Nurse Education in Practice 14 (2014) 271–274

Contents lists available at ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/nepr

For us or against us? Perceptions of faculty bullying of students during undergraduate nursing education clinical experiences

Michelle Seibel*

Thompson Rivers University, School of Nursing, 900 McGill Rd., PO Box 3010, Kamloops, BC V2C 0C8, Canada

ARTICLE INFO

Article history:
Accepted 29 August 2013

Keywords:
Faculty
Bullying
Nursing
Student
Clinical education

ABSTRACT

The purpose of this review is to determine what we currently know about faculty bullying of nursing students during undergraduate clinical experiences. The review included 31 peer-reviewed articles and dissertations investigating faculty bullying of nursing students and those factors which can influence the phenomenon. A significant finding of this review is that faculty bullying of students arises out of complex contextual influences involving the practice setting, as well as perceptions and coping strategies of both faculty members and students. This belies the current understanding of bullying within nursing education as intentional, and arising from the personal pathologies of the teacher or student. This has implications for clinical faculty members as well as Schools of Nursing. As well, it highlights future directions for research, including interventions to decrease faculty bullying of students.

Bullying by and between nurses in the practice setting is widely acknowledged to be a serious concern in today's health care system. An extensive body of research has informed anti-bullying strategies that are known to effectively address this concern; however, the extent of workplace bullying in nursing practice continues to escalate (Roche et al., 2009; Woelfle and McCaffrey, 2007). Recently, some authors have suggested that one of the reasons that workplace bullying continues to thrive in nursing practice is that the origins of bullying behaviour exist prior to nurses working in the profession; i.e., bullying begins in undergraduate nursing education (Clark and Olender, 2011; Luparell, 2011; Magnavita and Heponiemi, 2011; Pope, 2010).

Recent studies highlight the concerning fact that faculty members are commonly viewed as perpetrators of bullying behaviour towards students (Clarke, 2009; Cooper, 2007; Del Prato, 2010). It is critical that we understand this phenomenon, as it is destructive in terms of student learning and wellness, and also antithetical to our stated intent as instructors. The purpose of this paper is to conduct a critical review of research reports regarding bullying in basic undergraduate nursing clinical education, with a specific focus on faculty roles. Factors that contribute to the perception of faculty members as bullies in the clinical setting will be examined, and strategies to address the issue will be identified. The paper will conclude with a discussion of the implications for nursing education and future research.

Review of the literature

Specific types of behaviour are identified as bullying and are highlighted in the literature with startling consistency across professional, educational, and role boundaries. Those who work in specifically in healthcare identify being ignored, humiliated, undervalued, excluded, and receiving negative criticism or evaluation as particularly impactful on their ability to prosper in those environments. Students report the same types of bullying behaviour (Del Prato, 2010; Thomas, 2012). The review of papers and unpublished reports/dissertations is based on the following themes; i.e., systemic factors, faculty-specific and student-specific factors that contribute to the perception of faculty bullying nursing students in clinical settings. First, however, a brief overview of the phenomenon of bullying is needed in order to examine definitions, prevalence, and to understand its significance.

Definitions and significance

A clear definition of 'bullying' is important, as both nurses and student nurses may have difficulty identifying bullying behaviour (Hoel et al., 2007; Seibel, 2007; Sweet, 2005). Bullying is defined herein as both direct and indirect acts of violence that expose the victim to "negative or abusive behaviour, often over a considerable time, where the targets have difficulty in defending themselves" (Hoel et al., 2007, p. 270). This definition highlights both the dimension of time, and the presence of a relational power differential between the victim and the perpetrator.

* Tel.: +1 250 371 5834; fax: +1 250 371 5909.
E-mail address: mseibel@tru.ca.

1471-5953/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.nepr.2013.08.013

The consequences of bullying for nurses and nursing students are decreased job satisfaction and commitment, attrition, as well as overall decreased physical and mental health (Katrinli et al., 2010; Oore et al., 2010). There is no direct correlation between severity of bullying or violent behaviour and its effects on the recipients (Flannery, as cited in Ferns and Meerabeau, 2007; Holmes et al., 2012). In nursing practice, patient safety outcomes are compromised by hostile working conditions (International Council of Nurses [ICN], 2006; Roche et al., 2009). As students are typically on the lower end of hierarchical structures in healthcare and education, they are exceptionally vulnerable to bullying (Clarke, 2009; Hoel et al., 2007).

Systemic factors

There is a significant body of research that correlates the incidence of bullying in nursing with stressors inherent in the workplace environment and within healthcare (Oore et al., 2010; Roche et al., 2009). Hodgins (2008) proposes that, "individual[s] cannot be treated in isolation from the larger social unit or system in which they operate" (p. 17). Consequently, when nursing students are present within a clinical agency or the academic institution, they may be victims of bullying that is a symptom of organizational stress. Hoel et al. (2007) propose that increased workload in a clinical area negatively impacts the student experience, as increased unit stress results in deteriorating interpersonal interactions. Negative socialization experiences within the profession perpetuate the problem of bullying as these learned behaviours and negative coping mechanisms are repeated post-graduation (King-Jones, 2011; Randle, 2003; Thomas, 2010).

Other perspectives on bullying include the application of oppressed group theory, which describes nurses as a subjugated group, and postulates that the struggle to achieve status in the profession includes the reinforcement of negative behaviours (Freire, 1972). By extension, nursing faculty members have been socialized into the profession, and some promote the belief that bullying behaviours from coworkers are to be expected. In this context, bullying behaviours actually serve a purpose in that they help to establish such behaviours and their influence as normative within the workplace and the profession (Katrinli et al., 2010). It is this normalizing of bullying that is troubling, and likely influences the passive and resigned manner in which nurses often respond to bullying (Ferns and Chojnacka, 2005; Katrinli et al., 2010; Seibel, 2007). Randle (as cited in Sweet, 2005) states, "traditional approaches to nurse education have helped [to] entrench bullying behaviours, so that each new generation of nurses becomes socialized to regard it as normal" (p. 16). Within schools of nursing, the failure to address bullying can inadvertently lead to a culture of tolerance towards inappropriate conduct (Clark et al., 2009) i.e., it communicates the message that it is a legitimate means to express a point of view or opinion (Clark and Olender, 2011; Sweet, 2005).

Faculty factors

Numerous factors influence individual faculty members' approaches to clinical nursing education, as well as how they perceive and address practice issues among students. Among these are a lack of knowledge and understanding of the clinical teaching role, and the requirement to mediate between various parties and expectations within the clinical setting.

Lack of knowledge/preparation

Faculty must communicate expectations and address disciplinary issues as they arise within clinical nursing education (Kolanko et al., 2006); however, this is not typically something they in which they have competence as novice faculty (Cederbaum and Klusaritz, 2009). Nursing faculty typically rise up through the ranks of nursing, first attaining professional competence and then graduate degrees and then engaging increasingly in academic life, and while they may be experts in a particular field of nursing, they are not necessarily expert instructors (Cangelosi et al., 2009; Clarke, 2009; Cooper, 2007). Benner et al. (2010) concluded that lack of teaching experience and knowledge leads to ambiguity about the role, and not knowing if what they observe in students is to be considered normal, what action to take when concerned about students' performance, and the appropriate avenues to seek guidance about their role.

A balancing act

Due to the fact that clinical faculty typically do not work as nurses on the unit, they are often considered outsiders. Inherent in this dynamic are struggles that involve territory, competing priorities, and varying expectations. Faculty are considered 'guests in the house' in the clinical arena and as such are limited in their influence and rights within that setting (Glass, 1971). Clinical faculty attempt to mediate these variables, maintain functional working relationships with staff and provide a positive learning experience for their students. At times, this results in faculty behaviour that may be perceived by students as bullying; e.g., a faculty member who tries to keep the clinical staff 'happy' by restricting students' access to patients' charts risks complaints of bullying by students (Paterson, 1991).

Finding a balance between the providing students support and challenge, being directive but allowing students to shape their practice, and leading but allowing the student to exercise leadership can contribute to faculty stress and the perception by students that their needs are being overlooked (Del Prato, 2010). For example, students commonly perceive written clinical assignments as onerous, yet these are also helpful to their learning and developing practice; faculty who are novice may emphasize the necessity of the written work without having the skill and experience to understand that students need support to be able to understand the benefits of such assignments (Benner et al., 2010).

Teaching goals, values and ideals

Clinical faculty often have ideas about what a nurse should be, look like, and act; their willingness to embrace alternate styles shapes how they respond to students who are different from this perspective (Cederbaum and Klusaritz, 2009; Forbes, 2010; Paterson et al., 2004; Pope, 2010). For example, if faculty highly value caring, and perceive a student to be uncaring, this is likely to cause conflict between them (Forbes, 2010). Faculty ideals of the perfect nurse may include any aspect of the students' person, including gender, ethnicity, age, and sexual orientation (Cangelosi and Moss, 2010; Paterson et al., 2004).

One consequence of faculty preferring a certain type of student to others is favouritism. Faculty may perceive some students as better than others because they are congruent with faculty's perspectives of the ideal nurse or student. This results in faculty evaluating these students with a less than critical eye (Del Prato, 2010; Pope, 2010). Faculty may single out students who do not comply with either their personal or larger professional norms and identify them as students who need more focused attention (Pope, 2010). Intense scrutiny typically upsets students, increases their chances of making mistakes, and has an overall negative effect on student confidence and development (Del Prato, 2010).

Student factors

Multiple factors can influence how faculty's behaviour is perceived or interpreted by a student, including whether or not a