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Coercion and the Corruption of Care in Mental Health Nursing: Lessons from a Case Study

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The study of workplace deviance and wrongdoing, particularly workplace bullying, has captured the attention of clinicians and researchers in the nursing field in recent years (Cleary, Hunt, Walter, & Robertson, 2009; Cleary, Hunt, & Horsfall, 2010; Hutchinson, Vickers, Wilkes, & Jackson, 2009; Jackson, Peters et al., 2010; Vessey, DeMarco, & DiFazio, 2011). A limitation of this body of work is that it has primarily focused upon the emotional consequences of the behaviour for nurses and the effect on recruitment and retention (Simons & Mawn, 2010; Spence Laschinger, Grau, Finegan, & Wilk, 2010; Yildirim, 2009). Very few studies have specifically examined how bullying or other forms of wrongdoing can erode work group dynamics and lead to unethical behaviours that may impact upon care delivery or harm those in the care of nurses (Jackson & Raftos, 1997). Similarly, little is known about whether, and how often, nurses may in certain circumstances intentionally engage in behaviours and practices that risk harm to patients or hamper care. Little is understood, too, about how nurses who witness or learn of these behaviours may eventually come to accept wrongdoing, or even go a step further and engage in the behaviour themselves.

Given that a large number of nurses experience or witness bullying and other forms of counterproductive behaviours in their work teams (Cleary, Walter, Andrew, & Jackson, in press; Jackson, Peters et al., 2010), the likely flow-on effect of these behaviours in relation to patient care warrants attention. In this column, we analyse a case study of coercive bullying that involved

nurses within a mental health unit and identify the corrupting impact of this behaviour upon patient care. For the patient affected, his family, and the staff implicated, the chain of events had devastating consequences.

BACKGROUND

For a number of decades, the examination of counterproductive, unethical, or socially unacceptable workplace behaviours has been studied by organisational researchers, particularly those seeking to understand deviance within and against the organisation (i.e., theft, sabotage, corruption) (Coleman & Ramos, 1998; Potter, 2004). Purposeful bullying, aggression, and wrongdoing that violate significant professional or organisational norms have been examined in a number of disciplines, including the police force, financial services, white collar workers, and nursing (Gordon, Kornberger, & Clegg, 2009; Huggins & Haritos-Fatouros, 1998; Jackson, Peters et al., 2010; Potter, 2004). It is widely recognised that, under certain situational pressures, many individuals may knowingly violate their own ethical standards and engage in behaviour they would otherwise deem unacceptable. As a consequence of violating their personal belief systems, these individuals may then become distressed (Hirigoyen, Moore, & Marx, 2000), self-punitive, disengaged, or withdrawn (Hutchinson, Wilkes, Jackson, & Vickers, 2010).

Even if not directly involved, people who witness or know about wrongdoing or unethical acts can, nevertheless, be harmed through their distress for the victim, personal fear of punitive retribution because of their insider knowledge, or concern that they will be entrapped or coerced to participate further in

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the behaviour in some way (Jackson, Hutchinson et al., 2010; Jackson, Peters et al., 2010). In the face of being powerless to prevent wrongdoing, individuals can suffer trauma that leads to anxiety and depression (Peters et al., 2011). Importantly, through their connection to the harmed individual and their desire to protect, family and friends also can become traumatised and experience despair, anger, and pain (Giacalone & Promislo, 2010; Wilkes et al., 2011).

Although this body of work provides useful insight, much of it originated from the organisational management or organisational psychology literature. As a result, the focus of understanding counterproductive work behaviours has largely been organisation-centred, with organisational outcomes and financial concerns used to justify the need to understand such behaviours. Importantly, in the human service context a more human-centred approach is warranted, with attention directed towards understanding the impact of bullying and counterproductive behaviour on care recipients. We suggest it is also important in human service organisations to understand how wrongdoing or unethical behaviour is reproduced within work teams. Accordingly, in the case we present, we highlight the corrosive effect that bullying and coercive behaviours can have in nursing teams, and the impact upon team dynamics, leadership, care delivery, and the well-being of others, including patients, caught up in the behaviour.

CASE SUMMARY AND FINDINGS

In 2011, following complaints in relation to the care of a psychiatric patient (Patient X), an Australian nurse regulatory tribunal made a decision concerning the professional misconduct of two nurses (Nurse A and Nurse B). Transcripts from the inquiry are publicly available and include statements from colleagues, hospital management, treating doctors, the patient's family, and excerpts from the patient's diary. These transcripts reveal a pre-occupation with controlling the patient, rather than care; the degrading of nursing practices; the separation of ethics from action; the apparent lack of individual concern for the patient's suffering; and the eventual callous disregard for the patient as a person. The transcripts detail the evolution of a coercive moral vacuum of wrongdoing that ruined nursing care, replacing it with punishment and mistreatment. To protect anonymity of those involved, some details of the subjects (such as gender) have been altered (Minichiello, Aroni, Timewell, & Alexander, 1995).

COERCION AND THE CORRUPTION OF NURSING CARE

The narratives of nurses and experiences of family members and the patient were shaped by the dominance of language and imagery that characterised the patient as deficient and troublesome. Enacted openly within the nursing team and under the lead of a senior nurse, the language and actions of certain nurses became a coercive force—marginalising the patient, devaluing

his agency and worth, labelling him as troublesome—while influencing others towards wrongdoing.

Influencing Others: Attack upon Individual Agency and Worth

Documents assert that Nurse A on a number of occasions stood outside Patient X's room during handover (in earshot of Patient X) and spoke loudly to the group of nursing staff:

Patient X should not be on painkillers, he says that he is in pain to get drugs ... he is a danger to others ... [and is] so horrible even his mother doesn't love him. (Nurse testimony)

On others occasions during handover, again in earshot of the patient, Nurse A spoke about her experience of finding Patient X following his recent attempted suicide and expressed her opinions about the validity of his illness. A nurse recounted Nurse A as saying:

Patient X was "red and not breathing" ... he wasn't really suicidal; ... he is just an attention seeker. If he was serious, he would not have pressed the [emergency] button [to call for help after attempting suicide] ... he was attention seeking and we were not to give him attention. (Nurse testimony)

The public and deliberate nature of the nurse's demeaning statements about Patient X was underlined in the nurse's response to concerns raised by other nurses that Patient X had heard the comments:

[Nurse A said], "Of course I know, he was meant to hear it, I'll say it again!" (Nurse testimony)

These public incidents involved the larger nursing team, were repeated openly, and succeeded in persecuting the patient, positioning the patient (for the nursing team) as difficult and somehow deficient, and making other team members out to be condoning or participating in the behaviour. Available and perceived support was thereby removed from the patient, and Nurse A was elevated to the privileged position of "expert" or informal group leader. The panopticism of these practices ensured both the patient and nurses were constantly made aware of the regulation of their agency and their visibility to others.

The Corruption of Care to Torment and Isolate

Under the guise of therapeutic care, it was recounted that nursing practices were deliberately misused to torment Patient X. Testimony detailed that following his attempted suicide, Patient X was kept on hourly observations for a prolonged period and staff were given specific instructions by senior Nurse A:

Patient X was "not [to] be rewarded" for the behaviours that led him to being placed on hourly observations [i.e., his attempted suicide]; explicit instructions were given to a junior nurse that "having his own nurse was not to be a pleasant experience for him" [Patient X] and "we'll do his observations every hour ... just to annoy him." (Nurse testimony)

Patient X recorded in his diary:

Nurse A is back on tonight and stood outside my door telling my special that my attempt was pure attention seeking (otherwise why would I have pressed the bell?)... She stood outside my door telling my special this and more that I couldn't hear, but my special nodded in agreement, and I was feeling awful.

Narratives from the patient's diary and letter of complaint, the testimony of his family and treating medical officers, and nursing staff statements all detailed how the hourly observation continued for a prolonged period, deliberately depriving the patient of sleep, even though the treating medical officer had explicitly instructed that on-going observations were not necessary. These observations even continued following concerns being raised by the family that:

Patient X was not getting enough sleep and when he was trying to sleep, nursing staff would, in a punitive or persecutory way, come and perform observations that were unnecessary and disturbed his sleep. (Doctor recounting complaint of family members)

By deliberately segregating the patient from other nursing staff and instituting unwarranted and extended hourly observations, nursing interventions were altered to serve a punitive rather than therapeutic purpose.

Having allegedly tormented Patient X by denying him sleep and publicly and repeatedly undermining the credibility of his claims to illness, the mistreatment escalated to exclude him from contact with Nurse C, with whom he had formed a trusting therapeutic relationship. This nurse was said to "care too much," had "bucked the system several times, not just once," and was prohibited from any contact with Patient X. Furthermore, within earshot of Patient X, this nurse was discredited "as a liar," further removing any avenue of support for this patient.

The process that had labelled and demeaned the dignity and worth of the patient was alleged to escalate. Nurse A, upon discovering that Patient X had attempted self-harm, dealt with him in a manner described as "physically rough." The patient's diary recounted Nurse A telling him "he was behaving badly" and "had attempted suicide purely for attention." Nurse A was also recounted to say to Patient X words to the effect of, "You don't expect me to carry you" and "then laughed," leaving Patient X to attempt to "crawl back into bed" before [Nurse A began] dealing with him in "a physically rough manner to get him back to bed."

DISCUSSION

The events reported by nurses, Patient X, and his family depicted a moral vacuum that sustained inappropriate practices. In this case study, the moral vacuum that evolved in this work unit enabled nursing practices to be used punitively. Care processes were corrupted and misused, to seemingly become about a means of "breaking the will" or punishing the patient. Under the influence of a nurse who operated as a "ringleader," others in the team were influenced and themselves became functionar-

ies of corrupted care processes. Patient X was treated merely as a means to an end in reproducing control within the team (O'Mathu'na, 2010).

It is unlikely that these practices were enacted out of anger or sadism, or even necessarily a belief that they were the right thing to do. Furthermore, the behaviours had become tolerated or viewed as acceptable within the work team. The narratives highlight how surveillance can flow into spheres of practice that threaten the caring process. In the case presented, one key individual appeared to play a role in recruiting newcomers to these aberrant processes; reinforcing them as part of the "normal order of things" and punishing staff who resisted the practices.

In general, examination of the factors that enable or inhibit unethical behaviour has focused upon individual and situational factors. In the case study presented, nurses in the work team were reported to repeatedly engage in or condone the violation of ethical standards, with apparent disregard for justice and while making personal attacks upon the patient, restricting their interactions with and withholding access to support for the patient. When recurrent and tolerated, it is known that wrongdoing can create permissive climates that foster unethical conduct by subordinates (Ashforth & Anand, 2003). The reported culture of concealment in health care organisations and the tendency for managers to ignore or suppress criticism only further serves to reinforce the likelihood of this type of conduct (Davies, 2005). As the behaviours reported in the case study occurred within an institutional context, it is important to focus attention upon the influence of this context in enabling and supporting behaviours of this nature.

In various health care settings, particular patients can be perceived as difficult and they risk being treated with less respect because of failure to comply with implicit views about "proper" patient conduct (Koekkoek, Hutschemaekers, van Meijel, & Schene, 2011). It also is recognised that the label of "difficult" can be given to patients by nurses and reinforced through behaviours within work teams. It is known that patients with certain diagnoses are more likely to be viewed as "blameless," while those with a perceived degree of control over their illness or considered to have non-medical causes of their illness, are more likely to be labelled as "difficult" and treated with less respect, excluded from services, or subjected to neglect or passive treatment (Koekkoek et al., 2011). Violence and bullying against female patients has been found to occur when medical or nursing authority is threatened (Cleary et al., 2009; Cleary, Hunt, & Horsfall, 2010; Dietsch, Shackleton, Davies, McLeod, & Alston, 2010) and reports have been made of neglect and abuse of the elderly (MENCAP, 2007) and those with a disability (Michael, 2008). The patient in this case study represented a "difficult" case for staff and this, in turn, appeared to dictate various aspects of the treatment described.

For the inpatient, mental health institutions represent—for potentially lengthy periods of time—the totality of the patient's life. Such total institutions (Thompson, 2003), characterised by obedience to technical rules and with a monopoly over

individuals' daily existence, run the risk of distorting organisational routines and processes to the extent that they become corrupted by a form of logic that can result in these processes being used for wrongdoing (Adams & Balfour, 1988; Clegg, 2002).

In psychiatric settings, isolation and seclusion are employed in certain circumstances to protect the patient or those around them (Holmes, Kennedy, & Perron, 2004; Horsfall & Cleary, 2003). As isolation can potentially be used punitively, many countries regulate the use of seclusion rooms to protect against the risk of abuse. Patients' experiences of seclusion in mental health units have been reported to intensify their feelings of being less worthy, of being abandoned or rejected (Holmes et al., 2004). It is worth emphasising that isolation does not require the use of a seclusion room. In the case of Patient X, isolation was instituted through corrupting care practices. Critical analysis of the use of seclusion in mental health could usefully extend to include informal forms of exclusion that can emerge from the corruption of legitimate care processes, such as those reported here.

It is evident from this case study that nurses have the potential to be deviant, controlling, aggressive, and destructive. This is an uncomfortable truth that must not be ignored. Further, such behaviours can be associated with considerable risk for vulnerable patients and can lead to distress among colleagues who witness or are caught up in the behaviours. In drawing attention to a particularly disturbing incident of unethical nursing behaviour, we have focused upon an aspect of nursing practice that has received little scholarly attention. The case study presented here extends our understanding of instrumental and unethical behaviour within nursing teams, as well as the factors that may contribute to such behaviour and their consequences for patients, their family, and other care workers.

We recognise that most nurses make considerable effort to ensure the quality of the care they provide; even in adverse working conditions, most strive to promote safe and improved health outcomes, and we do not wish to detract from this work. At the same time, deliberately or unwittingly, no member of the profession is necessarily immune from changing to a more harmful mode of practice. In drawing attention to the corrupting impact of bullying and coercion on team dynamics and the delivery of nursing care, our desire is to encourage research and interventions to mitigate or prevent such unethical and socially irresponsible activities within nursing work teams. Such research, we suggest, will shed light on ways to focus attention to the problem and reduce unethical behaviour and minimise its detrimental consequences.

CONCLUSION

Behaviours we identify in this case study are largely unexamined in the extant nursing literature. In particular, we note that violations of patient dignity through humiliation, domination, and abuse have received sparse attention. Furthermore, little is

known about moral disengagement that can occur within health care teams, what contributes to such behaviour among nurses, and whether it is a rare or widespread phenomenon. Regardless of the motives underlying deviance or counterproductive behaviours, or whether it is an infrequent occurrence, when nursing practice is affected it should be of concern. Aside from its capacity to disrupt team processes, poor behaviour has a corrosive effect on the quality and safety of nursing care provided. Despite an array of research undertaken in other fields, little work has been done to understand deviant or counterproductive behaviours in which nurses may engage. This omission is significant as such deviance may have a corrupting impact on the workplace climate and, even more crucially, on care outcomes.

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