

UNIVERSITY *of*
TASMANIA

**The Organisational and Social Environment of the
Simulation Laboratory, a Mediator of Vertical and
Horizontal Abuse (VHA) among Second-Year Nursing
Students: A Critical Ethnography**

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Declaration of Originality

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

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Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University. Protocol number 2014/018.

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Glossary of Terms

Bachelor of Nursing (BN)	University degree of 3 years' duration (standard program), which provides students with the qualification to practise as a registered nurse (RN) in Australia
Simulation	A learning activity that usually occurs in a dedicated space (simulation laboratory or centre) and replicates clinical practices and situations
Session	14 weeks of weekly learning and teaching
Undergraduate	A person studying at a university for a first-level degree; e.g. an award at associate diploma, diploma, associate degree, Bachelor or Bachelor (Honours) level
Simulated hospital laboratory	A dedicated environment that replicates clinical spaces to allow people to undertake clinical simulation learning and teaching
Nursing student	A person who is currently enrolled in a nursing education program but has not yet graduated
Clinical nurse	An RN working in the healthcare industry
Clinical training	A form of clinical experience (also known as clinical placements) in a regulated health profession
High fidelity	Experiences that are highly interactive and realistic, using for example, a simulated patient or full-body patient simulator programmed for multi-dimensional responses
Low fidelity	Experiences that are static and situational to the context eg. case studies, role playing partial task trainers
Academic	A teacher or scholar in a university

Sessional staff	Academic employed on a contract basis as needed per semester
Straight-from-school student(s) (SFS)	A student who has just completed secondary school
Mature-aged student(s) (MAS)	A student who is aged 21 or over on 1 March of the academic year they commence their study. Mature-age students who have not previously enrolled at a university
Higher education sector	Refers to providers of Levels 6, 7 and 8 of the 2011 version of the International Standard Classification of Education structure
Healthcare sector	Refers to providers of healthcare services
Healthcare industry	A collection of providers of healthcare, such as doctors, nurses, hospitals and pharmaceuticals
Bullying	Intentional negative behaviour that typically occurs with some repetitiveness and is directed against a person who has difficulty defending himself or herself
Mobbing	Acts of hostile and unethical communication directed in a systematic way by one (or more) person(s), mainly towards one individual
Abuse	Unnecessary or avoidable acts or words of a negative nature inflicted by one person on another person or persons
Incivility	Actions that violate acceptable social behaviour and may result in unintended harm. Can involve physical, verbal or emotional abuse

Vertical violence	Abusive behaviours occurring where there is a power imbalance between the perpetrator and the target. Can involve physical, verbal or emotional abuse
Horizontal/lateral violence	Abusive behaviours perpetrated by those in a similar position. Can involve physical, verbal or emotional abuse
Workplace violence	Intentional use of physical force or power, threatened or actual, against oneself, another person or a group or community, which results in, or has a high likelihood of resulting in, injury, death, physiological harm, maldevelopment or deprivation
Enrolled nurse (EN)	Provides nursing care, working under the direction, delegation and supervision of an RN
Assistant in nursing (AIN)	A healthcare worker who supports the delivery of nursing care by assisting people with personal care and activities of daily living

List of Abbreviations

AHPRA	Australian Health Practitioner Regulatory Agency
AIN	Assistant in nursing
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMF	Australian Nursing and Midwifery Federation
AQF	Australian Qualifications Framework
AWB	Australian Workplace Barometer
BN	Bachelor of Nursing
CSU	Charles Sturt University
EN	Enrolled nurse
HPSN	Human Patient Simulation Network
HREC	Human Research Ethics Committee
ICN	International Council of Nurses
ILO	International Labour Office
JB	Joanna Briggs Institute
MAS	Mature-aged student(s)
NABS	Nursing Assessment By Simulation
NAQ	Negative Acts Questionnaire
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
RN	Registered nurse
SFS	Straight-from-school student(s)
TAFE	Technical and Further Education
UK	United Kingdom
US	United States
VET	Vocational and Educational Training

WHO World Health Organisation

Publications and Conference Presentations Resulting from This Research

Conference presentations

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Lambert, K. (2012) *How does the socio-materiality of the simulation laboratory enable acts of vertical and horizontal abuse among second-year nursing students? A critical ethnography*. Paper presented at ProPel International Conference, Learning in Troubled Times: Emerging Practices and Transgressive Knowledges, University of Stirling, Scotland, 9–11 May 2012.

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(VHA) within an undergraduate nurse simulation environment. *Collegian. The Australian Journal of Nursing Practice, Scholarship and Research* (Ref: COLL_2019_105).

Abstract

Vertical and horizontal abuse (VHA) has been reported in the nursing literature for more than 30 years. Previous research has focused specifically on VHA among nurses employed in the health sector, with some studies examining nursing students' exposure to VHA during clinical training. Little attention has been paid to simulated environments used in the education of student nurses as a potential arena for VHA. This critical ethnographic study sought to address this knowledge deficit by investigating whether the organisational and social environments of a simulated hospital laboratory may enable episodes of VHA.

Carspecken's critical ethnography informed the conduct of this research endeavour. Ethical clearance was obtained from the university's Human Research Ethics Committee. In all, 43 participants consented to participate in the study. Monological and dialogical data were collected over 24 weeks, in two sessions. Data collection tools included observations, field notes and artefacts such as codes and policies. Semi-structured interviews were conducted with the key informants. The data were analysed using Carspecken's pragmatic horizon analysis and the findings were explained using Pierre Bourdieu's social practice theory.

The key finding was that episodes of VHA were evident among second-year nursing students and academics engaged in learning and teaching in a simulated hospital environment. This study showed that the organisational and social spaces of learning and teaching have been influenced by curriculum design. More

significantly, however, by the modern managerial approaches to university and healthcare sectors. In this context, the pressures from outside the university, as well as the challenge for capital within the university, have begun to fracture various fields of practice and in particular, the field of the simulation laboratory.

This study contributes to a body of evidenced-based work that argues that education curricula embed values and act as a mechanism to reinforce dominant practices.

Chapter 1: Introduction to the Study

No doubt agents do have an active apprehension of the world. No doubt they construct their vision of the world. But this construction is carried out under structural constraints. (Bourdieu, 1989, p. 18)

1.1 Introduction

In recent years, there has been an increasing focus on limiting violence in healthcare workplaces (Al Dameery & Mrayyan, 2018; Copeland & Henry, 2017; World Health Organisation [WHO], 2001), where the effects of violence have been linked to endangerment to healthcare workers and patients, as well as difficulties in recruiting and retaining staff. Violence in healthcare can be both physical and psychological violence. Psychological violence is described as unwanted workplace behaviours such as bullying and harassment. Unwanted workplace behaviours are context specific and often covert in nature, which makes it difficult to address them.

The way in which unwanted work place behaviours is perceived and understood is diverse which makes the phenomenon difficult to clarify and measure (Birks, Budden, Biedermann, Park & Chapman 2018). Hartin, Birks and Lindsay (2019 p. 88) indicate that bullying is both a theoretical and subjective concept that is complex involving a multitude of antecedent factors, organisational, and interpersonal power-oriented dynamics.

These behaviours endanger healthcare workers and patients. According to the WHO, they negatively affect the psychological well-being of staff and lead to financial loss in the healthcare sector (WHO, 2002.)

One of the issues facing researchers in the field of unwanted workplace behaviour is the variation in the terms used to describe it, which makes it difficult to draw comparisons across disciplines and countries (Boyle & Wallis, 2016). The

literature review chapter explores some of the definitions and language used by researchers and from organisations such as the International Labour Office (ILO) and the WHO to describe these acts. In this study, the term ‘vertical and horizontal abuse’ (VHA) was adopted to signify unwanted workplace behaviours. This decision is justified in Chapter 2.

VHA has affected nursing for more than 30 years, with the phrase ‘nurses eat their young’ coined in 1986. The perpetration and normalisation of VHA is perpetuated within the Australian nursing workforce culture despite it being recognised as unacceptable and irrespective of the implementation of preventative strategies enforced in workplace policies (Chachula, Myrick, & Yonge, 2015; Eley, Eley, & Rogers-Clark, 2010; Hutchinson, Vickers, Jackson, & Wilkes, 2006a; Longo & Sherman, 2007; McKenna, 2003; Schaffner, Stanley, & Hough, 2006; Thomas & Burk, 2009).

It is unclear how, or even when, nurses learn, accept and model VHA. There is evidence that student nurses encounter VHA when they participate in clinical training during their educational programs (Birks, et al, 2018; Curtis, Bowen, & Reid, 2007; Budden, Birks, Cant, Bagley, & Park, 2017; Longo, 2007; Magnavita & Heponiemi, 2011; Tee, Özçetin, & Russell-Westhead, 2016). Therefore, the nursing education process may be an unwitting partner in supporting a culture that is characterised as ‘eating its young’.

This study aimed to determine whether the organisational and cultural environment of a contemporary, simulated hospital laboratory used by academic nursing staff to prepare nursing students for the reality of practice supported the conditions that enable VHA to be perpetrated and normalised. This chapter details the impetus for undertaking this study. Background informing the research and the

significance of the study, delineation of the research question and the methodological approach adopted are presented. The chapter concludes with an overview of the structure of the thesis.

1.2 Call to the Question

Undertaking this research was motivated by my perception that there is a lack of understanding of why or how VHA is sustained in the nursing profession. I begin here with a short recount of my educational and professional journey through nursing:

By the time I had completed my secondary education in a small New South Wales (NSW) rural town, nursing education had been transferred from hospital-based training to higher education. I took the first step into a larger world and became the first in my family to attend university. This had mixed reviews by my family. Some were excited, but some also reminded me “not to get too big for my boots.” In the 1980s, the Nightingale apprenticeship model of nurse training, which was conducted in the hospital, was moved to the federally funded colleges and then to the university sector. This was seen by nursing organisations as a significant achievement. By the time I graduated from university in 1993, the undergraduate qualification had changed from being a Diploma to a Bachelor’s degree. Subsequently, I was among the first to graduate from a university with a Bachelor of Nursing (BN) Degree.

My first position as a registered nurse (RN) was at a reputable metropolitan tertiary hospital. I was required to sit an entry examination for a new graduate transition program, which was at the time, and still is, a competitive process. It was at this hospital that I learned about the professional and social aspects of nursing. I understood that nurses ‘ate their young’ and I knew I had to ‘earn my stripes’; the

first time one of my patients died was considered a 'rite of passage'. I was among the very few RNs who had a Bachelor's degree and as a minority, I felt the exclusion and the not-so-covert threat from the dominant forces on the ward. At the time, nurses with a Bachelor's degree earned 50 cents an hour more than other nurses earned. I was often reminded that just because I earned more, it didn't mean I knew more. I was subjected to unreasonable rosters and unfair patient loads. I was not allowed to sit at the table in the tearoom; I had to sit on the single chair against the back wall. I needed to 'know my place'.

I undertook further education, completing a Master's degree in nursing, and became a clinical nurse specialist in adult intensive care. I view this phase of my career as a time of personal and professional growth. It was during this time that I began to reflect on the ways of the nursing world. I had seen many colleagues and friends leave the profession because they felt ostracised and continuously berated.

As a nursing academic, I still say goodbye to colleagues who leave academia because they feel bullied. The students I teach tell stories of their clinical training experiences, with the RN making disparaging remarks about them and making them feel ignored and like they were 'in the way'.

In my role as a nursing academic, I regularly teach nursing students within simulated learning environments. These environments are designed to replicate or simulate real clinical hospitals. This led me to question what we were actually teaching in simulated laboratories. Were we replicating the 'good' and the 'bad' of the real world of nursing? Were we inadvertently teaching VHA behaviours to students, as well as to each other as academics? Was unintended learning of VHA occurring within this contemporary learning and teaching space?

1.3 The Australian Nursing Workforce

According to the Australian Institute of Health and Welfare (AIHW), RNs and midwives currently represent 68 per cent of the registered health workforce, comprising approximately 245,000 RNs (AIHW, 2018). The majority (88.6 per cent) of the RN workforce in Australia is female (AIHW, 2018). The number of male RNs has increased by 3,452 since 2014 (Health Workforce Data, 2018). The average age of RNs in Australia is 43 years and they work 32.3 hours per week, with almost half the workforce (48.8 per cent) working at a part-time level, less than 35 hours per week (AIHW, 2018). Overall, 63.8 per cent of RNs are employed by the public health sector, primarily practising in a hospital setting (HWD, 2018).

It has been projected that by the year 2025, Australia will experience a 23 per cent shortfall of 85,000 in the workforce of nurses and midwives. This figure is predicted to increase to 123,000 by 2030 (Australia's Future Health Workforce [AFHW], 2014). An ageing nursing workforce, the part-time nature of the workforce and high workforce attrition rates have been flagged as contributing to the predicted workforce shortage (AFHW, 2014; AIHW, 2016-17).

Population health trends, such as increased chronic conditions (e.g. heart disease, dementia and obesity) mean that increased numbers of nurses are required to meet healthcare demands. Over time, the nursing workforce shortage could undermine Australia's healthcare system. Nurses are at the front line and have the workforce size to prevent ill health through early intervention, as well as to support people living with chronic ill health. With the focus now turning to wellness, to limit the spiralling costs of healthcare, the impact of the shortage in nurses will be felt most in aged-care, rehabilitation and primary healthcare services. This shortfall will be exacerbated if the current workforce trends continue, with high student attrition in

courses leading to RN registration, lower-than-historical rates of RN graduate employment and low retention of early-career RNs (AFHW, 2014).

1.4 Nursing Workforce Attrition

Nurse researchers, nationally and internationally, have found that up to one in three nurses consider resigning from the nursing profession (Chachula et al., 2015; Eley et al., 2010; Hutchinson et al., 2006; Longo & Sherman, 2007; McKenna, 2003; Schaffner et al., 2006; Thomas & Burk, 2009). The decision to leave the profession is occurring early in the nurses' career, with up to 60 per cent of new graduates leaving nursing in the first six months of practice (Griffin, 2004; McKenna, 2003; Randle, 2003a; Weinand, 2010). Reasons for this attrition have been cited as issues with navigating the healthcare system, negotiating the social hierarchies, traumas and challenges, and the lack of reward for the effort made (Chachula et al., 2015).

Organisational and individual factors contribute to nurses deciding to leave the profession. Organisational factors include work environment and culture, while individual factors incorporate job satisfaction, demographics and burnout (Chan et al., 2013). Work environment and cultural factors incorporate the values and beliefs of the organisation, which shape employees' behaviours. If inconsistencies arise in an organisation's culture, nurses are likely to resign (Goodare, 2017). Further, if a nurse cannot identify with the values of the organisation nor observe execution of those values, the nurses' attitude towards the organisation will be altered and this inevitably leads to a disconnect and influences a nurse's intention to leave the profession (Goodare, 2017; Chan et al., 2013).

Individual factors contributing to a nurse's intention to leave the profession include personal circumstances such as child care responsibilities, as well as burnout. Burnout is described as emotional exhaustion arising from a prolonged

discrepancy between what the individual gives and receives in the workplace (Goodare, 2017). The psychological well-being of nurses is important, as nurses who experience changes in their psychological well-being are more likely to exit the workforce. Disorders such as anxiety, depression and compassion fatigue are heavily linked to the nursing profession (Goodare, 2017). Another option cited by nurses who struggle with the impact of shift work, work intensification and ageing is to reduce their employment level to part time (Drury, Craigie, Francis, Aoun, & Hegney, 2014; Goodare, 2017).

Over the past 20 years, research has linked episodes of VHA in workplaces to a range of physical health problems and psychological health and well-being outcomes, including general mental health issues, anxiety, depression, post-traumatic stress, generalised strain, psychosomatic symptoms and burnout (Nielsen & Einarsen, 2012). Overall, VHA in Australian workplaces have been reported as the reason for nearly a third of all mental health stress compensation claims, which in turn, generated the largest proportion of cost relative to all other claims (Safe Work Australia, 2014). Further, in 2014, a university report on a survey undertaken by the Australian Nursing and Midwifery Federation (ANMF) found that 40 per cent (n = 4,891) of the respondents had experienced VHA within the previous 12 months (De Cieri, Shea, Sheedan, Donohue & Cooper 2015).

1.5 Nursing Education

There are three levels of nurses: enrolled nurses (ENs) prepared through vocational and educational training (VET) such as Technical and Further Education (TAFE), the RN prepared through higher education and the nurse practitioner, also prepared through the higher education system. Currently, ENs complete a Diploma through the VET sector, while RNs require a Bachelor's degree or a Graduate Entry

Masters in Nursing (where another degree is already held). After gaining a Bachelor's degree, RNs may complete higher awards through universities, such as graduate certificates and diplomas, Master's degrees and Doctoral degrees (National Review Nursing Education, 2002).

To become an RN in Australia today, a student may complete a three- or three-and-a-half-year-equivalent full-time Bachelor's entry, or a two-year Master's entry, to a practice-accredited course (Nursing and Midwifery Board of Australia [NMBA], 2019). In addition, there are options to complete double degrees such as a BN with a Bachelor of Science, Midwifery or Paramedicine, or students can enrol in a two-year accelerated program (APHRA, n.d.).

The Australian Qualifications Framework (AQF) encompasses the whole range of qualifications, from school through to university, that are endorsed by the Australian Government. The AQF's objective is to regulate qualifications in the Australian education and training system to ensure consistency in qualifications across Australia.

At the time this study was conducted, there were 10 levels in the AQF, and undergraduate nurse education was an AQF Level 7. Graduates at this level should have a broad and coherent knowledge and the skill development for professional work; well-developed cognitive, technical and communication skills; and the ability to analyse and evaluate information, generate and transmit solutions to complex problems, and transmit knowledge, skills and ideas to others. In addition, they will be able to demonstrate autonomy, judgement and responsibility (AQF, 2013).

The standards set by the Australian Health Practitioner Regulatory Agency (AHPRA, 2012.) establish the content, staff profile and workplace experience that must be included for a course to be approved for leading to registration as an RN.

These standards detail the minimum requirements expected from the higher educational provider.

Each Higher Education provider develops their own curriculum in accordance with the AQF policy. The Australian Nursing and Midwifery Accreditation Standards Council aim to ensure the quality of nursing programs, especially in terms of maintaining public safety and confidence. The quality of undergraduate nurse education is essential in producing graduates who protect the public and the recipients of care and who are safe and effective caregivers (Lampley, Curia, Vottero, & Hensel, 2016; Ralph, Birks, Cross, & Chapman, 2017). The purpose of the council is to ensure that the standards, policies and procedures underpinning assessment and accreditation are 'effective, fair and based on contemporary research and best practice in the interests of promoting and protecting the health of the community' (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2012d).

The predominant model of undergraduate nurse education offered by Australian universities follows a model whereby students receive theoretical teaching through face-to-face engagement at the university or in online modalities. Simulated clinical practice is conducted at the university on a weekly basis (or during residential school for online students) and in real-life clinical training in the clinical setting. Typically, in Australia, student RN's receive between 800 and 1,100 hours of real-life supernumerary clinical immersion, in the form of blocks of placements scheduled throughout the academic year under a variety of clinical supervision models (National Review of Nursing Education, 2002; NMBA, 2016). Comparing Australian standards with international standards, Singapore mandate 1280 hours of immersive clinical training, while New Zealand require 1100 hours, the UK 1530

hours. (ANMF 2019). Furthermore, the Singapore Nursing Board (SNB) has authorised up to 80 clinical training hours being replaced with simulation at a ratio of 1 hour: 1 hour. (Schwartz 2019). While in the USA some Nursing Boards (Colorado, North Carolina and Michigan) allow up to 50% of clinical training time to be replaced with simulation.

1.6 Simulated Learning and Nursing Education

The National Review of Nursing Education (2002, pp. 17–18) identified that a partnership approach is ‘essential for quality practice and education’ and provides a way to find solutions to many of the challenges currently facing the nursing profession. The higher education sector should not continue to admit large intakes of nursing students into university courses without careful collaboration and planning of quality education, clinical practice, graduate employment outcomes and wider workforce issues (Turner, Davies, Beattie, Vickerstaff, & Wilkinson, 2006).

Providing quality clinical training is an ongoing challenge in nurse education (ANMAC, 2018). Issues are the increasing numbers of student enrollments in pre-service nursing programs; difficulty in securing clinical training sites; a decrease in nurse academics; lack of physical spaces, technical training and support; fatigued clinical staff; the reluctance of health professionals to supervise students in clinical training; and fierce competition for access to the same placements by a other providers (Baxter, Akhtar-Danesh, Valaitis, Stanyon, & Sproul, 2009; Berndt, 2010; Gates, Parr, & Hughen, 2012; Health Workforce Australia [HWA], 2010; Warland, 2011). These challenges have led to a need to find alternative strategies that can achieve similar learning outcomes. Increasingly, one strategy has been simulated learning (Lapkin, Levett-Jones, & Gilligan, 2013).

Simulated learning is described as a learning and teaching strategy that incorporates goal-based role playing to practise technical and non-technical skills without risk to real patients (Bogossian et al., 2018). The ultimate purpose of simulation-based education in undergraduate programs is to improve the quality and safety of healthcare delivery (Seaton et al., 2018). According to Gaba (2004), simulation has the potential to improve patient safety in nurse education. Simulated learning and teaching is designed to facilitate learning opportunities in a realistic but non-threatening environment (Akhtar-Danesh, Valaitis, Stanyon, & Sproul, 2009; Alconer-Camarero, Gualdron-Romero, Sarabia-Cobo, & Martinez-Arce 2016; Al-Ghareeb & Cooper, 2016; Berndt, 2010; Miller & Bull, 2013; McNiesh, 2015; Nehring & Lashley, 2009).

Patient safety refers to the actions taken by individuals and organisations to protect consumers of healthcare (National Patient Safety Foundation, 2008). It is currently governed in Australia by the National Safety and Quality Health Service standards. The standards provide an evidence-based and nationally consistent set of measures of patient safety (Seaton et al., 2018). As patient safety is a major national priority (Australian Commission on Safety and Quality in Health Care, 2016–17), simulation has received government support, with funding provided to establish simulated-learning environments (Australian Government Department of Health and Workforce Australia, 2015). Therefore, the use of simulation for undergraduate healthcare education has increased and is embedded in most tertiary education provider programs of undergraduate nursing degrees (Bogossian et al., 2018).

Theory related to patient safety should be embedded in curriculum content, while the application of patient safety strategies is commonly practised in simulation laboratories overseen by academic staff (Usher et al., 2018). Other teaching

techniques adopted to ensure students understand why and how patient safety is a priority in nursing care include role plays (Lee, Phan, Dorman, Weaver, & Pronovost, 2016; Tella, Smith, Partanen, & Turunen., 2014), written assignments (Lee et al., 2016), debriefing sessions following simulation activities (Lee & Kim, 2011) and immersion in practice (Botma, 2014). Studies addressing patient safety and teaching approaches vary, depending on school curricula (Lee et al., 2016; Seaton et al., 2018; Steven, Magnusson, Smith & Pearson 2014). Currently, the undergraduate nursing curricula commonly reinforce individual's clinical safety, including monitoring medication administration and consistency with infection control procedures. Human sociocultural factors such as communication and teamwork, which can also contribute to the safety of practices, are less commonly considered (Mansour, 2012).

Several studies have found that VHA among healthcare providers adversely affects safe patient care (Houck & Colbert, 2017; Phillips, Stalter, Winegardner, Wiggs, & Jauch, 2018; Spence-Laschinger & Fida, 2014). Episodes of VHA have been associated with increased patient falls (Stanely, Martin, Michel, Welton, & Nemeth, 2007), errors in treatment or medication administration (Farrell, Bobrowski, & Bobrowski, 2006; Roche, Diers, Duffield, & Catling-Paull, 2010; Rosenstein & Naylor, 2012; Rosenstein & O'Daniel, 2008; Rowe & Sherlock, 2005; Stanely, Martin, Nemeth, Michel & Welton 2007), delayed care (Roche et al., 2010), patient adverse events (Laschinger, 2014; Rosenstein & Naylor, 2012) altered thinking (Bonner & McLaughlin, 2007; Rosenstein & Naylor, 2012) and inhibited communication (Rosenstein & Naylor, 2012; Rowe & Sherlock, 2005; Thomas & Burk, 2009; Wilson & Phelps, 2013). In response, there is growing recognition that the focus of patient safety must expand from focusing on individual's unsafe

practices to recognising and including the influence of human sociocultural factors such as VHA (Duhn et al., 2012; Lukewich et al., 2015; Robson, Clark, Pinnock, White, & Baxendale, 2013; Tregunno, Ginsburg, Clarke, & Norton, 2014; Usher et al., 2017). While there is a clear link between VHA and unsafe patient care, the effect of VHA on a nurse's work has not been explored fully. A number of researchers have recommended further investigation into VHA at the interface of society, organisations and individuals (Gillian, Sinclair, Kernohan, Begley, & Luyben, 2017; Phillips et al., 2018) as a method to uncover the contributing factors that enable episodes of VHA that affect patient care negatively.

It is important that graduate nurses have sufficient awareness of the general risks to patient safety and the ability to protect patients from potential harm (Usher, 2017.) Nurse education providers have an important role in preparing graduate nurses to provide safe care environments for patients (Cant & Cooper, 2017). However, there is recognition that nursing curricula does not pay sufficient attention to the sociocultural aspects that influence patient safety and well-being and graduate nurses should be able to recognise and act to prevent perverse sociocultural factors such as VHA that contribute to unsafe environments. (Doyle, VanDenKerfhof, Edge, Ginsburg & Goldstein, 2015; Duhn et al., 2012; Ginsburg, Tregunno, Norton, Mitchell & Howley, 2013).

1.7 Aims and the Significance of the Research

The primary aim of this critical ethnography is to determine whether acts of VHA occur among second-year student nurses and academics who are learning and teaching in a simulated hospital environment and if so, to provide greater understanding of the conditions that support VHA occurring in this space. As described earlier, simulation is a learning and teaching strategy that incorporates role

playing to practise technical and non-technical skills without risk to real patients (Bogossian, Cooper, Kelly, Levett-Jones, McKenna, Slark & Seaton 2018). By examining the strategies used in nursing simulation education, this research gives detailed insight into the ways organisational and social structures may enable VHA in a simulated hospital environment.

This research study sought to answer the following question:

Does the organisational and cultural environment of the simulation laboratory mediate episodes of VHA among second-year nursing students?

1.8 Methodology and Methods

Critical research is a valid approach for understanding a social phenomenon, as it examines day-to-day activities to identify the way the current situation became the status quo. While social theory can be used to explain ‘what is’, critical social theory is used to consider ‘what could be’ (Thomas, 1993).

The purpose of this critical ethnography is to explore the ways the organisational and social context of the simulated hospital environment could enable acts of VHA among second-year nursing students studying at a regional university in NSW. It aimed to uncover the reality and nature of the subtleties of power that are socially and historically constituted in the simulated hospital learning environment, which may manifest as episodes of VHA (Carspecken, 1996). A critical paradigm is used to address phenomena of social injustice and marginalisation, rather than simply gaining a greater understanding of a social phenomenon, as a critical lens combines theory and practice and seeks social change (Thomas, 1993). Critical theory begins with the important proposition that certain social groups within a society are more privileged than others (Carspecken, 1996). The ontological perspective is that reality

is shaped over time by social, political and cultural factors. This critical ethnography used Carspecken's (1996) five-stage approach.

Philip Carspecken, a sociologist has a specialised interest in critical theory and education. His technique is a valuable tool for researchers, as it offers a strong theoretical foundation to create research in an ethical manner (Hardcastle, Usher, & Holmes 2006; Smyth & Holmes, 2005). A number of Doctoral studies have used Carspecken's technique, such as Mills' (2006) investigation into literacies in the face of cultural diversity, Beekhuyzen's (2009) examination of file-sharing communities and Nam's (2013) investigation of the challenges of helping students to develop responses to 'English as a second language' reading texts. Mahon (2014) adopted this technique to investigate the determinants of nurses' job satisfaction. Harrowing, Mill, Spiers, Kulig and Kipp (2010) used Carspecken's approach to explore the concept of cultural safety and Bidabadi, Yazdannik and Zargham-Boroujeni, (2017) used it to reveal the cultural factors that may obstruct patients' dignity in intensive care.

Carspecken's approach has a five-step cyclic process. The first stage involves the researcher compiling a primary record by immersion in the field to observe interactions. This stage is referred to by Carspecken as being monological, as it contains only the researcher's voice (Carspecken, 1996, p. 42). The second stage is the preliminary reconstructive phase, where analysis begins. This stage begins to reveal the roles, routines and patterns of power relations. It is called 'reconstructive' because it articulates cultural themes and system structures that are not visible to the participants (p. 42). The third stage is referred to as the dialogical data generation phase, in which the participants' voices contribute to the dataset. The fourth stage examines the systems relationships of the social site of focus and other sites that bear

relation to it (Carspecken, 1996, p. 42). The final stage uses the system relations to explain the findings.

The research question of this study requires inquiry about VHA, both generally and specifically, among second-year undergraduate nursing students and the academics teaching them. As the researcher is a lecturer in nursing at the university in which the research was undertaken, the second-year undergraduate nursing students who were targeted as participants were not taught by the researcher during the academic year the data were collected, to avoid any suggestion of participant coercion. The second-year cohort was familiar with the simulated laboratory from their first-year classes in that space and they were not under pressure of training completion, as would have been the case in a third-year cohort.

As this research is student focused, the academic teaching team was not initially included in the study. However, after preliminary observations it was clear that academics had a direct impact on the way classes were structured (Fowler, Baker, & Geraghty, 2017). Therefore, an amended ethics application (see Appendix A) was submitted and members of the academic teaching team were included in the study as participants.

Carspecken's approach requires three data sets: observational, interview and document analysis. The data generated through non-participant observation and field notations were analysed using Carspecken's thematic analysis approach. All of the analysed data were then collated, to provide insight enabling a rich ethnographic description of the culture of student nurses and academic staff engaged in learning and teaching in the simulated-learning environment. Bourdieu's (1977) social practice framework was used to interpret the findings and enable the research question to be answered.

According to Alvesson and Deetz (2000), there are three major responsibilities when conducting critical research: to explore the nature of a phenomenon at a local level; to question the assumptions that undermine organisational practices; and to produce knowledge and understanding that enables change and pathways to a new way of being. Each of these tasks is addressed in this research.

1.9 Organisation of the Thesis

This thesis comprises seven chapters. Chapter 1 provides a rationale for this research in terms of the prevalence of the phenomena and positions this research in a contemporary context. This chapter identifies the challenges that the current terminology used to describe unwanted workplace behaviours has on future research in terms of being able to compare and contrast findings.

Chapter 2 provides an overview of the research literature to date in the area of unwanted workplace behaviours, nursing and education, and simulation education. In response to the need for more conceptual clarity in the terms that are currently being applied to unwanted work place behaviours, a new phrase was introduced in this chapter; vertical and horizontal abuse. The literature review begins with the general literature on this type of behaviour, followed by the specific literature on nursing and education, and nursing students. Research on the current legislation and interventions is provided and finally, the gap in the literature is revealed.

An innovative approach that was used to explore the non-essentialist enablers of unwanted behaviours relevant to student nurses learning in simulation is detailed in Chapter 3. Carspecken's (1996) critical ethnographic methodology as it was used to generate and analyse data is outlined.

Chapter 4 presents the research findings in two parts: the context of simulation in undergraduate education and the findings and analysis. Part 1 provides detail of the milieu in which the study was undertaken, using a descriptive ethnographic account. Part 2 presents the collated major findings isolated from the analysis of all generated data.

Chapter 5 presents Bourdieu's social practice theory (1977) and social reproduction theory, which was implemented to interpret the findings described in the previous chapter. Chapter 6 provides a discussion of the major themes arising from this study in relation to what is already known and what this research has added to knowledge.

The thesis concludes with Chapter 7, which contains a summary of the results and concluding comments regarding the implications of the research for undergraduate nurse education. The significance of the research and limitations are discussed, as well as recommendations for nurse education, the profession, research and practice. A number of appendices offer additional information about the processes and methods used in the research.

Throughout this thesis, reflexivity boxes have been utilised to capture musings that helped me to question my beliefs, presuppositions and assumptions and to track the decisions that I made throughout this research endeavour. These reflexivity boxes contain glimmers of ideas that were generated from pondering on early writing and possible notions that were pursued as the argument being made was advanced and matured. The notations in these reflexivity boxes were and are not data; rather, they record moments in time during the thesis process and it was cathartic and advantageous to the integrity of this research to record this inner dialogue.

1.10 Summary

This chapter has provided an introduction to the thesis, with description of the background to the study, the impetus for undertaking this research, and the delineation of the research question and aims. The methodology, critical ethnography and its applicability for this research, has been outlined, followed by some detail of the process adopted. Finally, the structure of the thesis has been detailed.

Chapter 2 introduces the research literature relevant to the topic. Section 2.2 identifies the terminology used and provides justification for a new term (VHA) to be adopted, to represent the diversity of ways in which unwanted behaviours are perpetrated. The search strategy used in this literature review is then presented, which leads to a discussion of the literature produced on VHA in organisations generally, and then specifically in nursing and higher education. This chapter identifies and evaluates current preventative strategies and interventions. Literature on simulation and nurse education is then explored and gaps are highlighted.

Chapter 2: A Review of the Literature

The unconscious is never anything other than the forgetting of history which history itself produces by incorporating the objective structures it produces in the second natures of habitus: in each of us, in varying proportions, there is part of yesterday's man. (Bourdieu, 1972, pp. 78–79)

2.1 Introduction

The chapter begins with defining terms associated with unwanted work place behaviours and justifies the adoption of VHA to reflect the diversity of ways in which such behaviours are enacted. The search strategy used to locate literature is presented, followed by the results of the review. A narrative synthesis of the included literature is discussed under five headings, enabling the identification of a deficit in knowledge that this study seeks to address.

2.2 Defining Terms

Phrases used in the literature to describe and define unwanted workplace behaviours vary across disciplines. Organisational literature, for example, uses the term 'bullying' (Einarsen, Hoel, Zapf, & Cooper, 2011; Einarsen & Skogstad, 1996; Nielsen & Einarsen, 2012). Although bullying is just one category of violence, it is the term most frequently used to describe unwanted workplace behaviour. Bullying is defined as intentional negative behaviour occurring with some repetitiveness and being directed against a person who has difficulty defending himself or herself (Olweus, 2011, p. 151). However, organisational literature originating from Europe uses the term 'mobbing' (Leymann, 1990) to describe acts of hostile and unethical communication aimed, in a systematic way, at one or a number of persons.

In contrast, medical and allied health literature often uses the term 'abuse' (Celik & Bayraktar, 2004; Rosenberg & Silver, 1984; Silver, 1982). Abuse has been

generally defined as ‘unnecessary or avoidable acts or words of a negative nature inflicted by one person on another person or persons’ (Silver & Glick, 1990, p. 527). Silver and Glick (1990) further defined as

any form of mistreatment, spoken or unspoken that leaves you feeling personally or professionally attacked, devalued or humiliated. It is communication through words, tone or manner that disparages, patronizes, threatens, accuses, or is disrespectful towards another. (Silver & Glick, 1990, pp. 527–528)

In the nursing literature, the terms incivility (Inch, 2007; Longo, 2007; Sellers, Millenbach, Kovach, & Yingling, 2009; Weinand, 2010) and ‘lateral’ or ‘vertical and horizontal’ violence (Curtis, 2007; Duffy, 1995; Farrell, 1997, 2003; Fudge, 2006; Glass, 1997; McKenna, 2003; Smith, Cowie, Olafsson, & Liefoghe, 2002) are often used to describe unwanted workplace behaviours.

Incivility (Clark, Olender, Cardoni, & Kenski, 2011; Luparell, 2011) is described as a antecedent to more serious events and differs somewhat from bullying, in that it incorporates actions that violate acceptable social behaviour, yet may result in unintended harm (Courtney-Pratt, Pich, Levett-Jones, & Moxey, 2018; Hunt & Marini, 2012). Vertical violence refers to abusive behaviours that occur in a situation that involves a power imbalance between the perpetrator and the target, such as academic to student (Thomas & Burk, 2009). Horizontal violence describes abusive behaviours perpetrated by those in a similar position, such as other nursing students (Courtney-Pratt et al., 2018). Both of these forms of violence are acts of covert or overt aggression towards another person by an individual or a group and can involve physical, verbal or emotional abuse (Longo, 2007).

The term ‘vertical and horizontal violence’ refers to violence as a type of behaviour. The International Labour Office (ILO, Nurses, World Health Organisation, & International, 2002) defines violence in the workplace as the intentional use of physical force or power, threatened or actual, against oneself, another person or a group or community, which either results in, or has a high likelihood of resulting in, injury, death, physiological harm, maldevelopment or deprivation (p 4).

However, when the ILO worked with the WHO and the International Council of Nurses (ICN) to develop guidelines for addressing workplace violence specifically in the health sector (2014), they defined workplace violence as

a spectrum of unacceptable behaviours. It includes incidents where staff are abused, threatened, discriminated against or assaulted in circumstances related to their work, including commuting to and from work, and which represent a threat to their safety, health, and well-being. (p. 85)

These two definitions denote the physical aspects of violence, while the more subtle acts of psychological violence are left to be inferred. The first definition from the ILO begins with ‘physical force’ and continues with words such as ‘injury’, ‘death’ and ‘physiological harm’, whereas the definition developed in conjunction with the WHO and the International Council of Nurses (ICN) is less prescriptive and uses general phrases such as ‘unacceptable behaviours’ and ‘threat to safety’.

While the terms described above are often used interchangeably to describe unwanted workplace behaviour, the definitions of mobbing, incivility and abuse do not refer to power (Clark et al., 2011; Leymann, 1990; Silver & Glick, 1990). In contrast, definitions of bullying and vertical and horizontal violence do make that connection (see Einarsen et al., 2011; Einarsen & Skogstad, 1996; Lindström,

Hottinen, & Bredenberg, 2000; Olweus, 2011). Bullying behaviours that are stated specifically as conflicts between parties with perceived equal power are not considered bullying (Lindström et al., 2000). However, the power differential between the perpetrator and the target is not referred to consistently in other definitions, such as Etienne (2014) and Cox & Goodman (2005), who provided descriptions of bullying behaviours that included withholding information, spreading gossip, being shouted at, unnecessary intrusions and emotional blackmail.

The terms ‘vertical’ and ‘horizontal’ violence that are frequently used in the nursing literature (Curtis, 2007; Duffy, 1995; Farrell, 1997, 2003; Fudge, 2006; Glass, 1997; Inch, 2007; Longo, 2007; McKenna, 2003; Sellers et al., 2009; Weinand, 2010) reflect the possibility that the power dimensions of a relationship can be both vertical and horizontal (e.g. from individuals with perceived power to individuals perceived as having less power and vice versa). This suggests that formal power differences are a possible source of imbalances of power between a target and a perpetrator.

Although the meanings of all these terms overlap, these terms are being applied inconsistently and appear to be assumed more than clearly defined, making it difficult to integrate the research in this area. While the cataloguing of behaviours can be useful, there have been calls for a synthesis of these terms, to provide greater conceptual clarity (Aquino & Thau, 2009; Boyle & Wallis, 2016; di Martino, 2003). Given the need for clarity around the language used, a term that explicitly captures both the power dimensions and the associated behaviours is needed. As this thesis explores workplace violence in the psychological sense, the term VHA, which conceptualises both the dimensional nature of power and the type of behaviour, was adopted.

Reflexivity

On presenting my research at a professional development session, a nursing colleague who had travelled widely questioned me on the use of the word 'violence' and asked, 'Is this really violence?' She proceeded to share stories of violence that she had witnessed in her role as an international aid worker. This led me to question the language used, both in general and specifically, around unwanted workplace behaviours. I do not want to dilute the word 'violence', but at the same time, I do not want to reduce the impact this behaviour has on the targets and organisations as a whole.

2.3 Search Strategy

Both published and unpublished literature that referred to VHA was located. The search for grey literature included hand searching reference lists and searching Open Grey online, dissertations and conference proceedings. While the primary search focus was on Australian research, international studies were also included. All published articles included in the literature review were peer reviewed. Studies published in languages other than English were excluded.

A search of ProQuest Central, CINAHL, Ebscohost, Pubmed, the Cochrane Central Register of Controlled Trials and the Joanna Briggs Institute databases was undertaken, initially, using the search term 'bullying' and the time span of January 1985 to January 2018. This date range was selected because unwanted workplace behaviour was first identified in the literature in the late 1980s by a psychologist in Sweden (Leymann), a journalist and activist in the United Kingdom (UK) (Adams) and a professor in nursing (Meissner).

The ProQuest Central database produced over 34,000 results for the term 'bullying'. The search was then refined to include the words 'health' (over 14,000 results) and 'nursing' (over 2,000 results). Adding the phrase 'nurses eat their young' led to 116 results, with the majority (n = 99) published between 2006 and 2018.

Interestingly, using the same search terms in the databases frequently accessed by clinicians (e.g. CINAHL) led to fewer results than stated above but they still reflected a high level of interest and output. Within CINAHL, the term ‘bullying’ resulted in over 7,000 items, adding ‘health’ resulted in over 2000 items and ‘bullying’, ‘health’ and ‘nursing’ resulted in over 500 publications. Using the terms ‘vertical violence’ and ‘horizontal violence’ produced 52 articles.

The Cochrane Central Register of Controlled Trials produced two trials, both conducted in 2016, on bullying and engagement in nurses working in Portugal, Spain and Brazil, as well as workplace bullying and general health among nursing staff in Greek hospitals. Only one review (written in 2017) was found in Cochrane Reviews, with the focus on preventing bullying in the workplace. The authors concluded there was a distinct lack of quality evidence that supported organisational or individual interventions that could prevent episodes of bullying: Cochrane Protocols contained one protocol (2017) on preventing aggression and one protocol (2018) on interventions for reducing occupational stress; the Joanna Briggs Institute (JBI) database contained one systematic review (2013) on the experience of lateral/horizontal violence in nursing and two protocols, one (2015) referring to online learning and bullying and one (2016) on the prevalence of bullying exposure.

The search process revealed that most studies in this area were qualitative in design, while the quantitative studies relied heavily on mailed and electronic surveys. Studies that were descriptive (Beech, 2001; Begley & Glacken, 2004; Layne, Anderson, & Henderson, 2019), quasi-experimental (Chipps & McRury, 2012), correlational (Kassem, 2015) and longitudinal (Beech & Leather, 2003; Clark, Nguyen, & Barbosa-Leiker, 2014) were found as well. The qualitative designs included phenomenology (Altmiller, 2012; Del Prato, 2013), discussion articles

(Clark & Ahten, 2012; Lim & Bernstein, 2014), qualitative exploratory studies (Clark & Springer, 2010; Griffin, 2004), descriptive studies (Clark, Ahten, & Macy, 2013; Lux, Hutcheson, & Pede, 2014; Keller, Allie & Levine, 2019; Smith et al., 2016), non-experimental descriptive studies (Cooper et al., 2009; Cooper et al., 2011) and descriptive cross-sectional studies (Choi & Park, 2019).

Reflexivity

Why is there less interest in unwanted work place behaviours in databases usually accessed by practising clinicians? Has bullying become something to theorise about rather than operationalise? Is it too big to grapple with? Have clinicians lost hope or have they accepted the behaviours?

2.4 VHA in Organisations Generally

It was identified in the literature that unwanted workplace behaviours cause serious harm to employee health, both physically and psychologically, as well as to organisations (Bond, Tuckey, & Dollard, 2010). The Australian Productivity Commission estimated the total cost of VHA to the Australian economy at between \$6 billion and \$36 billion annually (Productivity Commission 2015.), with work-related bullying and harassment contributing to a third of mental stress compensation claims, which according to Safe Work Australia generate the largest share of costs over all other claims (Safe Work Australia, 2016).

This organisational impact is due to the cost of low staff morale, increased absenteeism, decreased staff retention and reduced job productivity (Eriksen, Hogh, & Hansen, 2016; Johnson, 2009; Kieseker & Marchant, 1999; Nielsen & Einarsen, 2012; Rodwell & Demir, 2012; Safe Work Australia, 2016; Salin, 2003). On an individual level, a meta-analysis conducted by Nielson and Einarsen (2012) found a significant cross-sectional relationship between VHA and psychological disorders such as anxiety, depression, burnout and physical health ailments. In addition, their

study identified a positive lagged relationship from reported exposure to VHA and future mental health symptomology. Similarly, a cross-sectional survey of public servants ($n = 3,345$) by Hurley, Hutchinson, Bradbury and Browne (2016) in one Australian state reported a causal relationship between poor organisational responses to VHA and mental ill health. The participants in their study reported abuse of power and having adverse emotions at work, suggesting that their mental ill health had been triggered by bullying episodes. Further, the literature reported that the effects of witnessing episodes of VHA may be similar to actually experiencing episodes of VHA (D'Cruz & Noronha, 2011; Emdad, Alipour, Hagberg, & Jensen, 2013; Hoel & Cooper, 2001; Hurley et al., 2016; Vartia, 2001).

To obtain national prevalence data on VHA in Australian workplaces, the Australian Workplace Barometer project (AWB) was initiated in 2009. The study was longitudinal, with data collection commencing in 2009/10, and the final collection obtained 2014/2015. The project randomly selected participants over the age of 18 years, across all Australian states and territories, who were currently employed full time. The total number of participants for the 2014/2015 cohort was 4,242. There were 2,404 females (mean age = 49.2) and 1,838 males (mean age = 47.7). The participants were mailed a written information sheet that was followed up with a telephone interview. The information sheet included two definitions of workplace bullying: one definition from the World Health Organisation and the other from Safe Work Australia. The project revealed increases in the prevalence of VHA in most states and territories, when comparing rates from 2009, 2010 and 2011 to those of 2014/15. The electricity, gas and water supply industries, government administration, Defence industries and Health, Education and Community Services sectors had a higher prevalence of VHA than other sectors.

Reflexivity

Why do we have a greater prevalence of unwanted workplace behaviours in socially constructed sectors?? Sectors that have been designed to support society? Is this a statement on society as a whole?

Additionally, the data revealed that of the workers who reported episodes of VHA, 12.2 per cent experienced it on a daily basis; 32.6 per cent per cent experienced it once a week; and 27.9 per cent experienced it at least once a month. In 62.3 per cent of cases, the perpetrator was a supervisor, with the next most highly cited perpetrator being the co-worker (28.0 per cent). Butterworth, Leach and Kiely (2016) found similar results in the prevalence of VHA among the Australian workforce. Their longitudinal study used a self-labelling questionnaire and interview with 1,466 employees who worked in a variety of government and private industries, finding that 46.6 per cent had experienced episodes of VHA during their employment.

The tools used to measure prevalence of VHA are important. The literature has shown, depending on the measurement scale used, incidences of VHA ranging from 1 to 55 per cent (Galanaki & Papalexandris, 2013; Nielsen, Matthiesen, & Einarsen, 2010). The majority of the prevalence data found in this literature review had been measured using self-assessment and the Negative Acts Questionnaire (NAQ), which is a validated instrument that is used to identify bullying in the workplace (Einarsen, Hoel, & Notelaers, 2009). This 22-item questionnaire has been used extensively within the healthcare sector (Chowdhury, Husainat, & Suson, 2019). Overall, it can be said that self-reported episodes of VHA are prevalent in the Australian workforce in general.

2.4.1 The organisational context

Many authors have suggested that VHA relates to the structure of Australian society, which is often portrayed as egalitarian but is fundamentally hierarchical (Butterworth et al., 2016; Dollard, Dormann, Tuckey, & Escartín, 2017; Morrison, 2013; Stylianou & Savva, 2016; Watters & Hills, 2015). As the AWB Project (2009) and other researchers (Hurley et al., 2016; Eriksen et al., 2016; Nielson & Einarsen, 2012) have demonstrated, VHA in the workplace is especially common in large hierarchical organisations such as governments, the public service, business corporations, the churches, health, law, the defence force and the police force.

In an organisational context, a defining factor of power is the ability of the power holder to make something happen as she or he wishes (Lumby, 2017). Similarly, Lunenburg (2012) suggested that leaders use power to get things done and achieve organisational goals and Ebert and Griffin (2015) noted that power in organisations was necessary to influence the actions of individuals. Ultimately, people are more likely to be influenced by, or to follow, those with power or social status within an organisation rather than those without it (Clark et al., 2012). While power is necessary for organisational success, the literature suggests that power is often abused (Barling, Christie, & Turner 2008; Pearce & Manz, 2014) and the individuals who hold power are often the perpetrators of abuse (Parker, 2014).

In a review conducted by Kemp (2014), it was concluded that ‘workplace bullying is best seen as a manifestation of power’ (p. 365). This was supported by the results of the Hurley et al. (2016) survey in which respondents described organisational power as a central mechanism for bullying behaviours, particularly from those holding positions of authority within a hierarchically structured organisation. Respondents have commented that the very struggle to gain power and

organisational positioning is a contributing factor to VHA behaviours and that senior management seldom use their leadership power to stop bullying behaviours (Hurley et al., 2016). Their failure to act normalises these behaviours and gives the impression there are low perceived costs, fiscally and human, associated with the behaviour by the perpetrator (Clarke et al., 2012; Hoel, Glasø, Hetland, Cooper, & Einarsen, 2010).

The literature strongly depicts inadequate leadership as an antecedent of unwanted workplace behaviours (Skogstad, Torsheim, & Einarsen, 2011). Samnani and Singh (2012) referenced weak or passive leadership as stimulators of VHA and similarly, a study of Finnish workers found that poor leadership contributed to an increase in VHA in the workplace (Salin, 2013). Fleming's (2017) quantitative correlational regression study found that laissez-faire leadership was a positive predictor of VHA, while transformational leadership was a negative predictor. Further, in a survey of 4,500 Norwegian employees, Glambek, Skogstad and Einarsen (2018) used the NAQ five-point Likert-type scale and found that laissez-faire leadership was a condition under which the bullying process could endure and progress. The enactment of laissez-faire leadership behaviour may itself signal that bullying is an acceptable behaviour within the organisation (Nielsen, 2013; Skogstad et al., 2011).

Laissez-faire leadership, which is an identified passive and inactive form of leadership (Fleming, 2017; Glambek et al., 2018) has been associated with a lower intervention rate in actual cases of bullying. Namie and Lutgen-Sandvik (2010), for example, found that managerial intervention tended to either not take place or made things worse in the majority of VHA incidents. These ideas are in line with the early

model proposed by Leymann (1990), which held that VHA processes cannot develop unless those with the power to intervene fail to do so.

Reflexivity

Power and oppression. The concept of nurses being an oppressed group stems from the historical premise that their practice is dominated from outside of the profession. The male-dominated medical profession and the typically male administrators are seen as controlling nurses' practice, resulting in nurses feeling powerless to effect change. Are we now oppressing ourselves and each other under the guise of leadership?

2.5 VHA in Nursing

A systematic review and meta-analysis conducted by Sfantou et al. (2017) found that effective leadership in healthcare was critical for quality patient care. In 18 studies, leadership styles were strongly correlated with quality healthcare. They found that transformational leadership had a positive relationship with quality care and nursing culture, while transactional leadership had a weak relationship. In addition, laissez-faire leadership was negatively related to the nursing culture and quality of care, as that leadership style involves a leader who does not make decisions, meaning staff act without direction or supervision (Sfantou et al., 2017).

Few studies have explored the relationship between leadership and episodes of VHA among nurses, despite the findings that leadership and organisational culture have a significant impact on workplace behaviour. This review found one survey on nurse perception of incivility and experienced leadership styles (Kaiser, 2017) and two surveys that used the NAQ, one exploring the relationship between organisational culture and VHA in Korean nurses (An & Kang, 2016) and the other investigating the relationship between VHA, leadership and culture (Yun & Kang, 2018).

Kaiser (2017) assessed staff nurses' perceptions of incivility and the leadership styles they experienced, using both the Vannsimpco Leadership Survey (Vann, Coleman, & Simpson, 2014) and the Nursing Incivility Scale (Guidroz Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010) with 237 participants. Their research failed to show definitively that leadership style was a factor in episodes of incivility; however, it did show that leaders' behaviours have an effect on the level of incivility between staff.

An and Kang (2016) used the NAQ to explore the relationship between organisational culture and VHA among 298 Korean hospital nurses. They used the descriptions described by Han, Gu, Ah & Koo (2014), who defined a relationship-oriented culture as one in which the members have a high regard for community spirit, humanness, intimacy and mutual respect, while a hierarchy-oriented culture is one in which the members have high regard for authority, obedience, order, stability and strictness. They found that nurses who practised in a hierarchy-oriented organisation were 2.58 times more likely to experience VHA than were nurses who worked in a relationship-oriented culture. They reported a significant relationship between organisational culture and VHA among Korean nurses. However, the authors recommended further investigations/research to explore the societal culture of nursing organisations.

Yun & Kang (2018) investigated the influencing factors of VHA among nurses, comparing leadership with relationship-oriented cultures. They applied the NAQ, the symptom inventory, the authentic leadership questionnaire, the Psychological Capital Questionnaire, the Intention to Quit Scale and the Nursing Organisational Culture Measurement Tool to 301 clinical nurses. They discovered that a relationship-oriented culture had a direct effect on VHA, concluding that to

prevent VHA in nursing workplaces, it was necessary to consider the organisational culture (Yun & Kang 2018).

The People Matter Survey administered by the Victorian Public Sector Commission found that 25 per cent of healthcare employees had experienced VHA. These results were among the highest of all Victorian public sector agencies. Further, a survey implemented by the ANMF on behalf of university researchers found that 40 per cent of nursing professionals had experienced bullying or harassment within the previous 12 months (Monash University, 2011).

Spector et al. (2014) conducted a review into nursing violence using parameters such as type of violence experienced, setting or environment, source and origin. This revealed that one-third of nurses worldwide had been exposed to violence in some capacity. A cross-sectional survey by Park, Cho and Hong (2015) found that 71 per cent of the participants had encountered some form of violence which included acts perpetrated by patients and or their families. Acts of violence included verbal abuse, threats, physical violence or sexual harassment. However, their study highlighted when nursing colleagues were identified as the primary perpetrators, VHA, had the lowest prevalence. Farrell and Shafiei's (2012) descriptive questionnaire of Australian nurses and midwives (n = 1,495) found that their participants were more concerned about VHA from their peers than VHA from patients. However, in both studies, because a shared understanding of the phrase 'bullying and violence' was not provided to participants, the results were based on individuals' perceptions of what constituted acts of VHA. Both studies supported the allegation that peer-to-peer violence is common in nursing workplaces and the phenomenon is difficult to manage.

Berry, Gillespie, Gates and Schafer (2012) administered an internet-based descriptive cross-sectional survey design using the NAQ. They found that 72.6 per cent (n = 147) of new RNs reported VHA, 57.9 per cent reported being a direct target of VHA and 14.7 per cent reported witnessing episodes of VHA. The authors of this study called for a root cause analysis approach to VHA to correct the environmental conditions that make VHA possible. Even though some researchers (Georgakopoulos, Wilkin, & Kent, 2011) have been able to identify individual and organisational root causes of episodes of VHA, an analysis of the causes has yet to be conducted.

The literature suggested that episodes of VHA were linked to patient safety (Dumont, Meisinger, Whitacre, & Corbin, 2012; Houck & Colbert, 2017; McNamara, 2012; Purpora, Blegen, & Stotts, 2012; Smith, 2011). However, there was little empirical data to confirm this. Nonetheless, these researchers inferred that when nurses were feeling intimidated and harassed, they were more likely to make errors in clinical decision making. These errors in judgement could result in adverse patient events such as increased patient falls, medication administration errors and delayed care (Houck & Colbert, 2017). Hutchinson and Jackson (2013) conducted a mixed-methods systematic review on 30 peer-reviewed qualitative and quantitative studies that examined the relationship between VHA and patient care. While they found that VHA among clinicians could unfavorably affect patient care, they conceded there was little robust evidence detailing the nature and the extent of the impact (p. 9). Houck & Colbert's (2017) integrative review covered 11 studies, nine of which had used surveys in descriptive and correlational designs. They found there were significant risks to patient safety when nurses were experiencing or witnessing episodes of VHA.

2.6 VHA in Higher Education

VHA in higher education was identified in the literature (Clark & Athen, 2012; Courtney-Pratt et al., 2018; Lewis, 2006; Miller et al., 2019; Murray, 2009; Randle 2003; Rowell, 2007; Skinner et al., 2015; Smith & Coel, 2018; Stevens & Crouch 1998). A self-reported survey of 21,994 Australian university staff revealed that bullying and harassment were more common in rural, regional universities than in metropolitan universities (Skinner et al., 2015). One-third of academic staff at four regional universities reported experiencing bullying during the course of their academic careers, which was 150 per cent more than the rate at the Group of Eight (GO8) Universities (Sydney University, Western Australia University, Monash University, University of New South Wales, The University of Queensland, The National University and The University of Adelaide). In one regional university, 42 per cent of the staff had been bullied while at work (Skinner et al., 2015). However, the participants had not been given a definition of bullying or harassment, nor the context in which the terms were used. Therefore, it was not possible to achieve consistent findings, as participant comprehension of the terms may have differed. This study may have been more about the *perception* of bullying, rather than the *experience* of actual identified bullying behaviours.

The VHA reported in the higher education sector is predominantly horizontal from academic to academic (Giorgi, 2012; Hunt et al., 2012; Yildirim et al., 2007) and from student to student (Clark, Werth, & Ahten, 2012; Lampley et al., 2016). However, there are reports of vertical abuse from academics towards students and from students towards academics as well (Clark & Athen, 2011; Lewis, 2006; Murray, 2009; Randle, 2003; Rowell, 2006; Skinner et al., 2015; Stevens & Crouch, 1998). A behavioural survey of nursing teaching staff in Turkey found that 91 per

cent (n = 210) of staff from 11 university-level nursing schools had encountered bullying from students (Yildirim & Yildirim , 2007). Conversely, Mott (2014) and Celik and Bayraktar (2004) found that students could become targets of educators who engaged in behaviours such as unreasonable assessment items, harsh marking and humiliation in front of class groups and peers. They suggested that symbolic acts of educator abuse, such as overwhelming students with their knowledge, degrees and years of experience and using academic language, leave students feeling belittled and these are all acts of VHA. In their study of student perceptions of faculty bullying, Cooper et al. (2011) established that unrealistic deadlines and belittling behaviours were considered by students to be acts of VHA.

Despite the reports that both students and faculty viewed VHA in nurse education as a serious problem (Luparell, 2011), Hoel, Giga and Davidson (2007) found in their behavioural survey study that students and faculty both had difficulty identifying acts of VHA. Additionally, Cooper and Curzio (2012) found that two-thirds of their participants were unable to identify actual acts of bullying, with 19 per cent (n = 156) reporting a humorous exchange as bullying. This suggested that again, these studies were more about perceptions of VHA than about experiences of the actual behaviours.

In their survey study of faculty (n = 15) and student (n = 168) perceptions of VHA in nurse education, Clark and Springer (2010) found that high stress loads, high-stake testing and constant changes were conditions that supported episodes of VHA. This was in keeping with Hunt and Marini (2012), who found that constant changes, stressful conditions, large numbers of staff and the range of interactions in the workplace contributed to episodes of VHA.

2.7 VHA in Nursing Students

A number of nursing researchers have focused on student nurses' experiences of VHA while on clinical training (Birks et al., 2018; Budden, Birks, Cant, Bagley, & Park, 2016; Curtis et al., 2007; Longo, 2007; Tee, Özçetin, & Russell-Westhead, 2016; Magnavita & Heponiemi, 2011). Birks et al. (2018) used a cross-sectional survey instrument, the Student Experience of Bullying During Placement tool (Budden et al., 2016), to ask 884 Australian baccalaureate nursing students about the nature and extent of their experiences of bullying behaviours during clinical training. Although over half of the surveyed students responded that they had experienced VHA during clinical training, it was unclear whether they were all reporting actual experiences of VHA or witnessed experiences.

Longo (2007) surveyed final-year nursing students' (n = 47) experience in VHA in the practice setting, using a two-part anonymous survey that included descriptions of VHA obtained from the literature and 'yes/no' questioning. The survey revealed 25 per cent of participants felt they had been put down by ward staff, 40 per cent had been humiliated and 34 per cent had witnessed bullying of a classmate, with close to half (49 per cent) not reporting VHA (or bullying). Although the researcher used specific descriptions of bullying behaviours from the literature, it was unclear whether the participants were provided with a shared understanding of the term 'bullying'. A limitation of this study was that it involved participants from only one education facility and one clinical training site and as such, the findings might not be applicable to other facilities. Nonetheless, given the results, further investigation is warranted. A similar study was conducted in Australia by Curtis et al. (2007), who surveyed 152 second- and third-year nursing students. They found that 86 students (57 per cent) had experienced and/or witnessed VHA

during their clinical training. This study involved only a single site, but it included multiple training venues. Although a definition of VHA was not provided in the research paper, a definition was included in the questionnaire. Interestingly, a study by Thomas and Burk (2009) found that 100 per cent ($n = 128$) of their participants had experienced some form of self-reported VHA while on clinical training. Further, a descriptive comparative study by Kassem (2015) between two faculties of nursing students in their final year ($n = 338$) found a direct correlation between students who were bullied and their perceived self-efficacy. That researcher applied the general self-efficacy scale and a bullying in nurse education questionnaire, with a descriptive behaviour Likert scale.

Magnavita and Heponiemi (2011) conducted a retrospective comparative study on the prevalence of violence between student nurses and clinical nurses. The results of the questionnaire revealed that 43 per cent of clinical nurses ($n = 275$) and 34 per cent of student nurses ($n = 346$) had experienced or witnessed episodes of VHA in the clinical environment. The data demonstrated that clinical nurses experienced more abuse from patients and relatives, while student nurses experienced more verbal abuse from colleagues, staff and academics. In a quantitative descriptive study, Clarke et al. (2012) explored the frequency, types and sources of bullying behaviours experienced by nursing students while participating in clinical training in healthcare facilities. Using a rating scale data collection tool, the results revealed that 88.72 per cent of participants had experienced at least one act of bullying perpetrated by the RN while in the clinical environment. More recently, Tee et al (2016) found similar results in a cross-sectional survey distributed across nursing schools in the UK, with 42.18 per cent of students ($n = 657$) indicating they

had experienced bullying in the past year while on clinical training and a third (30.4 per cent) stating they had witnessed episodes of bullying.

Salin and Hoel (2013) argued that VHA is a gendered phenomenon, rather than being gender neutral. However, in their studies into incidences and manifestations of VHA experienced by nursing students, Cooper and Curzio (2012) and Clark, Kane, Rajacich and LaFreniere (2012) found no significant difference between female and male students' experiences: 84.8 per cent (n = 95) of male participants and 89.2 per cent (n = 498) of female students said they had experienced bullying behaviour at least once. These students were not given a definition of bullying or descriptions of behaviours. Given the number of students (both male and female) who reported experiencing acts of VHA, these results indicate the need for further investigation.

In contemporary nursing socialisation, episodes of VHA are not seen as abuse but rather, as part of the normal socialisation process, with many students accepting VHA as a 'rite of passage' (Birks et al., 2018; Hutchinson et al., 2006b; Smith et al., 2015; Stevens & Crouch, 1998). Longo's (2007) single-site survey of senior male (n = 9) and female (n = 38) nursing students asked them if they had heard the phrase 'Nurses eat their young' and if they had, whether they believed this was true. Sixty-six per cent of them had heard the phrase and 72 per cent believed it was true.

Many authors debate whether VHA continues within nursing because the origins of the behaviour begin before entering the industry, suggesting it commences at the undergraduate level (Magnavita & Heponiemi, 2011). Conversely, Edwards and O'Connell (2007) suggested that nursing academics transfer these behaviours via recruitment from the healthcare sector to higher education. Mott (2014) agreed, suggesting that many nursing students' first exposure to a culture of incivility is in

the academic setting. However, Cooper and Curzio (2012) proposed that the behaviours could be transferred from clinical rotations to the university setting and vice versa.

While it has been useful to understand the prevalence of the experience of bullying, these examples have done little to increase awareness of the causative factors. It is acknowledged by the nursing community that the research focus needs to move beyond the lived experience and towards a deeper analysis of contributing factors (Rittenmeyer, Huffman, Hopp, & Block, 2013).

Reflexivity

Florence Nightingale is renowned as the founder of modern nursing and a ministering angel in the Crimea war: the 'lady with the lamp' (Daly, Speedy & Jackson, 2007). However, she was also known as the 'Iron Maiden', which suggests she might have also been the founder of VHA in nursing. Is she responsible for the current subservient role of nurses? The question should be: are nurses subservient?

2.8 Prevention of VHA

The prevention of VHA currently occurs at three levels: the workplace level, the organisational level and the national and state levels. At the workplace level, controls include leadership commitment to a mentally healthy workplace, policies and procedures for the prevention of unreasonable behaviours, and a process for consultation with workers. At an organisational level, controls may include the designing of safe systems of work practices; workforce planning to ensure the balance between work demands and time pressures are within the workers' capacity; role clarity, autonomy, recognition and reward; and flexible work arrangements (Parker, 2015). At the national and state level, legislation and laws are in place to assist and support both workers and employers (Johnstone, Quinlan, & McNamara,

2011). This section of the literature review is divided into sections reflecting these three levels of VHA prevention.

2.8.1 Workplace Level

The prevention of VHA is being addressed in three ways in the workplace: through managerial presence; normalising behaviours through development and implementation of codes of conduct; and controlling behaviours through disciplinary actions. Workplace bullying prevention strategies focus on the individual (Johnson, 2015), viewing bullying as a personality conflict rather than as a reflection of the rule- and outcome-oriented organisational practices that are common in organisations involved in higher education and healthcare (Hutchinson & Hurley, 2013, p. 557).

2.8.2 Organisational Level

The concept of prohibitive policy, such as zero-tolerance policies, was introduced in the United States (US) in 1994, referring to specific actions or behaviours that should not be accepted in the workplace. This approach has been used in relation to drug crime and in the schoolyard. However, governments in countries such as the UK and New Zealand, along with Australian states and territories, have adopted a zero-tolerance policy towards violence in the healthcare sector. In NSW, for example, NSW Health published a policy and framework document (2015) titled *Zero Tolerance, Response to Violence in the NSW Health Workplace*. This document requires health services to work towards ‘establishing and maintaining a culture of zero tolerance to violence’ (NSW Department of Health, 2015).

Despite the zero-tolerance policy directive being implemented in 2003 across all NSW public healthcare facilities, an external review of the healthcare system in Australia in 2008 described the phenomenon as being ‘endemic’ (Garling, 2008).

The persistent nature of VHA in nursing suggests that the policies aimed at addressing the problem are either unsuccessful or are not being implemented effectively and further investigation is needed.

A major legislative development occurred in Australia at a state level through the enactment of the *Crimes Amendment (Bullying) Act 2011 (Vic)*. Brodie's Law was introduced following an incident of persistent workplace bullying that caused 19-year-old Brodie Panlock to take her own life. Under Brodie's Law, serious workplace bullying results in a maximum penalty of 10 years' imprisonment (Victorian State Government, 2018). Currently, Brodie's Law has been legislated only within Victoria, where it is now legally recognised that serious bullying is a criminal offence and extends the application of stalking provisions in Victoria's *Crimes Act 1958*.

2.8.3 National Level

The *Occupational Health and Safety Act 2004* aims to secure the health, safety and welfare of employees and others at work and eliminate risks at the source. This means an employer must provide and maintain a working environment that is safe and without risks to health. This includes identifying and eliminating risks to health and safety. An employee must also take reasonable care of his or her own health and safety and have regard for the health and safety of others.

The *Fair Work Act 2009* covers national workplace relations laws, National Employment Standards, protection against unfair treatment and discrimination, and grievance-handling mechanisms. Under this Act, a worker who reasonably believes that he or she has been bullied at work can apply to the Fair Work Commission for an order to stop the bullying. The *Crimes Act 1958* made it a crime to use, perform or direct abusive and offensive words or acts towards or in the presence of a target, or to

act in way that could reasonably be expected to cause physical or mental harm to a target (including self-harm). However, it was not until 2010, following an Australian Parliamentary Inquiry into Bullying (House of Representatives Standing Committee on Education and Employment, 2012), that stop-bullying orders were introduced by the Fair Work Commission (2016). The *Fair Work Act 2009* conferred power upon the Commission to make orders to stop bullying from 1 January 2014. Before this, the Commission had no power to deal with complaints of workplace bullying.

2.9 Interventions

To date, many recommendations have been made by researchers to prevent episodes of VHA (Clark & Ahern, 2012; DeMarco, Roberts, Norris, & McCurry, 2008; Lewis, 2006; Littlejohn, 2012; Murray, 2009; Randle, 2003; Rowell, 2006; Sergeant & Law-Chapman, 2012; Stevens & Crouch, 1998) but there have been very few studies on interventions to prevent VHA (Barrett, Piatek, Korber, & Padula, 2009; Glass, 1997; Griffin, 2004). Further, there is very little empirical evidence that supports the effectiveness of interventions in reducing workplace VHA (Escartín, 2016; Hodgins, MacCurtain, & Mannix-McNamara, 2014). In 2014, a systematic review of workplace bullying and incivility interventions was conducted (Hodgins, MacCurtain, & McNamara, 2014), critically appraising 12 interventions to address workplace bullying or incivility. The review revealed that half of the interventions focused on changing the individual behaviours. Two of the interventions were classified as effective. Both of these incorporated the civility, respect and engagement (CREW) process noted in the Workplace Intervention tool, which gives people the opportunity to explore the social relationships in their work group. The effectiveness of this tool could be owing to the proposition that people benefit from being part of a social grouping (Aquino & Thau, 2009) and that workplace

behaviours are contextually defined (Osatuke, Moore, Ward, Dyrenforth & Belton, 2009).

Other interventions frequently referred to in the literature include conscious healing (Glass, 1997) and cognitive rehearsal (Griffin, 2004). Both of these interventions focus on educating the individual perpetrator and target involved in the behaviour. Researchers of these interventions relied upon data generated by participants' lived experience and reflective journal recounts. However, Warner, Sommers, Zappa, & Thornlow (2016) applied Griffin (2004) cognitive rehearsal technique training to healthcare providers (n = 99) in a 60-bed orthopaedic ward and measured the prevalence of VHA via the Nursing Incivility Scale (Guidroz, Burnfield, Clark, Schwetschenau & Jex 2010), before and after an education session. They reported a significant improvement in the area of awareness of incivility. However, only 22 per cent of their participants were RNs and there has been no validation of the way a nursing incivility tool could be applied to physicians, patients, visitors or supervisors.

Another intervention used for preventing VHA in nursing was the use of a journal club (Kerber, Jenkins, Woith, & Kim, 2012). This mixed-methods study found that the 79 undergraduate student nurses involved in the journal club were more aware of civility and incivility and were better prepared to manage episodes of incivility. However, no recommendations were made on ways to prevent incidences of the unwanted behaviour.

From a pedagogical perspective, the curriculum has been identified as a possible tool for preventing VHA among students (Curtis, Bowen & Reid, 2007; Kelly & Ahern, 2009; Sidhu & Park 2018). There are two distinct approaches: developing psychomotor skills to combat episodes of VHA (Curtis, Bowen & Reid,

2007; Kelly & Ahern, 2009) and focusing on the philosophical frameworks that inform curricula (Sidhu & Park, 2018).

Curtis, Bowen and Reid (2007) suggested that the undergraduate nursing curriculum needs to incorporate assertiveness and conflict resolution skills. Likewise, Kelly and Ahern (2009), following their phenomenological study of newly graduated nurses in Australia, proposed that nursing students would be better prepared to face a profession of ‘bitchiness’ (p. 917) by including socialisation issues in the curriculum. However, there is little robust discussion on the way the curriculum influences student learning and professional development with regard to VHA.

After conducting an integrative literature review of the nursing curriculum and bullying, Sidhu and Park (2018) suggested that curriculum design could be useful in preventing VHA. They noted that the most commonly used theory used to guide interventions and strategies against episodes of VHA in nursing was Social Cognitive Theory (Anthony & Yastik, 2011; Clark et al., 2014; Dulaney, 2015; Fleteau-Lux & Gravel, 2013; Gillespie Gates & Mentzel 2012.; Hakojärvi, Salminen, & Suhonen, 2014; Lux, Hutcheson & Peden, 2014; Sanner-Stiehr & Ward-Smith, 2017; Thomas, 2010). Social cognitive theory (Bandura, 1986) suggests that learning occurs within a social context whereby learners model behaviours that they see. Dulaney (2015) suggested that when undergraduate nursing students attend clinical training, they model the behaviours of RNs and managers; however, when they are at university, they model the actions and behaviours of academic staff.

2.10 Simulation in Nursing Education

In Australia, simulation is used extensively in nursing education, both undergraduate and postgraduate, as well as in education in other areas such as midwifery education (Al-Ghareeb, McKenna, & Cooper, 2019; Hardenberg et al.,

2019; Al-Ghareeb, Cooper & McKenna 2017; McKenna, Bogossian, Hall, Brady, Fox-Young, & Cooper, 2011). One reason simulation is accepted by regulatory bodies as a learning and teaching modality in universities is the increasing difficulty of securing clinical training sites. Additional considerations include increased student enrollments in nursing programs, decreased number of nursing academics, lack of technical training and support, fatigued clinical staff and the reluctance of health professionals to supervise students in clinical practice (Baxter et al., 2009; Berndt, 2010; Gates et al., 2012; HWA, 2010; Warland, 2011). Despite many nursing researchers efforts to produce evidence for the efficacy of simulation (Bogossian, Cant, Ballard, Cooper, Levett-Jones, McKenna, Ng, & Seaton 2019; Cant & Cooper 2017; Tremblay 2017), simulation in nurse education is still emerging in regard to producing robust research outcomes (HWA 2010).

Gaba (2004) defined simulation as

a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion. (p. i2)

Jeffries (2005) defined simulation as

activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making, and critical thinking through techniques such as role playing and the use of devices such as interactive videos or mannequins. (p. 97)

Waxman (2010, p. 29) extended this definition, proposing that simulation is to immerse the student in a representative scenario in a ‘setting that mimics the actual environment with sufficient realism to allow learners to suspend disbelief’.

A more contemporary definition of simulation was offered by ANMAC (2018, p 22), who stated

Simulated learning refers to a variety of activities using patient simulators, including devices, trained persons, lifelike virtual environments, and role playing. Simulation-based education experiences strengthen, mimic or replace real-life clinical situations. Simulation-based education aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing.

The literature notes that simulation can take many forms: anatomical models, role playing, computer-assisted instruction, standardised patients, virtual patients and high- and low-fidelity mannequins (Bogossian et al., 2018; Seaton et al., 2019; Weller et al., 2012). Fidelity refers to how authentic or lifelike the experience is and to the extent to which the simulation mimics reality (Bland, Topping, & Tobbell, 2014; Lapkin & Levett-Jones, 2011). To facilitate this way of learning and teaching, universities have developed simulation centres or laboratories that mimic real-world clinical areas. These simulated areas are predominantly based on contemporary acute-care settings and they are updated as the need arises (Al Fozan, Yousria, & Farida, 2015).

A systematic review of simulation literature, conducted by Cant and Cooper (2010), found simulation was a valid teaching and learning strategy. However, they noted that the reliability and validity of the studies varied because of the differing assessment models and study designs. Their systematic review examined quantitative studies published between 1999 and 2009. Of the 2019 studies found, only 12 met the study's inclusion criteria. Of these, one was an Australian Random Controlled Trial (RCT) (Jones & Sheppard 2011). It showed that students who used simulation

as a learning tool to develop patient assessment skills scored significantly higher on a post-test than those students who used learning modalities such as case studies via PowerPoint and self-directed packages. Similarly, Kim, Park & Shin (2016) conducted a meta-analysis of the effectiveness of simulation in nurse education, using quantitative studies from 1995 to 2013. From the 40 studies that met their inclusion criteria, they found that simulation in nurse education was effective in the psychomotor domain. They noted it was difficult to compare the studies because of the varied approaches and designs of them.

Cant and Cooper (2017) identified three of four high-quality reviews that supported simulation for the development of psychomotor skills (the fourth had found too few high-quality studies to make a statistical comparison). They found that simulation statistically improved self-efficacy in pre- and post-test studies. In experimental designs, simulation improved self-efficacy more effectively than other teaching methods. The reviews reported strong student satisfaction with simulation education and some studies reported improved confidence and critical thinking. However, they noted that lower-level research designs limited further comparison.

Kaakinen and Arwood (2009) argued that simulation in nursing education is commonly used as a teaching tool rather than as a learning modality. Their systematic review found that of the 120 nursing simulation articles they reviewed, 104 did not mention a learning theory and 94 discussed simulation as a teaching method (Kaakinen & Arwood 2009, p. 2). Therefore, it could be argued the acceptance of simulation in nurse education is somewhat premature. In terms of underpinning learning theory that supports the practice of simulation, learning paradigms such as Kolb's Experiential Learning Theory (1984) (Aliner, Hunt, & Gordon, 2004; Edward, Hercelinskyj, Warelow, & Munro, 2006) and Knowles Adult

Learning Theory (Aliner, Hunt, & Gordon, 2004; Campbell, Themessl-Huber, Mole, & Scarlett, 2007; Edward, Hercelinskyj, Warelow, & Munro, 2006; Feingold, Calaluce, & Kallen, 2004) have been cited regularly in simulation education literature, if not actually applied. Some simulation literature drew upon social construct theory (Lasater, 2007; Lathrop, Winningham, & VandeVusse, 2007; Reilly & Spratt, 2006). These authors believed that students learn in the simulated environment by doing and receiving feedback through which they construct new learning. Although it used a social construct theory, their research was limited to skill development and did not explore what the students were doing or learning regarding the social constructs of the profession.

Parker and Myrick's (2012) work explored the socially derived meanings of simulation, focusing on the scaffolding of simulation supports rather than exploring the socialisation and meaning making of students in the simulation environment. McNiesh (2015) engaged in an ethnographic mode of inquiry, the only ethnographic study conducted on student nurses in a simulated environment before the current research. McNiesh described the culture of clinical simulation within the simulation laboratory of the Bachelor of Nursing program in the US. Data were generated from (n = 99) observations and interviews that described several cultural norms of the simulated environment, such as collective learning, skill performance, reflection, being watched and evaluated, making mistakes in a safe place, familiarisation to the setting and enacting the full nursing role. This research offered insight into the learning structure of the simulation environment but it discussed these observations unilaterally, leaving out the influence of the actual learning space and the influence of the people who were enaging in the space.

Research evidence has confirmed that simulated learning benefits student knowledge and practice (Lapkin, et al 2013). Simulation activities are thought to be an adjunct to clinical training; however, simulation is currently being considered an alternative to clinical training. The best available evidence comes from a randomised, controlled, longitudinal multi-site trial conducted in the US (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). Cohorts of students (n = 666) enrolled in undergraduate nursing programs (n = 10) were randomised to receive varying amounts of high-fidelity simulation as a substitute for traditional clinical training. The findings provided evidence that using high-fidelity simulation as a substitute for clinical training resulted in no differences in nursing knowledge, clinical competence or overall readiness for practice. Alexander et al. (2015) outlined the conditions required for reproducing these outcomes: sufficient numbers of educators who were trained in simulation education; a simulated environment with appropriate resources and authentic scenarios; and debriefing that linked theory to practice.

In education, simulation is seen as a safe environment for students to apply, in a practical sense, the theory they have been taught, without risk to patients or actors who are simulating patients. Some researchers have suggested that simulation used in undergraduate nurse education may provide a distracting and stressful environment for learning (Tremblay, Lafleur, Leppink & Dolmans 2017), however other authors suggest simulation provides a safe environment for students to develop and practise their clinical skills (Akhtar-Danesh, Valaitis, Stanyon, & Sproul, 2009; Alconer-Camarero, Romero, Sarabia-Cobo, & Arce, 2016; Berndt, 2010; McNiesh, 2015; Miller & Bull, 2013; Nehring & Lashley, 2009). Arguing, a simulated environment provides a realistic but low-stress environment for students to practise

without the risk of harming patients. Consequently, it has been held that this type of learning has the potential to improve patient safety (Gaba, 2004).

2.11 Unanswered Research Questions

This review of the literature has demonstrated that VHA exists in organisations generally (Eriksen et al., 2016; Johnson, 2009; Kiesecker & Marchant, 1999; Nielson & Einarsen, 2012; Rodwell & Demire, 2012; Safe Work Australia, 2016; Salin, 2003) and specifically in healthcare (Park et al., 2015; Spector et al., 2013) and higher education (Clark & Athen, 2011; Courtney-Pratt et al., 2017; Lewis, 2006; Miller et al., 2019; Murray, 2009; Randle, 2003; Rowell, 2006; Skinner, Peetz, Strachan, Whitehouse, Bailey, & Broadbent, 2015; Smith & Coel, 2018; Stevens & Crouch, 1998). The evidence has shown there are organisational and social costs associated with this phenomenon and that in nursing, new graduates and student nurses are the most vulnerable. However, the literature also highlights that the perceptions and actual episodes of VHA are difficult to measure.

The nursing literature to date has largely focused on the experience and perception of bullying within industry settings, including hospitals (Anthony & Yastik, 2011; Curtis et al., 2007; Efe & Ayaz, 2010; Hutchinson, Vickers, Jackson & Wilkes, 2006b; Kelly & Ahern, 2009; Lampley et al., 2016; Purpora, Cooper, & Shrifi, 2015). Researchers have relied heavily on self-reports of negative behaviours that reflect VHA. A common understanding of what constitutes VHA has not been realised, nor have observed behaviours of the perpetration of VHA been detailed.

This is especially the case when exploring VHA that occurs with educational settings. Rather than assuming that the actual learning objectives are the only knowledge that nursing students assimilate when engaged in a simulated hospital

laboratory, an investigation into the unintended learning outcomes that can occur is warranted.

Important questions yet to be addressed relate to the relational structures that influence and enable episodes of VHA. Traditional methods of investigating episodes of VHA have not explored the relational influences on workplaces. Hence, the nursing community has turned to other fields, such as education, the humanities and social sciences, for theoretical and philosophical support and research design to address this missing link.

There has been little research that has combined the relational structures that influence VHA and the simulation environment that nursing students learn within. At this point, there is a growing awareness in the nursing community for the need for research that employs a non-essentialist approach in gaining a better understanding of the phenomenon. A critical ethnographic study that investigates the organisational and social/cultural environments of a simulation laboratory would add knowledge about the way the simulation learning and teaching space can enable acts of VHA. The methodology of this study separates perceptions of VHA from actual observed behaviours, to support the critical ethnographic exploration used in this Doctoral research.

2.12 Overview of Research to Date

VHA is evident in the workplaces of nurses. However, depending on the way it is measured, its frequency and distribution varies. Studies have shown there is a positive relationship between the perception of VHA and a nurse's intention to leave the profession and there is a negative relationship between VHA and job satisfaction. Although the reviewed literature revealed laws, guidelines and opinions, along with recommendations for interventions to prevent episodes of VHA, to date there has

been no experiential research showing whether any of these measures are effective. A number of theoretical models have proposed that VHA in organisations is the outcome of the interplay between individual, situational and cultural factors. However, there has been no investigation into the relationship of these factors specifically contributing to episodes of VHA in a simulated hospital environment.

This current research study applies a critical theoretical lens to an ethnographic investigation that aims to determine whether episodes of VHA occur among nursing students and academics engaged in learning and teaching in a simulated hospital environment. The research described in this chapter has established that VHA is evident in organisations generally, as well as specifically in healthcare and higher education. Despite policies and legislation aimed at addressing the issue, VHA still impacts organisations, directly affecting recruitment and retention of staff and the overall well-being of employees.

The next chapter presents the unique methodology that guides this research. The chapter begins with an exploration of critical theory according to Carspecken's approach to critical ethnography and explained by Bourdieu's social practice theory (1977).

Chapter 3: Methodology and Methods

The very practical problems that carrying out such field research continually posed, often in a quite dramatic way, forced one to engage in a continuous reflection on the reasons and the *raisons d'être* of the study, on the motives and intentions of the researcher (Bourdieu, 2000, p. 9).

3.1 Introduction

This chapter opens with an overview of the philosophical assumptions underpinning qualitative research. The adoption of a critical ethnographic methodological approach, specifically Carspecken's critical ethnography, is justified as appropriate for guiding this research. The methodological approach and design used in the current study is illustrated in Figure 3.1.

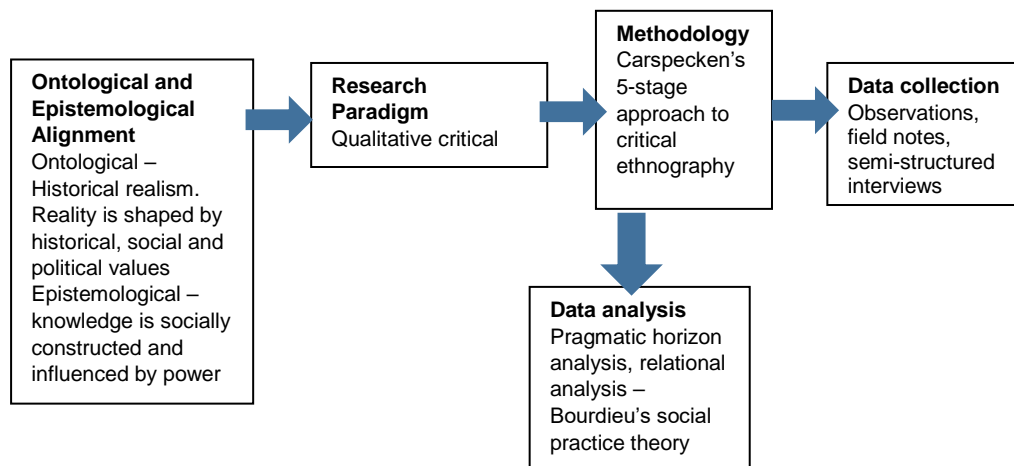


Figure 3.1. Summary of research design.

3.2 Research Paradigm: Qualitative Research

Qualitative research methodologies are adopted when describing and exploring persons in the context of their social environment. Qualitative research takes a humanistic approach, which intends to capture the subjective interactions of people with place through naturalistic and interpretative inquiry (Denzin & Lincoln,

2005; Polgar & Thomas, 2008). Qualitative research does not attempt to gain insight into a phenomenon through the discovery of causes nor attempts to control or predict outcomes; rather, qualitative research investigates the phenomenon in its natural setting to make sense of and interpret the meaning people bring to it (Denzin & Lincoln, 2005). The essentials of qualitative research are that it is subjective; values human experience; appreciates that every person is unique and their experiences are therefore also unique; there is no singular truth but rather, multiple truths; and does not attempt to generalise but rather, to provide insight from which lessons can be learned (Denzin & Lincoln, 2005; Polgar & Thomas, 2008).

According to Denzin and Lincoln (2005), a complex, interconnected set of assumptions surround qualitative research. The traditions associated with qualitative research include foundationalism, positivism, post-positivism, constructivism and participatory frameworks. Further, each of these traditions has its own set of assumptions and methodological approaches that guide researchers in the way they explore human phenomena.

The methodological approach chosen for any research project is determined by the research question/s. The most common approaches in qualitative research are case study (Yin, 2003), grounded theory (Strauss & Corbin, 1994), phenomenology (Creswell, 2012) and ethnography (Carspecken, 1987). Phenomenology is the most commonly used methodological framework in qualitative inquiry (Liamputtong, 2013, p. 7). The purpose of phenomenology is to describe and interpret the lived experience of the participant (see Passmore, 2009; Schumacher, 2010). The intention of case study is to enhance knowledge of a particular case within a bounded system (Liamputtong, 2013, p. 215). Case study examples include Asmusssn and Creswell (1995), who investigated a campus response to a student gunman and Smith and

Sparkes (2008), who examined the life of a young man with a spinal cord injury. In contrast, instead of investigating a single case, a grounded theory approach develops a theoretical explanation for the process or action under investigation (Liamputtong, 2013, p. 218). Examples of grounded theory include Charmaz's (2010) study on living with chronic illness and Karp's (1996) work on depression in individuals. However, the purpose of ethnography is to discover how humans create meanings and behave within their cultural contexts (Liamputtong, 2013, p. 6).

3.2.1 Ethnography

Ethnography is a research tradition that was developed in the field of social anthropology and therefore, it has a theoretical orientation towards culture (Thomas, 1993). Ethnography is the exploration of daily routines, beliefs, morals, codes of conduct, patterns and tools that are rarely visible to those who are within the culture (Gulati, Paterson, Medves, & Luce-Kapler, 2011). The focus of ethnography is the meaning of actions, rather than the actions themselves; the methodology, rather than the method (Savage, 2000); the *opus operatum*, rather than the *modus operandi* (Bourdieu, 1972, p. 79).

Schwartzman suggested that ethnography allows a researcher to 'learn about a culture from the inside out' (1993, p. 3). Culture is viewed from two different perspectives: emic and etic. The emic perspective is commonly referred to as the insider's view of the world. The language and expressions used by the group to tell of their experiences include tacit knowledge that is unspoken and unquestioned. The etic perspective refers to the outsider or researcher's representation or interpretation of the culture under investigation (Polit & Hungler, 1999). The researcher may completely immerse themselves in the culture or observe it periodically. The observations are conducted (either overtly or covertly) by participating in the daily

lives of people to understand and explicate the culture in which they are a member. This includes watching, listening, asking questions and collecting artefacts and documents that provide an in-depth understanding of the issues surrounding the focus of the research topic (Hammersley & Atkinson, 2007).

3.2.2 Critical Ethnography

The qualifier ‘critical’ differentiates research approaches from being descriptive or interpretative. Descriptive methods are known for an objective, value-free orientation to knowledge; critical approaches align themselves with the philosophical tradition of post-enlightenment, whereby the research is situated socially, incorporating the values of the participants and producing value-mediated findings (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; Denzin & Lincoln 2005). Critical ethnography begins with the theoretical assumption that societies are flawed, which serves to maintain and sustain social inequities. In addition, critical theory assumes that some social groupings are more privileged than other groups and therefore, inequity exists, either structurally or systematically (Carspecken, 1996). This social inequity leads to oppression, which is reproduced as subordinate agents normalise their social status.

The purpose of critical ethnography is to uncover patterns in social realities, to develop insights into the meanings of cultural practices and discover the possibility of social injustice. With its antecedents in Marxism, neo-Marxism and the Frankfurt School of Critical Theory, critical ethnographers adopt the perspective that social constructs sustain and perpetuate social injustice. However, the main point of difference between ethnography and critical ethnography is that a critical perspective strives to not only describe these constructs but also change them for the better, with the ultimate goal being empowerment and liberation. As Holmes and Smyth (2011,

p. 146) stated, 'critical ethnographers are not content to merely describe a culture; they intend to transform it'. As Allen, Chapman, Francis and O'Conner (2008) wrote,

critical ethnography delves beneath the surface to examine the power relations and influences affecting phenomena by using field methods to identify not only culture, the consciousness or the lived experiences of others but also exposing the political, social and material empowerment of individuals and disadvantaged groups to elicit change. (p. 228)

Critical theorists are concerned with structural inequalities. This has guided research into social change through individual agency (Carspecken, 1996).

Therefore, critical researchers begin from the premise that cultural life is in constant tension between control and resistance (Thomas, 1993, p. 9). The said tension is revealed through a participant's behaviours, rituals, norms and social structures.

Thus, a critical ethnographic study observes seemingly mundane ordinary practices, rituals and behaviours and reproduces them to expose the social processes of control causing them, revealing the social mechanisms that prefer one set of meaning rather than another (Thomas, 1993).

Exposing the cause of social practices and the forces behind the behaviours and inequalities enables the participants of the research to understand the mechanisms and the ways they can be overcome through emancipatory practices. These aims have been a catalyst for many critical ethnographies investigating social inequities (e.g. Henderson, 1995; Manias, 2001; Street, 1992). Nurse researchers have applied critical ethnography to investigate cultural factors in intensive care (Bidabad et al., 2017), nurses' experiences in providing sexual healthcare to

adolescents with physical and/or developmental disabilities (McCabe & Holmes, 2014) and the relationship between the casualisation of the nursing workforce and the culture of nurse communication (Batch & Windsor, 2015).

3.2.3 Carspecken's Critical Ethnography

Philip Carspecken, a sociologist with a specific interest in critical theory and education, developed a five-stage approach to critical ethnography. Many authors have recommended Carspecken's technique as a valuable tool for researchers, offering a strong theoretical foundation for conceptualising ethical research (Hardcastle, Usher, & Holmes, 2010; Smyth & Holmes, 2005). Consequently, the five-stage approach has informed Doctoral studies, such as Mills (2006) investigation into literacies in the face of cultural diversity, Beekhuyzen's (2009) exploration of file-sharing communities and Nam's (2013) investigation of the challenges of helping students develop responses to 'English as a second language' reading texts. Carspecken's approach was applied by Mahon (2014), who investigated the determinants of nurses' job satisfaction; Harrowing et al (2010), who explored the concept of cultural safety, and Bidabadi et al. (2017), who used this approach to reveal the cultural factors that may impede patients' dignity when in intensive care.

The five stages of Carspecken's methodology are compiling the primary record, preliminary reconstructions, dialogical data generation, describing system relations and system relations as explanations of findings. Each of these is explained in the next sections.

3.2.3.1 Stage 1: Compiling the primary record

This stage refers to the collection of monological or observational data. The data collected in this stage are referred to as monological as there is minimal dialogue with the research participants and the primary record is compiled by using

only the researcher's voice. Carspecken (1996) recommended that the observer should be as unobtrusive as possible within the social site and apply an observation schedule to filter the dynamic action of the site under observation.

Carspecken's (1996) method of priority observation requires the researcher to focus on one person in the setting and record everything that person does as a first priority. The second priority is to document everything that other people say in interactions with this person and the third priority is noting other things that may be going on in the space around that person. Carspecken suggested this process should take around five minutes before the focus is shifted to another person.

3.2.3.2 Stage 2: *Reconstructive analysis*

Here, the primary record is examined for cultural themes and system factors that are not observable by the participants. The purpose of this stage is to take the actions observed in the first stage and articulate them (Carspecken, 1996).

To establish the validity of the reconstructions, Carspecken suggested pragmatic horizon analysis, which is based on the pragmatic theory of meaning associated with Habermas's Theory of Communicative Action. Habermas believed that people make a shared reference to things in the objective, normative and subjective worlds to find consensus (Habermas, 1981). The first ontological category is the objective realm, which asserts that objects and events are verified through direct observation (Habermas, 1981, pp. 308–309). This realm assumes any disagreements on these claims can be resolved through repeated observations (Carspecken, 1996). In the second realm, the normative claims are references to what is right and wrong, good or bad, in the normative context (Habermas, 1981, pp. 307–308) so that the participant and the observer both recognise the claim as legitimate.

Once these claims are recognised, they become tacit knowledge by other participants within the field (Carspecken, 1996).

While a subjective claim is concerned with the existing states of emotions, beliefs and feelings, the validity of these claims necessitates the support of non-verbal expressions such as body posturing, as only the participant has true access to these thoughts and feelings, therefore the claims can only be inferred by the observer (Carspecken, 1996).

3.2.3.3 Stage 3: Dialogical data generation

In this stage, researchers invite the voices of participants to contribute to the data set. Rather than recording information about the participants, this stage creates data with the participants (Carspecken, 1996). Carspecken recommended the use of an interview protocol with four categories: pre-defined topic domains (2–5 domains), one lead-off question for each domain, a list of covert categories and a set of follow-up questions.

Carspecken (1996) recommended that researchers should begin with these first three stages of the five-stage model, one stage following after the other, but then progress in a cyclical use of the stages, whereby earlier steps may be repeated as preliminary findings and analysis create new information, before continuing to the last two stages.

3.2.3.4 Stage 4: Describing system relations

The purpose of this stage is to examine the relationships between sites, if more than one site is involved in the research, or to discover system relations that may be influencing the research site.

3.2.3.5 Stage 5: System relations as explanations of findings

This last stage focuses on explaining how the wider system influences events which occur in various fields. Carspecken (1996) suggested that it is this stage that contributes to emancipation and social change.

Carspecken's five-stage design was selected to underpin this study because it provided a forthright practical guide for conducting a critical ethnographic study (Smyth & Holmes, 2005).

3.3 Conducting the Study

3.3.1 The Intention of the Research

The purpose of this research was to understand whether VHA occurs within a hospital simulation space among nursing students engaged in learning and teaching related to applied nursing practice. The following research question was addressed by this study:

Does the organisational and social environment of the simulation laboratory mediate episodes of VHA among second-year nursing students?

3.3.2 Ethics

This investigation was conducted in an ethical manner consistent with the guidelines of the governing Universities Human Research Ethics and the National Statement on Ethical Conduct in Human Research. Guidelines for ethical behaviour are based on the philosophical principles of respect for human beings, research merit and integrity, justice and beneficence (National Statement on Ethical Conduct in Human Research, 2007, updated 2018, p. 9). Even though the National Health and Medical Research Council updated this National Statement in 2018, the ethical process for this study was framed by the National Statement revisions of 2014/15. Approval was granted by the Charles Sturt University's (CSU) Human Research

Ethics Committee (CSU HREC Protocol No. 2014/018). Ethics approval can be found in Appendix A.

The research proposal included in the ethics application for this study targeted second-year undergraduate nursing students and observations of the way they engaged with the simulated hospital learning environment. The National Ethics Application Form, participant information sheet, consent form and advertising material was submitted to the HREC. Feedback on the submitted application included further clarification of the risks and benefits of the study and more transparency around the participant consent. Specifically, the Committee suggested adding appropriate counselling services to the participant information sheet, in case participants were left feeling uncomfortable or if confronting issues were raised during the interviews. On inclusion of the counselling services, approval was granted.

The initial ethics application was amended soon after data collection commenced, to include academics teaching second-year nursing students in the simulated laboratory as participants in the study. This variation was approved.

3.3.3 Recruitment

All second-year nursing students from one campus were invited to participate in the study. Second-year students were selected for participation because the design of the BN program at the research site meant second year students were developing more psychometric skills in the simulation laboratory, while in the first year program students were being introduced to simulation and the third year program included more clinical placement hours which resulted in less face to face time on campus. Furthermore, I was not involved in teaching the second year of the BN program and therefore, targeting this cohort reduced my concerns with regard to a perception of

coercion. After the preliminary observations, the invitation was extended to the academic staff involved in teaching this cohort of nursing students.

Reflexivity

After collecting preliminary data, it became clear that the academics in the laboratory influenced and controlled, to some degree, the learning environment. As this study was concerned with the enabling factors of the cultural and organisational environments of the simulation space, the academic was potentially a key informant.

Recruitment was undertaken through flyers and information sessions. On-campus recruitment tools such as posters and flyers were disseminated across the campus. In addition, social media was used to alert possible participants of the study and ways to register interest in being involved. This flyer can be found in Appendix G.

A convenience sample of 43 eligible participants agreed to participate in the study. The participants included undergraduate second-year nursing students ($n = 40$) enrolled in an acute and chronic and complex clinical subject, as well as the three academics who taught this cohort across the two sessions. The student participants consisted of straight-from-school students (SFS) and mature-age students (MAS). SFS were defined in this study as students who had a higher school certificate or equivalent and enrolled in the Bachelor's degree straight from high school. A MAS was defined as a non-school leaver who may or may not have a higher school certificate. These definitions were based on university admission criteria (University of Melbourne, 2017; Queensland University, 2017; Western Sydney University, 2017; Deakin, 2017; Charles Sturt University, 2017; Sydney University, 2017).

The participants were able to consent to observations *and* interviews or to observation or interview only. Students who agreed to participate in the observation sessions were given a red dot sticker to apply to their clinical uniform shirt, which

was also red. This method ensured that students who did not consent to observations were not readily identifiable by the group.

Twelve key informants were identified from the consent options. The use of key informants was originally used in the field of cultural anthropology and is an ethnographic technique (Marshall, 1996). According to Tremblay (1957), a key informant can describe the social and cultural patterns of their group because they have access to the information required to answer the research question and understand the information as well. An ideal key informant needs to be willing to communicate their knowledge and understanding, as well as able to identify relevant biases. The benefits of using key informants are associated with time: key informants can provide quality information in a relatively short period. However, incorrect selection of key informants (e.g. by perceiving a key informant as possessing social knowledge when in fact they do not) has the potential to weaken the approach. Another possible challenge is that the informant is unlikely to represent the majority of participants and may divulge only information that they consider socially acceptable; thus, the information may be skewed (Marshall, 1996).

The participants selected as key informants in this study were included on the basis of the above described criteria. These participants were observed to know the setting and routine and they showed a willingness to be a translator and commentator in Stage 3 of Carspecken's recommended methodology. The key informants represented different social structures and groups from within the learning and teaching space of the simulation laboratory: academic and student participants; male and female students; English as second language students; and SFS and MAS.

Even though the participants did not request pseudonyms, they were assigned them because otherwise, they could be identified easily, given the relatively small

numbers of on-campus academics and students enrolled in the second-year clinical subjects. Confidentiality was an important consideration in this research. A profile summary of the 12 key informants is in Table 3.1

Table 3.1

Key Informant Profiles

Participant	Profile
Ann	Ann had been a lecturer in nursing for more than 3 years.
Betty	Betty had more than four years of academic experience.
Cathy	Cathy was a sessional academic and full time clinician.
Albert	Albert identified himself as a MAS. He also had prior learning as an EN.
Beatrice	Beatrice was a MAS with no prior nursing knowledge.
Carol	Carol was the first person in her family to go to university and is SFS student.
Danielle	Danielle was a MAS. She told the group she had a limited support network, as her family lived interstate. Her goal was to obtain high distinction in every subject.
Elizabeth	Elizabeth was a MAS. She had been working as an assistant in nursing (AIN) in a rural base hospital for many years.
Francis	Francis was a MAS. He had industry prior learning and worked as an AIN.
Gail	Gail was a MAS. She had industry prior learning and worked as an AIN.
Heather	Heather was a MAS and worked as an AIN. She said she felt insecure about her age, being 'here with all these young ones'.
Isobel	Isobel was a MAS and worked as a carer in an aged-care facility.

Table 3.2

Participant Profile Summary

Participant profile	Academic (n = 3)	Student (n = 40)	%
Male	0	3	6.9%
Female	3	37	86%
SFS	-	22	51%
MAS	-	18	41%

The participant profile reflected the current health workforce data published in 2017, whereby 88.6 per cent of the RN workforce was female and male RNs comprised 11.4 per cent of the workforce (NHWDS, 2017).

3.3.4 Data Collection

As per Carspecken's five-stage approach, data collection occurred in Stages 1 and 3. The data were divided into monological or observational and dialogical data sets. The observational data were collected in Stage 1 and formed the primary record that established the rituals of the social routine in the simulated hospital space, recording when and where the actions took place. Dialogical data were collected in Stage 3.

Stage 1 data were collected within the simulated hospital environment in which the academics demonstrated skill sequences and the students had the opportunity to engage in developing the skill. Journal notes were the primary data collection tool used in this first stage. The primary data in the first stage were collected in a field journal, whereby events, descriptions of non-verbal communications (e.g. body language, sketches) and analytical notes were compiled. My thoughts, ideas and interpretations were included in the fieldwork journal, dated, timed and aligned with the observations. Eighteen three-hour laboratory classes were observed during the period of two 12-week sessions.

Reflexivity

I was acutely aware of my possible biases and power dynamic as both researcher and academic when I was observing and interviewing student and academic participants. Although the power dimension was affected by my pre-existing rapport with specific students and academics, I think I was usually seen as an insider when interviewing student participants. This was not the case when I was interviewing the academics. The academic participants were not used to having a peer observing their teaching and therefore, even though I was a colleague, I was not participating in the teaching; I was outside the teaching team. I was not one of them. I was a researcher. Conversely, the student participants were familiar with my role as a lecturer, watching them and asking them questions; these were usual and expected behaviours.

Decisions to record specific interactions were based on Carspecken's priority observation schedule. The priority observation protocol and schedule used in this study can be found in Appendix D.

Reflexivity

A dilemma arose when I was following the priority observation schedule and was focusing my observations on the academic. I observed the academic demonstrating a less-than-best-practice technique to the students. I was unsure of how to react. It felt inappropriate as a researcher to interrupt or intervene in the class, so I continued with the data collection; I made notes in my field journal about the incident and continued with the observation schedule. Although in the moment I felt I was acting ethically by prioritising the research (Baker, Phelan, & Snelgrove, 2016; Street 1987), the issue troubled me. I informed my primary supervisor who informed the head of school. I sent a letter to the HREC describing the situation. The ethics committee were satisfied the dilemma was appropriately addressed.

The termination of laboratory class observations occurred when the observational data reached saturation. Saturation in qualitative research is a criterion for discontinuing data collection (Fusch & Ness, 2015; Saunders et al., 2018). If

there is no new data, then one has most likely reached the point of no new themes, which means one has reached data saturation. Within this study, saturation was based on the notion of ‘informational redundancy’, which is the degree to which new data repeat what has been expressed already in previous data (Saunders et al., 2018). This perspective positions saturation in the early stages of the data collection, preceding the formal analysis. Once the range and variation of activities of the participants started to repeat, observational data saturation had been reached.

Stage 3 was the collection of dialogical data. This stage brought the participants’ voices into the data set. The data were based on verbal interactions with participants to gain their insights and perceptions of events.

Reflexivity

I was mindful of my responses, verbally and nonverbally. The use of ‘bland encouragements’, low-inference paraphrasing, non-leading leads and active listening all provided me with the means to extract information in an ethical manner.

Although the participant information sheet suggested interviews would take place off campus at a ‘convenient time and place for the participant’, all participants elected to have the interviews on campus.

To ensure the research question was answered, I applied Carspecken’s interview protocol. The four domains included in this study were the participants’ baseline understanding of VHA; social and psychological issues; organisational issues; and power and resistance. The baseline-understanding domain identified the participants’ understandings and perceptions of VHA and what constituted an episode of VHA. The psychosocial domain asked questions related to participants’ experiences, which aided in classifying which participants identified with being a target or a perpetrator of the behaviours. The organisational domain provided

questions that encouraged the participants to reflect on their position within the field of the simulated environment. The power and resistance domain asked questions related to perceived dominant structures. The interview protocol can be found in Appendix E.

Reflexivity

I had been a lecturer in nursing in the school for four years and the academic staff were very aware of my research. I had discussed it numerous times and presented the project at school professional development meetings. This knowledge certainly influenced the information the academic informants chose to reveal during the interviews. Similarly, I was familiar to the student informants, as I had taught that particular cohort the year before. Although the student participants were less informed on my stance on VHA, they may have tailored their responses to what they thought I may have wanted to hear, as ‘people’s willingness to talk to you, and what people say to you, is influenced by who they think you are’ (Drever, 1995, p. 31).

The second style of verbal interaction was ‘vox pop’ interviews, which was an effective way to capture students and academics quickly and on the run. Vox pop comes from the Latin *vox populi*, meaning ‘voice of the people’. It involves a single question being posed to a string of people over a short period, to elicit ‘what comes to mind’ answers as opposed to thought-out structured responses (Brush et al., 2014). The vox pop interview style has been used in qualitative studies exploring the mediation of women and politics (O’Brien, 2014) and comparing personal versus online social networks (Zacho, 2015). These interviews usually take place in a public space and in this study, I interviewed the participants after class outside the laboratory as they were leaving for other classes or heading home. The interviews consisted of concrete questions, such as why they did or did not wear a uniform to the laboratory classes. According to Carspecken (1996), the clarifying of events with

concrete questions in Stage 3 facilitates the validation of reconstructions. A summary of the interviews can be found in Appendix F.

Reflexivity

As the participants had consented to semi-structured interviews, I discussed with my supervisors the use of the vox pop style to determine whether a separate ethics approval was required. The supervisory panel concurred that vox pop interviews were still semi-structured and would be supported under the current ethics application. I found the vox pop interviews very useful in clarifying my observations; they provided rich data rather than thick description (Fusch & Ness, 2015).

3.3.5 Data Management

The data were collected via hand-written notations and digitally recorded interviews that I subsequently transcribed. The data were securely stored on the grounds of the research site and were accessible by only the primary researcher. The stored data included paper copies and audio and computer files. The data will be stored for a minimum period of five years after the completion of the project, at which time the paper copies will be shredded and the digital files will be erased.

3.4 Analysis

In Carspecken's five-stage approach, analysis begins towards the end of Stage 1 when the primary record is near completion and continues through to the end of Stage 3 (Carspecken, 1996; Smyth & Holmes, 2005). I adhered to this process.

Initial-meaning reconstructions are important to clarify the researcher's impressions of the observations made, as impressions of meaning involve tacit realms (Carspecken, 1996). The participants' usual routines and processes were recorded and possible underlying meanings were noted. Unusual events were highlighted. Patterns started to emerge and the data were categorised and coded into

domains that were targeted by the research question. These tacit schemes were discussed with the supervisory panel, as peer reviewers. Peer reviewers encourage the researcher to probe for biases and deeper meaning, to ‘calibrate’ reconstructions. This role was fulfilled by my supervision team and through presentations of the study during my candidature (Barber & Walczak, 2009; Carspecken, 1996).

The application of an electronic data management and analysis tool (NVIVO 10) was considered; however, Carspecken (1996, p. 149) warned against using software programs that break the data into segments. He believed this process risked obscuring the interactive rhythms and syntax of the data. Therefore, data coding occurred using word processing software only, while the validity of the reconstructions were achieved through pragmatic horizon analysis, as recommended by Carspecken.

Transcripts and field journal data were copied into a Microsoft Word file and then uploaded into a ‘word cloud’ (Wordart.comTM). Several iterations of word clouds were undertaken for each of the topic domains to provide a representative sample of participants’ descriptors in relative order of importance.

Bourdieu’s social practice theory was applied to identify the relationships between the fields of higher education, healthcare and the wider social system, all of which may enable episodes of VHA in a simulated hospital laboratory. This relational analysis occurred in Stages 4 and 5.

3.5 Bourdieu’s Social Practice Theory

Bourdieu’s social practice theory (1972) was used as a theoretical framework to explain the research findings. Pierre Bourdieu was a French social anthropologist and ethnographer who, like many other colonial ethnographers of the time, was mediated by war. In the 1950s, Algerian society was struggling through a war of

independence, resisting colonisation and although he served in the French army, Bourdieu opposed the military actions being taken by the French. It was at this time Bourdieu conducted his ethnographic fieldwork among the Kabyle, Algeria's indigenous peoples. Bourdieu observed the effects of the 'external' colonisation exerted by France on the North African people and this experience became the foundation of his epistemological position. The theory he developed enabled him to understand his ethnographic findings, which fused ethnology and sociology as a means to acknowledge 'the complexities of the "real" [that were] resistant to theoretical simplification' (Yacine, 2004, p. 487). Bourdieu developed this theory specifically to overcome the traditional dualism of the subjective and the objective. He believed that the subjective places too much emphasis on the power of the participant to create independent action, while the objective presupposes that external forces determine a participant's action without explaining how the participant contributes to sustaining the social structures. Bourdieu's framework recognises that social reality is multifaceted and complicated and his theory of practice offers a way to describe, analyse and understand the origin of the person within social structures and groups (Harker, Wilkes & Mahar, 1990).

Wacquant, a fellow researcher and colleague of Bourdieu, stated [Bourdieu's method of a] living laboratory to cross-analyze the other enabled him to discover the specificity of the 'universally prelogical logic of practice' and to initiate the decisive break out of the structuralist paradigm by shifting his analytic focus 'from structure to strategy', from the mechanical mental algebra of cultural rules to the fluid symbolic gymnastics of socialized bodies. (ibid., p. 389)

Bourdieu explained the strategy or practice via the interconnectedness of his trilogy of concepts, namely field, habitus and capital. The interconnectedness of these main elements means that one cannot be explained without referring to the other.

- **Field:** For Bourdieu, a ‘field’ theorises the objectivity of the social situation. Fields are characterised as political and cultural connections and at times, they can interact with other fields. This interaction has been described as ‘cross-field effects’ (Rawolle, 2005). Cross-field effects suggest that all social practices can be explained by the operations of the field and the influences of other fields on that given field. Although fields are unlikely to change, the social practice exhibited within the field will be the result of the legitimisation of the habitus and capital of the agent (Bourdieu, 1972; Rawolle, 2005).
- **Habitus:** The concept of habitus explains the dispositions that influence agents to become who they are, which a participant has acquired through their lifelong journey of learning and socialisation, including the conditions of existence (Bourdieu, 1989, 1999). Therefore, while dispositions make up a person’s habitus, a habitus is also formed by an individual’s history.
- **Capital:** To enter a field, an individual must possess a specific quantity and type of resource that is of value to the field, which Bourdieu called ‘capital’. An individual’s social network is measured by the actual and potential resources available to them. These resources include material and immaterial assets such as knowledge or advice that can be legitimised by the social network (Bourdieu, 1986).

3.6 Research Integrity

In the methodological literature, a large number of concepts have been developed explicitly to ensure ‘quality’ in qualitative research (LeCompte & Goetz, 1982). This suggests there are difficulties agreeing on a quality framework specifically by people external to the use of qualitative research. In the literature, there is debate over whether qualitative and quantitative methods should be assessed via the same criteria of reliability and validity or whether qualitative research should focus on the ‘trustworthiness of data’ (Morse, Barrett, Mayan, Olson, & Spiers, 2002). While Morse et al. (2002) were concerned that the introduction of parallel terminology and criteria would downgrade qualitative research from scientific legitimacy and challenge its rigour, Tobin and Begley (2004) suggested that the development of parallel terminology would not weaken rigour but rather, position it within the epistemology of qualitative research methodology.

Meanwhile, Carspecken (1996) refers to validity as the ‘soundness’ of an argument rather than the truth of an argument. He suggests that truth claims are fallible, that they can be regarded as true in one field but not true in another. Therefore, a truth claim must meet validity conditions to win consensus. Carspecken recommends translating all truth claims into validity claims so they can be examined (p. 56). This research was designed to make transparent the validation actions taken, focusing on reliability, validity and transferability, as shown in Table 3.3 and the descriptions in the following sections.

Table 3.3

Carspecken's Validation Methods (1996 p. 140)

Carspecken's recommended validation methods	Validation actions in this research
Truth claims need to be translated into validity claims	The three ontological realms of objectivity, subjectivity and normative/evaluative were used to validate the raw datasets.
Multiple recording devices and observers	Field notes, reflections, direct observations and participant reconstruction served as triangulation.
Flexible observation schedule	Priority observation schedule was used.
Practice prolonged engagement	Twelve weeks of laboratory sessions were observed (3-hour labs twice a week).
Use low-inference vocabulary	Coding of the field notes denoted subjective references; e.g. 'observer comment' (OC).
Peer debriefing	The supervisory team frequently reviewed my fieldwork journal, checking for possible biases in language or inference.
Member checking	Field notes were shared with the participants to obtain consensus and interviews were used to validate reconstructions.

3.6.1.1 Reliability

External reliability addresses the issue of whether other researchers would develop the same constructs in the same or similar setting, while internal reliability refers to the accuracy of the data collected (LeCompte & Goetz, 1982). In this research, reliability was determined by the accuracy and consistency of the data and the interpretation of that information to reflect the reality in which it was collected. Through member checking and peer debriefing ensured data were an honest reflection of the participants' realities. Authenticity was achieved through

documenting explanations and descriptions of the time, place and the participants, when the data were captured.

3.6.1.2 Validity

LeCompte and Goetz (1982) suggested that reliability could pose a threat to the credibility of ethnographic studies; however, the validity processes are seen as a strength. Validity demonstrates that the constructs generated match the casual conditions in which they were obtained. Validity checks can be either internal or external. Internal validity refers to the extent to which observations and measurements are authentic representations of some reality. External validity addresses the degree to which such representations may be compared legitimately across groups (LeCompte & Goetz, 1982, p. 32). However, LeCompte and Goetz write

problems of uniqueness and idiosyncrasy can lead to the claim that no ethnographic study can be replicated. However, generation, refinement, and validation of constructs and postulates may not require replication of situations. Moreover, because human behavior is never static, no study can be replicated exactly, regardless of the methods and designs employed (1982, p. 35).

3.6.1.3 Transferability

While the above methods for ensuring validity and reliability are crucial to qualitative research, reliability is determined by the rigour of the study. If an investigation is rigorous, it is more likely to be valid and reflective of wider contexts, and therefore findings may be transferable.

According to Morse et al. (2002), rigour is best maintained and managed in the analysis of research data. 'It is the analytical work of the investigator that

underlies these strategies that ensure their effectiveness' (p. 10). The constant analysis, from the beginning of the data collection in Stage 1 through to the relational analysis in Stages 4 and 5 was a feature of this research's methodology.

Rigour can be achieved through engaging with practices such as triangulation as well. Triangulation is the use of multiple collection methods, which are applied to the same area of study to substantiate the findings (Gulati et al., 2011; Hardcastle, Usher, & Holmes, 2006). Adami and Kiger (2005) questioned whether triangulation confirms 'truth' or rather, 'completeness'. Triangulation is a way of deepening and extending the depth and breadth of the analysis and understanding of a phenomenon rather than producing an objective 'truth' and therefore, it is consistent with critical ethnographic research. Seale (1999), wrote

triangulation exercises enhancing the quality of politically driven research projects, whose emancipatory or enlightening effect is enhanced by the elicitation of multiple perspectives on, or constructions of, a phenomenon.
(p. 475)

In this study, triangulation is used to ensure completeness of the data. Triangulation of data in ethnographic investigations increases confidence that the findings are reliable. Data for this study were sourced from observations, interview data, field journal entries and researcher reflections. In addition, completeness of the data was realised through comparing what is already known in the literature against the themes developed from analysis of the observations, participant responses in the semi-structured interview data and document analysis. The triangulation of data produced different data sets as illustrated in Figure 3.2. Each data set had its own merit and when they were merged, they provided a more complete truth.

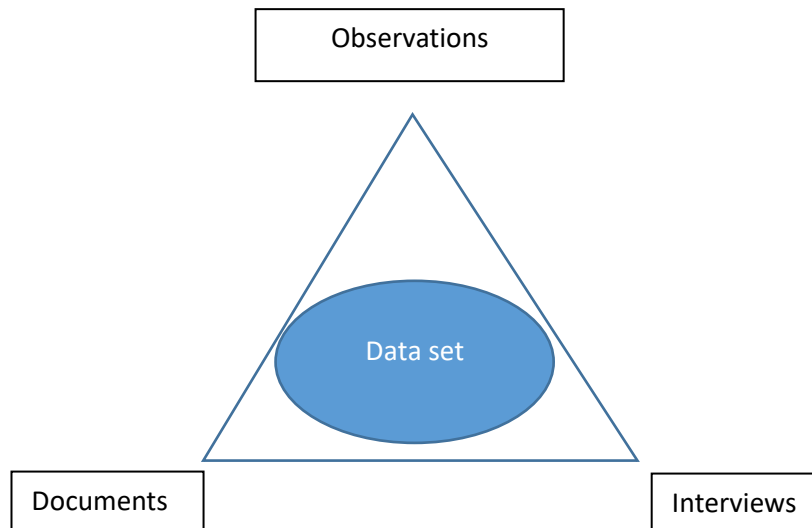


Figure 3.2. Triangulation methods (adapted from Flick, 2015).

These strategies of choosing multiple sources and data types while regularly checking theoretical assumptions against the data, testing interpretations with participants and conducting preliminary analysis at the time of data collection, create what Morse et al. (2002) considered crucial aspects of ensuring reliability and validity. They wrote

collecting and analyzing data concurrently form a mutual interaction between what is known and what one needs to know. This pacing and the iterative interaction between data and analysis is the essence of attaining reliability and validity. (pp. 12–13)

3.6.1.4 Hawthorn Effect

The quality of observational data by an emic/etic researcher has been challenged because of what has been called the ‘Hawthorn Effect’ (Hardcastle et al., 2006). This term is used to describe the way the presence of a researcher can change the dynamics of the phenomenon under investigation. In this study, the students were initially very aware of my presence and they would alter their behaviour to suit what

they thought I was investigating. Despite the participants being informed that I was not observing their clinical practice, students would say, for example, ‘oh you’re here, I better wash my hands’. However, Carspecken (1996) argued that the ‘Hawthorn Effect is not damaging to a qualitative study . . . alterations in behavior brought about by the presence of a researcher usually do not correspond to alterations in a cultural milieu’ (p. 52). He suggests that what is important is *how* the behaviours change.

In this study, observer effects or the Hawthorn Effect was addressed through prolonged engagement in the field and plain language used during the information sessions; as I did not use the term VHA during Stage one, the participants were unaware of the practices or behaviours that I was observing.

3.7 Summary

This chapter has justified the use of a qualitative research methodology, critical theory and Carspecken’s five-stage approach to critical ethnography. Bourdieu’s social practice theory has been argued as a critical framework for interpreting Stages 4 and 5. The process of obtaining and conducting ethical research has been explained and the manner in which participants were recruited and consented to participate in the study has been described. The management of data, data collection schedule, tools and the analytical process have been explained.

Chapter 4 reports the results of this critical ethnography in the simulated hospital laboratory in which episodes of VHA had occurred. The research site, participants and simulation schedules are described to provide a context for the results.

Chapter 4: Main Findings

All individuals in this universe bring to the competition all the (relative) power at their disposal. It is power that defines their position in the field and, as a result, their strategies. (Bourdieu, 1996)

4.1 Introduction

Chapter 3 described the five-stage methodological design of this critical ethnography, including the selection of participants, the data collection site and the analytical tools adopted for the interpretation of data. The primary purpose of this chapter is to detail the study findings that are presented in two parts. Part A of this chapter begins with an ethnographic description of the physical space and cultural routine of the simulation laboratory where the research was conducted. Part B presents the findings distilled from the application of pragmatic horizon analysis described in Chapter 3.

4.2 Part A: The Context of the Investigation

The site of this investigation was a simulated hospital laboratory situated in a tertiary educational facility in NSW, Australia. The campus was located in a rural town that has a population of 58,000 people. The town is situated on a river in NSW. It is well connected with Sydney, Canberra and Melbourne through air, rail and road services. The town has had a long-standing relationship with the military and as a result, the town's population could be described as transient. In 2011, 8.7 per cent of the town's population were aged 20 to 24 years, a proportion that was 3 per cent higher than that for regional NSW combined (ABS, 2011). At the time, the town had a 5 per cent unemployment rate. Healthcare and social assistance was the largest

employer, making up 14.4 per cent of total employment. Of the working population, 19.1 per cent had a Bachelor's (or higher) degree (ABS, 2011).

According to the Australian Education Network (2017), at the time of this research, the university where this study was undertaken catered to over 33,000 students domestically. The University was distributed across five campuses, with 9,000 enrolled in the Faculty of Science and of these, 2,000 were enrolled in the undergraduate nursing degree. The campus where this research was conducted was multi-disciplined, with four faculties: Science, Education, Arts and Business.

The simulation hospital laboratory was situated on the second floor of a blonde brick two-storey building, one of many blonde brick buildings situated on the 640-hectare campus.

4.2.1 The Simulation Laboratory

The simulated hospital laboratory was designed to reflect NSW healthcare facilities. It had a utility room; a nurse's station; a patient bathroom; and a central corridor with 10 designated patient bed spaces in three different rooms (two rooms with four patient bays and one room with two patient bays). Only the two rooms with four patient bays were routinely used for learning and teaching purposes. The third room was commonly used for midwifery and the full-body midwifery manikins were often stored in the beds (see Figure 4.1). The teaching spaces were arranged to accommodate two or three students per bed space, resulting in a class size of 16 to 18 students. However, there were up to 25 students in the laboratory class.

The entry from the tutorial room was at one end of the corridor and at the other end there was a technician's office space. The technician was responsible for maintaining all the laboratory spaces and for liaising with the academic staff to

ensure the equipment and other teaching materials required were available for the simulated scenarios.

The tutorial space was an open space with individual chairs with flip-down writing benches. There was an analog clock at one end of the room and a data projector and a screen hidden behind closed doors at the other end.

During the period of this study, the tutorial space was used for students to gather and sign the attendance sheet and for them to store their personal belongings, such as bags and laptops. Each laboratory lesson began in this space with a pre-briefing of the learning outcomes of the lesson. There was no seating plan or academic's desk or chair. Students entered the room and sat within their social groups. The academic delivering the lesson stood in the front of the room to commence the class.

Reflexivity

Despite the pre-briefing that occurred in this space, when participants were asked to identify the learning and teaching areas of the laboratory on a floor plan, the tutorial room was not identified (by the academic nor by the student participants) as a space of interest with regard to their learning or teaching. So, what determines a learning and teaching space?

Despite the nurse's station having a working computer, telephone line and several relevant texts, during the simulation lesson the nurse's station was not used. All patient documentation was presented in folders at the patient's bed space. It was observed that the nurse's station was usually used for storage of equipment and consumables, Field Note number (FN) 23.

Reflexivity

Instead of holding the usual collection of patient files, vases full of flowers, thank you cards and boxes of chocolates, as in a 'real' ward, this nurse's station looks uninhabited. Does authenticity matter? What exactly is required to suspend disbelief? Where does the simulated experience begin and end?

The central corridor was used as a thoroughfare for the students to enter and exit the simulation space. The corridor also housed the handwashing basins, which were used by students to wash their hands before the simulation component of the lesson began. However, the ritualistic practice of handwashing became an opportunity for social conversations, such as

I got smashed on the weekend . . . I'm going home tomorrow . . . I can't wait to see Dad. He's been sick (FN53a and b).

Reflexivity

The professional ritual of handwashing offered some reprieve for students and the academic from the learning and teaching, which was didactic and involved students observing a demonstration of a nursing intervention. Students openly engaged in social chatter during this activity. When they were at the bedside, they were covert with their social chat. There appeared to be an understanding that it is unprofessional to engage in social chitchat at the bedside; however, they still chatted socially and off-topic at the bedside but stopped as soon as the academic walked into the room. Is this because they felt judged, were instructed not to chat among themselves unless conversation was related to the activity?

The Dangerous Drugs cupboard was positioned in the corridor. When the scenario included the administration of such medications, the corridor became crowded and noisy. The students engaged in social chatter and some students were using their mobile phones while they waited to access the cupboard. An example of student-to-student interaction observed involved Francis (FN33), who apologised (in a sarcastic manner) for taking too long at the drug cupboard. He turned to face the queue and said, 'sorry guys, I'm taking too long'.

When the students commenced the scenario and entered the patient bed space, there was a flurry of activity. The students would start by reading the patient

notes and pulling the curtains around the patient to ensure privacy. However, behind the curtains, some students were found to be sitting on the bed and chatting about unrelated topics.

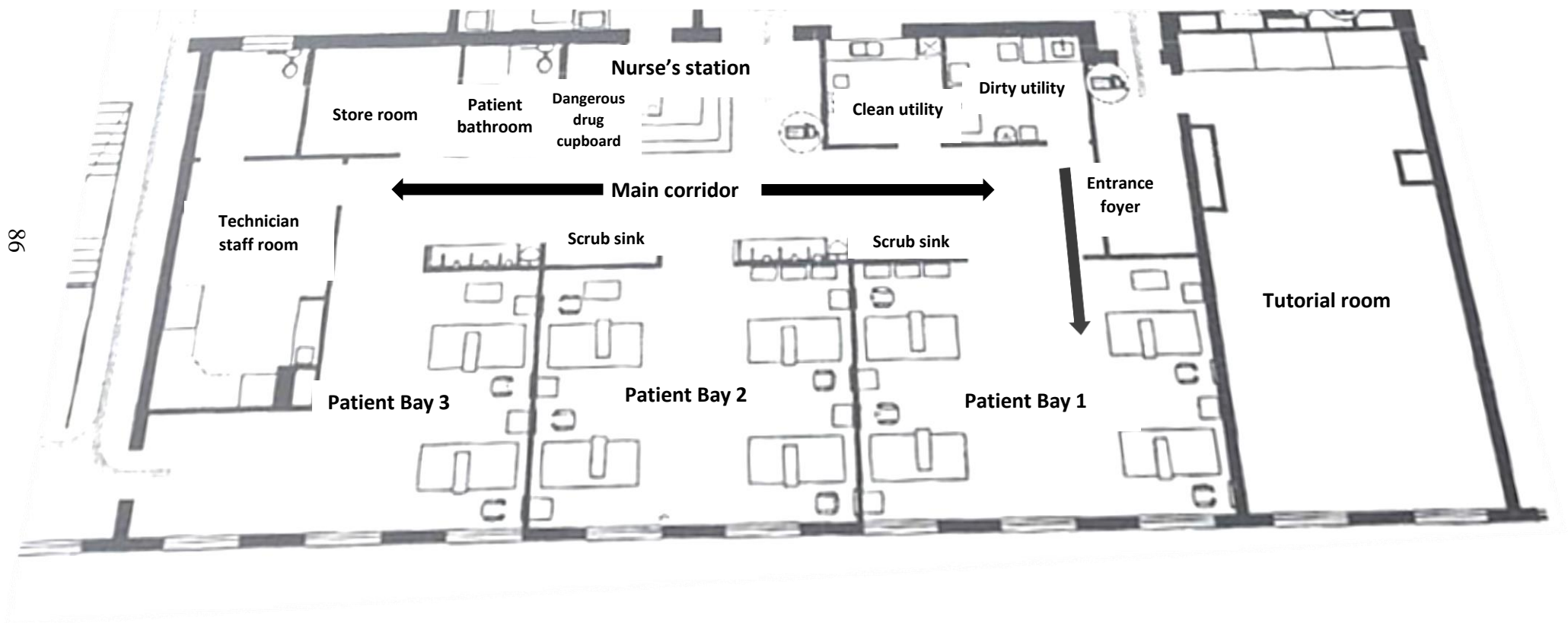


Figure 4.1 Floor plan of the simulated hospital environment.

4.2.2 The Simulated Hospital Laboratory Lessons

The aim of the simulated hospital laboratory lessons was to enable learners to collaborate with each other and plan nursing care for acute, chronic and complex patients. The learning outcomes included comprehensive nursing assessment skills; appropriate use of clinical data; critical thinking and problem solving; administration of medication; ability to describe physiological and mental health conditions; and demonstration of communication, and evaluation skills (School of Nursing Midwifery and Indigenous Health Curriculum, 2016-2019). The students were expected to achieve these learning outcomes via high- and low-fidelity simulations, which included learning and teaching techniques aligned with best practice in simulation, as described in Chapter 1. The simulation hospital laboratory classes were scheduled to take three hours; however, this varied from week to week and from academic to academic. Table 4.1 contains a typical laboratory lesson plan.

Table 4.1

Breakdown of a Simulation Lesson

Clinical laboratory lesson schedule	Time
Sign the attendance sheet in the tutorial room	10 minutes
Academic outlines learning outcomes and expectations of the lesson	10–20 minutes
Academic demonstrates clinical skill sequence	Up to 90 minutes
Students practise the skill in small groups	Up to 60 minutes

4.2.3 The Demonstration

The demonstration time was used differently by each academic observed. For example, Ann ensured the students stood around the bed space to watch the demonstration. Betty allowed the students time to reorganise the space from a clinical environment to more of a tutorial environment. She encouraged the students

to bring chairs and writing materials to the session and they arranged the chairs in an arc around the bed space. Cathy did not modify the laboratory teaching space; the students gathered randomly around the room to watch the demonstration.

Following the demonstration, the students moved into small groups of three or four to practise the skills that had been demonstrated.

4.2.4 The Clinical Scenario

The skills taught and practised during the simulation lesson were embedded in a clinical scenario, which is an objective-driven patient presentation including deliberate clinical learning experiences that are designed to facilitate students in achieving the learning outcomes (Waxman, 2010). A clinical scenario includes a patient's name, history and several learning objectives that the instructor can edit to fit the clinical condition.

The usual way the academics alerted the students to the scenario was with a verbal clinical handover, presenting a fictitious patient history. The manikins used in the laboratory session were programmed with vital signs via the simulation hand-held device. Medication charts and various forms of documentation were provided in a patient folder located at the end of the patient bed.

The students self-selected the groups in which they would perform the scenario and the group members designated the roles and tasks that each person would fulfil. For example, one of the students would be responsible for the medication, one for the dressings and others would document the vital signs. The allocation of roles was usually dictated by the most dominant member in the group.

4.2.5 The Manikin

The manikins used during the simulation scenarios in the laboratory were full-body, high-fidelity patient simulators: Nursing Ann 320-05050 Simulators™ with SimPad™ PLUS system (Laerdal, 2019). Thus, the manikins used in the

simulation laboratory under investigation had the capabilities to provide extensive physiological feedback. The physiological parameters were heart, breath and bowel sounds, vocal sounds, changeable pupils and palpable anatomical landmarks that enabled procedural interventions such as urinary catheterisation and venepuncture. They were considered high fidelity, as they were capable of reproducing authentic replication of human-like physiological parameters within a learning environment (Jeffries, 2007; Waxman, 2010).

Moulage was often used, meaning the manikins were ‘made up’ to represent a patient, with wigs, glasses, wounds, dressings, intravenous access and in-dwelling catheters. The manikins wore identification armbands and if applicable, allergy bands.

4.2.6 The Debriefing Session

Although debriefing has been deemed an essential aspect of the simulation process (Arthur, Levett-Jones, & Kable, 2013; Dreifuerst, 2012; Lusk & Fater, 2013; Neill & Wotton, 2011; Shinnick, Woo, & Horwich, 2011), at the time of data collection there were no policies or simulation models in place to guide the learning and teaching in the simulated hospital laboratory.

Reflexivity

Both the academics and the students were observed interacting with the manikins in unintended ways. Students sat or flopped on the manikins while the academics rested their arms on the manikin’s face during discussions and demonstrations. Students posed with the manikins for ‘selfies’.

The manikin was there to represent the patient. Does this reflect how they will treat actual patients? Does this simulation process desensitise students to actual patients?

4.2.7 Uniforms

Wearing the university clinical practicum uniforms to laboratory classes was identified by some academics as a way to create a work-like environment Transcript

Number (TN23), suggesting the uniform added to the fidelity of the simulation.

Researchers have suggested that wearing a uniform helps students to suspend reality and become fully engaged in the learning process (Parr & Sweeney, 2006; Prescott, Garside, & Hope, 2010; Shaw & Timmons, 2010; Timmons & East, 2011).

At the time of the data collection, there was no policy related to the wearing of uniforms in the simulation laboratory. Some students wore the full official uniform every week in the simulated hospital environment but the majority wore the uniform shirt with casual pants/trousers.

4.2.8 The Usual Routine

The observations revealed there was a standard routine that was followed in the academic sessions. The lessons typically began in the tutorial space, where the students gathered and signed the attendance sheet. The tutorial room became noisy as students greeted each other. Students sat in the same place each week and had their own personal routines. Some would get their computers out; some would get out paper, pens and water bottles; some students were still eating their breakfast.

The academic greeted the students and reminded them to sign the attendance register for participating in the session. Students who had not yet complied with this expectation rose from their chairs and walked to the front of the room to sign on. At the time of the study attendance was compulsory however, make classess were offerd toward the end of each session. The academic then discussed the learning objectives and asked students if they had any questions. Students rarely responded, although there was often a low murmur from students, indicating they had heard the request but either did not have any questions or were unwilling to ask questions.

The students would then move into the laboratory space, leaving their personal belongings in the tutorial room. The demonstration of the skill sequence would then take place. The demonstration stage lasted from 45 to 72 minutes. As

previously mentioned, this stage varied, depending on which academic was facilitating the session. As the demonstration occurred, some of the academics talked through each step. When Ann conducted the demonstration, she verbalised each step while the student stood in an arc around the demonstration bed, silently looking on. Betty silently demonstrated the skill as they sat in chairs around the room and then asked the students if there were any questions. When Cathy demonstrated, the students were scattered around the room: on the beds, in wheelchairs and on the floor.

Following the demonstration, the clinical scenario, with a fictitious patient history, was presented to the students as a handover. The manikins were allocated names, dates of birth, histories and families, and at this point became 'patients' who required nursing care. The following example shows the level of detail provided to the students:

Mrs Dorothy Parker DOB 01/07/1938 MRN 152764. Mrs Parker has a history of diabetes and congestive heart failure. Mrs Parker is receiving intravenous antibiotics via a double-lumen central line and requires a central-line dressing change. (FN5)

Medication charts and various forms of documentation, such as observation charts and medication order charts, were provided in a patient folder located at the end of the patient bed. The students self-selected the groups in which they would perform the scenario. The critical aspects of the lesson were the ability of students to reproduce the psychometric skills they had observed and apply it to the clinical scenario.

At the commencement of the scenario, the students proceeded to the handwashing basins, which took some time as the student took the opportunity to catch up with one another.

Physiological data such as heart rate, respiratory rate, blood pressure, oxygen saturation and temperature were uploaded to the hand-held device. However, students were encouraged not to retrieve this data from the device and instead, to take the ‘patient’s’ vital signs, as a nurse would on an actual patient.

During the scenario, the academic attended to each bed space and asked the students questions. However, it was noted that the far end room was not well supervised during the observed scenario (FN12, 23, 45). The academic did not routinely attend to the end bed bay.

At the end of the class, the students would lie on the beds and chat. At this time, the academic would say, ‘When you're done, you can go’. (FN18)

Reflexivity

There did not appear to be a learning model used in the design of the simulation lessons. What models of simulated teaching could be used?

Why is there no debrief process??

Are the academic: student ratios contributing to VHA?

If we want students to learn and model behaviours that we applaud, then limiting the perpetuation of VHA is necessary.

4.3 Part B: Pragmatic Horizon Analysis

This section presents the pragmatic horizon analysis outcomes under the question domains as described in Chapter 3: baseline understanding, social-psychological, organisational physical and power and resistance.

The analysis, interpretation and synthesis of the key informant interviews, observations, documentation and field journal notations resulted in the identification of 22 themes. To answer the research question, priority was given to the recurring data that specifically related to the domain questions. The interview schedule with topic domains can be found in Appendix D.

Ann's understanding of the bidirectional flow of the behaviours. Ann's perceptions of VHA were analysed in the following pragmatic horizon analysis (see Table 4.2).

I have seen it, and I have definitely been the recipient of manipulations and targeting. I can't say I have never been a perpetrator because you can never know how the other person is feeling when you are talking to them.

Sometimes you have to 'bring people into line' as a manager, it is your role to do so, but I didn't create that, it is part of my role. (TN23)

Table 4.2

Pragmatic Horizon

Horizon analysis (TN23)
Possible subjective claims
Foregrounded <i>I can't say I have never been a perpetrator.</i>
Backgrounded <i>I am a manager.</i>
Possible objective claims
Foregrounded <i>It's your role.</i>
Backgrounded <i>Sometimes you have to bring people into line.</i>
Possible normative-evaluative claims
Foregrounded <i>Managers need to bring people into line.</i>
Backgrounded <i>I didn't create that, it is part of my role.</i>

Here, the foregrounded and backgrounded meanings of the academic's claims indicate that the academic understands her role to be a manager rather than a teacher. The academic perceived that the students need to be managed and 'brought into line', but does not accept responsibility for her actions as a manager, as she believed this role had been created. She distanced herself from the responsibility of the role through the backgrounded normative claim.

Conversely, Betty denied having experienced any form of bullying.

Ohh, not really. Students talk and give their opinion, and students may laugh if someone says something funny, but we always encourage respect for each other. (TN24)

However, she conceded that it was a subjective experience and like Ann, suggested, 'the student may take it as VHA' (TN24).

Betty considered that VHA was

maybe like if someone said something that really hurt someone, causing harm, I guess treating students unfairly. I try to avoid those things as [much as] possible. But it hasn't happened to me. (TN24)

Betty denied having experienced VHA, she stated that she avoided those situations and highlighted the importance of being respectful and fair to others. However, Betty backgrounded the suggestion that episodes of VHA did not occur in her teaching space, which implied that her understanding of the phenomena was assumed, rather than known.

Cathy was predominantly a clinician (i.e. she worked primarily in clinical practice); therefore, she reflected on the clinical environment when answering this question about her understanding of VHA, rather than on the learning and teaching space of the laboratory.

It is huge in nursing, more so vertical than horizontal. I haven't experienced any here [at the university] but at work, [the] bosses are expecting you take a working lunch, calling you at home all the time asking you to do a shift, or calling you at home asking you if you had checked a trolley or filled in paperwork, always hammering you in the hospital. (TN25)

Within the simulated environment, Cathy could not recall episodes of VHA among the students. She qualified this statement, stating, 'I guess I'm not looking for it' (TN25). Then she added 'the younger ones talk a lot but are more standoffish, but I think it is more prevalent with the mature-age students' (TN25).

Despite Cathy stating she did not look for episodes of VHA, my field notations suggested that she was a target of VHA. For example, I noted that the

students often talked over the top of her and during her demonstrations. They stood around with their arms crossed or their hands on their hips. Some students were on their mobile phones, having social conversations, when she was conducting a class. Moreover, I noted that on an occasion, Cathy could not find a piece of equipment she wanted to use in the demonstration. She would say, ‘I’m so disorganised’. The students would roll their eyes and huff as Cathy went in search of the equipment.

(FN42) When I asked Cathy if she had noticed these behaviours, she replied

Yeah, they get frustrated with me because I don’t really know what I’m doing and I can’t find stuff. I don’t get the content for the class until two days before and the students can see that I’m not prepared, but what can I do?

(TN25)

On analysis, Cathy foregrounded being disorganised and backgrounded that fact she is new to this environment, which legitimises her confusion. Cathy acknowledged the students’ frustration and adopted a powerless position with regard to changing it. Cathy believed that because she was new and disorganised, she was vulnerable to episodes of VHA (see Table 4.3).

Table 4.3

Pragmatic Horizon

Horizon analysis (TN25)
Possible subjective claims
Foregrounded I am so disorganised.
Backgrounded I am a new academic.
Possible objective claims
Foregrounded I don’t get the content for the class until two days before.
Backgrounded But what can do?
Possible normative-evaluative claims
Foregrounded They get frustrated with me.
Backgrounded I’m not prepared.

Similar to Cathy, Albert was unaware of being a target of episodes of VHA. As a student, Albert's understanding was that VHA was acts of intimidation from peer to peer, or from an academic to a student or vice versa. He could not recall being a perpetrator, a witness or a target of it (TN26). However, I documented in my fieldwork journal that he was a frequent target of VHA, as shown in the following example:

Albert raised his hand again to answer the question on central-line dressings. A groan came from the class. Several students rolled their eyes. Even the academic told him to put his hand down and asked for someone else to answer. (FN35)

Although Albert produced a succinct understanding of VHA, he was unaware of what it looked like.

Reflexivity

Has Albert experienced VHA all his life, so much so that he has normalised the behaviours and is unable to see it?

Is this his normal??? The longer we are exposed to a behaviour, the more accepting of it we become. Nurses who only ever see the abnormal forget that 'normal' is normal.

Beatrice acknowledged that Albert was a target of VHA. She stated, 'it happens all the time in all our classes'. She justified this behaviour with 'his opinions are very strong, but he can back up everything he says' (TN27). Danielle suggested that Albert was 'on the spectrum, it is just his way I don't think it is intentional. I think lecturers are mean to him' (TN29). Carol commented on another student who she felt 'is always in his face, and it pisses me off, she is so negative to him all the time' (TN28).

Danielle argued that she did not think Albert understood that people bullied him, saying, 'I don't think he . . . maybe he doesn't actually realise'. Then she said,

A situation that occurred in the corridor of the laboratory when another student almost bumped into Gail was recorded in the field notes. The incident involved

Carol who bumped into Gail in the corridor. Carol said, 'Oh sorry'. Gail responded with 'You better be'. (FN23)

When I asked Gail what she meant by this, she said, 'I was only joking'. I then asked Carol how she had felt when Gail said that to her. She replied, 'Oh, she is always like that'. She rolled her eyes, adding 'but she makes me feel stupid'. I then asked her why Gail made her feel stupid. She said it was because Gail and Francis worked as AINs and they 'knew stuff' (TN28). On analysis, it was revealed that prior knowledge was a valuable currency in the laboratory space and afforded those who had it with specific exemptions: the episode of VHA was being excused because Gail had a power base.

Following the demonstration period, the students divided themselves into groups to work through the clinical scenario. The student groupings were observed to be the same each week. During the interview, I asked Ann about the students' social groupings. She responded by reflecting on the construction of groups, offering that

there is a group of four [students] always together because they went to school together, and there is always a group of students who are from a non-English-speaking background that ends up together as well . . . sometimes, I try to mix the groups up, but they always go back to where they are comfortable. (TN23)

Cathy, however, referred to the social mix of students as 'socially problematic', adding

I think it would be good to allocate the groups because they get too comfortable within their social groups, and then some groups take shortcuts .

. . mature-aged students are overconfident and they think they know more.

They say, 'I can do everything' but shy away from doing the clinical skill. . . .
they talk, talk, talk, but let other people do the practical'. (TN25)

From a student perspective, Danielle believed that as they were in the second year they had had enough time to identify the students who were serious about their learning. She affirmed 'We've weeded out the people who really wanted to be a nurse and those who didn't' (TN29).

The student key informants (Elizabeth, Danielle and Carol) all felt there was increasing pressure among the cohort to be competitive, which led them to be less generous with sharing their knowledge, confirming that the group were 'being prepped for the end of the degree, and we need[ed] to fight for positions'. Carol also felt the pressure to align herself with certain peers. She had developed a strategy of not associating with students who had taken advantage of her in the past and towards whom she now held a grudge. She explained that 'people who don't do the work and take advantage of you. You start to build grudges' (TN28).

Danielle revealed that her group actively excluded other students in the laboratory and beyond. She commented that she did not want to be associated with them, justifying this with

I think [by] understanding why people are the way they are, you can maintain a friendship [by appreciating their way of being in the world, because they don't even realise they are doing it]. It makes me feel awful. I don't want people to think I'm like that, though. (TN29)

Social groups were not only identified within the student cohort, there was evidence of the cohort coming together and behaving as a ‘mob’. Elizabeth reflected on a time she was part of a cohort who targeted an academic.

The lecturer was targeted because she was soft and people couldn’t hear her, but she was awesome and if they just gave her a chance, she was a really good lecturer. . . . The style of delivery [she used] was much different [from other lecturers]. It was more jokey, more friendly, whereas the others were more authoritative, showed more strength. I found that there was a pack mentality this one day and I found it distressing. I could see the lecturer was visibly upset, but they just kept going. (TN30)

Danielle referred to this event as well, stating, ‘I felt it was unfair, completely uncalled for and it felt like the ‘pack’ was ganging up on the lecturer. I left very upset’ (TN29).

Reflexivity

The examples offered by students reflect accounts highlighted in the literature on the impact on witnesses of VHA. However, there are no innocent bystanders. Is this where the distress comes from? Feelings of guilt or powerlessness, perhaps?

Another example of a student group ‘mobbing’ an academic was observed during the demonstration time. Carol explained,

We have a casual academic and she kinda doesn’t know what she is doing. She doesn’t tell us to stop talking; she just waits until we have finished because she does not have that strong personality, she doesn’t get taken seriously. The class commences at 8 a.m. and the lecturer doesn’t like people being late, but she tells us that she only got the content a week ago so I asked if I could [leave]. She was so disorganised, but it’s not our problem, she gets paid to do this. . . . I didn’t get up early to get to this class for this. If we are

expected to be here, then she should be prepared. I just travelled an hour and a half to be here. We felt like the labs were pointless. She even said, ‘Ok, these are not running well, what I can do?’ (TN28)

Beatrice also believed that the students were bullying the academic (TN27).

The students responded well to the authoritative approach of an academic who was deemed legitimate, while a less-authoritative approach resulted in another academic being vulnerable to episodes of VHA. The students justified this behaviour by foregrounding that authoritative lecturers were organised, which left the tacit assumption that soft or gentle lecturers were not.

The students’ behaviours were justified by the power relationship of the ‘customer’ and the ‘service provider’. The students did not feel they were receiving what they had ‘paid’ for. Their expectations were not being met; therefore, they validated and justified their responses.

4.3.3 Topic Domain 3: Organisational and Physical Environment

Topic Domain 3, organisational and physical environment, provided questions that encouraged the participants to reflect on their position within the field of the simulated environment (see Figure 4.4).

end up outside the room . . . if they sit down they can't see because they are sitting behind each other but also they get distracted; they are on their phones and stuff. I'm standing, so they can too. But really it is because this is supposed to be a hospital environment and in practice, they wouldn't sit on a patient's bed. I like to create a work-like environment. (TN23)

Beatrice justified her preferred approach, explaining

I need to demonstrate and they need to look at what I am doing, and that takes about 45 minutes to one hour. . . . I cannot stand for that long not doing anything, but they can take a chair because that is what I like. I don't know what the students prefer. I do not like them sitting on the beds, but they can take a chair. (TN24)

Cathy did not alter the laboratory space. She said, 'I don't really care if they stand or sit, as long as they are paying attention to what's going on' (TN25).

Reflexivity

Are the academics educationally equipped for their roles teaching clinical practice?

The physical structure of the simulation environment was identified as a possible source of social exclusion by peers or a mechanism for creating opportunities for student vulnerability. Even though both simulation rooms were four-bed spaces, some students preferred one room over the other. It was observed that the same student groups went to the same bed spaces each week. The students appeared to understand that one of the simulation rooms was not supervised by the attending academic as much as the other one.

Ann confirmed that she had seen students (being) ostracised by other students, explaining

The fact that we have two distinct rooms makes it hard, but I think because we work in groups, no one gets left out. But some students don't like being in a group environment. Having those two rooms when you can only see half at a time can leave some students vulnerable. I can miss some things. (TN23)

Cathy agreed that the two separate teaching spaces made it a challenge to supervise students effectively, as 'it is hard to be in two rooms' (TN25).

However, the students were able to take advantage of the physical layout. While the academics found the two separate rooms a limitation and a risk, some students found it a haven. Danielle elaborated, 'The lecturer does not come to this end much, so we can slack off in here. We can get away with not doing stuff' (TN29). Beatrice agreed, adding, 'Yeah, we get away with heaps down there'. However, she acknowledged, 'When we walk through that door, we should be professional' (TN24). Danielle then added 'If you're not in the mood or [you're] feeling lazy, you can go to the second room' (TN29). The insights offered by Danielle and Beatrice confirmed that the students were aware of the limitations of the spaces and acknowledged that they often adopted practices to undermine the academic's capacity to supervise them during the simulation activities. This was supported by observations that the groups of students who elected the second patient bay did not engage with the simulated activities scheduled for that laboratory session. They sat on the beds with the manikins and spent most of the simulation time chatting socially (FN18, 23, 31, 45). The second bay was also where the group of students who had English as a second language routinely congregated (FN18, 19).

Although the academic informants structured their teaching spaces differently, they identified similar social spaces in which students took time out from

Consistent with Carspecken's critical ethnographic research tradition, an assumption of this research was that all action is mediated by power (Carspecken, 1996, 2003). Topic Domain 4, power and resistance, asked questions about the perceived dominant structures.

Uniform, student and *powerlessness* featured prominently in this word cloud, followed by *avoidance, authority* and *class*. While the focus on uniforms was triggered by my observations, the questions regarding the use of uniforms in simulation were included as a preconceived question as well, as per the interview schedule (this is discussed further in Chapter 7 as a limitation of the methodology). Choosing to wear the uniform was a point of difference among the students.

Wearing the university's designated clinical training uniforms to simulated laboratory classes was identified as a way to create a 'real' workplace hospital environment. Although at the time of the observations, as noted earlier, it was not compulsory for students to wear their workplace learning uniform to classes, Ann said

I would prefer to wear a uniform myself because it would be easier to teach in and I wouldn't have to think about what to wear and make sure my outfit works with closed-in shoes. (TN23)

Field notations (FN18) emphasised that all but two students in Ann's class wore a uniform. Ann commented

I highly recommend [to] them to wear a uniform but only stipulate [they must wear] appropriate attire. . . . holes in them [are] inappropriate attire. (TN23)

Ann explained that one student who did not wear a uniform resisted right to the very end but she chooses not to conform. She only wore her uniform for Nursing Assessment by Simulation (NABS) [clinical exams]. She was sent home from placement because she had coloured hair. In the

university setting, we don't mind the coloured hair, but there was an issue at the commencement of her placement because of her coloured hair. In the university setting there is no reason why you couldn't have coloured hair, but we did speak to her and at the end of the day, there were no rules stating anything about coloured hair, just that it was clean and well kept. [The healthcare facility] didn't like it. It was a bit of a win for her because she didn't have to change the colour of her hair. She is very much a nonconformist. Her friend has torn jeans and Doc Martin boots but wears her uniform shirt. They stick to themselves. So, it wasn't just us trying to get her professional. University organisation is very much reflecting industry. I take my jacket off; they take theirs off. (TN24)

She justified her approach, saying, 'at the end of the day, I am the lecturer and they are the student. They know my rules' (TN24).

Francis and Gail wore their uniforms to every class. Francis clarified: 'I like it. I get attention when I wear it down the street' (TN31).

Albert wore his uniform to the laboratory classes each week as well. He said that it was clinical and he liked to be in the 'zone', adding that he wanted to wear the uniform as it made him stand out. Wearing a uniform was so important to this student, he loaned a new student one of his shirts, bringing it into class on a clothes hanger and saying it was a spare one. However, the care that he took of his 'spare' shirt indicated otherwise (FN32).

Betty explained that academics teaching in the simulation laboratory were not required to wear a uniform saying, '[students] can ask us why we are not wearing them. . . . I would wear one teaching if there was one for us'. However, she concluded this thought process with, 'For me, ultimately I would like them to wear

uniforms. That's why I wanted to be a nurse. I saw all these smart people and I wanted to identify with that' (TN25).

One student, Carol, stated, 'I'm going to the gym after this, but sometimes I don't know what to wear, so I just wear the uniform' (TN28). She had paired the uniform top with lycra gym pants. Danielle usually wore the uniform. She said, 'I feel like it puts me in the zone, but today, the sole of my shoe fell off' (TN29). Elizabeth thought it was compulsory and said, 'I always thought I had to. I didn't think we had a choice. I'm in the routine of wearing it now, so I will [continue]' (TN30).

Cathy noted that wearing the uniform in the simulated hospital environment 'seems to be an issue. I was teaching and another academic came into the room and said, "If it were me, you would be wearing uniforms." I felt bad' (TN26).

Cathy also said

I guess a uniform defines what they are here for and it's supposed to be clinical. I know they need to wear closed-in shoes. The ones that don't wear it are a different type of student; they don't really care. I probably shouldn't be dressed in a scarf and jewellery. If I had a uniform, I would probably wear it. (TN26)

Enforcing the wearing of the university uniform in the simulated hospital space was perceived to be a method of forcing students to be compliant with the expectations established by individual academics, a tool for establishing and maintaining a power base. Perhaps not wearing the full uniform was a method that some students adopted to resist being compliant and for others, not wearing the uniform at all was simply a choice they made when they could.

The observational and dialogical data in Topic Domain 4, power and resistance, revealed that the wearing of uniforms often led to episodes of struggle. This was evident for both the academics and the students. The data revealed there was a level of legitimised authority in wearing a uniform and it was identified by the participants as the junction where university met industry.

Power was exerted through the delineation of the social groupings as well, with some students complicit in excluding other students. This was evidenced through the way some students wanted to stay with their own friendship group while working through the clinical scenarios and resisted working in other groups. However, the minority groups found acceptance among the minority and developed their own power base and processes of exclusion.

Both student and academic participants established their power by adopting behaviours that were designed to belittle or undermine other participants and in the way they navigated the space. For example, one academic made the students remain standing through long demonstration periods so she would be admired for her authority; when one student held up access to the medication cupboard, her explanation seemed to indicate that she held a position of power, as the students did not complain about it.

In addition, power was exerted in the way students who were perceived to have relevant prior learning were given certain exemptions by their colleagues. Students and academic participants whose power was legitimised within the simulation space were granted privileges that were not accessible by those without legitimised power.

Further discussion of power, privilege and social class is presented in Chapter 5, where the issue of power is situated within the wider system.

4.4 Summative Analysis

This chapter has provided a rich description of the culture of learning and teaching of second-year nursing students within the simulated hospital environment in which this study was situated. It was evident that although the participants (both academics and students) had a shared understanding of VHA, subconscious, common and overt behaviours that perpetrated VHA were embedded in the cultural norms.

When the participants were conscious of their behaviours, they were able to legitimise them and those of others. This was seen in both academics and students, who offered justifications that allowed them to disown the behaviours or show that they were entitled to them.

It was clear through both dialogical and observational data that there were tools used to perpetrate episodes of VHA, such as perceived legitimised authority, group forming and humour. First, legitimised authority was seen in both cohorts of participants; students who were perceived to have prior knowledge were given permission to behave in a way that had previously been described as VHA. Second, when students formed their own groups, some students were subjected to marginalisation and exclusion. However, when the academic structured the groups, the students felt vulnerable. Finally, humour and sarcasm were used to perpetrate episodes of VHA.

The physical environment was seen to have both the potential to leave students vulnerable to episodes of VHA and to provide spaces of reprieve. While the data highlighted the importance of the physical structure, a number of the issues raised by participants were actually due to organisational structures. The difference between the two structures were not clear to the participants and the data sets were not able to distinguish between the two types.

The first manuscript included in this study, titled ‘A critical ethnographic study using Bourdieu’s social practice framework to explore vertical and horizontal abuse (VHA) within undergraduate nurse simulation environment’, which has been submitted to *Collegian. The Australian Journal of Nursing Practice, Scholarship and Research* provides an overview of how Bourdieu’s social practice theory (1977) was used to interpret the outcomes of this ethnographic study. Modifications to the application of the theory were made after this article was written.

Title: A critical ethnographic study using Bourdieu's social practice framework to explain vertical and horizontal abuse (VHA) within an undergraduate nurse simulation environment.

Abstract

Background: Vertical and horizontal abuse (VHA) has been reported in the nursing literature for over thirty years. VHA has also been referred to as workplace bullying, incivility, harassment, and mobbing. Previous work has explicitly focussed on VHA in nurses working in the industry, while other studies explore VHA generally in nursing students. However, there has been little attention paid to episodes of VHA, which may occur among nursing students learning in simulated environments.

Aim: This study aimed to identify factors which enabled episodes of VHA among second-year nursing students learning in a simulated hospital environment, through the application of Bourdieu's social practice theory.

Method: This research used a critical ethnographic approach. Methods included observations, and semi-structured interviews with student (n=40) and academic participants (n=3) from a second-year undergraduate nursing program.

Results: Episodes of VHA were evident among second-year nursing students and academics learning and teaching in a simulated environment. This study showed that the organizational and the social spaces of learning and teaching had been influenced by healthcare industry culture and the challenge for capital within the university. This has resulted in the simulated laboratory, becoming a space for cultural reproduction.

Conclusion: This study calls for both an educational and organizational response to the findings. An educational response would require a curriculum review to reveal and acknowledge symbolic violence which may be embedded. An organizational response to recognize the symbiotic relationship between the higher education and health care sectors which may result in the reproduction of VHA is also required.

Keywords - students, nursing, simulation, bullying, cultural

Summary of relevance

Issue - Little is known about the enabling factors which contribute to episodes of VHA in an undergraduate nursing simulation laboratory.

What is already known – VHA has been reported in the nursing literature for over 30 years, and nursing students have been identified as a vulnerable population.

What this paper adds - The application of Bourdieu's social practice theory is a unique way of exploring enabling factors which contribute to VHA in contemporary undergraduate nursing learning and teaching environments.

ACCEPTED

1 **1. Introduction:**

2 This paper reports on a study focusing on second-year undergraduate nursing students and
3 academics, which explored the situational factors of the simulated hospital learning space
4 that may enable acts of VHA. Situational factors include the interaction between individuals
5 and the cultural and organizational dynamics of both the higher education and health care
6 sectors.

7 This paper introduces a new term to describe unwanted workplace behaviours, vertical, and
8 horizontal abuse (VHA). While a discussion on the prevalence and current understanding of
9 the phenomena is provided generally and then specifically in nursing, the importance of
10 exploring the phenomena in the context of undergraduate nurse education by simulation is
11 justified as there is a paucity of research investigating VHA in simulation particularly in
12 undergraduate education. This study was conceptualised to explore if the phenomena
13 occurs in this contemporary environment of learning and teaching.

14 A critical ethnographic approach informed by Bourdieu's social practice theory framework
15 was utilised to advance understanding of the conditions that facilitate VHA in a simulated
16 laboratory. The study also sought to uncover the reality and nature of the subtleties of
17 power that may be socially and historically constituted in the simulated hospital learning
18 environment (Carspecken, 1996).

19 Bourdieu's social practice theory provided a useful lens to interpret how the cultural and
20 organisational dynamics of the simulated environment utilised in undergraduate nurse
21 education, support the acceptance and perpetration of unwanted behaviours. This unique
22 application of Bourdieu's theory is demonstrated.

23 **2. Literature review**

24 Unwanted workplace behaviours have been reported in the literature for over 30 years. It is
25 also referred to as workplace bullying (Nielsen & Einarsen, 2012) or mobbing (Leymann,
26 1990). Unwanted workplace behaviours have similarly been described as abuse (Celik &
27 Bayraktar, 2004) and incivility (Weinand, 2010). Although the manifestations of the terms
28 used overlap, these terms are being applied inconsistently and appear to be more assumed
29 than clearly defined, making the research in this area challenging to integrate. While the

30 cataloging of behaviours can be useful, there have been calls for a synthesis of these terms
31 for greater conceptual clarity (Boyle & Wallis, 2016). Given the need for clarity around the
32 language used, a term is needed that explicitly includes both the power dimensions and the
33 type of associated behaviours. To this end, the phrase vertical and horizontal abuse (VHA)
34 has been adopted and will be used throughout the remaining paper.

35

36 *2.1 Prevalence of violence in the health sector*

37 In recent years there has been increasing focus on violence in the health care sector. Issues
38 driving this focus are workforce recruitment and retention; endangerment to health care
39 workers and patients, negative impacts on the psychological wellbeing of staff, and the
40 subsequent financial loss in the healthcare sector. Some nurse researchers have suggested
41 up to one in three nurses consider resigning from the nursing profession with bullying being
42 described as one of the main influences on their intention to leave (Chachula, Myrick, &
43 Yonge, 2015). Furthermore, new nurses have been identified as being most at risk of
44 experiencing episodes of unwanted workplace behaviours. Some researchers reported up to
45 60% of new graduates leave nursing in the first six months of practice, naming unwanted
46 workplace behaviours as one of the contributing factors (Weinand, 2010).

47 *2.2 Origins of the phenomena*

48 Many authors debate whether VHA continues within nursing because the origins of the
49 behaviour begin before entering the industry, suggesting it commences at the
50 undergraduate level (Magnavita & Heponiemi, 2011). While on the other hand, Edwards
51 and O'connell (2007) suggested nursing academics transferred these behaviours via
52 recruitment from the health care sector to higher education. Mott (2014) agrees, suggesting
53 that many nursing students' first exposure to a culture of incivility is in the academic setting.
54 However, the majority of the literature highlights that VHA typically occurs while the
55 student is on clinical placement (Thomas & Burk, 2009).

56 *2.3 Undergraduate nurse education*

57 Today, undergraduate nursing programs typically consist of a combination of traditional and
58 online modalities, face to face lectures, tutorials, clinical simulation, and residential schools
59 with most university programs incorporating a prominent online presence. The programs

60 require the student to participate in workplace learning (WPL) practicums and develop skills
61 and standards by simulation (ANMAC, 2017). However, providing quality clinical experiences
62 is an ongoing challenge for nurse education. The reason for this is an increase in student
63 enrollments in undergraduate nursing programs, the increasing difficulty of securing clinical
64 placement sites, a decrease in nursing academics, a lack of physical spaces, a lack of
65 technical training and support, fatigued clinical staff, and a reluctance of health
66 professionals to supervise students in clinical practice (Gates, Parr, & Hughen, 2012). These
67 challenges have led to a need to find alternative strategies for achieving similar learning
68 outcomes. Increasingly, the strategy has been simulation (Lapkin, Levett-Jones, & Gilligan,
69 2013).

70 *2.3 Simulation as a learning and teaching tool*

71 Simulation is described as a learning and teaching strategy that incorporates goal-based role
72 play to practice technical and non-technical skills without risk to real patients (Bogossian et
73 al., 2018). Gaba (2004 p i2) defines simulation as “simulation is a technique—not a
74 technology—to replace or amplify real experiences with guided experiences that evoke or
75 replicate substantial aspects of the real world in a fully interactive manner.” Muckler (2017,
76 p. 4) extends this concept and proposes simulation is to immerse the student in a typical
77 scenario in a “setting that mimics the actual environment with sufficient realism to allow,
78 learnings to suspend disbelief.”

79 To facilitate this way of learning and teaching, universities have established simulation
80 centers or laboratories that ‘mimic’ real-world clinical environments. Nursing education
81 simulation spaces need to be sufficiently realistic in order to assist students in suspending
82 disbelief. Therefore, commonly, these environments are designed to reflect contemporary
83 acute care settings (AL Fozan, El Sayed, & Farida, 2015). The ultimate purpose of
84 simulation-based education in undergraduate programs is to improve the quality and safety
85 of healthcare delivery (Seaton et al., 2018).

86 *2.4 Social practice theory*

87 The theoretical underpinnings of Bourdieu’ Social Practice Theory was influenced by
88 Marxism, with the primary premise being that subjectivity and objectivity are intrinsically
89 linked; structure versus agency, structuralism versus constructivism, determinism versus

freedom (Bourdieu 1977). For example, from a structuralist lens, people behave by following the rules; on the other hand, from an agency perspective, individuals are free to act how they choose. Bourdieu's theory was developed specifically to overcome this dualism within society, as he asserts, a fixation on binary oppositions and explanations is not apt to reflect current societal complexities and tends to oversimplify a phenomenon. By examining practice through the interplay of his central concepts of field, habitus, and capital, the use of labels is avoided and deconstructed to reveal the complexity of phenomena and uncover the contradictions they contain (Bourdieu 1977).

Bourdieu's social practice formula is detailed below and illustrates the interwoven relationship of the concepts.

100

101 **Bourdieu's Theory of Practice**

102
$$[(\text{Habitus}) (\text{Capital})] + \text{Field} = \text{Practice}$$

Figure 1 Habitus and capital come together in any given field to result in a practice (Bourdieu, 1977)

103

104 **Habitus**

105 For Bourdieu, habitus is how we are taught to behave, think, and act; we are taught what is and what is not socially acceptable within our context or particular field (Bourdieu, 1999).

107 Habitus is both how we practice and the result of our practice (Bourdieu 2000, p 19).

108 However, habitus is not an independent entity: it is created through the capital of a specific field or fields and results in a practice.

110 **Capital**

111 For Bourdieu, there are five types of capital available to agents; economic, cultural, physical, social, and symbolic. As with the interrelated relationship of Bourdieu's trilogy concepts, types of capital are also interdependent. Economic capital is intrinsically linked with cultural capital as cultural capital is expressed in terms of social artefacts such as clothing and credentials. Whereby physical capital is referred to as the embodiment of cultural capital. Social capital is the amount of power and/or resources available to that person which is symbolically recognised. Symbolic capital is the conversion of all other forms of capital, "the

118 form that the various species of capital assume when they are perceived and recognized as
119 legitimate" (Bourdieu 1989 p. 17).

120 **Field**

121 For Bourdieu (1989), fields are structured spaces of position, where there are laws and rules
122 which are tacit but have been legitimised by the occupants of the field. Extending the
123 concept of a single field of practice to a network of fields interrelated, competitive and
124 'symbiotic.' Lingard & Rawolle (2004) add that these relationships allow for examination of
125 the cross-field effects. Rawolle (2005) describes a cross-field as "particular fields, though
126 separable, in practice periodically interact with the stakes and practice of other fields"
127 (p.722).

129 **Practice**

130 Bourdieu understands practice to be the result of structures of a field (macro) combined
131 with a person's habitus (micro) (Bourdieu 1999). He refers to 'practice,' not as a mechanical
132 reaction and not necessarily the product of an identifiable process but the outcome of
133 interactions between habitus and external influences or conditions of a field which are
134 dependent on available forms of capital (1990).

135 The three main elements of Bourdieu's theory, field, habitus, and capital, lead to a practice.
136 In this study, vertical and horizontal abuse is considered a practice and therefore the result
137 of the interactions between the participant's habitus, the field of the simulated hospital
138 environment, and the buying and selling of various forms of capital.

139 Bourdieu's Social practice theory (1977) was used to interpret the ethnographic results.

140 **3. Methodology and methods**

141 *3.1 Design*

142 Critical research is a valid approach to understanding social phenomena as it is an
143 examination of the day to day routines in order to consider how the current situation
144 became the status quo. Carspecken's 5 stage design informed this study (Carspecken 1996).
145 The 5 step cyclic process includes; compiling a primary record by immersion in the field to
146 observe interactions; stage two is the preliminary reconstructive phase where analysis

147 begins. This stage begins to reveal roles, routines, and patterns of power relations. Stage
148 three is referred to as the dialogical data generation phase. The data ceases being
149 monological, and the participant's voices are invited to contribute to the dataset. Stage four
150 discovers system relations. This stage requires an examination of the social site of focus and
151 other sites that bear relation to it (Carspecken, 1996). The final stage, stage five, is using the
152 system relations to explain the findings.

153 *3.2 Participants*

154 Second-year nursing students and academics from one campus were invited to participate
155 in the study. As a result, 40 students and three academic lecturers participated in the study.
156 The information sheet informed the participant of the options they were to consent to;
157 observation sessions only, or interviews only or they could consent to participate in both the
158 observations and interviews. Participants who opted to contribute to the observation data
159 set were identified by a red sticker dot on their uniform shirt which was also red in colour.

160 Of those 43 participants, twelve were identified as key informants. The key informants
161 included 3 academics, one Enrolled Nurse, 4 Assistant in Nursing, one personal carer and
162 one straight from school student and two mature aged students.

163

164 *3.2 Data collection*

165 Data was collected from an emic and etic perspective. The data collected was divided into
166 two data sets; monological or observational and dialogical. The observational data were
167 collected using an observation priority schedule as per Carspecken (1996), during lessons in
168 the simulated hospital laboratory. Observations were taken over two academic sessions
169 and formed the primary record to establish the rituals of the social routine in the simulated
170 hospital space. Observations were collected and notated via a fieldwork journal.

171 An interview protocol guided the collection of the dialogical data. As per Carspeckens'
172 design, the interviews followed an interview protocol under four topic domains; baseline
173 understanding, social and psychological domain, organisational and power and resistance.
174 The interview protocol kept both the interviewee and interviewer on topic. The interviews
175 were semi-structured and audio recorded. The duration of the interviews ranged from 15

176 min to over an hour. Saturation was reached when new data repeated what had already
177 been expressed in previous data (Saunders et al., 2018).

178 3.3 Data analysis

179 The analysis of the data followed Carspecken's pragmatic horizon analysis. Pragmatic
180 horizons come from regarding the action as the most primary in experience (Carspecken,
181 1996). Carspecken developed this approach based on the pragmatic theory of meaning
182 associated with Habermas' Theory of Communicative Action.

183 The trustworthiness of the data sets was strengthened through member checking and peer-
184 reviewing. As patterns started to emerge, data were categorised and coded into domains
185 that were targeted by the research question (Carspecken, 1996). The data were then
186 interpreted through Bourdieu's social practice theory.

187 4 Results

188 As a result of the pragmatic horizon analysis and synthesis of the key informant interviews,
189 observations, documentation and field journal, a total of 22 themes were extracted and
190 organised under the topic domains.

191 Table 1. Themes under topic domains

Topic domain 1	Topic domain 2	Topic domain 3	Topic domain 4
<i>Base line understanding</i>	<i>Social and psychological</i>	<i>Organisational and physical</i>	<i>Power and resistance domain</i>
Overt episodes	Power/ Powerlessness	Physical design	Industry
Practice	Frustration and Vulnerability	Learning and teaching	Legitimisation
Role	Moral guide	University	Uniforms
VHA common	Groups	Marginalisation	Authority
	Avoidance and acceptance	Expectations	Experience

192

193 *Topic domain 1. Baseline understanding*

194 This domain was used to gain insight into the participants understanding of VHA. Ann, an
195 academic participant, described VHA as '...it's bullying or power shifting, making people feel
196 uncomfortable, up and down the chain.' (TN 23) The phrase 'Up and down the chain'
197 highlights Ann's understanding of the bidirectional flow of the behaviours. Betty, on the
198 other hand, denies having experienced any form of bullying, stating;

199 ...ohh not really. Students talk and give their opinion, and students may laugh if
200 someone says something funny, but we always encourage respect for each other.
201 (TN 24)

202 However, she concedes that it is a subjective experience, and like Ann, suggests, '.... the
203 student may take it as VHA.' (TN 24)

204 Betty considered VHA is;

205 ...maybe like if someone said something that really hurt someone, causing harm, I
206 guess treating students unfairly, I try to avoid those things as possible. But it hasn't
207 happened to me. (TN 24)

208

209 *Topic domain 2. Social and psychological*

210 The psychosocial domain asked questions about participant experiences. This line of
211 questioning aided in classifying which participants identified with being a target or
212 perpetrator of the behaviours.

213 A situation that occurred in the corridor of the laboratory whereby a student participant
214 bumped into another student, Gail.

215 Carol bumped into Gail in the corridor; Carol stated, '...oh sorry'. Gail responded with
216 '...you better be.' (FN 23)

217 On asking Gail what she meant, she stated, '...I was only joking.' However, Carol suggested
218 Gail was, '...always like that. She rolled her eyes, adding '... however, she makes me feel
219 stupid'. Carol explained that Gail and Francis work as assistants in nursing, and they know
220 stuff (TN 28). On analysis, it was revealed that prior knowledge was a currency in the

laboratory space and afforded those 'with,' specific permissions. The episodes of VHA was being excused because Gail had a power base.

Topic domain 3. Organisational and physical

The organisational and physical domain provided questions which encouraged the participants to reflect on their position within the field of the simulated environment. The physical structure of the simulation environment was identified as a possible source of social exclusion by peers or a mechanism for creating an opportunity for student vulnerability. The simulation laboratory consisted of 3 patient bays, two of which had four-bed spaces, the last bay only two-bed spaces. Some students preferred one room over the other. It was observed that the same student groups went to the same bed spaces each week. Students appeared to understand that one of the simulation rooms was not supervised by the attending academic as much as the other.

Danielle (TN 29) stated '...the lecturer does not come to this end much so we can slack off in here. We can get away with not doing stuff'. Beatrice (TN 24) agreed adding, '...yeah, we get away with heaps down there'. Beatrice, however, acknowledged that '...when we walk through that door, we should be professional'. (TN 24) In response, Danielle added, '...if you're not in the mood or feeling lazy, you can go to the second room. (TN 29) The perceptions offered by both Danielle and Beatrice confirmed that the students were aware of the limitations of the spaces and acknowledged that they adopted practices to challenge academics ability to supervise them during the simulation activities.

Topic domain 4 Power and resistance domain

A numbers of authors (Hope, Garside & Prescott 2011 Kesten et al. 2010; Prescott & Garside 2009) have suggested that the practice of wearing a uniform in a simulated hospital environment is symbolic of being a nurse (uniform) and enables students to realistically embrace the role of a registered nurse. However, it has been argued that the uniform may symbolise power and status differences that exist between nurses and others (Hurteau, 1963). In this study, the wearing of uniforms, or not, in the laboratory space was viewed by both student and academic participants as a mechanism of power or oppression. For example, Betty, a nursing academic, identified with the '... smart people in uniform' (TN 23). While the act of wearing a uniform for students encouraged the role modelling of

251 Registered nurse behaviour. This was expressed as, '... I feel like it puts me in the zone' (TN
252 29). Other students found wearing the uniform was a way to stand out in the community
253 and receive acknowledgment of being a nurse, with comments such as, '... I like it; I get
254 attention when I wear it down the street' (TN31). However, Elizabeth thought that wearing
255 the uniform to simulation classes was compulsory, '... I always thought I had to, I didn't think
256 we had a choice. I'm in the routine of wearing it now, so I will' (TN 30).

257

258 **5 Discussion**

259 Despite the academic participants in this study suggesting that they had not witnessed VHA
260 in the University, the literature reports that a third of academic staff have reported
261 experiencing VHA within a University environment (Skinner, Peetz, Strachan, Whitehouse,
262 Bailey & Broadbent 2015; Hollis 2019). This study confirmed that VHA occurred and that
263 participants were complicit in perpetrating VHA or were a target of VHA.

264 Capital can be both a weapon and a stake of struggle, which allows its possessor to wield
265 power and influence and thus to exist, instead of being considered insignificant (Bourdieu &
266 Wacquant 1992 p.98). The search for capital and the need for acknowledgement and
267 legitimisation results in episodes of VHA. This study provided evidence which suggested
268 episodes of VHA occurred when participants were seeking capital within the field of the
269 simulated hospital laboratory. Capital in the field of the simulated environment was
270 awarded to those participants with perceived prior knowledge for example those who were
271 assistance in nursing or enrolled nurses.

272

273 A simulated hospital laboratory is situated in-between the healthcare sector and higher
274 education; it is a metaphysical space of representation of the healthcare industry while
275 being physically located in the reality of higher education. In this study the simulated
276 hospital space is where nursing students made sense of their being (Gieryn 2000). Students
277 took on the form of a nurse in two ways; through the nursing processes they engaged with
278 and secondly through the material or symbolic form of the space through wearing uniforms.

|

279 The symbolism of the nurse's uniform has been debated for many years, and still today, the
280 debate continues. Some believe that the uniform symbolises nurturance and security, and
281 that street clothes are anti-therapeutic, while on the other hand some suggest the uniform
282 symbolises and highlights the power and status differences (Hurteau, 1963). However, today
283 wearing a uniform plays an important role in defining occupational boundaries and the
284 development of professional identity (Shaw and Timmons 2010; Timmons & East 2011; Parr
285 and Sweeney 2006).

286 **6 Limitations**

287 Some of the difficulties associated with using Bourdieu's framework to understand the
288 findings included difficulties in reading his written work. His sentences are rarely short and
289 to the point. Bourdieu discards a correlational analysis for a systematic approach while his
290 theoretical stance is abstract and his methods ambiguous enough to generate more
291 questions than answers.

292 The study was only conducted in one university with a limited number of student and
293 academic participants, therefore generalisability could not be assured.

294

295 **7 Conclusion**

296 Through critical ethnographic inquiry, Bourdieu's social practice theory, provided a lens to
297 explore the workings of power concerning episodes of vertical and horizontal abuse among
298 second-year nursing students and academics learning and teaching in a simulated hospital
299 environment.

300 Fundamentally, the findings from this study suggest that there is a need for educational and
301 health care providers to recognise how violence is embedded in undergraduate nursing
302 curriculum and develop strategies to mitigate against normalising and reproducing VHA
303 behaviours. This study calls for educational providers to reconsider the skills required to be
304 a registered nurse in contemporary Australian health care networks. The study also
305 highlights simulation in undergraduate nurse education needs to combine practices from
306 health care and educational providers, in a symbiotic relationship where one sector is not
307 valued over the other.

|

308 **Ethical statement**

309 The manuscript reports on human research. The universities human research ethics
310 committee approved the study on the 4th June 2015. Protocol number 2014/018.

311 **Conflict of interest**

312 The author/s has no conflict of interest or received any outside sources of support.

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4.5 Chapter Summary

This chapter has contextualised and reported the findings of this critical ethnography. A key finding was acts of VHA occurred among second-year nursing students within the simulated hospital environment. Episodes of VHA were observed between students of different social groupings, between academics and other academics, and between students and academics. VHA was enacted through both verbal and non-verbal interactions. The mechanisms of VHA included the use of legitimised authority, social groupings and humour.

Relational analysis is a powerful element in the interpretation of critical ethnographic results. The final stage of Carspecken's (1996) approach is presented in Chapter 5, with a discussion and interpretation of the findings using Bourdieu's social practice theory.

Chapter 5: Exposing and Interpreting Why and How VHA

Is Learned, Accepted and Institutionalised Within a

Simulated-Learning Environment

Symbolic violence is violence wielded with tacit complicity between its victims and its agents, insofar as both remain unconscious of submitting to or wielding it. (Pierre Bourdieu, 1997, p. 141)

5.1 Introduction

The previous chapter revealed the reality of student nurses' and academics' teaching and learning experiences in a simulated hospital environment. It described the use of this space, for academic staff to teach and for the students to learn and practise the skills required to be an RN. Multiple data sets enabled the exposure of practices that were enacted consciously or subconsciously by academic staff and students and that constituted acts of VHA. Utilising Bourdieu's social practice theory, this chapter provides insights into why, and under what conditions, VHA is learned, accepted and institutionalised as normal behaviour by academic staff and student nurses within a simulated-learning environment.

It is a requirement of critical ethnography to situate the data within broader structures of power and privilege (Carspecken, 1996). Critical studies that fail to do this risk interpreting the findings as if they existed independent of, and uninfluenced by, the wider societal systems (p. 201). Through the analysis of system relationships, dominant societal structures that distribute power and privilege are examined to reinforce the validity of this critical ethnography. Consequently, the simulation hospital laboratory is not viewed in isolation of the wider social system (p. 38). In this current research, the influence of the physical, organisational and social environments of the simulation laboratory were key in explaining episodes of VHA.

The following four substantive themes developed from the analysis: VHA is common and overt; powerlessness versus authority; industry versus university; and groups and roles. These are discussed in relation to the wider social fields using Bourdieu's (1972) social practice theory as a lens to interpret these findings. The next section outlines Bourdieu's trilogy concepts, which were briefly introduced in Chapter 3.

5.2 The Bourdieusian Lens

Social practice theory's major premise is that subjectivity and objectivity are intrinsically linked: structure versus agency, structuralism versus constructivism, determinism versus freedom (Bourdieu, 1972). For example, from a structuralist lens, people behave in accordance with the rules; conversely, from an agency perspective, individuals are free to act how they choose. Bourdieu's theory was developed specifically to overcome this dualism within society, as he asserts that a fixation on binary oppositions and explanations is not likely to reflect current societal complexities and tends to over-simplify a phenomenon. By examining a practice through the interplay of his main concepts of field, habitus and capital, the use of labels are avoided and deconstructed to reveal the complexity of phenomena and uncover the contradictions they contain.

Bourdieu's social practice formula is detailed below and illustrates the interwoven relationship of the concepts.

Bourdieu's Theory of Practice

[(Habitus) (Capital)] + Field = Practice

Figure 5.1. Bourdieu's practice theory (Bourdieu, 1984, p. 101).

5.2.1 Habitus

For Bourdieu, habitus is how we are taught to behave, think and act; we are taught what is (and what is not) socially acceptable within our context or particular

field (Bourdieu, 1999). Habitus refers to a series of transferable dispositions within a specific space, shaped by the objective structure and social capital, which can be perceived or actual. Habitus is both how we practise and the result of our practice (Bourdieu, 2000, p 19). However, habitus is not an independent entity: it is created through the capital of a specific field or fields and results in a practice.

5.2.2 Capital

Bourdieu asserted that there are five types of capital available to agents: economic, cultural, physical, social and symbolic. As with the interrelated relationship of Bourdieu's trilogy concepts, types of capital are interdependent as well. With regard to economic capital, he maintained that wealthy people are considered higher in society than people who have fewer monetary resources; thus, economic capital is linked intrinsically with cultural capital, as cultural capital is expressed in terms of social artefacts such as clothing and credentials. Physical capital is referred to as the embodiment of cultural capital. Social capital is the amount of power and/or resources available to a person. This power and/or access to resources can be actual or perceived, meaning the value of the social capital is symbolically recognised. Symbolic capital is the conversion of all other forms of capital, 'the form that the various species of capital assume when they are perceived and recognized as legitimate' (Bourdieu, 1989, p. 17).

Bourdieu illustrated capital and class distinction through two dimensions. Class locations are defined relationally within a space that is grounded by a person's orientation towards the culture (Bourdieu 1989).

5.2.3 Field

For Bourdieu (1998), fields were structured spaces of position, with laws and rules that are tacit but have been legitimised by the occupants of the field. A field is where capital is bought, sold and exchanged and the structure of the field controls the

distribution of capital and therefore, the power relations of the agents within.

Bourdieu referred to fields as places of struggle and negotiation, stating

a field is a structured social space, a field of forces, a force field. It contains people who dominate and others who are dominated. Constant, permanent relationships of inequality operate inside the space, which at the same time becomes a space in which the various actors struggle for the transformation or preservation of the field. All individuals in this universe bring to the competition all the (relative) power at their disposal. It is power that defines their position in the field and, as a result, their strategies. (pp. 40–41)

Extending the concept of a single field of practice to a network of fields interrelated, competitive and ‘symbiotic’, Lingard and Rawolle (2004) added that these relationships allowed for examination of the cross-field effects. Rawolle (2005) described a cross field as ‘particular fields, though separable, in practice periodically interact with the stakes and practice of other fields’ (p. 722). Cross-field effects result from the interrelations between different fields where the interconnections are uncontested and assumptions are made about the role and function of the fields which are classified as structural, event, systemic, temporal, hierarchical and vertical (p. 714). Bourdieu (1985) asserted,

each field has its logic and its hierarchy that prevails among the different kinds of capital and the statistical link between the different types of assets tends to impose its logic on the other fields (p. 724).

5.2.4 Practice

For Bourdieu, practice was the result of social structures on a particular field. Bourdieu (1999) understood practice to be the result of structures of a field (macro) combined with a person’s habitus (micro). He referred to ‘practice’ not as a

mechanical reaction and not necessarily the product of an identifiable process, but as the outcome of interactions between habitus and external influences or conditions of a field, which are dependent on available forms of capital (1989). The three main elements of Bourdieu's theory (field, habitus and capital) lead to a practice. In this current study, VHA was considered a practice and therefore, the result of the interactions between the participants' habitus, the field of the simulated hospital environment, and the 'buying and selling' of various forms of capital.

5.3 Interpreting the Ethnographic Insights

5.3.1 Groups and Roles (Enabler—Social Distinction and Class) HABITUS

In the simulation hospital laboratory, the participants used their habitus as capital. Bourdieu's (1977) notion of habitus, defined as a set of dispositions through which the world is perceived, understood and evaluated, seemed to be linked to a form of symbolic capital within the simulation laboratory. Harker, Wilkes and Mahar (1990) noted

The most powerful conversion to be made is to symbolic capital, for it is in this form that the different forms of capital are perceived and recognised as legitimate. (p. 13)

This current study revealed that a social distinction was made between students who had prior knowledge in the field, such as AINs and ENs, and the SFS.

The participants maintained their social class throughout the academic year. There was no evidence of participants moving from one social grouping to another. The student participants' behaviour reflected Bourdieu's proposition that people learn to adapt their expectations and their own view of themselves to their position within a field. Bourdieu (2000) explained that the social order of being is inscribed in

people's minds through the social divisions that organise the image of the social world.

Reflexivity

How do the participants evaluate levels of capital? How do they know what people know and what they don't know? Is it all based on assumption and perception? If so, what influences perception?

The student participants referred to their social groups as 'cliques' or 'us and them'. The academic participants said although they had tried to 'mix them up', the varied social groups did not last long and by the next week, the original groups had reformed. The students in the dominant group said, 'we only want to work together' (TN27). The excluded participants, who did not possess the appropriate capital to belong to the dominant social group, developed a commonality, their shared experience of exclusion. They said, '[the other groups] don't listen to us' (TN28).

For Bourdieu, group making was a mental construct turned into a social reality through the legitimisation of a dominant perception (Wacquant, 2013, p. 275). In this current study, Ann claimed it was her role to be authoritative and to 'manage' the students, denying all responsibility for her approach to learning and teaching. She justified her position with, 'it is my job. I didn't make it that way' (TN23). In this situation, Ann used her position as teacher to establish her power base without consideration of the principles of educational pedagogy underpinning the program of study, the terms and conditions of employment and the university's stated learning and teaching ethos.

Bourdieu (1994) recognised that people produce social realities through practice but highlighted the importance of acknowledging that social realities are created through the position a person occupies within the field and the perceptive tools that are authorised and available to them within the field. He explained:

the position occupied in social space, that is, in the structure of the distribution of the different species of capital, which are also weapons, governs the representations of this space and the stances adopted in the struggles to conserve or transform it. (p. 28)

Groups of people are defined by their position within the field and a person cannot occupy opposing positions. Bourdieu (1985) suggested that while alliances between similarly positioned people are inevitable, alliances between those who are distantly positioned within the field are never impossible (p. 726).

In this study, when the academic attempted to allocate students into different groups, the participants did not shift their positions within the field nor transfer their capital to assert a new position. The participants from different field positions and capital returned to their usual social groupings the following week. Bourdieu (1985) believed that one could not group anyone with just anyone, ignoring their fundamental differences in capital (p. 726). The grouping's grounding in the structure of the field in terms of capital is what made the groups sustainable.

People who occupy similar positions in a field and who are placed in the same conditions have every likelihood of having a comparable habitus and are, therefore, more likely to adopt like stances. This results in reproduction of dominant homogeneous practices, which may explain why VHA has been entrenched in nursing culture (Birks et al., 2018; Cleary, Hunt, & Horsfall, 2010; Longo, 2013).

Reflexivity

What would happen if the dominant practice did not include acts of VHA? Would the capital shift? Would the dominant culture be dominant without acts of VHA?

Even though Bourdieu suggested that habitus was not static, the ability for a participant in this current study to move from one social class to another was limited, as neither the social structures nor the capital valued within the simulation laboratory had changed. There appeared to be no other capital that was valued; therefore, the

participant would have to change to be accepted into the higher social class.

However, even if the participant gained the necessary qualification to have the required capital, they would still need to be *socially connected* for their qualifications to transfer or exchange into capital, to gain admission into the class of higher status. Therefore, the participant would be required to assume a habitus with which they were not familiar and of which they had little understanding. Overall, however, as the habitus of the participant was exchanged for social capital and power within the field of the simulation laboratory, the concept of habitus in this study accounted for the reproduction of social class division, rather than opportunities for change or transformation.

In this study, the participants (both student and academic) created their own social reality; their perceived reality was only possible through their position in the field. Students with prior knowledge of nursing, such as AINs or ENs, had a different social reality in the simulation laboratory than the SFS. Similarly, the social reality of the experienced academic was different from that of the casual sessional academic.

Figure 5.2 identifies the positions the participants took within the field of the simulated hospital laboratory, according to Bourdieu's two dimensions of capital and class. One axis represents the space of social positions and the other the space of cultural position. The vertical dimension represents the overall volume of capital (from low to high), and the horizontal dimension represents the overall composition of capital. This space is then used to identify the social location or class of the participant.

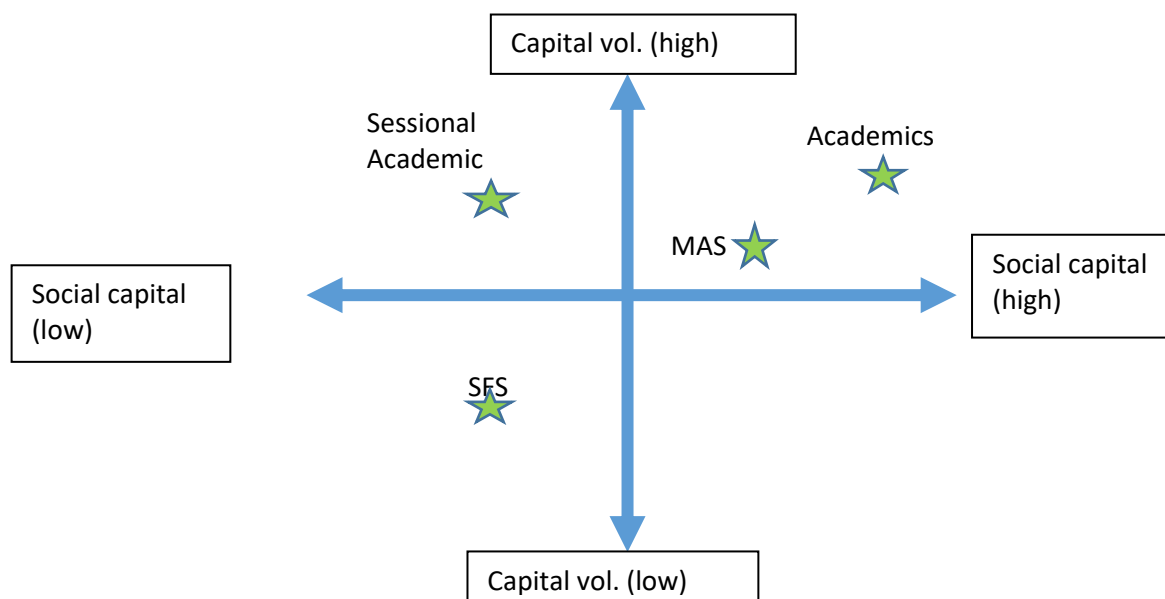


Figure 5.2 Social positions in the simulation laboratory (SFS = straight-from-school student(s); MAS = Mature-aged student(s); adapted from Bourdieu, 1980).

As illustrated in the above figure, in terms of cultural and social capital, the sessional academic was considered the least valuable in the field of the simulated hospital laboratory. Although Cathy had a high level of overall capital (because she was an academic and had recent clinical experience), she had low social capital in the laboratory because of her limited experience in learning and teaching in simulation. This position within the field resulted in Cathy being a target of episodes of VHA.

The SFS were considered to have overall capital, as they were student nurses and belonged within the space; however, they had low social capital because they did not possess the currency of prior learning and therefore, were not valued as highly as the MAS. Further, the analysed data indicated some evidence that linked participants who had high levels of social and cultural capital with the perpetration of VHA.

According to Bourdieu, an agent's position within a field is determined by their relationship to the system of meaning that is operating there (the amount of field-specific capital a person has). At the same time, the system of meaning that

provides the foundation for the habitus of action within a field is itself determined by the individuals and groups who occupy the positions. This positioning enables the dominant culture to shape and determine the rules and laws of the system. However, there is room for mobility of class distinction, meaning people can move up and down each axis. Thus, social class location is variable over time and fields.

5.3.2 VHA Is Common and Overt (Enabler—Social Capital) CAPITAL

Capital can be both a weapon and a stake of struggle, which allows its possessor to wield power and influence and thus to exist, instead of being considered insignificant (Bourdieu & Wacquant, 1992, p. 98). The search for capital and the need for acknowledgement and legitimisation results in episodes of VHA. This current study provided evidence that suggested episodes of VHA occurred when participants were seeking capital within the field of the simulated hospital laboratory.

Academically talented students are often those who have a higher level of cultural capital, come from dominant social classes and fit the profile of the institution's academic capital and classification (Naidoo, 2004). However, in this study, it was not the academically talented students who formed the dominant social class and became perpetrators of VHA; rather, it was the students who had developed social capital and power through their tacit knowledge that made up the dominant social class. Acts of VHA came from a position of dominance achieved through the establishment of social capital, which was traded for power and resulted in certain privileges.

Capital is dependent on the social conditions of the field, meaning that capital is dependent on whatever is valued in a field (Bourdieu, 1989). The data analysis in this study provided evidence that the type of capital the participant possessed allowed acts of VHA to be readily accepted and permitted within the simulation

laboratory. In the simulated hospital laboratory, the students valued prior knowledge; therefore, the participants used their prior knowledge to establish themselves socially (see 4.3.2).

The group with prior knowledge were given permission to behave in ways that had been previously deemed acts of VHA. The participants that were considered by their peers to have tacit knowledge had social capital. Those who were rich in social capital were given privileges and permissions over those who were perceived to lack social capital. For instance, it was observed that Gail, a MAS, was often dismissive and disparaging towards Carol, who was an SFS; however, Carol justified Gail's behaviour with, 'Oh, she is always like that but she knows her stuff' (TN28), referring to Gail's prior knowledge. Here, Gail had exchanged her social capital for power and her acts of VHA were subsequently permitted, accepted and legitimised by Carol.

The second theme that was revealed in the data analysis was that episodes of VHA in the simulation laboratory were common and overt. According to Keashly and Neuman (2010), when episodes of VHA are visible, this suggests there is a level of cultural acceptance of the behaviour within the organisation. In addition, it can mean that a number of people witness the behaviours.

Previous studies have suggested that acts of VHA can cause serious physical and psychological harm to both those experiencing it and to those witnessing the behaviour (Hoel, Cooper, & Faragher, 2001; Hoel & Cooper, 2001; Nielson & Einarsen, 2012; Vartia, 2001). In this current study, several participants who had witnessed the behaviours said they had felt uncomfortable and powerless to intervene.

It makes me feel awful; I don't want people to think I'm like that, though. I found it distressing. Thinking about it now, I wish I would have done something. (TN27)

However, this awareness was only achieved when the participants had had time to reflect, which allowed them to recognise that what they accepted as 'normal' behaviour was actually VHA.

Reflexivity

Could the process of self-reflexivity be timely enough to prevent subsequent actions of VHA? Could reflective thought be established as a form of social capital in this space?

5.3.3 Industry Versus University (Enabler—Cross-Field Effects) FIELD

Bourdieu (1985) asserted

Each field has its logic and its hierarchy that prevails among the different kinds of capital and the statistical link between the different types of assets tends to impose its logic on the other fields. (p. 724)

As Bourdieu suggested, a field is a field of struggles (1993) because of the varied positions and levels of power that form subordinative relationships, based on the legitimisation of authority. In this study, the academic participants were all RNs (as required by the NMBA, 2018) with previous clinical experience in the healthcare system. The student nurses valued the academics' clinical expertise and assimilated the concepts from the healthcare field, as well as its rules and modes of operation, into the way they behaved in the simulation hospital laboratory; that is, the students adopted or imitated the academics' habitus. Therefore, the academics, justified and legitimised by their qualifications and clinical experience, were seen as agents of the dominant healthcare ideology. The task of teaching in the simulation laboratory had

become a process of cultural and social reproduction, based on the rules and laws of the field of the healthcare sector.

According to Bourdieu (1985), fields are context dependent and governed by social laws. He argued that social laws are the legitimised ways for those who dominate the field maintain power and create power differences (Bourdieu & Wacquant, 1992, p. 197, footnote 158). Through the education practices used by individuals endowed with authority, the higher education system helps to enforce the dominant ideas as being natural. It is a way of perpetuating the status quo and maintaining symbolic power within the fields.

Extending the concept of a single field of practice to a network of fields that are interrelated, competitive and ‘symbiotic’, Lingard and Rawolle (2004) allowed for examination of the cross-field effects of the higher education sector and the healthcare sector. Rawolle (2005) noted, ‘particular fields, though separable, in practice periodically interact with the stakes and practice of other fields’ (p. 722).

In this current study, practices in the field of the simulation laboratory were co-determined by policies from the field of healthcare and from nursing authorities, as identified in Chapter 1. The simulated hospital laboratory was not only influenced by the social macrocosm but also by the relationship that existed between two distinct interconnected fields: higher education and healthcare. The laboratory was situated within higher education, but the practice within it was governed by healthcare regulation enforced by the nursing regulatory authority through the accreditation process.

Cross-field effects can be classified as structural, event, systemic, temporal, hierarchical and vertical (Rawolle, 2005). A structural cross-field effect relates to the links between the structures of the fields in question. The links impose one field’s logic of practice on the other. Event effects and temporal effects relate to specific

situations whose impacts flow between fields and are transient in nature. Systemic effects relate to broad changes in the values that underpin the fields.

In Australia, the Bachelor-level nursing curriculum that leads to registration as an RN is developed and delivered by higher education providers. Curricula must be approved and accredited by the national nursing regulatory authority (the NMBA) before being offered. Students are required to evidence competence in industry-based standards of practice before they are eligible to graduate. This process culminates in an alliance between the healthcare industry and higher education providers. To ensure the competence level established by the NMBA is reached, students undertake clinical training under the supervision of RNs within a diversity of practice contexts throughout their programs of study (NMBA, 2018). Therefore, the healthcare sector relies on the higher education sector to produce graduates that it can then recruit, but the higher education sector is only able to deliver a curriculum that is approved by healthcare sector governing bodies. Thus, the higher education sector is ultimately being governed by the healthcare sector to produce a homogeneous workforce that responds favourably to their organisational environment and is compatible with the organisational characteristics and ideology. According to DiMaggio and Powell (1983), this homogenisation

results from both formal and informal pressures exerted on organizations by other organizations upon which they are dependent and by cultural expectations in the society within which organizations function (p. 150).

The hierarchical and vertical effects of the healthcare field affect the higher education field. With regard to pre-service, the nursing curriculum governing bodies such as AHPRA change the standards of practice that have to be reflected in the learning outcomes of the curriculum. For example, once the new Registered Nurses

Standards of Practice (currently being updated from the 2016 standards) are finalised, the new curriculum will need to demonstrate clearly that the new learning outcomes are achieved.

The profile of a university graduate includes attributes such as academic literacy and numeracy, information and research literacies, digital literacies, ethics, professional practice, lifelong learning, indigenous cultural competence, global citizenship and sustainable practices (Graduate Learning Outcomes, CSU, 2017), while the healthcare standards of practice attributes include:

- critical thinking and analysis of nursing practice
- engagement in therapeutic and professional relationships
- maintenance of capability for practice
- ability to conduct comprehensive assessments
- development of plans for nursing practice
- provision of safe, appropriate and responsive nursing practice
- capacity to evaluate outcomes to inform nursing practice. (NMBA, 2018)

The dominant groups who create the documents that govern nursing practice make use of the rules and distinctions to their advantage and have the power to create the ‘official version’ of the world (Harker, Wilkes & Mahar, 1990, p. 13).

Subsequently, instead of the core business of higher education being teaching and learning, it has become a field of cultural reproduction for the healthcare industry (DiMaggio & Powell, 1983). In other words, the education produces outputs that meet the industry demand.

DiMaggio and Powell (1983) used Bourdieu’s concept of field to discuss the connectivity between organisations and the isomorphism that promotes sameness in organisations. As reported in Chapter 2, the literature has uncovered episodes of VHA in both healthcare and higher education. It is reasonable, therefore, to postulate

that VHA is a result of institutionalised isomorphism, which is a ‘constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions’ (DiMaggio & Powell, 1983, p. 66). According to these authors, there are three processes that generate isomorphism: coercive, normative and mimetic. Coercive isomorphism derives from ‘both formal and informal pressures exerted on organisations by other organisations upon which they are dependent’ (p. 150). Normative isomorphism refers to personnel that flow between organisations. Mimetic isomorphism is the process by which agents within the organisations view one another. The authors maintained that these three processes are evident in the network of interaction between the healthcare and higher education sectors. They concluded that fields that are highly structured tend to be organisations in which these processes are extensive and effective and as a result, the organisations demonstrate a high level of similarity to each other (p. 148). The higher education and healthcare sectors are locked in a social and cultural reproductive loop, connected through structural pathways of coercive, normative and mimetic isomorphism.

5.3.4 Powerlessness Versus Authority (Enabler—Legitimisation of Authority)

PRACTICE

Bourdieu (1990) understood practice to be the result of structures on a field (macro) where certain rules or laws apply, together with the habitus (micro). He referred to ‘practice’, not as a mechanical reaction and not necessarily the product of an identifiable process, but as the outcome of interactions between habitus and external influences or conditions that are dependent on the available forms of capital. The three main elements of Bourdieu’s theory (field, habitus and capital) lead to practice. In this study, VHA was considered a practice and therefore, was seen to result from the interactions between habitus, field and capital.

Reflexivity

Could the higher education sector become independent from the healthcare sector, or are the politics and economics too tightly bound within a managerial framework?

A numbers of authors (Hope, Garside, & Prescott, 2011; Kesten, 2011; Prescott & Garside, 2009) have suggested that the practice of wearing a uniform in a simulated hospital environment is symbolic of being a nurse and enables students to authentically embrace the role of an RN. However, it has been argued that the uniform also symbolises and makes salient the power and status differences that exist between nurses and others (Hurteau, 1963). In this current study, the wearing of uniforms (or not) in the laboratory space was viewed by both student and academic participants as a mechanism of power or oppression. For example, Betty, a nursing academic, identified with the ‘smart people in uniform’ (TN23), while for students, the act of wearing a uniform encouraged the role modelling of RN behaviour. This was expressed as, ‘I feel like it puts me in the zone’ (TN29). Other students found wearing the uniform was a way to stand out in the community and receive acknowledgement for being a nurse, with comments such as, ‘I like it; it makes me stand out’ (TN29). However, Elizabeth thought wearing the uniform to simulation classes was compulsory, saying, ‘I always thought I had to. I didn’t think we had a choice. I’m in the routine of wearing it now, so I will’ (TN30).

Enforcement and non-enforcement of students wearing a uniform in the simulation hospital laboratory may have contributed to the socially constructed perception that Cathy ‘doesn’t know what she is doing’ (TN27) and that Ann is ‘more regimented’ (TN29). Ann stated, ‘If it were me [teaching you], you would all be wearing uniforms’ (TN26). This statement was used to create a social division between herself and Cathy. The perception was that Ann had the authority to enforce

the wearing of uniforms but Cathy did not. The participants' perceptions of Cathy were reinforced through the symbolic use of the uniform by Ann as a tool to wield power. Thus, wearing the uniform was legitimised as a symbol of power and control.

Mahar, Harker and Wilkes (1990) suggested, 'the most powerful conversion to be made is to symbolic capital, for it is in this form that the different forms of capital are perceived and recognized as legitimate' (p. 13). It is the defence of this symbolic capital that leads to situations of power.

The system relations identified as 'influences' on the simulation laboratory are illustrated in Figure 5.3 as a conceptual framework. The diagram situates the simulated hospital environment in the wider social and political context and illustrates the cross-field effects of the higher education sector and the healthcare sector. The conceptual framework traces the line of capital that is dependant across each field, with the habitus crossing the capital continuum, as capital in this study was conditional on the participant's habitus.

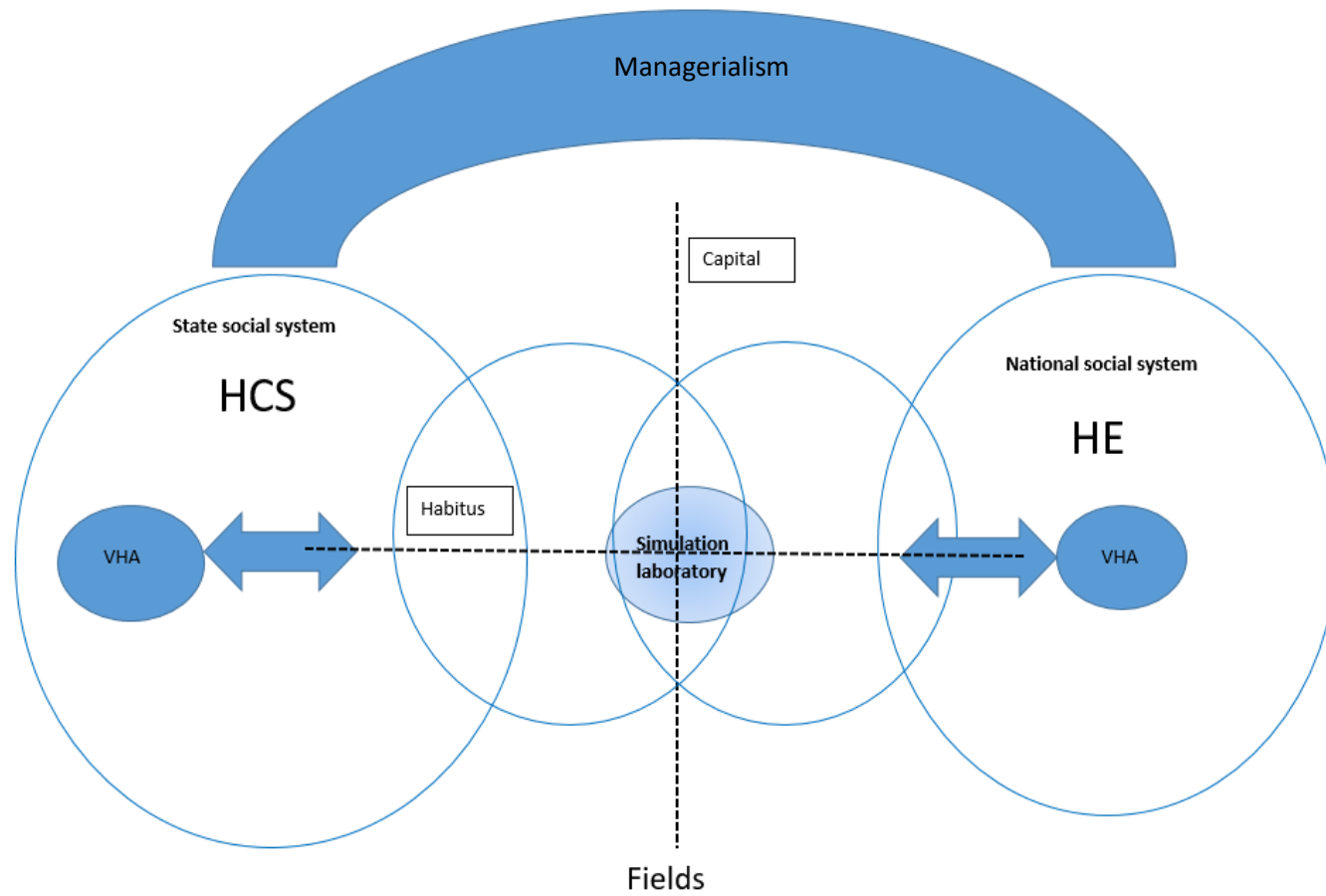


Figure 5.3. Conceptual relational framework analysis

5.4 Summary

The aim of this chapter was to provide an explanation of the way acts of VHA were enabled in the simulated hospital environment in which this study was conducted. The academic and student participants in this research contributed to the production and reproduction of acts of VHA in the simulation laboratory. The institutional structures of the higher education and healthcare systems resulted in isomorphism. Thus, the participants' actions were facilitated by the institutional structures.

The four substantive themes arising from the analysis were:

- VHA is common and overt
- powerlessness versus authority
- industry versus university
- groups and roles.

These themes have contributed to an explanation for the way the patterns of practice in the simulation laboratory were reflective of the wider social system. The outcomes of this study have provided insight into the ways the unintended consequences of learning and teaching in a simulated hospital environment served to reproduce acts of VHA. Even though the practice of VHA is framed within the context of the simulated hospital environment, it is not presumed by the normal routine of the field.

Bourdieu's interrelated framework recognises that social reality is complex and complicated. While his theory of practice provided a mechanism for investigating the complexities of learning in the simulated environment, Bourdieu also offers a way to describe, analyse and understand the origin of an individual

within social structures and groups (Mahar, Harker, & Wilkes, 1990). As a social practice, VHA is not static; it is defined moment by moment in the interactions between organisations and groups. It is not possible to extract the practice of VHA from the social space in which it occurs and therefore, a theory that attempts to surrender the dichotomy of subjectivity and objectivity is required.

Applying Bourdieu's theory helps with an exploration of the enabling structures of the field of simulation used in undergraduate nursing education, resulting in the practice of VHA. Application of his theory to the study of VHA in the simulated hospital learning environments for undergraduate nursing students has widened the lens of investigation, from a neoliberal approach of individualising the phenomenon of VHA to revealing the power and social inequity that may have been legitimised or hidden within the organisational and cultural contexts of the simulated hospital laboratory.

The next chapter discusses the key findings from the research data in relation to the literature and highlights the way this study has contributed to the body of knowledge investigating VHA in nurse education, specifically within a simulated hospital environment.

Chapter 6: Discussion

Pedagogical action can . . . , because of and despite the symbolic violence it entails, open the possibility of an emancipation founded on awareness and knowledge of the conditionings undergone and on the imposition of new conditionings designed durably to counter their effect. (Bourdieu, 1999, p. 340)

6.1 Introduction

In this chapter, the key findings generated from this research are discussed and situated within the current body of knowledge. The unique, contemporary environment of a simulated hospital in a university setting used as learning and teaching space for pre-service nursing education provided the opportunity for episodes of VHA to occur. This study has argued that VHA is framed, but not necessarily prescribed, by normal rituals and routines. Recognition of the mitigating factors that permit VHA to occur enables isolation of practices to raise awareness with regard to VHA and to limit the normalisation of contraindicated behaviours.

6.2 A Shared Understanding

As highlighted in Chapter 1, there are no agreed definitions of terms that describe unwanted workplace behaviours in the health sector. Terms such as ‘bullying’ and ‘vertical’ and ‘horizontal’ violence, ‘harassment’, and ‘incivility’ have been used interchangeably in the literature (Boyle & Wallis, 2016; Hawkins, Jeong, & Smith, 2019). This non-standardisation of language results makes it difficult for researchers to compare and contrast findings in this research space. For this study, consistency in the language required a term that explicitly captured both the power dimensions and a description of the observed behaviours. Therefore, the term VHA was adopted.

During the dialogical data collection phase, the participants were not provided with a definition of the term VHA; instead, they were invited to describe, in their own words, their understanding of the term VHA and provide, if possible, examples of their experiences. These descriptions and examples aligned with what has been reported in the current literature. Behaviours such as abusive, insulting or offensive language or comments; unjustified criticism or complaints; deliberately excluding someone; withholding information; and setting unreasonable timelines have all been mentioned in the literature (Cleary et al., 2010; Garling, 2008; Hutchinson et al., 20013; Lewis, 2006; Murray, 2009; Randle, 2003; Skehan, 2015).

Cooper and Curzio (2012) found that their participants could not identify actual acts of bullying. In this current study, one student and one academic participant believed they understood what constituted VHA but they denied witnessing any acts of VHA, both generally and specifically, in the simulation laboratory. However, the majority of the key informants could describe acts of VHA clearly and concisely, as well as draw from personal experiences of being a target, witness and at times, perpetrator. Participating as a key informant in this study encouraged reflection on the topic, with some recognising they had been unwitting perpetrators of VHA. Other research has revealed there is a strong attachment to the notion that acts of VHA are principally problems of interpersonal behaviour. Critical interpersonal reflection will lead to an improved ability to recognise these behaviours in self and in others (Hodgins, MacCurtain & Mannix-McNamara, 2013).

Both the academic and student participants reverted to using the term ‘bullying’. In the literature, the only identified characteristic that differentiates bullying from other acts of unwanted behaviours has been its repetitive nature (Olweus, 2011). Bullying is a common term that is widely used among the public. The term has received recent media attention in the context of the schoolyard in

projects such as ‘Bullying, NO WAY’ (<https://bullyingnoway.gov.au>) and ‘Bully Project Australia’ (<https://thebullyproject.com.au>). These public awareness initiatives have resulted in the term becoming familiar across generations and in different contexts.

The literature reports that a third of all academic staff have reported experiencing VHA within a university environment (Hollis 2019; Skinner et al., 2015). However, although the academic participants in this current study said they had not witnessed VHA in the university, the data confirmed that VHA had occurred and that they were either complicit in perpetrating VHA or a victim of VHA.

6.3 Codes and Policies to Enforce Acceptable Behaviour

Policies are developed in response to government legislation and organisations’ underpinning ideologies (Freedon, 2006). An organisation’s policies, procedures and practice standards are acceptable means of enforcing expected workplace behaviours (Industrial Relations NSW government, n.d.). Policies include codes of conduct and codes of ethics that align with an organisation’s purpose and mission and set the standard of professional conduct and performance (NSW Public Service Commission, n.d.). Within the higher education sector, the codes of conduct stipulate the behavioural expectations of all employees (TEQSA, 2017–2018). Common elements of such documents are maintaining public trust and confidence in the organisation; personal and professional conduct; intellectual freedom; the appropriate use of university resources; conflicts of interest; and consequences if the code is breached.

At the time of this study, there were no specific policies or ethical codes of practice or conduct to regulate the behaviour of academic staff and students in the simulated hospital environment, although laboratory rules that stipulated enclosed

footwear were in place across the university, for all laboratory settings. This policy addressed the physical safety of students and staff from harmful environmental hazards such as chemical spills and injury from inappropriate use of equipment, but it did not address interpersonal safety (Work Health and Safety Policy, CSU, n.d.). The University Student Charter detailed the behaviours expected of the university students, primarily targeting academic expectations (Student Charter, CSU, n.d.). The university's Harassment and Bullying Prevention policy (Harassment and Bullying Prevention Policy, CSU, n.d.) was the primary mechanism for highlighting behaviour that was unacceptable to the university.

In Australia, RNs are expected to practise according to the standards established by the AHPRA. The International Code of Ethics (ICN, 2012) for nurses was adopted for Australian nurses and midwives in March 2018, ensuring globally common ethical practices. The code has four principal elements, which outline the standards of ethical conduct expected by an RN. Element 1 is entitled 'Nurses and people' and highlights the importance of safeguarding the patient. Element 2, 'Nurses and practice', emphasises the importance of responsibility and the accountability of nursing practice as well as stating that nurses should strive to maintain a positive and ethical practice culture. Element 3, 'Nurses and the profession', stresses the importance of standards and evidenced-informed practice, as well as stating that nurses must contribute to an ethical organisational environment and challenge unethical practices. Element 4 focuses on 'Nurses and co-workers', stressing the need to be respectful and collaborative (ICN, 2012).

The Registered Nurses Code of Conduct consists of domains, principles and values. The four domains are practise legally; practise safely, effectively and collaboratively; act with professional integrity; and promote health and well-being.

The values cover bullying and harassment, teaching and supervising, and the health and well-being of self and colleagues (NMBA, 2018).

The Registered Nurse Standards of Practice consist of seven standards: thinks critically and analyses nursing practice; engages in therapeutic and professional relationships; maintains capability for practice; conducts comprehensive assessments; develops a plan for nursing practice; provides safe, appropriate and responsive quality nursing practice; and evaluates outcomes to inform nursing practice (NMBA, 2016).

Despite the multiple levels of policy and codes that regulate the behaviour of nursing academics and student nurses who are learning and teaching in simulation laboratories, acts of VHA still occur. It is reasonable to conclude that these policies are not understood, not being implemented or not being enforced. The theoretical explanation for this policy/practice divide is based on the dichotomies of macro-versus micro-politics or structure versus agency (Schulte, 2018). However, as recent literature and this study have both shown, implementers of policies do not always act as part of or in line with the organisation (Schulte, 2018). The local actors may bypass the logic of practice within their environment in favour of larger political narratives, which may not align with the local organisational goals (Schulte, 2018). This can be seen in the dichotomy between the graduate outcomes required in the higher education sector and the graduate attributes required in the healthcare sector.

A review of the current codes and standards of higher education and healthcare sectors revealed a managerial influence. McGregor (2001) found that public health and education are managerially governed (p. 83), evident in the language used in the various codes and standards that govern the behaviours within these sectors. For example, 'quality assurance' and 'results orientation' was a feature in the simulation code of ethics, while the Registered Nurse Practice Standards

included phrases such as ‘best practice’, ‘standards’ and ‘performance indicators’, which are the basis of managerialism.

Reflexivity

Does the language that has been used in the development of established codes and standards legitimise authority that reinforces institutional myths, as opposed to establishing behavioural guidelines?

6.4 Causal Factors Supporting VHA Within Workplaces

As identified in the literature review, many authors have suggested that unwanted workplace behaviours are subjectively perceived and understood which makes the phenomenon difficult to clarify and define (Birks, Budden, Biedermann, Park & Chapman 2018; Hartin, Birks and Lindsay 2019). However, many authors have also argued that VHA is related to the structure of the wider Australian society, which is democratic but also described as fundamentally hierarchical (Butterworth et al., 2016; Dollard, Dormann, Tuckey, & Escartin, 2017; Kemp, 2014; Morrison, 2013; Savva, 2016). A managerial framework supports hierarchical structures and the principles of managerialism have been applied equally to the public and private sectors. In the health sector, it has resulted in a power shift away from the practising clinicians and towards the managers. In higher education, activities in this sector are tied to the success of the organisation as a business, not as a social enterprise. With this shift of power, a change in the primary concern has also occurred. Increasingly, in health, public funding is linked to reductions in patients’ length of stay and other formal criteria, while in the higher education sector, priority is given to criteria such as vocational skills, rather than intellectual values (Komesaroff, Kerridge, Isaacs, & Brooks, 2015).

The ‘market’ has become the dominant force in decision making in both the higher education and healthcare sectors. Other measures such as loyalty, trust,

commitment and critical reflection have become displaced and devalued because of the dominance of managerialism (Komesaroff et al., 2015). This was seen when the Royal Australasian College of Physicians, established in 1938, was modernised and corporatised in 2007. This corporatisation included replacing the Council with a Board, centralising the functions of the College and replacing democratic involvement of physicians within the College with administrative functions carried out by paid managers. Risk aversion became a focus of the Board on behalf of the College and the traditional physician-led roles of the College, such as expert advisory groups, were abolished without consultation. All Board and administration activities were characterised by secrecy. The adoption of the label ‘commercial in confidence’ ratified the secrecy of financial transactions undertaken by the Board on behalf of the College membership. In addition, the salaries of officials were no longer disclosed to members (Komesaroff et al., 2015). It was reported that many members felt undermined and staff morale plummeted as membership diminished. Behaviours that had previously been regarded as VHA had become accepted organisational processes (Komesaroff et al., 2015; Salin, 2003).

Characteristics of managerialism in the higher education sector, described by Whitchurch and Gordon (2010), include 1) a greater separation of academic work and management activity; 2) increased control and regulation of academic work by managers; 3) a perceived shift in authority from academics to managers; 4) an ethos of enterprise; and 5) an emphasis on income generation. Three of these characteristics refer to the division between managers and academics. This process has the potential to create social class distinctions within the higher education workforce: managers and others. This class distinction was observed among the participants in this current study, both academic and students, where the social

division was made between those who were perceived to have tacit knowledge and those who did not have it.

Managerialism promotes competition above all else (McGregor, 2001; Sakellariou & Rotarou, 2017). Managerialism in the tertiary sector has forced universities into a competitive relationship, where the reductions in governmental financial support, mean that universities have become competitors rather than collaborators (Walker, 2009) and students have become rivals. This rivalry is evident when nursing students compete for new graduate positions. The emphasis on the individual in managerialism has resulted in individuals operating as entrepreneurs who aim for their interest within a societal context that values competition. Thus, individual worth becomes tied to capital, whereby the individual is constructed as ‘human capital’ (Cannella & Koro-Ljungberg, 2017).

The healthcare and higher education sectors are established and politically sensitive entities that are undergoing significant reforms in policy, governance and funding (ANMAC, 2012a, 2012b, 2012c, 2012d). The isomorphic relationships between higher education and the healthcare system affect nursing education on a political, ideological and economic basis. There is often tension between educational providers and the healthcare sector about the theoretical and practice components of nursing education. Education providers need to ensure satisfactory completion of degree requirements and the healthcare sector is primarily concerned about the practicalities of delivering safe patient care within ever-changing clinical environments.

The healthcare sector relies on the higher education sector to produce health professionals, including RNs, for future workforce recruitment. While, the role of higher education is to deliver a curriculum approved by AHPRA (2019) to meet the workforce needs. Therefore, higher education is ultimately being directed by the

healthcare sector to produce a homogeneous workforce. Nursing students completing programs of study to qualify as RNs are being educated in higher education to respond favourably to the healthcare organisational environment, to be compatible with the organisational characteristics determined by the organisation's ideology.

Reflexivity

Can the hierarchical world of nursing be altered by the development of a new social narrative?

6.5 Management/Leadership, Legitimised Authority or a Tool for Enforcing Workplace VHA?

Some authors believe that nursing, as a collective, is structurally an oppressed group (Duffy, 1995; Embree, 2010; Glass, 1997; Lewis, 2006; Randle, 2003; Rodwell & Demir, 2012). Freire's famous quote, the 'oppressed become the oppressor' (Freire, 1970, p. 44), has been used by many researchers to explain acts of VHA in nursing (Duffy, 1995; Farrell, 2003; Hutchinson et al., 2006a; Roberts, 2015). However, there has been little research to validate this assumption.

To determine whether the oppressed becomes the oppressor was not the focus of this current study. Rather, this research has demonstrated that acts of VHA in the simulated hospital laboratory environment came from a position of dominance achieved through the establishment of social capital, which was traded for power, resulting in certain privileges for the dominant group. The findings of this study align with Lovell's (1980, p. 79) contention, 'once an oppressive relationship is established, violence has already begun'.

In an organisational context, Lumby (2017) suggested a defining factor of power is the ability of leader with power to make something happen. That managers

and leaders use their power to get things done and achieve organisational goals (Lunenburg 2012). Ebert and Griffin (2015) described power in organisations as being necessary to influence the actions of individuals. While power is needed for organisational success, the literature has suggested that power is often abused, shown in areas such as explicit or implied job insecurity, or direct and overbearing supervision (Barling et al., 2008; Pearce & Manz, 2014). According to Parker (2014), the individuals who hold the power are often the perpetrators of the abuse. Within organisations, there are always incentives to abuse power because of its importance in affecting action and acquiring subsequent rewards (Hollis, 2019; Salin, 2003).

The power of managers and leaders to influence the organisational culture and environment has been well documented (Barling et al., 2008; Hollis, 2019; Parker, 2014; Pearce & Manz, 2014). Leaders and managers are seen as role models and their actions communicate what is acceptable behaviour within an organisation (Kaiser, 2017). However, leadership and management styles within organisations varies. According to Burns (1978), there are three primary organisational leadership styles: transformational, transactional and laissez-faire.

Transformational leadership is known as an active form of leadership. This style of leadership motivates employees to achieve organisational goals (Fleming, 2017). It has the ability to influence employees' moral values and ethics in such a way that they perform better than expected. Further, transformational leaders are considered more trustworthy, realistic and practical, which could help them to accomplish their goals and stimulate innovative work behaviour (Hui, Sajjad, Wang Ali, Khaqan, & Amina, 2019). Employees of transformational leaders, respect and trust their supervisors.

Transactional leaders are more common in organisations. They provide rewards for good performance, watch for deviant behaviours and intervene when

issues arise, yet they avoid making controversial decisions (Bass, 1999). This type of leadership involves goal setting and achievement. It consists of an exchange between a manager and an employee, with employees given incentives to meet performance expectations (Rowold & Borgmann, 2014). According to Bass (1999), transactional leadership often results in mediocrity, as transactional leaders lack the charisma and ability to motivate employees. Followers of transactional leaders do what is expected and are not inspired to exceed a manager's expectations (Breevaart, Bakker, Hetland, Demerouti, Olsen & Espevik 2013), which makes this style of leadership less effective than the transformational style.

Laissez-faire leadership is a inactive, form of leadership (Bass, 1999; Skogstad, Hetland, Glasø, & Einarsen, 2014). It is characterised by leadership avoidance and being unresponsive to the needs of the workers (Bass, 1999; Glambek et al., 2018; Skogstad et al., 2014). This form of leadership has been associated with an increased incidence of VHA; for example, Namie and Lutgen-Sandvik (2010) found that laissez-faire managerial intervention tended either not to take place or to make things worse in most bullying incidents. This inaction may signal to workers that bullying is seen as acceptable behaviour (Nielsen, 2013; Glambek et al., 2018; Skogstad et al., 2007).

Each of the academic participants had qualities of the various types of leadership and management. Betty demonstrated transactional leadership by allowing students to bring chairs into the clinical space so they did not have to stand during the demonstration. Here, the use of chairs within the simulation spaces was authorised as an incentive to listen. Ann showed the qualities of a transformational leader who motivated the students to achieve the goals of the organisation, healthcare and higher education. 'I like to create a work-like environment. I take my jacket off;

they take theirs off' (TN23). Cathy displayed a laissez-faire approach when she said, 'I don't really care' (TN25).

This study confirmed that a laissez-faire leadership style leads to episodes of VHA; Cathy was subjected to acts of VHA perpetrated by both academic and student participants. Cathy knew the students were frustrated with her; however, she did not attempt to address this frustration. Her inaction may have established the premise that it was permissible for students to vent their frustration aggressively and inappropriately.

6.6 Curriculum and Simulation Pedagogy: Beginning

Acculturation

As highlighted in Chapter 1, higher education has a crucial role in undergraduate nurse education. However, the neoliberal educational agenda of the 1990s shifted power away from educators and students and placed it with the curriculum and surveillance authorities (Davies & Bansel, 2007). Consequently, the BN curriculum featured in this study was approved for implementation by the NMBA, ANMAC and the Australian Government through compliance with the AQF policy.

The preparation and professional socialisation of novice practitioners begins in the higher education system. Usually, an introduction to the profession of nursing is offered with a focus on the knowledge that underpins professional nursing practice (Kemmis et al., 2014; Rooney Hopwood, Boud, & Kelly, 2015). However, the undergraduate nursing curriculum currently assumes the context in which nursing graduates will practise, even though the future of healthcare is not stable nor knowable (Harteis et al., 2012; Rooney et al., 2015). A common theme arising from the literature was the need for flexibility and transference of knowledge skills and capabilities. Some authors referred to this concept as agility (Rooney et al., 2015),

which requires students to be agile in their learning, open to learning opportunities and able to evaluate their own practice and the practice of others.

Assessment has a strong influence on what and how learners' study and it drives the learning process (Boud, 2010). However, there are no measures of assessment for professional agility at this time; this suggests that agility is not valued by the curriculum. This current study found that participants valued skill-based knowledge, the ability to perform a set task or skill. This was evidenced by the social capital awarded to the student participants who were perceived to have relevant prior knowledge, or who had worked in the healthcare sector (e.g. Gail and Francis). In addition, it was seen in the academic participants who could manage the learning and teaching space of the simulated hospital laboratory (e.g. Ann).

6.6.1 Simulated Learning and Teaching

The reasons for the incorporation of simulation into undergraduate nurse education have been highlighted in Chapter 1. The primary purpose of simulation-based education is to improve the quality and safety of healthcare delivery (Agency for Healthcare Research & Quality, 2012; Seaton et al., 2018). A key reason that simulation has the potential to improve patient safety (Gaba, 2004) relates to students having a safe environment to develop and practise nursing without the risk of harming patients (Akhtar-Danesh, Valaitis, Stanyon, & Sproul, 2009; Alconer-Camarero, Gualdron-Romero, Al-Ghareeb, & Cooper, 2016; Berndt, 2010; McNiesh, 2015; Miller & Bull, 2013; Sarabia-Cobo & Martinez-Arce, 2016; Seaton et al., 2018).

As patient safety is a top national priority (Australian Commission on Safety and Quality in Health Care, 2016–2017), the Australian Government has invested in simulated-learning environments (Australian Government Department of Health and Workforce Australia, 2015). As an outcome of infrastructure enhancement, the use of

simulated learning and teaching in undergraduate healthcare professional education has increased (Bogossian et al., 2018).

Despite the investment in simulation learning and teaching infrastructure and agreement that practice is necessary, there is no evidence establishing the baseline hours required to ensure practice confidence and competency of health students, including nursing students (Bogossian et al., 2018; Larue, Pepin, & Allard, 2015; Persico, 2018). Rather, there has been, and continues to be, debate regarding the efficacy of simulated learning that replaces mandated immersion in practice hours within health professional courses, including nursing education. The mandatory hours for student nurses undertaking programs of study to license as an RN in Australia is currently set at 800.

In addition to the mandated 800 hours in workplace practice, the NMBA (2018) requires that nursing students have simulated hours in the curriculum to practise nursing skills. This compares with 1,280 hours of immersive clinical training in Singapore, 1,100 hours in New Zealand and 1,530 hours in the UK (ANMF, 2019). Further, the Singapore Nursing Board has authorised up to 80 clinical training hours being replaced with simulation at a ratio of 1 hour: 1 hour (Schwartz, 2019). In the US, some Nursing Boards (Colorado, North Carolina and Michigan) allow up to 50 per cent of clinical training time to be replaced with simulation. However, evidence supporting the number of hours that are required to ensure competence in practice has not informed these expectations.

Bogossian et al. (2018) found that the majority of leading nursing academics in Australia and New Zealand considered that if simulation was adequately resourced, a proportion of the required clinical training (workplace immersion) could be taught through simulation. However, there appears to be an overwhelming endorsement for the minimum hours of clinical training being exclusive of

simulation, with simulation remaining an adjunct to clinical training (ANMAC, 2018). According to Schwartz (2019), the variation in opinions about simulation hours versus clinical placement hours reflects the varying levels of quality, resourcing and regulation of simulation practices in undergraduate nurse education.

In 2018, a team of healthcare simulation experts from countries across six continents, including representation from a range of industry partners and simulation organisations, established a working group to develop a code of ethics specifically for healthcare simulation professionals (Park et al., 2018). The code aimed to promote, strengthen and support an ethical culture among individuals and organisations engaged in healthcare simulation. The Healthcare Simulation Code of Ethics (Park et al., 2018) asserts six fundamental values deemed necessary to the practice of simulation: integrity, transparency, mutual respect, professionalism, accountability and being results oriented. Integrity refers to the organisational environment being respected and ethical, meaning the healthcare simulationists, should maintain standards of integrity that include honesty, truthfulness and fairness. Transparency addresses unnecessary deception within the simulation activity; this includes the disclosure of the aims and expected outcomes of the simulation. Mutual respect highlights the importance of maximising safety and minimising the physical and psychological risk for all parties involved in the simulation experience. Professionalism covers professional competence, while accountability incorporates the 'role modelling' of ethical behaviours by all parties, as well as vigilance with regard to not only the desired learning outcomes but also the unintended learning that may occur. The code takes a 'results orientation', which includes continuous quality improvement. It creates and measures human performance and systems improvements that are reflected in the final value, quality improvement and performance indicators (Park et al., 2018; Bogossian et al., 2019)

Reflexivity

Why aren't students and academics modelling behaviours that reflect the Code of Conduct for Nurses (NMBA, 2017)? Are the codes not really 'taught' or reinforced, or are the simulation environments not considered realistic by staff or students?

6.6.2 Simulation Is Not a Pedagogy

As described in Chapter 1, simulation as a learning and teaching modality has been embraced by healthcare educators. In more recent years there has been increased interest in investigating theoretical frameworks that guide the development and delivery of simulated learning and teaching within curricula (Lavoie, Michaud, Belisle, Boyer, Gosselin, Grondin, Larue, Lovoie & Pepin 2018; Miles, 2018; Weeks, Coben, O'Neill, Jones, Weeks, Brown & Pontin 2019). However, researchers within the healthcare simulation community are calling for research to establish a transferable simulation pedagogy. This includes theoretical educational frameworks that underpin simulated-learning activities (Berragan, 2011; Burke & Mancuso, 2012; Schiavenato, 2009).

It is important to note that the modalities of simulation used do reflect the pedagogic intent. Some modalities focus on specific skill development (psychomotor) such as task trainers, low-fidelity simulation, while other types aim to engage the student in a holistic clinical scenario (clinical reasoning/decision making). Hence, a range of learning theories would be appropriate and dependent on the learning focus or outcome.

Social constructivism and constructivist learning, championed by Vygotsky and others, are strongly aligned with simulation (Jarvis, Holford, & Griffin, 2003). However, to date, Kolb's Experiential Learning Theory (Kolb, 1984) has been a conventional learning theory used to guide the development of simulation-based education in undergraduate nursing programs (Aebersold, 2018). This theory

involves four steps: concrete experience, reflective observation, abstract conceptualisation and active experimentation. When applied in simulation, concrete experimentation occurs initially when learners or students engage in a simulation scenario. After the scenario, the students participate in reflective observation as they debrief and reflect on their performance. Abstract conceptualisation occurs when the facilitator helps the learners to incorporate what they have learned. The process by which learners put newly gained knowledge into practice is the active experimentation step (Aebbersold, 2018; Zigmont, Kappus, & Sudikoff, 2011).

The National League for Nurses proposed another simulation theory, the Jefferies Simulation Theory (Rodger, Adamson & Jeffries, 2015). This theory has been widely supported in undergraduate nurse education (Adamson, 2015) as it addresses the need for more contextual and experimental approaches to simulation. The framework includes a context, background and simulation design, linking to outcomes of the simulation that occur in three areas: the system, the patient and the participant.

As described in Chapter 4, simulation learning within undergraduate nurse education occurs in a simulated hospital laboratory setting to which the students come for a defined period and engage in activities specifically designed around a set of learning objectives. These activities are usually developed into simulation scenarios, which contain the learning objectives and patient information (e.g. background, current condition, medications and other relevant information). However, the scenario does not conclude with a debriefing.

The concept of debriefing is one of the most studied areas in the field of simulation (Aebbersold, 2018) and it is believed the real learning in simulation occurs during the debriefing phase. Debriefing is thought to facilitate the development of clinical reasoning and improve teamwork and situational awareness, skills that are

necessary for nursing practice (Aebersold 2018; Cheng et al., 2014; Levett-Jones & Lapkin, 2014; Shinnick, Woo, Horwich, & Steadman, 2011). Debriefing is defined as ‘a discussion between two or more individuals in which aspects of a performance are explored and analysed with the aim of gaining insights that impact the quality of future clinical practice’ (Cheng et al., 2014). Despite the assumption that debriefing improves learning, there are conflicting views with regard to the type of debriefing, the length of time for debriefing and who should be involved in the process (Levett-Jones & Lapkin, 2014).

Reflexivity

Do various forms of simulation learning models increase or decrease the likelihood of an episode of VHA?

My study revealed that debriefing had not been incorporated into the simulation process. Could debriefing be used as a tool in identifying episodes of VHA??

The quality of the students’ simulation experiences relies on the quality of design and implementation of the simulation (Arthur, Kable, & Levett-Jones, 2010; Bogossian et al., 2018). Simulation experiences typically involve several different staff members, ranging from full-time academics, part-time and casual clinical educators, to technical and information technology staff. However, Arthur et al. (2010) identified that insufficient training is the most significant barrier to the successful implementation of simulation into undergraduate curricula.

Reflexivity

In this study, academic participants were not specifically trained in simulation education. Did this lack of training and understanding with regard to simulation contribute to the episodes of VHA observed in the laboratory?

In this current study, clinical scenarios guided simulated learning and high-fidelity simulation manikins were used in the demonstration of skills and by students

when practising the skills they had observed. This facilitated the students' goals of replicating a skill sequence, informed by clinical reasoning. The structure of the learning was facilitated by the tools provided, enabling the students to perform the skill while incorporating higher-order critical thinking to achieve the expected (and unexpected) outcomes. However, according to Hager and Hodkinson (2009), practice should be highly contextual and holistic, rather than atomistic and context-free (p. 625). Therefore, a scenario needs to be representative of an authentic patient experience, with a focus on social constructions, to make it a simulation in social practice (Hager & Hodkinson, 2009, p. 626) rather than just an isolated skill sequence.

6.6.3 Hidden Curriculum

Despite simulation being embedded in the nursing education curriculum, the efficacy of simulation is under-researched (Cant & Cooper, 2010; Lapkin & Levett-Jones, 2011). It remains unclear whether the actual learning that takes place during a simulation is intended or otherwise.

The concept of a 'hidden curriculum', which has been defined as 'the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school' (Zhang & Luo, 2016, p. 218) has been established (Allan, Smith, & O'Driscoll, 2011; Giroux & Penna, 1979; Jackson, 1968; Snyder, 1971). The function of the hidden curriculum is to socialise students into professional behaviours and practice.

The hidden curriculum is found in every educational context, including student–teacher interactions and the physical and organisational structures of the learning environment (Giroux & Penna, 1979). Giroux and Penna (1979) argued that educational facilities are microcosms of the wider societal value system in which education takes place (p. 25). At the micro level, the social dynamics in the

classrooms include the teacher–student relationships, teachers’ informal practices (such as non-verbal signals) and the varied academic expectations. At the macro level, the hidden curriculum is linked to the broader social inequalities (Giroux & Penna, 1979), who wrote, ‘At the heart of the social, educational encounter is a hidden curriculum whose values shape and influence practically every aspect of the student’s educational experience’ (p. 32). The hidden curriculum establishes the social norms and beliefs of the dominant culture. Zhang and Luo (2016) suggested that while the formal curriculum covers the lessons and content of the syllabus, the hidden curriculum provides the socialisation content, which is exchanged via verbal and non-verbal modes of transmission.

In this current study, the participants appeared to have a symbolic framework that defined and developed their meaning and way of being according to their habitus and experiences. This meaning making resulted in actions that were based on institutional norms and were about the management of perceived competence within the laboratory. The perception of competence became currency, a symbolic economic exchange.

Zhang and Luo (2016) found that the source of ‘violence’ in learning came from academic performance. According to Erlam et al. (2017), an educator’s pedagogical knowledge has the most profound influence on the teaching/learning environments that he or she creates. In this current study, tacit knowledge of how and why the academics constructed the learning and teaching space a certain way, or how the academics engaged with the manikins, shaped the hidden curriculum and contributed to the economic value system within the simulated hospital space. The verbal and non-verbal actions of the academics were witnessed and interpreted by the students as being the accepted manner in which a nurse acts or behaves in the clinical environment. Students often value the academics as credible sources of information,

based on what the academic has achieved. Thus, the healthcare system legitimises the value of the academic in terms of previous clinical experience.

The value of professionalism (Park et al., 2018; Cant & Cooper 2017a)), as described in the code of ethics for simulation, is specifically designed to combat the hidden curriculum. The value refers to the ethical obligation of the academic to role model professional behaviours and be aware of the unintended learning that may occur.

6.7 Adoption of Symbols to Promote Professionalism or Not?

What a person wears serves as a form of non-verbal communication. According to Beattie and Ellis (2017), clothing is a consistent feature of interaction that influences how others perceive and behave towards the wearer. The symbolism of the nurse's uniform has been debated for many years and today, the debate continues to be polarising. Some believe that the uniform symbolises nurturance and security, and that street clothes are anti-therapeutic. The other end of the spectrum suggests the uniform symbolises and makes salient the power and status differences that exist between nurses and others (Hurteau, 1963), as highlighted in Chapter 5. These days, wearing a uniform plays a vital role in the delineation of occupational boundaries and the formation of professional identity (Parr & Sweeney, 2006; Shaw & Timmons, 2010; Timmons & East, 2011).

The concept of 'acculturation' began in the field of anthropology and sociology and has been used to explain the dynamics involved when people from diverse cultural backgrounds come into continuous contact with one another (Ngo, 2008), as seen in the learning and teaching space of the simulated hospital laboratory. Acculturation is defined as 'those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact' (Sam & Berry, 2010, p. 473). The ultimate aim of acculturation is assimilation into the

dominant culture (Ngo, 2008). Acculturalisation is the process of cultural and psychological change, as individuals and groups bring their own cultural and psychological qualities to a field that already has its own set of qualities and values. The complex processes of acculturation include the adoption of the social constructs of the field such as language, attire, habits, traditions, communication styles, cultural identity and cultural values. As found in this current study, incompatibility of the cultural values and norms can lead to episodes of VHA. The assumption, therefore, is that acculturalisation occurs when the artefacts that define a group are adopted (e.g. wearing a uniform, hanging a stethoscope around your neck, wearing a veil) and that power can be achieved when a person puts on a guise that is recognised, legitimised and accepted.

In this study, the student participants identified that when they wore a uniform, it encouraged the role modelling of professional behaviour. A number of researchers have advocated the adoption of mandatory wearing of uniforms in simulated-learning and teaching environments, as they assert that wearing the symbols of being a nurse (uniform) and adopting professional behaviour helps to minimise the feelings engendered by pretending to be a nurse, rather than nursing itself. This enables students to embrace the role and suspend disbelief (Hope, Garside, & Prescott, 2011; Kesten et al., 2010; Prescott & Garside, 2009).

Reflexivity

Do articulation pathways into the degree have implications for learning in the light of prior knowledge being capital?

Knowing how to succeed in a particular field is based on one's cultural capital, not only skills and knowledge but also a working knowledge of the social relations and hierarchies of the field (Hager & Hodkinson, 2009, p. 632). The possession of this cultural capital is the acculturation that delineates the social

structures among groups of learners: ‘full members’ and newcomers (Lave & Wenger, 1991). This current study demonstrated that the participants who had agency were those who had relevant prior knowledge or previous nursing experience.

6.8 Space, Place, Authority and Opportunity

Space can be considered organisational, physical and social. Organisational space is the ethical and legal framework that nursing students need to work within. It is determined by both the nursing regulatory bodies and the university’s regulations: ANMB, ANMAC, APHRA and the university’s student academic conduct policies. Organisational space is developed to regulate and replicate processes and to ensure that predicted outcomes are achieved.

The neoliberal influence on healthcare reform that has turned patients into consumers has directly affected the physical space of hospitals: how they are being designed and developed. As simulated hospital laboratories are designed to replicate contemporary healthcare facilities, it is important to understand the way these facilities are created. Evidence-based design, defined as the use of evidence to support design decisions (Hamilton, 2004), has taken the place of traditional hospital architecture. Hospitals no longer take ‘pride of place’, situated on a ‘sacred landscape’ (Brown & Barnett, 2004, p. 428). Today they are more luxurious, with hotel-style receptions, cafés, open atriums and landscaped courtyards, which are more appealing to consumers.

As stated in Chapter 1, the physical space of the simulated hospital laboratory was designed on a contemporary tertiary healthcare facility. The designers of these spaces are architects, policymakers, financial institutions and financial backers, regulatory agencies, developers and engineers, with minimal input from health professionals or academics. Gieryn (2000) referred to these people as ‘place

professionals'. These place professionals have been educated to understand that the physical environment affects human activity and behaviour (Hamilton, 2004).

Social processes occur through the material forms that are designed within places as spaces are created. Gieryn (2000) proposed, 'Space is what place becomes when the unique gathering of things, meanings, and values are sucked out' (p. 465), suggesting that a space becomes a place when it has meaning. However, Power & Somerville (2012) specified space as being 'between grounded physical reality and the metaphysical space of representation' (p. 2). This can be said especially for a simulated space, as a simulated hospital laboratory lies in between the healthcare system and the higher education system; it is a metaphysical representation of the healthcare industry while being physically located in the reality of higher education.

Hospitals are considered a contested space. Low and Lawrence-Zuniga (2006) defined contested space as a 'location where conflicts in the form of opposition confrontation subversion and resistance engage actors whose social positions are defined by differential control of resources and access to power', (p. 18). However, in her one-year ethnographic study exploring nurse–patient relationships, Jan Savage (1997) identified points of resistance, which she suggested open up the possibility of change in the relationships of power within nursing. She indicated that nurses resist power through manipulation of the space.

In this current study, the academics manipulated the simulated hospital spaces. Each academic constructed the space differently. Low and Lawrence-Zuniga (2003) referred to this as spatial tactics, meaning the use of space as a strategy or technique of power in social control. The simulated hospital space became an interpretative frame through which the participants measured themselves, their peers and their power. Aligned with Gieryn (2000), it was here that they could make sense of their being. Thus, these simulation laboratories became embodied spaces as the

students took on the spatial form in two ways: first, through the nursing processes they engaged with; and second, through the material or symbolic form of the space through wearing uniforms and the social artefacts of a nurse. The surface of the student participants' bodies became the backdrop for their enactment of nursing practice.

Reflexivity

Can the simulation space create a frontier for an alternative nursing narrative?

6.9 Summary

This chapter has highlighted the contribution of organisations and organisational structures to episodes of VHA. A discussion of the nursing curriculum as a mediator of VHA behaviours has been presented and the associated social artefacts, such as uniforms, which are used to establish power, have been presented.

The nursing profession in Australia has mandated practice standards that establish parameters to guide nursing practice. The adoption of a global code of ethics for nurses is testament to the profession's commitment to practise the preservation of respect for, and safety of, others.

Nursing and other health professionals' education in Australia includes simulated learning and teaching to enhance the confidence and competence of individuals and the group. However, there is a disconnection between the efficacy of simulated learning and teaching and immersion in practice. This phenomenon is reinforced by the regulatory agencies' mandated numbers of hours in practice and requiring simulated learning that is not underpinned by evidence.

Curricula in nursing programs include hidden curricula that lead to unintended learning outcomes, such as behaviours associated with VHA. The built

environment of the simulated learning and teaching space mediates the normalisation of these behaviours, which are unacceptable and not aligned to the afore-mentioned policies and standards of practice.

The lesson learned from this study is the need to raise awareness by building into the curriculum and specifically, into professional nursing practice, reflective opportunities to consider personal, group and professional behaviours to mitigate against perpetuating a culture that identifies itself as normalising VHA.

The next chapter summarises the results of this study and the significance of the study is argued. The chapter concludes with a discussion of the limitations and recommendations of this research.

Chapter 7: Conclusion and Recommendations

...habitus as a product of history, that is of social experience and education, it may be changed by history that is by new experiences, education or training.

(Bourdieu, 2005, p. 45)

7.1 Introduction

The primary aim of this critical ethnography was to determine if the organisational and cultural environment of the simulation hospital laboratory mediated episodes of VHA among second-year nursing students.

The research question was investigated using Carspecken's critical ethnography utilising monological and dialogical data obtained during eighteen three-hour laboratory classes over the period of two 12-week sessions. The data collection tools used during the class observations were field notes, reflective journal notes, floor plans and cultural artefacts such as learning outcomes, policies and codes of conduct and ethics.

The pragmatic horizon analysis advocated by Carspecken was used to analyse the verbatim speech and actions of relevant segments of data. Excerpts of transcript and observational data were entered into word cloud software, which confirmed the themes that were developed from these data sets. Finally, relational analysis drawn from Bourdieu's social practice theory (1977) was used to situate the simulation laboratory data within enabling powers of the wider social structures and systems.

This final chapter of the thesis summarises the analysed results that have been presented in Chapters 4 and 5. The conceptual framework arising from this synthesis, which was presented diagrammatically in Chapter 6, situates the study in the wider social structures. The significance of the study is explicated and recommendations for education, research, the profession and practice are offered.

7.2 Synopsis of the Study

Episodes of VHA need to be interpreted in the light of the duality between the subjective and the objective: between the participants and the structures within the organisations of higher education, healthcare and the wider social system, which enable VHA to occur as a normative and therefore replicated practice. The results of this research occupy a unique space and setting, as the simulated hospital laboratory was situated in both the healthcare and higher education systems.

Authors of simulation studies have described and defined simulation as a replication of the essential aspects of reality. Jeffries (2005) defined simulation as ‘activities that mimic the reality of a clinical environment setting [and] reflect the actual environment’ (p. 97). Although simulation has been used for learning and teaching for more than 40 years (Al-Ghareeb et al., 2019; Hardenberg et al., 2019; McKenna et al., 2011), there is little evidence with regard to the intended learning outcomes and the unintentional learning that may occur (Kelly, Berragan, Husebo & Orr 2016; Lapkin & Levett-Jones, 2013).

The tensions that have been highlighted within the field of simulation have the potential to contribute to the development of opportunities for social change in nursing education. However, the tension within this particular study field was not enough in itself to achieve transformation; instead, it reinforced the status quo of dominant cultural practices.

This study showed that VHA occurred among these second-year nursing students and associated academics as they engaged in learning and teaching within the simulated spaces. The enabling factors that were identified were the physical design of the learning and teaching spaces, organisational factors from the healthcare and higher education sectors and the social groupings established within the cohort of students. This study contributes to a body of evidenced-based work that argues

curriculum embeds values and acts as a reproductive mechanism to reinforce dominant practices.

A second manuscript included in this study, titled ‘Australian nursing students normalising and perpetuating vertical and horizontal abuse as an artefact of learning and teaching in a simulated hospital environment: A critical ethnographic study’, which has been submitted to *Nurse Education in Practice*, provides an overview of the whole study.

Australian nursing students normalising and perpetuating vertical and horizontal abuse as an artefact of learning and teaching in a simulated hospital environment: A critical ethnographic study.

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Abstract

This paper reports on the analysis and results of a doctoral study that acknowledges episodes of Vertical Horizontal Abuse (VHA) perpetrated and normalised in a simulated hospital environment used in undergraduate nurse education. A critical ethnographic methodology was used and involved a non-participant observation, focussed interviews, field notations, and document review.

The nursing workforce has an acknowledged culture of VHA. This study found that episodes of VHA occurred within a simulated hospital laboratory. Normalising VHA by not acknowledging behaviours that targeted, embarrassed, or challenged others' integrity isolated individuals and groups affirming legitimisation. Furthermore, the normalisation of VHA potentially supports a culture of VHA for the future of the nursing workforce.

Nursing students prepare for the reality of practice through simulated clinical learning. The way they interact within these environments has the potential to reinforce unacceptable behaviour. Episodes of VHA, however, cannot be viewed through one lens. It is important to consider the structures that potentially support unwanted behaviours. Raising awareness of the self and the behaviour of others impacts everyone in an environment; if not addressed properly, a workforce culture can become toxic and problematic. Nursing education must mediate against learning and normalising VHA in all learning and teaching environments.

Introduction

VHA has plagued nursing for over 30 years, with the phrase “nurses eat their young” coined in 1986 (Meissner, 1986). The perpetration and normalisation of VHA is perpetuated within the Australian nursing workforce culture (Chachula, Myrick, & Yonge, 2015; Eley, Eley, & Rogers-Clark, 2010; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Longo & Sherman, 2007; McKenna, 2003; Schaffner, Stanley, & Hough, 2006; Thomas & Burk, 2009) .

It is unclear how or even when nurses learn, accept and model VHA. There is evidence (Birks, Budden, Biedermann, Park & Chapman, 2018; Longo 2007; Tee, Ozcetin & Russell-Westhead, 2016; Magnavita & Heponiemi, 2011) confirming that student nurses encounter VHA when they participate in clinical training during their educational programs. Therefore, the nursing educational process may be an unwitting partner in supporting a culture characterised as “eating its young”.

In recent years, there has been an increased focus on violence in the healthcare sector (Copeland, 2017; Al Dameery, 2018). Issues driving this focus are the challenges associated with workforce recruitment and retention, endangerment to healthcare workers and patients in the workplace, along with psychological trauma experienced by staff and the subsequent financial impact this has to the healthcare sector.

Despite most studies addressing the incidence and prevalence rates of bullying (incivility) or examining the coping strategies of different groups (Salin, 2003) there is growing acknowledgement that bullying and other forms of aggression in the workplace are the result of interactions between individuals and situational factors (Salin, 2003). Little attention however has been paid to the impact of situational factors in simulated hospital environments on nursing students engaged in learning and teaching. This research has sought to understand if the organisational and cultural environment of simulated hospital laboratories in undergraduate nurse education supports harmful behaviours.

Background

In Australia, simulation is used extensively in nurse education in both undergraduate and postgraduate courses (McKenna, Bogissian, Hall, Brady, Fox-Young, & Cooper, 2011). Despite simulation still in its infancy when it comes to determining what is actually being learned in the environment, it has become a pedagogical corner stone of healthcare education (Cant & Cooper, 2017). Researchers within the healthcare simulation community are calling for further inquiry into simulation pedagogy to identify factors which may contribute to learning in simulation (Burke & Mancuso, 2012; Berragan, 2011).

A contemporary definition of simulation is offered by Australian Nursing and Midwifery Accreditation Council (2018, p. 22):

Simulated learning refers to a variety of activities using patient simulators, including devices, trained persons, lifelike virtual environments, and role-playing. Simulation based education experiences strengthen, mimic or replace real-life clinical situations. Simulation based education aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing.

There are many reasons why simulation has been accepted as a learning and teaching modality in universities, and they include the increasing difficulty of securing clinical placement sites, an increase in student enrollments in undergraduate nursing programs, a decrease in nursing academics, lack of physical space, lack of technical training and support, and a reluctance from health professionals to supervise students in clinical practice (Gates, Parr & Huguen, 2012; Berndt, 2010; Warland, 2011). The real driver and advantage of simulation, however, is its ability to influence patient safety (Seaton et al, 2018).

The National Safety and Quality Health Service standards are the current framework used in Australia governing healthcare safety. The standards provide an evidence based and nationally consistent set of criteria for patient safety (Seaton, 2018). As patient safety is a national priority (Australian Commission on Safety and Quality in Health Care 2016-17), simulation has received governmental support investing funding into simulated learning environments (Australian Government Department of Health and Workforce Australia, 2015). As a result, the use of simulation for undergraduate healthcare education has increased and simulation is embedded in most tertiary education provider programs (Bogossian et al, 2017).

There is growing recognition within the patient safety literature that the focus of patient safety content in undergraduate nursing programs needs to include the influence of human sociocultural factors such as VHA (Robson et al, 2013; Tregunno et al, 2014; Usher et al, 2017; Lukewich et al, 2015; Duhn et al, 2012). There is debate in the literature as to whether VHA continues in nursing because the origins of harmful behaviours begin before entering the industry, suggesting the behaviours are developed at undergraduate level (Magnavita & Heponiemi, 2011). Alternatively, it is also possible that nursing students transfer harmful behaviour from the healthcare sector to higher education (Edwards and O'Connell, 2007). Mott (2014) argues that it is in the academic setting that student nurses are first exposed to a culture of incivility. It has also been suggested, furthermore, that behaviours observed by students undertaking clinical rotations can be transferred to the university setting and vice versa (Cooper and Curzio, 2012). This study explores whether simulated hospital learning

and teaching spaces 'mimic' unwanted as well as wanted behaviours in the nursing profession.

Methodology

The primary aim of this critical ethnography was to determine if acts of VHA occur among second year nursing students and academics learning and teaching in a simulated hospital environment. If so, what are the conditions that support this behaviour?

This study used a critical ethnographic methodological approach. A critical lens is appropriate when issues concerning social injustice and marginalisation are the focus of the research (Thomas, 1993). Ethnography is a methodology suitable for the investigation of culture (Liamputtong, 2013). Therefore, adopting a critical ethnographic methodology was deemed suitable for this study and has sought to uncover the organizational and cultural environment of the simulation laboratory which may mediate episodes of VHA among second-year nursing students. Approval to conduct the study was obtained from the University Human Ethics committee; protocol number 2014/018.

Carspecken's five-stage approach (1996) to critical ethnography informed the conduct of this study. Forty second-year undergraduate nursing students and three nursing academics consented to be observed during learning and teaching sessions conducted in a simulated hospital laboratory. Data generation was achieved through non-participant observation, interviews, field notations, and document analysis.

Applying an observation schedule, the focus was on the social and organisational aspects of engagement of students and academic participants learning and teaching in university, which may have led to episodes of VHA. Following observations, the researcher conducted semi-structured interviews with twelve key informants, nine student nurses, and three academic staff involved in learning and teaching within the simulation space. Pseudonyms were used to increase confidentiality of the participants.

Data was analysed separately and then collated using Carspecken's pragmatic horizon analysis process. The results were then subjected to probing using Bourdieu's social practice theory (1977), which provided an insightful interpretation of the data, and was later abstracted into four topic domains that corroborated a definitive response to the research question.

Bourdieu's social practice theory views 'practice' as a result of interactions between habitus, capital, and field (Bourdieu, 1977).

Bourdieu's Theory of Practice

$$[(\text{Habitus}) (\text{Capital})] + \text{Field} = \text{Practice}$$

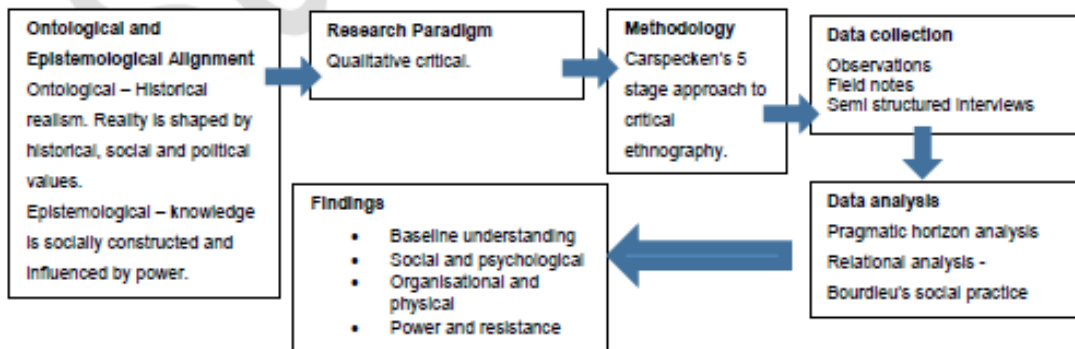
Figure 1 Bourdieu's practice theory (1984, p. 101)

According to Bourdieu, habitus refers to a series of transferable dispositions within a specific space, shaped by objective structure and social capital. However, habitus is not an independent entity, rather it is created through the capital of a specific field or fields. In order to enter a field an individual must possess a specific quantity and type of resource that is of value to the field. These resources include material and immaterial resources such as knowledge or advice that can be legitimized by the social network (Bourdieu 1986). In Bourdieu's (1990) social practice theory there are various types of capital, including economic capital, social capital, cultural capital, and symbolic capital.

Both the habitus and the field are formed independently by experiences. They are structured spaces of position where there are laws and rules. The rules are tacit but are legitimized by the agents within the field. If the legitimisation is left unchallenged, the rules of the field are unable to be transformed and social reproduction occurs. The structure of a field is telling of the power relations of the participants within the field and the distribution of capital.

Therefore, fields can be categorized as places of struggle and negotiation where capital is bought, sold and exchanged, creating the possibility to maintain or transform the status quo (Bourdieu, 1993; 1996).

Figure 2 Summary of research design



Findings

Four topic domains were distilled from the data sources; baseline understanding; social and psychological domain; the organisational and physical domain, and the domain of power and resistance.

Topic domain 1 - Baseline understanding

The first topic domain uncovered the base line understanding of VHA. It was evident that participants—academics and students—shared an understanding of VHA yet subconscious, common, and overt behaviours that perpetrated VHA were embedded in cultural norms.

Ann an academic participant explained VHA to be (TN 23) '...bullying or power shifting, making people feel uncomfortable, up and down the chain.' The phrase 'up and down the chain' highlights Ann's understanding of the bidirectional flow of behaviour.

Albert, a student participant, was unaware of being a target of VHA. As a student Albert's understanding of VHA were acts of intimidation from peer to peer or from an academic to a student. He could not recall being a perpetrator, witness, or a target (TN26). However, the researcher had documented in the fieldwork journal that he was a frequent target of VHA. An example of such an episode is detailed below:

Albert raised his hand again to answer the question on central line dressings. A groan came from the class. Several students rolled their eyes. Even the academic told him to put his hand down and asked for someone else to answer. (FN 35)

Although Albert produced a succinct understanding of VHA, he was unaware of what it looked like. Albert's peers acknowledged that he was a target of VHA. Beatrice stated, '.... it happens all the time in all our classes.' (TN 27) She justified this behaviour with '... his opinions are very strong, but he can back up everything he says.' (TN 27) Danielle, another student participant suggested '...it is just his way I don't think it is intentional. I think lecturers are mean to him.' (TN 29) Carol commented on another student whom she felt was '... always in his face, and it pisses me off, she is so negative to him all the time' (TN 28).

Topic Domain 2 - Social and psychological

The second domain explored the personal and social effects of VHA, which are discussed under the topic of social and psychological issues. This study revealed evidence which suggested episodes of VHA occurring when participants pursue capital within the field of the simulated hospital laboratory. This was due to the tacit understanding that power was

afforded to students who were perceived to have practice knowledge by their peers. The peers allowed those with perceived power to act inappropriately justifying their behaviour by normalising it.

For example, a student named Gail nearly bumped into another student Carol. Carol offered her apologies, however, Gail responded with '...you better be' (FN 23). When asked what she meant, Gail responded by saying, 'I was only joking.' Carol was subsequently asked how she felt when Gail said that to her. She replied, '... Oh, she is always like that. It was observed Carol rolled her eyes (FN 24) adding '... but she makes me feel stupid'. When asked why Gail made her feel stupid, she stated because she and Francis (another student) work as assistants in nursing and 'they know stuff' (TN 28).

Prior knowledge, such as being an AIN or EN, was a currency used in the laboratory space and gave those 'with', specific permissions. The episodes of VHA perpetrated by Gail was used as an excuse because Gail had currency, which lead to a power imbalance between the two students.

Topic Domain 3 - Organisational and physical

As Bourdieu suggests, every field has its own set of struggles, which occurs due to the varied positions and levels of power based and degrees of legitimised authority (1993). In this study, participants were all registered nurses (as required by the Australian Nurses and Midwifery Board, 2018) with previous clinical experience in the healthcare sector. Students valued the academics clinical expertise and adopted the academics habitus from the healthcare field, in the simulation hospital laboratory. The academic participants, therefore, were justified and legitimised by their clinical experience and the task of teaching in the simulation laboratory became an avenue for cultural and social reproduction based on the rules and laws of the healthcare sector.

During the demonstration of clinical skill sequences, Ann encouraged students to stand around the bed to observe the demonstration. Clarification was sought from Ann regarding why she required students to stand. She laughed and responded '...I have to stand so they can too' (TN 23). She then clarified this statement,

...I found that letting the students sit down takes time to get them sorted, sometimes we are so tight on time that we can't have students wasting time dragging chairs in and out, ... if they sit down they can't see because they are sitting behind each other but also they get distracted, they are on their phones and stuff. ...[B]ut really it is

because this is supposed to be a hospital environment and in practice, they wouldn't sit on a patient's bed. I like to create a work like an environment. (TN 23)

Topic Domain 4 - Power and resistance

Carspecken's critical ethnographic research tradition assumes that all action is mediated by power (1996; 2003). In this study, the wearing of uniforms or lack thereof in the laboratory space was viewed by participants as a tool of power or oppression.

For example, Betty, a nursing academic, identified with the '... smart people in uniform[s]' (TN 23) while the act of wearing a uniform for students encouraged the role modelling for registered nurse behaviour. This was expressed as, '... I feel like it puts me in the zone' (TN 29). Other students found wearing the uniform as a way to stand out in the community and receive acknowledgement for being a nurse, with comments such as, '... I like it; I get attention when I wear it down the street' (TN 31). Elizabeth, however, thought differently, '...I always thought I had to, I didn't think we had a choice. I'm in the routine of wearing it now, so I will' (TN 30).

For some participants, a way to create a 'real workplace' hospital environment was to encourage students to wear the university's designated workplace learning uniforms to simulated laboratory classes. At the time of the observations, however, it was not compulsory. All but two students in Ann's class wore a uniform (FN 18). Ann commented, '...I highly recommend (to) them to wear a uniform but only stipulate (they must wear) appropriate attire'.

Discussion

Data revealed that participants had a shared understanding of VHA. Many participants provided personal stories and experiences while others referred to times where they had witnessed these episodes. As highlighted in the current literature, the data supports the notion that observing episodes of VHA is just as distressing as being a target of VHA (Skehan, 2015).

The health and higher education sectors are established and politically complex bodies that undergo significant reforms in policy and governance (ANMAC, 2012a, ANMAC, 2012b, ANMAC, 2012c, ANMAC, 2012d). There is often tension between educational providers and the healthcare sector about the theoretical and practice components of nursing education. Education providers need to ensure satisfactory completion of degree requirements, while

the healthcare sector ought to be mainly concerned with the delivery of safe patient care within fluctuating clinical environments.

In this study, participants appear to have an understanding of a symbolic framework that defined and developed their meaning and way of being in the simulated environment according to their habitus and experience. This meaning-making resulted in actions based on institutional norms and were about the management of perceived competence within the laboratory. The perception of competence became currency and a symbolic economic exchange.

Despite simulation being embedded in the nursing education curriculum, the efficacy of simulation is under-researched (Lapkin & Levett-Jones, 2011; Cant & Cooper, 2010). It remains unclear if the actual learning that takes place during simulation is intended or otherwise. The concept of a hidden curriculum is '... defined as the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school' (Zhang and Luo, 2016, p. 218). The function of the hidden curriculum is to socialise students into professional behaviours and practice.

A number of researchers have encouraged the adoption of uniforms as mandatory in simulated learning and teaching environments (Hope, Garside & Prescott, 2011). In this study, student participants identified that when they wore a uniform they were encouraged to behave as professional nurses.

The described relationship between the clinical field, theoretical knowledge, and simulation reveal that the 'field' of the simulated hospital laboratory was an essential space of socialisation for student nurses. The socialisation nurses receive in particular educational environments such as simulated learning spaces and in the professional setting of clinical practice resulted in a shared understanding of ways of thinking, acting, and being a nurse. This study further highlights the complex struggles between structural and agentic dynamics in the creation of 'good' nursing practice and professional identity (Maranon & Pera, 2015).

Conclusion and recommendations

Episodes of VHA occurred in the learning and teaching environment of the simulated hospital laboratory. Acts were perpetrated by students towards other students and towards academics, while episodes were also observed by academics towards students and academics towards other academics. Episodes of VHA observed in this study align with the reports of incivility in clinical practice. It is suggested that the learning and teaching which

occurred in the simulated hospital laboratory went beyond the prescribed learning outcomes and mimicked the 'good' and 'bad' of clinical practice.

A key aspect yet to be fully explored relates to what is actually learned within simulation. Rather than assuming that learning objectives are the only skills students develop, an investigation into the unintended learning effects that occur in simulated realities would provide valuable insight to the field of VHA in nursing. Amongst the many lessons this study provides for readers and for the field of nursing is the importance of raising awareness for appropriate and professional behaviour within the workforce. Additionally, this study sheds light on considering personal, group, and professional behaviours and their relationship to VHA.

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Submitted

7.3 Summary of the Results

Themes from the simulation laboratory data were framed by the topic domains of the physical, social and organisational spaces of the simulated laboratory.

Table 7.1

Summary of findings

Significant findings	
Physical	<p>The two distinct learning spaces made students vulnerable to possible episodes of VHA.</p> <p>The design was based on industry recommendations.</p>
Social	<p>Students who were perceived as different were grouped together.</p> <p>The social structure within the cohort MAS made up the dominant culture, followed by SFS and then the perceived minority students.</p> <p>Students who had perceived tacit knowledge were permitted to enact behaviours deemed as acts of VHA.</p>
Organisational	<p>The curriculum legitimised the dominant culture of the students who had prior learning.</p> <p>The academic staff contributed to enabling acts of VHA among students and academics by role modelling VHA behaviours.</p> <p>The organisation did not support sound learning and teaching practices in simulation, which resulted in frustration and unmet expectations by the participants, which led to episodes of VHA.</p>

Further work in this field is required to build more evidence to support suggested reforms. However, fundamentally, these findings suggest that there is a need for educational and healthcare providers to:

- recognise the way violence is embedded in the undergraduate nursing curriculum and develop strategies to mitigate against normalising VHA behaviours
- appreciate the extent of institutional isomorphism in the healthcare and higher education systems

- re-evaluate the value of skill acquisition over the other forms of learning in simulation
- reconsider the skills required to be an RN in contemporary Australian healthcare networks.

7.4 Recommendations

Recommendations arising from this research apply to student nurses, nurse academics, universities and healthcare industries seeking to construct an inclusive learning, teaching and working space that is free from episodes of VHA.

The recommendations contribute insight into opportunities for change in the way groups are established and distinguished, with an emphasis on the power of the collective for social transformation. Further, it emphasises that habitus is fluid and not fixed and therefore, it is amenable to intervention.

7.4.1 Education

In times of neoliberal, managerialism hegemony over education and health policies, less socio-dominant forms of knowledge suffer from institutional marginalisation and they are disregarded at the curricular level. The types of embodied intercultural capital universities recognise as legitimate matters and a limited view of ‘knowledge’ undermines the value of people and as this study has shown, enables VHA.

In order to break the cycle of VHA, there is a need to develop a model of teaching in the simulated hospital environment that creates a social order and empowerment of students that supports graduates in being agents for change. As deficiencies in shared understanding by academics and students which may arise from curriculum disharmony and coherent pedagogy may enable episodes of VHA.

To counter such forms of VHA and to create learning environments that value a wide range of social capital and habitus, a curriculum needs to enable and

value the reflexivity and diverse habitus that is brought to the classroom. Habitus is not static and nor is the value of the capital within the field.

Habitus does not mean ‘fate’, as some people believe. As the product of history, habitus is an open system of dispositions that is constantly subjected to experiences and therefore, is constantly affected by them in a way that either reinforces or modifies its structures. It is durable but not eternal (Bourdieu & Wacquant, 1992, p. 133). By exposing the historically created naturalised state of the social laws governing a field, a researcher can provide an opportunity to render these laws vulnerable to change. Change can arise through exchanges between individuals in contested fields, which allows for transformation and renegotiation, both tacit and legitimised.

However, this kind of meaning and knowledge is accessible only through conscious reflexive investigations or unintended discovery, both of which are mediated by the individual’s habitus and can be substantially enabled or constrained by the fields of formal education and the broader sociocultural environment (Pollmann, 2016).

Fundamental processes such as debriefing are essential to the simulated practice experience (Levett-Jones & Lapkin, 2014). As discussed in Chapter 6, debriefing encourages situational awareness, creating a greater focus on the outcomes of practice, rather than the reproduction of the dominant practices. This would benefit both the student who is learning the ways of an RN and the academic who is learning the ways of simulation education. It is important for academics to receive feedback from other facilitators, as well as students or learners, when possible (Levett-Jones & Lapkin, 2014).

Teaching academics how to teach authentically in simulated hospital environments has not been a focus of nurse education, which may unwittingly be

enabling VHA to be normalised. Academics must keep informed about the current literature and research in the area of simulation and receive training in the various processes of simulation. In addition, they need to practise their skills (Alinier, 2014).

7.4.2 Research

To address the vagueness of the terms associated with unwanted workplace behaviour, researchers must clarify the behaviours they are studying, describing both what the behaviour is and what it is not. The concepts need to be consolidated and they need to provide specific examples. Otherwise, it is difficult to create broad agreement on what constitutes unwanted workplace behaviour and what researchers mean when they refer to unwanted workplace behaviours. The term VHA conceptualises both the dimensional nature of power and the type of unwanted behaviour; therefore, VHA should be considered an appropriate term.

The broad and often ambiguous character of workplace codes and standards make it difficult to decipher the institutional vision. Currently, the lack of consensus around the concepts positioned in codes of conduct, ethics and practice means they are difficult to enact and impossible to police and enforce. It might be possible for researchers to clarify understandings of institutional codes. Work is needed to ‘zoom in’ and apply a sharper lens to codes that govern professional practice. More clarification, discussion, examples and references in the implementation of policies and codes that govern workplace behaviours are required.

Rather than researchers increasingly narrowing the research gap within the literature, problematising assumptions could be considered. This means calling into question core assumptions around VHA, such as institutional myths (e.g. nurses are an oppressed group) (Duffy, 1995; Embree, 2010; Glass, 1997; Lewis, 2006; Randle, 2003; Rodwell & Demir, 2012). Researchers could investigate the way people relate to pressures around conformity and social groupings and the legitimised or perceived

authority. Lareau (2003) pointed out that the existing research on cultural capital has not paid sufficient attention to the difference between the possession of capital and the activation of capital. Further research on social and cultural capital would benefit from examining the links between power, class and pedagogical action as social and cultural capital, functioning from a perspective that privileges the dominant classes.

A wealth of research questions arose from this study which are begging for answers. Unanswered questions such as *Can the hierarchical world of nursing be altered by the development of a new social narrative?* And ‘*In this study, academic participants were not specifically trained in simulation education. Did this lack of training and understanding with regard to simulation contribute to the episodes of VHA observed in the laboratory?*’ indicate a need for further investigation into the cultural challenges beleaguering nursing education.

7.4.3 Profession

In the Australian health workforce, nurses are the largest occupational group (Cope, Jones, & Hendricks, 2016). However, as previously established, nurses are leaving the profession and by 2025, it is predicted that Australia will experience a nurse shortage of 85,000 (AFHW, 2014). The adverse effects of bureaucratic top-down decision making and VHA have been identified as reasons for nurses leaving the profession. According to Nairn (2019),

healthcare systems are having to cope with a social world increasingly dominated by market fundamentalism, extreme levels of inequality and a rise in xenophobia. These forces are undermining the provision of ethically sound health care, misdirecting research practice and contributing to a discourse of dehumanization. These forces need to be challenged. (p. 1)

Further, it may be argued that the predominant view that has shaped nurses’ thinking is influenced by their social world, which includes acting marginalised,

oppressed and dominated within the profession, with acts of VHA reinforcing feelings of inadequacy and powerlessness (Cope et al 2016). Nurses do not need to read any more ‘sad stories’ of disempowerment (Cope et al 2016). What is needed is to adopt a transformative or emancipatory goal. A reframing of the nurse’s narrative needs to begin, a twist of the kaleidoscope to alter the image (Darbyshire, 2010), focusing on the positives and successes in the workplace.

7.4.4 Practice

This study revealed that practices emerge from cultural expectations driven by inter- and intra-organisational factors. These factors are derived from both the higher education and healthcare systems.

The isomorphism of the healthcare and higher education systems influences practice in both sectors. Isomorphism, as previously described in Chapter 5, is the process of institutional homogenisation, which ‘results from both formal and informal pressures exerted on organizations by other organizations upon which they are dependent and by cultural expectations in the society within which organizations function’ (DiMaggio & Powell, 1983, p. 150). Research findings have shown that the driving force behind isomorphism is the legitimisation that an institutional regulation finds within an organisational field. An example is the introduction of zero-tolerance strategies implemented to reduce the incidence of VHA in the healthcare system, even though no causal relationship between these policies and the reduction of VHA has been established.

However, the described relationships among the clinical field, theoretical knowledge and simulation have revealed that the ‘field’ is an essential space of socialisation for nurses. The socialisation that nurses receive in the particular educational environment of nursing, and continuing in the professional setting of clinical practice, can lead to a shared understanding for ways of thinking, acting and

being a nurse. Theoretically, the current study highlights the complex conflicts between structural and agentic dynamics in the construction of ‘good’ nursing practice and professional identity (Maranon & Pera, 2015).

7.5 Limitations

Caution should be exercised when making generalisations from this investigation to other more extensive settings, as this research was limited to one site in regional NSW, with a target group of second-year students from one campus. The site under investigation was influenced by the academics and student participant’s conceptualisation of VHA, individual actions and responses to learning and teaching in a simulated environment and the wider system relations between the higher education and healthcare structures. Therefore, future research that adopts this approach will need to consider the specific context of the research site.

Another limitation is concerned with researcher bias. Although several actions were taken to ensure the trustworthiness of the data (see Chapter 3), there were a number of avenues through which bias may have skewed the outcomes of this study. The first avenue was that the observations were conducted in my place of work; this had the potential to impact on the academic and the student participant’s responses. They may have changed their practices to comply with perceived ideas of what I may have wanted to see. The second avenue concerned power differentials. When adopting a critical paradigm, the researcher must endeavour to maintain equal power relationships with the participants. Even though measures were taken in this study to reduce the power differences between the participants and the researcher, I was an academic conducting research in my place of work and the power differentials were real, for both student and academic participants.

Another possible limitation of the study was that the interviews were conducted on the university grounds. Even though the consent form stated the

interviews would be conducted at a location convenient to participant and interviewer, all interview participants opted to be interviewed on university grounds. The participants may have given different answers had they been interviewed outside the organisation.

A methodological limitation was the use of an interview protocol. The interview schedule, although a recommendation of Carspecken's research design, allowed me to ask preconceived questions based on my assumptions, experience and familiarity with the literature.

Despite adopting a critical paradigm that aimed to elicit social change, this study did not observe the social change it had intended to observe; however, that is not to say that it did not occur. Moments of realisation and reflexivity occurred among the participants during Stage 3, the collection of dialogical data. Despite a number of 'light bulb' moments for participants when they recognised they could have been perpetrators of VHA, a limitation of this study was the recommended cyclic design of Stages 1, 2 and 3 (Carspecken 1996) which were repeated only once. Consequently, any form of social change that may have occurred was not observed.

Observations were also limited to the interaction between participants and a manikin, as this was the only type of simulation which was utilised during the observation period. It is anticipated, however, a patient actor would have added a different dynamic and therefore produced different learning and teaching practices and behaviours.

7.5.1 Limitations of Bourdieu

Some of the difficulties associated with using Bourdieu's framework to understand the findings included difficulties in reading his written work. His sentences are rarely short and to the point. He uses long sentences, embedding phrases in one another, with multiple commas and semicolons and very few full

stops. Bourdieu discards a correlational analysis for a systematic approach, while his theoretical stance is abstract and his methods ambiguous enough to generate more questions than answers. He uses contradiction as his style of argument. DiMaggio (1979) wrote, 'In the original, Bourdieu presents an almost insurmountable challenge even to readers who find French empirical work relatively easy-going' (p. 1466). This makes new readers of Bourdieu turn to translators such as Richard Nice (1990) and Haker et al. (1990); however, Nice's (1990) translation has been viewed as so authentic to Bourdieu that he, too, is a challenge.

In spite of the difficulties, I posit that the theoretical perspective of Bourdieu can serve to broaden the understanding of VHA in nursing, especially for nursing students learning within a simulated environment. For example, Bourdieu's social practice theory can identify, at an individual level, the capital and habitus of each participant, as well as what they bring to the field of the laboratory. The habitus and capital of each participant can predict the position the participant takes in the field and this position can reflect the actual or perceived power the participant has. By exposing the social injustices on the individual level, it is possible to identify the injustices of the broader social structures of the field.

In this study, further developing the social trajectories of Bourdieu's social practice theory has provided a tool for exploring episodes of VHA among second-year undergraduate nursing students, contributing to an enhanced understanding of the contribution the physical, social and organisational environments make to episodes of VHA.

7.6 Concluding Statement

To secure the future of the nursing profession, we need to prioritise the values of communities of learning, transparency, honesty and the safety of self and others; we need to welcome doubt over the values of being right and feeling righteous. Even

though these democratic values are harder to achieve and maintain amidst the constant noise of a managerial world, we must accept responsibility for this work and nurture these values.

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Appendices

Appendix A: Ethical Approval



OFFICE OF ACADEMIC GOVERNANCE

Private Mail Bag 29
Panorama Avenue
Bathurst NSW 2795
Australia
Tel: +61 2 6338 4185
Fax: +61 2 6338 4194

4 June 2015

Ms Krishna Lambert
25 Lindsay Street
WAGGA WAGGA NSW 2650

Dear Ms Lambert,

The Charles Sturt University (CSU) Human Research Ethics Committee (HREC) operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans*.

The HREC has reviewed your report requesting a variation for your research project "*An exploration of student nurses' social and material interactions in a clinical simulation laboratory a critical ethnographic study*", protocol number 2014/018 and I am pleased to advise that this request for a variation meets the requirements of the *National Statement*; and variation for this research is granted for a twelve month period from 4 June 2015.

Please note the following conditions of approval:

- all Consent Forms and Information Sheets are to be printed on Charles Sturt University letterhead. Students should liaise with their Supervisor to arrange to have these documents printed;
- you must notify the Committee immediately in writing should your research differ in any way from that proposed. Forms are available at http://www.csu.edu.au/_data/assets/word_doc/0012/963768/Report-on-Research-Project_20130503.doc
- you must notify the Committee immediately if any serious and or unexpected adverse events or outcomes occur associated with your research, that might affect the participants and therefore ethical acceptability of the project. An Adverse Incident form is available from the website: as above;
- amendments to the research design must be reviewed and approved by the Human Research Ethics Committee before commencement. Forms are available at the website above;
- if an extension of the approval period is required, a request must be submitted to the Human Research Ethics Committee. Forms are available at the website above;
- you are required to complete a Progress Report form, which can be downloaded as above, by 15 April 2016 if your research has not been completed by that date;

Variation.doc

Last updated: March 2015
Next review: March 2016

www.csu.edu.au

CRICOS Provider Numbers for Charles Sturt University are 00005F (NSW), 01947G (VIC) and 02960B (ACT). ABN: 83 878 708 551

- you are required to submit a final report, the form is available from the website above.

You are reminded that an approval letter from the CSU HREC constitutes **ethical approval only**.

If your research involves the use of radiation, biological materials or chemicals separate approval is required from the appropriate University Committee.

Please don't hesitate to contact the Executive Officer: telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries about this matter.

Yours sincerely,

Julie Hicks
Executive Officer
Human Research Ethics Committee
Direct Telephone: (02) 6338 4628
Email: ethics@csu.edu.au

Cc: Dr Maree Bernoth Dr John Harper

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007)

Appendix B: Participant Information Sheet



School of Nursing, Midwifery and Indigenous Health

PARTICIPANT INFORMATION SHEET

“An exploration of student nurses’ social and material interactions in a clinical simulation laboratory: a critical ethnographic study”.

Researcher

Krishna Lambert RN MN*crit care* PhD candidate (CSU)

krlambert@csu.edu.au

Mobile: 0413024931

Supervisors

- Dr Maree Bernoth Senior Lecture School of Nursing Midwifery and Indigenous Health, CSU
mabernoth@csu.edu.au
- Dr John Harper Senior Lecturer School of Agriculture and Wine Sciences, CSU
jharper@csu.edu.au

Invitation

You are invited to participate in a research study on how the organisational, cultural and physical environments nurses work within impact on relations and exchanges in the workplace.

The study is being conducted by Krishna Lambert from School of Nursing, Midwifery and Indigenous Health at the Charles Sturt University as part of her PhD thesis.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being undertaken and what it will involve.

Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of this study?

The aim of this study is to gain a greater understanding of how the physical, social and organisational environments nurses work in impact on the interactions and relationships which develop in nursing. Research has shown student nurses and nurses’ exit the profession as a result of negative interactions within the workplace.

Nursing workforce shortages are predicted to continue. This project may inform policy and practice to address this problem.

2. Why have you been invited to participate in this study?

I am seeking second-year student nurses and second-year clinical academics who participate in clinical simulation practical laboratory classes to share their experiences working and learning in the clinical environment. If you are not a second-year nursing student or academic and you do not participate in clinical simulation laboratory classes then unfortunately you are not eligible to participate.

3. What does this study involve?

The study will include observations of student nurses and academic staff working within the simulated clinical simulation laboratory combined with individual interviews. These observations will take place over a minimum of one (1) session 12 weeks to a maximum of two (2) sessions 24 weeks. The observations will be focussed on the interaction between students and their environment and NOT nursing practice or skill development. However, in the event a dangerous practice is observed I am obliged as a mandated health professional, to comply with the national guidelines of the ANMAC code of conduct and code of ethics and report any violation of the code via the incident management system used at the facility. If you agree to participate, you may be asked to take part in an interview to discuss your experiences in the laboratory. Individual interviews will be arranged following receipt of the completed consent form. I will meet with the participants outside of the university at an agreeable time and place. Telephone interviews can be arranged if required. During the interviews I will be using a digital recorder to record the conversations. It is envisaged the interviews will take approximately 1 hour. The students and academics should also be aware they are under no obligation to answer questions.

Participants in the project will be provided with opportunities to ask questions and to seek further information before, during and at the completion of the interview and observation sessions. The interviews will be audio digitally recorded. Some participants may find talking about their experiences distressing and a referral to counselling services will be offered. The counselling services will be provided by the counselling service at CSU who can be contacted via this link

<http://student.csu.edu.au/study/appointments>

After your interview I will transcribe the audio recording. All identifying information including your name will be changed and a pseudonym used in the written transcript to protect your anonymity. The audio recording will be locked in my office filing cabinet at Charles Sturt University during the project and on completion the recordings will be destroyed at the end of 5 years.

Please be assured you are under no obligation to participate in the project. You may withdraw from the project at any time. You also have the option of participating in

observations only or just the interview, one or both of the components of the project. You can opt to participate in the interview only or observation only or both.

4. Are there risks and benefits to me in taking part in this study?

The most important benefit to you is that you will have the opportunity to reflect on the interactions which take place in the clinical laboratory and offer some insights into what is good and what needs improvement and what can be taken into clinical practice that could potentially inform policy, practice and knowledge base.

As a participant in research you will comply with the ANMAC competency standards. Risks associated with participating in this project may include feelings of discomfort or distress. At which time a counsellor would be arranged for the participant at no cost to the participant.

5. How is this study being paid for?

This study is supported by Charles Sturt University, School of Nursing Midwifery and Indigenous Health in the form of study leave, computer and library access. No financial reward is being made to the researcher or the participants.

6. Will taking part in this study (or travelling to) cost me anything, and will I be paid?

There is no payment or reward associated with you participating in this project.

7. What if I don't want to take part in this study?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you chose to participate, is your decision and will not disadvantage you either way.

8. What if I participate and want to withdraw later?

If you do decide to participate, you may withdraw from the project at any time without giving a reason. Participants who withdraw have the option of withdrawing their data; however where the data are de-identified this may not be possible.

9. How will my confidentiality be protected?

All information collected by the researcher will be stored securely and only accessed by the researcher unless you consent otherwise, except as required by law; however, it will not be possible to identify you from your answers.

Data will be retained for at least 5 years locked in my office filing cabinet at Charles Sturt University.

10. What will happen to the information that I give you?

If you decide to participate in this research project, the information gained from the observations and your interview will contribute to the body of knowledge surrounding the impact the environment has on the development of relationships and interactions in nursing. This information will be used and presented in a way which protects your

confidentiality and anonymity. Individual participants will not be identified in any reports arising from the project.

The information will be used in the thesis to be submitted by Krishna Lambert as part of the requirements for the Doctoral degree. The research results may be published in scientific journals and presented at nursing conferences.

11. What should I do if I want to discuss this study further before I decide?

If you would like further information please contact Krishna Lambert via email krlambert@csu.edu.au or call (02) 6933 2547

12. 'Who should I contact if I have concerns about the conduct of this study?'

NOTE: Charles Sturt University's Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Tel: (02) 6338 4628
Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

This information sheet is for you to keep

Appendix C: Participant Consent form



School of Nursing, Midwifery and Indigenous Health

Consent Form

“An exploration of student nurses’ social and material interactions in a clinical simulation laboratory: a critical ethnographic study”.

Researcher

Krishna Lambert RN MN*crit care* PhD candidate (CSU)

krlambert@csu.edu.au

Mobile: 04

Supervisors

- Dr Maree Bernoth Senior Lecture School of Nursing Midwifery and Indigenous Health, CSU
mabernoth@csu.edu.au
- Dr John Harper Senior Lecturer School of Agriculture and Wine Sciences, CSU
jharper@csu.edu.au (Please tick)

1. I agree to participate in the above research project and give my consent freely. ☐ ☐

2. I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained. ☐ ☐

3. I understand I can withdraw from the project at any time without repercussions and do not have to give any reason for withdrawing. ☐ ☐

I consent to (please circle);

☐ participate in observations to be made in the simulation laboratory Yes/No

☐ participate in individual interviews Yes/No

I do/do not (please circle) request a copy of the study results.

I have had the opportunity to have questions answered to my satisfaction.

Print

Name.....

....

Mobile:.....Email:.....

Signature:.....Date:.....

.....

Appendix D: Observation Schedule

The observation schedule follows the Carspecken's (1996) method of 'priority observation'. This requires the researcher to focus on one person in the setting and record everything that person does as a first priority. The second priority is to document everything other people say in interaction with this person and the third priority is other things that may be going on in the space. This process should take around five minutes before the focus is shifted to another person. As recommended by Carspecken, each observation session lasted no longer than two hours and the observations were conducted at different times of the day. This continued until saturation occurred and the same routines were being observed (Carspecken, 1996, p. 49).

Participant Observation and Clinical Simulation Laboratory Classes to be Observed

1. Clinical laboratory, layout

Lighting, heating, washbasins, nurses' station, clinical room, utility room, patient space, internal furniture such as chairs, bedside tables and patient modesty curtains, drug cupboard, corridors and doorways.

2. Equipment

Manikins, stethoscopes, IV pumps, paper work, procedures, documentation, hand sanitiser, fob watch, pens, Schedule 4 and Schedule 8 drug book, the use of uniforms.

3. Social interactions

Greetings, tones of voice, body language and posturing, topic of conversations, social groupings, how students arrive and depart from the clinical space, who they arrive and leave with, what are they saying and how they are saying it?

Appendix E: Interview Schedule

The interview protocol follows Carspecken's (1996) recommendations for conducting qualitative interviews. Four items make up the interview protocol. Carspecken recommends the use of pre-defined topic domains (2–5 domains), one lead-off question for each domain, a list of covert categories for each domain and a set of follow-up questions.

Topic Domain: Baseline understanding

Lead-off question:

1. What is your understanding of vertical and horizontal abuse?

Covert categories: Participant's perception of vertical and horizontal abuse; are they a victim or perpetrator of vertical and horizontal abuse; are they aware of what constitutes an episode of vertical and horizontal violence?

Possible follow-up questions: What types of things do your peers do that might be considered vertical or horizontal abuse?

Topic Domain: Social-Psychological Issues

Lead-off question:

1. Have you experienced an episode of vertical or horizontal abuse? If you have, can you describe it?

Covert categories: Does the participant understand the subtle acts of vertical and horizontal abuse; is the participant aware of the symbolic tools of violence available within the laboratory; what is the social capital of the participant?

Possible follow-up questions: Have you ever felt left out of group work? If so, can you describe the situation? Have you ever seen your peers roll their eyes or giggle at someone else?

Topic Domain: Organisational Issues

Descriptive question:

1. Here is a diagram of the clinical simulation laboratory with the beds, manikins and bedside tables. Can you take me on a tour of the space and describe a typical session in the laboratory?

Covert categories: Does the participant align non-clinical spaces, such as corridors and handwashing basins, as areas for social engagement; do they suggest the academic takes a powerful position in the laboratory?

Possible follow-up questions: Can you point to the areas of the laboratory that you would consider to be less educational and say why? Can you point to an area of the laboratory that you do not feel comfortable in? Can you identify a space in the laboratory that you would consider 'non-learning'?

Topic Domain: Power and resistance issues

1. Do you wear a uniform to the clinical laboratory classes? Why/why not?

Covert categories: Is the wearing of uniforms or the lack of wearing uniforms a symbolic sign of resisting domestication or conforming? By not wearing a uniform, do you feel powerful? Does wearing a uniform make you feel authentic and validated or authoritative?

Possible follow-up questions: Do you think uniforms should be made compulsory in the clinical laboratory classes? Why/why not?

Vox pop Interview Protocol

1. Concrete questions on an observed event that the participant took part in.
Uniforms

Appendix F: Summary of Interviews with Key Informants

Interviewee	Role	Comments on interview
Ann	Full-time academic, 2 years experience. Internal cohort lecturer. Sharing teaching time with Academic B. Session 1	My first interview. I was interested in interviewing an academic, as I had found that the academic constructs the space within the laboratory. It was a little disappointing, as the interviewee had attended an HRD symposium that I presented at and I found that she repeated the themes I had presented. Digitally recorded: 16 min 02 sec
<p>Key points from the interview:</p> <ul style="list-style-type: none"> • Perspective of a full-time academic. • Active attempts at reducing power imbalances. • Importance of making the learning experience as 'real' as possible. • Active processes are used to establish professionalism within the simulated environment. 		
Betty	Full-time academic, 6 years experience. Internal cohort lecturer sharing teaching time with Academic A. Session 1	A purposeful approach to constructing a relaxed environment because of the length of time of the labs (3 hours). Need to be comfortable. Understood vertical abuse to include student-to-academic and vice versa. Digitally recorded: 15min 14 sec
<p>Key points from the interview:</p> <ul style="list-style-type: none"> • Construction of space, very relaxed. A purposeful approach to constructing a relaxed environment because of the length of time of the labs (3 hours). Need to be comfortable. • Understood vertical abuse to include student-to-academic and vice versa. • Uniforms identify students, as nurses identify them as 'smart'. • Forgot the researcher was in the space. 		
Cathy	Casual academic, limited academic experience, a current practising clinician. Session 2	Very important interview. Pivotal in demonstrating the power of being and how the process can be instrumental in propagating VHA.

		Digitally recorded: 17min 38 sec
<p>Key points from interview</p> <ul style="list-style-type: none"> • Role differentiation—insider/outsider status of researcher. • The interviewee described the lived experience of VHA. • This interview gave the interviewee the opportunity to reflect on her own practice. • Differences between students—e.g. MAS or students with prior learning have a greater sense of confidence. • Felt self-conscious having the researcher in the space. 		
Albert	Second-year undergraduate nursing student, mature-aged female	Digitally recorded: 1 hr 04sec
<p>Key points from interview:</p> <ul style="list-style-type: none"> • Very vocal. Leader. Competitive nature of getting into graduate programs. Rural versus metropolitan—rural hospitals are more ‘cliquey’; metropolitan hospital staff are more approachable and easy-going. • MAS versus SFS. 		
Beatrice	Second-year undergraduate nursing student, female	Digitally recorded: 1 hr 04sec
<p>Key points from interview:</p> <ul style="list-style-type: none"> • Eye rolling. 		
Carol	Second-year undergraduate nursing student, mature-age female	Digitally recorded: 1 hr 04sec
<p>Key points from interview:</p> <ul style="list-style-type: none"> • Episodes of VHA works both ways, not identified as age related. 		
Danielle	Second-year undergraduate nursing student, mature-age female	Digitally recorded: 1 hr 04sec

Key points from interview:

- Splitting from other discipline changed the way students behaved.

Elizabeth

Second-year
undergraduate nursing
student, mature-age
male

Recording failed—too much
background noise
Approx. 15-min interview

Key points from interview

- Unaware of episodes of VHA, even though I had noted several episodes during my observations.
- He had a shared understanding of what VHA was and was able to give examples of types of abuse.
- Student was different socially but obtained social capital.
- Targeted by academics and peers in different ways, but with the same outcome.

Appendix G: Recruitment Flyer



WANTED SECOND YEAR NURSING STUDENTS!

School of Nursing, Midwifery and Indigenous Health



Let me introduce myself:

My name is Krishna Lambert and I am a nursing lecturer at Charles Sturt University
and a Doctor of Philosophy (PhD) candidate.

I am doing research into the interactions between student nurses and the clinical
laboratories.

If you are a 2nd year student nurse, and you participate in clinical laboratory classes.
I need YOU!

If you are interested and would like to receive an information pack please contact me
via email

klambert@csu.edu.au