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Physiotherapy students’ experiences of bullying on clinical internships: a qualitative study

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Abstract

Objectives To consider the experiences of final-year physiotherapy students who have experienced workplace bullying on a clinical internship.

Design Qualitative methodology using individual semi-structured interviews.

Setting A university in the Midlands region of the UK.

Participants Eight undergraduate physiotherapy students who had experienced one incident of bullying on a clinical internship.

Main outcome measures Thematic analysis of semi-structured interviews.

Results Four main themes were identified: (1) external and situational influences of bullying; (2) students’ reactions to the experience of bullying; (3) inability to reveal the experience; and (4) overcoming problems. Bullying had a range of adverse effects on the students, with many expressing self-doubt in their competence and viewing their supervisor as unapproachable and unsupportive. Five students were not initially able to recognise the experience as bullying. In addition, students did not feel able to report the experience and use the support mechanisms in place. This may have been a result of having concerns that the problem would escalate if they reported the experience and, as a consequence, have a negative effect on their grade. Students were keen to offer a range of strategies for clinical practice in order to prevent bullying for future generations of students.

Conclusions Students’ health, security and confidence in their ability as a physiotherapist can be at great risk from bullying. Steps are needed to ensure that students are better protected from bullying, and feel more able to address bullying behaviour during clinical internships.

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Keywords: Physiotherapy; Students; Bullying; Experiences; Clinical internships; Qualitative

Introduction

The Chartered Society of Physiotherapy defines workplace bullying as ‘any action taken which makes another feel intimidated, excluded or unsafe’ [1]. Evidence suggests that workplace bullying is often a repeated, deliberate and subtle behaviour that accumulates over time [2]. However, the term ‘bullying’ should be distinguished from other behaviours such as incivility and aggression [3]. The literature has categorised three types of behaviour that relate to bullying [4,5]: (1) physical intimidation (such as threats of violent behaviour); (2) work-related behaviour (such as removing responsibility or overworking an individual); and (3) person-related behaviour (such as being excluded socially and causing personal offence to another individual). This study has focused on the latter two types.

Bullying in healthcare settings is an international problem, with high levels being reported in Australia [6,7], Canada [8], India [9] and the USA [10]. In the UK, Quine [11] established that 37% of community therapists a had been bullied in the previous year. This was comparable with levels reported by junior doctors [12], although higher than reports from the Healthcare Commission [13]. Importantly, healthcare professionals with the least experience, such as students, may

a This included occupational therapists, speech and language therapists, chiropodists and physiotherapists. However, the exact number of each profession and breakdown of bullying experienced by profession was not provided.
be at greatest risk [14,15]. For instance, 25% of physiotherapy students [3] and around 50% of medical students [15–17] have reported being bullied during their clinical training.

Bullying has a significant impact on the organisation where it occurs, including an impact on productivity, financial costs and reputational costs [1,4]. In 2008, it was estimated that the financial cost of bullying and harassment to the National Health Service (NHS) was £325 million per annum [18]. In a work environment where bullying occurs, it acts as a strong reason for all individuals to leave the job [19,20], and has a negative impact on the victim’s well-being. For example, it causes psychological distress and somatic complaints [5,11,20]; it decreases motivation, job satisfaction and performance [5,21]; and it has a negative effect on the victim’s family [22].

Very limited research is available on student physiotherapists’ experiences of bullying in the workplace. Only one other study [20] has used a qualitative approach within a mixed methods study design to investigate bullying in the physiotherapy profession. The authors conducted semi-structured interviews with five senior physiotherapists in Ireland, and established that victims were often bullied when they were in a vulnerable position (new to the job) and did not realise what was happening. In addition, the bullying caused the physiotherapists to lose confidence and blame themselves; disturbingly, 90% (=30/34) of those individuals left their job as a result of being bullied.

In summary, very limited research has investigated bullying in the physiotherapy profession, and, to the best of the authors’ knowledge, no qualitative research has been conducted on physiotherapy students’ experiences of bullying. As such, the purpose of this study was to investigate physiotherapy students’ experiences of workplace bullying during clinical placements with a view to better protecting the future of the profession.

**Methodology**

**Design**

A single semi-structured interview was undertaken between the primary author and eight final-year physiotherapy students (see Table 1 for demographic characteristics). The semi-structured interview questions (Appendix A, see online supplementary material) were formed from the literature [3,11,12,20,23].

**Sample**

The sample included eight final-year undergraduate students (8/55; 15% of students) reading for a BSc (Hons) degree in physiotherapy at a UK university. The project used a purposive sampling [24] technique, and the selection criteria were students who were in their final year of study and had experienced at least one incident of bullying during a clinical internship. The incident could have been on more than one occasion and at any time over the course of their study. No exclusion criteria were used.

**Procedure**

An e-mail invitation was sent to all final-year undergraduate students explaining the project and asking for volunteers who met the inclusion criteria. Recruitment of participants was undertaken by the primary author (access was likely enhanced as the primary author was a student at the university at the time of data collection). Access to four individuals was obtained by e-mail (n = 4), and an additional four students were identified through informal face-to-face meetings. It is not known if all students within the cohort who met the inclusion criteria came forward. The study was conducted in a private room at the university using a digital recorder. The interviews lasted between 10 and 33 minutes (mean 20 minutes).

**Ethics**

Ethical approval was obtained from the University ethics committee (Life and Health Sciences Ethical Review Committee, Ref No. ERN_10-0037). Before commencing the interviews, all participants read the information sheets provided and gave informed written consent. In addition, students were given information about how to access support from the university or counselling services following the interview.
Analysis

After completion of the interviews, the responses were typed up individually using verbatim quotations. All interviews were analysed using thematic analysis [25]. To achieve thematic saturation, the sample size needed to be of a sufficient size that no new themes would occur. There were five stages of analysis. The first stage required the primary author to become immersed in all eight interviews [26], after which a senior investigator critiqued and validated the initial themes. The primary author created a thematic map and coded each interview using data-driven coding [25]. The senior investigator critiqued and developed the codes and categories (an audit trial is available from the primary author). The primary author subsequently illustrated the strength and consistency of each sub-theme by undertaking a quantitative content analysis detailing the frequencies of each sub-theme [27].

Results

Eight student physiotherapists agreed to take part and met the inclusion criteria (see Table 1).

The incidents of bullying experienced by the participants occurred in multiple placement settings. The majority of bullying incidents (75%) occurred whilst the students were in their second academic year. Following the procedure outlined in the methodology, four main themes were identified from the eight interviews: (1) external and situational influences of bullying; (2) students’ reactions to the experience of bullying; (3) inability to reveal the experience; and (4) overcoming problems.

Theme 1: external and situational influences of bullying

The students were frequently able to recall the feelings attached to the perpetrator, and reported feelings of isolation, inferiority and unworthiness. For example, one student could remember the experiences clearly:

‘He wasn’t ranting and raving, but I was frustrated, so I was like, I don’t know what I’m doing and I don’t know what is going wrong. He kept asking ‘why I was doing badly’ and I was like ‘I don’t know why I’m doing badly’ even though I knew exactly what the reason was, it was because I had him there constantly putting me down, all the time. He said the ‘f’ word but it wasn’t ‘f***ing’, it was ‘f***ing this’ and ‘f***ing that’’ (F4).

The negative impact this had on their willingness to attend placements was tangible. For example, one student stated:

‘It made me feel really intimidated which I don’t think you should have to feel, at work or at placement really. I used to cry all the time [nervously laughs] . . . There were days when I felt like, God, I really need to look at [learn about] ventilators for example. I’d read, and I just wouldn’t absorb anything, I was so paranoid about how I was going to put that knowledge across to the educator’’ (F5).

The three most prevalent factors within this theme regarding bullying were identified as: (1) perceived pressures of the placement where the bullying occurred; (2) lack of perceived support from the educator; and (3) a meta-perception that the educator had a lack of confidence in the student’s ability as a physiotherapist. A number of students articulated negative qualities of their supervisor, including feeling that the supervisor was not approachable. Students were able to identify the bullying methods used by supervisors with explicit detail, including devaluing comments and embarrassing situations (see Table S1, online supplementary material). Students were able to offer insightful and reflective accounts of possible contributing factors, including conflicts in personality and their perceived inapproachability and mannerisms, such as tone of voice and body language. Table S1 provides a full breakdown of Theme 1, including its sub-themes.

Theme 2: students’ reactions to the experience of bullying

Students frequently internalised negative cognitions of their bullying experience, and self-doubt was identified as the main consequence of bullying by students. Instead of confronting the situation with the supervising physiotherapist, students appeared to interpret the bullying behaviour as being their ‘fault’, and would typically question their own ability and future in the profession. Participant F5’s response illustrates the profound impact of bullying (this student achieved a first class honours degree):

‘It did make me feel like a bad physio and that I didn’t want to do it anymore and having been away from that placement a little while, I feel a bit better, but I would say, the residual effects are that I am full of self-doubt . . . All up until that time I’d cruised along fine, had good marks, had great experience but this last one seems to have really knocked my confidence. I’m going to still try [and] get into physio but if it doesn’t work out I won’t be heartbroken now as I have this fear that if I go in as a rotational band 5 and I have to come across that situation again, I am really scared of it to be honest as I just feel like, you know, you’re there, you’re trying to learn, you don’t really know what you’re doing and the person who is supposed to teach you is a bully, it makes your life a living hell basically’ (F5).

Students may have had a lack of insight into what constitutes bullying behaviour when they were involved in the situations on placement. The sub-themes in Theme 2 are listed in Table S2 (see online supplementary material).

Theme 3: inability to reveal the experience

The two main reasons that students gave for not reporting bullying were that: (1) they did not believe it was significant
enough to be reported (five of the eight students did not report their experience to the university); and (2) they were only on placement for a limited time. Some students felt that they should have been prepared to deal with such situations when they arose but were ill equipped to do so, whilst others felt that the university had not prepared them adequately for dealing with such situations whilst on placement. For instance, one student stated:

‘I don’t think that when they [university] prepare you for clinical placements, they don’t tell you if you get bullied or if you feel someone has said something inappropriate, the routes to go down to tell, to report it. I think half the time if you had a problem on placement you wouldn’t want to report it anyway because that’s going to affect [your mark]... you don’t want to annoy the person even more who’s marking you’ (F6).

The majority of students suggested that the best solution to dealing with bullying was to ignore it. This meant that the perpetrator would not be confronted by the student, university or hospital. Students were very clear on why they would not reveal such incidences; primarily, a number of students believed that revealing problems could have a negative impact on their mark and would cause further friction between them and their educator. In a similar way, some students believed that the problem would escalate if they contacted the university, and feared what would happen if formal proceedings took place.

However, a perceived lack of action following disclosure prevented one student from reporting the incident of bullying. The sub-themes in Theme 3 are listed in Table S2 (see online supplementary material).

**Theme 4: overcoming problems**

Students believed that implementing a procedure for dealing with problems was the best strategy for overcoming difficulties. This was closely followed by education to increase awareness of bullying and promote better communication skills. Suggestions for dealing with problems included a support system that feels accessible to the student. For example, one student stated:

‘I think they [the university] should maybe do a sort of mediation between you and your educator so that they can sit down and see and have an honest grown up conversation’ (F5).

The full content of Theme 4 is illustrated in Table S2 (see online supplementary material).

**Discussion**

This research examined final-year physiotherapy students’ experiences of bullying during clinical placements. All students identified two work-related types of bullying, including the perception of a highly pressurised environment on the clinical internship and a lack of support from their supervisor. An air of inevitability and acceptance of the bullying behaviour was identified through the students’ responses, with some students feeling that they had to ‘grit their teeth’ and get through the placement. Five students failed to report this experience to their visiting tutor from the university, and most students did not feel adequately prepared to deal with the situation. In most cases, the bully was the student’s clinical supervisor.

**Lived experiences of bullying and reactions to that experience**

The experiences of bullying identified in the present study mirror the experiences identified in previous research [3,11,12]. The current research was able to identify the personal nature of bullying both directly and indirectly [4]. A number of students reported that they had a difficult relationship with their educators and they were often unapproachable; this has been acknowledged previously in other healthcare professionals [28,29]. Some students were aware of the pressurised environment that may contribute to some types of bullying behaviour (e.g. unfair criticism), meaning that they recognised the bully’s situation or that the bully may be unaware of their behaviour. This has been reported previously [20,29,30]. In addition, it is possible that some behaviour may relate to the organisation and be blamed inappropriately on the bully [31]. Thus, it appears important for clinical educators to consider the types of verbal and non-verbal communication that are associated with or perceived by the student as bullying. It is important for supervisors to understand the difference between supervision that is constructive and undermines the student, and supervision that is constructive and supportive to the student [32]. Within this context, it is important to note that highly performing individuals are often the target of a bully [11,20,30,33]. Thus, the potential to damage highly talented students is great.

**Reasons why students did not report the bullying experience and suggestions to overcome bullying**

There is a tendency for bullying experiences to be under reported in the NHS [34], specifically among student physiotherapists [3]. When faced with a serial bully, even competent healthcare professionals do not speak up because of the fear of reprisal [33] or the fear that management will be unable to respond to a grievance procedure [20]. In the current study, many of the bullies were responsible for assigning a clinical mark to the students, and this influenced willingness to identify the bullies. This is an aspect that needs further consideration through policy.
Suggestions to overcome bullying and strategy for the profession going forwards

The current research illustrates several important points that need consideration:

(1) Appropriate pathways are needed where an open discussion about bullying can take place. This has been successful for other health-related professions [35].

(2) Clinical educators must consider the effects of being a role model to impressionable learners [36].

(3) A three-way partnership involving clinical training sites, universities and professional bodies is required to ensure that students’ learning and professional engagement is protected [11,35]. Research has highlighted that students who feel that adequate support or policies are lacking are at greatest risk [17]. It is important to acknowledge that victims who are able to report bullying experiences can be left dissatisfied with the outcome. This often acts to prevent further reporting by them and others [11,20]. At an organisational level, NHS trusts and universities should have policies and procedures that address the issue of workplace bullying comprehensively [11].

(4) Whilst nursing students are educated to deal with bullying and harassment [37], no current guidelines dictate the same within physiotherapy education [38].

Limitations of study

This study has several limitations. The main limitation was that it was not possible to investigate and consider why the bullies initiated their behaviour towards their students. Thus, there is a need to hear from these clinicians, identified as bullies, in order to gain a more detailed understanding of this issue. Secondly, it was difficult to establish if theoretical saturation had occurred, although given the focus of the topic and support from previous studies, further findings within the scope of this research seem unlikely. Third, this research focused on a sensitive topic and people with other experiences may be reluctant to participate. Finally, all interviews were conducted at one university, and it is not known whether or not the results are relevant to a wider population.

Conclusion

This study found that bullying can have profound and adverse effects on the health of physiotherapy students. Most respondents felt unprepared when dealing with bullying, and did not communicate their experiences directly to the university. This situation requires further consideration from institutions that train physiotherapists and their NHS partners. Importantly, each student must believe that the university will tackle the problem in a thorough, professional and confidential manner, and that the reporting of such incidents will not affect their grades.

Ethical approval: University ethics committee (Ref. No. ERN_10-0037).

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.physio.2013.06.005.

References


