017) and UK nursing students (Tee et al., 2016).

Minor adjustments were made to the survey to account for the NZ context. The survey was then tested for face validity by a group of academics and nursing students. The final instrument comprised a total of 91 items in 13 main questions, asking about bullying and/or harassment, (including intimidation, physical or verbal abuse and non-physical violence), and the reporting and management of such incidents. While the survey consisted of mainly Likert scale items, each question offered an ‘other’ response category and ability to give a textual response.

Following approval from the University Ethics Committee, students from all three-year levels of all programs across NZ were invited to participate via an invitation sent from their nursing school. Participation was voluntary and submission of the survey indicated consent for use of the data. Participants could refuse to answer any or all of the questions. The survey was open between August and October 2017. Results of the quantitative data have been published elsewhere (Blinded for review).

This paper presents focuses on the textual data provided by participants. This data contained considerable rich detail as it appeared many participants welcomed the opportunity to write about their experiences. Analysis began with reading all data repeatedly to achieve immersion and obtain a sense of the whole. It then consisted of grouping like concepts into codes and abstracting these codes into higher level concepts through a process Saldana (2016) refers to as ‘theming’. This process involved coding the data in sequential order from the survey questions. Data was first coded and then recurrent patterns where collapsed into the three themes to provide a condensed but descriptive representation of the students' experiences of bullying during their clinical placements.

3. Findings

A total of 296 surveys were returned in the broader study. Almost all (96.6%) participants were females with an overall median age of 21 years. Seventy six percent of participants were born in NZ, with English the first language for 84.4%. Most participants described themselves as NZ European or Maori (14.5%). Participants were enrolled in a range of years between year one and year three, with a small proportion (3.7%) recently graduated. A total of 324 comments that reflected bullying experiences of the students were extracted from the free text responses in the survey. Analysis of this data generated major themes of *manifestation of bullying and harassment*, *the perpetrators* and *consequences and impact* that reflect those of earlier work by Birks et al. (2017a, 2017b, 2017c) using a similar design.

3.1. Manifestations of Bullying and Harassment

There were numerous descriptions of uncivil behaviours students were subject to and witnessed while in the clinical environment that left them in no doubt of their place in the lower echelon within the hierarchy of nursing. These ranged from being ignored to being told frankly that they were worthless. Participant's provided a number of descriptions of harassment including physical, verbal, psychological and racial abuse directed at them or other nursing students.

Participants described the subtle acts by nurses and healthcare assistants that made them feel unwelcome and an annoyance. Commonly these negative behaviours consisted of being ignored which was described as the “cold shoulder” or “silent treatment”. Furthermore, to make students feel unwelcome nurses would whisper to each other about who wanted “the student”, making excuses as to why they could not have them for the shift, or use more subtle gestures such as rolling their eyes. Participants felt that these behaviours were intended to remind them of their place in the clinical setting:

> “…just enough to highlight my lowly level” (p6) Female, 2nd year.

> “Staff often act cold toward students as if we are a hassle, or ignore we are there at the start of the shift” (p7) Female, 3rd year.

Participants were confused as to whether the subtle negative behaviours actually constituted bullying. However, other behaviours such as constant lack of acknowledgment of who they were, was frequently reinforced by nurses:

> “Unsure as bullying to me can mean exclusion or not

acknowledging. I am still referred to as student rather than by name, even from recently graduated nurses. It is disheartening… I am… quite a sensitive person, and the convert nature of bullying at times wears me down" (P8) Female, 3rd year.

Other common behaviours participants described were situations when they were denied learning opportunities. Lack of instruction to the student of what needed to be done affected their ability to complete a task confidently. Conversely, incidences where students were pushed to do care that they felt was beyond their scope could result in negative behaviours towards them and result in limited learning opportunities thereafter:

"She lost her temper a bit when I said no for the third time and after that wouldn't allow me to do anything, even stuff I had done many times and was allowed to do" (P 2) Female, 2nd year.

Participants reported nurses getting the student to do tasks such as all vital sign observations because they did not want to do them or jobs that did not need to done at the time. Some participants also reported being told to wait outside the room while cares were undertaken with the patient and thus purposely preventing learning opportunities when they were clearly available.

Being spoken to about their clinical practice and knowledge level was also problematic, with reports of feedback being given negatively and in an aggressive and demeaning manner by nurses they had been working with.

"Instead of having a discussion with me and understanding why this might have been so, it was dealt with in a horrible way. Every time they met with me I would be left in tears and doubting myself" (P5) Female, 3rd year.

Not all behaviours participants reported were subtle, such as acts of sexual harassment. Although not reported often, they left students feeling uncomfortable and vulnerable. The perpetuators were not only patients; there were also incidents of this behaviour occurring by registered nurses, including senior nursing staff who touched a student's buttocks but was too scared to tell anyone because she thought no-one would believe her.

"I was sexually harassed multiple times… I was groped and sexual comments were made about me on shifts with particular nurses, this made me feel uncomfortable and made me feel like not going into clinical placement" (P) Female, 3rd year.

Another example of inappropriate behaviour consisted of a preceptor taking a student out for coffee during placement time and sharing information about their personal life such as dating and their relationship status making the students feel uncomfortable.

Reports of racist comments about students were described, although this was not common. These comments were directed at international students or those that had English as a second language. Furthermore there were also reports of racist comments made about or to Maori students:

"…judgement and neglect towards my Maori peers" (p 11) Female, 3rd year.

One participant described how they were put in a situation where they had to defend their culture and made to feel unsafe culturally and undervalued as a student.

3.2. The Perpetrators

Participants described being bullied or harassed mainly by clinical staff they were working with. Unfortunately, most instances of bullying were by registered nurses. Of concern, some bullying behaviours were also done by senior nurses, such as the ward charge nurses. Furthermore, there were incidences of students being bullied by their clinical tutors. Participants provided vivid accounts of being badly treated by healthcare assistances they worked with, and some of the distressing care they were subject to witness or assist with when working with vulnerable patients:

"The caregivers at the retirement homes treat student nurses poorly. Forced into doing improper practices and had a nasty review of them if [tasks] not done" Female 1st year.

Participants overwhelming identified the main perpetrators of bullying as their preceptors. Commonly, this took the form of preceptors not wanting to work with students:

"I was told straight by an RN "I don't know why we have to put up with you students and have you on the ward. You're not trained properly, I look stupid when you make a mistake and I don't get paid any extra money for your being on my shift with me" Female 2nd year.

There were many descriptions of how preceptors bullied students, and also how they witnessed many of their peers being bullied, with participants feeling powerless to do anything about it:

"I have seen too many of my nursing student friends crying because of bullying being carried out by their RN mentors… Students are not reporting this bullying as they do not feel they are in a position of power, or fear it will put a bad light upon their practice" (p19) Female 2nd year.

The ward culture seems to be an influence to the level of bullying that students were subjected to. One participant described an incident of a patient telling her about the length nurses in the ward would go to upset a student:

"I even had one man tell me that as a student I should not listen to the other nurses as he said that he can hear the nurses talking to each other about making students do their dirty work and then when a student would do the job he would hear them laughing about it" (P19) Female 2nd year.

The culture within the ward was described by participants as being set by the nurse manager as a precursor for how students may be treated. A welcoming and approachable nurse manager often meant ward nurses had similar behaviour, but a nurse manager who was rude to students set the tone for their experience:

"…my experience on a ward where the manager obviously didn't like students, it felt like this gave the other RNs the right to treat us badly. My other experience on another ward was completely the opposite, the manager was very welcoming and friendly right from our first day and so were all the RNs on the ward". Female, 2nd year.

The vulnerability of the student in the nursing hierarchy was noted as placing them at risk of being bullied:

"The very nature of student's work and position on clinical placement places us at risk of bullying because we are sub-clinical, supernumerary, untrained, young, vulnerable and frequently perceived as useless whether or not that is true" (p31) Female, graduated.

3.3. Consequences and Impacts

The consequences and impact of bullying described by participants in this study was at times harrowing. Participants described physical, psychological and financial implications that bullying had on them. Disturbingly, responses suggested that some students choose to leave the nursing profession because of the impact and degree of bullying they experienced:

"The old saying of "the old eating their young" describes what we

experience every time we walk through the doors to the facilities. It needs to stop or we will not have nursing students coming through the programmes" (p23) Female, 2nd year.

The degree of distress caused by bullying was obviously enormous for some who experienced or witnessed it. This distress manifested as physical and psychological symptoms when students remembered their clinical experiences, and everyday thereafter as they had to face time in the clinical environment. Participants described episodes of mental distress including acute anxiety, panic attacks, loss of control, and physical symptoms of stomach-aches and diarrhoea. The bullying experiences also affected their confidence and self-esteem; causing self-doubt, which then had a direct effect on their ability to make the most of learning opportunities. In spite of their distress, students generally did not speak up because of fear of jeopardising their ability to pass the placement. However, they recognise the potential long-term damage:

It's like having to stay in an abusive relationship – you can't escape it and you have to hope it gets better, all the while tip toeing around the abuser in the hope that you don't do anything "wrong". Just remembering my experience makes my heart race and my stomach twist" (p20) Female, 3rd year.

Participants described losing passion for their work as a nurse and wondered if they had made the right career choice:

"I have seen many younger students upset over the way they have been treated, and as I myself have done, debated why they have chosen the nursing profession. I suspect a large proportion of students have left due to the bullying that takes place and negative attitudes towards students" (p16) Female, 2nd year.

Many participants chose not to speak up about their bullying experiences to their clinical tutors. They feared not being believed and distrusted existing processes to deal with bullying. Students recognised the power the preceptors and clinical tutors had over them and feared speaking up in case they made them appear "useless and not up to standard" (p17). These participants felt there was no robust system in place to support students who were bullied while on clinical placement. On the rare occasion when students did speak up, there was generally an unsatisfactory response that just reinforced the absence of adequate systems in place:

"Students are not reporting this bullying as they do not feel they are in position of power, or fear it will put a bad light upon their practice. A 'deal with it' attitude is also very present. Tutors need to be more approachable… Being bullied has nothing to do with your ability to perform…, and it should not be a scheduled part of our nursing training" (p19) Female, 2nd year.

4. Discussion

The findings of this study indicate that students experience a significant amount of uncivil behaviour while on clinical placement. These findings share similarities to others (Budden et al., 2017; Courtney-Pratt et al., 2018; Smith et al., 2016). Most disturbing in this study is the total powerlessness and lack of control participants described from these negative behaviours. Students are a particularly vulnerable group who feel powerless to raise concerns about negative behaviours. Such bullying behaviour is therefore likely to flourish, given the imbalance of power between the perpetrator and victim (Scott, 2018).

The covert nature of some behaviours such as not using students' names, being ignored and experiencing eye rolling, has been described in earlier studies as the subtle behaviours that leave students unable to articulate these as bullying (Budden et al., 2017; Seibel, 2014; Smith et al., 2016). However, the cumulative effect of these behaviours results in students feeling unwelcomed in the clinical environment, a consequence that impacts negatively on their learning.

Reports of racism, particularly towards international students or those with English as a second language, as well as racist comments made about or towards Māori students, reflected similar experiences of students in previous studies using the same tool in other countries (Budden et al., 2017; Tee et al., 2016). The result is that students from these diverse backgrounds may feel particularly isolated. Workplace discrimination and difficulties experienced by migrant groups of nurses has been previously reported within the literature (Alexis and Vydelingum, 2004; Montayre et al., 2018; Xu, 2007). Humiliating and belittling behaviours towards another are forms of bullying that have previously been demonstrated to decrease a nurse's sense of self-worth, which over a period of time can undermine one's sense of self-esteem and self-concept (Hutchinson et al., 2010).

Nursing students attend placement for the purpose of learning. Accounts from participants in this study of not always being included in nursing activities, or being asked to carrying out repetitive menial tasks only, such taking vital signs, are detrimental to student learning. When students are given responsibility for patient care, allocated meaningful tasks and validated as knowledgeable, skillful future nurses, it builds their self-confidence (Birks et al., 2017a). It has previously been reported that students on clinical placement adopt the negative behaviours of clinical role models, with students adopting traits that they perceive to be good nursing practice. Even bad role models can impact positively on students when they recognise this is behaviour they do not wish to adopt (Baldwin et al., 2014). However, if students are excluded from being present during moments of care or doing repetitive tasks, this will impact on their ability to critique and develop their practice further.

Learning in the clinical environment is promoted when students feel safe in clinical and have a sense of belonging (Levett-Jones and Lathlean, 2009). However, an unwelcoming and at times hostile environment created stress for participants in this study, which impacted on their learning and made them feel excluded from the team. As demonstrated by other studies, the need to be accepted influenced the level of students' satisfaction and development as a nurse, and took precedence over the level of competency they aspired to achieve when on clinical placements (Borrott et al., 2016; Levett-Jones and Lathlean, 2008).

One of the most disturbing findings in this study was the fear and distrust students had of speaking up about their experiences of bullying. The fact they felt they could not even confide in their clinical tutor portrays the extent of their powerlessness. A study undertaken in NZ about bullying within nursing suggests a lack of constructive leadership in some areas has contributed to not only a culture which directly simulates bullying, but also a perception that bullying is tolerated; it is therefore not reported, because of the belief that nothing will be done (Blackwood et al., 2017). Earlier research in NZ on nursing students' experiences of bullying suggests a vicious cycle of bullying through the ranks of nursing (Foster et al., 2004).

The influence the clinical environment has on nursing students' choice to stay or leave a profession has received minimal attention. For a student to describe staying in the profession as being analogous staying in an abusive relationship illustrates the impact bullying has on these students. The Duluth Model Power-Control Wheel (PCW) was initially developed to illustrate patterns of abusive behaviours by men towards women, but has been adapted to illustrate bullying behaviours through the privilege of power and control (Scott, 2018). The negative behaviours participants described in this study all fit within this model. Themes in this model consist of the use of intimidation, emotional abuse, isolation, minimizing, denying and blaming, using employer privilege, economic abuse, and using coercion and threats. It should be of concern to the profession internationally that the evidence available about the experiences of nursing students can effectively be described using this model.

5. Limitations

While this study has drawn on a number of students, a relatively small percentage of students responded to this survey, and therefore may not represent a cross-section of all students' experiences across New Zealand, which may be considered a limitation of this study. Furthermore, it needs to be recognised that the title of the study may have only attracted students that had been bullied and felt comfortable recalling their experiences. Therefore positive experiences from clinical are not portrayed. The intent of this work is not that it be generalised, however, and therefore representativeness was not sought. Rather, the researchers aimed to explicate concepts that may be transferrable to other contexts and this had been facilitated as a result of the rich detailed data provided by students who did participate.

6. Recommendations

The clinical environment for students is clearly not always particularly nurturing; a situation that is unlikely to change imminently. It is the responsibility of academic institutions to develop students' ability to respond to incivility in these environments and to educate their own staff on how to recognise and respond to bullying in the clinical environment. The Duluth Model may be a useful framework to use in undergraduate education to assist students and clinical tutors to identify and articulate bullying behaviours. As victims of bullying are often overwhelmed by the experience, this model can be a useful guide (Scott, 2018).

Empowerment of students is fundamental to address bullying. Firstly, a curriculum design which involves collaboration between students and educators can remove the power differentials that prevent students speaking up. Therefore using a liberation pedagogy is more likely to cultivate a culture of partnership, as passivity in nursing education facilitates further oppression in nursing and inhibits students controlling their own learning (Sidhu and Park, 2018). Faculty staff, including clinical facilitators need to be aware of how they activity role model a culture that nurtures and encourages student emancipation from oppression. Nurse role models in a positive clinical practice has been identified by students as those who mentor, instill confidence, create a relaxed atmosphere, act as an advocate, tolerate students mistakes, demonstrate skills and show interests in students development (Baldwin et al., 2014).

In order to develop resilience, assertiveness and emotional intelligence, students need ongoing opportunities to develop these skills throughout their degree. The use of simulated experiences before clinical placements is useful to assist students to practice assertive behaviours and de-escalation of negative behaviours in a safe environment prior to exposure to the clinical environment (Clark et al., 2013; Ulrich et al., 2017). The role of debriefing not only after simulated and authentic clinical experiences is critical to ensuring that students have the necessary skills to deal with negative behaviours.

7. Conclusion

This study is the first to explore nursing students' experiences of bullying while on clinical placements in NZ. Internationally, nursing workforce issues such as staff satisfaction, recruitment, retention and an ageing workforce have attracted attention on how to grow the workforce. Little attention has been paid, however, to how to nurture and grow nursing students into the profession. The findings in this study should be a concern to the nursing profession in NZ in respect of growing their future workforce. The implications of this work can inform the development of policy, the culture of practice and the education of future nursing professionals.

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Conflict of Interest

None.

Ethical Approval

Massey University Human Ethics Committee (SOA 17/42).

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