# Workplace Bullying: The Midwifery Student Experience

by

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Thesis

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# Abstract

**Aim:** To explore and describe midwifery students' experiences of being the target of workplace bullying whilst on clinical placement in Australia and the United Kingdom.

**Background:** The incidence of workplace bullying has increased dramatically in recent years and is now a major global public health concern. Workplace bullying is generally referred to as repeated unwanted behaviour towards others that is intended to cause harm, occurring within the workplace. Students undertaking placement in the clinical environment, however, only need to experience a one-off incident of inappropriate or unfair treatment for it to have a lasting adverse effect upon them. Healthcare settings provide the ideal environment for such behaviours to flourish, particularly as they are places where power differentials are commonplace. This in turn can impact staff and student wellbeing, patient safety, staff absenteeism, turnover, and productivity. Midwives are reported to commonly experience workplace bullying, leading to work dissatisfaction and subsequent attrition from the profession. Limited research, which has been predominantly quantitative and mixed methods in nature has revealed that midwifery students too are being bullied whilst on clinical placement. Gaps in the literature exist where midwifery students offer their own personal experiences of being the targets of bullying whilst on clinical placement and how this impacts them and other relevant stakeholders.

**Methods:** This study was a qualitative descriptive design. Midwifery students based in the United Kingdom (UK) and Australia that had experienced perceived workplace bullying whilst on clinical placement were recruited via purposive sampling. Approval was obtained from the CQUniversity Australia Human Research Ethics Committee to conduct this study.

**Data Collection and Analysis**: Data was collected using an anonymous online qualitative survey. The survey consisted of two main parts; demographic questions and open-ended questions to enable the students to explain their experiences in more detail. In total, 335

midwifery students responded to the study advertisement and confirmed that they had experienced bullying whilst on clinical placement. A total of 215 participants completed just the demographic section of the survey however, 120 participants provided participant generated textual data by fully completing or partially completing the open-ended questions. Data were thematically analysed using Braun and Clarkes (2006) six phase process.

**Findings:** Midwifery students indicated that being the target of bullying effected them on several personal and professional levels which has the potential to have further reaching impacts upon the reputation of the profession, the quality of care provided to mothers and babies, and the quality of midwifery education. Moreover, the findings suggested that different groups of midwifery students experience bullying in different ways and the social context of the maternity unit significantly influences the way in which bullying behaviours are enacted and are accepted by others towards them. Midwifery students perceive a number of antecedents to being bullied exist and feel that both academic and clinical organisations could do more to provide support to them and tackle the issue of bullying in order to help ensure the future sustainability of the midwifery profession.

**Conclusions:** This study suggests that midwifery students being bullied may have a number of impacts upon students and other key stakeholders. In order to ensure and sustain the future of the midwifery profession, more needs to be done by academic and clinical organisations to address bullying towards midwifery students and prevent the continuation of the bullying cycle.
**Keywords:** midwifery students, workplace violence, bullying, qualitative description, clinical placement, midwifery education.

# Acknowledgements

I began this journey many, many years ago as a young midwifery student when I became somewhat confused about and interested in why so many of my fellow midwifery students chose to leave their course of study and never looked back. I want to thank the nine other students in my 'set' for the moral support and strength we provided one another with back in the late 1990's. The good and bad experiences we all had during that time inspired me to undertake this research.

This research would not have been made possible without the wonderful midwifery students who participated in this study. I know it would not have been easy for many to share their experiences and feelings. Thank you to you all. I am privileged to have heard all your stories and to share the highs and lows of your journeys towards becoming midwives.

Thank you to my supervisors Associate Professor Olav Muurlink that possesses the patience of a saint and Professor Moira Williamson for your friendship, guidance, and support.

Finally, I must thank my family, particularly my husband Dave for his unwavering love and support. The year 2020 has been an enormous challenge for everyone but this has been exacerbated by the significant health challenges he is currently facing. I hope I have inspired my three amazing children, Oscar, Megan, and Harriet to continue, and enjoy studying. And last but not least, I must of course acknowledge my two little dogs Toby and Maxwell that have been right by my feet the entire time.

Thank you to you all.

## Candidate's Statement

By submitting this thesis for formal examination at CQUniversity Australia, I declare that it meets all requirements as outlined in the Research Higher Degree Theses Policy and Procedure.

Tanya Capper Date: 5/12/2020

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## Statement of Authorship and Originality

By submitting this thesis for formal examination at CQUniversity Australia, I declare that all of the research and discussion presented in this thesis is original work performed by the author. No content of this thesis has been submitted or considered either in whole or in part, at any tertiary institute or university for a degree or any other category of award. I also declare that any material presented in this thesis performed by another person or institute has been referenced and listed in the reference section.

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## Previous Submission Statement

This thesis HAS NOT been submitted for an award by another research degree candidate either at CQUniversity or elsewhere.

Signed:

Tanya Capper Date: 5/12/2020

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# Conference papers and publications that have arisen from this thesis work

**Publications by the candidate relevant to the thesis:**

**Invited Paper: Paper 2**

**Capper, T**., Muurlink, O., & Williamson, M. (Accepted - forthcoming 2021). Being bullied on clinical placement: The student experience. *The Student Midwife Journal,* April 2021.

A copy of the email accepting this paper for publication can be found in the appendices of this thesis as appendix P.

**Peer Reviewed Papers:**

**Paper 1.**

**Capper, T**., Muurlink, O., & Williamson, M. (2020b). Midwifery students' experiences of bullying and workplace violence: A systematic review. *Midwifery*, 102819. https://doi.org/10.1016/j.midw.2020.102819

**Paper 3.**

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**Paper 4.**

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**Paper 5.**

**Capper, T.,** Muurlink, O., Williamson, M. (2020c). Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study. *Women and Birth.* https://doi-org.ezproxy.cqu.edu.au/10.1016/j.wombi.2020.12.005

The published versions of each of these peer reviewed papers can be found in the appendices of this thesis as appendix H, I, J and K.

**Peer reviewed conference presentations by the candidate relevant to this thesis:**
**Conference presentation 1.**

**Capper, T.** (2019b). Vertical Violence and Midwifery Students. Australian College of Midwives (ACM) Queensland (QLD) State Conference, Rockhampton, QLD, Australia Feb 2019 (Oral presentation).

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The abstracts for each of these conference presentations can be found in the appendices of this thesis as appendix M, N and O.

# List of Abbreviations

A number of abbreviations are used in this thesis and therefore need to be defined at the outset.

These abbreviations are as follows:

| Abbreviation | Full term |
|---|---|
| AHPRA | Australian Health Practitioner Regulation Agency |
| ANMAC | Australian Nursing and Midwifery Accreditation Council |
| AUS | Australia |
| CF | Clinical Facilitator |
| CM | Clinical Midwife |
| CoC | Continuity of Care |
| FTE | Follow through experience |
| HREC | Human Research Ethics Committee |
| MGP | Midwifery Group Practice |
| MUM | Midwifery Unit Manager |
| NHS | National Health Service |
| NMBA | Nursing and Midwifery Board of Australia |
| NMC | Nursing and Midwifery Council (UK) |
| NUM | Nurse Unit Manager |
| QD | Qualitative Description |
| RGN | Registered General Nurse |
| RM | Registered Midwife |
| RN | Registered Nurse |
| SM | Staff Midwife |
| TA | Thematic Analysis |
| UK | United Kingdom |

# Glossary

### Definitions of frequently used terms

A number of terms are used in this thesis that have multiple meanings, and therefore need to be defined at the outset. These terms are as follows:

**Bullying:** Perceived repeated negative behaviours towards another which may include intimidation, harassment, isolation, exclusion, and unwarranted persistent criticism.

**Clinical Educator:** A hospital employee who is responsible for staff development and education to help ensure optimal outcomes for women and their families through the promotion of best clinical practice.

**Clinical Facilitator:** A registered midwife employed in the clinical environment whose primary purpose is to facilitate student learning.

**Clinical Placement:** A clinical placement is an arrangement in which a midwifery student is present in an environment that provides midwifery care or related services to childbearing women and their families in order to gain practical experience.

**Consultant Led Unit:** A unit offering care to women experiencing complexities during the childbearing continuum and require care that is led by a senior obstetrician.

**Continuity of Care:** Is the provision of continuity of midwifery care to childbearing women and their families by one or more midwives as part of a multidisciplinary team of other health care providers.

**Continuity of Care Experience (COCE):** Refers to when a midwifery student recruits and follows a specified number of women through pregnancy, labour, birth and into the early postpartum period.

**Direct Entry Midwife:** A term that is still often used in the UK that refers to a midwife that did not undertake nursing training prior to completing a midwifery education program leading to registration as a midwife.

**District General Hospital:** Is a UK National Health Service (NHS) term for major secondary healthcare facilities available to people residing in the UK**,** which provide an array of services.

**Follow Through Experience (FTE):** Refers to when a midwifery student recruits and follows a specified number of women through pregnancy, labour, birth and into the early postpartum period. (This is another commonly used term for COCE).

**Horizontal Violence:** The bullying of a target of equal power.

**Hospital Trained Midwife:** Is a registered midwife that undertook midwifery education predominantly in the clinical setting prior to it moving into the tertiary environment.

**Mentor:** A registered midwife allocated responsibility for working alongside a midwifery student whilst providing him/her with clinical supervision whilst on clinical placement.

**Midwifery Student:** A term used in Australia that refers to a person enrolled in a program of study that leads to registration as a midwife.

**Midwifery Group Practice:** Is a model of midwifery care where women care cared for by a known midwife who works with one or more midwives as part of a small group during the childbearing continuum.

**Midwifery Unit Manager:** Is a senior midwife who is responsible for management and leadership within a clinical ward or department of the maternity unit.

**Post Graduate Midwifery Student:** Is a midwifery student that has already successfully completed an education program that that has led to registration as a nurse and is now undertaking a postgraduate midwifery program leading to registration as a midwife.

**Qualified Midwife:** A midwife that has successfully completed a prescribed program of midwifery education in the UK.

**Registered Midwife:** "A person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (ICM, 2017a p.1).

**Regional Unit:** A maternity unit that offers maternity care to women and their families that live in regional areas of Australia.

**Regulatory Body:** "Ensures the safety of the public through its regulatory mechanisms. The key function of a midwifery regulatory authority is to ensure the safety of mothers and babies (the

public) through regulatory mechanisms that ensure safe and competent midwifery care" (ICM, 2011).

**Rural Unit:** A maternity unit that offers maternity care to women and their families that live in rural areas of Australia.

**Set:** The UK term used to describe a group or intake of students that progress through their period of midwifery education together**.**

**Student Midwife:** A term used in the UK that refers to a person enrolled in a program of study that leads to registration as a midwife.

**Team Leader:** A experienced senior midwife that leads the team whilst working in the clinical setting of a maternity unit.

**Tertiary Unit:** A maternity unit that offers maternity care to women and their families that live in metropolitan areas of Australia and women that require more complex care than their local maternity unit can provide.

**Training:** A UK term used to describe the period of nursing or midwifery education which incorporates clinical placement.

**Tutor:** UK term to depict a clinically based lecturer who is employed by the educational facility.

**Vertical Violence:** The bullying of a target of lesser power.

**Ward Sister:** Is a UK term referring to a senior midwife who is responsible for management and leadership within a clinical ward or department of the maternity unit.

**Workplace Violence:** Violence or bullying that occurs within the workplace or clinical placement setting.

# Declaration of Contribution

I, Tanya Capper contributed a minimum of 60 per cent to the following papers:

**Capper, T.,** Muurlink, O., & Williamson, M. (2020b). Midwifery students' experiences of bullying and workplace violence: A systematic review. *Midwifery*, 102819. https://doi.org/10.1016/j.midw.2020.102819

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Tanya Capper

(Original Signature of Candidate) Date: 5/12/2020

I, as the Principle supervisor of the candidate endorse that this level of contribution by the candidate indicated above is appropriate.

Professor Moira Williamson

(Original Signature of Principle Supervisor) Date: 5/12/202

# Chapter One

# Background

## 1.1 Introduction

Midwives play a key role in the facilitation of optimal health outcomes for mothers and babies across the world (Renfrew et al., 2014a). If the United Nations (UN) Sustainable Development Goals (SDG) (United Nations, 2015) are to be achieved, particularly SDG 3.1 which aims to reduce maternal mortality rate across the world to less than 70 per 100,000 live births, it is vital that the number of midwives that are educated to an international standard are maximised (United Nations Population Fund (UNFPA), 2014) and retained in the profession (World Health Organization (WHO, 2015). The provision of quality midwifery education that meets international standards has recently been deemed a global priority by the World Health Organization (WHO, 2019). However, a recent Australian Delphi study identified a number of barriers that currently exist to achieving this goal and reducing the number of incidents of bullying that midwifery students are exposed to whilst on clinical placement was considered a priority (Sidebotham et al., 2020). Sidebotham et al., (2020) state that the bullying and poor treatment of midwifery students whilst on clinical placement must be effectively managed with an aim of "reducing incidents of bullying within the workplace by promoting a culture of support, and adoption of no bullying policies" (p. 3). This however is not a novel problem with researchers reporting as far back as over a decade ago that a significant number of midwifery students experience bullying and harassment whilst undertaking clinical placement (Lash, Kulakaç, Buldukoglu, & Kukulu, 2006) and this subsequently leads to career uncertainty and attrition from midwifery education courses (Gillen, 2008, 2009). In order to develop an effective solution to the bullying of midwifery students and sustain this vital profession, it is crucial to

better understand the experiences of bullied midwifery students and how they impact them and other relevant stake holders in both the short and long term.

The topic of this thesis became my area of research interest as a result of my own experiences of workplace bullying within the maternity setting spanning over two decades. I was bullied as midwifery student, but in turn, when I became a registered midwife, I witnessed midwifery students being bullied. Now as a midwifery academic, I have frequently received emotion filled phone calls from midwifery students planning to withdraw from their course due to being bullied whilst on clinical placement. I wanted to undertake this research to explore exactly *how* today's midwifery students experience workplace bullying and how it affects them both personally and professionally. I was also interested in gaining a better understanding of how the knock-on effects of this problem may impact other key stakeholders such as midwifery managers, education providers and the mothers and babies the midwives of the future care for.

In order to place this study in context, the chapter will begin by providing an initial overview of the issue of workplace bullying in wider society, and a definition of what constitutes bullying, including how this is believed to differ for students undertaking placement in the clinical workplace context. This will be followed by a summary of what is currently known about workplace bullying within the healthcare environment, specifically the midwifery profession, and how limited knowledge exists to suggest that this issue also extends to midwifery students being targeted whilst on clinical placement. The chapter will conclude by introducing the research problem, overarching research question, the aims and objectives of the study, and the justification for its need to be carried out.

### 1.2 Workplace bullying in society

Almost half of all employees in the developed world have experienced or witnessed workplace bullying at some time in their working lives (Butterworth, Leach, & Kiely, 2016; Fink-Samnick, 2017) subsequently creating a significant public health issue for adults (Nielsen, Tangen, Idsoe, Matthiesen, & Magerøy, 2015). Workplace bullying commonly occurs in places where power

imbalances exist (Shallcross, Ramsay, & Barker, 2013), and the 'enclosed system' of the workplace provides both the opportunity and the environment within which repeat offences can occur (Namie & Namie, 2009; Schumann, Craig, & Rosu, 2014). An enclosed workplace can place staff members at risk of inescapable repeated exposure, with *repetition* being one of the most common defining characteristics of bullying, particularly when occurring in the workplace (Namie & Namie, 2009). Workplace bullying is often separated into two main types; *vertical violence* which relates to the targeting of a person of lesser power, and *horizontal violence* which refers to the targeting of a person of equal power (Zhang & Wright, 2018).

Much of the scholarly research that has been carried out to explore bullying to date has taken place within child or young adult populations, and the majority of the recent literature continues to have a strong primary and secondary-school-age focus (Hellström & Beckman, 2019; Östberg, Modin, & Låftman, 2018). Being a target of bullying during these informative years has been linked to adverse effects upon the child's ability to reach developmental and educational milestones (Espelage & De La Rue, 2012). Amongst children, the word 'bullying' often relates to the role played by power differentials between the bully and the bullied, and this is now also believed to be commonplace and a potential antecedent to workplace bullying in the adult population (Johnson, 2011).

It is believed that workplace bullying is responsible for both short and long-term work absence amongst employees and is estimated to cost employers many billions of dollars every year (Gillen Sinclair, Kernohan, Begley & Luyben, 2017; Hassard, Teoh, Visockaite, Dewe, & Cox, 2018). This is often due to sickness and trauma experienced by targeted employees and is the most common cause of work-related stress and illness (Grynderup et al., 2017). The issue of workplace bullying has escalated in recent years, and as a result, the Australian government and employing organisations have acknowledged their legal responsibility to ensure that all employees are able to work in an environment that is free from discrimination and harassment (French,

Boyle, & Muurlink, 2014). Subsequently, a number of local, and national protocols, policies and guidelines have been developed in an attempt to tackle the problem (Australian Human Rights Commission, 2011; Fair Work Commission (FWC), 2017; Queensland Government, 2010; Safe Work Australia, 2017). Currently within the Australian context, in order to avoid potential legal action, employers must ensure that they have an implementable anti-discrimination policy in place which all employees are aware of, and the consequences of non-compliance are enforced (Australian Government, 2016). Despite the presence of such laws, many incidents of workplace bullying continue to go unreported, often due to uncertainty surrounding what types of behaviours actually constitute bullying (Kvas & Seljak, 2014).

### 1.3 Definitions of workplace violence

Several terms are used to refer to workplace bullying in the literature. These include *mobbing, bad attitude, personality clash*, *brutalism*, *intimidation*, and *psychological terror* (Crawshaw, 2009). Within the healthcare setting, the term bullying is often used interchangeably with the term's *workplace harassment, violence, discrimination, incivility, and aggression (*Bowling & Hershcovis, 2017). In this thesis I will refer to this behaviour as 'workplace bullying'. There is no clear consensus in the literature on what exactly constitutes bullying, however Boyle and Wallis (2016, p. 3) propose the following definition:

> *Bullying is a person's perception of repeated negative acts such as harassment, intimidation, exclusion, isolation, hostility, character assignation and constant criticism.*

It is important to recognise that definitions of bullying may vary from one context to another. For example, Mavis, Sousa, Lipscomb & Rappley (2014) define bullying that is directed towards the undergraduate student within the clinical workplace as:

> *Mistreatment, either intentional or unintentional occurs when behaviour shows disrespect for the dignity of others and unreasonably interferes with the learning process. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, or sexual orientation;*

> *humiliation; psychological or physical punishment; and the use of grading and other forms of assessment in a punitive manner* (p. 706).

As stated earlier in this chapter, much of the literature that has aimed to define bullying has stated that in order for the inappropriate behaviour to be considered bullying it must be repeated and take place over an extended period of time (Saunders, Huynh, & Goodman-Delahunty, 2007; Sercombe & Donnelly, 2013). Boyle and Wallis (2016) however dispute this and state that the frequency and repetition of episodes should not be considered when the target is a student undertaking placement in the clinical context. They state that the frequency and time frame over which episodes of inappropriate behaviour have occurred should not be considered, as one-off episodes can have a profound and lasting adverse effect upon students (Boyle and Wallis, 2016). My own anecdotal experiences support this, with students taking periods of leave due to sickness and illness or choosing to withdraw from their course as a result of one adverse event whilst on clinical placement.

### 1.4 Background to the study

Hospitals and healthcare settings in general are places where workplace bullying can thrive (Vessey, DeMarco, Gaffney, & Budin, 2009). This is thought to be partly due to the enclosed environment, the historical entrenchment of hierarchies, and the stressful working environment which further perpetuates the issue (Birks, Budden, Biedermann, Park, & Chapman, 2017). A significant amount of research has explored workplace bullying within the healthcare context, particularly amongst nurses (Brewer, Oh, Kitsantas, & Zhao, 2020; Logan & Michael, 2018; Olsen, Bjaalid & Mikkelsen, 2017). There has been a demonstrated relationship between workplace bullying and occupational burnout (Kim, Lee & Lee, 2019), anxiety and depression (Giorgi et al., 2016), and adverse patient outcomes (Houck & Colbert, 2017). Often the perpetrators are more senior nurses choosing to target their junior counterparts which suggests

that power and its inappropriate use plays a significant role in this behaviour (De Cieri, Sheehan, Donohue, Shea & Cooper, 2019).

The issue of workplace bullying within the maternity setting has been well reported over the past few decades. Midwives' work in a fast paced, inherently stressful clinical environment (Geraghty, Speelman & Bayes, 2019), making it a common place for acts of workplace bullying to take place. In as early as the mid nineteen nineties, the issue of workplace bullying within the maternity unit was brought to the attention of both healthcare providers and academics after a number of articles were published reporting upon the phenomenon (Hadkin & O'Driscoll, 2000; Hastie, 1995, 1996; Leap, 1997). Over two decades later it would appear that bullying is still a significant issue. Evidence continues to be generated that reports upon the problem (Cull, Hunter, Henley, Fenwick, & Sidebotham, 2020) and the poor workplace culture that continues to exist within many maternity units which is thought to further contribute to the situation (Catling, Reid, and Hunter, 2017). Research suggests that many midwives, much like their nursing counterparts, cite bullying as a significant contributing factor towards career burn out and decisions to leave the profession (Ball, Curtis, & Kirkham, 2002; Hadikin & O'Driscoll, 2000; Yoshida and Sandall, 2013).

In 2015 a number of serious adverse clinical events in a UK maternity unit were reported. A subsequent root cause analysis identified that poor workplace culture and dysfunctional working relationships were key contributing factors (Kirkup, 2015). This suggests that despite workplace bullying within the maternity unit being acknowledged as a significant issue for some time, it has continued to thrive and have a number of adverse impacts, and this has now extended to placing the quality of care provided to mothers and babies at risk.

Despite the quantum of research that has explored workplace bullying within the maternity setting increasing over the last two decades (Begley, 2002; Catling & Rossiter, 2020; Dietsch, Shackleton, Davies, McLeod, & Alston, 2010; Farrell & Shafiei, 2012; Hughes & Fraser, 2011),

the vast majority has focused upon the already registered midwife, rather than the midwifery student. Limited evidence does however exist to suggest that midwifery students too are experiencing workplace bullying whilst undertaking clinical placement as part of their midwifery education programmes (Gillen et al., 2008; 2009).

### 1.4.1 Midwifery students and workplace violence

In 2008, Gillen et al. (2008), assisted by funding provided by the Royal College of Midwives (RCM) in the UK undertook a multiphase research project which led to the development of a theoretical framework to represent the nature and manifestation of bullying in the midwifery profession. In the foreword of the final report, Dame Karlene Davis DBE, the RCM General Secretary at that time stated that it was of great concern that midwives were leaving the profession due to bullying, and in particular that young midwives were being bullied, the people upon whom the midwifery professions future depends (Gillen et al., 2008, p. 1). The theoretical framework was progressively developed through a 4-phase research project. The final of the 4 phases involved a survey questionnaire that asked midwifery students about any bullying behaviour they have been exposed to whilst on clinical placement. The data gathered through the questionnaire, which was later reported upon separately by Gillen, Sinclair, Kernohan, and Begley (2009) demonstrated that midwifery students were experiencing significant levels of bullying whilst on clinical placement. This was one of the very first studies that had specifically explored the bullying of midwifery students. This new knowledge built upon a limited pool of literature that had previously explored the placement experiences of midwifery students, much of which was quantitative or mixed methods in nature and had incidentally arrived at themes relating to workplace bullying (Begley, 1999, 2001a, 2001b; 2002; Hunter, Diegmann, Dyer, & Mettler, 2008). Since 2009, a small amount of literature that has specifically explored the bullying of midwifery students has emerged. These studies, all of which were quantitative or mixed methods in nature, continued to demonstrate that a significant number of midwifery students

experience bullying (Boyle & McKenna, 2016; Fathi et al., 2018; Jug Došler et al., 2014) which has several short and long term impacts upon them (Hakojarvi et al., 2014; Shapiro et al., 2017), and leads to many students avoiding clinical placement or considering withdrawing from their programmes of study (McKenna & Boyle, 2016), and most worryingly, even considering suicide (Gillen et al., 2009).

### 1.5 My personal interest in the phenomenon

It is important to explain my interest in the topic being researched in order to provide an audit trail of my personal reflexivity. As mentioned earlier in this chapter, as a midwifery student, I too was bullied and this had a number of impacts upon my own journey towards becoming a midwife. This experience will be elaborated on in the second of five journal papers produced as part of this thesis (Capper, Muurlink & Williamson, forthcoming – 2021). Being bullied skewed my personal thoughts about the profession and ultimately my decisions about the career path I chose to take. Having now worked extensively as a midwife and midwifery academic throughout the UK and Australia for over 20 years I recognised a lot of similarities relating to the bullying culture regardless of geographical location. Enthusiastic would-be midwifery students were applying to study midwifery in their droves, but once enrolled in their course, many lost their passion and enthusiasm and student numbers dwindled. I would hear stories from colleagues about students being reduced to tears in the labour ward/birth suite, often in front of other midwives and students. Similar stories emerged from midwives, midwifery students and midwifery academics in both countries – it was almost considered a cultural norm and part and parcel of becoming a midwife. Nothing seemed likely to change anytime soon.

Having been a midwifery student myself, I'd been there, but wondered what it was like for students over two decades later. Arguably the role of the midwife has changed dramatically since the 1990's, staffing levels are somewhat lower (Cull et al., 2020) – leaving midwives under enormous pressure, acuity is higher, midwives care for increasing numbers of 'high-risk' women,

often within a medically dominated environment, strict adherence to policies and guidelines is paramount and women centred care is now considered the gold standard (Homer, Brodie, Sandall & Leap, 2019). The student role has also changed significantly, students are studying at bachelor degree level or higher, they are required to follow a number of continuity of care experience (COCE) women through pregnancy, birth and the postnatal period, and students are attempting to navigate the ever changing maze of policies and guidelines whilst maintaining a positive 'can do' attitude. Due to the nature of tertiary level study, students are required to keep up with the challenges of academic work and clinical placement requirements, they also often have paid work responsibilities, and still try of course to have a personal life outside of midwifery. How do they manage to juggle all of this and then face the challenges related to being bullied whilst on clinical placement?

### 1.5.1 My own experiences

As outlined in the invited paper that is presented in Chapter Four of this thesis, I undertook clinical placement as a midwifery student in the mid-nineteen nineties and became all too familiar with the experience of being bullied. I was a very young, fresh faced, intelligent ( I was accepted into medicine however chose midwifery), and enthusiastic student that had had little to no exposure to the healthcare arena and was very naïve about what was to come.

I clearly recall being deliberately set up to fail, gossiped about, and some midwives were simply overtly rude to me for no reason whatsoever. I would regularly receive comments about being 'too young' to be a midwife and was repeatedly challenged about why I hadn't chosen to be a doctor as I was so clever. Other midwives would even try to encourage me to withdraw from my course and recommend that I reenrol when I'm older.

I remember feeling demoralised and frustrated by their behaviour, but I think the naivety of youth protected me from taking it all too seriously. I laughed it off and just got on with completing the course with the aim of proving them wrong. Sadly, many students were unable to

do this and chose to withdraw from the course due to the incessant bullying. Ten students commenced in our 'set', just four successfully completed the course, and only three went on to practice upon graduation. It was a well known fact that most of the group were being bullied and that certain midwives were known to be the perpetrators. Some students were unfortunate enough to have 'the well-known bullies' allocated to them as their link mentors – these were mainly the students that chose to withdraw from the course, it all became too much for them.

I can vividly recall being in the staff changing room getting ready for an early shift on the labour ward one morning along with another midwifery student peer. She suddenly ran into the toilet and began to vomit. She explained afterwards that this often happened to her prior to a labour ward shift as she was so scared of her mentor and was worried about how she would be treated during the shift. I remember being able to relate to this 100%. I also reflected upon this and wondered why this was allowed to happen? Why, when everyone knew who the culprits were, were they allowed to get away with it? Did they enjoy making the students' lives a misery? What did they get out of it? Why didn't management sack them? Why weren't the university helping us? All questions, that to this day still remain unanswered. In fact, I can clearly remember deciding to report the issues to the university I was studying at, so I did, but it had no effect. The university's response was, 'we have to keep the hospital happy as that is where you gain your clinical experience – without having the hospital on side, we cannot have a midwifery course'. This was fed back to my peers, we all felt weak and trapped. Upon reflection I probably had it a lot easier than many of my peers – I was in my very early twenties and didn't have a family to support, I had other career options if it all went wrong, I was also lucky enough to possess the resilience to brush of much of the bullying and carry on regardless.

Fast forward a few years, as a registered midwife I always enjoyed teaching students and valued their passion and enthusiasm for the profession – I was thrilled to see them thrive and develop their skills and knowledge. Many were young, much like I was, often very naive and shocked

when they are treated so badly by other midwives. I felt for them when allocated to a mentor that in no way shared my passion for teaching, often midwives that were known to be abrupt and impatient. I have witnessed midwifery, nursing, and medical students being belittled and berated by midwives. I have discovered students crying in the bathroom, vowing to leave their course of study.

Since moving into midwifery academia, I have encountered a number of midwifery students that have faced issues with bullying whilst on clinical placement. Upon enrolment in the course the students are all very positive, full of enthusiasm for midwifery, however, by their third term everything has changed – many of the students are jaded, fed up, worn out and worn-down often praying for it to all be over. During term time I've received teary phone calls or emotion loaded emails from midwifery students upset about being bullied and intimidated. I have even on occasions been approached by experienced nurses that are undertaking midwifery education that have previously been in charge of busy acute clinical areas devastated by how they have been treated. Many state that they have never been exposed to such offensive behaviour until they came into the maternity setting to complete their postgraduate midwifery education and choose to leave as a result. I hear accounts of older students feeling that they are being victimised more than their youngers peers but the younger students accounts are at odds with this as they report that they are disregarded and spoken to like children. I've also heard stories of students being physically grabbed, insulted, intimidated, mocked, and humiliated in front of their peers, other midwives, and even the women they care for. I have also received emails from women that have been cared for by the students, informing me of how poorly the student was treated and humiliated by the midwife mentoring them. I always ensure that policy is followed, incidents of bullying are reported to the appropriate persons, and counselling support offered, I am however yet to see any dramatic changes come about to break this cycle. Here in 2020 the pattern continues to be repeating.

After over twenty years in the midwifery profession recently hearing firsthand student accounts of being bullied has led me to reflect upon this ongoing issue that continues to plague the midwifery profession. I wanted to know more about how students actually experience bullying; how does it make them feel? Who are their bullies? Where are they being bullied? Why do they think they are being bullied? How are they being bullied? Does, their age impact they way in which they are being bullied? Do they tell anyone about it? If so, who? and if not, why not? Was anything being done about this? Do they regret entering midwifery? Do they plan to stay or leave? How do they think the problem could be addressed? Are their experiences similar to my own? I have so many questions and want to gain more information about this issue in order to describe what is happening to the midwives of the future during their midwifery education program.

### 1.6 Research problem

As stated above, I was a young midwifery student, I was a target of workplace violence enacted by the registered midwives that were trusted with the role of teaching and supporting me. I often struggled to understand why these midwives chose to target students who were both their future colleagues and the future of their profession. I regularly thought about leaving the course, however I pushed on, and as I neared the end of my training, I considered collecting my degree and walking away from midwifery completely. I feared what the future held for me as a member of this profession.

Sadly, the limited literature available on this topic suggests that I am not alone in my experiences. A sizable proportion of midwifery students continue to be placed in the same position as I was over 20 years ago - they too are victims of workplace bullying whilst on clinical placement. It is evident that this heavily influences the students' journeys towards becoming midwives in several ways, including whether they go on to successfully complete their midwifery education course and choose to practice upon qualification (Gillen et al., 2009; McKenna & Boyle, 2016; Shapiro,

Boyle, & McKenna, 2017). This potential failure of midwifery education to translate to career commitment can lead to a number of significant economic and health impacts for mothers and babies (Hughes, 2013; United Nations Population Fund (UNFPA), 2014; WHO, 2015, 2019). Whilst bullying continues to thrive and midwifery students choose to leave their programmes of study, a number of downstream effects will result, for not only the future of the midwifery profession, but also for the mothers and babies midwives care for, maternity service providers, universities, and of course, the midwifery students themselves.

While there are studies that have examined some of the outcomes associated with workplace violence in a registered midwifery context, this study aims to address the lack of research undertaken to date that has specifically explored midwifery students' *experiences* of being bullied whilst on clinical placement, particularly in Australia and the UK where the models of midwifery education are similar. Almost all of the existing literature that has focused specifically upon midwifery students has taken either a quantitative or mixed methods approach meaning that to date, knowledge in this area lacks the depth to capture the student's personal detailed experiences of the bullying experience. This thesis proposes to gather data that explores and describes these experiences and their multi reaching impacts.

### 1.7 Research question, aims and objectives

The aims and objectives of this study, and the overarching research question were developed based upon the researchers own anecdotal industry experiences, a systematic review of the literature, and were further informed by Gillen et al.'s (2008) theoretical framework relating to the nature and manifestation of bullying in the midwifery profession.

#### 1.7.1 Research question

The aims and objectives of the research were addressed through the following overarching research question:

*What are midwifery students' experiences of being the targets of workplace bullying whilst on clinical placement?*

### 1.7.2 Research aims and objectives

The aims of this research were to:

- generate new knowledge in relation to what it is like to be the target of workplace bullying as a midwifery student whilst on clinical placement.
- better understand how midwifery students being bullied can impact the students themselves, clinical organisations, universities, childbearing women, and the sustainability of the midwifery profession.
- understand from the student's perspective the perceived antecedents to being bullied and how these may be addressed.

The research aimed to address the following three research objectives:

1. To explore and describe whether the age of the midwifery student impacts the experience of being the target of workplace bullying.

2. To explore and describe if and how the social culture of the maternity unit impacts the midwifery students' experiences of being a target of workplace bullying.

3. To explore and describe whether the students perceive that any organisational factors foster workplace bullying and what they feel could be done to help tackle the problem.

## 1.8 Significance of the study

Given the well-publicised shortage of midwives, challenges in retaining students during their midwifery education (Green & Baird, 2009; Hughes, 2013), and midwives to the profession once registered (Ball et al., 2002; Harvie, Sidebotham, & Fenwick, 2019; Pugh, Twigg, Martin, & Rai, 2013) it is vital that one of the common causes of workforce attrition is explored and understood

in greater detail. The nursing and midwifery workforce is also aging (Graham & Duffield, 2010). It is therefore vital that we aim to ensure that the next generation of midwives are nurtured and supported to achieve registration and provide a vital contribution towards achieving optimal health outcomes for mothers and babies whilst enjoying long and satisfying midwifery careers.

It is currently known that;

- A significant proportion of midwifery students report being bullied whilst on placement (Gillen et al., 2008, 2009; McKenna & Boyle, 2016).
- Students report a number of long and short-term effects as a result of experiencing workplace bullying (Gillen et al., 2009; Lash et al., 2006).
- A number of midwifery students consider leaving their program of study due to bullying (Gillen, 2008, 2009).

Bullying in wider society is still considered a taboo subject for many reasons (Brown, 2016). Bullying in the midwifery student context potentially involves several additional factors that lead to a reluctance to speak out about being bullied whilst on clinical placement. Through this research, an issue that is usually silenced can be brought to light, leading to the midwifery students' experiences being heard and better understood. Any factors associated with the bullying of midwifery students can then be examined and considered for future prevention and solutions. To date no research has explored in any depth the midwifery student's personal experience of being bullied whilst on clinical placement in the UK and Australia and the multifaceted impacts of this. This research has potential to produce new descriptive knowledge that midwives, midwifery managers, midwifery education providers, policy makers and researchers would find useful. A qualitative descriptive study such as this will produce findings that will create a starting point to the development of further knowledge in this area (Braun & Clarke, 2013; Sandelowski, 2000). Descriptive knowledge is considered an appropriate approach

for solution focused research and thus creates a basis for development of an appropriate, needs based intervention (Gordon, 2018).

### 1.9 Chapter summary

This first chapter has introduced the background to this study by providing a discussion related to bullying in the wider societal context, and how bullying impacts the healthcare settings and the maternity arena in particular. This chapter has discussed the historical concerns raised in the 1990's surrounding bullying in midwifery and how this had led to attrition from the profession and how bullying continues to thrive leading to adverse effects on staff and the women and babies' midwives care for. This chapter concluded by introducing the research aims, objectives and the research question, followed by an outline of each of the chapters that comprise this thesis.

### 1.10 Chapters to follow

This thesis has been prepared to meet the requirements of a thesis with publication. The five papers presented in this thesis include four that have already been published in peer reviewed journals and one invited personal reflective paper that is due for publication in April 2021. Each journal article has its own reference list in addition to the final complete reference list that is located at the end of the thesis.

The papers are listed below in the order they appear in the thesis:

Capper, T., Muurlink, O., & Williamson, M. (2020b). Midwifery students' experiences of bullying and workplace violence: A systematic review. *Midwifery*, 102819. doi:https://doi.org/10.1016/j.midw.2020.102819

Capper, T., Muurlink, O., & Williamson, M. (Accepted Forthcoming - 2021). Being bullied on clinical placement: The student experience. *The Student Midwife Journal.* (Accepted - Due for publication April 2021).

Capper, T., Muurlink, O., Williamson, M. (2020a). Being bullied as a midwifery student: does age matter? *British Journal of Midwifery*, Vol 28, No3, 2-7. doi: https://doi.org/10.12968/bjom.2020.28.3.166

Capper, T., Muurlink, O., Williamson, M. (2021). Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration. *Nurse Education in Practice*. https://doi.org/10.1016/j.nepr.2021.103045

Capper, T., Muurlink, O., Williamson, M. (2020c). Midwifery students' perceptions of the modifiable organisational factors that foster workplace bullying. A qualitative descriptive study. *Women and Birth*. https://doi.org/10.1016/j.wombi.2020.12.005

In addition, three peer-reviewed conference papers emerged during the course of this thesis:

Capper, T. (2019b). Vertical Violence and Midwifery Students. Australian College of Midwives (ACM) Queensland (QLD) State Conference, Rockhampton, QLD, Australia Feb 2019 (Oral presentation).

Capper, T. (2020). Using an online anonymous qualitative survey to explore the experience of being bullied as a midwifery student. Accepted for oral presentation at the 7th Biennial ACSPRI Social Science Methodology Conference 2020. Dec 2020.

Capper, T. (2021). Midwifery students' experiences of being bullied whilst on clinical placement in the United Kingdom. Oral presentation at London 2021 Maternity and Midwifery Festival: Maternity and Midwifery Forum. Jan 2021.

In order to understand how the midwifery student fits within the wider midwifery context, Chapter Two will then introduce the profile of the midwifery profession and the role of the midwife within both the UK and Australian contexts. The professional bodies that regulate the midwifery profession and midwifery practice will also be introduced. The fundamental differences between midwifery education in the UK and Australia will be outlined, particularly in

relation to their structure and the way in which they prepare students for differing levels of midwifery autonomy upon registration.

Chapter Three presents the review protocol and a systematic review of the literature that was undertaken to establish what is currently known about workplace violence and bullying experienced by midwifery students whilst on clinical placement and to demonstrate the gap in knowledge. The systematic review of the literature section of the chapter is provided in the form of a published peer reviewed article (published in the journal, *Midwifery)* in its original submitted form.

Chapter Four presents a paper that was invited by the editor of the UK journal '*The Student Midwife'* following the publication of the systematic review article contained in Chapter Three. This invited paper, accepted for publication, provides a personal reflection of the researchers own multi perspective experiences of bullying and how they shaped the topic of research interest.

Chapter Five introduces the design of the study, while Chapter Six presents the research method undertaken.

Chapters Seven, Eight and Nine present the findings of the research which are provided in the form of journal articles in their original submitted form. Chapter Seven presents the findings that relate to how the age of midwifery students impacts their experiences of being bullied whilst on clinical placement. These findings are provided in the form of a published peer reviewed article (published in the journal, *British Journal of Midwifery)* in its original submitted form. Chapter Eight presents the findings that relate to how the social culture of the clinical placement setting impacts midwifery students' experiences of bullying. These findings are provided in the form of a published peer reviewed article (published in the journal, *Nurse Education in Practice*) in its original submitted form. Next, Chapter Nine presents the findings related to what organisational factors midwifery students perceive influence their experiences of being bullied and what they

think could be done to address these issues. These findings are provided in the form of a published peer reviewed article (published in the journal, *Women and Birth*) in its original submitted form.

Finally, Chapter Ten provides a synthesis of the study's findings and explores their importance and the implications for the midwifery profession. Chapter Ten also concludes the thesis and provides a discussion of the limitations of the study, and recommendations for midwives, managers, academics, policy makers and researchers.

# Chapter Two

# The midwifery profession in context

## 2.1 Introduction

Chapter Two will now introduce and outline both the profile of the midwifery profession and the role of the midwife in both the UK and Australian contexts. The midwifery regulatory bodies and their functions will then be introduced. Although the models of midwifery education are somewhat similar in the UK and Australia it is important to introduce the requirements students are required to meet in both countries to achieve registration as midwives. The purpose of providing this overview is to inform an understanding of how the midwifery student fits within the wider midwifery context.

## 2.2 What is midwifery?

Midwifery is a regulated profession that is defined as the provision of:

> *…Skilled, knowledgeable, and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life*
>
> (Renfrew et al., 2014a p. 1130).

The use of the title "midwife" is associated with several legal and professional accountabilities and responsibilities and is subsequently protected by law. A midwife is an autonomous healthcare professional who practices within predetermined legal boundaries to deliver woman centred midwifery care in partnership with healthy women and their babies (Pairman, Tracy, Dahlen, & Dixon, 2018). Midwives are considered to play a vital role in the provision of cost-effective high quality maternal and newborn care across the world and are therefore key to improving health outcomes for mothers and babies (Renfrew et al., 2014b). The provision of

continuity of midwifery care (maternity care which is provided to women and their families by one or a small group of midwives) (Homer, Brodie, Sandall, & Leap, 2019) in particular is considered the optimal way of achieving this (Sandall, Soltani, Gates, Shennan & Devane, 2016). Continuity of midwifery care enables a trusting relationship to be built between the woman and her midwife or the group of midwives caring for her. This in turn has been shown to lead to increased levels of confidence (Sandall, Devane, Soltani, Hatem & Gates, 2010) and better labour and birth experiences (Sandall, Soltani, Gates, Shennan & Devane, 2016) including decreased levels of intervention during labour and birth a few babies being born by caesarean section (McLachlan et al., 2012).

Midwives provide maternity care to women and their families in a variety of community and hospital settings within a broad range of models. Dependent upon their geographical location, women have a choice of the type of maternity care they wish to receive during the childbearing continuum. One thing is clear, regardless of the model of care women are being cared for within, midwives play a key role in the provision of their midwifery care (Renfrew et al., 2014a). Despite midwives being considered experts in 'normal' maternity care, if and when deviations from this arise, midwives consult, refer to, and provide care to mothers and babies in collaboration with other members of the inter and intra-professional healthcare team in order to achieve optimum outcomes whilst maintaining his/her relationship with the woman and her family (Australian College of Midwives (ACM), 2014).

The International Confederation of Midwives (ICM) is an international organisation that works to support, represent, and strengthen the midwifery profession across the world (ICM, 2018a).

The International Confederation of Midwives (ICM) define the midwife as:

> *A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired*

> *the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery* (ICM, 2017a p.1).

Ethical practice is integral to the midwifes role. The International Code of Ethics for Midwives and how it addresses the importance of professional midwifery relationships in particular will be discussed later in this chapter.

### 2.3 Midwifery scope of practice

Midwifery practice is essentially primary healthcare and midwives subsequently care for healthy 'low risk' women and their families autonomously. The midwifery *scope of practice* refers to the legal and professional boundaries within which midwives' practice and the extent to which they provide care as part of their role to mothers and babies across the childbearing continuum. The ICM define the midwifes full scope of practice as:

> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
>
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units*
>
> (ICM, 2017b p. 1).

It is however important to acknowledge that despite this ICM definition, the midwife's scope of practice will differ dependent upon the country the midwife practises in, and in some countries,

from state to state. In both the UK and Australian contexts, the midwife's scope of practice is dictated by the local codes, legislation, and standards (NMC, 2018b, ACM, 2016). As midwives are not permitted to practice to their full scope in all countries across the world, they are expected to consult with other members of the multidisciplinary team at various stages of the woman's care journey as dictated by their local guidelines. From the perspective of this study, which is an examination of bullying of midwifery *students*, it is worth noting that the students are in a position of doubly compromised autonomy. Students are being supervised by registered midwife mentors, but those mentors are themselves not able to operate as autonomously in the health care setting as (for example) medical practitioners.

### 2.4 Midwifery ethics

Midwives practising throughout the world must ensure that they work to uphold and maintain the ethical standards of the profession of midwifery. It is a fundamental part of the midwifes role to ensure that that the woman's rights and dignity is protected and promoted and the midwife must be accepting of her beliefs, culture, expectations, values and previous experiences (ICM, 2014a). When considering the context of this study, it is important to note that the International Confederation of Midwives (ICM) (2014a) code of ethics not only addresses midwives' ethical responsibilities towards the women they care for, but they also mandate how midwives relate to others including their colleagues and midwifery students, how they practise midwifery, how they uphold their professional responsibilities and duties, and finally, how they ensure the integrity of the profession (ICM, 2014a). The 'Midwifery Relationships' section of code of ethics point I. e. specifically states that:

> "*Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth."* (ICM, 2014a p. 1).

Further, in the Advancement of Midwifery Knowledge and Practice section of the code of ethics point IV. c. states that:

*"Midwives contribute to the formal education of midwifery students and ongoing education of midwives"* (ICM, 2014a p. 1).

A midwife that behaves in a way that is inconsistent with the International Code of Ethics for Midwives may face a threat to his/ or her professional registration. Thus, those midwives engaging in workplace violence type behaviours, not providing adequate support, and failing to act as a positive role model to midwifery students are in breach of this code.

**2.5 Midwifery regulatory bodies**

Midwifery practice is governed in Australia and the UK by separate key regulatory bodies. The *regulatory body* plays the role of ensuring that the midwife's practice is compliant with the laws of that country or state and is guided by the relevant regulatory framework of the country in which the midwife is practicing (NMC, 2018a; Australian Health Practitioner Regulation Agency (AHPRA), 2020). Further *Regulatory and professional frameworks* then guide the midwifes practice and these are governed by local legislation to ensure that midwives offer safe competent care to the women and families they are caring for. In Australia for example, local legislation defines the midwifes code of conduct, their level of autonomy, the standards for practice, and processes whereby the profession can be entered, accountability, and rules for assessing and maintaining competence (Nursing and Midwifery Board of Australia (NMBA), 2018a, 2018b). Similar frameworks exist in the UK and are developed by the Nursing and Midwifery Council (NMC). These identify the professional expectations and guide the professional practice of the midwife (NMC, 2018a, 2019a). Such frameworks are ever evolving and are regularly updated to reflect changes in the profession.

In the context of this study, it is important to consider what the UK and Australian codes of conduct and standards for practice for midwives say about bullying behaviours within the profession. Professionalism and trust were identified as being an integral part of the role of the

midwife in the 2015 updated version of 'The Code' (NMC, 2018a). Section 20 in particular states the following;

> *You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public* (p. 18)

Other sections of the document refer specifically to bullying behaviours and the support of students. In order for midwives to comply with the code they must:

> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment"*
>
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> *20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
>
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives, and nursing associates to aspire to.*
>
> (NMC, 2018a p.18).

Similarly, in Australia, the NMBA has now integrated similar statements into both the recently updated Code of Conduct for Midwives (2018a), and the Midwife Standards for Practice (2018b). The NMBA Code of Conduct for Midwives clearly addresses bullying behaviour in principle three of the document which is entitled Cultural Practice and Respectful Relationships. Section 3.4 in particular states the following:

> *When people repeatedly and intentionally use words or actions against someone or a group of people, it causes distress and risks their wellbeing. Midwives understand that bullying and harassment relating to their practice or workplace is not acceptable or tolerated and that where it is affecting public safety, may have implications for their registration (*NMBA, 2018a p. 9)

In addition to this the code states that midwives must:

a. *never engage in, ignore or excuse such behaviour*

b. *recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards people or colleagues*

c. *understand social media is sometimes used as a mechanism to bully or harass, and that midwives should not engage in, ignore or excuse such behaviour*

d. *act to eliminate bullying and harassment, in all its forms, in the workplace, and escalate their concerns if an appropriate response does not occur".*

(NMBA, 2018a p. 9).

Furthermore, standard three of the NMBA Midwife Standards for Practice (2018b) states that *"the midwife must contribute to a culture that supports learning, teaching, knowledge transfer and critical reflection".* (p. 5)

This suggests that midwives that behave in an inappropriate manner towards midwifery students are not only having an adverse impact upon wellbeing of midwifery students but are in breach of their own professional codes of conduct and standards for practice. Subsequently being in breach of these codes and standards can have implications for their professional registration.

### 2.6 Challenges faced by 21st century midwives

Despite the international definition of the midwife remaining mostly unchanged over time, the role of the midwife has changed somewhat, particularly over the last couple of decades. Midwives have been working in a demanding and complex environment for some time (Yoshida and Sandall, 2013, Young et al., 2015) and many midwives would agree that the midwifery profession is inherently stressful, however it is believed that many of these stressors are in fact caused by contextual and environmental factors (Geraghty, Speelman & Bayes, 2019). Changes in the demographic status of the women they care for, challenging workplace cultures and organisational pressures are placing midwives under exceptional levels of stress, often leading to burnout and dissatisfaction with their work (Ball et al., 2002; Yoshida & Sandall, 2013).

#### 2.6.1 Changing demographics of childbearing women

Many midwives provide care daily to women and families that are facing a number of complex and challenging circumstances. This can take its toll upon midwives both physically and emotionally and can place them under increasing pressure and challenges their professional and personal abilities to cope with the role (Mollart, Skinner, Newing & Foureur, 2013). Midwifery care is often provided with limited resources, to increasing numbers of women, many of which are experiencing physical, psychological, and psychosocial complexities, all within oppressive medically orientated institutions (Neiterman, 2013). Increasing numbers of women are becoming pregnant at an advanced age (Sauer, 2015), with many having pre-existing physical and mental health conditions (Franks, Crozier & Penhale, 2017; Murphy, Bell, Dornhorst, Forde & Lewis-Barned, 2018; Capper, 2019a) thus requiring higher acuity care involving the skills and input of the multidisciplinary team (Baldwin, Harvey, Willis, Ferguson, & Capper, 2019). Further, midwives are caring for women in less traditional settings such as correctional facilities (Baldwin, Sobolewska, & Capper, 2018; Baldwin et al., 2020; Capper, Baldwin, Rogers, & Wood, 2018) and specialist refugee maternity clinics, and therefore must be cognisant of the importance of the provision of culturally sensitive and inclusive care (Capper & Williamson, 2017).

### 2.6.2 Midwifery workplace culture

As outlined in chapter one, over the last decade the midwifery profession has been the subject of much publicity relating to how the poor workplace culture of the maternity unit and the associated knock-on effects can catastrophically impact the quality and provision of safe care for mothers and babies (Kirkup, 2015). Since 2015, a number of studies have been published that have explored the workplace culture of the maternity unit further and these have demonstrated how a poor workplace culture not only impacts mothers and babies, but also midwives and midwifery students (Catling and Rossiter, 2020; Catling, Reid and Hunter, 2017). In 2017 Australian academics Catling, Reid, and Hunter (2017) conducted group and individual interviews with midwives to explore midwifery workplace culture from the perspective of midwives. The findings of this study demonstrated that both newly graduated and experienced midwives found the working environment challenging due to issues with bullying, being fatigued, feeling powerless, and being hampered by the environment. The same lead researcher recently built upon this with a larger study that explored Australian midwives perceptions of their workplace culture using a specifically developed instrument and this study demonstrated that less than a third of midwives felt that their workplace had a positive culture with many feeling unsupported, disengaged and oppressed by the medically dominated area in which they worked (Catling and Rossiter, 2020). Other issues related to dissatisfaction with the resources available to provide care, lack of communication and leadership and time pressures which were exacerbated by inadequate staffing levels. Bullying or 'unacceptable behaviour' in the workplace also features in 15 of the responses with some respondents reporting horizontal bullying amongst peers, and vertical violence between staff, managers, and midwifery students (Catling & Rossiter, 2020). Furthermore, a study by Cull et al. (2020) explored the degree of job satisfaction experienced by early career midwives that had been in midwifery practice for less than 5 years. The study demonstrated that despite many midwives enjoying their work, they often felt overwhelmed and under pressure due to heavy workloads and low staffing levels which was further exacerbated by

having negative working relationships with their colleagues. These findings suggest that if the current and future midwifery workforce is to be healthy and retained, a better emphasis needs to be placed upon the importance of staff wellbeing, this includes the appropriate management of bullying behaviours in the midwifery workplace.

### 2.6.3 Organisational pressures

As highlighted above, contemporary midwifery practice often involves working in a fast paced, high pressure environment, and this is particularly the case in Australia and the United Kingdom where the majority of midwives practise within the medicalised hospital setting (Australian Institute of Health and Welfare, 2016; Hunter, Henley, Kenwick, Sidebotham,& Pallant, 2017). Midwives working within these environments are expected to adhere closely to unit policies and guidelines, and in addition to this their practice must align closely with frequently emerging new evidence, technological changes, and government directives (Catling et al 2020). It is often the perception of healthcare consumers that the right to healthcare is also the right to good health - this then leads to the expectation that healthcare professionals must always 'get everything right' and there is zero tolerance for anything less than an ideal outcome (Wilson and Symon, 2002; MacKenzie Bryers and van Teijlingen, 2010). This belief subsequently leads to many midwives having a heightened awareness of the need to be 'risk aware' which causes them to practice defensively with the aim of protecting themselves against any perceived risk of litigation (Healy, Humphreys & Kennedy, 2016). In addition to this, stress levels are heightened further by many maternity units being short staffed (Dent, 2018), often with an inadequate staff skill mix (Harvie, Sidebotham, & Fenwick, 2019), which places additional stress upon both newly graduated and experienced midwives.

It is evident that midwives face a number of challenges related to their role expectations and working environment, all of which feed into 'stress of the job' that midwives often speak of (Cull et al., 2020; Catling & Rossiter, 2020). It has been previously suggested that being subject to high

levels of stress can in part, contribute to bullying and aggressive behaviour in the clinical area which can extend to the poor treatment of midwifery students. (McIver, 2002).

### 2.7 The midwifery student

A midwifery student is a person that is undertaking an appropriately accredited midwifery education program that leads to initial registration as a midwife in the country where the program is being undertaken.

The educational path towards becoming a midwife varies across the world, and in both Australia and the UK a number of different routes towards registration as a midwife exist. These pathways will be discussed in more detail in the next section of this chapter.

### 2.8 Midwifery education

As stated in the introduction to this thesis, in 2019 the adequate provision of quality midwifery education that meets international standards was deemed a priority by the WHO due to the positive impacts that appropriately educated, trained, regulated, and licensed midwives have upon maternal and newborn health (Renfrew, 2014b; WHO, 2019). The ICM state that it is the expectation that all quality midwifery educations programmes offered throughout the world are accountable to childbearing women, the general public, employers, students, the midwifery profession, as well as one another (ICM, 2013). The ICM's midwifery education standards (ICM, 2013) also define a number of essential competencies for basic midwifery practice, and these represent the *minimum* level of skills and knowledge expected for any quality midwifery education programme. There is expected to be more upon the development of clinical skills than the achievement of academic degrees (ICM, 2013). It is an expectation that good quality midwifery education prepares all newly registered midwives to be skilled and competent, and develops their knowledge to provide compassionate, safe midwifery care to women and their babies across the childbearing continuum. This includes the optimisation of the normal processes of childbearing, identifying the need for multidisciplinary management of complexities as they arise, and working

in partnership with women and their families to optimise maternal and newborn outcomes (Renfrew, et al., 2014b).

In order to offer a midwifery education program that leads to registration as a midwife in the UK or Australia, education providers courses must be formally assessed to meet a minimum standard and be accredited and monitored by the appropriate accrediting body (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2014, NMC, 2019b). This is vital to ensuring the ongoing quality of the programme and the subsequent safety of the public.

The profile of midwifery as a career choice has been heightened in recent years as a result of popular television shows such as 'Call the Midwife' and 'One Born Every Minute" and this has led to an increase in the number people considering a career in midwifery (Royal College of Midwives (RCM), 2012; Bonar, 2014). However, entry to midwifery education programmes is often highly competitive and generally requires a high level of previous academic achievement. This results in midwifery being an unobtainable career for many. This has however not always been the case. Midwifery education has undergone considerable changes over the past two decades and still continues to change and improve. Prior to the mid-2000's, many midwives held diplomas, certificates or were hospital trained in midwifery. These qualifications were not earned in the university setting, but rather 'on the job' or in a college or a technical and further education (TAFE) setting. Becoming a midwife in 2020 requires the completion of a rigorous university-based midwifery education program which comprises of a combination of academic study and clinical experiences (ANMAC, 2014, NMC, 2019b). All midwifery preparation programmes offered in both the UK and Australia are now at a minimum of degree level, however programmes may also be offered at post graduate diploma or master's degree level. The move midwifery education has made from being a hospital-based training program to a university degree level course has not been entirely well received and has created a sense of distance between the theoretical learning environment (the university) and the clinical learning

environment and its staff (the midwives employed in the clinical placement setting) (Australian Government Department of Health, 2013). This has resulted in a great deal of effort being required by each to sustain a positive relationship and a partnership that is conducive to midwifery student learning.

Full time midwifery education courses in the UK and Australia are anywhere between 12 months and 4 years in length (or equivalent part time) depending upon the route chosen (ANMAC, 2014; NMC, 2019b). The routes available will depend upon the student's choice of curriculum and their prior learning. These courses will be discussed in greater detail in the following sections of this chapter.

An essential element of midwifery education programmes in both the UK and Australia is the undertaking of clinical placement. As outlined earlier in this chapter, midwives' practice in a variety of settings and within a number of different types of models of care. Subsequently midwifery students clinical based teaching and learning, where possible, should ideally take place across each of these settings and models. Clinical placements may be in the form of regular weekly placements, block placement, or within a continuity model of midwifery care. In order to graduate and achieve registration as a midwife in the UK, it is mandatory that students complete a set number of clinical hours and skills whilst undertaking clinical placement in a supernumerary capacity (NMC, 2017b). In Australia however, the number of clinical hours that the student must complete are not specified and students may attend clinical placement in a supernumerary capacity or are employed by the clinical placement provider as a midwifery student (ANMAC, 2014). Employed midwifery students are generally already registered nurses and are employed as such with an allocated number of days per week allocated to being their 'midwifery student placement days'. In order to pass the clinical component of the program, students must be able to demonstrate clinical competence. This is assessed by the midwives that are 'mentoring' or supervising the students and assessment takes place against the midwifery standards relevant to

the country in which the program is being undertaken (NMBA, 2018b; NMC, 2019b). In addition to this, currently in Australia, midwifery students are required to follow a minimum of ten continuity of care women throughout pregnancy, birth, and the postnatal period (ANMAC, 2014). In the UK however, the COCE requirements are less specific. The NMC's Standards for Pre-registration midwifery education (NMC, 2019b) states that in order for midwifery students to develop their scope of practice experience, they must *"be involved in the care of a small group of women throughout the childbirth experience, including antenatal, intrapartum, and postnatal care"* (p. 19). In addition to this, students in both countries are required to successfully complete the theoretical component of the program which makes up on average 50% of the courses' total learning hours (ANMAC, 2014; NMC, 2019b).

It is evident that midwifery students in both the UK and Australia require a great deal of commitment to complete both the academic and clinical components of their program. Although midwifery education is somewhat similar in both countries, there are some fundamental differences which will be outlined in the next section of this chapter.

### 2.8.1 Midwifery education courses in Australia

In Australia at present there are three main routes to achieving initial registration as a midwife, these include: an undergraduate Bachelor of Midwifery (BMid) (a direct pathway into midwifery for those without prior degrees), a postgraduate degree for registered nurses wishing to become midwives, and a four-year dual degree where students achieve registration as both a nurse and a midwife upon completion. Less commonly some universities offer graduate entry courses where strong applicants that hold a bachelor's degree in another discipline can undertake further bachelor or master's degree level study to become midwives. The first three-year direct pathway into midwifery (undergraduate BMid) program was offered in Australia in 2002 (Kitschke, 2019), and graduates of these programmes only practice midwifery unlike their predecessors that were all previously registered nurses (Australian Government Department of Health, 2013). In

Australia, pre-registration midwifery education programmes for registered nurses must be at least 12 months full time in length (ANMAC, 2014). ANMAC does not specify the required length of programmes for applicants that do not hold nursing degrees however, bachelor degree level courses in Australia must provide the volume of learning that is equivalent to three years full-time study (Australian Qualifications Framework Council, 2013). Although ANMAC does not state the number of clinical hours that must be completed by the midwifery student, the, type, and frequency of midwifery practice experience that students should undertake are clearly outlined (ANMAC, 2014).

Historically the multiple education pathways leading to midwifery registration in Australia led to some controversy. Despite the availability of undergraduate BMid education programmes (which are still commonly referred to as 'direct entry' courses in the UK) being commonplace in the UK since the 1980's they are still  a relatively new concept in Australia and when their introduction was first suggested in the late 1990's it was met with some resistance (Leap, 1999). Concerns were raised around their suitability to the Australian context, particularly as they were perceived to provide graduates with relatively limited career options and removed the flexibility the dual qualified workforce provided managers with, particularly those working in rural and remote locations (Kitschke, 2019). Many managers of small rural and remote health facilities seek to employ clinical staff that can provide both nursing and midwifery care to consumers on an organisational needs' basis. There was also concern that undergraduate Bachelor of Midwifery graduates do not possess the skills and knowledge to respond to complex and emergency situations that may arise, particularly in rural settings where other staff support may be limited (Leap, 1999). The fact that school leavers would be able to directly enter midwifery was also not well received as it was felt that entrants needed to be more mature and possess life experience in order to become a competent midwife (Leap, 1999). Despite these concerns, the course has now been offered for almost 20 years in Australia and itis believed to possess a number of strengths. The program being three years in length provides ample opportunities for midwifery students to

be immersed in continuity of care experiences, it addresses concerns about the rapidly ageing midwifery workforce, reinforces the identity of midwifery being a standalone profession, and finally, it eliminates the financial cost of requiring students to be registered nurses before undertaking their midwifery education (Kitschke, 2019).

### 2.8.2 Midwifery education courses in the UK

Broadly speaking, in the UK there are two main pathways towards becoming a midwife. One consists of three years full time study which comprises theory and practice totaling 4600 hours. Like the Australian model, this route is suitable for prospective students that do not possess a nursing qualification. The second route is designed for students that are already in possession of a qualification as a Level 1 Registered Nurse known as an RN – Adult. This route requires 18 -24 months of full-time study which comprises of both theory and clinical placement totaling 3000 - 3600 hours (NMC, 2019b).

In the UK, the three-year undergraduate midwifery programme leads to a bachelor's degree in midwifery with honours. As stated above, there is also a postgraduate course option which is designed for students that are already registered nurses, these 18 to 24-month courses lead to a Postgraduate Diploma, a Bachelor's, or Master's degree in midwifery. These are referred to as 'shortened' or fast-tracked courses. In addition, less commonly, a small number of universities offer postgraduate midwifery programmes for graduates with a relevant degree that lead to degrees or equivalent qualifications in midwifery. At present, unlike in Australia, there are no nursing and midwifery dual degrees available in the UK as this is not a form of midwifery education that the NMC currently approves.

Despite the distinct models of midwifery education now being well established in both countries, there is still often misunderstanding around the different 'types' of midwifery students when they are in the clinical setting. This is often evidenced by the midwives mentoring them

misunderstanding their needs relating to the achievement of clinical requirements and the amount of supervision and support necessary (Cummins, Catling, Hogan, & Homer, 2014).

### 2.9 Midwifery student learning

Students learn from a wide range of individuals in several distinct ways when undertaking clinical placement (James, D'Amore, & Thomas, 2011). The effectiveness of clinical learning is very much dependent upon a number of variables including the students' prior experiences of learning, their existing knowledge and skills, their levels of confidence, and the nature of the environment in which they are undertaking clinical placement (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). As adult learners, midwifery students are responsible for their own learning, and the value of that learning is shaped by the type and quality of their clinical experiences and how they respond to them (Billet, 2016). If students are to successfully progress through the first three stages of their career trajectory (from *novice* to *advanced beginner,* and finally to *competent practitioner*) (Benner, 1984) and become competent registered midwives, they must maximise all learning opportunities by embracing them, and demonstrate a keenness and motivation to learn (McCoy, Levett-Jones, & Pitt, 2013). Midwifery mentors should demonstrate positive role modelling and work closely with midwifery students to agree and set clear learning goals (Marshall, McKellow, & Muleya, 2020). These predetermined goals should ideally be communicated to all midwives the student works with prior to commencing each and every clinical placement. If students are to successfully learn what is required to complete their midwifery education program (which is generally primarily governed by the specific program of study they are undertaking), this ongoing communication is of vital importance (Billet, 2016). It is however important to consider that, in order for students to ensure that their learning remains on track, they must possess the skills and confidence to speak up and voice their needs and concerns should they arise. It has been suggested that in order to do this, midwifery students must possess skills in assertive communication, conflict minimisation (ICM, 2014b), and resilience (Richards, Sweet, & Billet, 2013). Developing resilience as a midwifery student is

crucially important for a number of reasons. Students are often exposed to adverse clinical events and outcomes, are required to deal with challenging and confronting clinical situations, including conflict with women, their families. and their midwife peers. Each of these scenarios require the student to remain resilient, a skill that can be developed using personal reflection (Clohessy, McKellar, & Fleet, 2019). As outlined earlier in this chapter, the clinical environment is fraught with a number of organisational pressures which can adversely impact the midwifery students' learning and teaching experiences. This can inadvertently lead to them adopting non-evidence-based skills (Armstrong, 2009) and at times, witnessing poor standards of care (Lash, Kulakaç, Buldukoglu, & Kukulu, 2006). It is therefore important that when faced with these situations, students possess the confidence and resilience skills to speak up and address these issues appropriately to help ensure the safety of mothers and babies.

**2.10 Midwifery students' in 21st century midwifery practice.**

Today's midwifery students face a significant number of challenges whilst on their journeys towards becoming registered midwives (McCarthy et al., 2018). Their workload is high; they are required to juggle theoretical learning, preparation of assessment tasks, navigate clinical placement and the associated shift patterns, complete COCE experiences and then in addition to this, find the time to have a personal life outside of midwifery. The first year of clinical practice can come as culture shock to some midwifery students with many experiencing a disconnect between the expectation and reality of midwifery education (Cummins, Catling, Hogan, & Homer, 2014). Midwifery as a profession is often idealised by commencing midwifery students (Carolan & Kruger, 2011a) with many perceiving midwifery as a career that involves working with mothers and babies at a joyful time in their lives (McCall, Wray, & McKenna, 2009). However, the reality of midwifery practice which includes caring for mothers and babies facing complex challenging circumstances and being witness to traumatic clinical situations, is at odds with this (Leinweber & Rowe, 2010). In addition, as discussed earlier in this chapter, midwifery workplace culture can be challenging, and students face the task of trying to integrate into and

become accepted into this brand new (to them) established workplace culture (Begley, 2001). Each of these factors can take their toll and lead to significant levels of stress and anxiety for many midwifery students (McCarthy et al., 2018). Research has shown that increasing numbers of todays generation of students, particularly women, are accessing university counselling and support services and are more likely to experience mental illness than previous generations (Thorley, 2017). An integrative review by Oates et al. (2019) that specifically explored the mental health and wellbeing of midwifery students, demonstrated that much like their registered midwife counterparts, found working in the maternity setting stressful and emotionally draining. Students face issues related to bullying and intimidation, are exposed to challenging clinical situations such as neonatal deaths and fear that their clinical skills are inadequate. In addition to this, Oates et al (2009) highlighted that they also face further stressors that relate to their academic studies and financial issues.

### 2.11 Summary/Conclusion

In order to place this study in context, this chapter has provided an overview of the profile of the midwifery profession and the challenges it faces. The roles of governing bodies and the models of midwifery education in both the UK and Australia were explored. Finally, some of the multifaceted challenges today's midwifery students face were explored and discussed.

Although some differences between midwifery in the UK and Australia exist, the role of the midwife and the models of midwifery education are somewhat similar. Midwifery degrees in the UK and Australia share several similarities and are guided by the same overarching ICM midwifery education recommendations (ICM, 2013). From the researcher's own perspective, having practised extensively as a midwife in both locations, the issues related to bullying faced by midwifery students are fundamentally the same, hence the decision was made for this study to explore the experiences of midwifery students in the UK and Australia.

### 2.12 Chapter to follow

Chapter Three will present a summary of the literature that has explored midwifery students' experiences of bullying and workplace violence to date. First, the review protocol that was developed prior to undertaking the systematic review of the literature will be presented. Following that, the systematic review of the literature will be presented to demonstrate the existing gap in qualitative knowledge related to this phenomenon.

# Chapter Three

# Review of the Literature

### 3.1 Introduction

Chapter Three will now provide the review protocol that was developed prior to undertaking the systematic review of the literature and the systematic review of the literature itself.

The section of this chapter that provides the systematic review of the literature is presented in the form of a published peer reviewed article in its original submitted form. This demonstrates the gap in qualitative research knowledge related specifically to midwifery students' experience of being bullied whilst on clinical placement.

### 3.2. Systematic Review Protocol

The purpose of developing a review protocol was to ensure a rigorous, structured, and systematic process upon which the systematic review could be built (Moher et al., 2015). The development of the systematic review protocol was guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses for Protocols (PRISMA-P) (Moher et al., 2015). The protocol was reviewed by a CQUniversity librarian using the PRISMA-P 17-item checklist (Moher et al., 2015) to ensure completeness and transparency and feedback was incorporated.

**Abstract**

**Background**: Workplace violence amongst registered midwives has been a recognised problem since the early 1990s. Whilst undertaking clinical placement in the maternity unit, midwifery students often become implicated, and subsequently find themselves to be the targets of bullying and harassment. These experiences have several adverse personal and professional impacts upon students and have a detrimental impact upon the future of and sustainability of the midwifery profession.

**Objective:** As a basis for designing a future response to the bullying of midwifery students, it is important to understand what is currently known about this phenomenon. This review aims to systematically identify and review the relevant literature on workplace violence and bullying experienced by midwifery students whilst on clinical placement.

**Methods:** A search will be undertaken of the following electronic databases[1]: CINAHL, Web of Science, MEDLINE, Embase and Google Scholar. The reference lists of included papers will be searched to identify any additional papers that were not captured by the search strategy. A search of the grey literature will also be undertaken. The inclusion criteria will consist of papers that include midwifery student participants that have experienced bullying whilst in their role as a student and are undertaking a midwifery education program that leads to initial registration as a midwife. All types of primary, peer reviewed, qualitative, quantitative, and mixed method studies that had a research question that focussed upon the bullying of midwifery students will be included. Articles must have been published in English from 1990. Studies that relate *only* to registered nurses and/or registered midwives, or pertain solely to *nursing* students, and papers where minor themes related to the bullying of midwifery students are reached rather than being the focus of the paper will be excluded.

**Keywords**: midwifery students, bullying, clinical placement, systematic review protocol

### 3.2.1 Background

Workplace violence is a significant growing problem that has become an international public health concern (Nielsen et al., 2015). Despite definitions varying widely, *workplace violence* or *bullying* generally refers to intentional *repeated* overt or covert inappropriate behaviour from another that is *intended* to intimidate and harm the target (Younan, 2019). It has however been argued that within the healthcare student context, frequency or duration of episodes of bullying

[1] In this section of the thesis, future tense will be used rather than past tense, in line with customary practice when describing review protocols.

is not considered a key element of this definition, as one-off incidents can have a profound negative effect upon the target (Boyle & Wallis, 2016).

Workplace violence amongst registered midwives has been a recognised problem since as early as the 1990s (Hastie, 1995; Leap, 1997). More recently it has become evident that whilst undertaking clinical placement, which forms a significant part of their course, midwifery students are becoming implicated, and the targets of bullying and harassment (Gillen et al., 2009; McKenna & Boyle, 2016).

Power imbalance is thought to play a key role in the bullying process (Johnson, 2011), and workplaces, particularly healthcare settings, which combine formal hierarchies with high levels of stress provide the ideal environment for bullying behaviours to flourish (Birks, Budden, et al., 2017). Being placed at the bottom of such an established organisational hierarchy renders midwifery students' vulnerable members of the team, and being bullied, further increases this vulnerability (Birks, Budden, et al., 2017).

Workplace bullying has been reported to have a number of adverse impacts upon the physical (Mikkelsen, Hansen, Persson, Byrgesen, & Hogh, 2020) and mental health (Balducci, Baillien, Broeck, Toderi, & Fraccaroli, 2020) of targets and leads to a significant number of midwifery students choosing to leave their education program or not practice upon registration (Gillen et al., 2009). This is likely to have a significant detrimental impact upon the future and long-term sustainability of the midwifery profession.

To date, much of the scholarly literature has focussed on workplace bullying that relates to registered midwives and the specific experiences of midwifery students have received considerably less research attention. As a basis for designing a response to the bullying of midwifery students, it is important to understand what is currently known about this phenomenon. This systematic review will identify and review the relevant literature on workplace violence and bullying experienced by midwifery students.

### 3.2.2 Review Question

What is known about workplace violence and bullying experienced by midwifery students whilst on clinical placement?

### 3.2.3 Inclusion Criteria

*Participants*

This review will consider studies that include midwifery students as participants that are undertaking a midwifery education program that leads to initial registration as a midwife in their respective country. This will include students who directly entered a Bachelor of Midwifery degree program, dual degree students who are studying both nursing and midwifery simultaneously and post graduate midwifery students that are already registered as nurses but are undertaking further study to become midwives. It was decided to include only include entry to practice course students and to exclude those students that are already registered midwives undertaking postgraduate midwifery courses that have a clinical component. This was because students that are already registered midwives are likely to have existing collegial relationships with the mentoring midwives, they are undertaking placement with and will therefore be at the same or a similar position in the organisational hierarchy. This equal positioning subsequently increases the likelihood that they will be treated as a peer rather than as a student that in the tradition sense is of lesser power. There is also potential that through the undertaking of higher levels of education students that are already registered midwives are perceived in fact to be at a higher position within the hierarchy or aspire to be, by preparing themselves academically for opportunities for professional promotion. This would have an impact upon the way in which they are treated by midwives and how their student status is perceived.

Studies that included registered nurses and registered midwives that are not students as participants that had experienced bullying will be excluded because as registered practitioners they are generally considered to be at an equal position in the hierarchy to the bullies and subsequently do not face the same vulnerabilities that a student does. Papers that pertain only to

nursing students will also be excluded as student nurses undertake the vast majority of their clinical placement in the wider hospital context and spend minimal, if any, time undertaking clinical placement in the maternity unit meaning very few opportunities exist for them to experience bullying.

The participants in the study must have been purposively recruited and have experienced bullying whilst in their capacity as a midwifery student.

### *Concept*

This review will include studies that have specifically explored bullying or workplace violence that relates to midwifery students. As stated earlier in this thesis, bullying is defined as *repeated* overt or covert inappropriate behaviour from another that is *intentional* and *intended* to cause harm to the target (Younan, 2019). However, students in the clinical workplace can experience one-off incidents that can however have a profound negative effect upon them and therefore frequency or duration of episodes of bullying is not considered a key element of this definition within this context (Boyle & Wallis, 2016). Bullying behaviours can manifest themselves in several ways. These include, but are not limited to, overt abusive behaviour such as verbal abuse including the use of intimidating and belittling comments, physical abuse, or sexual abuse and/or harassment (Zapf et al., 2020). Inappropriate covert behaviours can also be used to bully others. Behaviours such as deliberate ostracization and/or exclusion, withholding learning opportunities, setting others up to fail or whispering about others when in earshot can all constitute bullying (Zapf et al., 2020). The inappropriate use of power is also used by some bullies to terrorize their targets. In the midwifery student's context, an example of this is a midwife refusing to sign a students' clinical documents or failing them without clear academic grounds (Hakojärvi, Salminen, & Suhonen, 2014).

In order to be included in the review, papers must specifically explore aspects, or factors that relate to being bullied as a midwifery student. These may include but are not limited to; the

midwifery students' *personal experiences* of being bullied, their *perception* of being bullied, the *types* of bullying they experienced, the *impacts* of being bullied, how they *respond* to being bullied, or the *prevalence* of the bullying.

Papers where minor themes relating to the bullying of midwifery students were reached rather than being the focus of the paper will be excluded.

### *Context*

This review will consider international studies published in English that explore workplace violence or bullying of midwifery students that takes place when they are present in their capacity as a midwifery student.

Such environments may include but are not limited to, the clinical hospital setting which includes the ante and postnatal wards, birthing suites, antenatal clinics, and neonatal care areas, the community setting, primary healthcare settings or the academic environment such as the university or college campus.

## *3.2.4 Types of sources*

This systematic review will consider all available peer reviewed, primary research that has a research question that specifically pertains to the bullying of midwifery students.

The following types of studies will be considered for inclusion: all types of quantitative studies including experimental, quasi-experimental, observational, randomized controlled trials, cohort studies, and mixed methods studies. All designs of qualitative studies including, but not limited to, ethnography, phenomenology, grounded theory, qualitative description, and case study will be included. The studies will be limited from 1990 to current date. The year 1990 was chosen as the cutoff date as through an initial preliminary search that was undertaken to develop the search strategy, it was identified that this was when workplace violence in the healthcare arena started gaining research interest. Despite much of this literature focusing upon the nursing and medical

profession, the author felt it was important to capture and review these studies to ensure midwifery students were not included as participants. This was deemed necessary as in some country's midwifery is still considered to be a branch of nursing.

### 3.2.5 Methods

This development of this protocol was guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses for Protocols (PRISMA-P) (Moher et al., 2015). This protocol was not registered with the International Prospective Register of Ongoing Systematic Reviews (PROSPERO) as it does not lead to a health-related outcome and therefore did not meet the criteria for registration (Booth et al., 2012).

#### *Search strategy*

The search strategy aims to identify all peer reviewed primary research studies. A prior broad scoping review was undertaken with the assistance of a CQU librarian to identify the frequently used keywords, terms and phrases used in the wider workplace bullying literature. Following this, the search terms were agreed by the review team and the search will now be undertaken in three distinct steps. In the first step the scientific databases will be searched using following identified terms and keywords; "workplace violence", bullying, mobbing, "vertical violence" and "workplace incivility". These will each then be combined using the Boolean operator AND with each of the following terms: "midwifery student", "midwifery students", "student midwives" and "student midwife". Step two will consist of a follow up search of Google Scholar which will be undertaken using the same search terms. Finally, a hand search of the reference lists of the identified papers will be conducted to identify any additional papers that are not captured by the initial search.

### 3.2.6 Information Sources

The databases to be searched include Cumulative Index of Nursing and Allied Health Literature (CINAHL), Web of Science, Medline, and Embase. A follow up search of Google Scholar will

then also be undertaken. These databases were selected to undertake the search, as according to Bramer, Rethlefsen, Kleijnen, and Franco (2017) when undertaking a systemic review, they are the most appropriate to guarantee a thorough coverage of literature.

### *Study Selection*

Upon completion of the search, all located papers will be uploaded into version X9 of Endnote (Clarivate Analytics, PA, USA) and all duplicates will then be removed. The title and abstract of each paper will be screened by the author and her associate supervisor for consideration against the inclusion and exclusion criteria for the review. The full text of all potentially relevant papers will then be retrieved and reviewed against the inclusion and exclusion criteria by the same two reviewers. All reasons for the exclusion of the full text papers that failed to meet the inclusion criteria will be recorded and reported in the systematic review. Should any disagreements arise between the reviewers during the selection process, a third reviewer (the principle supervisor) will be asked to review the paper and resolve the conflict of opinion. The full results of the search will be reported in a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009).

### *Quality Assessment*

All of the final papers included in the review will be assessed for quality using Hong et al. (2018) mixed methods appraisal tool (MMAT). This tool requires two initial screening questions to be applied to each of the studies regardless of their methodology, and this is followed by the application of a further five criteria which are applied to each quantitative, qualitative, and mixed methods study. The developers of this tool state that an overall score should not be designated to each study, but a more detailed summary should be created to provide a thorough overview of the quality of included studies. No studies are to be excluded due to low methodological quality (Hong, Gonzalez-Reyes, & Pluye, 2018). In order to reduce the risk of bias, two reviewers will

quality assess the papers independently. Should conflict of opinion occur, a third reviewer will be asked to adjudicate.

### *Data Extraction*

All extracted data will be presented in tabular format. The table will be presented as: author, year, country of origin, type of study, purpose, sample, data collection method and key findings. A narrative summary will also be provided to accompany the tabular results and will provide a clear description of how the results of the review relate to the identified review question.

## 3.3 Systematic Review of the Literature

### Introduction

The next section of this chapter will present the systematic review of the literature which was built upon the review protocol outlined above. In Chapter One the research question was posed; *'What are midwifery student's experiences of being the targets of workplace bullying whilst on clinical placement?'* By undertaking a systematic search, the peer reviewed literature that related to this research question was identified, reviewed, and analysed. The aim of undertaking this process was to identify what is currently known about this phenomenon and to identify any gaps in knowledge. A systematic review of the literature was chosen to achieve these aims as they are considered a reference standard for rigorously synthesizing evidence, particularly in the healthcare context. This is due to their methodological rigour and resultant strength upon which to base clinical guidelines, policies and to aid clinical decision making (Moher et al., 2015).

This chapter will highlight that to date, little research exists that has specifically explored the bullying experiences of midwifery students whilst on clinical placement, and of the literature that does exist, the majority takes a quantitative approach and therefore lacks the depth of understanding of the experiences of the students that qualitative research provides. Whilst it is acknowledged that midwifery students are the targets of workplace violence whilst on clinical

placement, little is currently known about exactly how they experience this and the impacts it has upon them and other key stakeholders.

The systematic review of the literature, pertaining to the bullying of midwifery students whilst on clinical placement published between January 1990 and December 2019, is presented using a peer-reviewed paper which was published in the international journal, *Midwifery* in August 2020.

The review was undertaken in January 2020; therefore, the literature review is considered current at the time of thesis submission.

### 3.3.1 Declaration of Co-authorship and Contribution

| |
|---|
| Title of paper:<br>Midwifery students' experiences of bullying and workplace violence: A systematic review.<br>Full bibliographic reference:<br>Capper, T., Muurlink, O., & Williamson, M. (2020). Midwifery students' experiences of bullying and workplace violence: A systematic review. *Midwifery*, 102819.<br>https://doi.org/10.1016/j.midw.2020.102819 |
| Accepted and In Press<br>Published |

Nature of Candidates Contribution, including percentage of total.

| |
|---|
| Whilst undertaking this systematic review of the literature, I, Tanya Capper was responsible for forming the review question, developing the search terms, undertaking the search, collating and reviewing literature, quality assessment of each paper included study, analysing the included results, interpreting results, and drafting the paper.<br><br>This publication was written by me and my contribution was 70 %. |

Nature of Co-Authors' Contributions, including percentage of total

| |
|---|
| My co-authors Muurlink, O (20%) and Williamson, M (10%) contributed to the review design, analysis of the search results and to writing and editing the final manuscript. |

Has this paper been submitted for an award by another research degree candidate (Co- Author), either at CQUniversity or elsewhere? (if yes, give full details)

| |
|---|
| No. |

Candidate's Declaration

I declare that the publication above meets the requirements to be included in the thesis as outlined in the Research Higher Degree Theses Policy and Procedure.

Tanya Capper

(Original signature of Candidate) Date: 5/12/2020

### 3.3.2 Paper One

Capper, T., Muurlink, O., & Williamson, M. (2020). Midwifery students' experiences of bullying and workplace violence: A systematic review. *Midwifery*, 102819.

**https://doi.org/10.1016/j.midw.2020.102819**

This chapter presents a paper in its original form, published in *Midwifery*. This paper is provided, with permission, in its published form as Appendix H.

**Midwifery students' experiences of bullying and workplace violence: A systematic review.**


## Abstract

### Background

Workplace violence directed at registered midwives in the maternity setting has been a recognised issue since the early 1990s. More recently it has become evident that midwifery students are also victims of bullying and harassment whilst on clinical placement. Due to the short and long-term impacts this has on students, it is likely to have a detrimental effect on the future and sustainability of the midwifery profession. As a basis for designing a response, it is important to understand what is currently known about this phenomenon.

### Aim

To systematically review the literature to identify what is known about workplace violence and bullying experienced by midwifery students whilst on clinical placement.

### Method

Reporting of this review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. A search was undertaken of all primary research that focussed upon workplace violence and bullying involving midwifery students whilst on clinical placement, published between January 1990 and December 2019. Pre-defined terms were used to search the following five databases: CINAHL, Web of Science, MEDLINE, Embase, supplemented with Google Scholar. Additional manual searches of reference lists were conducted. An assessment of the quality of each eligible study was then undertaken using an appropriate mixed methods appraisal tool (MMAT). Extracted data were then synthesised using thematic synthesis.

**Findings**

Nine articles met the criteria for inclusion in the review. Studies were primarily qualitative, with some reporting descriptive statistics that do not enable key issues such as prevalence to be reliably addressed. The synthesis identified four main themes that related to workplace violence and bullying of midwifery students whilst on clinical placement. Results were clustered around the role of power in bullying, prevalence and impacts, the culture of compliance, and the victim's response.

**Conclusions and Implications for Practice**

A broader understanding of the nature of workplace violence and bullying and how it manifests itself is beginning to emerge, but more and higher quality research is required to establish an empirical base on which to design interventions. Studies suggest that bullying is common and has significant impacts at both a personal and professional level. This strongly reinforces a need for greater policy and organisational responses to bullying in the clinical education context, in order to break the bullying cycle and ensure the midwives of the future remain in the profession and sustain the workforce.

**Keywords:** midwifery students, bullying, placement, workplace violence, systematic review.

### 3.4 Introduction

Violence is increasingly recognised as a significant workplace risk (Pheko et al., 2017), predicting illness, absenteeism (Hassard et al., 2018) and lowered productivity. It has thus emerged as a significant contemporary public health (Nielsen et al., 2015) and managerial concern.

Much of the scholarly work on bullying is based on research undertaken in child populations in an institutional (school) context, and the bullying literature continues to have a strong school-age focus, linked with outcomes such as developmental and educational milestones (Espelage and De La Rue, 2012). In child populations, the word 'bullying' elucidates the role played by

power differentials between the bully and the bullied, with power differences also believed to be commonplace and an antecedent to bullying in the adult population (Johnson, 2011). It is the power differential that makes workplaces, with their distinct and formal hierarchy a focus of bullying research (Lewis, 2006). Hospitals and healthcare settings, in general, exemplify such structures (Vessey et al., 2009) combining historically entrenched hierarchies with a closed environment and high levels of workplace stress (Birks et al., 2017). Over the last few decades research has emerged that explored workplace violence in the maternity setting (Dietsch et al., 2010; Farrell and Shafiei, 2012; Gillen et al., 2008) with scholars identifying workplace violence as a cause for mid- wives becoming burnt out (Yoshida and Sandall, 2013) and deciding to leave the profession (Ball et al., 2002). Considering the significant organisational and financial investment in midwifery education, loss of students early in their pro- gram through bullying should be a policy priority. Midwifery regulators have responded to a degree by addressing bullying in their codes of conduct and standards for practice, highlighting the potential implications for the perpetrators' professional registration (e.g. for examples from Australia and the United Kingdom (UK) see Nursing and Midwifery Board of Australia (NMBA), 2018a, 2018b; and Nursing and Midwifery Council (NMC), 2015) Questions however now remain over whether this new regulatory emphasis will have a positive impact and effectively filter down to the midwifery student's clinical placement experience.

It is thus timely to review the body of literature exploring bullying at the point of overlap between midwifery practice and midwifery education. At this point in their career, the student experiences dual dimensions of vulnerability, as a relatively junior link in a professional hierarchy, and as a student in an educational structure. This systematic mixed-methods literature review aims to exhaustively identify all primary research studies that have explored the phenomenon of workplace violence and bullying relating to midwifery students. On the basis of recent reviews of bullying in nursing education (Eka and Chambers, 2019; Sidhu and Park, 2018) it was anticipated, a priori, that the literature will begin to answer questions as to the prevalence of

bullying of midwifery students, demographics and characteristics of both perpetrators and victims, impacts, contextual drivers, and the willingness of victims to engage in whistleblowing.

### 3.5 Methods

#### 3.5.1 Overview

The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). In order to reduce the risk of bias, the first two authors individually quality assessed all papers listed in Table 2 using a mixed methods appraisal tool (MMAT) (Hong et al., 2018). The MMAT tool enables concomitant appraisal of the methodological quality of quantitative, qualitative, and mixed methods research for mixed study systematic reviews (MSR). Any discrepancies were discussed, and consensus reached through conferral.

#### 3.5.2 Search strategy

A variety of terms are used interchangeably to describe work- place violence within the healthcare setting, including workplace bullying, discrimination, harassment, aggression, and incivility (Bowling and Hershcovis, 2017). The search strategy for this review was developed with this multiplicity of terms in mind and followed a broad scoping review of the literature undertaken in relation to bullying in midwifery and challenges facing midwifery workplace culture. During this process frequently used keywords, terms and phrases were identified and used to develop the protocol for this literature review. The search was undertaken in December 2019 using the following keywords and terms; "vertical violence", mobbing, bullying, "workplace violence", and "workplace incivility". These were each combined using the Boolean operator AND with each of the following terms "midwifery students", "midwifery student", "student midwife", and "student midwives".

The databases selected to undertake the search were considered the most appropriate to guarantee a thorough coverage of the literature when undertaking a systematic review (Bramer et

al., 2017). These included; CINAHL, Web of Science, Medline, and Embase. The second stage of the search process consisted of a follow-up search using the same terms in Google Scholar to ensure the inclusion of key literature that may be absent from the other databases. The third and final stage of the search process included a manual search of the citations and reference lists for additional material. The identified papers are presented in Table 1.

**Table 1: Search Results**

| Database | Search Term 1 | Search Term 2 | Search Term 3 | Search Term 4 | Search Term 5 | Total |
|---|---|---|---|---|---|---|
| | "Midwi* student*" OR "student midwi*" AND "vertical violence" | "Midwi* student*" OR "student midwi*" AND mobbing | "Midwi* student*" OR "student midwi*" AND bullying | "Midwi* student*" OR "student midwi*" AND "workplace violence" | "Midwi* student*" OR "student midwi*" AND "workplace incivility" | |
| CINAHL | 1 | 2 | 28 | 18 | 0 | 49 |
| Web of Science | 0 | 0 | 7 | 5 | 4 | 16 |
| MEDLINE | 0 | 1 | 7 | 3 | 1 | 12 |
| Embase | 0 | 1 | 9 | 4 | 0 | 14 |
| Google Scholar | 37 | 71 | 769 | 167 | 22 | 1066 |
| Hand search of ref lists | 0 | 0 | 3 | 0 | 0 | 3 |
| Total | 38 | 75 | 823 | 197 | 27 | **1160** |

### 3.5.3 Study selection

The described search yielded 1160 papers in total including those located through manual searching. 907 remained after duplicates were removed, all of which were screened by title and

abstract by the first author based on the inclusion and exclusion criteria (see Section 2.4). The full-text version of 57 papers considered to be potentially relevant was then accessed. See *Fig. 1* for the process by which the papers were reviewed and excluded. The review team then discussed the final nine papers and it was agreed that they met the inclusion criteria to be included in the review.

### 3.5.4 Inclusion and exclusion criteria

The following additional inclusion criteria were applied: primary, peer reviewed research that was published in English between 1990 and December 2019; full text available; research question/s focussed on the bullying of midwifery students, and midwifery student participants. The following exclusion criteria were applied: studies that related *only* to registered nurses and/or registered midwives, studies that pertained to *nursing* students and papers where themes related to the bullying of midwifery students were reached rather than being the focus of the paper. Papers that merely reported upon a review, were not peer-reviewed, or were discussion papers not offering additional empirical data were excluded, and finally, conference, abstract papers, and letters were excluded from the review.

A full list of the excluded papers with exclusion rationale is available on request. Due to the small number of initially identified qualitative research studies available that focussed upon the topic of interest, the review parameters were broadened to include qualitative, quantitative, and mixed methods studies. This was also considered important as it is believed that it is a challenge for one type of research approach alone to provide a depth of insight (Hong et al., 2018; Pluye et al., 2009).

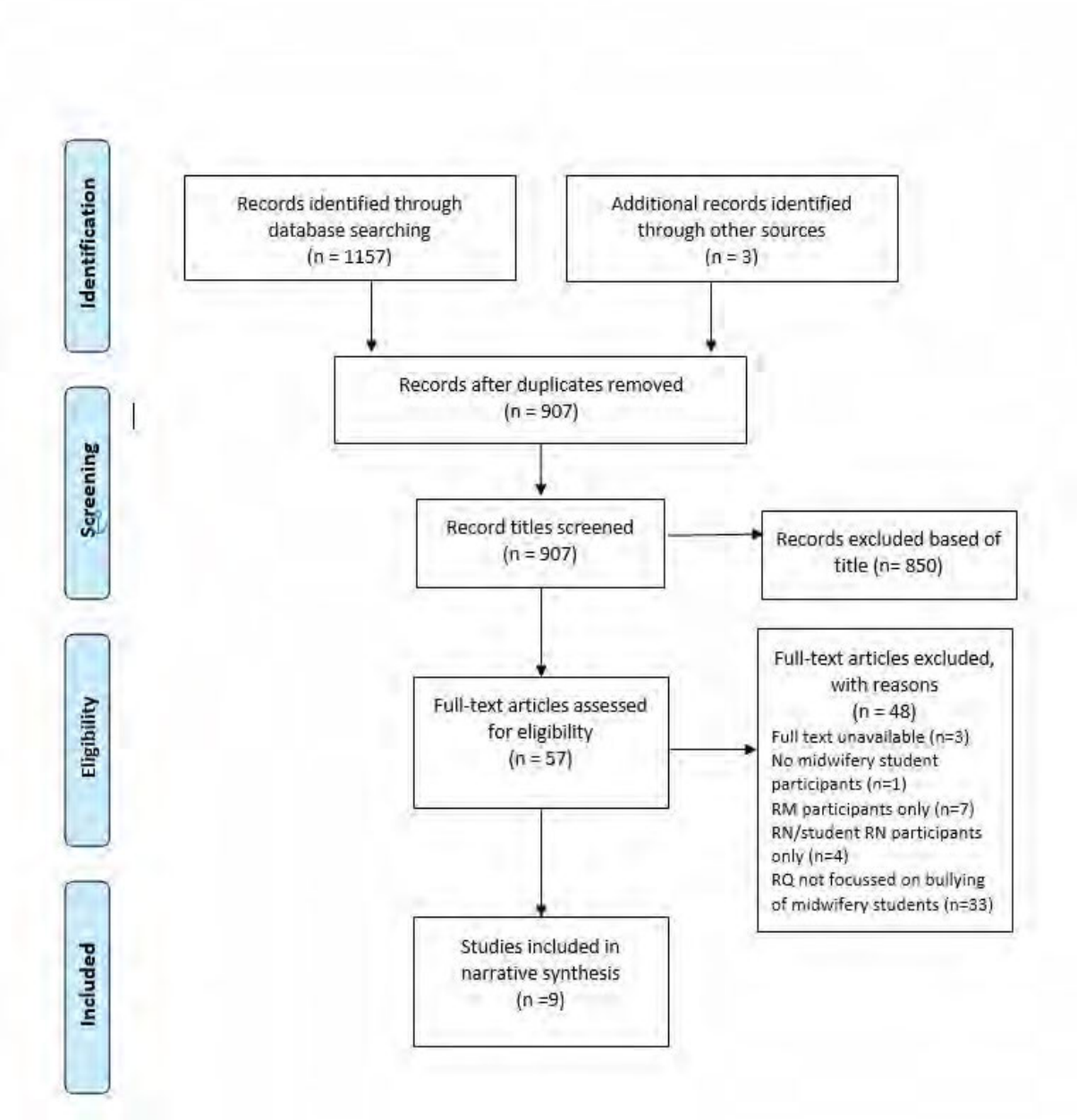


**Figure. 1. Flow diagram of literature search modified from the PRISMA statement.**

### 3.5.5 Quality assessment

The MMAT consists of two initial screening questions that are applied to all studies regardless of methodology, with five further criteria subsequently applied to each qualitative, quantitative, and mixed-method study. The risk of attrition, performance and se- lection bias was assessed as part of this process which is considered a central component of undertaking a systematic review (Viswanathan et al., 2018). The recently updated 2018 version of the MMAT tool (Hong et al.,

2018) recommends that an overall score should not be calculated from the ratings, and a more de tailed presentation of the ratings should be conveyed to provide a more thorough overview of the quality of the included studies. A detailed quality appraisal of each study was conducted and is available upon request from the corresponding author. As recommended by Hong et al. (2018) no articles were excluded based on their low methodological quality, therefore nine papers remained in the review following the quality appraisal. Considering the paucity of studies in the field identified by a relatively inclusive search strategy, a decision to eliminate studies on the basis of quality would have resulted in a further erosion of data.

### 3.5.6 Data extraction and synthesis

Included papers were tabulated under the sections first author, country, type of study, purpose, sample, data collection method, and key findings related to bullying (see Table 2). Initial thematic synthesis was used to synthesise the findings (Lucas et al., 2007). Each paper was read multiple times by two researchers, TC and OM, independently, with differences between the raters resolved by agreement, thus Cohen's Kappa is not reported. Results of the nine studies were structured under the six broad categories (prevalence, victim and perpetrator demographics, impacts, contextual drivers, and whistleblowing) established prior to initial thematic analysis. These categories did not reflect the findings contained in the pool of identified papers. Themes were then re-examined, and it was identified that there were duplication and overlap between the extraction questions and that the data more closely mapped to the following four themes, which will be presented in Section 3.4.

The four broad themes that can be expressed as broad research questions are:

1 How does organisational context mediate or moderate bullying?

2 What is the relationship between the identity of the perpetrators and the nature of the bullying?

3 How does the victim's dual identity as a student /worker interact with their response to bullying?

4 How does bullying impact students personally and professionally?

### 3.6 Findings

#### 3.6.1 Study characteristics

All nine studies included in the review specifically aimed to answer research questions that were directly related to bullying or workplace violence experienced by midwifery students whilst on clinical placement.

The studies showed geographical clustering. Of the nine papers, three drew upon samples from Australia, two from the UK, and single papers from Iran, Finland, Turkey, and Slovenia. Three studies (Boyle and McKenna, 2016; McKenna and Boyle, 2016; Shapiro et al., 2017) used the same 52 participants. However, as the research questions differed, and the data were analysed differently they were included in the final synthesis. A further two studies used the same 164 participants (Gillen et al., 2008; Gillen et al., 2009) but as the 2009 paper provided a more detailed and focussed-summary on the midwifery student questionnaire component of the authors earlier four-phase 2008 study, it was agreed that it too should be included.

It was impossible to determine the total number of midwifery students that participated in the studies in this review. Student numbers in each study ranged from 10 to 164, however, due to the inconsistent way results were reported, exact numbers were at times difficult to determine. Lash et al. (2006) for example, report on "nursing and midwifery students" without disaggregating the two categories.

Where the age of the participants was discussed, ages appeared to range from 18 to 45 years, however, one study stated that students at the upper end of the age range were 'aged 41 and over' (Gillen et al., 2009). Again, it is therefore difficult to determine with precision the upper age limit of mature-aged students included in this review. Indeed, two of the papers did not

explicitly mention the age of the participants. Similarly, four papers specified the gender of the midwifery students, and in these cases, all were female. The five remaining papers were silent on the gender variable.

Most of the participants were undertaking undergraduate courses leading to initial registration as midwives, i.e., they were not previously registered nurses. One paper did, however, refer to a section of their sample (13 students) being postgraduate students that were registered nurses (Gillen et al., 2009).

The student's relationship status was reported in just two of the nine papers and of these, the majority were married or living with a partner (Fathi et al., 2018; Gillen et al., 2009). Just one paper reported the participants' ethnicity data (Gillen et al., 2009).

### 3.6.2 Overview of study methodologies

Two studies (Hakojärvi et al., 2014; Lash et al., 2006) used a qualitative approach, employing content analysis and thematic analysis respectively to make sense of the data. Boyle and McKenna (2016), Fathi et al. (2018), Jug Došler, Skubic, and Polona Mivšek (2014) and Shapiro et al. (2017) all used quantitative methods, while Gillen et al. (2008); Gillen et al. (2009) and McKenna and Boyle (2016) used mixed methods approaches. All studies took a convenience sampling approach. None of the studies were longitudinal; none thus allowed a determination of causality. Instead, the studies were cross-sectional in nature, allowing a picture to be developed of bullying as it was experienced at a single point in time, rather than allow the determination of factors that lead to that point in time.

### 3.6.3 Study quality

Based upon original MMAT criteria, several of the studies would have been rated fairly low or even be excluded from the analysis but were included as recommended by Hong et al. (2018). Almost all the studies were exploratory in focus, and all, as noted previously, were cross-sectional in approach, which limits the ability of the studies to answer focused

hypotheses about the nature of bul- lying of midwifery students, such as the questions we set in advance. Almost all lacked a clear research question or narrow re- search aim which means that the research focused on describing the nature of bullying, rather than, for example, the setting conditions or possible targets for intervention. The studies that did use mixed methods tended to be stronger in the qualitative component than in their quantitative analysis, with the latter focusing even more narrowly on descriptive statistics that offered little depth of analysis. None attempted multi-factorial analysis, leveraging the more sophisticated statistical tools available. These shortcomings may reflect the ethical challenges of gaining more in-depth and specific data in relation to individuals subject to bullying. None of the mixed-methods studies fully leveraged the potential triangulation of the approach, delivering their results in additive style rather than integrating the qualitative and quantitative components.

Response rates tended to be high in studies that reported response rates, most exceeding 50%, with few studies addressing the issue of representativeness. The majority instead tended to focus recruitment upon a single institution within a country and there were no international comparative studies. This limitation does mean that with a high response rate or a narrow focus, each study is likely to have reflected the (albeit limited) characteristics of the bullying experience in the target institutions.

While nine studies were included in the final analysis this over-states the actual reach of data collection because multiple studies were based on a single population or sample. This reflects the fact that the research area is dominated by a small cluster of researchers operating from a small number of institutions. This also limits the geographic reach of this pool of work. Most of the studies were undertaken in either Australia or the UK with single studies from Iran, Finland, Slovenia, and Turkey.

**Table 2: Summary and characteristics of included articles.**

| First author/ Country | Type of Study | Purpose | Sample | Data Collection | Key relevant findings |
|---|---|---|---|---|---|
| Boyle et al., (2016)<br>*(Australia)* | Quantitative | To identify the type of workplace violence experienced by undergraduate paramedic and midwifery students. | A total of 136 participants, **52** of which were female BMid students. | Paper-based Paramedic Workplace Violence Exposure Questionnaire. | 83% of midwifery student participants reported verbal abuse whilst almost 70% reported intimidation. 7% of midwifery students also reported sexual harassment. Overall midwifery students experienced more acts of violence against them than paramedic students. |
| Fathi et al., (2018)<br>*(Iran)* | Quantitative | Aimed to examine the status of violence among the students of nursing, midwifery, and operating room. | A total of 155 participants, **29** of which were midwifery students. | Self-reporting questionnaire of violence at Workplace Violence in Healthcare Sector. | Almost 45% of the midwifery students in the study had experienced some sort of violence whilst on clinical placement in the previous year. This was most often in the form of verbal abuse from nurse instructors whilst working in the maternity unit in front of patients/women. 65% of students reported the violence to his/her supervisor. The students experienced several emotional responses including anxiety. |
| Gillen et al., (2008)<br>*(United Kingdom)* | Mixed Methods | To define and examine the nature and manifestations of bullying in midwifery. | **164** midwifery students participated in the 4th and final phase of the study. | Telephone interviews, a concept analysis was then undertaken, followed by confirmatory focus groups. | A third of students reported being bullied by more than one person, with 78% of students saying they had been bullied by someone who had previously or subsequently bullied another student. 36% of students had witnessed others being bullied. Often the bullies were midwives or mentors, although university staff were also implicated. Consequences of bullying included thoughts of leaving the course, psychological and physical |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Midwifery students then completed a questionnaire. | health impacts and even contemplation of suicide. Some students challenged the bully, but this was ineffective. Others put up with bullying to avoid risks of failing placement or not getting a job. |
| Gillen et al., (2009) *(United Kingdom)* | Mixed Methods | To define and examine the nature and manifestations of bullying in midwifery as experienced by a cohort of student midwives in the UK. | **164** midwifery students. | Questionnaire | Half of the students had either witnessed or experienced bullying themselves. The bully was most often a midwife or mentor, but university staff were also implicated along with doctors and ward sisters. Forms of bullying included verbal abuse, lack of support, and even physical abuse. 53% of students believed that the bullying was intentional and linked the workplace culture. When the bully was confronted the bullying continued. Bullying was linked to physical and psychological issues and thoughts of suicide. Leaving the course was also considered. |
| Hakojärvi et al., (2014). *(Finland)* | Qualitative | To describe the experiences, manifestations, consequences, and coping mechanisms of Finnish healthcare students that have been bullied during clinical placement. | 41 Finnish healthcare students, **10** of which were midwifery students. | Electronic questionnaire | Results were not specific to midwifery students; however verbal and nonverbal bullying was reported. The bully was most often the student's mentor. Students experiences psychological and physical symptoms as result of bullying. Students most commonly shared their experiences with other students however when their issues were escalated to their university faculty, the term 'bullying' was not always used in the conversation. |

| | | | | | |
|---|---|---|---|---|---|
| Jug Došler et al., (2014) *(Slovenia)* | Quantitative | To investigate Slovenian midwifery student's perception of mobbing. | **51** 2nd and 3rd year midwifery students | Questionnaire | 82.3% of participants experiences mobbing during their course – 58.8% whilst on placement and 23.5% whilst in the university. The students' mentor was most frequently cited as the bully and students felt that not having a consistent mentor contributed to this issue. Students were generally targeted as individuals and bullying had adverse effects upon their physical and mental health. 62.7% of students tried to find a solution to the bullying by either talking to their colleagues, friends and family, hospital, or university staff. Seldom did the students challenge the bully directly. |
| Lash et al., (2006) *(Turkey)* | Qualitative | To describe nursing and midwifery students' experiences with and perceptions of verbal abuse in clinical settings in Turkey. | 66 nursing and midwifery students. The exact number of midwifery students is **unclear.** | Focus groups | Students reported being blamed for adverse outcomes and were treated as outsiders. They were belittled by medical staff by being told they were 'only' becoming nurses Students were verbally abused by nursing and midwifery staff, particularly by those that were inexperienced and/or lacked degrees. Students were used as 'workers', preventing them from being able to achieve births and participate in higher order care. Students were also expected to participate in unethical care practises and 'go along' with the registered nurses. Some students reported sexual harassment and verbal abuse. Bullying had several physical and psychological effects upon their health and led to placement avoidance and thoughts of leaving the course. Students shared their concerns with their peers, family, friends, university staff and even the |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | bully. Students believed that staff needed a better understanding of the students learning needs and adult education principles. |
| McKenna et al., (2016) *(Australia)* | Mixed Methods | To examine undergraduate midwifery students' experiences of workplace violence during clinical placement. | **52** midwifery students | Paper-based Paramedic Workplace Violence Exposure Questionnaire | 30% of students were intimidated, 17% exposed to verbal abuse, 3% physical abuse and 3% sexual harassment whilst on clinical placement. They were blamed for others' mistakes, placed in situations where they felt out of their depth, and told off in front of mothers. Students reported that the partners of labouring women had intimidated them. Sexual harassment was reported as being from colleagues. Respondents reported being hesitant to report misbehaviour and malpractice. In over three-quarters of incidents, students were frightened, and apprehensive, which resulted in reduced self-confidence, career uncertainty and negative emotions. |
| Shapiro et al., (2017) *(Australia)* | Quantitative | To explore Australian midwifery students' responses to workplace violence as well as to gauge the impact of workplace violence on them. | **52** midwifery students | Paper-based Paramedic Workplace Violence Exposure Questionnaire | 88% do *not* complete an incidence report but verbally report bullying. A significant minority of students frequently failed to report incidents at all. Students report their experiences whilst in clinical placement as having impacts on their future careers, including PTSD. |

### 3.6.4 Analysis

#### *The role of power in bullying*

Over half of the studies included identified the clinical mentor as the main source of bullying for midwifery students. Other registered midwives, medical practitioners (Fathi et al., 2018; Gillen et al., 2008, 2009; Hakojärvi et al., 2014; Jug Došler, Skubic, and Polona Mivšek, 2014; Lash et al., 2006), the women they care for, the women's partners, and other family members were however also cited as perpetrators (Fathi et al., 2018; Lash et al., 2006; McKenna and Boyle, 2016). Beyond the clinical setting, students also reported experiencing bullying from university employees, administrative staff and even their student peers (Fathi et al., 2018; Gillen et al., 2008, 2009; Hakojärvi et al., 2014; Jug Došler et al., 2014; Lash et al., 2006). However, in common with current research on bullying beyond the health professions, the source of bullying is often inequity in power. Some supervising midwives were described as being on a 'power trip' (Gillen et al., 2009), and treating students as unpaid workers (Jug Došler et al., 2014; Lash et al., 2006). This notion of the students as cheap or free workers, required to undertake mundane tasks, which had the secondary impact of removing them from more meaningful pedagogical opportunities (Jug Došler et al., 2014; Lash et al., 2006) was a frequent sub-theme.

Misuse of power manifests itself in a number of ways such as excessive criticism or the absence of praise, resulting in students feeling belittled and undervalued (Gillen et al., 2008; Hakojärvi et al., 2014). Mentors were particularly identified in having substantial sway over the student experience. This was demonstrated by students reporting having learning opportunities denied (Lash et al., 2006; McKenna and Boyle, 2016). For example, one student was prevented from being present at a birth due to having earlier refused to undertake a menial non-clinical task (Lash et al., 2006). Some of this inappropriate use of power is experienced as pathologically intentional: with one student stating that a midwife had bragged that not one of his/her students had made it to the 3rd year (Gillen et al.,

2008), other students reported that they had been blamed for their mentors mistakes (Gillen et al., 2009; Hakojärvi et al., 2014; Lash et al., 2006; McKenna and Boyle, 2016) and another student reported that their clinical evaluation (assessment) was unfairly marked by a bullying mentor (Hakojärvi et al., 2014).

Some staff were overtly rude and at times verbally abusive toward students (Fathi et al., 2018; Gillen et al., 2008, 2009; Lash et al., 2006; McKenna and Boyle, 2016). Being publicly chastised or corrected in front of their peers, midwifery colleagues, and the women they were caring for was reported (Gillen et al., 2008, 2009; McKenna and Boyle, 2016). It was also perceived that some midwives simply did not like or want to work with students and made this very clear (McKenna and Boyle, 2016). For example, students were ignored, or deprived of handover sheets or even labouring women to care for (and thus the ability to develop their skills). Students were also treated as being outsiders or intruders (Hakojärvi et al., 2014; Lash et al., 2006; McKenna and Boyle, 2016).

Manipulative teaching strategies were also employed. This included using falsehoods or withholding information in order to 'catch the student out' (Gillen et al., 2009; Hakojärvi et al., 2014). Students also reported having no support to undertake clinical tasks (Gillen et al., 2009; McKenna and Boyle, 2016) or in more extreme cases even being asked to partake in unethical care practices (Lash et al., 2006).

Finally, a small number of students reported experiences of being sexually harassed whilst on clinical placement (Boyle and McKenna, 2016; Lash et al., 2006; McKenna and Boyle, 2016; Shapiro et al., 2017). The number of students that had experienced sexual harassment, in studies that touched on prevalence levels, was low and was often instigated by a work colleague (McKenna and Boyle, 2016). Physical abuse, similarly, was not as common as psychological abuse, however, the severity of reported attacks was at times alarming with one student reporting that he/she had been pushed around, and another had a bag of clinical waste thrown at him/her (Gillen et al., 2008).

### *Prevalence and impacts*

All but three of the studies explored the prevalence of abuse experienced whilst on clinical placement but did so in ways that make it difficult to determine prevalence with any great precision. Where it was reported, the prevalence ranged between 44.8% (Fathi et al., 2018) to 82.3% (Jug Došler et al., 2014).

While these studies are likely to have samples biased towards including positive cases of abuse, it is concerning to note the high prevalence of bullying in the clinical placement setting given the magnitude of the consequences. These impacts were discussed in eight of the nine papers, the exception being Shapiro et al. (2017) that solely explored the students' actual response to bullying. Eight studies explored the impacts upon the individual, with consequences felt at several levels including adverse effects upon the students physical and mental health, and their ability to enjoy and continue with their studies. A number of the students had considered leaving their course of study or changing their career plans due to bullying (Gillen et al., 2008, 2009; Hakojärvi et al., 2014; McKenna and Boyle, 2016). Some students took time off placement to avoid the bullies (Lash et al., 2006) and most worryingly, one student had considered suicide (Gillen et al., 2009).

Some students felt fear and anger towards the bullies (Fathi et al., 2018; Gillen et al., 2009; Hakojärvi et al., 2014) and this resulted in them having ongoing issues with their learning (Hakojärvi et al., 2014; Jug Došler et al., 2014), particularly as they felt unable to approach clinical staff and ask questions (Hakojärvi et al., 2014).

Finally, another concerning impact of bullying is the resultant effects it can have upon the standards of the profession (Gillen et al., 2008). Bullying can lead to low morale, job dissatisfaction, subsequent staff shortages and ineffective teamwork all of which can lead to poor standards of care for mothers and babies (Gillen et al., 2008).

### *Culture of compliance*

The influence of the organisational context on the culture of bullying was a common theme.

Most of the studies discussed how the clinical placement host organisation, or its culture can foster the bullying of midwifery students. A permissive organisational culture was specifically identified in the UK studies (Gillen et al., 2008, 2009), however, the majority of authors touched on the role of transparency and visibility in reducing the prevalence or con- sequences of bullying or harassment events (Fathi et al., 2018; Gillen et al., 2008, 2009; Hakojärvi et al., 2014; Lash et al., 2006; McKenna and Boyle, 2016). Concerningly, six of the nine papers discussed how bullying regularly occurred in front of other staff members, students, and mothers (Fathi et al., 2018; Gillen et al., 2008, 2009; Hakojärvi et al., 2014; Lash et al., 2006; McKenna and Boyle, 2016). Students were talked about in the tearoom by the midwives and referred to as 'slaves' (Hakojärvi et al., 2014). It is therefore evident that bullying is not taking place 'in private' and those who witnessed it did very little to intervene or support the bullied person (Gillen et al., 2009). Failure to report bullying is thought to be due to witnesses being aware that making such reports to management brought about no change, and subsequently having very little confidence in 'the system' (Fathi et al., 2018; Gillen et al., 2008). Jug Došler et al. (2014); Gillen et al., (2008) and Gillen et al., (2009) discuss how midwifery is strongly hierarchical and midwifery students are located very much at the lower end of this vertical structure (Lash et al., 2006) with a 'them and us' culture established amongst senior staff (Hakojärvi et al., 2014; Lash et al., 2006; McKenna and Boyle, 2016). Some authors reported that experienced midwives recast (or perhaps excused) bullying as a way of transmitting norms about hierarchy, as an initiation to the profession, or 'rite of passage' (Gillen et al., 2008).

The literature also touches on the issue of the 'responsibility' of the umbrella organisation for individual (mis)behaviour, suggesting that organisational pressures (such as stress related to time pressures and heavy workload) transfers through midwives to students (Jug Došler et al., 2014). These organisationally controlled moderators of bullying may include lack of time to teach (Fathi et al., 2018; Jug Došler et al., 2014) or mentors having too high

expectations of the students (Jug Došler et al., 2014).

Lash et al., (2006) proposed that the distinction between intentional abuse and poor teaching was in some cases unclear: it was perceived that some mentors lacked the teaching and communication skills required to support adult learning and were rendered defensive by their lack of confidence or differing levels of education to that of the student (Jug Došler et al., 2014). Not having a consistent mentor was also suggested to be an issue with students reporting that this impacts their enjoyment of placement (Gillen et al., 2009) and leads to them having to repeatedly demonstrate their level of competence to new mentors (Jug Došler et al., 2014).

### *Victim response*

The students engaged several coping mechanisms in order to 'get through' their experiences of being bullied. All but one paper (Boyle and McKenna, 2016) explored the strategies employed by students—notably confiding in peers and/or friends and family (Fathi et al., 2018; Gillen et al., 2008; Gillen et al., 2009; Hakojärvi et al., 2014; Lash et al., 2006; Shapiro et al., 2017). Some student sought support from the university staff (Fathi et al., 2018; Gillen et al., 2009; Hakojärvi et al., 2014), whilst professional counselling (Shapiro et al., 2017) also emerged as an option. Breaking their silence was not a universal response, however. Some students took a more 'stoic' approach and did nothing (Shapiro et al., 2017), 'just put up with it' (Gillen et al., 2008) or simply avoided the bully (Shapiro et al., 2017). A significant number of students avoided placement by cancelling shifts or withdrew from their course to escape the bully (Gillen et al., 2009; Hakojärvi et al., 2014; Lash et al., 2006; Shapiro et al., 2017).

The point at which the organisation's outcomes and the individual student-victim's outcomes sharply diverge is when students do decide to act on bullying or inappropriate behaviour. Students expressed a fear of not being seen as important enough to report bullying (Fathi et al., 2018). They also worried that they would not be believed (Hakojärvi et

al., 2014), would fail placement or not get a job upon graduation (Gillen et al., 2008). Midwifery students, as newcomers to the profession often feel the need to 'fit in' with the team, and subsequently feel explicit or implicit pressure to conform with the existing workplace rules, practices and behaviours (Gillen et al., 2008). With this sense of marginal belonging comes a reluctance to report not just bullying but also other issues that could relate to poor practice or even misconduct. Lash et al., (2006) provided an example of this where a student was expected to be dishonest about the medications a labouring woman had been administered when challenged by a medical practitioner.

In seven of the nine studies, the students gathered the courage to speak up and report their experiences to others. Reports were made to the university staff in the studies by Fathi et al., (2018), Gillen et al., (2009), Hakojärvi et al., (2014) and Jug Došler et al. (2014). Two of the papers stated that the university intervened to support the student (Gillen et al., 2009; Hakojärvi et al., 2014) however the outcome was unclear in the other two papers. Students also reported their concerns to clinical staff, hospital management and some even confronted the bully. The results of the reports were mixed with many students feeling that it either made no difference (Gillen et al., 2009), brought about a sense of relief (Lash et al., 2006) or the outcome was not specified (Jug Došler et al., 2014; Shapiro et al., 2017).

### 3.7 Discussion

The nine studies included in this review identified that being bullied as a midwifery student whilst on clinical placement has adverse impacts for the students themselves, maternity services, midwifery education facilities and the midwifery profession as a whole. The studies collectively provide support to the notion that upwards of one in two midwifery students experience bullying whilst on clinical placement and therefore the problem is common and serious. These prevalence figures accord with the literature in nursing more broadly. Budden et al. (2017), for example, found that half of the nursing students in their study had

experienced bullying in the preceding 12 months and subsequently experienced stress and anxiety. Eight of the nine studies included in this review explored the consequences and impacts of abuse upon the students. These ranged from psychological and physical symptoms through to suicide ideation, leading to subsequent decisions to leave the course - a finding in common with work in healthcare students in general (e.g. Hamshire et al., 2013).

Students are of course not always passive recipients of bullying and respond where possible to the circumstances they find themselves in. While students in these studies reported turning inwards, adopting a 'stoic' or 'resilient' approach to abuse, students also reach outwards for support. Collectively the studies suggest that midwifery students commonly turn to parties beyond the confines of the maternity unit or hospital itself with family, friends, professional counsellors, and university staff approached for assistance and advice (Fenwick et al., 2016; Hogan et al., 2018).

The studies included in this review suggest that whistleblowing is not undertaken lightly. Midwifery is known as a profession with a strong, established hierarchy (Pollard, 2005) and midwifery students are aware of this (Begley, 1999; 2001b, 2002) and how they fit within this structure. Students are also cognizant of the 'closed system' the world of midwifery represents, worrying that if they 'upset the apple cart' or complain they will fail to secure a job upon graduation or be denied academic progress. Students that participated in Begley's (2002) study of midwifery students views of hierarchy in midwifery felt pressure to keep the Matron on side as they relied upon her to provide them with references and a job upon registration. Students also feel pressured to keep the peace by conforming to unwritten rules (Hunter, 2005) and to keep quiet about clinical concerns for fear of being labelled as a troublemaker or a snitch (Mander, 2016). In most of the studies, however, there are reports of students summing up the courage to inform on, or even to confront their bully—with mixed results. The students' sense of vulnerability is partly due to the insular nature of the

profession: the fact that students' progression is determined to a significant (and potentially arbitrary) degree by a small number of gatekeepers at the clinical level. The students, for example, showed their vulnerability by their lack of willingness to whistle- blow, and their frequent choice of an 'exit' rather than 'voice' strategy of exercising a response (Hirschman, 1970).

The studies thus suggest more needs to be done to clarify pathways for redress for students with bullying concerns. Beyond considering the welfare and progress of students, and thus maintaining a succession of new midwives to the profession, bullying also represents a reputational risk to the profession, with students reporting incidents occurring in full view of the public—not just in front of other staff. There is some evidence in these studies that bullying is not seen just as a manifestation of aberrant midwifery workplace culture (Catling et al., 2017), but an intrinsic part of becoming a midwife, however the majority of studies reflect the view that the problem is systemic, rather than purely a matter of personalities in key positions.

This systemic nature of bullying is not unique to the midwifery profession of course. Midwifery students are a sub-population whose power is compromised in both their roles: as they are often seen as being a student and as 'junior employee' in the clinical context (Begley, 1999, 2001a). However, the maternity setting is often quite small, and run by a group of staff that are well known to each other. Thus, the culture of the maternity unit is relatively vulnerable to change through the influence of one or two key individuals. Not surprisingly, then, the research showed that manipulation of power in the midwifery education context, as in other organisational contexts, is a key component of the bullying experience. This misuse of power is expressed through both 'sins' of omission (verbal and physical) and commission (failure to provide support, the use of silence or other forms of ostracism). This ostracism can be significant as both a form of pedagogical and social abuse, as the midwifery student is dependent on access to appropriate clinical experiences in order

to achieve registration as a midwife. Giving students menial as opposed to meaningful tasks to undertake, restricts access to significant clinical experiences thus controlling the student's ability to progress, and can be disguised as 'best practice' arguments— "he/she is not ready for this experience". This finding is supported by a number of studies that explore the prominent role of the mentor and their influence upon midwifery students' clinical experiences and subsequent success in their education program (Armstrong, 2010; Bluff and Holloway, 2008; Gilmour et al., 2013; Hunter et al., 2008; Licqurish and Seibold, 2008; Shayan et al., 2019). It is evident that those who bully them have power not just over their present, but their future.

The papers included in this study do advance suggestions for a response to the problem, based on an understanding not just of the findings, but knowledge of the organisational context. Addressing shortfalls in knowledge and organisational/cultural sensitivities of mentors was touched on, as well as the need for education on expectations. Mentors themselves are under significant stress and need to be provided with support to manage their teaching responsibilities. In addition, while definitions of bullying generally specify repetition as one of the defining characteristics, some authors suggest that in the healthcare education context, a single incident can have lasting adverse effects upon students (Boyle and Wallis, 2016). Again, this hypothesis is not fully tested and warrants further research.

This review identified a small body of research relating to the bullying of midwifery students whilst on clinical placement. The relatively small cluster of research that emerged on what appears to be a significant workplace problem in itself has implications: more research is required. The current body of work lacks longitudinal designs, and response rates make it difficult to confidently assess the prevalence, and researchers to date have avoided strong quantitative designs that allow multi-factorial analysis. Studies tend to be small, and geographically and methodologically limited. Further comparative work exploring the

midwifery student bullying experience in (for example) private versus public hospital contexts, as well as gender and international differences would help build a picture of the problem and establishing an empirical base for the design of interventions. It is noteworthy that to date no intervention study has been attempted.

### 3.7.1 Limitations

In considering the limitations of this review it should be considered that the limited number of papers included in the review represented data with limitations noted in the parameters of the review: there may be additional papers in languages other than English and published in the grey literature. This review also follows the current convention in including all peer-reviewed papers, regardless of quality as assessed by the MMAT tool.

## 3.8 Conclusion

This review identified current knowledge of workplace violence and bullying experienced by midwifery student whilst on clinical placement. A small cluster of studies, drawn from a limited number of nations and institutional settings, provide an insight into the role power plays in the bullying process and how bullying behaviours can be both overt and covert in nature. Hospital staff, predominantly midwifery mentors are the main source of bullying, but academic staff and even mothers and their support persons are also implicated. There is evidence that organisational characteristics help sustain patterns of bullying, however further research is needed to clarify these relationships to ensure workplace violence does not continue to cycle through future generations of midwifery students and registered midwives. Students respond to bullying in several ways but fear backlash as a result of escalating their concerns. This underlines the vulnerability of midwifery students who rely on successfully achieving the clinical requirements of their course in order to gain registration as a mid-wife.

This review strongly reinforces a need for further research, particularly some basic

quantitative surveys that allow more accurate estimates of prevalence and severity, on which to base policy and organisational responses to bullying in the clinical education con- text. While bullying is a sensitive topic that requires sensitivity in research, there is a need for these studies to provide an evidence base for future strategy in the profession, with the retention and wellbeing of midwifery students and potentially the welfare of mothers and infants at stake.

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**Declaration of Competing Interest**

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### 3.10 Outcome of systematic review

This systematic literature review provided an analysis of the existing literature about the bullying of midwifery students whilst on clinical placement. Four main themes were identified following the analysis of the nine papers that were included in the review that were considered suitable for inclusion. The themes were: "The role of power in bullying', Prevalence and impacts", 'Culture of compliance', and 'Victim response'.

The quality of the nine papers was appraised using the Hong et al. (2018) mixed methods appraisal tool (MMAT). A copy of the MMAT tool can be found in the appendices of this thesis as table 3. Notably only two of the nine studies (Hakojärvi, Salminen, & Suhonen, 2014; Lash et al., 2006) were purely qualitative in design and neither specifically focussed upon the experiences of just midwifery students. The study by Lash et al. (2006) included both nursing and midwifery participants and the study by Hakojärvi, Salminen, & Suhonen, (2014) included a range of student participants from a range of healthcare disciplines. In both papers the results were not presented in a way that was specific to each different group of students thus making it difficult to determine which findings related to the midwifery student participants. None of the nine papers provided an in-depth exploration of the midwifery students' experiences of being bullied or how impacts them and others on professional and personal levels. This highlights this gap in knowledge and demonstrates the importance of and need for this study.

### 3.11 Chapter summary

This chapter has provided a detailed explanation of the literature review process that was undertaken prior to conducting this research study. A detailed description of the systematic review protocol that underpinned the systematic review of the literature was provided followed by the presentation of the peer reviewed published systematic literature review paper titled 'Midwifery students' experiences of bullying and workplace violence: A systematic review' in its

original submitted form. This review has demonstrated the gap in existing knowledge and identified the importance of this study.

### 3.12 Chapter to follow

Chapter Four will present a paper that the student researcher was invited to submit by the editor of the UK journal '*The Student Midwife*'.

# Chapter Four

# Invited Paper

## 4.1 Introduction

This chapter presents a paper the author of this thesis was invited to submit to *The Student Midwife Journal* following the publication of the systematic review of the literature which gained a significant amount of international attention. This invited paper provides a personal reflection of the authors own personal journal related to bullying within the midwifery context.

This paper has been accepted for publication in '*The Student Midwife Journal*' April 2021 edition (see appendix P).

### 4.1.1 Declaration of Co-authorship and Contribution

| |
|---|
| Title of paper:<br><br>Being bullied on clinical placement: The student experience. *The Student Midwife Journal.*<br><br>Full bibliographic reference:<br><br>Capper, T., Muurlink, O., & Williamson, M. (Forthcoming - 2021). Being bullied on clinical placement: The student experience. *The Student Midwife Journal.* (Due for publication April 2021). |
| Accepted<br><br>Forthcoming publication (April 2021 ed). |

Nature of Candidates Contribution, including percentage of total.

| |
|---|
| In conducting the study, I was responsible for drafting the paper.<br><br>This publication was written by me and my contribution was 95%. |

Nature of Co-Authors' Contributions, including percentage of total

| |
|---|
| My co-author Muurlink, O contributed to the review and editing of the final manuscript 5%. |

Has this paper been submitted for an award by another research degree candidate (Co- Author), either at CQUniversity or elsewhere? (if yes, give full details)

| |
|---|
| No. |

Candidate's Declaration

I declare that the publication above meets the requirements to be included in the thesis as outlined in the Research Higher Degree Theses Policy and Procedure

Tanya Capper

(Original signature of Candidate) Date: 5/12/2020

### 4.1.2 Paper Two

Capper, T., Muurlink, O., & Williamson, M. (2021). Being bullied on clinical placement: The student experience. *The Student Midwife Journal.* (Due for publication April 2021).

This chapter presents a paper, in its original submitted form, accepted for publication in *The Student Midwife Journal.* An email from the journal editor confirming acceptance for publication can be found in Appendix P.

## 4.2 Invited Paper: Being bullied on clinical placement: The student experience.

**Abstract**

A significant number of midwifery students experience bullying whilst on clinical placement. As a midwifery student back in the mid 1990's I was bullied, and it certainly impacted my perception of my future colleagues and the integrity of the profession. Fast forward 25 years and I am now a midwifery academic undertaking research to better understand how this serious problem continues to adversely impact midwifery students today. I hope that my PhD study exploring this phenomenon will ensure that the voices of midwifery students are heard loud and clear and will assist in the development of an intervention to break the bullying cycle.

Bullying is often about power and status: they call it 'vertical' violence for a reason, in that the bully is often someone 'higher up' targeting someone 'lower down'. Research on bullying only fully emerged in the 1970s (Monks and Coyne, 2011) and at first it was all about the schoolyard: powerful, older students bullying the smaller weaker or younger ones, or occasionally teachers, bullying students. But what happens when you are all grown up and the maternity care setting *is* the classroom, and you find yourself alone in the classroom with the teacher? My colleagues and I have been studying the bullying of midwifery students for three years now, a subject that is not just a hot topic of conversation within the midwifery community, but also personal to me.

I am now an academic, teaching midwifery students, but back in the mid-nineteen nineties I was a fresh-faced, somewhat nerdy, and highly motivated midwifery student at one of the United Kingdom's best-known colleges of nursing and midwifery. Very different times—in those days we were provided with a starchy knee length dress and belt, and I still remember the sense of pride I felt in getting myself ready for my first day of clinical placement. This was my second degree, and I had a sense it would be a very different experience to my first, but I was unprepared for the fact that from almost day one, as I climbed the steps of the hospital, that this would be like no other lecture theatre I'd experienced in my life.

At first, I was almost insulated by my bright and perhaps a little naïve sense of purpose—thinking that I had found my place in life. But by my second term that bubble of protection burst: I can vividly recall being in the staff changing room getting ready for an early shift on the birth suite along with another midwifery student. She suddenly dashed away without saying a word, the door swinging behind her. Concerned, I followed and saw her running into the toilet…. I waited. A few minutes later she emerged looking dishevelled and explaining this often happened to her prior to a birth suite shift as she was terrified of her mentor. It was at that moment I realised that it was not just me that felt this way...It was happening to others too.

I had grown up in a family of strong women and men—I was part of a tightknit family and had gone off to university at a very young age, but equipped with the knowledge that came from having older siblings, knew how to hold my own in tricky situations. For a while I thought that was going to be enough. How wrong I was...I would look around me whilst in the birth suite, the tea rooms, the corridors, the sluice, and the midwives' station with bewilderment. The walking wounded wearing the familiar starchy midwifery student uniform—psychologically wounded by what I think they referred to as the "toughening up" "sink or swim" culture that was common then (and it would appear still exists today). Ten students commenced in our 'set': Of the ten who considered themselves lucky to be selected for a place at what was considered to

be a top nursing and midwifery college, just four successfully made it to the far shore, finished the course, and of them only three went onto actually practice as midwives. 60% attrition is astonishing in undergraduate—or postgraduate—education. What was striking to me, was that it was public knowledge who the 'well known bullies' were. Ultimately, I was not protected by being "a capable fast learner", or "friendly and helpful" and it was all I could do to push on and get through it. I can vividly recall being deliberately set up to fail and placed in situations I was too inexperienced to handle, all with the aim of humiliating me in front of others (including the mothers I was caring for). The bullies would also use my previous degree against me: why didn't I become a doctor if I were so clever? My mentor even tried to encourage me to withdraw from my course and reenrol when I was older. I would often go back to my room in the nurses' home and cry, I would ask myself what I was thinking when I decided to become a midwife. My confidence was rock bottom, and my physical and mental health began to suffer too.

Fast forward to the 21st century, and now I am a midwifery academic at a university that is noted for its midwifery education program and its research. Part and parcel of this was a requirement to complete a PhD and I picked a topic and did not exactly pick at random. A colleague who is a psychologist focused on health research (OM) and I settled on a back-to-the-future examination of something I had almost forgotten and hoped I would never see again. Despite it now being 2020 it is evident that very little has changed, and that bullying during midwifery education continues to thrive.

I personally loved the teaching and mentorship role, I thrived upon the students' passion and their enthusiasm rubbed off on me. Many of the new students I worked with were young, they reminded me of who I had been…but unfortunately even to the detail of feeling treated badly by the system that was supposed to support and nurture them. Discovering students crying in the bathroom, vomiting, and vowing to leave the profession before they had fully entered it was not

unusual. It tended to happen by their third term—jaded, worn out, fed up, and wishing for it all to be over.

Prior to undertaking my PhD study, I undertook a systematic review of the existing literature on this topic. I was shocked to discover that, to date, very little research has been done to explore this important issue, a vitally important issue that I feel needs to be talked about loudly and clearly. Of the few studies that do exist on this topic, a number of themes are evident; the role that power plays in bullying, the prevalence and impacts of bullying upon midwifery students, the presence of a culture of compliance, and the victims response to being bullied (Capper, Muurlink and Williamson, 2020a).

Building upon this existing knowledge, my study has brought me closer to the lives of hundreds of midwifery students and their private moments of misery, but this in turn has helped me better understand how bullying impacts them on both personal and professional levels and the way in which certain variables may influence their experience . For example, our research has demonstrated how the midwifery students age can impact the way in which they are bullied (Capper, Muurlink and Williamson, 2020b). I have heard very concerning stories of bullying impacting the quality of care provided to mothers and babies, placing them at risk. This is simply unacceptable and cannot be allowed to continue. Midwifery is considered a caring profession, how can we provide quality care to mothers, babies and their families but fail to care for our colleagues?

The big question currently remains; how do we break the bullying cycle to prevent further students leaving the profession before they fully enter it? Much of the bullying literature is replete with advice to victims and other parties to 'confront' bullies as a 'solution' (Garrity, Jens, Sager, & Short-Camilli, 1997). But as the stories that I read as part of my study suggest, there is risk and danger involved in confronting and/or reporting a midwife or a mentor in the enclosed environment of the maternity unit.  Particularly when that midwife holds a position of power.

Students reported being fearful of being failed on placement, not getting a job upon graduation, or having learning opportunities withheld. I also heard stories of personal alliances and relationships between bullies and other senior midwifery staff within the hospital, and even stretching into the tertiary training institutes, the universities. This means that students felt, just as I did, that you are faced with two main options: attempt to absorb the damage or leave the course. This is particularly disappointing when the world needs midwives more than ever and if we aim to sustain the midwifery profession, we need to support the next generation.

The next stage is to design a solution.

### 4.3 References


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Monks, C. P., & Coyne, I. (2011). A history of research into bullying. *Bullying in different contexts*, 1-11.

### 4.4 Discussion

The fact that the student researcher was directly contacted by editor of '*The Student Midwife Journal*' following the publication of the systematic review of the literature with an invitation to submit a paper about the bullying of midwifery students demonstrates the significance of this research topic. This paper appealed to their readership due to a growing awareness of the number of midwifery students that choose to leave their midwifery education courses and suffering trauma as a result of their experiences of being bullied.

### 4.5 Chapter summary

This chapter presented a paper that was invited for publication by '*The Student Midwife Journal*' which is UK based journal that is targeted at student's undertaking midwifery education programmes across the world. The paper presented the researchers own experiences of being bullied and provided insight into how these led to the decision to undertake research into this topic.

### 4.6 Chapter to follow

In the next chapter, a discussion will be provided on the research design and theoretical framework that guided the development of the research question, and the aims and objectives of the study and the development of the qualitative survey questions.

# Chapter Five

# Research Design

## 5.1 Introduction

In Chapter Three it was identified that no studies to date have specifically explored midwifery students' experiences of being bullied whilst on clinical placement in any great depth. This chapter will now present the research design used to explore and describe this phenomenon. Due to the nature of the research question, the purpose of the study, and the researchers' own philosophical assumptions, a qualitative methodology called qualitative description was used to conduct this research.

This chapter will now present how the researcher's philosophical assumptions and worldview shaped the development of the research methodology, followed by a summary of the qualitative paradigm and qualitative descriptive research design specifically (Sandelowski, 2000). Finally, the justification for taking a qualitative descriptive approach to this study will be provided followed by an introduction to the theoretical framework that informed the overarching research question, the aims and objectives of the study, and the development of the qualitative survey questions.

## 5.2 Research paradigms

Research is divided into two broad classification types, known as qualitative and quantitative *paradigms* (Arghode, 2012). A researcher's paradigmatic position is influenced by several factors including their perspective of the world, which is often referred to as their 'worldview' or the 'theoretical lens' through which they view the world (Guba & Lincoln, 1998). The aims and objectives of the research, and the type of research question the study seeks to answer also influences the paradigmatic position (Holden & Lynch, 2004). For example, a research question that seeks to determine how many, or how frequently, thus seeking numerical data, would be suited to the positivist (quantitative) paradigm, however, a question that seek to achieve a deep

understanding of a phenomenon would be located within the naturalistic or constructivist (qualitative) paradigm (Morgan, 2007). The researcher's paradigmatic choice indicates their values, assumptions, beliefs and practices and therefore governs, in turn, the techniques used to undertake a research project such as how data is collected, analysed and interpreted (Braun & Clarke, 2013).

When developing the framework for any research project, the methodology is reliant upon ontology and epistemology (Scotland, 2012). These are theories about the nature of being or reality, and the nature of knowledge (Braun & Clarke, 2013). Van Manen (1997 p.27) states that methodology is the "philosophical framework, the fundamental assumptions, and characteristics" that determine the view that is being taken towards seeking the knowledge of interest.

It is the student researcher undertaking the study outlined in this thesis's ontological belief that that there is no one version of reality and that reality is multiple, differing for each and every being, and is perceived and interpreted in a variety of ways, and therefore multiple realities should be embraced, even for the same person (Braun & Clarke, 2013; Creswell & Poth, 2017). This positioning means that in the context of this study, the researcher seeks to gain subjective information about the experience of being bullied, a reality which may vary from person to person, developed in a way a person came to know it (Braun & Clarke, 2013). This ontological perspective lends itself to taking a qualitative approach to exploring the phenomenon of interest.

The student researcher's epistemological beliefs are also located within the qualitative paradigm, with the belief that knowledge is known and socially constructed through the subjective experiences of people, and a single absolute truth is impossible (Braun & Clarke, 2013). The qualitative paradigm was considered fitting for this study based upon the researcher's worldview and the nature of the research question it sought to answer.

### 5.3 The qualitative paradigm

Formal qualitative research has a long history spanning over one hundred years and originated in disciplines such as anthropology and sociology where questions are often asked about the human experience and how humans live (Denzin & Lincoln, 2011). Qualitative research is particularly useful when seeking to gain knowledge about topics that little is currently known about, and where the variables are not yet understood (Greenhalgh et al., 2019). It is commonly used in the fields of nursing and midwifery as it gives researchers the opportunity to ask how and why, gain deeper meaning, understanding, and insight into the phenomenon being explored (Holloway & Galvin, 2016). Denzin and Lincoln (2011) suggest that qualitative inquiry is generally inductive in nature and is shaped from the ground up by the participant rather than being influenced by the researcher or based on a set theory. This is achieved by gaining the perspective and experiences of people that have lived through the phenomena of interest (Borbasi & Jackson, 2015) thus enabling participants to make knowledgeable and meaningful contributions to the study (Greenhalgh et al., 2019). Qualitative studies aim to gain insight into, understand, describe, and explore the participants' experiences, and explore their feelings and thoughts in order to develop and build further knowledge in the field of interest (Silverman, 2016). This subsequently enables an understanding of phenomena that may have been previously unacknowledged or overlooked (Gallagher & Francesconi, 2012).

Taking a qualitative approach to this study was considered particularly appropriate because it empowers the participants in ways that standard quantitative approaches (deployed in many studies in a bullying context) do not. It foregrounds the participants' own experiences and views. Qualitative data can be collected in a number of ways including through interviews, focus groups, qualitative surveys, observation, or through the use of secondary sources such as printed materials (Braun & Clarke, 2013). The term *methodology* relates to the theory of how the data collected is used to progress the research, i.e. how it is then analysed (Braun & Clarke, 2013). Many nursing and midwifery researchers choose to adopt the more commonly used theories

which have become foundational for qualitative research. These include ethnography, phenomenology and grounded theory, however qualitative description, which has been chosen for this study serves to closely represent the characteristics of the research rather than focusing on culture, lived experience, or the building of theory (Bradshaw, Atkinson, & Doody, 2017). The use of a qualitative descriptive framework is considered an appropriate choice of research design when attempting to understand patterns and a variety of beliefs, opinions, and the attitudes of people, particularly within the healthcare setting (Beck, 2013; Colorafi & Evans, 2016).

### 5.4 The qualitative descriptive approach

A qualitative descriptive approach (Sandelowski, 2000) was selected as a framework to explore and describe the experiences of midwifery students that have been bullied whilst on clinical placement in the UK and Australia. The use of qualitative description is considered a useful and effective form of credible and rigorous enquiry (Colorafi & Evans, 2016; Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000), and is an excellent methodological choice for researchers seeking to explore and describe phenomenon experienced within the healthcare environment that little is currently known about (Beck, 2013; Colorafi & Evans, 2016). Polit and Beck (2014) state than over half of all qualitative studies undertaken in the field of nursing and midwifery have used qualitative description suggesting that the approach has gained popularity in this field in recent years (Bradshaw et al., 2017).

Qualitative descriptive research enables a rich, straight description of an experience or an event to be obtained as it was lived, enabling the researcher to not only stay closer to the surface of their data, but also to gather clear facts, and the meanings given to them by their participants (Neergaard et al., 2009; Sandelowski, 2000). The purpose of qualitative descriptive research is to explore and describe experiences of interest through the eyes of the study's participants, and not that of the researcher (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005). The process

involves the collection of a detailed description of the phenomenon obtained from the participants' perspective, followed by the analysis of the data, the development of themes and finally, the presentation of the findings (Neergaard, et al., 2009). According to Sandelowski (2000), as opposed to phenomenology or grounded theory, qualitative description involves a low-inference style of analysis and interpretation and therefore lends itself well to obtaining straight forward answers to questions which may be relevant to both policy makers and practitioners. Knowledge generated through qualitative descriptive studies is considered helpful in expanding healthcare professionals' ways of approaching challenges in the healthcare setting (Beck, 2013), thus making it an appropriate choice for this study.

Qualitative descriptive research is considered by some as the least theoretical of the many qualitative approaches and is often founded in the researchers existing knowledge, their disciplinary experiences, and the work of others in the field (Neergaard et al., 2009). Qualitative description allows flexibility around the use of theory when developing and undertaking a study (Sandelowski, 2000, 2010). This can be led by the research itself as the researcher may choose not to be initially guided by an existing framework or theory, but this can change as the research evolves (Sandelowski, 2010).

Despite many descriptive studies having an overall aim of describing a phenomenon of interest, whilst undertaking the analysis process some degree of interpretation is inevitable (Braun & Clarke, 2013). Sandelowski (2010) states that although the analysis of exploratory descriptive data does allow the researcher to remain closer to the data, further interpretation is generally required in order for the researcher to 'make something of their data' (p. 79). Therefore, to achieve a deeper understanding and improve the applicability of the findings to practice, further analysis and interpretation of the data may be undertaken through the use of a theoretical or conceptual framework (Osanloo & Grant, 2016) or using the researchers own worldview and disciplinary knowledge (Braun & Clarke, 2013).

### 5.5 Qualitative description and midwifery research

Bradshaw et al. (2017) states that the use of qualitative description in midwifery research is considered an appropriate approach as it is clearly aligned with the philosophies and principles that underpin the profession. This is evidenced by the fact that qualitative descriptive designs have previously been widely used in the field of midwifery research to explore and describe the experiences of midwifery students and midwives (Bradshaw, Murphy Tighe, & Doody, 2018; Catling et al., 2017; Coughlan & Patton, 2018; Cummins, Denney-Wilson, & Homer, 2015).

For example, Cummins (2016) doctoral study used a qualitative descriptive approach to explore and understand the experiences of new graduate midwives working in continuity models of midwifery care in Australia and the midwifery managers that employ them. The justification given for using this approach was that there was very little known about newly graduated midwives working within the midwifery continuity of care models at that time. Further, Bly, Ellis, Ritter & Kantrowitz (2020) used a qualitative descriptive approach to explore and describe midwives' attitudes towards men in midwifery. This approach was selected due to the paucity of data on this topic and the need to gather data upon which to develop an appropriate approach to expand and diversify the workforce. Another example of a midwifery study that has used a qualitative descriptive approach is work by Bradshaw et al. (2018), their study explored midwifery students' experiences of their internship period in Ireland. Their justification for using qualitative description was that they aimed to facilitate the generation of results that remained close to the data to provide information to inform practice and policy (Bradshaw et al., 2018).

### 5.6 The rationale for taking a qualitative descriptive approach to this study

A qualitative descriptive approach was selected to explore the experiences of midwifery students that are being bullied as this is considered an appropriate choice when exploring a phenomenon that has previously received very little qualitative research attention. The use of a qualitative descriptive framework is considered an appropriate approach to exploring new and emerging

topics such as this and 'gives voice' to a group of people that very little is known about (Braun & Clarke, 2013). Obtaining a description of a phenomenon is an important step in the identification and solution process, as before it is possible to research *why* something happens, it is important to understand *who*, *what* and *where* it happens (Eldredge et al., 2016; Sandelowski, 2000). Furthermore, the findings of qualitative descriptive research can assist with the creation of a platform in which to build upon with more focussed, solution-based work in the area of midwifery student bullying.

The personal experience of being bullied is unique to each individual and is socially constructed via a complex convergence of interactive processes and is deeply personal in nature (Lutgen-Sandvik & Tracy, 2012). In order to explore and describe this experience it is essential to go directly to the source of the experience to better understand it; the individual who experienced bullying. Qualitative description enables the researcher to obtain a rich, straight description of the students' experiences or the events they were exposed to (Sandelowski, 2000; Neergaard et al., 2009). This means that during the initial analysis process and presentation of the data, the researcher is able to stay closer to the data without viewing it through a predetermined philosophical lens thus producing a final description of participants' experiences in a language similar to their own (Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

When looking to the future and considering ways in which this research may be used to inform interventions to decrease the incidence of bullying in the clinical placement setting, it is important to determine that the content, approach, and timing of such interventions are commensurate with the needs of the bullied midwifery student (Gordon, 2018). In order to ensure this is the case, an in depth understanding of the issues midwifery students face is essential. Qualitative descriptive research is an appropriate way to gather such information as it requires data to be collected directly from participants that have experienced the phenomena of interest using their very own words (Sullivan-Bolyai et al., 2005).

### 5.7 Theoretical frameworks and qualitative midwifery research

A theoretical framework is defined by Eisenhart (1991, p. 205) as "*a structure that guides research by relying on a formal theory…constructed by using an established, coherent explanation of certain phenomena and relationships*". Theoretical frameworks provide an understanding and representation of the viewpoint of the researcher, allowing readers to understand how the research should be viewed (Eisenhart, 1991). Concepts and definitions contained within theoretical frameworks influence not only the research problem, but also the methodological approach and methods selected to conduct the research (Anfara Jr & Mertz, 2014; Osanloo & Grant, 2016). Not all midwifery research however is guided or underpinned by an existing theory or theoretical framework, however, when used, they can be applied to qualitative research in a number of different ways (Bradbury-Jones, Taylor, & Herber, 2014). For example, as stated above theoretical frameworks may provide a rationale for the research methodology or the methods selected to conduct a study. They may however also be used to provide a comparative context or a lens through which to collect and/or interpret the data or may serve as a blueprint for representing research findings (Bradbury-Jones et al., 2014; Sandelowski, 1993a).

#### 5.7.1 The nature and manifestation of bullying in midwifery theoretical framework

This study was broadly guided by an existing substantive theoretical framework developed by Gillen et al. (2008) that represented theory relating to the nature and manifestation of bullying in midwifery. This framework, in conjunction with the researchers own anecdotal experiences and the findings of a systematic review of the literature helped inform two distinct stages of this research project. It was firstly used during the initial stage to inform the development of the study's aims, objectives, and the overarching research question. It was then used to inform the development of the qualitative survey questions.

This theoretical framework was chosen for several reasons; firstly, it is practice based and was developed using empirical research that was undertaken by registered midwives working in the

midwifery field. Secondly this is also the only theoretical framework to date that has been developed within the UK or Australian contexts that have specifically focussed upon workplace violence in the midwifery setting and has included data from midwifery students during the development process. And finally, the concepts identified within the framework were closely aligned with the researchers own anecdotal experiences and the findings of the systematic literature review undertaken prior to commencing this study. Building upon existing relevant research-based theory was considered appropriate in order to remain problem focused and to provide the potential to change or improve the issue being explored (Stevens, 2013). This theoretical framework will now be discussed in more detail.

The nature and manifestation of bullying in midwifery (NMBM) theoretical framework was developed by Gillen et al (2008) with funding from the Royal College of Midwives in an attempt to better understand how bullying in midwifery presents and manifests itself in the UK setting. The framework was developed from a 4-phase research project using both qualitative and quantitative methods. The 4 phases are outlined as follows:

- Exploratory telephone interviews with 3 midwives from practice and academia.
- Concept analysis of bullying in the workplace using Walker and Avant's (1995) framework.
- Inductive confirmatory focus groups were held with practising midwives, midwife managers, academic midwives, and union representatives to confirm and validate the findings of the concept analysis.
- Finally, a questionnaire survey of midwifery students was used to further confirm and validate the findings of the concept analysis.

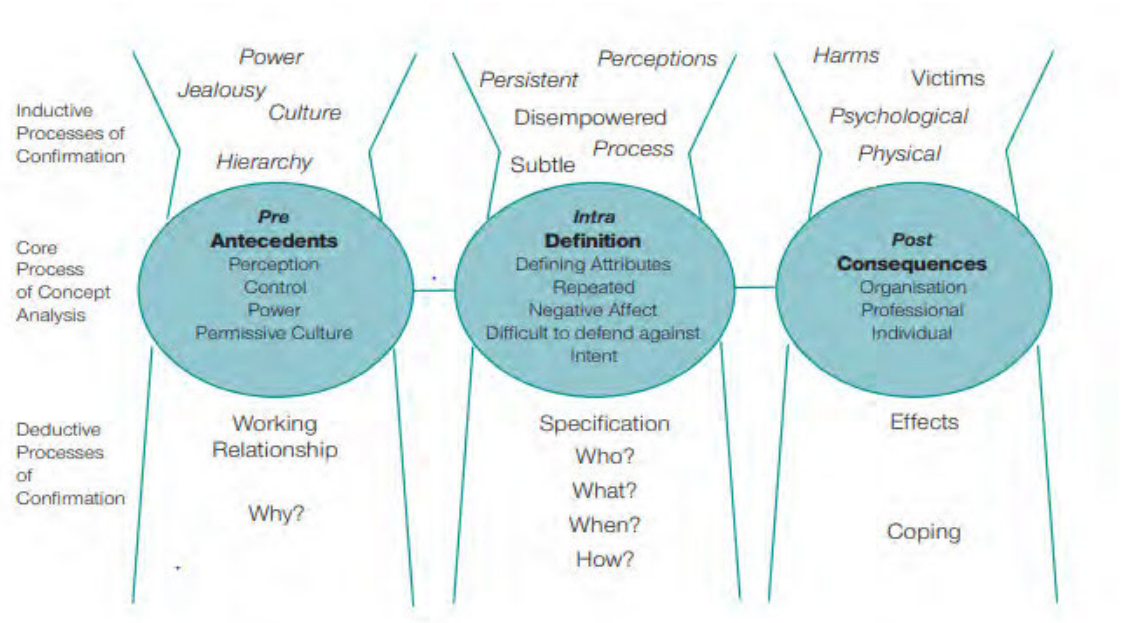


**Figure. 2. Theoretical Framework – Part 1**
Diagrammatic representation of the overall theoretical framework developed by Gillen et al. (2008) to represent the stages and factors that influence bullying in midwifery (used with written permission – see Appendix Q).

It was suggested by Gillen et al. (2008) that bullying in the midwifery setting occurs over three distinct stages; pre-bullying; bullying; and post-bullying. These three stages formed the initial constructs of their theoretical framework. The following diagram (figure 3) demonstrates a representation of stage four, the student questionnaire phase only:

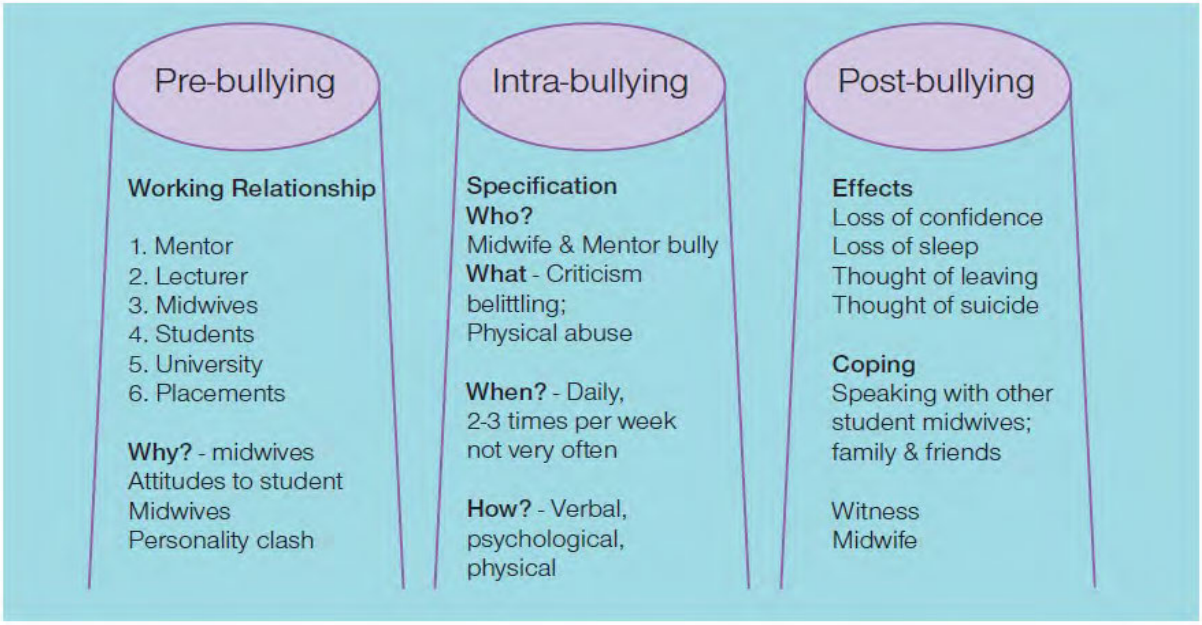

**Figure. 3 Theoretical Framework – Part 2**
Diagrammatic representation stage of the development of the theoretical framework developed by Gillen et al. (2008) which represents the stages and factors that influence bullying in midwifery (used with written permission – see Appendix Q).

The individual concepts and the overall viewpoint that is expressed by Gillen et al (2008) in the theoretical framework at both stage four and at the final complete stage (see diagrams 1 and 2) underpinned and guided the development of the overarching research question, and the aims of the study, all of which could only be answered and achieved by taking a qualitative approach to this study. The open-ended qualitative survey questions used to collect data for this study were also informed by this theoretical framework. The qualitative survey and the questions the participants were asked will be discussed further in Chapter Six of this thesis.

## 5.8 Conclusion

This chapter has provided an explanation of how the researcher's philosophical assumptions or worldview shaped the research and presented a detailed summary of the research design used to undertake this study. A discussion on the use of qualitative descriptive approaches was provided followed by and introduction to the theoretical framework that informed two distinct stages of the research project.

## 5.9 Chapter to follow

The following chapter will provide an in-depth explanation of the research methods used to undertake this study. The setting of the study, the recruitment process, ethical considerations, data collection and analysis processes will be discussed in detail whilst providing a justification for the reason each process was selected to undertake this study.

# Chapter Six

# Research Methods

## 6.1 Introduction

This chapter will present the research methods used to undertake the study. The term 'methods' refers to the processes used to gather and interpret evidence, including the tools and techniques used to do this (Bradshaw et al., 2017). The setting of the study will be described, followed by how the participants were accessed and recruited. The researcher's positionality and reflexivity will then be discussed. The data collection instrument, the survey questions and the analysis approaches used will then be presented and then, finally, the rigor of the study will be addressed.

## 6.2 Setting

Midwifery students located across Australia and the United Kingdom were invited to take part in this study. As discussed in Chapter Two of this thesis, Australia and the UK were selected as the two contexts for this study due to the midwifery education and placement models being comparable. The qualitative survey was administered online via the SurveyMonkey platform to enable participants from both countries ease of access, anonymity, and to increase the likelihood of participation (Atkeson & Alvarez, 2018). Braun and Clarke (2013) state that conducting a survey via an online platform is particularly well suited to sensitive topics such as bullying as they afford participants the highest level of anonymity and therefore raise fewer ethical concerns which was of vital importance for this study. Further to this, online surveys enable data to be collected from a greater number of geographically dispersed participants including those that are considered 'difficult to reach' such as students living rurally or studying via distance education. As this study sought to recruit midwifery students from a range of geographical areas that were undertaking clinical placement in all types of maternity settings within the UK and Australia, an online survey was considered the most appropriate method of data collection for this study. In

addition, ethical concerns were raised at the ethical clearance stage, that lead to a shift of focus from in-person interviews to an online methodology. See section 6.5 and 6.6.

### 6.3 Recruitment

Purposive sampling was used to recruit midwifery student participants from the UK and Australia that had experienced the phenomenon of interest. Recruitment occurred via two separate Facebook groups. One group provided support to midwives and midwifery students that are experiencing or have experienced workplace bullying in the maternity setting. The second Facebook group was set up specifically to enable midwifery students to network with one another across the world. Written permission was gained from both group's administrators prior to advertising for participants (see Appendix B for advert). With permission the advert was re placed a total of 5 times over a period of 6 months. After the initial advert placement over 60 participants completed the survey in its entirety. Each time the advert was re placed after this time, a further 5 to 12 participants completed the survey in its entirety. Participation was entirely voluntary, and no reward was provided for participation. Potential participants were asked two screening questions prior to agreeing to take part in the study:

1. Whether they were a midwifery student based in either Australia or the United Kingdom?
2. Whether they had experienced what they perceived to be bullying or harassment whilst on clinical placement.

If the answer was 'yes' to both questions, they were eligible to participate.

### 6.4 Participants

As stated above, participants were eligible to participate if they currently were, or had in the past experienced what they perceived to be bullying or harassment whilst on clinical placement as a midwifery student. Students undertaking clinical placement in any type of clinical maternity setting and from all UK or Australian universities apart from CQUniversity Australia were able to participate.

In total 335 participants commenced the qualitative survey and 116 completed it in its entirety. A further 4 participants completed some of the open-ended questions in detail. Qualitative data collected from incomplete surveys was therefore included and analysed thus 120 participants in total were included in the study. For the demographic data of the participants that completed both the closed and the open-ended questions please see Appendix G.

### 6.5 Ethical considerations

Ethical clearance was obtained to undertake this study from the Human Research Ethics Committee at CQUniversity Australia (see Appendix A).

A number of issues related to anonymity, confidentiality, consent, protection of the rights of student's and emotional considerations were considered. In addition to this, the storage, protection, and ownership of data were addressed. Importantly, the researcher's dual status as a registered midwife and midwifery lecturer, and the subsequent power imbalance and her mandatory reporting requirements were also considered and addressed. Subsequently ethical clearance was then granted.

#### 6.5.1 Ethical challenges

Research that aims to explore sensitive topics such as bullying in the workplace is often complicated by several methodological challenges such as access to participants, recruitment, and retention (Fahie & McGillicuddy, 2017). In addition to these challenges, ethical issues also arise, particularly when the participants have been, or continue to be the targets of bullying and are therefore considered to be *vulnerable* (Mishna, 2012). Several researchers have previously written about their experiences when seeking to explore the experiences of and hear the voices of the vulnerable (Braun & Clarke, 2013; Neville, Adams, & Cook, 2016). It is deemed vital that the vulnerability of the research participants is taken into consideration throughout the entire research process and that appropriate adjustments are made, as necessary, to ensure their comfort and safety (Bracken-Roache, Bell Macdonald and Racine, 2017).

As mentioned above, researchers from most disciplines face several ethical challenges when working with participants from vulnerable groups. However, the Australian registered midwife researcher has a number of additional professional responsibilities related to mandatory reporting of disclosed episodes of bullying that they must be aware of (NMBA, 2018a, 2018b). Furthermore, in the context of this study, the researcher must also consider the power imbalance that exists between themselves and the midwifery student research participant, this is particularly significant in this context as the researcher is both an experienced registered midwife and a midwifery academic.

In order to overcome the issues related to the mandatory reporting requirements and the power imbalance, a data collection tool was selected to allow the participants total anonymity and the subsequent inability of the researcher to identify to identity of the student participant or vice versa. The researcher's positionality in relation to this study will be discussed in greater detail later in this chapter.

### 6.5.2 Informed consent

It was ensured that informed consent was obtained from all participants prior to them completing the qualitative survey. All participating students were provided with access to the participant information sheet which outlined the purpose of the study, its aims, and the potential risks and benefits of taking part. It was also explained that taking part in the study was entirely voluntary and that all information collected would be anonymised and remain confidential. Participants were however warned that where notifiable behaviour was described, if those involved were able to be identified, as a registered midwife, the student researcher would have a professional mandatory obligation to report this to the appropriate authority.

No incentives were provided for participation in this study. A copy of the participant information sheet and the consent form can be found in Appendices D and E.

In order to access the survey, all participants had to confirm that they had read the information sheet and ticked a box consenting to participation prior to proceeding. Details of resources for appropriate counselling support were supplied for participants based in both the UK and Australia respectively.

### 6.5.3 Anonymity and confidentiality

As discussed earlier in this chapter, due to the sensitive nature of the topic of this study, ensuring anonymity for the participants was deemed vital.

Anonymity was achieved by collecting data via an online anonymous qualitative survey and therefore the participants were unable to be traced and identified. All participants were asked not to reveal any identifying information in their responses, including the health facility where they were undertaking clinical placement, the name of their university, or the names of their colleagues and peers. In addition to this, pseudonyms were used when reporting data findings.

Bullying is a sensitive topic that lends itself well to being explored using an anonymous form of data collection such as an online survey (Braun & Clarke, 2013). This is due to participants feeling completely anonymous - they cannot see the researcher, and the researcher cannot see them or know their name, which also addresses the perceived power imbalance (Surmiak, 2018). The desire for complete anonymity leads to many people choosing not to participate in research on sensitive topics such as this, particularly if face to face or group interviews are being used to collect data. Subsequently, the ability to remain anonymous leads to an increased number of participants that are prepared to share their experiences, and often, they are more open and honest in their descriptions than they would otherwise be (Braun, Clarke, Boulton, Davey, & McEvoy, 2020). Furthermore, being anonymous is also thought to have the additional benefit of encouraging the voices of those that are perceived to be part of marginalised or over-looked groups to be heard (which includes bullied students). This can also lead to the inclusion of a

range of 'within group' voices therefore resulting in maximum heterogeneity within the group (Fassinger, 2005).

As stated earlier, midwifery students are considered vulnerable participants, particularly if they are providing their experiences of being the target of bullying by those that are perceived to be in a position of relative power over them. Midwifery students, as learners are reliant upon their clinical mentors and registered midwives to provide them with access to learning opportunities and support the development of their theoretical knowledge, skill acquisition and consolidation, and also provide a fair and equitable assessment of their levels of competency. The students may therefore be potentially compromised should their experiences be publicly exposed in the form of a thesis or the resultant publications. The student participants may fear, that if identified, others, such as the midwives they work with, midwifery managers, their own peers, and their university lecturers would become aware of their disclosure and that this could have a significant impact upon their future clinical experiences, clinical assessment grading and opportunities for future employment.

The qualitative survey was subsequently designed to ensure that that no information revealing the identity of the informants was transferred to the researcher when the survey was completed. The participants were informed that all comments read by the student researcher will remain confidential and when the research is published, no identifiable data will be available to the reader.

### 6.5.4 Level of risk

Bullying is a sensitive research topic to explore, particularly when exploring the experiences midwifery students who, by nature, are considered a vulnerable group. When requesting students to look back and re-live traumatic events there is a risk of them experiencing significant levels of distress as a result (Bingley & Grinyer, 2020). It was therefore deemed important that students were made fully aware of the nature of the study prior to consenting to participation, were free

to discontinue the survey at any time, and were provided with the contact details for appropriate means of support should it be required in their respective countries.

As data were collected via an online anonymous survey, there were no personal safety risks posed to the student researcher that needed to be addressed.

### 6.6 Researcher positionality and reflexivity

The term *positionality* refers to how a researcher delineates their own position in relation to the study being conducted. Consideration of one's own positionality is important as it can influence the way in which the research is designed and data is collected and/or interpreted (Qin, 2016). Taking a *reflexive* approach is therefore of vital importance in order to ensure credibility of the study findings (Anney, 2014). Being *reflexive* is an integral part of the role of all qualitative researchers. Being reflexive requires the researcher to examine his or her own judgments, beliefs, and practices throughout the research process and consider how these may influence the research (Berger, 2015).

I have 'experienced' the bullying of midwifery students from several distinct perspectives. I subsequently hold a dichotomy of roles; I have experienced bullying as a midwifery student, I have witnessed other midwives bullying students, and I have received reports of students being bullied whilst on clinical placement whilst working as a midwifery academic. I can therefore, as a researcher, be considered to occupy the unique position of being both an 'insider' and an 'outsider' (Burns, Fenwick, Schmied, & Sheehan, 2012). As a researcher that occupies both positions, I must remain aware of the potential pre-existing perceptions I may have and consider how they may influence the analysis of the data.

Greenhalgh, Bidewell, Warland, Lambros, & Crisp ( 2019) state that it is important to acknowledge that qualitative research, by nature is dependent upon the subjective experiences of both the researcher and the participants and is grounded in the real world and the real-life experiences of human beings, and as a result, researchers will often have their own cultural or

personal connection with participants. Greenhalgh et al. (2019) goes further and states that this does not mean that the research should be considered weak, and in fact, to the contrary, researchers should be applauded for undertaking research as insiders, and that it is important to consider that there is no way of fully avoiding researcher bias.

By undertaking this study, I am researching my own homogenous groups – my own profession, workplace, and its culture, and as an insider I have existing knowledge of the profession's past, present and future (Jenkins, 2000). This brings certain risks, but also certain advantages. I have a lived familiarity which leads to a feeling of sameness (Klein, 2014); I share several characteristics with the participants – I was the target of bullying as a midwifery student and I am familiar with their clinical language, clinical experiences, the profession, their working practices and workplace culture. This therefore renders me as being an 'insider' – I have experience of being centrally situated within the phenomenon – As a result of this, as a researcher there is potential for an empathetic response to be produced when reading the participants accounts. However, as a registered midwife and academic I may also be considered by the participants as being an 'outsider'; as a member of the midwifery profession, a midwife, I could be seen as being a member of the group that is deemed 'the enemy' and the source of the problem. Sharing these commonalities led to a dilemma. Whilst undertaking this study, as I read through the participants accounts of their experiences, I felt somewhat ashamed of the profession that I belonged to. It caused me to reflect back upon my own experiences as a young midwifery student and despite it now being many years later, I was still able to vividly recall the emotional and physical impacts that being bullied had upon me. As I recounted the students' experiences it was apparent that bullying was still happening and continues to have similar impacts upon today's midwifery students.

Through the undertaking of this reflective process and identifying the dilemma I faced led me to better appreciate the concept of myself as the student researcher and that of the study

participants, the midwifery students. Working through this process allowed me to become reflexive and contemplate the effects and the influences of my own subjectivity and this therefore increased the trustworthiness of the findings of my study. Being dually situated in relation to the phenomenon of interest, meant that it was vital that both a professional and reflexive approach was to be taken when analysing the data. To assist with this process, throughout the research process I recorded my thoughts and feelings in a reflexive research diary (Barrett, Kajamaa, & Johnston, 2020) which enabled me to keep a record of my positionality and the reflections upon my research experiences at the starting point of the study, through to thesis completion.

As mentioned earlier in this chapter, as a researcher that occupies several roles within the midwifery arena, I must also be cognisant of the various potential ethical conflicts that can arise. For example, ethical codes exist for registered midwives and separate ethical codes exist for researchers. In 2011 a group of researchers explored this specific scenario by looking at the dual role of the registered midwife when undertaking research. Ryan et al., (2011) examined five case studies of midwifery-researchers projects and determined that the midwifes obligations and responsibilities dictated by their professional standards and codes of conduct must override those that exist as a researcher, and therefore this is the duty of care that must be adhered to first and foremost. Registered midwives are obliged to be mandatory reporters and as such have an obligation to escalate as appropriate any cases of abuse and bullying when the target and/or perpetrator can be identified as per their code of conduct.

### 6.7 Data collection

As stated above, an online qualitative survey was used to collect participant generated textual data. The next section of this chapter will introduce the qualitative survey method of data collection and how it was deemed appropriate for use in this study. It will also be explained how

the research instrument, the qualitative survey was developed to collect participant-generated textual data (Braun & Clarke, 2013).

### 6.8 Qualitative surveys

Qualitative surveys are considered an appropriate way to collect rich and complex qualitative participant generated textual data (Braun, Clarke, Boulton, Davey, & McEvoy, 2020; Braun, Clarke & Gray, 2017). Qualitative surveys generally consists of a number of demographic and open-ended questions about a phenomenon of interest and are available to respond to in three main formats: handwritten responses, email responses and online surveys which are delivered via a software platform such as *SurveyMonkey* or *Qualtrics.* Qualitative surveys can be used to gather data to answer a range of different types of research questions but are particularly well suited to questions relating to personal experiences, and clinical practice-based issues (Braun & Clarke, 2013). Fully qualitative surveys lend themselves well to obtaining data about the participants narratives, subjective experiences, practices, discourses and positionings (Braun et al., 2020).

Online surveys provide advantages; primarily that they pose less ethical challenges as they allow the participants to remain completely anonymous and, providing in fact, the highest level of research anonymity (Braun & Clarke, 2013). In addition to this, they are far reaching, they enable participants that are often difficult to reach and/or geographically dispersed to take part in the research with ease. This includes participants in international locations and those living in rural and remote locations within the same country providing they have internet access (Atkeson & Alvarez, 2018).

As discussed earlier, remaining anonymous when participating in research on *sensitive* topics such as bullying is considered particularly important to participants that may be considered vulnerable, where a perceived power imbalance exists between the researcher and the participant, and where the risk of being identifiable may have detrimental effects for the participant (Surmiak, 2018). Gathering research data through the use of an anonymous online qualitative survey can 'give

voice' to people who may otherwise choose to avoid participating in face-to-face research due to the sensitive nature of the topic (Braun, Clarke & Gray, 2017). An additional benefit of the qualitative survey being anonymous (and easily accessible to large geographically diverse groups of people) is that larger numbers of people often opt to participate in the research study thus providing a 'wider-angle lens' on the topic of interest (Beninger, 2017). This helps to reduce the risk of small groups of participants speaking from solely their own perspectives about their specific demographic or background (Braun et al., 2020). Braun et al., (2020) goes further and states that the flexibility qualitative surveys provide helps to address any potential representational and ethical issues that may arise around how we ensure the inclusion of and hear the experiences and perspectives of a range of 'within-group' voices, including those from marginalised or overlooked groups (Wilkinson & Kitzinger, 1996). They therefore help to ensure the 'maximum level of heterogeneity' (Cardano, 2020) or 'maximum variation' (Sandelowski, 1995) amongst a group of study participants and decreases the likelihood of the results being immediately skewed by having only 'braver' people participate that are happy to take part in an interview or focus group, or have a hidden agenda for participating (Sue & Ritter, 2012). Qualitative survey data also has the additional benefit of remaining focused upon the topic of interest, and due to all participants being asked exactly the same questions in exactly the same way enables a greater standardisation of responses (Braun & Clarke, 2013).

The increased number of people that tend to partake in qualitative survey research compensates for the fact that the data gathered is sometimes considered 'less rich' or somewhat 'shallower' than that of interview data (Braun & Clarke, 2013), however, when a research topic is interesting, and participants are passionate about the phenomenon under exploration they are more likely to provide deep detailed responses to the survey questions. Qualitative survey data has been demonstrated to lend itself well to thematic analysis (Braun & Clarke, 2013, p. 45).

### 6.8.1 Qualitative survey use in midwifery and healthcare student bullying research

Qualitative surveys have been widely used to collect participant generated contextual data in midwifery research, particularly when exploring sensitive topics. For example, Pollock et al. (2019) used a qualitative survey to gather data about the stigma experiences of bereaved parents that have experienced stillbirth. The survey was advertised via Facebook and accessed via Survey Monkey. Demographic data was collected to place the study in context and open-ended questions were used to gather qualitative data which was then analysed using Braun and Clarkes six step (2006) thematic approach. Khajehei and Doherty (2018) also used an online qualitative survey to collect data to explore Australian women's personal experience of changes in their sexual function during pregnancy and following childbirth. A total of 273 women participated in the study that had given birth within the previous 12 months. An online qualitative survey was considered appropriate for a study such as this for a number of reasons; newly postpartum women are a difficult to reach population and would benefit from the opportunity to take part in the study from the comfort of their own homes, and this is considered a sensitive topic therefore many women would prefer to remain anonymous when discussing it. Finally, Hakojärvi et al., (2014) used a qualitative survey to explore the bullying experiences of 41 Finnish health care students. The justification given for using a questionnaire to collect data was because of the sensitive nature of the research topic.

### 6.8.2 The rationale for the use of a qualitative survey in this study

The qualitative survey design was selected to collect data for this study as it enabled the description and exploration of the phenomenon of interest, whilst providing a large sample representation of the experiences of the population under investigation (Bowling, 2014). Further, and most importantly it also enabled the participants to remain anonymous, which as discussed in detail earlier in this chapter, is important when exploring sensitive topics such as bullying, particularly where power differentials are perceived to exist.

### 6.9 The qualitative survey questions

As stated in Chapter Five in order to establish a conceptual and theoretical basis for the qualitative survey questions I drew upon my own anecdotal experiences, the existing literature identified through the systematic literature review, and the theoretical framework outlined in Chapter Five developed in 2008 by Gillen and her colleagues to demonstrate the nature and manifestation of bullying in midwifery.

Once complete, the initial draft of the questionnaire was piloted by seeking feedback and suggestions for improvement from registered midwives, midwifery academics in Australia and the UK, and 14 midwifery students at Central Queensland University. No major changes were required following this process. The final survey included both open and closed questions. The survey comprised two main parts; first the students were asked to complete their demographic data (10 items); they were then asked a series of open-ended questions (6 items) to enable them to explain their experiences in more detail.

#### 6.9.1 Demographic questions

The collection of demographic data from participants is important as this enables the researcher to conduct good quality research by 'situating their sample' (Braun & Clarke, 2013). Braun and Clarke (2013) state that the systematic collection of demographic data in qualitative research is vital in order to situate the knowledge which is necessary to be able to reflect upon the relationship between the results and the sample. Ten demographic questions were asked of the participants in this study. Please see Appendix G for the participant demographic data.

#### 6.9.2 Open ended questions

Six open ended questions sought the students' descriptions of experiencing of bullying whilst on clinical placement and how it impacted them personally and professionally (3 items); how the students felt the organisational context impacted and/or could improve the issue (2 items); and

finally, whether they have reported bullying whilst as students' in the past, and if not, why not (1 item). Please see Appendix F for the qualitative survey questions.

It was decided that no specific definition of bullying would be provided to the students prior to undertaking the survey. This was due to the fact that it is believed that within the healthcare student context, the frequency and time frame over which bullying has occurred should not be applied as students can experience one off episodes that have profound adverse effects upon them (Boyle & Wallis, 2016). This viewpoint was also reflected in the student researchers own anecdotal experiences where a number of midwifery students have opted to take periods of leave due to sickness and illness or choosing to withdraw from their course as a result of a one off adverse event whilst on clinical placement.

### 6.10 Saturation

The survey method of data collection enabled qualitative data to be collected from a greater number of participants. Braun and Clarke (2013) state that in cases where relatively 'shallow data" is gained on just one occasion through a qualitative survey, more participants are often required to ensure enough data is gathered to tell a rich story. In qualitative research, no set formula that can be used to determine sample size, therefore when the researcher reaches a point where no new data is being generated from the participants it can be considered that the sample size is adequate and that data saturation has been reached (Greenhalgh et al., 2019). Data saturation was observed during the coding process, with the number of participants taking part in the study exceeding that required to reach saturation.

### 6.11 Data analysis

Thematic analysis (TA) is a method that is widely used to analyse qualitative data and was selected to analyse the data in this study. TA was chosen as it provides a flexible research method, which offers a rich, detailed and complex account of the collected data (Braun and Clarke, 2006). Through the identification of themes imbedded in the data, this approach serves

to identify answers to research questions (Mihas, 2019) and is an appropriate method for identifying patterns across a qualitative dataset (Braun, Clarke, Hayfield, & Terry, 2019). Thematic analysis allows for a rich description of a phenomenon to be gathered which is particularly useful when exploring a topic that little is known about (Braun & Clarke, 2006) such as midwifery students' experiences of workplace bullying.

Specifically, Braun and Clarkes (2006) six step thematical analysis process was used to analyse the data. This data analysis process was also chosen due to its suitability to exploratory descriptive designs where data has been collected via a qualitative survey (Braun & Clarke, 2013, p. 45). The six-step approach outlined by Braun and Clarke (2006) was undertaken as follows.

**At step one**, each of the qualitative survey reports were read and re-read several times to familiarise myself fully with the data. In order to search for pattern and meaning I immersed myself in the data in an active way (Braun & Clarke, 2006). Some initial codes were also noted down at this time. In addition to this, a notebook was kept to record ideas and thoughts about each individual survey report.

**The second step** in the process was the organisation of the raw data. This occurred through the generation of the initial codes. The data was coded line by line to gradually identify concepts. Each sentence, phrase and word within the data that linked to the research question was examined and a code was allocated to each piece of data (Merriam & Grenier, 2019). All of the interesting features identified across the data set were then progressively coded in a systematic fashion. Tentative labels were allocated to each of the codes which were then collated into groups. The groups changed and developed as the analysis process continued. Concepts that were similar were clustered together and formed preliminary themes and/or sub themes, then gradually, relationships between the themes were identified. All coding was done by entering the data in the NVIVO software program (Bazeley and Jackson, 2013). The NVIVO platform was chosen as I have previous experience of using it and the inputting process enabled further

familiarisation with the data. It also provided a good way to safely store the data in the CQUniversity password protected NVIVO program.

**The third step** in the process involved starting to sort the codes into themes. The codes were collated into each of the potential themes (Braun & Clarke, 2006) and all relevant data was allocated to the relevant potential theme. The initial themes were predominantly data driven and were descriptive in nature, however, as the process evolved, a number of overarching themes developed. A mind map was developed to visualize the relationships between the different codes, themes, and subthemes and how they may fit together.

**The fourth step** involved reviewing and refining the themes that had developed during step three and checking that they 'worked' in relation to the coded extracts and the overall data set. This involved reading through all the data extracts that related to the codes to ensure that they supported the identified theme, identifying whether they overlapped, and to determine if any contradictions existed. It was important that the data within each theme was cohesive and meaningful, however, having a clear and identifiable distinctions between each theme was also important (Braun & Clarke, 2006). Where contradictions did exist within a theme or where it became too broad, consideration was given to separating the theme into separate themes or codes were moved into an existing theme where it fit better. This process continued across the entire data set until a set of themes were identified that were distinctive and coherent. Once complete, the entire dataset was re-read to ensure that the themes represented its content and to determine whether any missed uncoded data should be coded as it fit within a theme, or whether a new theme should be created. This stage was an iterative process which involved going back and forth between codes, themes, and data extracts to ensure the data was accurately represented.

**The fifth step** involved describing and naming the themes identified in the earlier steps. Where possible the themes names allocated were descriptive and engaging. Theme names where

possible should define the essence that each theme is about, so where possible when naming the themes in this study, the aim was for the theme name to 'tell the story' of the theme (Braun and Clarke, 2006).

**Step six,** the final step involved writing up the research reports. The reports involved embedding the data extracts within the analysis (Braun and Clarke, 2006). Using extracts from the data provided evidence of and supports the generated themes. This phase of the analysis process is very important as it provides the analytical narratives which go beyond the descriptions of the data and demonstrates the argument in relation to the research questions (Braun & Clarke, 2013). The written reports enable the reader to evaluate the quality of the research project. Please see Appendix L for an example of the data coding. This NVivo screenshot was included with written permission from the CQUniversity ethics committee.

I, the student researcher undertook all phases of the data analysis process, however checking and re-checking of emerging themes between the student the students' doctoral supervisors took place along with the use of quotes from the participants accounts to ensure rigour in the analysis as recommended by Houghton, Casey, Shaw, & Murphy (2013).

### 6.12 Rigour in qualitative research

In order for research to be considered rigorous it is vital to ensure that the methodology adopted to undertake the study, including the methods used to collect, analyse and interpret the data are consistent with the research design (Maher, Hadfield & Hutchings, 2018). There has been much debate over the past few decades about the rigour of the data analysis processes in qualitative research. It has been argued that due to the flexible nature of both the researcher and the methods used there is opportunity for bias, and manipulations of the research process and subsequently the findings (Sandelowski, 1986; Sandelowski, 1993b). The use of a named and structured framework for data analysis when carefully described is important to demonstrate the rigour of a study (Bradshaw et al., 2017). The use of frameworks such as this provide researchers

with a clear and transparent audit trail of the research processes undertaken that acknowledges both the credibility and authority of the process (Houghton, Casey, Shaw, & Murphy, 2013). In order to ensure that the data analysis process for this study was considered to be rigorous and trustworthy Braun and Clarkes (2006) six step framework for thematic analysis was used.

### 6.12.1 Trustworthiness in qualitative research

Trustworthiness is of upmost importance in qualitative research (Lincoln and Guba, 1985). They outlined four research standards which should be applied to all qualitative research studies to determine whether the methods used to undertake the study were rigorous and trustworthy. The four standards are credibility, dependability, confirmability, and transferability (Lincoln and Guba, 1985). Each will now be discussed in relation to this study.

### 6.12.2 Credibility

Credibility is considered to be the overriding aim of qualitative research and refers to the truth of the data including the participant views and the way in which the researcher interprets and represents them (Polit & Beck, 2017). A research study is considered credible if the descriptions of human experience are able to be immediately recognized by individuals that have shared the same experiences (Sandelowski, 1986). It was therefore important when undertaking this study that the reader was confident that the findings were a true reflection of the participants own descriptions of their experiences. Through the use of purposeful sampling, it was possible to identify participants that were most ideally placed to provide rich, detailed descriptions of their experiences of being bullied whilst on clinical placement. Further, in order to avoid the influence of the researcher impacting the study and the subsequent risk of bias, it was vital that I remained self-aware and reflexive throughout the data analysis process.

### 6.12.3 Dependability

For a research study to be considered dependable it is important that the study can be replicated in a similar context and this requires the research to be logical, traceable, and carefully

documented (Tobin & Begley, 2004). In order to achieve this, an audit of the decision-making processes and the methods that were used to conduct the study should be available. The dependability of this qualitative study is reflected in the clearly described steps that were undertaken at each point in the project and a justification for each. This thesis has provided a clear explanation of how the participants were recruited, and how the data was collected and analysed.

### 6.12.4 Confirmability

Confirmability refers to the objectivity of the research and therefore the researcher must be able to demonstrate that the findings are a true representation of the participants responses and are not influenced by the researcher in anyway, including their own viewpoint or biases (Polit & Beck, 2017). In this study, confirmability was demonstrated by describing how the analysis process was undertaken and subsequent conclusions were reached. This was also achieved by exemplifying that the findings were derived from the data by including the participants quotes that depicted each identified theme.

### 6.12.5 Transferability

Transferability refers to whether the research findings can be transferred to other settings or other groups (Polit & Beck, 2017). It is the researcher's responsibility to provide adequate descriptive data to allow readers to determine the applicability of the study's findings to other settings or groups. Descriptive data would generally include demographic data including, for example, the geographical locations included and a summary of the recruitment inclusion policy for the study (Thomas & Magilvy, 2011).

The transferability of this study's findings was able to be determined as a detailed description of the participants demographics and the contexts in which they were undertaking clinical placement was provided. This allowed readers to make informed decisions about the findings of this study's transferability to other groups of students, better understand the experiences of

midwifery students that are bullied to subsequently develop targeted strategies to tackle this issue.

### 6.13 Conclusion/summary

This chapter has provided a detailed presentation of the methods that were used to undertake this study. Qualitative descriptive research methodology was used, and data were collected using a qualitative survey. The participants responded to approved adverts placed in two Facebook groups. Participants anonymously completed a qualitative online survey consisting of both open ended and contextual questions. Data collected were thematically analysed using Braun and Clarkes 6 step process (Braun and Clarke, 2006). The analysis process was data driven. The researcher's positionality and reflexivity were discussed along with the how rigour was addressed.

### 6.14 Chapter to follow

The next three chapters of this thesis will present the findings of this research higher degree project. The findings from this study have either been published, accepted, or submitted for publication in peer-reviewed journals. The author of this thesis led this project by designing the study, applying for, and gaining ethical approval, designing, and distributing the qualitative survey, analysing the data, and drafting the peer reviewed research papers for publication. Following the three chapters of results, Chapter Ten discusses the findings, makes recommendations for the future, and concludes the thesis.

# Chapter Seven

# Findings

# Being bullied as a midwifery student, does age matter?

## 7.1 Introduction

This chapter presents the findings of this research that relate to how the age of the midwifery students impacts their experiences of being bullied whilst on clinical placement and addresses the first objective of this study. The data from two distinct groups of midwifery students was collated, analysed, and then compared. Students aged between 18 and 21 years of age (n=20) and students aged over 43 years of age (n=20) were included in this section of the study. The findings are presented using a peer–reviewed paper published in the *British Journal of Midwifery,* an international journal aimed at registered midwives working in clinical practice. The article is provided, with permission, in its published form as Appendix I.

### 7.1.1 Declaration of Co-authorship and Contribution

| |
|---|
| Title of paper:<br>Being bullied as a midwifery student: does age matter?<br>Full bibliographic reference:<br>Capper, T., Muurlink, O., Williamson, M. (2020). Being bullied as a midwifery student: does age matter? *British Journal of Midwifery*, Vol 28, No3, p. 166-171.<br>https://doi.org/10.12968/bjom.2020.28.3.166 |
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Nature of Candidates Contribution, including percentage of total

| |
|---|
| In conducting the study, I was responsible for the design and implementation of the research, the analysis of the results and drafting the manuscript.<br><br>This publication was written by me and my contribution was 65 %. |

Nature of Co-Authors' Contributions, including percentage of total

| |
|---|
| My co-authors, Muurlink, O (25%) and Williamson, M (10%) contributed to editing the final manuscript. |

Has this paper been submitted for an award by another research degree candidate (Co- Author), either at CQUniversity or elsewhere? (if yes, give full details)

| |
|---|
| No. |

Candidate's Declaration

I declare that the publication above meets the requirements to be included in the thesis as outlined in the Research Higher Degree Theses Policy and Procedure

Tanya Capper

(Original signature of Candidate) Date: 5/12/2020

### 7.1.2 Paper Three

Capper, T., Muurlink, O., Williamson, M. (2020). Being bullied as a midwifery student: does age matter? *British Journal of Midwifery*, Vol 28, No3, p. 166-171.

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# Being bullied as a midwifery student: does age matter?


## Abstract

Clinical placement is a compulsory component of midwifery education and a time when some midwifery students become targets of workplace bullying. An anonymous, online qualitative survey was used to collect data from two contrasting groups of purposively recruited UK and Australian midwifery students that responded to a call for experiences of bullying while on clinical placement. Participants in group were either aged between 18–21 years (n=20) or over 43 years of age (n=20). The data collected from each group was thematically analysed and compared. While younger midwifery students have an additional power disadvantage compared to their older counterparts, the pattern of bullying experience between the two groups was remarkably similar. Younger students however, experience more verbal and overt forms, and are more likely to respond passively to the experience. Results are discussed in terms of impact on individual welfare and the viability of the profession.



## Keywords

Bullying | Midwifery students | Harassment | Power | Clinical placement


## Key points

- Student midwives are caught between two roles: student and worker
- Age operates as a mediator of the bullying experience, with younger students being subjected to great direct, verbal attack, and older students targeted with a more strategic, covert approach
- Midwives, specifically mentors, are the most common perpetrators for both younger and older students according to this study

## 7.2 Introduction

The increased numbers of older students undertaking midwifery education (Carolan, 2011) adds an interesting dimension to the issue of bullying on clinical placement.

With research on bullying still heavily focussed upon teenagers, this study examines the role of age in altering the bullying experience. Regardless of age, the risk of bullying is thought to be closely related to power differentials (Hodson et al, 2006), with age a potential avenue of power leverage.

The term 'bullying' tends to be limited to repeated unwanted behaviour from another that is malicious, abusive and intimidating in nature (Gillen et al, 2004). However, a single incident can be 'enough' to trigger lasting adverse consequences with a recent study suggesting this is particularly true in a healthcare student context (Boyle and Wallis, 2016).

Students enrolled in pre-registration midwifery programmes in Australia and the UK are required to undertake clinical placement in order to develop, and evidence the skills and knowledge required to gain professional registration as midwives (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2014; Nursing and Midwifery Council, 2019). Several studies report that this gateway to the profession is tainted with bullying experiences (Gillen et al, 2008; 2009; McKenna and Boyle, 2016). Bullying has been linked to attrition from the profession, short- and long-term physical and mental illness, and even suicide (Hastie, 1996; Ball et al, 2002; Gillen et al, 2008).

A single paper has examined the role that age of the student might play in mediating the bullying experience with Fenwick et al (2016) finding that younger students experienced age-related prejudice from both clinical staff and their older student peers. This study places age at the centre of its focus, exploring whether the age of midwifery students influences the experience of being bullied while on clinical placement.

## 7.3 Method

### 7.3.1 Participants

Ethical approval was obtained to purposively recruit participants based in the UK and Australia via two closed online groups: one for midwifery students, and the second specifically for registered midwives and midwifery students that had experienced bullying in the clinical setting.

Eligibility criteria included: currently enrolled in an initial entry to midwifery programme in either the UK or Australia and having experienced at least one episode of bullying or unacceptable behaviour while on clinical placement. Of the 284 respondents, 20 were selected from the youngest and oldest age categories, respectively.

### 7.3.2 Analysis

Due to the first author's role as a midwifery educator and resultant ethical concerns around mandatory reporting requirements, a fully anonymous online approach to data collection was taken. The survey consisted of two sections, demographic variables and open-ended questions developed from a systematic review of the literature, and the framework advanced by Gillen et al (2008) on the nature and manifestation of bullying in midwifery.

Data was analysed using Braun and Clark's (2006) six-phase framework for thematic analysis. This approach enabled the codes to emerge from reading the data and then became further defined during the data analysis process. The analysed themes were then organised in response to four dimensions, perpetrator status, bullying type, bullying context and aftermath.

## 7.4 Findings

### *Perpetrators: senior players on the 'team'*

The registered midwife-mentor was identified as the main perpetrator of bullying, regardless of the age of the midwifery student reporting the experience. Much of the midwifery student's

clinical placement time is spent in the birthing suite and students referred to the 'stressful' atmosphere that emerges in this context.

In addition to midwifery-mentors, nursing and midwifery staff outside the birthing areas, obstetricians and even educators (including university staff) significantly removed from the clinical setting were identified by the respondents as perpetrators. Age (or at least experience) of the mentors, rather than the students, did emerge in the data. For example, a student noted that there was a tendency amongst more senior midwives in the birthing suite to focus more rigidly on policy and guidelines and de-emphasise the context of care.

'*There is a general attitude [in my experience]- more so from older, nursing background midwives who operate to satisfy policy and guideline over the experience and care provided to women.'* -Younger student 5

Respondents also reported that the perpetrators either operated in groups and, at times, actively influenced peers to join them in bullying the student.

'*She (the mentor) is the bully of the unit, other staff join in to avoid being the next victim.'* -Older student 15

Midwifery-mentors are often well-established staff, having developed functional horizontal working relationships in the maternity unit over time, and this set of more-or-less comfortable alliances can become problematic when a bullying complaint emerges against one of the allied group. One student reported how this conflict of interest played out:

*'I contacted a lecturer at the uni. I kept a diary of events ... basically I told the [lecturer] what happened. She said she was shocked and disgusted and knew there was a culture of bullying in maternity and that I should move to another unit. She then asked me who the person was who bullied me (she used those words). I told her, she then told me that the midwife involved was her best friend. I was mortified. She said she would probably not continue the investigation because of a conflict of interest. Next few days were awful for me and I got the impression [from]a few midwives who had previously been normal with me, now ignored me and there were a lot of whispered comments when I walked into a room.'* -Older student 6

### *Nature of bullying: overt versus covert*

When it came to the content or type of bullying experienced, differences by age group did emerge. Younger students were more likely to report overt verbal abuse and 'open' use of power and intimidation ('I've been called names, made to feel and look dumb'), with little attempt to disguise the denigration by the perpetrator, although as younger student 11 notes, just as the attack might take place in public, the attempt to ameliorate the impact also became a public display:

*'She would yell at you, publicly humiliate you in front of the whole ward. When you started crying, she would pull you into hugs and become very emotionally manipulative*.' -Younger student 11

Rarely was age itself deployed as a tool of bullying and only then, explicitly, in the case of younger students:

*'He mocked me in front of the other staff members and was derogatory about my age, making comments such as "I could have delivered you". I was never taken seriously.*' -Younger student 19

This theme of strategic and covert manipulation of the target emerged to a greater degree in the older cohort. Here, the perpetrators, almost as if they realised their 'victims' were not 'really' students anymore, used more indirect techniques to exert power. The events might take place in plain sight, once again, but they often aimed to intimidate:

*'I respectfully asked the senior midwife, who had a few other midwives with her, if I could be allocated a labouring woman if one came in. She unleashed a barrage of questions at me, including: "Why was I asking now?" She then stared at me for about five seconds and said nothing; I found this very intimidating.'* -Older student 10

This 'five seconds' of silence in some cases extended to elaborate ostracisation:

*'I said a polite "hello" to her in passing, and she looked straight through me and didn't reply.'*

-Older student 13

*'I was excluded from tea breaks and conversations and was given so many tasks to do. I was on my feet for 12.5 hours while the midwives sat chatting and laughing together. I was made to feel like an outsider, not part of the team.'* -Older student 8

Five of the older cohorts reported, tellingly, that they had failed or otherwise been removed from the course, while none of the younger cohorts volunteered that experience. The older cohort were much more likely to report being subjected to unrealistic expectations, denied meal or toilet breaks, or grilled/interrogated to expose 'ignorance'.

However, using elements of the mentoring and education process as a power strategy was not unique to the older students. The following case shows a student trapped in a web of conflicting demands:

*'The midwife was doing paperwork while I was cleaning the room and making the bed post-birth while mum was in the shower. The baby was swaddled in the cot and became fussy. I pulled the cot over to where I was making the bed so I could continue with my task and soothe the baby. The midwife demanded I pick the baby up because you "never leave a baby [to] cry". I picked the baby up and began swaying gently from side to side, attempting to soothe baby with gentle rocking movements however, the midwife still wasn't happy and yelled at me, "What are you doing?! You never, ever shake a baby, that's how you give them brain damage!" I stopped all movement trying to appease her when she continued berating me, asking me what I thought I was doing: "That bed isn't going to make itself".'* -Younger student 5

The 'strategic' use of power to manipulate the educational progress of students was experienced by both groups of students, but this 'goal-post shifting' was more common in the younger groups. Here, typically, students were shifted from the role of 'student' to the role of 'worker' (and back again), and experienced that shift as harassment:

'*I'd be asked to do mundane tasks like photocopying, printing and stripping beds while I was in the middle of something and actually learning.'* -Younger student 3

### *The context of bullying: centre stage*

There were few striking differences between the two groups of midwifery students when it came to the 'where' of bullying. Many incidents, as noted earlier, occurred in the birth suite for both older and younger students, often with mothers present as 'witnesses' or even as 'props' for bullying:

*'One midwife stood over a labouring woman and asked what I should be looking for visually on her abdomen, turning the woman into a learning experience at the most inappropriate time, when she was alone, in pain, and vulnerable ... she [the midwife] used that experience to highlight just how insignificant I was and just how much I had to learn to be approved by her.'* -Younger student 5

The experience of having bullying perpetrated while caring for women in the birthing room was clearly scarring for the students and did not go unnoticed by the women they were caring for:

*She [the midwife] would criticise me in front of the women to the point the women would tell me, "You shouldn't let her treat you like that".' -Younger student 20*

Older students were more likely to report that bullying incidents took place outside the at-times intense environment of the birth suite and in the 'privacy' of staff areas. The following account, from one member of the younger cohort, is an exception, but demonstrates the 'use' of other settings, such as corridors and storerooms to 'conduct' abuse:

*'I have worked with one midwife who prefers belittlement and beratement over sharing information and knowledge—she would take you into the equipment room and ask you to find random things for her, hurrying you along if you became flustered.'* -Younger student 5

Students from the younger group also reported isolated episodes of bullying by registered nurses when undertaking placements in the neonatal care areas and general wards. Here, friction between the 'neighbouring' professions arose. Some nurses were vocal about their belief that

midwifery was an 'inferior' or limited profession, and students were belittled for choosing it, particularly those becoming midwives without undertaking nursing education first.

### *The effects of being bullied: voice versus walking away*

A desire to 'leave' the site of the bullying, and even the profession, emerged in over half of the respondents, regardless of age. For a minority, the exit strategy they contemplated was suicide.

Even though the older students may have been targeted for harassment as 'fair game' because they came with a great degree of battle hardness or experience to the position of 'student', there was no evidence in the data that the older students were any less traumatised by the experience. An older student explained how her earlier enjoyment of working in the birthing suite has been replaced by fear:

*'I have developed a strong fear of [the] delivery suite—which is sad as during my observational weeks, I was blown away by what I saw happening there and enjoyed the learning that presented itself.'*

—Older student 13

One of the younger students similarly noted:

*'I never wanted to go back to [the] birth suite. I changed all of my shifts to [the] postnatal ward just so I did not have to deal with the negativity and hate there.'*— Younger student 17

The trauma had spread from being associated with a person to a place:

*'I would be physically sick before entering placement.'* -Older student 4

This general aversion converted, in some students, to a sense of defeat that drove them to contemplate leaving the profession before they had fully entered it. The following quote touches not just on a determination to leave, but extraordinarily mixed feelings about the profession:

'*Definitely am leaving once I do my preceptorship- [I] can't leave now as I'm close to qualifying. Worst decision I made was applying for midwifery – I wish I looked into this more – but I know that it's not the end of the world*

*and I was a part of something beautiful with those families, and will forever treasure that but I can't carry on like this … The disgusting behaviour [witnessed and experienced on placement] makes me embarrassed to be part of this profession.*' —Younger student 12

This resolve (words like 'determined' and 'never' appear frequently in the discourse of our study participants) reflects the sense of shattered trust, both in the profession and in their own capacity. For the younger cohort, in particular, this damage tended to turn inward into grief (*'I cried all the way home that night'* —younger student 5) and for the emotion to be turned back onto the perpetrators and the profession. For the older students, this confidence shattered a pre-existing sense of self-confidence in their working life:

*'I felt absolutely worthless and disheartened, and made to know that's exactly how I was viewed, regardless of how hard I worked or the impact I've had on the woman's experience.'* —Younger student 5

*'[I] lost my confidence, as before as a nurse I was highly respected.'* —Older student 3

Anxiety and depression were not surprisingly common, with physiological correlates such as digestive disorders and headaches. One element of the student response that did differentiate the two samples was the degree to which passivity was present.

The younger students were less likely to report bullying, take a leave of absence, and other avoidance activities in response to the experience. The older students were more likely to respond by whistleblowing, but also showed a greater sense of emotional resignation to the culture they found themselves in. The younger students felt vulnerable and wondered about an escape route should they complain ('I didn't report. I was scared it would impact upon my passing the placement'). For those who did complain, this often added to the emotional toll or a sense of powerlessness.

*'I reported it, nothing happened.'* -Older student 5

*'I reported but won't again as I was made to feel like it was my fault, so I deal with things and people in my own way.'* -Younger student 8

A minority of the students expressed outright defiance and two younger students were plotting arguably the best 'revenge':

*'I don't want the midwives who treated me terribly to win.'* -Younger student 5

Another said she had ambitions of climbing the ladder in order to ensure better treatment of students in the future:

*'[I want to become] a team leader so I can become in charge and make sure that new students aren't treated the same way.'*-Younger student 3

This sense that 'one day' they will rectify the situation themselves was also expressed by those who planned to act on the bullying upon graduation.

*'I promised myself that once I qualify, I will escalate these matters to HR and the [national midwifery governing body] because this is not on!'* -Younger student 12

**7.5 Discussion and Conclusion**

The aim of this paper was to explore and compare the bullying experiences of two contrasting groups of midwifery students; those aged between 18–21 years and those aged over 43 years of age. To the authors' knowledge, no research to date has specifically explored how age interacts with the bullying experiences of midwifery students.

Research addressing the issue of bullying of midwifery students is sparse and tends to focus on the types of bullying experienced, the status of the perpetrators and the consequences of bullying (Gillen et al, 2009; Boyle and McKenna, 2016; Shapiro et al, 2017). The literature confirms that students experience a range of physical and mental health issues and are impacted sufficiently to

question their decision to continue their education programmes and/or practice upon registration (Shapiro et al, 2017; Gillen et al, 2008).

This paper adds depth to this body of work but, in addition, shows that at least as far as the nature of the perpetrators, the location in which the bullying primarily occurred, and the degree of impact on victims, there was no pattern of difference between the older and younger groups of midwifery students. Both groups of students face the same set of perpetrators, primarily those mentoring students in the birthing areas. When it came to the nature of bullying, however, age does emerge as a factor.

Perpetrators appear more willing to be direct and overt in the use of power and intimidation when faced with a younger midwifery student. With the older students, there appears to be a more covert attempt to undermine. Similarly, in terms of impact, while there was no difference between the two cohorts as far as magnitude of impact, the 'next steps' for the two cohorts differed. For the younger students, the impact was often internalised, with self-blame and self-doubt frequently appearing. For the older cohort, their experience in the world of midwifery did not occur on a blank slate of employment experience however, confidence built up in their previous working lives was often shattered.

Younger students were more passive in their response to the bullying experience, with older students showing greater grasp of workplace practice by being likelier to whistleblow. For both cohorts, occasionally their response escalated to outright defiance, with students resolving to push on in the profession despite the obstacles placed in their path. These students were plotting revenge of sorts: an intent to reform the profession. The descriptions that the participants give of their bullying experience makes grim reading, particularly in those cases where the students speak of suicidal ideation or intent. This is the most severe expression of the students' desire to leave the profession without even having fully entered it.

Hirschman's (1970) influential work on how consumers respond in the face of deteriorating quality of service or goods has been expanded to a broader understanding of how employees respond to workplace stressors. He proposed three options for an employee under pressure: express voice, double down in their loyalty to the organisation, or depart (exit). The cost to an organisation of students choosing to exit as a response to stress is extraordinary, particularly in a profession where the cost of training is high and can be measured in the welfare of mothers and babies.

The fact that this study confirmed the findings of early work by Begley (2001), suggesting students feel most vulnerable to bullying when working in the birth suite, is particularly concerning. The birth suite is an area known to intensify staff stress levels (Geraghty et al, 2019) but it's also the area where both midwifery students and many women feel vulnerable and in need of additional care and support (Brunstad and Hjälmhult, 2014; Chang et al, 2018). This study is not the first to arrange responses to bullying on an active to passive spectrum, with Jóhannsdóttir and Ólafsson (2004) looking at age as a predictor of response to bullying in store and office workers. They explored assertiveness and avoidance as two possible responses in their sample and did not find age as predictor of either. Age did show a significant relationship with the likelihood of 'doing nothing' increasing with age, in contrast to our current study.

Leap (1997) describes oppressed groups, such as midwives, often direct their frustrations and dissatisfactions towards each other in response to a network or system that has excluded them from power. In the context of this study, it was frequently observed that students experienced this internecine rivalry, particularly with the nursing profession. It is notable that students rarely referred to bullying instances by mothers or their support persons. It is important to be mindful that the mother's midwives care for are also experiencing acute stress and the wellbeing of the healthcare workforce affects the wellbeing of those in their care (Boorman et al, 2009; Keogh, 2013).

The issue of age and bullying of midwifery students is interesting due to the unusual profile of students who choose to study midwifery. Our broader sample shows that they can be split into two groups: school leavers entering the workforce for the first time and mature age students with previous work experience choosing midwifery from a position of relative strength. In choosing to become midwives, this latter group opt in a sense to 'infantilise' themselves by taking a subordinate role in an existing strict and fixed hierarchy, a transition that has been rarely explored in the literature (Best, 2002).

Put in terms of power relations, the mature age student enters a midwifery education programme, bringing a wealth of previous experience to the role. It appears that in becoming a victim of bullying, they are being asked or forced to leave that experience at the door. Bullying is cast in the healthcare literature as a function of power relations (Hutchinson et al, 2010), including in midwifery where there is a strong hierarchy (Catling et al, 2017). This stands at odds with a view of the profession as being one that works in partnership with women and their families to provide holistic care and support at a potentially vulnerable time in their lives. The shock that our participants experienced in encountering bullying in the early stages of their career is a mark of the degree to which regardless of age of the student, the reality of midwifery education is not matching the expectation.

**CPD reflective questions**

- What type of behaviour do you consider to be 'bullying'?
- Would you speak up if you witnessed workplace bullying? If so, how?
- What types of changes do you think your maternity unit could implement to shift the bullying culture?

**Declaration of interests:** The authors have no conflicts of interest to declare.

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### 7.8 Conclusion/Summary

Chapter Seven has provided a description of the bullying experiences of two distinct groups of midwifery students; one group that was aged under 21 years and a second group that was aged over 43 years. Four main themes emerged: 'Perpetrators: senior players on the 'team'', 'The effects of being bullied: voice versus walking away', 'Nature of Bullying: overt versus covert', and finally, 'The context of bullying: centre stage'.

### 7.9 Chapter to follow

Chapter Eight will next present the findings that relate to how the social context of the maternity unit influences the midwifery students' experiences of being bullied whilst on clinical placement.

# Chapter Eight

# Findings

# Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration.

## 8.1 Introduction

Chapter Eight is the second chapter that will present the findings from the research and addresses the second objective of this study. This chapter explores how the social culture of the maternity units influences midwifery students' experiences of being bullied whilst on clinical placement. The findings are presented in a paper that has been submitted for publication in *Nurse Education in Practice* and has been accepted and is in press.

### 8.1.1 Declaration of Co-authorship and Contribution

| |
|---|
| Title of Paper:<br>Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration.<br>Full bibliographic reference:<br>Capper, T., Muurlink, O., Williamson, M. (2021). Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration. *Nurse Education in Practice.* https://doi.org/10.1016/j.nepr.2021.103045 |
| Accepted and in press. |

Nature of Candidates Contribution, including percentage of total

| |
|---|
| In conducting the study, I was responsible for the design and implementation of the research, the analysis of the results and writing the draft manuscript.<br><br>This publication was written by me and my contribution was 70 %. |

Nature of Co-Authors' Contributions, including percentage of total

| |
|---|
| My co-authors Muurlink, O (20%) and Williamson, M (10%) contributed to the design and implementation of the research to the analysis of the results to editing the final manuscript. |

Has this paper been submitted for an award by another research degree candidate (Co- Author), either at CQUniversity or elsewhere? (if yes, give full details)

| |
|---|
| No. |

Candidate's Declaration

I declare that the publication above meets the requirements to be included in the thesis as outlined in the Research Higher Degree Theses Policy and Procedure

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(Original signature of Candidate) Date: 5/12/2020

### 8.1.2 Paper Four

Capper, T., Muurlink, O., Williamson, M. (2021). Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration. *Nurse Education in Practice*. https://doi.org/10.1016/j.nepr.2021.103045

This chapter presents a paper, in its submitted original form to *Nurse Education in Practice*. The article is provided, with permission, in its published form as Appendix J.

## Social culture and the bullying of midwifery students whilst on clinical placement: a qualitative descriptive exploration.

**Abstract**

The context within which midwifery students are professionally socialised is thought to impact upon the development of their sense of belongingness, their attitudes and values, and their commitment to the midwifery profession. Negative forms of socialisation are known to lead to undesirable outcomes including desensitization about humanistic needs. This has potential to extend to an acceptance of workplace bullying and unfair treatment of others, including midwifery students whilst on clinical placement. This study aimed to explore how the social culture of the maternity setting influences midwifery students' experiences of being bullied whilst on clinical placement. One hundred and twenty midwifery students from Australia and the United Kingdom completed a qualitative online survey and the data was thematically analysed. One main overarching theme and four sub themes were identified. These were: 'the organisational culture of acceptance: "in front of"', 'brazen expression', 'group buy-in', 'suppression of dissent', and 'collateral damage'. Each of these factors enabled replication of the problem and led to perpetuation of the bullying cycle. This study illuminated that an entrenched culture of acceptance exists which impacts the students educational experience, the care received by mothers and babies, and the reputation of the midwifery profession.

**Keywords**

Midwifery education, bullying, workplace culture, clinical placement

**Highlights**

- Midwifery students encounter a workplace culture surprisingly accepting of bullying.
- Midwifery students are often bullied 'in front of' others, including mothers.
- The culture suppresses whistleblowing and leads to attrition.

- The culture of acceptance impacts the professions reputation, educational experiences, and quality of care.

### 8.2 Introduction

With clinical placement accounting for a substantial part of midwifery education in Australia and the United Kingdom (UK), midwifery students are placed in a setting designed to be an immersive learning experience, but too often find themselves exposed to organisational dysfunction, with a significant number experiencing bullying and harassment (McKenna and Boyle, 2016, Capper et al., 2020a, 2020b, 2020c, Gillen et al., 2009). When students enter the midwifery profession they embark upon a process of professional socialisation and this is heavily influenced by the culture of the organisation where they undertake clinical placement (Marshall, 2019), and being bullied whilst in this setting has the potential to shape the profession in the future.

The existence of a poor workplace culture (Catling et al., 2017) and bullying have been well reported in the maternity context (Gillen et al., 2008, Farrell and Shafiei, 2012). The maternity unit is a relatively enclosed workplace environment that is emotionally challenging and fraught with organisational pressures and tensions (Coldridge and Davies, 2017) which leads to it being a common setting for acts of workplace bullying (Gillen et al., 2008). As early as 2002, workplace bullying has been linked to attrition from the midwifery profession (Ball et al., 2002), and having adverse physical and mental health impacts on staff (Gillen et al., 2008), and has been linked with a risk of suicide (Capper et al., 2020a).

There is now a growing body of evidence that suggests that bullying is a significant issue for midwifery students, with many experiencing resultant physical and mental health issues and questioning their decision to continue their education program, or practice upon registration (Gillen et al., 2009, Boyle and McKenna, 2016, Shapiro et al., 2018, Capper et al., 2020a).

This transition from student to professional is dynamic and ever-changing (Dinmohammadi et al., 2013), and plays a vital role in the students' sense of belongingness, their personal and professional identity, the development of their attitudes and values, and commitment to the midwifery profession (Clements et al., 2016). Negative forms of socialisation can lead to undesirable outcomes such as high levels of staff turnover, ritualized delivery of care, and bureaucratic views (Dinmohammadi et al., 2013). Gradual desensitization to humanistic needs, which has also been reported (Mackintosh, 2006), has the potential to extend to an acceptance of workplace bullying and unfair treatment of others, including midwifery students.

Despite definitions varying, bullying is generally considered to be intentional *repeated* overt or covert inappropriate behaviour from another that is *intended* to intimidate and harm the target (Younan, 2019). Within the healthcare student context, however, frequency or duration of episodes is not considered a key element in this definition, as one-off incidents can trigger long term adverse consequences for the target (Boyle and Wallis, 2016).

This qualitative explorative study is focused on the experiences of UK and Australian based midwifery students. The two contexts were chosen because of several shared characteristics: in both nations: midwifery is considered a distinct profession in the UK and Australia, and midwives have separate registration to nurses. Midwifery students in both locations must complete under the direct supervision of a midwife a set number of mandatory experiences to successfully obtain midwifery registration (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2014, Nursing and Midwifery Council, 2009). To date, little research has explored how the culture of the clinical placement setting influences midwifery students' experiences of being bullied. This study addresses that gap.

### 8.3 Methods

Qualitative descriptive methodology (Sandelowski, 2000) underpinned this study. Qualitative description was selected for its rigour when deployed to explore new and emerging topics that have received little qualitative research attention (Braun and Clarke, 2013, Sandelowski, 2000), particularly within the healthcare setting (Beck, 2013).

#### 8.3.1 Ethical approval

Approval was granted to recruit students online, from both the UK and Australia, by CQUniversity Australia's ethics committee. Ethics Approval No: 0000021372.

#### 8.3.2 Study participants and recruitment

Participants were drawn from a study exploring midwifery students' experiences of being bullied whilst on clinical placement. Students based in the UK and Australia who were enrolled in a midwifery program leading to initial registration as midwives were invited to participate. Following extended discussion with the ethics panel, a decision was made to change the protocol from in-person to online, to ensure anonymity for participants—mindful in particular of the role of two of the authors as midwifery academics overseeing midwifery students in Australia. Participants were recruited via two separate online groups; one for midwifery students and one for registered midwives and midwifery students that had experienced bullying in the clinical setting. Prior consent was gained from group administrators to recruit via these means, and individual consent was gained from participants as part of the structure of the questionnaire. Only those students indicating an understanding of the purpose of the study, and a willingness to proceed, were able to access the survey.

In total, 335 midwifery students participated in the study. Of those, 120 provided complete data, 53 of which were from the UK, and 67 from Australia. This study utilised the full dataset of completed qualitative surveys. The student groups consisted of both undergraduate midwifery students and graduate entry midwifery students (registered nurses studying to become midwives), three participants were male, and all were between 18 and over 50 years of age. All participants

confirmed that they had experienced what they perceived to be bullying whilst on clinical placement.

### 8.3.3 Data collection

Both demographic data and participant-generated textual data (Braun and Clarke, 2013) were collected anonymously using open-ended qualitative survey questions via an online tool. This data collection method was chosen due to it being ideally suited to researching the *sensitive* topic of bullying, partly because it offered privacy and anonymity to the participants, but also because it raised fewer ethical concerns.

### 8.3.4 Data analysis

The qualitative comments were thematically analysed using Braun and Clarkes' (2006) six steps to thematic analysis (Maguire & Delahunt, 2017).

The data were repeatedly read and entered into the NVIVO software program (Bazeley and Jackson, 2013). This enabled the codes to be developed as nodes, which then led to the subsequent identification of themes. These themes then became further defined during the continued data analysis process of re-reading and writing.

Data analysis was independently undertaken by the first author and following discussion within the authorial team, one overarching theme and four further subthemes were agreed. The overarching theme was *"in front of"—a culture of acceptance*. The subthemes were *group buy-in, brazen expression, suppression of dissent, and collateral damage.*

This overarching theme and the subthemes will now be explored in greater detail.

Pseudonyms were given to the participants that enable the tracking of comments attributed to a single participant, but all participants completed the study anonymously and were asked in advance to not disclose details that would enable identification of themselves or their specific clinical placement location.

**8.4 Findings**

Students found themselves in a clinical environment where they were exposed to a combination of intrinsic and extrinsic challenges. *Intrinsic*, insofar as they needed to adapt quickly and effectively to an inherently novel learning environment and workplace culture to succeed. *Extrinsic*, insofar as there was undue pressure exerted upon them to conform to the workplace status quo by members of an established hierarchy that were in positions of greater knowledge and power to themselves. The students in many cases entered the maternity unit having anticipated and accepted these dual pressures '*The unit I was bullied in was well known for it'* (David) and *'I knew I was new there and had a lot to learn. They didn't know me from Adam, and I needed to prove myself. ...They expected me to know where everything was on my very first day and to just get on with doing their job without guidance'* (Judy). However, those who participated in this study had all experienced a tipping point at which the expected stress levels of a high-pressure workplace had become toxic. The dominant theme that emerged from the analysis of students' accounts was one of a surprising degree of *acceptance* of bullying, termed a 'culture of acceptance' (see Figure 4) which leads to a replication of the problem.

This aspect of workplace culture emerged indirectly in the student discourse, chiefly through using the phrase "in front of". The student's descriptions of the bullying incidents often included this exact sequence of words, they occurred "in front of" other students, other staff, mothers, or members of the public. The publicness of the bullying led to an amplified sense of humiliation and hopelessness in the students. Two subthemes represented this sense of being overpowered: "brazen expression", which refers to the fact that the perpetrators appeared unconcerned about being censured or reprimanded, and "group buy-in", where a pair or group of clinical staff participated in bullying in two main ways. The group buy-in included an active or passive component with both providing a sense that the bully was actively supported. This led to an additional subtheme, '*suppression of dissent*—the degree to which bullied students' voices self-suppressed due to fear of repercussions, the belief that whistleblowing is fruitless and that they

will not be supported or were actively repressed with complaints not being actioned appropriately. Each of these three subthemes enable replication of the problem and leads to the final theme '*collateral damage*'. This theme relates to the damage that occurs as a result of bullying. The student's education, the care received by mothers and babies, and the reputation of the midwifery profession are all adversely affected as a result. Each of these themes will now be discussed in turn.

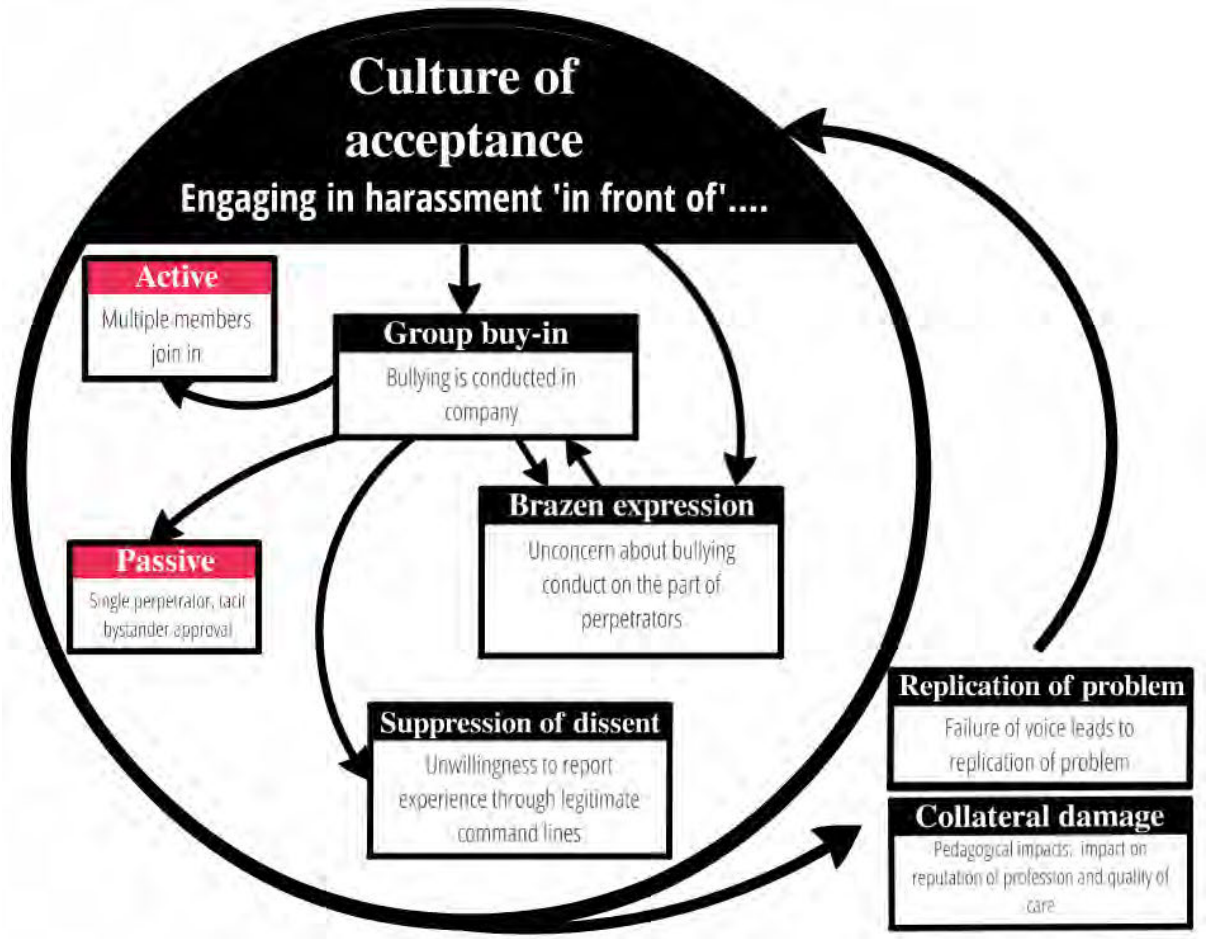


**Figure. 4. Cycle of the culture of acceptance.**

**The organisational culture of acceptance: "in front of"**

The physical environment of the maternity unit is generally separate from the broader context of the hospital, and whilst the unit interacts with the greater organisational structure, it is usually staffed by distinct team members. This smaller team structure makes it more difficult to "hide" bullying incidents, so perhaps it was not surprising that the primary theme to emerge from the

data was the sheer publicness of the bullying. It was also inevitable that there were almost invariably witnesses to the bullying events that the students described. Almost half of the participants in this study reported that episodes of bullying occurred in the presence of others. Of the 120 participants, 53 used the exact words "in front of" in describing what occurred. For example, Dot described one incident where she had asked her mentor for help with completing a new task:

'*When I asked for help, I was told "what are you asking me for". I was humiliated and belittled in front of other members of the disciplinary team'*.

**Subtheme one: Brazen expression**

Witnesses to bullying included other students and employees of the unit including midwives and medical staff, with no attempt made to minimise onlookers, and in fact, at times, an attempt was made to draw an audience:

*'The Nurse Unit Manager would pretend she didn't remember your name every shift at handover then laugh with staff - she would talk down to and belittle us in front of others. She would also take students aside to have a talk but speak loudly and point finger in our faces so other staff could hear'* (Paula).

Surprisingly, there was little attempt made to protect mothers from witnessing bullying with over one-third of the participants reporting that bullying occurred at least on one occasion in front of the women they were caring for. This was particularly upsetting for students when they felt that the embarrassment of being bullied had adversely impacted the strong professional relationship they had built with the woman and her family, drawing the mothers into the bullying 'dialogue'.

*'One mentor would highlight what she believed was incorrect practice in front of the mothers. So for example, if I took blood a certain way, she would tell me in front of mothers that I was doing it wrong, despite having taken blood like this for numbers of years in my job as a nurse and being trained in this particular way by the same trust she worked for! It was like she enjoyed stating her authority'*.

(Robin).

**Subtheme two: Group buy-in**

As noted in the previous theme, bullying was taking place "in front of" others, but this was not simply a case of an active 'actor' and a passive 'audience', but an actor active in the attempt to include the audience in the bullying. At times, there were cases however where the audience clearly attempted to separate themselves from the bullying event.

Kate shared her experience of not being defended or supported by other midwives after questioning a senior midwife's inappropriate comments. and was subsequently yelled at and threatened; *'The other senior midwife looked uncomfortable and walked out of the room. Others looked uncomfortable and left the room also'.*

This suggests a culture of fear is present leading to other midwives fearing to defend the students when bullying was occurring right under their noses. Monique for example recalled :

*'All the other staff looked the other way or at the floor. No one stood up for me. In a room with at least 20 midwives, supposed professional advocates allowed her to scream at me that I was useless and stupid'.*

The students speculated that this failure to, or fear of speaking up relates to the midwives' own fears of 'being next' or fear of jeopardising any existing positive relationships they may have with the perpetrator. Kelly went as far as to say that midwives even join in to be accepted *'She (the midwife) is the bully of the unit, other staff join in to avoid being the next victim'.*

Many of the perpetrators clearly do not fear the ramifications of their repeated unprofessional behaviour. The students suggested that this is due to their awareness that there are no real consequences for their bullying behaviour and that they perceive themselves to be 'untouchable'. In other cases, the 'audience' actively demurred or attempted to support the victim, however, more often, there was an uneasy acceptance that the culture was imbued with bullying.

Selma shared how she sought support from other midwives: *'I spoke to other midwives about it (the bullying) and they would sympathise but say that she bullies other student midwives and registered midwives as well'.*

The students were in no position to comment on whether the culture preceded the individual bully, or a single influential personality within the maternity unit had 'recruited' others to a culture that they played a leadership role in creating. However, despite no longitudinal evidence of their own to draw upon, the students appeared to have formed a lay theory as to the reason behind the acceptance of bullying, which they termed "the system". There was a tacit acceptance on the part of the midwifery students that the bullying incidents were an expression of a 'system' that was larger than the individuals who were either bullying them or allowing the bullying to continue.

On occasions, the perpetrator was not a single individual, but rather bullies operating in groups or pairs. *'In the hospital, there is definitely a very bad local culture. However, it operates mainly within certain groups'* (Chloe).

This group form of bullying not only increased the frequency of bullying in the eyes of students but also its intensity. The sense that students were being attacked from multiple sides, or at least they found themselves second-guessing where to seek support, amplified the impact of the bullying. One student reported that she had witnessed a group of midwives speaking poorly about midwifery students in the tearoom whilst in earshot. Leesa said, *'I witnessed a student (from a different university to my own) leave the room and a midwife exclaim behind her back that the student was so useless "she needs to be taken out the back and shot".*

**Subtheme three: Suppression of dissent**

This theme refers to how the more powerful encultured midwives, which in this case was part of what the students referred to as 'the system' were perceived to silence and not provide the midwifery students with the support and action they so desperately needed.

Students spoke of a perceived level of acceptance of bullying at three distinct levels of the midwifery education structure: clinical, managerial, and academic: *'The hospital was a cliquey environment in which staff accepted the behaviour of colleagues in the hopes of improving their own status'* (Jessica).

Selma spoke of an example of how managerial staff were unsupportive when a group of students plucked up the courage to complain about a senior midwife that had been treating them poorly consistently or persistently. *'We were told "that's just her don't take it personally she is just set in her ways".* This experience left them feeling unimportant, unheard, and unsupported and sent an indirect message that bullying was deeply entrenched in midwifery workplace culture. Clearly, the students were in no position to judge *how* the transition to an environment conducive to bullying had evolved, however, they witnessed what appeared to be a hospital hierarchy supportive of bullying.

The university was occasionally perceived as a place of refuge for students experiencing poor treatment whilst on clinical placement, but when they reported concerns to academic staff, previously hidden relationships between the academic and clinical staff emerged. For example, Kate in the following account, notes that support vanished when she attempted to escalate her concerns:

*'I contacted a lecturer at the uni. ... I told this tutor what happened. She said she was shocked and disgusted and knew there was a culture of bullying in maternity... She then asked me who the person was who bullied me, I told her, she then told me that was her best friend. I was mortified. She said she would probably not continue the investigation because of a conflict of interest'.*

Bullies were often secure in their position, with the perpetrators supervising multiple intakes of midwifery students.

*'There were a lot of negative anecdotes by various people about this educator and the timeline of these stories spanned to before I was even a student myself. I think everyone was aware, but nobody had the courage to go to HR and stand up to put an end to it.'* (Maxine).

One clear consequence of the culture of acceptance was that students either internalised the bullying as part of the process of professionalisation, or they felt reluctant to report concerns. Believing that 'the system enables bullying' meant that students turned to other students or those in their private sphere for support, and not those holding a duty of care over their welfare. Reporting was considered fruitless and at times even risky. Chloe stated, *'I reported these incidents in the first year. Despite five students from the years above also complaining, no one was disciplined, and the worst offenders were promoted'*. Bridget echoed these concerns, of consequences of whistleblowing: *'... if you had made a report you are at risk of ostracising yourself further and have midwives refuse to work with you'*.

**Subtheme four: Consequence of Culture 'Collateral damage'**

The students observe the clinical environment with relatively fresh eyes and focus on their own experience. The experience shapes how they see the profession and the professional context, but as they moved from one clinical area to the next several students reported that the harassment they had experienced was not unique to themselves. Bea stated:

*'It does make me anxious about being newly qualified though as this sort of harassment seems so commonplace nobody really thinks of it as harassment'*.

It was evident that this culture of acceptance enables a self-perpetuating cycle and therefore further replication of the problem. This had knock-on effects, not just upon the next generation of midwifery students' educational experiences, but also the quality of care delivered to mothers and babies, and the reputation of the midwifery profession.

### *The education of the next generation of midwives*

Some students felt that the culture impaired their midwifery education. The clinical setting should be a place for the transfer of knowledge, and an opportunity for students to apply theory to practice. This pedagogical framework, in some cases, directly broke down. *'My mentor refuses to answer my questions and expects me to know stuff we haven't studied yet'* (Angela) and Eloise's words illustrate how bold mentors can be: *'She (the midwife) proceeded to go on and say it wasn't her job to teach me and that she disliked having students'.*

Poor role modelling and unprofessional behaviour were frequently witnessed by the students. A student reported the reaction she got after questioning inappropriate comments made by a senior midwife about a newborn's appearance.

'*She (the midwife) then came towards me, I was sitting down, she stood above me with a pointed finger moved towards my face and said if I repeated the f**king ugly kid comments to anyone, they would make my life a living hell at the hospital, she then walked off'* (Kate*).*

While some of this poor behaviour was rationalised by the perpetrators as a way of 'hardening the troops' (*"it's important to put students through their paces"* (Sally)), such was their sense of comfort in their culture, that they generally did not bother to justify their behaviour. *"Ninety percent of midwives behave like they hate women, and they make it pretty obvious that they don't like students either"* declared one student (Clare). Far from focusing on pedagogy, at times the mentors appear to be set on a path of humiliation:

*'I was asked to check the equipment trolley and identified missing stock, which they then sent me to replace.....After an hour of searching for the missing items, I returned to the office to report this. All present burst out laughing and jeered, "We haven't used those things for ages!"* (Chloe*).*

Further evidence that the clinical context as a pedagogical environment had broken down emerged from frequent references by the participants to being "free labour". Leesa shared: '*I have often been asked to do menial tasks instead of being with my follow-through women ...'. (*The student was

referring to a woman she had followed the care of through pregnancy, birth, and the postnatal period as part of her course).

Students that were not registered nurses, but instead were entering midwifery directly were singled out in this regard: they were seen as "useless" and ill-equipped to become "proper" midwives and were seen to lack all the dimensions of knowledge and experience required for the role: *'From the very first day on birth suite I was treated with disrespect and made to feel small. Being a Bachelor of Midwifery student with no prior nursing experience I was made fun of'* (Leesa).

Concerningly, regardless of their background, the students reported being left to care for mothers and babies without supervision. *'I was left alone with a high-risk labouring woman, out of my depth completely, while [the] mentor sat chatting & drinking tea in office for two hrs, when mentor returned to delivery room, told me off for not alerting her to a slightly rising fetal baseline on CTG which I wasn't yet experienced enough to spot, she then told all her colleagues I was incompetent'.* (Sam)

### *The quality of care delivered to mothers and babies.*

There were frequent anecdotes presented in the participants' accounts suggesting that the climate of acceptance of bullying adversely impacts the quality of care received by mothers and babies. On occasions the treatment of women bordered on physical assault:

*'She physically barged me out of the way while waiting for a birth, then proceeded to exert hard downward traction causing massive perineal damage. She then stalked off and in front of the woman said "everyone loves a student and this hands-off stuff. THATS how you get a baby out"'.* (Kelly).

Apart from suboptimal care being provided to mothers and their babies, it was evident that mothers not only witnessed bullying but were on occasions victims of bullying themselves.

*"Due to personal issues, this mentor regularly turned up late and in a foul temper, which she happily took out on me and the women.'* (Chloe).

Women that witnessed bullying often sympathised with students, some encouraging them to stand up for themselves. Emma said, *'She (the midwife) would criticise me in front of women to the point they (the women) would tell me I shouldn't let her treat me like that'.*

### *The reputation of the profession*

The fact that much of the bullying takes place in front of others including women and their families has risks of damaging the reputation of the midwifery profession. The students frequently spoke of the surprise of women and their families verbalised when they were witnesses to bullying incidents.

*'She (the midwife) told a patient that very first shift that I would never be a midwife -- they would make sure of it. The patient and her husband, who greatly appreciated my care, were very shocked, and went out of their way to warn me of what was going on'* (Chloe).

Some of the behaviours that the students were subjected to left them questioning their career choice and feeling ashamed of the profession:

*'I was spoken to with no respect and humiliated in front of patients. I left the shift wondering whether I wanted to go into this profession, working with people like that'* (Tracey).

Zelda went further and shared how she felt about the midwifery profession after she witnessed a senior midwife bullying a junior student: *'Disgusting behaviour and makes me embarrassed to be part of this profession'.*

Over a quarter of the participants in this study stated that they had either withdrawn or were considering withdrawing from their midwifery education program due to bullying. When students hadn't actively planned to withdraw, they were left questioning their career choice and this impacted upon their decisions around whether to practice upon registration. '*I plan on doing my preceptorship and (then) leave this profession, ...because my mental health is more important'* (Zelda).

### 8.5 Discussion

This study has explored how the culture of the maternity unit influences midwifery student's clinical placement experiences and presents concerning evidence that a culture of acceptance of bullying pervades this environment. It is clear that despite midwifery being a profession that is underpinned by formal codes of conduct that specifically address the responsibilities of all midwives concerning the prevention of bullying (Nursing and Midwifery Board of Australia (NMBA), 2018, Nursing and Midwifery Council (NMC), 2015), bullying continues to take place and it is not taking place *in private*. The students spoke about experiencing the problem across multiple sites, and their discourse is imbued with evidence of the brazen nature of bullying. This openness suggests a sense of comfort on the part of the bullies to continue their unprofessional behaviour with a surprising lack of fear of being challenged or reprimanded. It also suggests a pathway forward: if the bullying is not 'hidden', then it can be addressed relatively more easily through workplace mechanisms. Better preparation, resources and support for stressed mentors and midwifery staff, and improved paths of escalation of complaints are means that students have identified as potential avenues for action (Capper et al., 2020c).

Although this study did not explore prevalence there is substantial literature on "bad apple" including experimental literature attempting to manipulate variables to judge what proportion of staff need to engage in a particular antisocial practice to spoil the whole "apple barrel". This literature sheds light on the question of prevalence. For example, Kerr et al. (2008) note that the threat of exclusion from the team in an organisational context is often sufficient to encourage individuals to follow the example of a "bad apple" particularly in smaller groups—groups such as a maternity unit team. In the relatively enclosed environment of the maternity unit, the individual perpetrator may have a greater influence on culture than they would in a larger organisational setting. Clearly, the perpetrator feels a sense of invulnerability that enables them to brazenly engage in wholly unprofessional behaviour in front of other staff, students, and

mothers. Work on the bystander effect is one of the staples of social psychology, and again, this literature concerningly hints that the incidents and culture described in this study are not unusual. Bullying in a broader social context such as the maternity unit involves not only the bully and the victim but also bystanders (Sandstrom et al., 2013). Studies suggest a potential explanation for this may be a reluctance to defend victims due to the belief that there is a network of support for bullies (Pozzoli and Gini, 2010).

This is not the first study to identify a culture of acceptance with other authors previously identifying that a permissive organisational culture enables bullying in midwifery (Gillen et al., 2008). Earlier research has explored how bullied healthcare students need greater support and organisational accountability when escalating concerns (Hakojärvi et al., 2014), however despite this, the current study indicates further progress needs to be made. This progress will be impeded by the fact that this is an environment dominated by groups of staff that are well known to each other, and the fact that mentors with sufficient experience to supervise students, particularly in the birthing suite are often staff of many years practice, and difficult to replace should administrators seek a change of culture.

This study also suggests that despite impediments to change, change nevertheless is urgently required. The continuation of a culture of acceptance of bullying has serious implications for the reputation and future of midwifery. If bullying is deeply entrenched in the clinical culture, then it has motivational impacts upon the potential future generation of midwives' willingness to apply to study midwifery. This study adds to a body of work that has emerged in recent years suggesting that workplace bullying leads to attrition from midwifery education (Capper et al., 2020, Gillen et al., 2009). The participants in this study entered midwifery with a clear career plan, are committed to the profession and express a sense of vocation. This enthusiasm is damaged, and even if they do emerge as registered midwives, their sense of what is acceptable in

the workplace may be impaired by what they have observed and experienced, and as a result of picking up cues from the culture that encompassed them during their studies.

Clinical mentors play an influential role in the midwifery students' immersion into the profession and are seen as role models (Nieuwenhuijze, Thompson, Gudmundsdottir, & Gottfreðsdóttir, 2020). Inappropriate role modelling, which includes bullying behaviour perpetuates a culture of midwifery that does not meet professional expectations. This study suggests that the messages midwifery students are receiving in the clinical setting are at the very least mixed. Positive clinical experiences are vital if students are to develop the capacity to be confident, assertive, and autonomous midwives (Miles, 2008).

### 8.5.1 Limitations

One of the questions a study such as this cannot answer is the question of prevalence. This study also only included participants from the UK and Australia. It is, therefore, possible that the participants represented the experiences of students located in just a small cluster of hospitals in these countries. These uncertainties need to be addressed in future studies.

## 8.6 Conclusion

When on clinical placement midwifery students are exposed to a workplace culture that is accepting of workplace bullying which often occurs brazenly in front of others including the women the students are caring for. Students fear whistleblowing and if they do, they struggle to be heard. If bullying occurs in an environment where the bully feels safe from consequences, the bullying cycle is likely to self-perpetuate. This culture has consequences in terms of the student's education as well as their physical and mental health, but also has implications for the mothers and babies they care for, and the reputation of the profession. Further work needs to be done to explore how midwifery students can escalate, and have their concerns heard and acted upon when being bullied in the clinical placement setting.

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### 8.8 Conclusion /Summary

Chapter Eight explored how the social culture of the maternity setting influences midwifery students' experiences of being bullied whilst on clinical placement. One main overarching theme and four sub themes were identified. The overarching theme was: 'the organisational culture of acceptance: "in front of"' and the subthemes were: 'brazen expression', 'group buy-in', 'suppression of dissent', and 'collateral damage'. Each of these factors enabled replication of the problem and led to perpetuation of the bullying cycle. These findings illuminated that bullying is cyclical and an entrenched culture of acceptance exists which impacts the student's educational experiences, the care received by mothers and babies, and the reputation of the midwifery profession.

### 8.9 Chapter to follow

Chapter Nine will next present the findings that relate to the midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours towards them whilst on clinical placement and the potential ways these could be addressed.

# Chapter Nine

# Findings

# Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study.

## 9.1 Introduction

Chapter Nine is the third chapter that will present the findings from the research and addresses the third objective of this study. This chapter explores whether midwifery students perceive that any modifiable organisational factors exist that foster bullying behaviours towards them, and if so, their perceptions of what could be done to address the issue and break the bullying cycle. The findings are presented in a paper that has been published in Women and Birth. The article is provided, with permission, in its published form as Appendix K .

### 9.1.1 Declaration of Co-authorship and Contribution

| |
|---|
| Title of Paper:<br>Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study.<br><br>Full bibliographic reference:<br>Capper, T., Muurlink, O., Williamson, M. (2020c). Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study. *Women and Birth.* https://doi.org/10.1016/j.wombi.2020.12.005 |

| |
|---|
| Accepted and in press. |

Nature of Candidates Contribution, including percentage of total

| |
|---|
| In conducting the study, I was responsible for the design and implementation of the research, the analysis of the results and writing the draft manuscript.<br><br>This publication was written by me and my contribution was 70%. |

Nature of Co-Authors' Contributions, including percentage of total

| |
|---|
| My co-authors Muurlink, O (20%) and Williamson, M (10%) contributed to the design and implementation of the research to the analysis of the results to editing the final manuscript. |

Has this paper been submitted for an award by another research degree candidate (Co- Author), either at CQUniversity or elsewhere? (if yes, give full details)

| |
|---|
| No. |

Candidate's Declaration

I declare that the publication above meets the requirements to be included in the thesis as outlined in the Research Higher Degree Theses Policy and Procedure

Tanya Capper

(Original signature of Candidate) Date: 5/12/2020

**9.1.2 Paper Five**

Capper, T., Muurlink, O., Williamson, M. (2020c). Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study. *Women and Birth.* https://doi.org/10.1016/j.wombi.2020.12.005

This chapter presents a paper, in its original form, as submitted to *Women and Birth*

**Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study.**


## Abstract

**Problem:** An increasing body of research suggests midwifery students experience bullying and harassment whilst on clinical placement. Little is known, however, about factors that foster bullying within this context and how they may be addressed.

**Aim:** To explore and describe midwifery students' perceptions of what modifiable organisational factors foster bullying behaviours and to map the identified factors against the students' perceptions of a solution.

**Methods**: A qualitative descriptive design was used. A total of 120 midwifery students from the United Kingdom and Australia participated in this study. Participants completed an online qualitative survey and data was thematically analysed.

**Findings:** The midwifery students in this study perceive that several organisational factors exist that help foster bullying behaviours towards them whilst undertaking clinical placement. Three overarching themes were identified relating to ineffective midwifery mentorship, the high stress environment of the maternity unit, and challenges faced with transparency and whistleblowing. Students identified a range of potential structural responses to bullying.

**Conclusions:** Recommendations are made that midwifery managers and academics acknowledge how students perceive several potentially modifiable organisational factors which either lead to or exacerbate the likelihood of them being the target of bullying whilst on clinical placement. Consideration should be given to solutions that from the student's perspective may help tackle

bullying and subsequently lead to fewer students leaving midwifery education and further depleting the future workforce.

**Keywords:** midwifery students, bullying, causes, solutions

**Statement of Significance**

**Problem:** To date, little is known about the organisational factors that foster bullying and harassment towards midwifery students and how they may be addressed.

**What is Already Known:** A significant number of midwifery students experience bullying and harassment whilst on clinical placement. This has short and long-term personal and professional impacts upon the student and leads to attrition from the profession.

**What this Paper Adds**: Midwifery students in this study identified a range of organisational factors that fostered bullying behaviours towards them and suggested appropriate strategies that could help address the issue.

**Highlights**

•Midwifery students perceive that several organisational factors foster bullying behaviours towards them whilst on clinical placement.

•Midwifery students perceive that dysfunctional models of mentorship contribute to them being bullied and treated poorly whilst on clinical placement.

•The stressful nature of midwifery work and organisational pressures are believed to contribute towards midwives treating midwifery students poorly.

•Inadequate organisational supports and managerial responses to reports of bullying are perceived to enable the bullying cycle to continue.

## 9.2 Introduction

Clinical placement is known to powerfully shape the educational experiences of midwifery students (Gilmour, McIntyre, McLelland, Hall, & Miles, 2013), and as it comprises on average half of all the learning hours required to successfully complete a pre-registration midwifery course in both Australia and the United Kingdom (UK) (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2014; Nursing and Midwifery Council, 2019), it is concerning that a significant number of students continue to report being bullied whilst undertaking this component of their program (Capper, Muurlink, & Williamson, 2020a, 2020b; Gillen, Sinclair, Kernohan, & Begley, 2008). These studies confirm that the perpetrator is most likely to be a midwife or more specifically, the students' mentor or practice supervisor. The impacts of being bullied can be severe for both the individual and the profession: students suffer physical, emotional and mental health issues (Gillen et al., 2008), with many questioning their decision to become midwives, avoiding clinical placement, withdrawing from their course of study, and if they do complete the course, choosing not to practice upon graduation (Capper et al., 2020a). The implications of bullying do however extend beyond merely the experience of students in a vulnerable power position in the maternity unit, and beyond the consequences in terms of reputational damage to the profession: it is clear the quality of care offered to mothers and babies may also be placed at stake (Kirkup, 2015).

Workplace bullying research is a subdiscipline with its roots in abuse occurring within the school context (Samnani & Singh, 2012). Researchers have identified several broad themes in the search for antecedents, including individual-focused studies (for both bullies and victims) (e.g. Podsiadly & Gamian-Wilk, 2017) as well as group-level variables. There have been a cluster of studies (e.g. Aquino & Douglas, 2003; Glomb & Liao, 2003) demonstrating that bullying fosters bullying: those who witness aggressive behaviour at work are more likely to become bullies, establishing new group benchmarks or norms. Some studies have shown that the characteristics of the workplace itself (such as tasks that engender conflict or foster low communication openness) are

more likely to promote bullying behaviours (O'Farrell & Nordstrom, 2013). Self-managed teams and teams that are experiencing work related stress (such as those working within the maternity services) may also be more likely to foster bullying behaviours (Arthur, 2011). Finally, a tertiary (organisational) level of explanation for bullying has been ventured by some researchers. Organisations with a strong power imbalance (Salin & Hoel, 2011), a cultural acceptance of aggressive behaviour (Einarsen, Skogstad, Rørvik, Lande, & Nielsen, 2018), and authoritarian management styles (although *laisse faire* leadership has also been linked to the growth of bullying culture) have all been identified as fostering bullying (Salin & Hoel, 2011). Research suggests that there is a 'permissive culture' towards abusive workplace behaviours present in the midwifery educational context (Gillen, 2008). Indeed, some scholars argue that bullying in a generic organisational context may be accepted as the cost of doing business: as a way of ensuring compliance with work routines, or improving performance (Salin & Hoel, 2011). Others argue that there is no managerial incentive to act on complaints of bullying due to the risks associated with altering the delicate balance of power within an organisation (Liefooghe & Mac Davey, 2010).

This study explores the antecedents of bullying in the midwifery education context from a different perspective: it explores what the midwifery students themselves *perceive* to be the causes of bullying behaviours towards them whilst in the clinical placement setting. It asks them to explain how they would address workplace violence themselves. There is a small but significant amount of literature exploring adult victims' perceptions of antecedents and responses to bullying (e.g. Karatuna, Jönsson, & Muhonen, 2020; Šléglová & Cerna, 2011). Šléglová and Cerna's work on cyberbullying victims is particularly influential but focuses on a context quite different to that of the current study. In the current study, the organisational context is foregrounded in the bullying experience, in recognition of the formal organisational structures in which midwifery education takes place. In this sense, this study represents an early step in

designing organisational interventions to address what appears, based on the scholarly literature, to be a chronic characteristic of the clinical educational environment of midwifery students.

Despite persistent reports of midwifery students being bullied whilst on clinical placement, to date no research has specifically explored appropriate individual and organisational responses to the presence of bullying towards this group. This study aims to map both the perceived causes and remedial responses, through the eyes of midwifery students who report experiencing bullying during their pre-registration midwifery education program.

### 9.3 Aim of the study

This paper represents part of a larger qualitative study exploring midwifery students' experiences of being bullied whilst on clinical placement. This paper aims to explore midwifery students' *perceptions* of the nature of the modifiable organisational factors that foster the bullying of students, and their views on how these factors may be addressed.

### 9.4 Methods

A qualitative descriptive design (Sandelowski, 2000) was employed to describe and explore the phenomenon of interest. Qualitative description is deemed an appropriate research methodology to deploy when exploring topics that are yet to receive significant research attention (Braun & Clarke, 2013; Sandelowski, 2000), particularly when they relate to the healthcare context.

#### 9.4.1 Ethical approval

Ethical approval was obtained to undertake this study by CQUniversity Australia ethics committee. Ethics approval number: 0000021372.

#### 9.4.2 Participants

A total of 120 midwifery students provided full data for the study. Recruitment was conducted through two closed Facebook groups thematically focused on midwives and midwifery students. The recruitment post contained a brief overview of the nature of the study and called for

students who had experienced bullying whilst on clinical placement. Potential participants were asked two screening questions: they were asked whether they were a midwifery student based in either Australia or the UK and if they had experienced what they perceived to be bullying or harassment whilst on clinical placement. The UK and Australia were chosen as sites due to the midwifery education models being remarkably similar: in both locations students can enter courses either directly or with existing nursing registration, and clinical placement commences as early as possible.

In total, 335 students provided full or partial responses to the survey questions. Of the participants reporting full data, 53 were from the UK and 67 were from Australia. The students were undertaking clinical placement in a range of clinical settings which included small midwifery-led birth centres through to large tertiary consultant-led maternity units in hospital settings. Students were undertaking either undergraduate or postgraduate midwifery education courses in the UK or Australia, on a pathway to initial registration as a midwife.

### 9.4.3 Data Collection

Data was collected between January 2019 and April 2020 using an online anonymous survey consisting of both demographic and open-ended questions. Demographic data was collected to provide context to the research (Braun & Clarke, 2013). An anonymous qualitative survey was deemed the most appropriate way to collect data for this study as it allowed the survey to be easily accessed regardless of geographical location, and enabled the participants to remain anonymous, particularly appropriate for questions of a *sensitive* nature (Braun, Clarke, Boulton, Davey, & McEvoy, 2020). Students were specifically asked to *not* include any information of an identifying nature, either about themselves, perpetrators, or the identity of their clinical placement setting.

### 9.4.5 Data Analysis

As part of the larger study the students were asked the two following questions:

1. *Do you feel that the organisational context (i.e. the hospital) helped foster the incident(s) or was it really just a case of 'one rotten apple'?*
2. *Do you think there are things about the organisation that could be changed to help ensure this type of incident(s) does not happen again?*

The responses to these questions were thematically analysed using Braun and Clarkes' (2006) staged thematic analysis. This required the student's responses to be collated, read repeatedly, and coded thematically, in this case using the NVivo software program (Bazeley & Jackson, 2013). Through this process, it was possible to develop identified codes into nodes which then enabled the identification of themes. The themes became further refined as the re-reading and coding process evolved. Data analysis was independently undertaken by the first author and following discussion with the other members of the research team, three main overarching themes were agreed. These were '*dysfunctional models of midwifery student supervision*', '*pressure cooker*', and '*deaf ears*'. The students suggested potential interventions and solutions that organisations could implement to attempt to tackle the issue of bullying. These themes and potential solutions will now be discussed in greater detail. In the following, pseudonyms are used to maintain anonymity.

## 9.5 Findings

### 9.5.1 Theme 1 - Dysfunctional models of midwifery student supervision

*Cause 1 - Two jobs, one unwanted*

Employing organisations expect all registered midwives working in clinical settings in both the UK and Australia to fulfil two distinct, and at times contradictory roles: they are required to provide safe, competent, woman-centred care to mothers and babies whilst simultaneously providing mentorship to midwifery students undertaking clinical placement as part of their midwifery education program. However, while midwives receive extensive preparation for providing the former, fewer receive specific education on how to effectively communicate with,

teach and support students. This knowledge and skill deficit can lead to heightened levels of stress, confusion, and miscommunication which in turn can lead to students being treated poorly and left to fend for themselves. This lack of preparation appeared at times somewhat obliquely in the data as students described their mentors' pedagogical skills. The following account captures elements of the full range of responses to the students' sense of bewilderment:

> *My mentor expected far too much from me as a first-year student. Whenever I struggled to understand, grasp what was going on, made the same silly mistakes or asked repeated questions, I was made to feel stupid that I couldn't achieve what they wanted of me. I was asked "well how do you learn then?" when I told them I didn't know how to do what they expected. I hated every minute of a shift, couldn't retain information, felt unsafe, at risk. I came away feeling demoralised, stupid, like I'd made a huge mistake taking on the course. I felt it was all me, now I realise it was their methods taking me down* (Jenny).

Here a sense of 'thrown in the deep end' and 'sink or swim' elements appeared—. In some cases, this was almost a perverse pedagogical philosophy—but elsewhere a more negligent note appears in student accounts:

> *I was allocated a mentor that often asked me to look after several postnatal women and babies during night shifts while she disappeared on a two-hour break. When she returned from break, I would ask questions that she was too busy to answer properly at the time. After a few more hours had passed she would eventually look at the documentation of care notes and pick holes in them quite loudly in front of several other midwives which was extremely embarrassing* (Emily).

Here, little attempt is made to disguise antipathy and abuse. Students reported that the negative emotions that mentors felt about their pedagogical role was at times extremely transparent. The sense of students as an unwanted burden was sometimes on public display. Introduced to her allocated mentor at the beginning of a shift, Clara notes, "*I said "hello I'm X and I'm working with you today" with a smile and I'd get an eye roll and a flat "ok*"' while other students also referred to eye rolling and exaggerated sighs. "*They don't hide their displeasure'* (Billie).

### *Proposed solution*

The participants of the study suggested ways that they perceive the issues around the mentorship role could be overcome with strategic organisational input. Several of the students felt that only those that actually want to teach students, and are approved to do so, should be allocated this role. Donna said, '*a specific mentor role is required and must be volunteered for'.*

The students went further to suggest that midwives that are interested in undertaking the role of a mentor should be provided with ongoing education and support to undertake the role effectively and their contribution should be acknowledged by senior staff members and managers. It was perceived that ongoing education should include information around the key elements of successful adult education, communication skills, the student's role, midwifery course types, and the clinical needs of students. Hattie suggested *'I think it would be helpful for midwives to know what is expected of them when they are mentoring a student'*. Megan suggested that midwives who are interested in teaching students should be provided with professional development opportunities related to teaching and supporting students; *'[Midwives need] courses on how to teach and interact with students so they get the best experience possible. Not every midwife is going to be a great teacher'.*

It was also suggested that midwives that are working as mentors should undertake compulsory awareness sessions on bullying and how it impacts others, particularly students. Selma said, '*Regular staff education is required about the impacts of bullying in the workplace and how to work with people who you may not particularly get along with'.*

*Cause 2 - Entering an unknown world, as unknowns.*

Smaller cohorts of midwifery students often undertake clinical placement within a single relatively enclosed maternity unit, in stark contrast to their nursing student counterparts who often undertake multiple clinical placements across a number of clinical specialities as part of

larger groups. Despite this, the perpetrators of bullying within the maternity unit appear to take advantage of the decreased likelihood of scrutiny and transparency in the 'privacy' of the birth suite in particular. In fact, it appears that working within this smaller context encourages bullying in a very different way: the perpetrators feel comfortable amongst a relatively small cohort of known and trusted colleagues with which they have an interdependent continuing relationship. The students are seen as outsiders, entering a small well-established context where the perpetrators, not the students, feel safe. *[I've been] humiliated in front of other staff or women and telling me I'm incompetent',* Sandra noted, for example.

For the students, their presence in the birth suite or a ward is a transitional stage they are passing through; for their mentors however, it is their professional 'home'. Students identified the discontinuity of their own learning experience. Leesa said '*It is very difficult trying to build a rapport with a new midwife every shift who doesn't know or doesn't want to know where you are at and what your competencies are. So much wasted time'.*

### *Proposed solution*

Students acknowledged that they needed to do 'something' to strengthen the relationships they build with their mentors. The students enter their clinical placement as strangers to the environment. The participants acknowledged that knowing their mentors, perhaps through an expanded induction process, would alleviate a number of the challenges they face around having to tell every mentor the stage they are in their course, which skills and experiences they require and having to develop a rapport with a new person on each shift. None of them explicitly pointed to the value of a formal period of getting to know the mentors outside the pressurised context of the hospital prior to the commencement of their placement; instead they imagined themselves in a future where they would be accepted into a world that they had idealised before entry.

### 9.5.2 Theme 2 - Pressure Cooker

*Cause 3 – The high stress clinical environment*

The maternity unit, particularly the birth suite is by nature a workplace that is fraught with stress, which is added to by the high levels of perceived responsibility and risk. In addition to this are the stressors related to high workloads, staff shortages, poor skill mix, high levels of complex and often medicalised care, and in some instances, poor treatment by managers. The toxicity of politics may have caught them by surprise, but the students were aware of this factor in the high intensity of the environment they were entering as new students and at times had quite an understanding perspective on their tormenters:

> *I feel that the pressure on labour ward changes people. Midwives are run off their feet and having to teach students as well as protect their registration. Students need certain competencies signed as well as births. I think midwives ... are changed by the pressures and environment. Often, I've had mentors crying to me over the pressure they're under.* (Cathy).

> *Midwives are treated badly by their managers - this filters down to their treatment of students (and women) - the lowest link in the chain* (Clara).

When the units were short staffed, the students in this study frequently spoke of being used as an extra pair of hands to undertake non-midwifery related tasks rather than learning or on occasions were completely ignored as staff were too busy to teach them. Here, behaviour sometimes drifted towards abuse. Niamh noted that *'certain midwives and a team leader exploiting us for free manual labour of mundane tasks, such as photocopying pages, printing, stripping beds... while we're in the middle of something and actually learning'*. Chloe went further, noting that the 'work' she was assigned, like Niamh, whilst being in the middle of a useful learning experience, was assigned with intent to humiliate:

*'After an hour of searching for the missing items (I had been sent to look for), I returned to the office to report this. All present burst out laughing and jeered, "We haven't used those things for ages!".*

### *Proposed solution*

The midwifery students were cognisant of the fact that long term issues related to staffing shortages, recruitment and retention (particularly of senior, experienced staff), skill mix and lack of resources were not easily overcome but did suggest ways that they felt the working environment could in some way be improved to benefit the student experience.

Their accounts clearly implied that additional resourcing, linked to anti-bullying measures, would function to reduce the incidence of bullying. In order to lessen the stress levels of registered midwives and improve their mental capacity to work effectively with students the participants in this study suggested that better support mechanisms needed to be in place for their mentors, in particular they needed better managerial support but also access to counselling services when required.

Stephanie shared '*the midwives are struggling; the managers don't help them or listen to the issues they raise. Midwives working in the hospital need to be able to get support from others to manage their stress, like a counsellor provided by the hospital. I think that would make it easier for us to all work together'.*

The participants also felt that the maternity unit managers needed to foster a better teamwork approach to tackling high workloads, staff shortages and poor skill mix. The students gave examples of certain groups or 'cliques' of midwives only assisting other members of their own groups with their workloads, whilst leaving others to struggle.

*'The culture within the wards of the hospital seemed quite "cliquey" ...some midwives would look out for and help certain midwives and not others'* (Chantelle). This tendency to an enclosed culture with tight interpersonal ties had its organisational benefits and individual (as well as organisational) costs.

Placing restrictions upon both universities and clinical facilities regarding the number of students (if any) they can accept and safely support was suggested by a number of participants. Students suggested that universities should conduct regular audits of placement settings to ensure they provide a safe environment for students and have adequate resources to support effective student learning. *'Hospitals should be made to demonstrate that they have enough staffing numbers and appropriately trained mentors to take students'* argued Kelly, for example.

The role of the university providing students with placements was foregrounded on several occasions by the students. Universities' duty-of-care responsibilities had been annulled:

> *The university is focused on money making, so has multiple cohorts out at once. I don't think the university staff can keep up and give each student the support they need- there are too many of us being shoved through the machinery of training* (Sandra).

### 9.5.3 Theme 3 – Deaf ears

*Cause 4 - No one (with any power) can hear you scream*

The lack of adequate avenues for whistleblowing was a key mechanism the students identified as enabling the replication of bullying experiences. This emerged in two ways. Firstly, the students spoke of missing an *opportunity* for complaint, and secondly, they noted that they feared the *independence* of avenues of complaints that were available. Complaints that were not withheld were expressed with fear of subsequent backlash.

> *'Previous students have [reported], and it has been used against them at a later date. There was no anonymity to the reporting process so students who complained were named and shamed and had a black mark against their name in the eyes of the mentors and therefore nobody wanted to work with the student any more'* (Kim).

Other students had reported bullying to both their university lecturers and/or the clinical managers however with no effect; their reports had either been ignored, brushed over, or the

perpetrators received no punishment for their bullying behaviours, or worse—'*I've reported being bullied on at least three occasions, all with similar results. The culture is to victim blame'* (Layla) and *'we now get joked about and classed as problem students"* (Bethany).

The students perceive that the clinical organisation, particularly midwifery managers, do not feel comfortable challenging or punishing the bullies who are subsequently left feeling that they are 'untouchable'.

### *Proposed solution*

The students argued that 'the system' needs to change so that clear avenues of complaint were created, and publicised, and ideally independent ombudsmen or auditors should handle the complaints process. Students argued for escalation of complaints beyond the maternity unit, where power relations limited formal response. Some suggested escalating their complaints of bullying to the union, the hospital human resources department or even the appropriate midwifery governing body; '*perhaps (we should) involve the ... union rep'* (Melanie) and *'I will escalate these matters to HR and NMC because this is not on'* (Natalie).

Perpetrators needed to be held account:

> *'[Managers must] take matters seriously and even if you suspend these midwives for a few days as they would reflect back and realise how their behaviour is negatively affecting people and how this will cause poor care for women and will eventually be the cause of mortality and morbidity'.* (Zelda)

On a more practical level, the students also felt that the opportunity to provide anonymous feedback on mentors should be available to them. The students are in a position, as students, of being judged, without a symmetrical opportunity to provide feedback on the systems around them. If these systems were highly visible and functional, and allowed complaints to be stored in a database, students argued, the incidence of bullying behaviours would likely be reduced.

*"There's no way students can [provide] feedback on mentors – [if we could] I'm sure there would be a pattern"*

one student, (Leesa) noted. *'I feel like having anonymous reporting of incidences being available for students and staff to access could help raise red flags on people who systematically chose to put others down and make life for students difficult'* (Hannah).

*Cause 5 - Crime without punishment*

Students expressed significant frustration about the freedom from consequences for perpetrators. Students themselves felt that they were closely policed. Minor transgressions had major consequences.

> *'She would come up to me and tell me not to 'f***' things up and would shout at me and other students in front of patients if our knowledge of drugs or pathophysiology was not at the level she rendered acceptable for first year/ second year students'* (Maxine).
>
> *'I used a curved bowl to catch the placenta, for example, as I find they fit closer to a woman and are easier to handle - she yelled at me and made me switch to a square bowl without listening to my reasoning'*. (Clara).

For the perpetrators however, impunity reigned. *'Reported it [being bullied, and], absolutely nothing happened'* (David). *'I feel like it's a known problem. A particular group of midwives that have been allowed to get away with it for so long'* added Chantelle.

### *Proposed solution*

Participants in some cases argued that academic staff which are 'separate' to the clinical context, need to be more formally, regularly present, and involved with students whilst on clinical placement.

> '*Many of my colleagues feel that if the university had a bigger presence at the Trust [UK], that the staff in the Trust would treat us better'* (Sandra).

It was also suggested that midwifery leadership within the hospital needs to be strengthened. Several participants suggested that mangers should have formal qualifications in management or be expected to undertake training in how to manage bullying in their workplaces.

> *'Midwifery leadership whereby if you (a student) bring this to the attention of someone it should be brought further and summoned. The midwife bullying should be questioned and made revaluate her practice and should be reported to the director as you cannot do this to students. I think it takes good leaders in midwifery to do this'.* (Pip).

As noted earlier, one of the factors holding back change was the existing close-knit midwifery culture. In this 'small yet established world', many managers hold previous or have current friendships with perpetrators which placed them in a position of conflict of interest when addressing disciplinary issues. '*It's hard for them as often the managers are close friends of the bullies'*, Sam argued.

Finally, once again the students felt that universities had a key role to play in ensuring that students are adequately prepared for the clinical placement environment, particularly how to respond to and 'manage upwards' bullies and bullying.

> *'Students need to be better prepared for this behaviour. We are all adults and will experience this in our day to day lives but if I had known about how bad it can be (especially being a direct entry [sic] midwifery student and not an RN) it would've made the placement transition smoother. We also need to feel supported and empowered. We need to know we ARE allowed to stand up for ourselves and that this behaviour is not acceptable, and we are allowed to report it if we choose to'* (Penny).

**9.6 Discussion**

Midwifery students' perceptions of what modifiable organisational factors they believe foster bullying behaviours and mapping the possible responses to bullying as perceived by the students themselves has been described and explored. Exploring pathways to prevention, in particular,

has received little research attention to date. It must be acknowledged that this paper is based on the *perceptions* of midwifery students, relatively new to the profession, and not professional analysts of organisational dynamics. It is also important to note that these student accounts may not represent the normative experience of a midwifery student progressing through their midwifery education program: what is largely (but not entirely) missing from these narratives of course is the positive learning and growth experiences of students placed in constructive clinical learning environments. The students that took part in this study are insiders, but new insiders, fresh to the context. It is however important to consider that 'ignorance' has previously been identified as a source of insight into ossified organisational problems, and there is a developing field of agnotology, the study of ignorance including amongst student groups (Thomsen et al, 2020).

This study found that students categorise the causes of bullying into three broad themes. Notably, not all responses could be cleanly categorised as 'organisational' in isolation of other factors (individual and structural)—if by 'organisational' it is inferred that these are issues caused by flaws enclosed in the university or the maternity unit where clinical placement occurs.

Firstly, students saw flaws in the dual role foisted on midwifery mentors: the mentor was expected to teach and support students in addition to their 'day job' as midwifery clinicians. Students observed that mentorship was a role for which some midwives neither had adequate preparation or inclination. Clinical mentors, are generally considered best equipped to teach, support and assess student learning, given that the clinical placement environment is the most appropriate location to develop skills, knowledge and a professional attitude (Liljedahl, Björck, Kalén, Ponzer, & Laksov, 2016). However, this study offers evidence that the position of power and influence that mentors hold is—at least occasionally—abused. The behaviours their mentors displayed often left students feeling belittled, a burden, unsupported and on occasions, unsupervised. Research has previously suggested that having negative clinical mentorship

experiences can adversely impact the learning process and lead to pedagogical breakdown including becoming the target of bullying (Hunter, Diegmann, Dyer, & Mettler, 2008). Conversely, the presence of a mentor as a positive role model has been demonstrated to play a key role in students clinical experiences (Longworth, 2013), development of confidence (Bäck & Karlström, 2020), evidence-based skills (Armstrong, 2010) and positive attitudes towards their midwifery practice (Nieuwenhuijze, Thompson, Gudmundsdottir, & Gottfreðsdóttir, 2020). The students proposed that midwives placed in mentorship positions be given greater support and professional development opportunities and that the mentorship role only goes to midwives volunteering for this task and with proven pedagogical and support skills. A recent study by Gray and Downer (2020) explored the challenges mentors face when working with midwifery students and demonstrated that midwives feel that recognition from their managers of the importance of the mentoring role would be welcomed along with better formal education as often they feel inadequately prepared for the teaching role. Possessing the appropriate pedagogical knowledge and skills to undertake the role of the mentor is vital if students are to develop knowledge, clinical competence and a profession attitude towards the role (Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011). The students also felt that having a succession of mentors required them to repeatedly 'prove themselves' which is time consuming and stressful (Hunter et al., 2008). The students in this study called for greater continuity in mentorship arrangements as a possible way forward.

Secondly, students saw the birth suite as a particularly tight knit and settled 'society' that they were ill-prepared for, parachuted in and out of, with relatively little time spent on orientation. The lack of symmetry between a settled, closed world of interdependent relationships (that included university stakeholders) and the student as a newcomer, was, the students argued, highly problematic. Thirdly, the environment was not just cloistered: it was highly stressful, and many of their clinical mentors and other key stakeholders were underprepared, poorly resourced and subsequently under significant pressure. The students in this study frequently spoke of being

used as an extra pair of hands or as 'free labour' and were removed from learning opportunities to undertake mundane tasks on behalf of overworked midwives. This is not a new phenomenon with research from as early as the late 1990's discussing this issue (Begley, 1999, 2001). Adding to this, students felt at times that the 'cliquey culture' of the maternity unit led to some midwives (including their own mentors) facing higher workloads than others, particularly when other members of the clique assisted their 'friends', but not others. The impacts of a negative midwifery workplace culture and how it affects midwives and midwifery students alike has been previously explored and it has been shown to lead to staff shortages due to attrition, burn out, bullying, and can adversely impact the care provided for mothers and infants (Catling & Rossiter, 2020; Catling, Reid, & Hunter, 2017; Kirkup, 2015; Mollart, Skinner, Newing, & Foureur, 2013). The students perceived that midwives need better support from both their managers and colleagues, and that professional support mechanisms should be made available to them to help manage stress, and teamwork needed to be better encouraged by managers. These findings resonate with others who have explored midwifery workplace culture (Catling & Rossiter, 2020) and have demonstrated that midwives feel that they lack the support of their organisation and managers and teamwork is not encouraged and supported.

The students also saw a role for extended orientation periods for students, perhaps with the opportunity to get to know mentors outside the pressured environment of the birth suite, prior to beginning their placement. Students acknowledged that the pressure emerged at times from under-resourcing (with human resources or otherwise) of the maternity unit, and they called for a greater role for universities in ensuring that clinical settings were 'student ready'. Students perceived universities as being in a conflict-of-interest position in relation to these placements: they need clinical placements to provide students with clinical experience during the course and are sometimes unwilling to disrupt positive existing relationships with hospitals which may subsequently jeopardise these by escalating complaints of bullying.

Finally, the students saw a need to reinforce whistleblowing avenues. Systems for whistleblowing lacked transparency and independence, and there were few clear, well-established consequences or remedial actions for perpetrators. The existing complaint mechanisms lack independence from either the university, hospital, or indeed its staff. No independent ombudsman with sufficient power to act in cases of dispute, currently exists. The students in this study felt that escalation beyond the maternity unit should be encouraged and supported. The students spoke of the perception that bypassing the midwifery unit manager and reporting the bullies directly to the human resources department may increase the likelihood of their complaints being taken seriously, addressed, and actioned. Other students suggested that reporting the bullies to their regulatory bodies such as the Nursing and Midwifery Council (NMC), the Nursing and Midwifery Board of Australia (NMBA) and even the union should be encouraged and supported. They identified a need for greater availability and independence, and a need to ensure a closing of the loop in relation to complaints lodged.

Here again, inadequate training for leadership roles in the birthing suite was raised. By virtue of the fact that many advertised midwifery unit manager or ward sister roles do not require applicants to possess a formal management qualification many midwives in these positions are perceived by the students as being inadequately prepared to effectively manage issues relating to workplace culture and bullying. This is made particularly difficult when the manager has existing alliances with those that they are required to address bullying behaviours with. The students in this study perceived that this again leads to a conflict of interest and a reluctance to address bullying behaviours with midwives. It was also perceived that this was the reason many of their complaints were not addressed and why many felt reporting bullying was fruitless. The students felt that managers needed to have the knowledge and skills to address bullying quickly and effectively and the bullies and their peers needed to be sent a message that bullying is not acceptable. Without this, the bullies perceive themselves to be 'untouchable' and the problem is

allowed to continue. At present, few hospitals have instituted formal feedback mechanisms that encourage the passage of complaints.

Even as 'victims', students felt ill prepared by their university for the experiences they endured and suggested that preparation for dealing with conflict would be beneficial. They suggested that greater bullying awareness training be implemented and saw a need for universities to become more involved in ensuring students were better prepared for the possibility of bullying and procedures to follow should such incidences occur. A greater presence of academic staff in the clinical area was identified as a way forward. It was suggested that having the ability to work alongside members of the academic team and having ease of access to them when they sought support with negative experiences would help strengthen relationships with both clinical and teaching staff. Students rightly see universities as having a duty of care to prepare them for the realities of the clinical environment and its culture. The students who provided data, while providing rich insight into their experiences, it is surprising that accounts of collaboration and support between students in responding to the workplace climate was absent. Peer-to-peer support was absent.

While further research still needs to be done to evaluate the effectiveness of the 'solutions' the students proposed, it is important to note that the students' accounts were not lacking in perspective. They recognised the bind that the mentors were in; under-resourced and underprepared for roles that they were expected to take on in addition to a significant clinical workload. They recognised both their own lack of preparation, and the lack of organisational support for their mentors in the maternity unit. The 'solutions' that the students propose—the need for better structured and visible feedback mechanisms and empowered ombudsmen, greater resources for both students and midwives, greater preparation for students about to enter the professional context for the first time, and greater accountability (and consequences) for perpetrators—have face validity as solutions, but clearly each intervention needs to be

empirically tested. The existing literature from other contexts is suggestive that these proposals have value. There is nuanced literature examining the benefits (and risks) of whistleblowing procedures in the healthcare sector (Rauwolf & Jones, 2019) and scholars have drawn a causal link between under-resourced organisational contexts and bullying (Broeck, Baillien, & Witte, 2011).

### 9.7 Conclusion

Experiencing bullying whilst on clinical placement is known to have significant short-and long-term adverse impacts upon midwifery students. Whilst undertaking midwifery education, students face a multitude of new and complex challenges, and bullying against this challenging background adds to feelings of vulnerability. The project of exploring the efficacy of solutions to this problem within the midwifery education context is for future scholars, and intervention studies are admittedly expensive, both organisationally and financially. The costs of not addressing this issue, however, are also significant. Regardless of who or what is to 'blame'--and the students in this study demonstrated reasonable dimensionality to their perceptions—it is clear that both education providers and health services must play a key role in addressing this serious issue.

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### Conflict of Interest

None declared.

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**9.10 Conclusion and summary**

Chapter Nine has presented the findings of the study that explored midwifery students' perceptions of the organisational factors that foster bullying behaviours towards them and proposed solutions that they feel may help address the issue.

**9.11 Chapter to follow**

Chapter Ten will now present a discussion and synthesis of the study's findings and explores their importance and the implications for the midwifery profession. Chapter Ten will also conclude the thesis and provide a discussion of the limitations of the study, and recommendations for midwives, managers, academics, policy makers and researchers.

# Chapter Ten

# Discussion and conclusion

## 10.1 Introduction

The preceding three chapters of this thesis have presented the key findings from this study, which through the use of a qualitative methodology has provided new understandings and a greater depth of detail of the experiences of midwifery students bullied whilst on clinical placement. The findings of this research are novel, as prior to this study (as identified in the systematic review that forms part of this thesis) very little research had specifically explored the topic of midwifery student bullying. Subsequently, the depth of existing knowledge on this topic and current understanding of how midwifery students experience bullying within this context has been expanded and new insights have evolved. This new knowledge now has potential to help inform practice and interventions that may transform the student experiences of clinical placement and subsequently increase the likelihood of them remaining in the midwifery profession.

This final chapter, Chapter Ten, will now revisit the aims and objectives of the study and the key findings will be summarised, highlighting the most significant aspects of the students' experiences and their implications. Recommendations will be made for midwifery students, clinical organisations and midwifery managers, midwifery education providers, midwifery policy makers, and future researchers. Finally, the chapter will conclude by addressing the limitations of the study.

## 10.2 The research

### 10.2.1 Aims and objectives of the research

This study addressed three broad aims:

The first aim was to generate new knowledge in relation to the experience of workplace bullying amongst midwifery students whilst on clinical placement.

The second aim was to better understand how the bullying of midwifery students can impact the students themselves, clinical organisations, universities, childbearing women, and the sustainability of the midwifery profession.

The final aim was to understand from the student's perspective the perceived antecedents to being bullied and how these may be addressed.

The studies included in this thesis produced a body of findings that addressed the study's three objectives as follows:

1. *To explore and describe whether the age of the midwifery student impacts the experience of being the target of workplace bullying.*

Paper three (Capper et al, 2020a) illuminated how midwifery students from two diverse age groups experience some elements of bullying in the same way, but very differently in others. Midwifery tends to attract a wide variation, in terms of maturity of new students: those who undertake midwifery training either straight out of compulsory education, and those who choose the profession as a second career. This diversity in age, my own anecdotal experiences, and the current lack of research that has explored this factor triggered this choice of analysis. The students in the study provided rich detailed descriptions of their experiences which were thematically analysed to reveal significant broad range of new knowledge on the topic. While the younger students had a power disadvantage, the pattern of bullying behaviours was somewhat similar. The younger students did however experience increased levels of overt and verbal abuse and were more likely to respond in a passive way to the experience than their older counterparts.

2. *To explore and describe if and how the social culture of the maternity unit impacts the midwifery students' experiences of being a target of workplace bullying.*

Paper four (Capper et al, 2021) reported upon how the deeply entrenched maternity unit culture is surprisingly accepting of bullying behaviours and also indicated that bullying is a cyclical process in the clinical context, that is enabled by the presence of ineffectual reporting and inappropriate management systems. This study has confirmed the significant adverse impacts experiencing bullying has upon midwifery students on several personal and professional levels. It was evident that being bullied results in a number of physical and mental health challenges and also leads to students questioning their career choice or withdrawing from their program of study altogether. Moreover, mothers and their families were also witness to, or implicated in the bullying process which impacted on them and their experiences of receiving care as evidenced by the student's descriptions of the events. Finally, bullying adversely impacts the quality of midwifery education and jeopardizes the reputation and future sustainability of the midwifery profession.

3. *To explore and describe whether the students perceive that any organisational factors foster workplace bullying and what they feel could be done to help tackle the problem.*

Paper five (Capper et al, 2020c) demonstrated that midwifery students perceive a range of clinical placement organisational factors fostered the bullying behaviours towards them and enabled their continuation. Ineffective midwifery mentorship, the stressful environment of the maternity unit, and challenges faced with transparency and whistleblowing were all identified as perceived issues. The midwifery students in this study believe that through the implementation of some clinical level organisation changes, the issue of bullying could be addressed, and its incidence decreased.

### 10.2.2 Method

A total of 335 midwifery students located in the UK and Australia responded to a call for participants to take part in a study that aimed to explore the experiences of midwifery students that have been bullied whilst on clinical placement. Data was collected using an anonymous

online survey consisting of demographic and open-ended questions. The approach was designed to protect student identity (particularly valuable since the candidate is a senior midwifery educator with potential power over the Australian-based participants), and also to encourage depth and honesty in responses. Of the respondents, 116 midwifery students provided a full set of data, including responses to all of the open-ended questions and a further 4 completed the majority of the open-ended questions and therefore that data was included in the analysis. The collected data was then thematically analysed using Braun and Clarkes six-stage process (2006). It is noteworthy that the participants generated in some cases over 5000 typed/texted words in response to the questions posed by this study—without any incentive or possibility of reward, due to the anonymity of the context. This in itself indicates the important and contested nature of the topic: students were highly motivated to participate.

### 10.3 Discussion of findings

A summary will now be provided of the study's findings as they confirm and extend existing knowledge. The findings of this research have clearly demonstrated that a wide range of factors play a significant role in midwifery students' experiences of being bullied, and whilst some of these factors were anticipated on the basis of previous research, summarised in the systematic literature review, others emerged during the study. The findings can be broadly grouped into three main categories, however, there is some overlap present. The three main categories are: 'organisational issues', 'individual issues', and 'educational and professional issues (see Figure 5). Each Category will now be discussed in greater detail and integrated back into the literature.

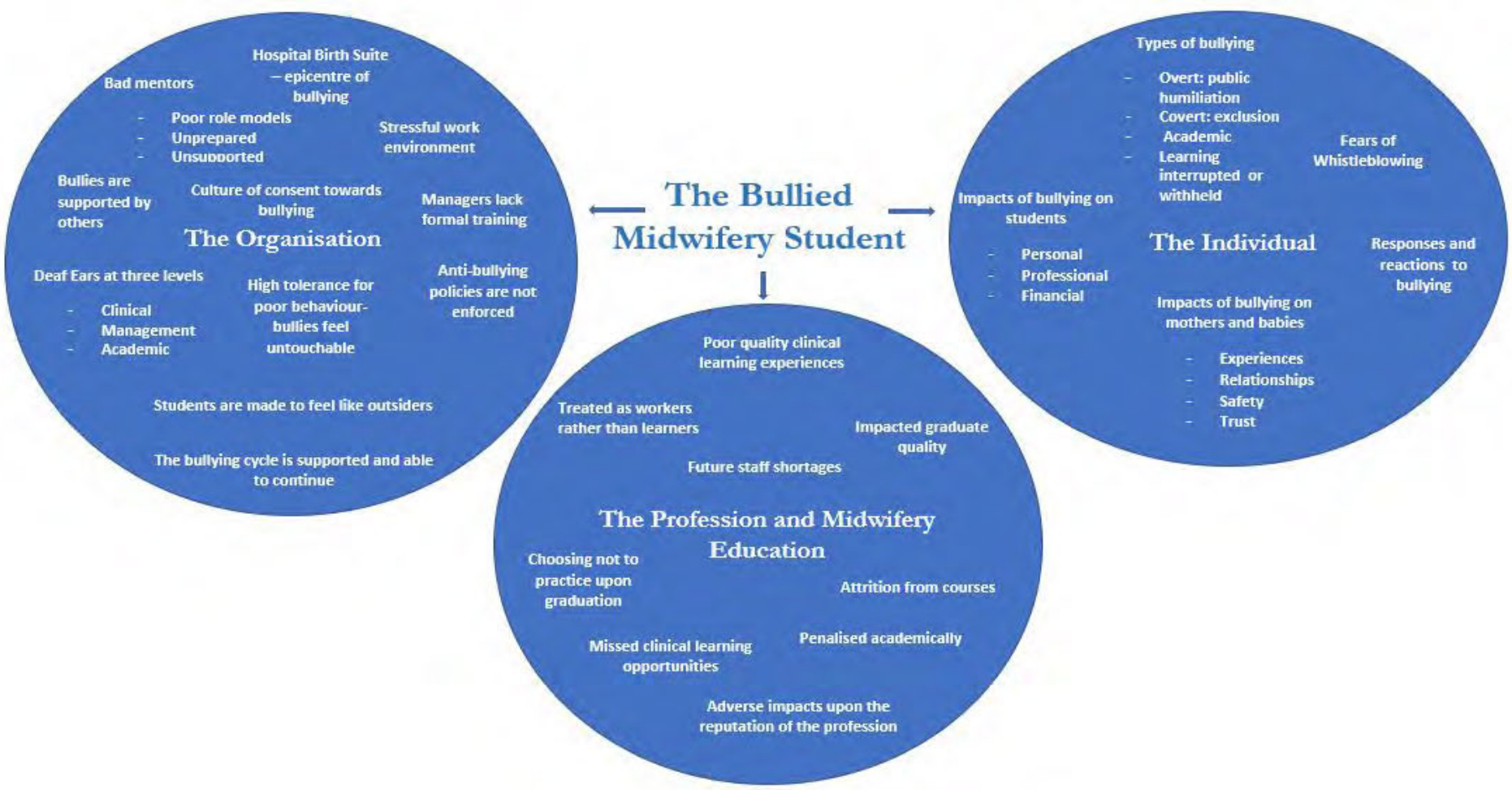


**Figure 5. Three categories of findings**

### 10.3.1 The organisation

The findings of my study have demonstrated how a number of factors at an organisational level impact the midwifery students' experiences of being bullied whilst on clinical placement. The findings demonstrate that in the vast majority of cases, the perpetrator of bullying behaviours towards midwifery students included in this study is a midwife, in particular, the midwife tasked with the mentorship role. This finding was foreshadowed by the systematic review of the literature and supports the earlier work of Gillen (2008; 2009) and Hakojärvi (2014). This study has however elaborated on this existing knowledge by exploring exactly how students are being bullied by their mentors, their perceptions of why their mentors bully them, and the impacts this behaviour has upon the students themselves, their clinical learning experiences, the reputation of the profession, and the mothers and babies they care for.

That mentors were identified as the main perpetrator of bullying is an unfortunate but not entirely surprising finding given that midwifery students spend the vast majority of their clinical placement time with a mentor working across a range of areas within the maternity service. The mentor holds a pivotal role central to the students' education development. However, considering that the evidence suggests that the clinical mentor should be viewed as a positive role model and is deemed the key person to impart a professional attitude (Vinales, 2015) and help students grow and learn (Chenery-Morris, 2014) this is a disappointing finding. The nursing literature has highlighted that the failure to be provided with an effective clinical mentor can have a number of adverse impacts upon the development of student knowledge, skills and confidence, and furthermore can interfere with their feelings of 'belonging' and trust in their mentors, all of which can subsequently hinder their ability to develop the qualities required to practice safely as a graduate (Aston, Aston & Hallam, 2014). Lack of support whilst on clinical placement has been identified as one of the leading causes of attrition from midwifery education courses (Carolan & Kruger, 2011b; Green & Baird, 2009; Hughes, 2013) with first year students

being the most likely to leave (Green & Baird, 2009). This is understandable considering that when entering the midwifery profession, students assume that by enrolling in a midwifery education program, attending clinical placement and being allocated a mentor, they are entering into a 'contract' with those that are tasked with the role of teaching them (Mijares, Baxley & Bond, 2013). This failure of the mentor to fulfil their side of this contract subsequently leaves students feeling disillusioned, isolated, unsupported and unnurtured. (Jack et al., 2017). The findings of my study confirm the impact and add detail to the educational and professional implications. Midwifery students are in great need of robust and effective clinical supervision and support if they are to achieve their course requirements and transition smoothly into the role of a registered midwife. Many of the midwifery students that took part in the study described existing models of midwifery mentorship as dysfunctional, failing to provide appropriate consistent positive role models. They in fact perceived that the provision of positive mentorship and giving clinical care were at times seen as two distinct roles which on occasions, were contradictory. The students frequently spoke of mentors, despite teaching being an integral part of their clinical role, rejecting students or not possessing the appropriate teaching skills required to provide them with adequate opportunities to simultaneously care for women safely and effectively learn. The students believed that many of the mentors they were allocated to work with *did not want to* teach students and felt that their presence, as students, was unwelcome; large workloads, high levels of stress, lack of preparedness for the role, and being poorly supported by both *their* managers and academic staff—this is how the students saw their mentors' dilemma. Again, this finding was consistent with the results of Gray and Downers' (2020) study that reported similar sentiments after interviewing a group of midwifery mentors about their experiences of undertaking the role. This supports the findings of Licqurish and Siebold's (2008) study where students felt like an inconvenience due to midwives asking each other in front of the students '*who wants the student?'* . Research has shown that the mentor that the student works with on each shift has a significant impact upon the quality of student learning and students

frequently refer to mentors as being either 'good' or 'bad' (Gilmour, McIntyre, McLelland, Hall, & Miles, 2013). It is important to note that even some of the students in my study (that took part in the study because they had identified themselves as having experienced bullying) nevertheless *did* on occasions refer to having worked with some great mentors whilst on clinical placement and felt that the ability to be consistently placed with those midwives would have improved their experiences significantly. However, in contrast to this a greater number of students spoke of being relieved that when placed with a 'bad' mentor, they may be working with a different person on their next shift and this in fact kept them going. The provision of continuity of mentorship has been identified as the gold standard and it can certainly be agreed that where a positive dynamic exists it provides a positive way of strengthening the relationship between the midwife and student which in turn promotes the learning process, and the development of confidence, skills and knowledge (Chenery-Morris, 2014). The NMC (2018c) support this by stating that whilst students are in clinical practice there should be continuity of support to ensure that students experience safe and effective opportunities to learn.

It is clear however from my study, that when a poor relationship exists, continuity is not the key to successful learning. Having a poor relationship or negative experiences with a clinical mentor can lead to pedagogical breakdown which often includes becoming the target of bullying (Hunter, Diegmann, Dyer, & Mettler, 2008), a finding which frequently arose and was supported by my study. Brunstad and Hjälmhult (2014) state that in order for midwifery students to commence the learning process, they needed to feel accepted by their mentor, and acceptance was vital in order for learning to be effective. Therefore, if continuity of mentorship models are to be considered standard practice in the future, the findings of my study suggests that mentors must be properly prepared, orientated and supported to undertake this role effectively, and their commitment to this role must be recognised by their managers.

Another interesting element of the findings that related to the mentorship role was, despite students frequently referring to undertaking placement across all types of maternity services and within a number of different models of care, when poor experiences with mentors occurred, they generally took place within the context of the hospital setting, in particular the birthing areas. To date there has been no literature that has demonstrated a clear association between increased levels of bullying behaviours towards students within the hospital setting, specifically the birth suite as opposed to the community or within group practice settings. This is therefore new knowledge that would benefit from further exploration. Research has however demonstrated a link between midwives working in continuity models of care and lower levels of burnout and increased job satisfaction compared to those working within the rostered hospital context (Newton, McLachlan, Willis, & Forster, 2014).

The findings presented in Capper et al (2020c) related to possible factors that foster bullying behaviours were presented and stress was identified by the students as a perceived antecedent. The presence of high levels of stress when working in the hospital setting may provide a possible explanation for the more frequent episodes of bullying behaviours taking place compared to the community or within continuity models of care. Another potential explanation for increased levels of bullying occurring within the hospital setting is that midwives are more comfortable behaving inappropriately when they are surrounded by known and supportive colleagues, whilst being comfortably located inside in their 'home environment'. To date, no midwifery-specific research has explored this concept, however, research within child populations has demonstrated that bullying behaviours are more likely to occur when they are endorsed by peer group 'norms' and therefore the bully feels more comfortable whilst enacting the behaviour (Duffy & Nesdale, 2009).

This theory is also in alignment with the students in my study's reports of midwives often operating in 'teams' when bullying students or drawing other midwives in to support them

during an attack. The process of 'buying in' supporters during a bullying incident is yet to be explored within the midwifery unit, however, within the broader non-clinical context it is known that bullying often involves more than just the bully and the bullied person and that bystanders also are involved and have a key role to play regardless of their response to the incident (Sandstrom et al., 2013). Often however, like in our study, bystanders feel reluctant to intervene or defend the bullied person due to the perception that there is a network of support for bullies (Pozzoli and Gini, 2010), or as stated by my participants, they fear being the bully's next target.

The students frequently described feeling like an outsider in the hospital and that the bully was surrounded by his or her friends ready to back them up and help 'cover their tracks' which meant that the behaviour was able to continue without being challenged. As a result, the bullies perceived themselves as being 'untouchable' and this therefore fuels the bullying cycle's ability to continue. Begley (2001b) has previously explored midwifery students' experiences of becoming a midwife and identified that they are frequently made to feel like outsiders that quickly realise that being accepted into a culturally entrenched workplace is fraught with challenges that often left them feeling dehumanized and at times humiliated.

My study has identified that students perceive bullying to be a 'normal part' of midwifery culture and this was due to the strong degree of acceptance of bullying behaviours towards both midwives and midwifery students which was seldom challenged. As discussed in Chapters One and Two of this thesis, over the past couple of decades research has emerged that has reported upon the poor midwifery culture that is present in maternity units and bullying behaviours are sadly seen as an inherent part of this (Catling & Rossiter, 2020; Catling, Reid, & Hunter, 2017; Hadkin & O'Driscoll, 2000; Hastie, 1995, 1996; Leap, 1997).

It would appear that midwifery students too are being initiated into this culture. As far back as 2001 Begley reported that there is an unspoken expectation that midwifery students are used as and when required to meet the needs of the unit which often resulted in them being ordered

around and expected to take on the dirty work. Furthermore, students were kept in line by a number of publicly enforced rules and regulations such as which chairs they are allowed to sit on and when and where they were allowed to take their meal breaks (Begley, 2001b; Gilmour et al., 2013). In my study, the students spoke of such treatment going unquestioned as it was perceived to be a way of initiating students and getting them to conform to existing culture of the unit: rather like studies of hazing in professions such as policing (Steinþórsdóttir & Pétursdóttir, 2018), bullying was recast as giving students a realistic induction to their new work context. My findings showed that this failure to address the bullying behaviours towards students did not just sit with staff working at the clinical level, other key stakeholders also had a key role to play in acting to address this behaviour and subsequently breaking the bullying cycle.

My study illuminated the sense that the failure to act on bullying, disappointingly occurs at three distinct levels: clinical, managerial, and academic. As stated earlier, midwifery students, from the outset of their courses are being immersed in a clinical contextual environment where a culture exists that is accepting of bullying behaviours. The bullies often brazenly express their feelings towards the students in front of other staff and even women and their families with little consideration or care given for the potential repercussions.

When bullying behaviours occur blatantly in front of others, are accepted, and go unchallenged, this was perceived to further enable and encourage repeated behaviour as this sent a message that bullying is acceptable as there are no ramifications or consequences for their poor behaviour. As mentioned earlier, often the perpetrators operate in groups or encouraged other midwives to join in, or the witnesses to bullying simply ignored what was going on and failed to step in to support the student. This culture of acceptance led to the students perceiving that bullying is 'just an inherent normal part of midwifery' which in turn increases the chances of the problem being replicated, perpetuated the bullying cycle, and decreased the likelihood of the students escalating their concerns to academic or managerial staff.

This entrenched culture of acceptance impacts the student's educational experiences, the care received by mothers and babies and the reputation of the midwifery profession. It is important to note that quality of care was not measured in this thesis, and it was only students' perception of flow-on effects of bullying and their implications for mothers and babies, that was analysed—not reality of quality of care. A number of the students in my study had considered reporting the bullying to midwifery managers and their academic staff but were fearful of the potential risks of doing so. The students spoke of others that had reported and had had their complaints were ignored, or things got a whole lot worse for them as they were labelled troublemakers, and this led to their own fears of 'rocking the boat'**.** The students spoke of not knowing who to trust and having no safe place to go, with many subsequently choosing to lean upon their family and friends for support and guidance. No research to date has specifically reported upon midwifery students' experiences of officially escalating complaints to those in a position of power with the ability to address the issue, however Gillen et al., (2008) did speak of students putting up with bad behaviour so not to risk their assessment marks or future job opportunities.

Of the students in my study, those that did pluck up the courage to complain often found that their voices were left 'unheard' with mechanisms set up to offer students an opportunity to report issues either left unused, or when used, led to the students experiencing a lack of adequate resolution. Amongst the insights here is the finding that students saw the 'alliance' between tertiary education providers and the clinical setting mitigated against action on bullying complaints. The important bilateral relationships between hospitals and higher education providers took precedence too often. As a result, the students felt powerless and trapped and felt the only solution may be to escalate the issue outside the maternity unit and the university to the hospitals human resources department or the national governing bodies. Since the students have learnt that the codes of conduct have sections that specifically refer to bullying, they felt that these may help provide a solution. The students felt that a way of providing both managers and academic staff with anonymous feedback on their mentors would be a step forward,

however there was some uncertainty around whether such feedback would be taken onboard and addressed appropriately due to many managers being poor at managing bullying within their units. The reason for this was perceived to be due to midwifery managers lacking leadership skills, having little formal management training, lack of knowledge around how to manage bullying, and having existing relationships with the bullies that they are hesitant to disrupt. Currently it is not considered mandatory for clinically based managers to possess formal management qualifications and this led to the students questioning their suitability to the role, particularly when issues related to managing bullying behaviours arose. This failure to act demonstrated to the students that there is a high level of tolerance for unprofessional behaviour in the clinical workplace and managers are in need of education and support to effectively address this chronic issue. Whilst bullying is occurring in an environment like this where the bully feels safe from consequences, the bullying cycle can continue to self-perpetuate leading to attrition which has potential to result in a lack of graduates to staff maternity units in the future.

### 10.3.2 The individual

This study has revealed a detailed understanding of the ways in which two distinct groups of individuals are impacted by bullying behaviours directed towards midwifery students. The first group are midwifery students themselves who are impacted on both personal and professional levels; however, mothers and babies can plausibly experience collateral impact. Mothers and babies may suffer adverse impacts to the standard of care they are provided with: their childbearing experiences may be tainted, and their relationships with the midwifery student are disrupted. Again, it is important to underline that this study dealt with student perceptions, and was not focused on mothers' experiences.

Being at the bottom of an established hierarchy, midwifery students are seen to be at a natural disadvantage (Curtis, Bowen & Reid, 2007). This is mainly due to the significant power disparity and the students poorly developed resilience skills which in turn leads to them being left in a

vulnerable position and unprepared to deal with bullying (Crampton, Wilkinson, Anderson, Walthert & Wilson, 2015). The students in my study described both overt and covert behaviours that led to them becoming distressed. Chapter Seven of this thesis has already presented the interesting findings of this study that related to how midwifery students from diverse age groups experienced and responded to bullying differently. It appeared that the age of the student mediated or impacted the way in which they are bullied. From the students' accounts it was interpreted that the younger students appeared to be targeted in more overt ways such as being yelled and screamed at or openly mocked in front of others, whilst the more mature students reported more covert and 'strategic' behaviours such as exclusion from the group, being left alone in a situation where they felt out of their depth, being undermined, not being offered tea breaks, and in some cases, complete ostracization. With the midwifery profession, often seeing an intake of two distinct cohorts of students—students choosing midwifery straight out of high school, and mature age students, or nurses, choosing to undertake midwifery education—these findings are valuable for tailoring support for students entering the maternity clinical placement setting for the first time.

However, regardless of the age of the student, as stated earlier, bullying behaviours are often enacted quite brazenly, in front of other staff members, students and women and their families. This leaves the bullies feeling a strong sense of power and they perceive themselves as being 'untouchable' which further fuels the issue. Brazen bullying also sends a non-verbal message to the victim about the relative confidence and power of the bully over the victim. Turning back to the previous section briefly, it is this message that likely helps suppress whistleblowing and has serious potential psychological implications for the victim. It amplifies their sense of isolation and increases the probability that the student will be left feeling like *they* and not the perpetrator, are the problem. It is noteworthy that in the UK, formal mechanisms for whistleblowing are in place to a greater degree than in Australia, but these pathways are still policed by the midwifery hierarchy. Sir Robert Francis in his *Freedom to Speak* Up report (2015) talks of creating "the right

conditions" for staff to speak up. The evidence collected in this thesis suggests that the right conditions still do not exist in the UK.

The focus of impact-related bullying research particularly in the very narrow sector we are examining here (midwifery students) has, not surprisingly been concentrated largely on the direct student impact. However, this project has revealed that students perceive that mothers and babies are also at risk as a result from the culture associated with bullying. For example, students reported being left alone with labouring mothers whilst their mentors sat and drank cups of tea and chatted. The students spoke of experiencing a sense of bereavement when they were removed from opportunities to care for their continuity of care women when asked to undertake photocopying or cleaning – particularly if it meant that they missed being present for the birth, but these impacts would of course also be experienced by the mothers themselves. Earlier research by Begley (2001b) has previously explored the experiences of students undertaking their midwifery education in Ireland, revealing how students are often used as workers and this in turn impacted their abilities to develop their skills and knowledge. These secondary impacts of bullying clearly deserve further exploration.

There is a plethora of research that has explored the personal impacts of bullying within a range of contexts, and this thesis adds to that body of work, however, in a very specific workplace context. As with other bullying research, the victims experience a range of emotions and responses to being bullied and not all of these consequences are concurrent with the act of bullying.

The students in my study highlighted how they moved through a range of emotions at each stage of the bullying experience which finally left many facing a number of long term physical and emotional challenges. Immediately after the event, many students described a sense of anger and would be driven to tears, with many stating that they regularly cried all the way home from shifts. Some of these emotional responses became chronic for the students in this study with many

reporting feeling physically ill with both physical and mental health challenges as a result of bullying. A very small number of students in this study referred to feeling suicidal and needing to seek a psychiatric assessment. The physical illnesses described led to dreading and/or placement avoidance which then subsequently resulted in a further decrease in the student's clinical confidence and skills.

The students expressed a sense of grief for their dreams of what they thought becoming a midwife would be. Many were shocked that a profession that was supposed to be about caring for others was full of so many people that either are bullies, support bullying or simply turn a blind eye. Many students had prior perceptions of the profession and felt that these were destroyed after just a few clinical placement shifts. Frequently the students recalled being humiliated in front of other staff, students and mothers and their families. In fact, in some cases the women or their family members stepped in to protect them. This was particularly embarrassing for the students when the mother was one of their continuity-of-care experience women that they had grown to know well and has developed a professional relationship with.

Longer term, the students described how being bullied in front of women and their families adversely impacted their confidence levels and set their learning back. They felt a sense of shame and wished that they could respond but felt silenced due to risk of further backlash or harsh assessment.

As stated earlier, to date little research has explored how midwifery students being bullied impacts the women they are caring for. However, there is significant amount of literature that has demonstrated the adverse impact that bullying has on the quality of patient care within the broader medical and nursing contexts (Houck & Colbert, 2017; Laschinger, 2014; Francis, 2013). My study has revealed new knowledge about how midwifery students being bullied might impact the care provided to mothers and babies on a number of levels. The students in this study shared their experiences of mothers being used as props for bullying and frequently witnessing episodes

of bullying which made the women feel uncomfortable and embarrassed – this was evidenced by the fact that they or their support persons made comment about how rude the midwife had been to the student and offered to step in and confront the bullying midwife. The participants also spoke of being left alone with women requiring complex care and were fearful that they would not recognise a potential emergency situation should it arise. Women were also reported to be placed at risk when they were used by midwives to prove a point, for example, the students shared experiences of witnessing care by midwives that bordered on assault which understandably had an adverse impact upon the woman's experiences. In addition to this, as mentioned earlier, students described being deliberately called away from providing care to their continuity of care women which interrupted the known support they were providing to the woman and her family. The importance of having known and continuous support during labour and birth has been well reported in the literature (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017). This review supports the student's belief that the deliberate and unnecessary interruption of this established relationship would have a number of adverse impacts upon the woman and her family. The students feared that as a result of this intrusion, their relationships with the women would be undermined and that this could potentially impact women's confidence in the students' abilities and the standard of care they were capable of providing.

### 10.3.3 The profession, and midwifery education

As noted in the previous section, the impact of a midwifery student being bullied in the maternity care setting ripples out well beyond purely at the student level, and this thesis has identified a number of educational and professional impacts. It has been highlighted by this study that bullying behaviours have an impact upon the quality of midwifery education and the reputation and sustainability of the midwifery profession. The quality of midwifery education compromises graduate quality, and also poses a threat to retention. This in turn will result in a depletion in the number of registered staff available to fill midwifery positions in the future.

Furthermore, such a shortfall will lead to impacts on existing staff (in terms of workload) and quality of care, and the future sustainability of the profession.

Experiencing bullying behaviours directly colours the pedagogical experience of students. Students reported experiencing bullying by mentors who deliberately withheld or altered learning experiences as an exercise in wielding power. At times (but not always) these bullying behaviours were packaged as organisational demands. Students were assigned menial tasks or were designed to lighten the workload of the midwife they were working with. Students reported feeling they were filling a dual role – one of midwifery student and one of cheap or free labour – it all depended upon the needs of the unit at that time and attitude of the midwife that were working with.

In some cases, the conduct of bullying even at a surface level had no workplace or organisational justification. Students reported feeling humiliated by for example the requirement to conduct trivial and meaningless tasks which had neither workplace or pedagogical value: the students experienced a constant 'moving of the goalposts', chastising them for very minor errors, deliberately dropping items onto the floor and telling them to pick them up, making students search for items in cupboard whilst they watched, hurrying along as they went, and sending students to search for items that do not exist.

The 'tools' of bullying were workplace-related, but there was no pretence of the tasks having a value beyond the exertion of power. This study has demonstrated that midwifery students' experiences lead them to respond in ways that should be of serious concern to the profession. Some of the midwifery students expressed a sense of determination not to let the bullies win so decided to push on and complete their studies despite their experiences with a goal of becoming team leader to improve things for the next generation of students. This 'lemons to lemonade' response may be of some comfort to those taking a panoptical view of the state of the profession, but it is clearly not ideal. Others felt a responsibility to complete their course to set a

good example to their children – no matter how awful things were, they just kept going, particularly as many were now in debt and has spent a great deal of time away from their families in pursuit of the dream of becoming a midwife.

The impact of bullying can thus be seen to, counterintuitively, have positive impacts, if a cohort of students are energised to change the culture of clinical contexts when they, in turn, rise to positions of influence. However, there is also a body of research showing that the opposite happens: students exposed to bullying are more likely to replicate those behaviours and continue to enact the institutionalised behavioural norms (Begley, 2001b). At the least, it can also be assumed that students that do not receive high quality midwifery education are more likely to be unprepared for clinical practice, more likely to experience burn out, and under conditions of stress provide a suboptimal placement experience to the next generation of midwifery students.

Hirschman's (1970) influential work has been taken into a broad range of workplace contexts, showing that a common response to distortion of employee voice and by implication harassment is to exit the organisation/profession. This current study notes that 'exit' may be an extreme response to workplace bullying, but it is not rare. The cost to midwifery of exit as a response to the workplace bullying of midwifery students is very high, particularly considering that midwifery education costs within the profession are high, and the loss of potentially empathic and skilled future midwives can be measured in the welfare of mothers and babies.

Even if the majority of midwifery students choose to stay, there are still serious implications for the profession. The students reported being worried that being bullied in front of the women had undermined the woman's confidence in them and would lead mothers to question the standard of care the student was capable of offering. At times, the students were not left in doubt: mothers openly expressed concern about the treatment of the students to the students. My data found students frequently reported being asked where the supervising midwife was and would overhear the woman discussing this with her partner or family. Mothers appeared

shocked and upset by the treatment of the student. This led to the mothers voicing disappointment and decreased trust and confidence in the midwives caring for them and saying that they planned to make a complaint. It can also be assumed that the women and her family would then proceed to discuss their experiences with others including other maternity care consumers in either online or face-to-face parents' groups.

In summary, my study demonstrates that bullying occurring towards students within the clinical workplace adversely has significant impacts in the pedagogical and professional sense: it impacts the quality of midwifery education, the reputation of the profession, the likelihood of student progression and the experience of mothers and infants. It adds to studies indicating pedagogical breakdown whilst working with poor role models and witnessing non-evidence-based care (Bluff and Holloway, 2008; Armstrong, 2009), As noted earlier, to date no research has been undertaken to explore how bullying impacts the COCE relationship between mothers and students and clearly further research is required in this area.

The impacts of bullying highlighted by this study may place the future sustainability of the midwifery profession at risk, particularly if large numbers of students choose to withdraw from their courses or choose not to practice upon graduation. There is potential that this will lead to a decrease in the number of practising midwives and subsequently a shortage of staff. If the United Nations Sustainable Development Goals are to be achieved this issue must be overcome as a matter of priority.

### 10.4 Limitations and recommendations

The role of the university when the student is experiencing bullying 'off campus' is conflicted. The university is well positioned to act as 'referee' but is critically dependent on maintaining positive relationships with clinical facilities to ensure the provision of placements (and associated mentorship) in order to be able to provide midwifery education courses. Conducting research on bullying presents major methodological challenges, particularly when the researcher (as was the

case in this study) is embedded in the system that is thought to at least partially engender bullying. Qualitative researchers are often placed in positions that challenge their own perspective and their own involvement in the 'object' of research, however, bullying presents challenges that amplify the difficulty of analysis.

This study was a qualitative study and was thus not able to objectively begin to answer questions related to capturing for example, the financial cost of bullying of midwifery students, let alone the prevalence of bullying. As a qualitative study, it speaks to the lived experience of the students who participated, and while the studies such as the current study are able to suggest how variables such as age and gender interact to reduce or amplify the prevalence or impact of bullying, they can only form the basis of designing interventions with a number of important codicils. Designing interventions on the basis of research, particularly when the stakes (as in midwifery) are high, needs to be done with sensitivity and care. A closed system such as the small organisational setting of the maternity unit can react in unexpected ways (Harris & Ogbonna, 2002); while the researcher may not be ultimately directly 'responsible' for any particular unintended consequence, they may well be seen as directly responsible or at the very least, part of the problem. Conducting research on the past avoids this ethical dilemma: exploring secondary data to see what happened when organisations of their own accord (rather than a researchers') intervened to alter bullying behaviours is a partial solution, but studies of the past do not offer the control of variables required to make determinations about causation. Some of the questions that were largely left untouched by this project are important questions: who *wasn't* bullying—what are the characteristics of those who are able to act in a functional positive way as mentors in a high stress small organisational context where bullying and maladaptive behaviour in general is often surprisingly consequence-free. Where was bullying *not happening*? It is noteworthy that students did *not* mention bullying in the Midwifery Group Practice context or the community, and while I did not explore this aspect in this study, it is likely that the reputational damage of bullying within the maternity units is leaking beyond the

boundaries of the hospital into the increasingly common 'safe spaces' of social media and parents' groups. How does the race or ethnicity of the student influence the ways in which they are bullied? None of the students in this study referred to experiencing any type of racial abuse. There are a number of comparison studies that present themselves as obvious next steps: how does midwifery compare to nursing in terms of its treatment of students—is midwifery worse, and if so, how, and why? Does genderplay a significant role in altering the likelihood or consequences of bullying ? Does the race or ethnicity of the students' or the women the bullying is occurring in front of impact how it is being conducted or its impacts? Does the size of the unit have an impact? Does the question of whether the student is an undergraduate or a postgraduate alter the experience? Does experience in other work or clinical settings play a role? And finally, while the study touched on the difference between the UK and Australian experience, understanding how the regulatory context, the broader cultural context and traditions of midwifery education impact on the nature of bullying is clearly a project of value to the profession. If it were possible to identify national contexts that were less likely to lead to bullying of midwifery students, this would open up avenues for change, with the important proviso that holistic context (not just organisational or regulatory context for example) can influentially alter how an intervention plays out.

With these limitations in mind, in conclusion, a number of recommendations for midwifery students, clinical organisations and midwifery managers, midwifery education providers and policy makers are worth advancing, with the codicil that these recommendations emerge from a qualitative study with the inherent limitations of that study. These recommendations are intended to facilitate better educational experiences for midwifery students with an aim of retaining students in the profession and should be viewed as a step towards breaking the bullying cycle.

### 10.5 Clinical Organisations and Midwifery Managers

This study has highlighted how midwifery students perceive that several potentially modifiable organisational factors exist which either lead to or exacerbate the likelihood of them being the target of bullying whilst on clinical placement.

#### 10.5.1 Recommendation One

Staff should be required to attend in-service training, with a focus on a range of areas with pertinence to reducing the prevalence of bullying in the maternity environment. This includes the potential professional impacts of unprofessional behaviours in the workplace including implications for their registration, and training on how to provide mentorship in the midwifery context. Mentors should be provided with adequate orientation to the role and have an awareness of the student's clinical requirements.

#### 10.5.2 Recommendation Two

Midwifery managers and educators (where appropriate) should only be recruited to such roles if they possess the appropriate skills and knowledge to manage workplace conflict or must be provided with training as a condition of appointment to a management role.

#### 10.5.3 Recommendation Three

Clinical organisations need to provide ease of access to professional counsellors to help midwives manage the stresses that arise from working in an inherently stressful and fast paced working environment. The opportunity to debrief with their peers and managers should also be supported.

#### 10.5.4 Recommendation Four

Midwifery students should be provided with a 'safe place' to voice their issues in confidence with organisational staff demonstrating an awareness of the power imbalance and how this may impact the reporting of issues. Students should be provided with the opportunity to provide

anonymous feedback on mentors and feedback should be heard, acknowledged, and professionally addressed. This should ideally occur after each placement in each clinical area.

### 10.5.5 Recommendation Five

Complaints of bullying should be automatically followed up and addressed, and when the quality of care delivered to mothers and babies has been impacted this must be formally actioned and escalated. Input should be sought where appropriate from the regulatory bodies such as the Nursing and Midwifery Council (UK) or the Nursing and Midwifery Board of Australia. Records should be kept by the organisations' Human Resources department relating to accusations of bullying and officially addressed. Staff must be made aware of the professional consequences of bullying and it is therefore vital that policy is consistently followed without exceptions. Perpetrators need to recognise that bullying behaviours will not be tolerated in the workplace and that action will be consistently taken against them.

### 10.5.6 Recommendation Six

Staff rotation should be implemented and mandated for all staff regardless of seniority, to ensure that inappropriate behaviour does not develop in a 'safe space' of familiar or interdependent colleagues. By rotating staff, it is less likely that staff develop the sense of invincibility that emerged in the accounts given by the students in this study.

### 10.5.7 Recommendation Seven

Organisations should provide and publicise to students an avenue for complaint that is distinct from the organisational structure, that will enable them to whistleblow in a 'safe space'. These avenues should be connected with effective, fast mechanisms of investigation, support, and redress.

### 10.6 Midwifery Students

#### 10.6.1 Recommendation One

Midwifery students should keep contemporaneous, clear, concise, and objective records of their experiences should they be required at a later date.

#### 10.6.2 Recommendation Two

Midwifery students should seek appropriate support and or counselling when appropriate. This may be in the form of family and friends, a professional advocacy or counselling service, or the family doctor.

#### 10.6.3 Recommendation Three

Students should provide clear concise feedback on their mentors, and give where possible, examples of positive and negative experiences. This feedback should ideally be provided to both midwifery managers and academic staff placing students in maternity services for clinical placements.

#### 10.6.4 Recommendation Four

Students should seek opportunities to find out as much as possible about the new clinical placement setting before starting. Seeking opportunities for orientation, speaking to peers and academic staff prior to commencing placement is beneficial as this reduces the feeling of 'newness' and unfamiliarity with the unit.

### 10.7 Midwifery Education Providers

The following recommendations are drawn from the broader implications of this thesis: that several modifiable organisational factors exist that either lead to, or exacerbate, the likelihood of midwifery students being the target of bullying whilst on clinical placement. The following recommendations focus on these modifiable factors.

### 10.7.1 Recommendation One

Midwifery education providers should ensure that they seek clinical placements in areas that have the organisational capacity to provide adequate pedagogical support and are able to nurture students' learning.

### 10.7.2 Recommendation Two

Education providers should ensure that they work in partnership with clinical organisations to provide education and support to mentors. This should include education on student needs, their clinical requirements and if required, adult education theory.

### 10.7.3 Recommendation Three

Processes need to be put in place to enable students to provide feedback anonymously on mentors and ensuring all feedback is addressed with midwifery managers in a timely manner. This should ideally occur after each placement in each clinical area to ensure all feedback can be promptly actioned if necessary. Improved levels of collaboration between academia and industry may be necessary to facilitate this.

### 10.7.4 Recommendation Four

Education providers should offer a 'safe place' for students to voice their issues without fear of repercussions or backlash. This point was addressed in Section 10.5.7.

### 10.7.5 Recommendation Five

Academic staff should have a stronger presence and be visible in the clinical areas on a regular basis. This gives students the opportunity to report issues promptly and for them to be addressed. This also serves to strengthen inter-collegial relationships between clinical organisation and academic staff.

### 10.7.6 Recommendation Six

Adequate counselling services should be free and easy to access for academic and clinical facilitation staff.

### 10.7.7 Recommendation Seven

Midwifery education providers should aim to prepare students for managing challenges faced in the workplace. This should be through the development of the student's skills in resilience, having difficult conversations, assertiveness and by reassuring them that they should report to either the university or midwifery unit manager if they feel they are being bullied. Students should be told that they will be fully supported during this process.

### 10.7.8 Recommendation Eight

Academic staff should try where possible to provide students with preplacement orientation to ensure they are familiar with the staffing structure, shift processes, the location of equipment and layout of the unit.

## 10.8 Midwifery Policy Makers

### 10.8.1 Recommendation One

Anti-bullying policies must encompass the student role and not just registered staff regardless of whether they are undertaking placement in a paid or a supernumerary capacity.

### 10.8.2 Recommendation Two

Consideration should be given to the sections of the Nursing and Midwifery Board of Australia/Nursing and Midwifery Council (UK) codes of conduct that refer to bullying and this should be incorporated into anti-bullying policies and enforced as appropriate.

### 10.8.3 Recommendation Three

Policy makers should develop policies that states that midwives undertaking the mentorship role must possess adequate preparation for the role or be prepared to undertake relevant training.

### 10.8.4 Recommendation Four

Policy makers should develop policies that states that midwives undertaking the management roles must possess formal qualifications for the role or be prepared to undertake these.

### 10.9 Final conclusions

These recommendations are relatively 'safe' recommendations, but while simple on the surface, may prove complex to implement due to the complex social and organisational systems that surround midwifery education. This study reveals not just patterns of bullying of students, and potential antecedents and consequences, but also illustrates the interconnected nature of relationships between the stakeholders. Universities may 'wish' to act on behalf of their students' welfare, but in effect may hesitate due to consequences on important relationships with clinical placement providers. In addition to this overarching conflict of interest, within the clinical setting there are personal relationships that build over time which compete with the relatively transient relationships with students. The importance of these long-term connections may well outweigh, in either the perpetrators or the bystander-staff's minds, the relatively short-term obligations to an individual student.

Rather than offering an innovative solution, these recommendations often conform with the stated expectations of tertiary education providers and training facilities, as well as codes of conduct. That does not imply, however, that these recommendations are currently already being acted on. There is a substantial literature on the vast difference between written policy and regulation and enacted behaviour (e.g. Elliott, 2014). Despite the difficulty of bringing about change in an organisational context, and the potential impacts of unintended consequences if interventions fail to deliver, the treatment of midwifery students must change. The WHO has identified that making improvements to the standard of midwifery education across the world is a global priority (WHO, 2019), a move that recognises the critical role the midwifery profession plays in supporting improved health outcomes for mothers and babies. It is worth noting, again, that the voice of mothers and their families in missing in this thesis, and the midwifery profession needs to ask itself whether that voice is sufficiently taken into account when designing maternity services. It is said that with great power comes great responsibility. The

midwifery profession has power, but that power is compromised by its status within the hospital organisational context. Its responsibility, however, cannot be compromised.

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# Tables and Figures

**Table 3: Criteria used to determine Methodological Quality of Papers**

Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong et al., 2018).

| **Category of study designs** | **Methodological quality criteria** | **Responses** | | | |
|---|---|---|---|---|---|
| | | Yes | No | Can't tell | Comments |
| Screening questions (for all types) | S1. Are there clear research questions? | | | | |
| | S2. Do the collected data allow to address the research questions? | | | | |
| | *Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.* | | | | |
| 1. Qualitative | 1.1. Is the qualitative approach appropriate to answer the research question? | | | | |
| | 1.2. Are the qualitative data collection methods adequate to address the research question? | | | | |
| | 1.3. Are the findings adequately derived from the data? | | | | |
| | 1.4. Is the interpretation of results sufficiently substantiated by data? | | | | |
| | 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation? | | | | |
| 2. Quantitative randomized controlled trials | 2.1. Is randomization appropriately performed? | | | | |
| | 2.2. Are the groups comparable at baseline? | | | | |
| | 2.3. Are there complete outcome data? | | | | |
| | 2.4. Are outcome assessors blinded to the intervention provided? | | | | |
| | 2.5 Did the participants adhere to the assigned intervention? | | | | |
| 3. Quantitative non-randomized | 3.1. Are the participants representative of the target population? | | | | |
| | 3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? | | | | |
| | 3.3. Are there complete outcome data? | | | | |
| | 3.4. Are the confounders accounted for in the design and analysis? | | | | |
| | 3.5. During the study period, is the intervention administered (or exposure occurred) as intended? | | | | |
| 4. Quantitative descriptive | 4.1. Is the sampling strategy relevant to address the research question? | | | | |
| | 4.2. Is the sample representative of the target population? | | | | |
| | 4.3. Are the measurements appropriate? | | | | |
| | 4.4. Is the risk of nonresponse bias low? | | | | |
| | 4.5. Is the statistical analysis appropriate to answer the research question? | | | | |
| 5. Mixed methods | 5.1. Is there an adequate rationale for using a mixed methods design to address the research question? | | | | |
| | 5.2. Are the different components of the study effectively integrated to answer the research question? | | | | |
| | 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? | | | | |
| | 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? | | | | |
| | 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? | | | | |

# Appendices

## Appendix A: HREC Approval

**From:** ethics@cqu.edu.au

**To:** Moira Williamson; Olav Muurlink; Tanya Capper

**Appendix A: Ethical Approval**

**Cc:** Ethics Committee Secretary

**Subject:** Human Ethics Application outcome - 0000021372

**Date:** Tuesday, 8 January 2019 1:25:05 PM

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Application reference: 0000021372

Title: Vertical violence in the midwifery student experience.

This project has now been approved by the Human Research Ethics Committee, either at a full committee meeting, or via the low risk review process.

The period of human ethics approval will be from 08/01/2019 to 30/09/2020. The standard conditions of approval for this research project are that:

(a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

(c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

(d) you provide the Human Research Ethics Committee with a written Annual Report on each anniversary date of approval (for projects of greater than 12 months) and Final Report by no later than one (1) month after the approval expiry date;

(e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project

(f) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Human Research may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee wishes to support researchers in achieving positive research outcomes. If you require an approval letter on university letterhead, please do not hesitate to contact the ethics officers, Sue Evans or Suzanne Harten or myself.

Yours sincerely,

Ms Susan Evans Senior Ethics Officer

on behalf of the Chair, Human Research Ethics Committee Research Division - Central Queensland University

## Appendix B: Advert

**Project Title: Vertical Violence in the Midwifery Student Experience**

Ethics Approval No: 0000021372

Hi all UK and Australia based midwifery students, I am undertaking a study to explore midwifery students experiences of being bullied whilst on clinical placement. If you are interested in participating, please read on:

Project Title: Vertical Violence in the Midwifery Student Experience
Ethics Approval No: 0000021372

The incidence of workplace violence, more commonly referred to as workplace bullying, has increased in recent years and is now a major global public health concern. This research project at Central Queensland University explores how workplace bullying plays out in the healthcare context, in particular, the experiences of bullying of midwifery students whilst on clinical placement.

Studies show that bullying can have a number of short and long term effects upon an individual's mental and physical health, and subsequently adversely impact the individual's journey through a training course, job or profession.

We are looking for midwifery students that are based in Australia or the United Kingdom who would like to volunteer to share their experience of being bullied or harassed whilst on clinical placement. Volunteers will be asked to complete an online questionnaire that will enable you to tell your story about being bullied. Should you choose to participate, you will not be able to be individually identified in any of the research results. Please note that due to concerns about conflict of interest, we are not able to include current or past midwifery students from CQUniversity Australia in this project.

If you would be willing to participate in this study, please click the below link:

https://www.surveymonkey.com/r/KNKMRCY?fbclid=IwAR3g5bEt34MxR3Q0PTD3i13VSl6iIxo0RA_SYYjg3y11qtK7dtGFWy-lcsI

## Appendix C: Survey Monkey Landing Page


Welcome!

**Welcome to the vertical violence in the midwifery student experience questionnaire.**

Thank you for your interest in taking part in this important research.
This study is about your experience of being bullied whilst on clinical placement as a midwifery student. We're really interested in finding out about your experience and how it has affected you in both the short and (potentially) the long term.

When answering questions, please provide as much information as possible. There is no limit on the word count you can provide.

Next up is the official information sheet for this study, followed by the official consent form required by the university.

Please click 'Next' to begin.

**Appendix D: Information Sheet**

**Research Information Sheet**

# Project Title: Vertical Violence in the Midwifery Student Experience

Ethics Approval No: 0000021372

**Student Researcher**

Ms Tanya Capper, Registered Midwife, Dip/HE Midwifery, Grad Dip Midwifery, MMid, PhD Candidate. School of Nursing, Midwifery and Social Sciences, Central Queensland University, Brisbane, QLD 4000. Email: t.capper@cqu.edu.au

**Research Supervisors**

Associate Professor Olav Muurlink | School of Business and Law, Head of Course – Sustainable Innovation. CQUniversity Australia, Level 21, 160 Ann Street, Brisbane QLD 4000. P +61 07 3295 1154 | X 51154 | M +61 427 619 800 | E o.muurlink@cqu.edu.au

Professor Moira Williamson. Dean, School of Nursing, Midwifery and Social Services Tertiary Education Division, CQUniversity Australia, Building 1.05, 90 Goodchap Street, Noosaville 4566 P: 07 54407083 E: m.williamson@cqu.edu.au

**Why is this research being conducted?**

This research is being performed to explore midwifery students' lived experiences of vertical violence (or being bullied) whilst on clinical placement.

Participation in this research will provide valuable information from the student perspective that will potentially be used to improve the clinical placement experience and better inform, universities, clinical placement providers and the midwifery profession as a whole. The study may have implications for addressing bullying and harassment in health care settings in general, and in particular clinical education settings within healthcare facilities.

**Who can participate in the research?**

You are able to take part in this project if you are a student undertaking a midwifery program, leading to initial registration as a midwife in Australia or the United Kingdom. As a midwifery student, your participation is voluntary and will involve completing online survey questions about your experiences of vertical violence (or bullying) whilst on clinical placement. Due to concerns about conflict of interest (the study is being conducted at Central Queensland University (CQU) by currently serving staff) we are not able to accept current or past students at CQU into this study.

**Your Consent**

Please read this information sheet carefully. Take your time and feel free to ask the researcher questions about any information contained in this document. Once you understand what the project is about and if you agree to take part in it, please commence the questionnaire and tick to confirm that you consent to participation when prompted.

**What will you be asked to do?**

If you agree to take part in this research, you will be asked to participate in an online questionnaire about your experiences of being bullied as a midwifery student. The questionnaire will give you the opportunity to tell your story.

**Possible Benefits and Risks**

Participation in this study may benefit you as a participant by having the opportunity to explain and describe your experiences of being bullied as a midwifery student, however, we do not anticipate any significant personal benefit to you as a participant.

It is possible that some participants may experience some discomfort when asked about aspects of their student experience of being bullied however these social and psychological risks are anticipated to be minimal and no more than would be experienced in daily work and participation in classroom discussions. Should you experience significant discomfort during the completion of the questionnaire, please be aware that there is no penalty for choosing to withdraw from the study at this time. Should you experience significant discomfort after completing the questionnaire, we recommend you contact: In Australia - Nurse and Midwife Support (NMS) on 1800 667 877. Should for some reason you feel that NMS is not suitable to address your needs, you are encouraged to contact Lifeline Australia on 13 11 14. If you are in the UK – please contact The Samaritans on 116 123.

Note that workplaces are closed contexts, where information about bullying may be spread or distorted. Therefore, you are advised to be cautious in sharing your participation in this study with friends or colleagues.

**Confidentiality and Privacy**

All information collected during this research will be anonymised during transcription.

Your questionnaire comments will be read by the student researcher and will remain confidential.

Please be aware that if we are informed of serious and reportable activity we will be obliged as registered midwives to report this if we are able to identify who is/was involved.

Respective electronic data material will be securely stored on computers with password protection on university property at CQU. Data materials such as transcripts and research logs used for the purpose of this research that are not stored on secure university servers will be stored in a locked filing cabinet on the Brisbane campus of CQU, and retained for five years after the completion of data collection. After this five-year period the data will be destroyed. If you decide to discontinue your involvement in the project, all data collected from you will not be able to be removed from the data already collected; as it will have been de-identified as part of

the transcription process.

**Results of the Project**

Results of this project will be submitted for thesis publication, as well as prepared for submission to peer reviewed journals as well as conference proceedings at appropriate forums. In these documents there may be extracts from your questionnaire; however, this information will be presented so that no specific individual will be able to be identified.

**Further Information or any Problems**

The ethical aspects of this research project have been reviewed and approved by the Human Research Ethics Committee of CQU (Approval No: 0000021372). If you wish to discuss the project with an independent person, or express concerns, please contact the Chairperson of the Human Research Ethics Committee at CQU: ethics@cqu.edu.au

**Appendix E: Consent**


## Vertical Violence in the Midwifery Student Experience

CONSENT FORM

**Project Title: Vertical Violence in the Midwifery Student Experience**

I consent to participation in this research project and agree that:

1. I have read and understood the Research Information Sheet provided to me;

2. I have had any questions I had about the project answered to my satisfaction by the Information Sheet;

3. I understand that my participation or non-participation in the research project will not affect my academic standing or clinical placement opportunities;

4. I understand that I have the right to withdraw from the project at any time without penalty;

5. I understand the research findings will be included in the researcher's thesis and potential publication(s) on the project and this may include conferences and articles written for journals and reports;

6. I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used, any publication(s), and my identity will be preserved by removing my name and any identifying features from the answers to the questionnaire.

7. I agree that I am providing informed consent to participate in this project.
*1. I agree to all of the above
☐ Yes

## Appendix F: Survey Questions

**Q1: Consent Question**

**Project Title: Vertical Violence in the Midwifery Student Experience**

I consent to participation in this research project and agree that:

1. I have read and understood the Research Information Sheet provided to me;

2. I have had any questions I had about the project answered to my satisfaction by the Information Sheet;

3. I understand that my participation or non-participation in the research project will not affect my academic standing or clinical placement opportunities;

4. I understand that I have the right to withdraw from the project at any time without penalty;

5. I understand the research findings will be included in the researcher's thesis and potential publication(s) on the project and this may include conferences and articles written for journals and reports;

6. I understand that to preserve anonymity and maintain confidentiality of participants that fictitious names may be used, any publication(s), and my identity will be preserved by removing my name and any identifying features from the answers to the questionnaire.

7. I agree that I am providing informed consent to participate in this project.

**I agree to all of the above**

☐ Yes

**Q2: What is your gender?**

- Female
- Male
- Other
- Rather not disclose

**Q3: What is your age group?**

- 18-21 years
- 22-25 years
- 26-30 years
- 31-35 years
- 36-42 years
- 43-50 years
- Over 50 years

**Q4: Location of Clinical Placement?**

Australia

United Kingdom

Rather not disclose

**Q5: Main unit of placement birthing number per year?**

1-50 births

51-500 births

501-2500 births

2501-5000 births

Over 5000 births

**Q6: Are you already a registered nurse?**

Yes

No

**Q7: If yes, how long have you been a registered nurse?**

0-1 year

1-5 years

5-10 years

10-15 years

15-20 years

Over 20 years

N/A

**Q8: How far into your program of study are you?**

Up to a quarter of the way through the course

Up to a half of the way through the course

Up to three quarters of the way through the course

Final quarter of the course.

**Q9: Is English your first language?**

Yes

No

**Q10: If English is not your first language, which language do you speak at home?**

(Free text option)

**Q11: You've indicated that you were bullied or harassed whilst on clinical placement. Describe what happened, but please refrain from identifying persons involved or the location of the incident. (There is no limit on the length of your text)**

(Free text option)

**Q12: How did being bullied impact on you personally? (There is no limit on the length of your text)**

(Free text option)

**Q13: Has bullying ever caused you to consider withdrawing from your program of study and/or reconsider your career choice? (There is no limit on the length of your text)**

(Free text option)

**Q14: Do you feel that the organisational context (i.e. the hospital) helped foster the incident(s) or was it really just a case of 'one rotten apple'? (There is no limit on the length of your text)**

(Free text option)

**Q15: Do you think there are things about the organisation that could be changed to help ensure this type of incident(s) doesn't happen again? (There is no limit on the length of your text)**

(Free text option)

**Q16: During your career as a nurse/student midwife have you previously reported any experiences of bullying? If not, why not? (There is no limit on the length of your text)**

(Free text option)

## Appendix G: Demographic Data of Participants

**Complete Surveys: (n=116)**

| ID | Sex | Age group | Country | Birth No's | RN? | How long RN? | How far into program? | English 1st lang? | N? Which lang? |
|---|---|---|---|---|---|---|---|---|---|
| UK1 | F | 22-25 | UK | 501-2500 | N | - | >3/4 | Y | - |
| UK2 | F | 18-21 | UK | 2501-5000 | N | - | >1/2 | Y | - |
| UK3 | F | 43-50 | UK | Over 5000 | N | - | >3/4 | Y | - |
| UK4 | F | 36-42 | UK | 501-2500 | Y | 1-5 yrs. | Final 1/4 | Y | - |
| UK5 | F | 31-35 | UK | Over 5000 | N | - | Final 1/4 | Y | - |
| UK6 | F | 31-35 | UK | Over 5000 | N | - | Final 1/4 | Y | - |
| UK7 | F | RND | UK | 501-2500 | N | - | >3/4 | Y | - |
| UK8 | F | 31-35 | UK | 2501-5000 | N | - | >3/4 | Y | - |
| UK9 | F | 26-30 | UK | 2501-5000 | N | - | >1/2 | Y | - |
| UK10 | F | 26-30 | UK | 2501-5000 | N | - | >1/2 | Y | - |
| UK11 | F | 43-50 | UK | Over 5000 | N | - | >1/2 | Y | - |
| UK12 | F | 18-21 | UK | Over 5000 | N | - | >1/2 | Y | - |
| UK13 | F | 43-50 | UK | 501-2500 | N | - | >1/2 | Y | - |
| UK14 | F | 43-50 | UK | 1-50 | N | - | >1/2 | Y | - |
| UK15 | F | 43-50 | UK | Over 5000 | N | - | Final 1/4 | Y | - |
| UK16 | F | 43-50 | UK | 2501-5000 | N | - | Final 1/4 | Y | - |
| UK17 | F | 26-30 | UK | 2501-5000 | N | - | >1/4 | Y | - |
| UK18 | F | 31-35 | UK | 2501-5000 | N | - | >1/2 | Y | - |
| UK19 | F | 31-35 | UK | 2501-5000 | N | - | Final 1/4 | Y | - |
| UK20 | F | 31-35 | UK | 2501-5000 | Y | 5-10 yrs. | >1/2 | Y | - |
| UK21 | F | 31-35 | UK | 1-50 | N | - | >1/2 | Y | - |
| AUS22 | F | 18-21 | AUS | Over 5000 | N | - | Final 1/4 | Y | - |
| AUS23 | F | 22-25 | AUS | Over 5000 | N | - | >3/4 | Y | - |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **AUS24** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **>1/4** | **Y** | **-** |
| **AUS25** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS26** | **RND** | **36-42** | **AUS** | **2501-5000** | **Y** | **0-1 yrs.** | **>1/2** | **Y** | **-** |
| **AUS27** | **F** | **22-25** | **AUS** | **2501-5000** | **Y** | **0-1 yrs.** | **Final 1/4** | **Y** | **-** |
| **AUS28** | **F** | **22-25** | **AUS** | **1-50** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS29** | **F** | **18-21** | **AUS** | **51-500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS30** | **F** | **22-25** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | |
| **AUS31** | **F** | **31-35** | **AUS** | **1-50** | **N** | **-** | **>1/4** | **Y** | **-** |
| **AUS32** | **F** | **26-30** | **AUS** | **1-50** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS33** | **F** | **26-30** | **AUS** | **2501-5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS34** | **F** | **22-25** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS35** | **F** | **43-50** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS36** | **F** | **31-35** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS37** | **F** | **36-42** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS38** | **F** | **36-42** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS39** | **F** | **22-25** | **AUS** | **501-2500** | **Y** | **1-5 yrs.** | **Final 1/4** | **Y** | **-** |
| **AUS40** | **F** | **26-30** | **AUS** | **1-50** | **N** | | **Final 1/4** | **Y** | **-** |
| **AUS41** | **F** | **22-25** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS42** | **F** | **18-21** | **AUS** | **51-500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS43** | **F** | **22-25** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS44** | **F** | **31-35** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK45** | **F** | **31-35** | **UK** | **501-2500** | **N** | **-** | **>1/4** | **Y** | **-** |
| **UK46** | **F** | **Over 50** | **UK** | **2501-5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **UK47** | **F** | **26-30** | **UK** | **2501-5000** | **N** | **-** | **>3/4** | **N** | **Czech** |
| **UK48** | **F** | **18-21** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK49** | **F** | **31-35** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK50** | **F** | **18-21** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **N** | **Arabic** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **UK51** | **F** | **22-25** | **UK** | **Over 5000** | **Y** | **0-1 yr.** | **Final 1/4** | **Y** | **-** |
| **UK52** | **F** | **26-30** | **UK** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK53** | **F** | **43-50** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK54** | **F** | **36-42** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK55** | **M** | **43-50** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK56** | **F** | **Over 50** | **UK** | **Over 5000** | **Y** | **Over 20 yrs.** | **> ½** | **Y** | **-** |
| **AUS57** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **> 3/4** | **Y** | **-** |
| **AUS58** | **F** | **43-50** | **AUS** | **2501-5000** | **Y** | **10-15 yrs.** | **> 1/2** | **Y** | **-** |
| **AUS59** | **F** | **26-30** | **AUS** | **2501-5000** | **Y** | **1-5 yrs.** | **>1/4** | **Y** | **-** |
| **AUS60** | **F** | **18-21** | **AUS** | **501-2500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS61** | **F** | **18-21** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK62** | **F** | **31-35** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK63** | **F** | **31-35** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK64** | **F** | **36-42** | **UK** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK65** | **F** | **26-30** | **UK** | **501-2500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **UK66** | **F** | **36-42** | **UK** | **2501-5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK67** | **F** | **26-30** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK68** | **F** | **18-21** | **UK** | **Over 5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS69** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS70** | **F** | **31-35** | **AUS** | **Over 5000** | **Y** | **5-10 yrs.** | **>1/2** | **Y** | **-** |
| **AUS71** | **F** | **22-25** | **AUS** | **2501-5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS72** | **F** | **26-30** | **AUS** | **Over 5000** | **Y** | **1-5 yrs.** | **>1/2** | **Y** | **-** |
| **AUS73** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS74** | **F** | **22-25** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |

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|---|---|---|---|---|---|---|---|---|---|
| **UK75** | **F** | **31-35** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK76** | **F** | **26-30** | **UK** | **Over 5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS77** | **F** | **18-21** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS78** | **F** | **31-35** | **AUS** | **501-2500** | **N** | **-** | **>1/4** | **Y** | **-** |
| **AUS79** | **F** | **18-21** | **AUS** | **501-2500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS80** | **F** | **18-21** | **AUS** | **2501-5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS81** | **F** | **22-25** | **AUS** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS82** | **F** | **36-42** | **AUS** | **2501-5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK83** | **M** | **Over 50** | **UK** | **Over 5000** | **Y** | **Over 20 yrs.** | **>1/2** | **Y** | **-** |
| **UK84** | **F** | **31-35** | **UK** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS85** | **F** | **31-35** | **AUS** | **51-500** | **N** | **-** | **>1/4** | **Y** | **-** |
| **AUS86** | **F** | **36-42** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS87** | **F** | **26-30** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS88** | **F** | **18-21** | **AUS** | **1-50** | **N** | **-** | **>1/2** | **Y** | **-** |
| **UK89** | **F** | **43-50** | **UK** | **501-2500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS90** | **F** | **18-21** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS91** | **F** | **22-25** | **AUS** | **2501-5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS92** | **F** | **18-21** | **AUS** | **2501-5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK93** | **F** | **22-25** | **UK** | **Over 5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK94** | **F** | **26-30** | **UK** | **Over 5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK95** | **F** | **31-35** | **UK** | **Over 5000** | **N** | **-** | **>1/2** | **Y** | **-** |
| **UK96** | **F** | **43-50** | **UK** | **Over 5000** | **N** | **-** | **>1/4** | **Y** | **-** |
| **UK97** | **F** | **26-30** | **UK** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS98** | **F** | **31-35** | **AUS** | **501-2500** | **Y** | **5-10 yrs.** | **>1/2** | **Y** | **-** |
| **UK99** | **F** | **26-30** | **UK** | **501-2500** | **N** | **-** | **>1/2** | **N** | **German** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **AUS100** | **F** | **22-25** | **AUS** | **501-2500** | **Y** | **1-5 yrs.** | **>1/2** | **Y** | **-** |
| **UK101** | **F** | **Over 50** | **UK** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK102** | **F** | **31-35** | **UK** | **2501-5000** | **N** | **-** | **>3/4** | **Y** | **-** |
| **UK103** | **M** | **36-42** | **UK** | **2501-5000** | **Y** | **15-20 yrs.** | **Final 1/4** | **Y** | **-** |
| **AUS104** | **F** | **31-35** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS105** | **F** | **26-30** | **AUS** | **1-50** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS106** | **F** | **31-35** | **AUS** | **1-50** | **N** | **-** | **>1/4** | **Y** | **-** |
| **AUS107** | **F** | **18-21** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS108** | **F** | **31-35** | **AUS** | **51-500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS109** | **F** | **26-30** | **AUS** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS110** | **F** | **26-30** | **AUS** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS111** | **F** | **36-42** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS112** | **F** | **26-30** | **AUS** | **501-2500** | **N** | **-** | **.1/2** | **Y** | **-** |
| **AUS113** | **F** | **31-35** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS114** | **F** | **18-21** | **AUS** | **51-500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS115** | **F** | **26-30** | **AUS** | **501-2500** | **N** | **-** | **>3/4** | **Y** | **-** |
| **AUS116** | **F** | **36-42** | **AUS** | **501-2500** | **N** | **-** | **>1/2** | **Y** | **-** |

**Incomplete included data with qualitative responses (n=4)**

| SM number/Code | Q's answered | Sex | Age | Birth no's | RN? | If Rn, how long? | How far into course? | English? | N? Where? |
|---|---|---|---|---|---|---|---|---|---|
| **AUS117** | **11, 12, 13, 14, 15, 16** | **F** | **RND** | **51-500** | **N** | **-** | **>1/2** | **Y** | **-** |
| **AUS118** | **11** | **F** | **26-30** | **501-2500** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **AUS119** | **11** | **F** | **26-30** | **2501-5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |
| **UK120** | **11, 12, 13, 14** | **F** | **36-42** | **Over 5000** | **N** | **-** | **Final 1/4** | **Y** | **-** |

## Appendix H
## Published Version of Paper One

Article Redacted

## Appendix I
## Published Version of Paper Three

Article Redacted

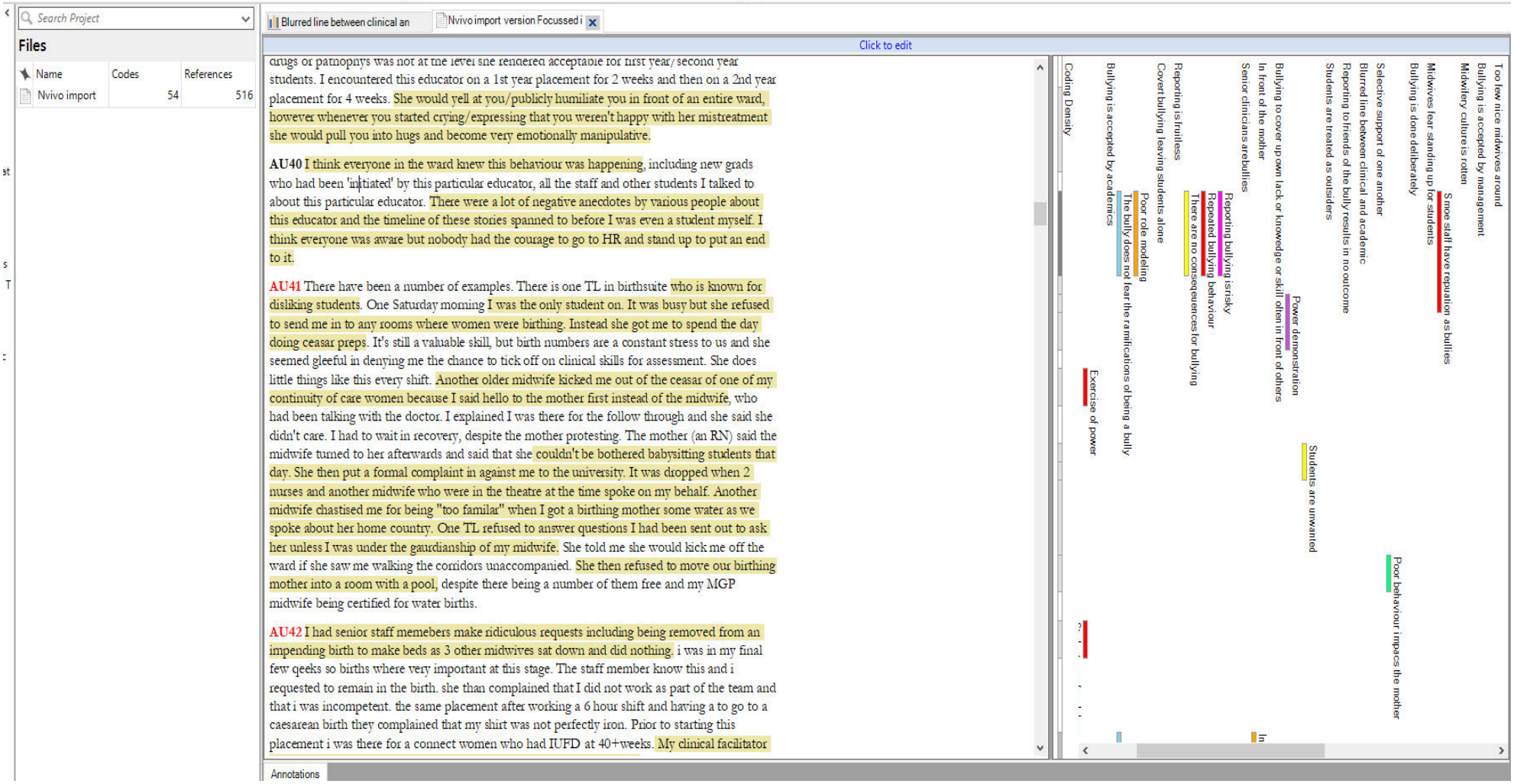
## Appendix J
## Published Version of Paper Four

Article Redacted

## Appendix K
## Published Version of Paper Five

Article Redacted

# Appendix L
## Example of Data Coding



## Appendix M
## Peer Reviewed Conference Presentation 1

**Australian College of Midwives (ACM) Queensland State Conference 2019**
**Oral Presentation, 9th February 2019.**

Article Redacted

## Appendix N
## Peer Reviewed Conference Presentation 2

**7th Biennial ACSPRI Social Science Methodology Conference 2020.**
**Accepted for Oral Presentation, December 2020.**

Article Redacted

## Appendix O
## Peer Reviewed Conference Presentation 3

**London 2021 Maternity and Midwifery Festival: Maternity and Midwifery Forum.**

Article Redacted

**Appendix P**

**Email from the editor of 'The Student Midwife Journal' accepting invited paper two**

**From:**
**To:** Tanya Capper
**Subject:** The Student Midwife Journal Submission
**Date:** Monday, 31 August 2020 4:01:47 AM
**Attachments:** image002.png

---

Dear Tanya,

Thank you so much for your submission to The Student Midwife Journal – it is FANTASTIC!

I wish to publish it in our April issue. Is this ok with you? We only publish 4 times a year, so there can be a bit of a wait.

Alternatively, it could be a blog in the student midwife blog area of all4maternity.com (although I would LOVE it to be in the journal!)

Should you wish to be featured in the journal, a member of the editorial team will contact you re edits in January.

Let me know what you want to do, I look forward to hearing from you!

Warm regards,

all4maternity
LEARNING • SHARING • CARING

## Appendix Q
## Permission to use theoretical framework images

**From:**
**To:** Tanya Capper
**Subject:** RE: Permission request
**Date:** Thursday, 31 October 2019 3:10:42 AM
**Attachments:** image001.png

---

Dear Tanya,

Thank you for your email and your interest in using the images from my theoretical framework from the nature and manifestations of bullying in midwifery.
I am very happy for you to use the images, given that my original work will be referenced and cited appropriately.

I would also request that opportunities for me to contribute to publications are considered as there are not too many of us who are working in this particular area of research in midwifery.

Another text that may be of use to you is:

May I take this opportunity to wish you well with your PhD research. Balancing your work as an academic and PhD researcher can be challenging but it is worth it!

Kind regards