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Research article

Nursing students' experience of bullying and/or harassment during clinical placement

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ABSTRACT

Problem or background: Bullying is a recognised problem in nursing. Nursing students are particularly vulnerable. Bullying and harassment of nursing students can be detrimental to both students and recipients of care.
Aim: This study aims to identify the incidence and nature of bullying and/or harassment experienced by nursing students in Sri Lanka.
Methods: A cross-sectional survey consisting of eight demographic questions and 15 items specific to the experience of bullying and harassment was administered to nursing students online.
Findings: A total of 656 students from 26 nursing education institutions in Sri Lanka participated. The majority were female with a mean age of 24.4 years. More than a quarter of respondents reported that they had experienced bullying and/or harassment while on clinical placement, with a further 16.7 % being unsure. Most bullying or harassment (55 %) occurred in hospitals with 29 % experienced in community settings. Registered nurses, including nurse managers and clinical facilitators were the most common perpetrators. Verbal abuse was the most frequent type of behaviour reported.
Discussion: These findings support existing literature that indicates that bullying of nursing students is an international phenomenon. The context of this study provides clues as to how culture may influence the problem. There is a need to better understand bullying and harassment in the environments in which it occurs, in order to identify strategies that can bridge cultures and settings.
Conclusion: The incidence of bullying and harassment of nursing students in Sri Lanka is concerning. Further research is needed to identify and evaluate targeted strategies to help prevent negative outcomes in all nursing contexts.

1. Introduction

Workplace bullying is prevalent within the health professions internationally. Despite its prevalence the term bullying has no universally accepted definition (Boyle and Wallis, 2016). A scoping review conducted by Hartin et al. (2019) found 'bullying is a theoretical and subjective concept that is in the eye of the beholder' (p.88). These authors state that 'bullying is a response-related behaviour attributed to complex intra- and interpersonal organizational dynamics within the workplace' that leads to negative, harmful outcomes for the person being bullied (Hartin et al., 2019, p. 89). Evidence of bullying in nursing and other healthcare professions is well documented across developed nations (Binmadi and Alblowi, 2019; Capper et al., 2021; Harb et al., 2021; Hartin et al., 2018; Major, 2014; Malik et al., 2020; Meier et al., 2021; Minton and Birks, 2019; Shorey and Wong, 2021; Smith-Han et al., 2020).

Bullying in nursing manifests in many ways with detrimental consequences to nurses, the people to whom they provide care, health care institutions, and to the profession itself (Castronovo et al., 2016; Hartin et al., 2018; Hawkins et al., 2021; Üzar-Özçetin et al., 2020). Workplace bullying affects resilience and well-being and is positively related to burnout in healthcare professionals (Lang et al., 2021; Livne and Goussinsky, 2017). Rikos et al.'s (2022) study established that verbal abuse in the workplace results in adverse physical and psychological

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effects on nurses. Workplace bullying affects mental health (Harb et al., 2021), with the long term effect negatively affecting a nurse's ability to manage their workload, increasing stress and anxiety (Courtney-Pratt et al., 2018) and ultimately impacting the care they provide (Berry et al., 2012; Budden et al., 2017). Exposure to uncivil behaviour and bullying is one predictor affecting nurses' intent to remain in the workplace (Evans, 2017). With nurse retention a significant concern globally (Buchan et al., 2018; International Council of Nurses [ICN], 2021), the need to address the problem of bullying intensifies. Fostering a positive workplace environment is fundamental to supporting the retention of nurses (Buchan et al., 2018; Harrison et al., 2020b; Huntington et al., 2011; Laschinger et al., 2010).

Sri Lanka is an independent republic with a rich history. In recent years, Sri Lanka has experienced social, political and economic instability, the effects of which persist today. While influenced by advances in western societies, Sri Lanka nonetheless retains traditional eastern values, particularly in respect of gender roles and expectations. In this context women lack power, protection and representation, and thus are at greater risk of exclusion and abuse (Hoole, 2021). This cultural reality has implications for the predominantly female nursing profession, with nursing students being particularly vulnerable.

Bullying of nursing students undertaking clinical placement during their tertiary education continues to be reported in developed nations including Australia, New Zealand, USA, and Ireland (Budden et al., 2017; Courtney-Pratt et al., 2018; Minton and Birks, 2019; Tee et al., 2016). Exposure to bullying has been found to affect the wellbeing of both the student and that of their patients (Birks et al., 2018). In Sri Lanka, with limited research on the topic of bullying nursing generally (Jagoda and Rathnayake, 2022), no research could be located that examines nursing students' experience of bullying or harassment while on clinical placement. This paper reports on a cross-sectional study undertaken to explore the incidence and nature of these forms of incivility as experienced by Sri Lankan nursing students while undertaking clinical placement.

2. Methods

This study was undertaken using a cross-sectional design. The tool used was the *Student Experience of Bullying During Clinical Placement* (SEBDCP) survey developed by Budden et al. (2017). The survey had been tested by the originators, with subscales determined to be reliable with the following Cronbach alpha coefficients: Non-violent behaviour 0.93; physical behaviour 0.66; sexual harassment 0.72; impact on feelings 0.94 and work impact 0.84. For the purpose of the current study, the survey was reviewed by the team with only minor modifications made to account for the local context. The survey was administered through an online subscription survey service following functionality and content validity testing.

The survey consisted of eight questions that sought sociodemographic information, including age, gender, area of residence and program of enrolment details. Fifteen broad questions, many with multiple items, asked about bullying and/or harassment related experiences. The first of these questions sought to determine whether students believed they had been bullied while on clinical placement in the preceding 12 months. Regardless of the response, participants were all asked to respond to specific questions about experiences. The reason for not taking respondents to the end of the survey if they indicated they had not been bullied or harassed was to identify cases where students had experienced uncivil behaviours that they did not identify as such. For this reason, the survey did not contain a definition of bullying or harassment. The survey included opportunities to clarify responses to various items and concluded with a free text question that allowed students to make any additional comments about bullying and harassment of students while on placement.

Participants were recruited following approval from Bioinquirer Ethics Review Committee Welisara, Sri Lanka and reciprocal approval from James Cook University, Australia. A total of 26 nursing education institutions in Sri Lanka (21 public; 5 private) were contacted and asked to disseminate the survey link to students enrolled in their pre-registration nursing programs. The first page of the survey contained the information sheet. Participants indicated their willingness to be involved via a consent question on that page. Submission of the survey implied consent. Responses were collected between March 2021 and July 2021. Survey data were analysed using SPSS 25 (Statistical Package for the Social Sciences). Frequency tables and descriptive analyses were conducted to summarise demographic and main outcome variables. A chi-square test was performed to examine the differences between the incidence of bullying and/or harassment by age and year level. Not all participants provided a response to all questions on the survey, therefore the sample size and percentages were based on the number of completed values for each variable. Sample size is presented with each frequency table. While a number of students took the opportunity to provide comments to the open text options in the survey, the quantity and quality of these responses was not sufficient to render analysis. A selection of these comments has been included in the following sections for illustrative purposes.

3. Results

3.1. Respondent's demographic characteristics

The number of respondents who consented to and participated in the survey was 656. Table 1 presents the baseline characteristics of the respondents. A total of 594 (90.55 %) participants responded to demographic items on the survey. Table 1 percentages were based on the number of completed values for each demographic variable. Most respondents were female ($N = 520$, 87.54 %) with only 12.46 % ($N = 74$) males. The age of respondents ranged from 19 to 29 years with a mean age of 24.42 years. Almost all respondents ($N = 575$, 99.1 %) were aged 20 years or over, with approximately half aged between 20 and 24 ($N = 291$, 50.2 %), however respondents' young age was not associated with bullying and/or harassment ($X^2 = 0.2844$, $p > 0.05$). Most respondents were Sinhalese ($N = 562$, 94.93 %,). Approximately one third lived for most of their life in the cities of Kurunegala ($N = 208$, 37.7 %) and Gampaha ($N = 71$, 10.8 %) with the remaining living or residing in towns/communities <10 % individually. Over half of the surveyed respondents ($N = 345$, 61.17 %) were enrolled in a Diploma of Nursing, approximately a quarter in a Bachelor of Nursing ($N = 159$, 28.19 %), and some in an Advanced Diploma of Nursing program ($N = 55$, 9.75 %). Over half of the respondents ($N = 326$, 58.11 %) were in 2nd year, with

Table 1
Respondent's demographic characteristics ($N = 560$–594).

Sociodemographic characteristics		N (%)
Gender	Female	520 (87.54)
	Male	74 (12.46)
Race or ethnicity	Sinhalese	562 (94.93)
	Sri Lankan Tamil	16 (2.7)
	Sri Lankan Moor	5 (0.84)
	Indian Tamil	1 (0.17)
	Other	8 (1.35)
Enrolled program	Bachelor of Nursing	159 (28.19)
	Advanced Diploma of Nursing	55 (9.75)
	Diploma of Nursing	345 (61.17)
Year of enrollment	Pre-2017	30 (5.36)
	2017	118 (21.07)
	2018	311 (55.54)
	2019	86 (15.36)
	2020	15 (2.68)
Current enrolled year	1st year	58 (10.34)
	2nd year	326 (58.11)
	3rd year	146 (26.02)
	4th year	29 (5.17)
	Other	2 (0.36)

the remaining respondents in 1st year ($N = 58$, 10.34 %), 3rd year ($N = 146$, 26.02 %), and 4th year (N = 29, 5.17 %).

3.2. Incidence of bullying and/or harassment

A total of 447 students responded to the item regarding bullying status on clinical placement in the previous year. One third ($N = 149$) of these respondents reported that they were bullied and/or harassed, and a chi-square test indicated significant association between the incidence of bullying or harassment and year level of the program ($X^2 = 10.2927$, $P < 0.05$) (Table 2). More respondents experienced bullying and/or harassment in the hospital setting ($N = 276$, 54.98 %) than in the community setting with only 29.01 % ($N = 143$) experiencing bully and/or harassment (occasionally, sometimes, often) (Fig. 1). Out of those who experienced bullying and harassment, only 10.08 % ($N = 38$) of surveyed respondents reported the incident to the relevant authorities such as university, clinical facility, and police. Despite reporting the bullying and harassment, only one third of respondents ($N = 12$, 31.58 %) reported satisfactory actions were taken in response to their report. The top four reasons behind students' decisions to not report to relevant authorities were: fear of being victimised ($N = 147$, 17.54 %), don't know where to report ($N = 145$, 17.3 %), it's part of the job ($N = 82$, 9.79 %), and it's not important to me ($N = 79$, 9.19 %).

Reporting is not [an] option (Female, 25, 2nd year).

3.3. Sources of bullying and/or harassment

Between 410 and 484 students responded to items measuring sources of bullying and harassment. The most common perpetrators are nursing professionals with many respondents reporting bullying and/or harassment (occasionally, sometimes, or often, collectively) by registered nurse(s) ($N = 267$, 55.39 %), nurse manager(s) ($N = 233$, 48.23 %) and clinical tutor(s)/facilitator(s) ($N = 193$, 40.12 %) (Table 3). Support staff were the least likely to bully and/or harass with only 18.8 % ($N = 90$) of respondents reporting bullying and/or harassment (occasionally, sometimes or often, collectively) by support staff. Doctors and other health professionals were less likely to be the perpetrators of bullying and/or harassment with 26.2 % ($N = 127$) of doctor(s) and 38.6 % ($N = 186$) of other health professional(s) the reported perpetrators of bullying and/or harassment (occasionally, sometimes or often, collectively).

I think bullying and harassment treatment [happens] because they themselves feel fear or feel inadequate with their education or qualifications. And I see it in increasing amount specially directed towards nursing undergraduate students (Female, 26, 3rd year).

I was bullied by staff nurses this year and previous years also. It was a bitter experience that I never expected. I think they try to rag us like that to maintain their seniority (Female, 25, 2nd year).

3.4. Form of bullying and/or harassment

Student responses to the items exploring the forms of bullying or harassment ranged between 302 and 433. The most common forms were verbal and non-verbal bullying and/or harassment with over half respondents reporting they were verbally abused e.g., sworn, shouted or yelled at ($N = 250$, 58.01 %), shown negative non-verbal behaviour e.g., raised eyebrows & rolling eyes (N = 250, 57.74 %), and ignored ($N = 245$, 56.98 %). Exposure to a racist remark(s) was the least common form of bullying and/or harassment with only 27.55 % ($N = 116$) of respondents reporting this behaviour. The bullying and/or harassment

Table 2
Incidence of bullying and/or harassment ($N = 447$).

Report of bullying and/or harassment			N (%)
I was bullied and or harassed last year on placement	Yes		149 (32.89)
	No		304 (67.11)
Venue where I was bullied and/or harassed	Hospital		276 (54.98)
	Community settings		143 (29.01)
Ever reported bullying and/or harassment	Yes	38 (10.08)	
	Who did you report the episode of bullying and/or harassment	To the university	15 (39.47)
		To the clinical facility	16 (42.11)
		To the police	5 (13.16)
		Other	7 (18.42)
	Was action taken in response to your reporting	Yes, and the issue was resolved to my satisfaction	12 (31.58)
		Yes, but the issue was not resolved to my satisfaction	9 (23.68)
		No action was taken	11 (28.95)
		Unsure if action was taken	6 (15.79)
	No	339 (89.92)	
	Reasons for not reporting	I have never been bullied or harassed	191 (22.79)
		It is part of the job	82 (9.79)
		Nothing will be done about it	132 (15.75)
		I am afraid I will be victimised	147 (17.54)
		It is not important enough to me	77 (9.19)
		I do not know where/how to report it	145 (17.3)
		Other	64 (7.64)
Witnessed bullying and/or harassment of other nursing students	Never		191 (52.76)
	Occasionally (1–2 times)		98 (27.07)
	Sometimes (3–5 times)		49 (13.5)
	Often (>5 times)		24 (6.63)

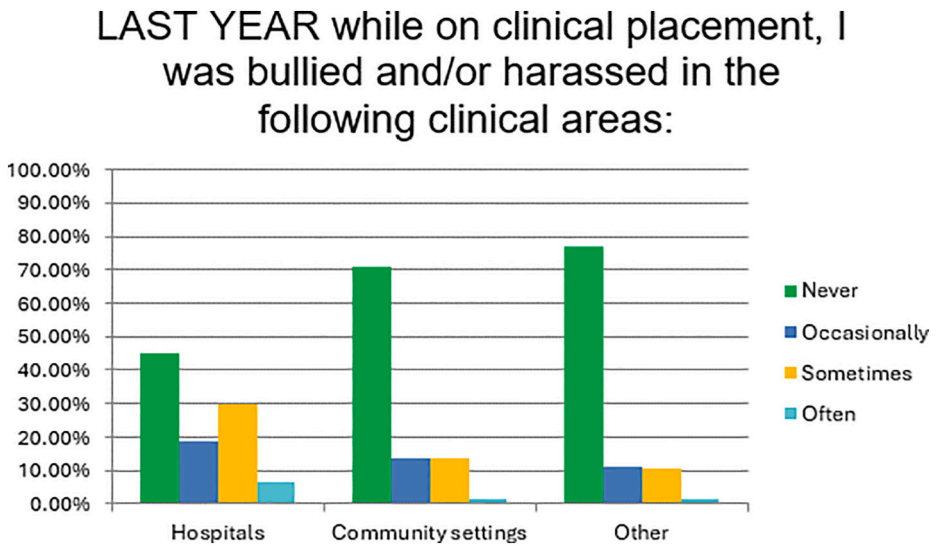

Fig. 1. Venues of bullying and harassment by frequency.

Table 3
Sources of bullying and/or harassment by frequency ($N = 410$ to 484).

Source	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Registered nurse(s)	63 (13.07)	106 (21.99)	98 (20.33)	215 (44.61)
Clinical tutors/facilitator(s)	36 (7.48)	70 (14.55)	87 (18.09)	288 (59.88)
Nurse manager(s)	33 (6.83)	100 (20.70)	100 (20.70)	250 (51.76)
Other nursing student(s)	24 (4.98)	68 (14.11)	72 (14.94)	318 (65.98)
Nursing assistants	23 (4.83)	62 (13.03)	69 (14.50)	322 (67.65)
Patient(s)	18 (3.74)	59 (12.27)	73 (15.18)	331 (68.81)
Other health professional(s)	15 (3.11)	88 (18.26)	83 (17.22)	296 (61.41)
Other health professional student(s)	12 (2.50)	57 (11.88)	53 (11.04)	358 (74.58)
Supportive staff e.g. food services, cleaning	10 (2.09)	44 (9.19)	36 (7.52)	389 (81.21)
Patients' relative(s) or friend(s)	8 (1.67)	49 (10.25)	47 (9.83)	374 (78.24)
Administrative staff	8 (1.66)	53 (11.02)	58 (12.06)	362 (75.26)
Doctor(s)	4 (0.83)	52 (10.74)	71 (14.67)	357 (73.76)
Other	3 (0.73)	32 (7.80)	22 (5.37)	353 (86.10)
Preceptor(s)/Mentor(s)	3 (0.63)	61 (12.71)	44 (9.17)	372 (77.50)

behaviours reported by respondents as occurring most *often* were being ignored ($N = 54$, 12.56 %), neglected ($N = 50$, 11.66 %), and unfairly criticised ($N = 42$, 9.79 %) (Table 4 $N = 327$–433). Physical and violent bullying behaviours frequently occurred although less intense than nonviolent behaviours, with being pushed ($N = 69$, 16.91 %), shoved ($N = 51$, 12.53 %) and personal items being deliberately damaged ($N = 34$, 8.42 %) identified as the top three reported behaviours (Table 5 $N = 302$–409). Exposure of various types of sexual harassment at clinical placement was reported (Table 6 $N = 316$–400) although the number affected was much smaller ($N = 12$–28, 3–7 %) compared to other nonviolent and violent behaviours.

Table 4
Type and frequency of nonviolent bullying behaviours (N = 327–433).

	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Ignored	54 (12.56)	103 (23.95)	88 (20.47)	185 (43.02)
Neglected	50 (11.66)	90 (20.98)	81 (18.88)	208 (48.48)
Unfairly criticised	42 (9.79)	80 (18.65)	86 (20.05)	221 (51.52)
Verbally abused e.g. sworn, shouted or yelled at	34 (7.89)	109 (25.29)	107 (24.83)	181 (42.00)
Shown negative non-verbal behaviour e.g. raised eyebrows, rolling eyes	32 (7.39)	105 (24.25)	113 (26.10)	183 (42.26)
Ridiculed	30 (7.08)	63 (14.86)	67 (15.80)	264 (62.26)
Unfairly treated regarding rostering schedules	26 (6.10)	75 (17.61)	79 (18.54)	246 (57.75)
Harshly judged	26 (6.06)	85 (19.81)	85 (19.81)	233 (54.31)
Given unfair work allocation	25 (5.84)	79 (18.46)	82 (19.16)	242 (56.54)
Denied learning opportunities	25 (5.83)	93 (21.68)	89 (20.75)	222 (51.75)
Treated as though I am not part of the multidisciplinary team	24 (5.73)	68 (16.23)	81 (19.33)	246 (58.71)
Denied acknowledgement for good work	24 (5.61)	94 (21.96)	83 (19.39)	227 (53.04)
Other	13 (3.98)	18 (5.50)	24 (7.34)	272 (83.18)
Exposed to a racist remark	10 (2.38)	47 (11.16)	59 (14.01)	305 (72.45)

Table 5
Type and frequency of violent bullying behaviours ($N = 323–409$).

	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Pushed	6 (1.47)	30 (7.35)	33 (8.09)	339 (83.09)
Other	4 (1.24)	9 (2.79)	10 (3.10)	300 (92.88)
Kicked	3 (0.73)	12 (2.93)	12 (2.93)	382 (93.40)
Shoved (knocked on)	2 (0.49)	19 (4.67)	30 (7.37)	356 (87.47)
Threatened with physical violence	2 (0.49)	9 (2.21)	16 (3.92)	381 (93.38)
Slapped	2 (0.49)	9 (2.22)	14 (3.45)	381 (93.84)
Punched	2 (0.49)	10 (2.47)	11 (2.72)	382 (94.32)
Threatened with an object/weapon	2 (0.49)	5 (1.23)	12 (2.95)	388 (95.33)
In a position where something of mine was deliberately damaged	1 (0.25)	15 (3.71)	18 (4.46)	370 (91.58)
Hit with an object/weapon	0	8 (1.97)	8 (1.97)	391 (96.07)

Table 6
Type and frequency of sexual harassment behaviours (N = 316–400).

	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Was inappropriately touched	3 (0.75)	11 (2.75)	14 (3.50)	372 (93.00)
Other	2 (0.63)	6 (1.90)	5 (1.58)	303 (95.89)
Had an unwanted request for intimate physical contact	1 (0.25)	9 (2.26)	7 (1.75)	382 (95.74)
Was threatened with sexual assault	1 (0.25)	5 (1.25)	6 (1.50)	388 (97.00)
Had a sexist remark directed at me	0	10 (2.50)	12 (3.00)	378 (94.50)
Had a suggestive sexual gesture directed at me	0	8 (2.00)	9 (2.25)	383 (95.75)

Table 7
Perceived feeling because of bullying or harassment (N = 287–381).

	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Depressed	49 (12.86)	95 (24.93)	100 (26.25)	137 (35.96)
Angry	43 (11.32)	103 (27.11)	104 (27.37)	130 (34.21)
Anxious	39 (10.24)	91 (23.88)	106 (27.82)	145 (38.06)
Fearful	34 (8.95)	78 (20.53)	108 (28.42)	160 (42.11)
Confused	29 (7.65)	106 (27.97)	112 (29.55)	132 (34.83)
Humiliated	27 (7.12)	65 (17.15)	73 (19.26)	214 (56.46)
Embarrassed	26 (6.93)	74 (19.73)	95 (25.33)	180 (48.00)
Inadequate	23 (6.15)	85 (22.73)	76 (20.32)	190 (50.80)
Unsafe	17 (4.51)	64 (16.98)	79 (20.95)	217 (57.56)
Other	4 (1.39)	17 (5.92)	14 (4.88)	252 (87.80)

3.5. Impacts of bullying and/or harassment

Between 287 and 381 students responded to the items concerning the affects of bullying and harassment. Instances of bullying and/or harassment impacted negatively on respondents' emotions, placement engagement and performance. Feeling angry, depressed, anxious and confused were experienced by almost two thirds of respondents (N = 236–250, 61.94–65.80 %) whilst feeling humiliated, embarrassed, fearful, inadequate, and unsafe were also reported (N = 160–220, 42.44–57.90 %) (Table 7 N = 287–381). Victims of bullying and/or harassment while on clinical placement also expressed their willingness to quit nursing (N = 182, 47.77 %) and reported how it impacted on their work performance (Table 8 N = 293–381), such as calling in absent (N = 123, 32.37 %), being afraid to engage (N = 146, 38.42 %), negative work relationships (N = 136, 36.08 %) and poor care quality (N = 114, 30.07 %).

> *I started regretting about the choosing this profession since the very first day of placement* (Female, 22, 2nd year).

4. Discussion

The findings from this study shed light on the bullying and harassment experiences of nursing students in Sri Lanka and reinforce existing knowledge about bullying as a continuing concern for students of nursing (Birks et al., 2017; Birks et al., 2018; Bowllan, 2015; Budden et al., 2017; Clarke et al., 2012; Courtney-Pratt et al., 2018; Fang et al., 2020; Fernández-Gutiérrez and Mosteiro-Díaz, 2021; Gamble Blakey et al., 2019; Karatas et al., 2017; Minton and Birks, 2019; Smith et al., 2016; Xu et al., 2023; Zhu et al., 2019). According to findings from this study, nearly one third of the participants had experienced bullying or harassment during their clinical placement, with the majority of these experiences occurring in a hospital setting. Compared to the total responses, only a small percentage of participants indicated that they had reported their bullying or harassment experience, and when they did, very few expressed satisfaction with the outcome.

Table 8
Perceived impact of bullying or harassment (N = 293–381).

	Often	Sometimes	Occasionally	Never
	N (%)	N (%)	N (%)	N (%)
Made me consider leaving nursing	33 (8.66)	73 (19.16)	76 (19.95)	199 (52.23)
Made me afraid to verify the orders given to me when I wasn't sure	22 (5.79)	63 (16.58)	61 (16.05)	234 (61.58)
Negatively affected the way I worked with others	13 (3.45)	45 (11.94)	78 (20.69)	241 (63.93)
Negatively affected the standard of care I provided to patients	8 (2.11)	45 (11.87)	61 (16.09)	265 (69.92)
Caused me to call in absent	6 (1.58)	52 (13.68)	65 (17.11)	257 (67.63)
Other	1 (0.34)	9 (3.07)	16 (5.46)	267 (91.13)

Workplace bullying is a problem that plagues different disciplines across the globe, and Sri Lanka is no exception (Edirisinghe and De Alwis, 2015). Unfortunately, a societal stigma persists in Sri Lanka, as is the case in many other countries globally, where nurses, in spite of the service they provide, lack professional recognition and status. Gender inequality in Sri Lanka (Hoole, 2021) serves as an aggravating factor in this environment. Therefore, there is potential for their experiences to be disregarded or discredited when they raise concerns about bullying and harassment. Healthcare professionals may believe that this reduced status is a natural aspect of their work because it is so pervasive and persistent. A failure to report an incident of bullying or harassment, whether experienced or witnessed, could be a characteristic of societal standards, where it is more acceptable for people to turn a blind eye to injustice in the name of personal protection, support and societal or group norms (Bambi et al., 2018; Ghosh, 2017).

The context in which this study was conducted may provide clues as to how culture influences the perceptions and expectations of group behaviour and interaction. Societal standards and perceptions about how people are expected to behave, communicate, and interact, can be carried into the workplace. Some behaviours perceived by a profession as bullying or harassment may not be considered as such within a particular society (Ghosh, 2017). Differences in societal values and norms can lead to varied levels of acceptance and tolerance for bullying behaviours, particularly where hierarchy informs societal relationships (Ghosh, 2017; Karatuna et al., 2020). Speaking up to authority figures or against group decisions may be unacceptable (Ghosh, 2017), contributing to the continued prevalence of bullying and harassment in nursing in these contexts. Of note in this research, the limited number of free text comments by participants may reflect reluctance to openly express feelings towards socially taboo subjects such as bullying and harassment. Previous research undertaken by members of this team in other contexts (Birks et al., 2017; Budden et al., 2017; Minton and Birks, 2019), found that students embraced the opportunity to express their perspectives on this topic often with a heavily emotional element.

Research by Lee et al. (2023) explored registered nurses' perceptions and experiences with speaking up for patient safety in Korean hospitals. While not specifically concerned with nursing students, this study found that social interactions within Korean culture, such as hierarchical respect, influenced how individual nurses communicated concerns for patient safety. Participants in that study reported that a hierarchical culture influenced some nurses' decisions to speak up to authority figures, such as physicians and nurse managers, as staying silent was more likely to preserve work relationships (Lee et al., 2023). Where the perpetrator is a senior nurse, such as a manager or clinical facilitator, as was identified in this study, the issue becomes even more complex.

While professional status, societal context, hierarchical and power structures can influence acknowledgement and reporting of bullying and harassment in the workplace, these factors have particular relevance for nursing students. Limited knowledge, experience, and position as the most junior in workplace hierarchies, can create even greater difficulty for this vulnerable group (Bowllan, 2015; Fernández-Gutiérrez and Mosteiro-Díaz, 2021; Zhu et al., 2019). Their position in this context may explain the reluctance of nursing students to report an incident, particularly where there are concerns about having to continue to work in close proximity with a perpetrator after an inquiry or report. Findings of previous research would suggest that this is the case (Birks et al., 2017; Courtney-Pratt et al., 2018; Zhu et al., 2019). Bullying has long been accepted as a rite of passage in nursing (Birks et al., 2018), in that a student is expected to endure these experiences as part of their transition to becoming a nurse. This concept is engendered as a part of the hierarchical element of the nursing profession and health system. As long as this situation remains unchallenged, students will continue to suffer the consequences, both in the short and long term, of exposure to workplace incivility.

> *There were countless situations that had me wishing I had never chosen to pursue this path and sadly, we're more "adjusted" to the situation now which in my opinion shouldn't be the case* (Female, 22, 2nd year)

As was evident in this study, nursing students exposed to bullying and harassment were left feeling depressed, angry, anxious and fearful. These participants indicated that their experience of bullying and harassment was likely to impact patient care and drive students to consider leaving the profession. Earlier work has shown similar findings, including the negative impact of bullying and harassment on students' health (Bowllan, 2015; Courtney-Pratt et al., 2018; Fang et al., 2020; Fernández-Gutiérrez and Mosteiro-Díaz, 2021; Karatas et al., 2017; Zhu et al., 2019), learning (Bowllan, 2015; Karatas et al., 2017; Lee et al., 2018; Smith et al., 2016; Thomas et al., 2015; Zhu et al., 2019), professional socialisation (Thomas et al., 2015; Zhu et al., 2019), attitude towards nursing and career choices (Birks et al., 2017; Bowllan, 2015; Courtney-Pratt et al., 2018; Furst, 2018; Minton and Birks, 2019; Smith et al., 2016; Xu et al., 2023) and potentially, patient care (Bowllan, 2015; Clarke et al., 2012).

> *I [hoped] I could work with good nursing professionals and supportive working staff. It is the most important for reducing anxiety and depression in [the] working environment and learning environment.*

Exposure to bullying and harassment early in their education and career can hinder the development of students' professional identify and professionalism (Xu et al., 2023; Zhu et al., 2019), and the required confidence and capabilities to practice safely (Harrison et al., 2020a, 2020b). For new nurses entering the workforce, the transition is known to be challenging and requires a level of confidence and resilience to manage the process and safely undertake the responsibilities of their new role. Nursing students who have been victims of bullying or harassment may enter the workplace as fearful and ill-equipped to provide nursing care confidently and independently. More concerningly, given the influence of role models in undergraduate nurse education (Baldwin et al., 2014; Jack et al., 2017) nursing students may develop similar behaviours as a means to cope with workplace bullying, carrying these forward into their nursing career (Hartin et al., 2018). Registered nurses in the workplace are pivotal role models that students look up to and from whom they learn the behaviours expected of nurses. The cycle needs to be broken if we are to reduce the attrition currently impacting the profession on a global scale (Buchan et al., 2018; ICN, 2021).

The outcomes from this study suggest the need to better understand bullying and harassment in the various contexts in which it occurs. It is widely accepted that the professional culture of nursing contributes to the problem (Hartin et al., 2018). In addition, while COVID-19 created unique challenges in the healthcare workplace (Poon et al., 2022), the contexts in which nurses work have long been high pressure environments. When we add the additional layer of societal culture, with their associated perceptions and expectations, the potential negative impact of bullying and harassment intensifies. The unique vulnerability of nursing students in this context increases the urgency in which strategies that bridge cultures and settings must be identified.

Policies and professional standards advocating ethical behaviours and a zero tolerance to workplace violence go some way to tackling the problem, however more comprehensive practical strategies to prevent, expose and manage bullying and harassment of nursing students are needed. Strategies identified in the literature as effective emphasize the need for a holistic approach that includes education and organizational strategies that address factors perpetuating from both within the profession and healthcare environments. These include educational opportunities for staff and students to learn about, recognise and develop skills to address bullying, strategies to encourage students to report uncivil behaviours and access to social support to mitigate negative outcomes on their health and wellbeing (Alberts, 2022; Birks et al., 2018; Fang et al., 2020; Gamble Blakey et al., 2019; Sidhu and Park, 2018; Smith et al., 2016).

Nursing students should be educated regarding guidelines and punishments with bullying and harassments, then they can take appropriate actions when something happens (Female, 26, 4th year).

Some limitations with this study are noted. Despite measures taken to ensure clarity in language and comprehension in the survey tool, language and cultural differences may have impacted student responses. The similarities in the results reported in this study and those conducted in other countries instil confidence that students completing the survey had an adequate level of understanding to answer the questions accurately, and thus that the results have generalisability to the broader population. The high percentage of reports of bullying and harassment in hospitals presents as a skewed incidence of these phenomena in this setting. This finding is, however, somewhat expected as the greatest number of placement hours occur in hospitals. A further limitation of this study is that only students' perspectives were captured in the survey. No other perspectives or contextual information related to circumstances or situations about students' experiences were collected. Finally, as with any anonymous, self-reporting tool, there is potential for misinterpretation or social desirability bias in respect of certain items.

Future research that identifies and examines the universal and unique antecedents, characteristics, and impact of bullying behaviours in Sri Lanka could inform the development of targeted strategies to help prevent negative outcomes in this context, and prepare nursing students for the complexities of their role. Similarly, cross cultural research that explores students' bullying experiences amongst different health professions and in different healthcare settings may be warranted. Such research may help to identify specific strategies to help students cope with incivility and mitigate the detrimental impact of these behaviours in the Sri Lankan context and beyond.

5. Conclusion

Bullying and harassment are longstanding, ever-present features of nursing that have proven difficult to understand and address in spite of decades of research. Findings from this study add to the current body of knowledge about the global presence of these negative behaviours and their impact on nursing students. This work also raises the potential influence of culture as a factor contributing to the persistence of this problem in the workplace. While detailed and accessible evidence-based strategies have been posited over time to offer guidance on how to recognise, prevent and address bullying behaviours are available, these have failed to stem its development and prevalence. Globally healthcare workplaces are complex and often under resourced in terms of financial and workforce requirements. Determining ways to tackle bullying and harassment of nursing students in healthcare settings relies on consideration of the societal, cultural and professional context in which these experiences occur. The findings of this paper challenges the profession to identify such solutions.

Bullying or harassment [should] not be hidden or ignored anywhere. It should be reported and the necessary actions should be taken. People have to know the rights of others [and] respect others while at work and at any place (Female, 22, 3rd year).

Ethical statement

Ethics approval for the above named study was granted through the Bioinquirer Ethics Review Committee Welisara, Sri Lanka ERC 2020/201 (02) on 27th January 2021 and the James Cook University (JCU) Approval number HREC 8374 on 17th March 2021.

CRediT authorship contribution statement

Melanie Birks: Conceptualization, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. **Helena Harrison:** Conceptualization, Investigation, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing. **Lin Zhao:** Formal analysis, Writing – original draft, Writing – review & editing. **Helen Wright:** Data curation, Formal analysis, Writing – review & editing. **Ylona Chun Tie:** Conceptualization, Writing – original draft, Writing – review & editing. **Nadun Rathnayaka:** Conceptualization, Data curation, Investigation, Writing – review & editing.

Declaration of competing interest

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None of the above named authors have any conflict of interest to report in respect of the research described in this paper.

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