The anatomy of coercive practices in healthcare settings

Robert D Schweitzer, Cherie Sonnenburg, Rohani Mitchell

Background
In healthcare settings, there can be a fine distinction between genuine performance management and vexatious complaints occurring in the context of bullying. The most common manifestation of such behaviour involves repetitive interpersonal abusive behaviours within the context of a power hierarchy. These interactions might well be experienced as bullying behaviour; however, the interpersonal dynamics underpinning such behaviours remains largely unexplored.

Objective
This paper offers a psychological perspective on bullying and harassment and adopts a psychodynamic case study approach, utilising a case vignette involving a senior and junior doctor within a general practice context. Conflict can be mitigated by understanding the intra- and interpersonal dynamics that interfere with rational performance management.

Discussion
Psychological processes such as projection, displacement and projective identification are useful in understanding the genesis of bullying and harassment within demanding workplaces. Reflecting upon the psychological processes underpinning such conflict might help mitigate coercive workplace behaviour.

THE BODY OF LITERATURE addressing bullying and harassment within healthcare services is growing. Issues of prevalence, trends and impacts upon healthcare practitioners are well known.[1] For instance, one in four doctors in the Australian workforce has reported experiencing persistent behaviours that undermine their professional confidence or self-esteem,[2] with 21% of general practitioners (GPs) affected.[3] Bullying includes repeated, unreasonable and systematic behaviours that adversely affect an individual, including harassment, intimidation, degradation and humiliation.[4] Jamieson et al observed a 'tacit tolerance of intimidating and destructive behaviours' affecting some 60% of medical trainees.[1] The detrimental impacts of bullying and harassment on healthcare professionals are significant, leading to shame, anxiety, depression and even a move away from medicine.[5] Furthermore, a lack of psychological safety for healthcare professionals might hinder quality improvement efforts and jeopardise patient safety.[6]

The characteristics inherent to healthcare settings might amplify interpersonal dynamics and intrapsychic processes that predict conflict, bullying and harassment. These settings are characterised by high-stakes decision making, alongside an entrenched culture emphasising hierarchy, self-sacrifice, resilience and deference.[6,7] Within this context, medical doctors identify 'fear of making mistakes' and 'making the right decisions' as significant sources of work-related stress.[8] These stressors might be both initiated and amplified by difficult relations with senior colleagues.[8] Senior medical staff have been consistently identified as the most common source of bullying, harassment, discrimination and/or racism targeting doctors.[1,2,9,10] In healthcare settings, the responsibility and strong desire to 'protect the public' from harm might serve as justification for dominating, hierarchical behaviours, which might or might not be deemed appropriate.

This paper aims to better understand harassment and bullying through a case study (Box 1), drawing upon contemporary psychodynamic explanatory constructs within a healthcare setting.

Methods

Design

The paper draws upon familiar behaviours within healthcare settings to present a vignette. The vignette describes the dynamics of common occurrences of conflict within such settings and the opportunity for analysis of behaviour. The paper refers to key psychodynamic concepts such as power hierarchy, projection and blaming behaviour, displacement and projective identification. These concepts serve as fundamental explanatory constructs for understanding the psychological mechanisms underpinning bullying and harassment behaviours,

particularly in high-pressure contexts where irrational forces might be at play.

The power hierarchy refers to the unequal distribution of authority, decision making and influence within a setting. Relationship dynamics are fundamentally affected by power differentials and social positionality, and an individual's level of power might impact the way they unconsciously manage anxieties in different situations. Projection is commonly understood as an ego defence mechanism in which individuals unconsciously attribute their own undesirable thoughts, feelings or traits onto others. It allows them to avoid acknowledging or dealing with these aspects of themselves, often leading to misinterpretations and conflicts in interpersonal relationships.

In the workplace, attributing blame or projecting blame onto others might serve to shield one's ego, solidify positions within a power hierarchy and defend against anxiety. In contrast to constructive performance management, which aims to foster growth and development in employees, being subjected to blame can trigger defences in the recipient, potentially paving the way for interpersonal conflict and undermining morale and performance. Displacement refers to a process that involves redirecting emotions or impulses from their original target to a less threatening alternative. Similar to projection, displacement serves to manage uncomfortable feelings, but can lead to misunderstandings in relationships if not addressed.

Projective identification is more complex and involves a person unconsciously projecting their own undesirable qualities onto others and then influencing them to adopt and express these qualities. It is a complex defence mechanism that can influence interpersonal dynamics and might serve as a way to manage internal conflicts or exert control over the person's environment.

Box 1. Vignette[A]

A senior general practitioner (GP) in a group practice had taken to closely monitoring the practice of a junior registrar, offering frequent, unsolicited commentary. Besides overseeing the registrar's client numbers, cancellations, appointment lengths and interventions, the senior GP had begun intermittently reviewing incoming correspondence and test results. Additionally, they sought regular performance reports from practice nurses and other administrative staff regarding the registrar's work. In this instance, the senior GP was towards the end of their career and dealing with a number of issues relating to their giving up a role that had been important in their sense of esteem. Despite meeting the minimum required professional development, they found themselves exposed to frequent revisions of theories of disease aetiology and rapid developments in practice and technology. They were also observing the retirement of many colleagues from their generation and found it challenging to connect with emerging practitioners.

A recent case handled by the junior registrar was selected for review during a general practice peer review meeting. The senior GP observed substantial deviations from their usual practice in a procedure carried out by the registrar. Despite the registrar citing recent research and practice guidelines, the senior GP questioned their approach, critiquing multiple aspects of the procedure in a dismissive, condescending and somewhat denigrating manner. When the registrar expressed dissatisfaction with the delivery of the senior GP's comments and sought constructive dialogue with the other GPs present, the senior GP became enraged and adopted an intimidatory stance, threatening to escalate the matter. Following a heated exchange, the senior GP indicated their intention to escalate the incident for investigation, alleging incompetence.

Subsequently, the senior GP initiated a private meeting with the practice manager responsible for handling complaints. The senior GP was a partner in the practice and the practice manager was therefore the senior GP's employee, with whom they had enjoyed a long-standing working relationship. The senior GP reportedly referred to the registrar in disparaging terms and complained about multiple aspects of the junior registrar's performance. The senior GP suggested termination of the registrar's employment and hinted at reporting them to the Australian Health Practitioner Regulation Agency (AHPRA). Without fully understanding the professional and interpersonal dynamics at play, or seeking information from the registrar, the practice manager promptly ordered a review of the registrar. The registrar was subsequently instructed to immediately cease performing the routine procedure without explanation. A formal investigation found no deficits in the registrar's practice and the senior GP's claims of incompetence to be unsubstantiated. However, no apology was offered, and the practice manager continued to oversee a 12-month performance management process. During this time, the registrar reported being threatened, humiliated and undermined by both the senior GP and the practice manager. Subsequently, the registrar left the practice and was denied a professional reference.

[A]Although this vignette is an adaptation of a real case example, details have been omitted and changed for anonymity and speculative details added to demonstrate the common psychological concepts that might underpin cases of bullying and harassment in the medical setting. It is noted that the dynamics described might be applicable to multiple medical disciplines and contexts.

Reflexive comment

Each author comes from a background in psychology and shares an interest in healthcare settings. The first author, a cisgender man, academic and clinical psychologist, has taught clinical psychology students for over two decades and has extensive experience as a psychodynamic teacher and practitioner. Additionally, he has chaired Australian Health Practitioner Regulation Agency (AHPRA) State Boards and dealt with complaints arising within healthcare settings for almost a decade.

The second author is a cisgender woman and general psychologist with a Master of Clinical Psychology, who is currently undertaking further training in psychodynamic therapy as part of the Clinical Registrar program. Her previous work included almost a decade spent in Human Resources, addressing incidents of workplace conflict and bullying.

The third author is a postgraduate trainee and Provisional Psychologist practising from a psychodynamic and experiential orientation. She is a cisgender woman of Anglo-Celtic and New Zealand Māori (Ngāi Tahu) ancestry, born and raised in Australia. In her previous work in the social services sector, she has engaged with issues of power, conflict and collaboration, including involvement in family violence support, mental health advocacy and community engagement.

A specific vignette

Although the dynamics of complaints and workplace conflicts in the workplace vary depending on the situation and the

organisational culture, the following example sheds light on the underlying dynamics involving a senior general practitioner (GP) (Box 1). The example is used to gain a better understanding of conflict, excessive criticism and undermining approaches to resolution.

Results and discussion

Interpretation

Implicit intrapersonal factors

There are several psychological theories that might provide insight into coercive and bullying behaviours that occur within healthcare settings. Inquiry into these underlying processes can be particularly useful where a person's actions seem disproportionate or entirely irrational to the situation at hand. In considering the actions of the supervising senior GP in the case example, it is useful to explore the role of the psychological processes referred to as *projection* and *displacement*.

Projection might have involved the senior GP's unwitting ejection of their own unacknowledged sense of incompetence, and projection of this incompetence onto the registrar. This sense of incompetence was likely activated in the senior GP during the debate about latest practice recommendations. This is likely to have left the senior GP with unconscious, unprocessed anxieties about their current practices, and an increasing sense of professional obsolescence, compounded in the context of a range of rapid developments in the field. Through the process of *projection*, the senior GP disavows and ejects any anxiety from their conscious awareness. The senior GP therefore failed to reflect on their internal processes that might be influencing their responses to the interpersonal process, genuinely believing that the incompetence belonged to the registrar. Similarly, the senior GP might have redirected (*or displaced*) their negative emotions influenced by factors arising within their personal life and impending retirement, which are experienced as unsafe, and instead directed them towards a 'safer' receiver, the less-threatening younger registrar. The level of hostility, which was not commensurate with the situation, might reflect an array of complex feelings and conflicts associated with their potential transition away from a professional career, which had been a core part of their identity.

Ageing and identity

Writing from the stance of psychotherapists supervising junior colleagues, Yerushalmi suggests older supervisors' self-esteem can be threatened by encounters with young supervisees, facilitated in part by the losses experienced with ageing.[11] He describes the psychological difficulties in terms of a need to be idealised by younger colleagues, with problems integrating the consequential polarities in their self-image when this does not occur. This process might be particularly salient where traits of narcissism are involved, a commonly identified element in organisational bullying.[12]

Applying this observation to the current case, the senior GP might have experienced feelings of humiliation arising from the perceived challenge to their authority and dismissal of their advice by a younger colleague during the case review meeting. This humiliation might have been amplified by the senior GP's awareness of their professional limitations as they confront their retirement and begin to experience rivalry – a perceived obstruction to their acceptance and esteem – from upcoming younger practitioners. Their initial reaction to the registrar, who was the target of their complaint, might constitute an expression of 'narcissistic rage', which might involve feelings of envy in response to the perceived reputation and acceptance of the colleague.[13]

In narcissism, rivalry might be experienced as a severe threat or injury to one's self-esteem. The sense of threat might elicit intense anger towards others who fail to comply with their need to be idealised. The threat might also elicit a desire to devalue non-complying others, to reduce the threat through both internal processes and external actions. The target individual is subsequently used to embody the narcissistic individual's emergent unwanted feelings of incompetence through the process of *projection*, as described above.[14]

Implicit organisational and interpersonal factors

Those in positions of leadership who are involved in overseeing performance management might equally be unknowingly engaged in implicit processes that emerge in the workplace. Scholarship suggests the health milieu engenders anxiety.[15] Anxiety might be understood in terms of the German expression, *angst*, referring to unfocussed feelings of profound anxiety or dread. Medical environments might engender such feelings due to chaos, under-resourcing, the pressures of general practice, and exposure to human pain and sometimes misery, in a context where outcomes can be critical. The ways in which we defend against anxiety includes the use of psychological processes including *denial*, *projection* and *collusion*. These phenomena emerge within both general practice and institutions such as hospitals as a way of defending against the anxieties permeating the workplace.[16] As such, health environments can cultivate 'tribal' and collusive organisational dynamics, where members of the same rank or discipline engage in tacit agreements regarding decision-making processes or perceptions of others to meet or avoid shared needs or anxieties respectively.

How do we understand the practice manager taking actions without first seeking any input from the registrar being complained about? Similarly, how do we understand a decision to implement performance management processes and not attend to bullying behaviours following an investigation where no deficits had been identified? Through an understanding of dynamics involving the organisational culture, it might be suggested that the practice manager unknowingly 'colluded' with the senior GP's perceptions and emotions in order to meet their shared needs of self-esteem preservation and connection, and to prevent shared anxieties around patient safety, exclusion or loss of power within the hierarchy.

On an interpersonal dynamic level, one way to understand this process is by drawing upon a concept well known in the psychotherapy literature, called *projective identification*. *Projective identification* refers to a dynamic phenomenon whereby one person places their unwanted feelings, perceptions or parts of the self upon another person (*projection*), with the receiver of those projections unwittingly taking them on board and behaving accordingly (*identification*). For example, the practice manager might have automatically identified with the feelings of the senior GP (complainant), the depth of emotion associated with their experience, and their projected expectation that the

practice manager act, without conscious regard or consideration for the registrar who was the target of the senior GP's anger. In this way, the practice manager identifies with the *projection*; that is, they become what the senior GP projects onto them and expects of them, albeit unconsciously. *Projective identification* likely resulted in the bypassing of the mental processes necessary for procedural fairness, including consideration and reflection upon multiple sources of information, and unbiased decision making independent of the senior GP influence. In contrast, a performance management approach would focus upon a goal-directed process in which risk would be identified from the available evidence, and actual deficits and areas for remediation would form the basis for any action.

Conclusions

Implications for practice

Doctors in leadership positions have a duty to promote patient safety, supervise constructively and oversee complaints processes with sensitivity. Medical settings are improving responses to unhelpful behaviours to ensure client safety (see for example,[17–19]); however, further work is needed to ensure worker safety, particularly the safety of less senior workers. Healthcare settings impose significant demands upon professionals involved in the provision of care. Where senior colleagues perpetrate bullying and harassment, it can be difficult to delineate problematic behaviours from the legitimate processes of direct line management and performance management. Understanding the intrapsychic dynamics in the context of power hierarchies that influence workplace bullying, conflicts and complaints might help avert harmful outcomes.

Intrapsychic dynamics, by nature, frequently operate at the unconscious or semi-conscious level, and therefore are not always immediately apparent to parties involved, or amenable to intervention. To prevent and respond to coercive management practices, it is therefore imperative that self-reflection is embedded in management processes, and that remedial action is taken at a systemic, interpersonal and individual level.

Although existing workplace bullying interventions exist (for reviews, see[10,20–22]), these have frequently focussed on broader organisational activities, such as policy change and awareness raising; interventions targeting bystanders or victims, such as assertiveness intervention training, or victim support; or instruction on appropriate or civil behaviour and communication. Few interventions have directly targeted perpetrators' potential internal motivations or mental processes (see for example,[23]). We assert the need to make intra- and interpersonal processes overt, to mitigate conflict and facilitate procedural fairness. Interventions at the individual level might include minimum training for healthcare leaders and managers in reflective practices. Adopting a psychodynamic understanding, such reflection could focus on the dynamics of power and coercion in hierarchical management structures; how this intersects with the operation of power in the broader social context of race, gender, class and more, particularly around who bullies compared to who is bullied, and how those in powerful positions might be unintentionally influenced to manage their unconscious anxiety through power over and projection onto others less powerful than themselves. Such training could develop managers' capacity to reflect on and identify current and future mental processes that might put them at risk of unintentionally adopting extreme or coercive management practices. Such risk factors might theoretically include feelings of loss of control, threats to status or feelings of inadequacy at work, precipitated by circumstances such as prolonged workplace pressure, personal stress or professional or personal life changes.

It is further imperative that others adjacent to managers are not unconsciously or consciously co-opted into coercive, bullying dynamics. Cultural interventions to prevent such behaviours might include manager-level peer supervision meetings that promote non-judgemental reflection on leadership pressures, management practices and debriefing. Other structural changes might include mandatory review of all newly initiated performance management or internal complaints processes, by a manager of equivalent status and adequate distance and impartiality. Such a review might include independent assessment of the objective evidence for poor performance of junior staff, and consideration for any interpersonal dynamics and the intrapsychic reflective capacity of the manager – before more formal performance management processes are imposed.

Where coercive, bullying behaviours have occurred, there remains an imperative to address this injustice through disciplinary action, as well as restorative justice processes to (at least partially) repair the intrapsychic wounds inflicted on victims. Such processes should further promote reflective practice in perpetrators to prevent reoffending. In certain circumstances, those culpable of frequent re-perpetration, and resistant to self-reflection, might need to be removed from the workplace, for the safety of both staff and patients, and the overall health of the workplace culture.

To return to the challenge posed by Jamieson et al,[1] will the practice of medicine remain complicit in bullying culture or champion a new era of workplace civility within healthcare settings?

Key points

The following key principles provide a basis for understanding the psychological mechanisms that might underpin coercive and bullying behaviour in healthcare settings.

- Healthcare settings involve high-stakes decision making, which can foster a culture of blame and lead to coercive and controlling behaviours.
- This paper highlights how blaming others, especially those in subordinate positions, can function as a defence mechanism against stress and uncertainty in chaotic healthcare environments.
- Key mechanisms include blame, displacement and projection, whereby junior staff members might be subjected to coercive behaviours irrespective of their role.
- Psychological theories underpinning coercive and bullying behaviours emphasise how individuals, such as the senior GP in the presented vignette, might unconsciously project anxieties onto others, thereby fuelling workplace conflicts.
- Recognising the dynamics involved in conflicts within healthcare settings might contribute to a more rational appraisal of key issues.

Authors

Robert D Schweitzer PhD, Adjunct Professor in Psychology, School of Psychology and Counselling, Queensland University of Technology, Brisbane, Qld

Cherie Sonnenburg BHSc, BBehavSc (Hons), GradDipPsych, Master of Clinical Psychology, School of Psychology and Counselling, Queensland University of Technology, Brisbane, Qld

Rohani Mitchell BA (Hons)(Psych/PolSci), GradCertHealthProm, School of Psychology and Counselling, Queensland University of Technology, Brisbane, Qld

Competing interests: None.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

Correspondence to:
r.schweitzer@qut.edu.au

References

1. Jamieson J, Mitchell R, Le Fevre J, Perry A. Bullying and harassment of trainees: An unspoken emergency? Emerg Med Australas 2015;27(5):464–67. doi: 10.1111/1742-6723.12465.
2. Askew DA, Schluter PJ, Dick ML, Régo PM, Turner C, Wilkinson D. Bullying in the Australian medical workforce: Cross-sectional data from an Australian e-Cohort study. Aust Health Rev 2012;36(2):197–204. doi: 10.1071/AH11048.
3. Askew DA, Schluter PJ, Dick ML. Workplace bullying—What's it got to do with general practice? Aust Fam Physician 2013;42(4):186–88.
4. Chadwick S, Travaglia J. Workplace bullying in the Australian health context: A systematic review. J Health Organ Manag 2017;31(3):286–301. doi: 10.1108/JHOM-09-2016-0166.
5. Johnson K. I'm stepping back from medicine because of bullying. But the problem is bigger than my case. ABC News. 2 November 2020. Available at www.abc.net.au/news/2020-11-02/bullying-in-medicine-policies-do-not-change-culture/11980240 [Accessed 3 December 2023].
6. Nembhard I, Edmondson A. Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. J Organ Behav 2006;27(7):941–66. doi: 10.1002/job.413.
7. Colenbrander L, Causer L, Haire B. 'If you can't make it, you're not tough enough to do medicine': A qualitative study of Sydney-based medical students' experiences of bullying and harassment in clinical settings. BMC Med Educ 2020;20(1):86. doi: 10.1186/s12909-020-02001-y.
8. Beyondblue. National mental health survey of doctors and medical students. Beyond Blue Ltd, 2019. Available at https://medicine.uq.edu.au/files/42088/Beyondblue%20Doctors%20Mental%20health.pdf [Accessed 22 October 2023].
9. Medical Board of Australia. Medical Training Survey national report. AHPRA, 2022. Available at https://medicaltrainingsurvey.gov.au/Results/Reports-and-results [Accessed 3 December 2023].
10. Averbuch T, Eliya Y, Van Spall HGC. Systematic review of academic bullying in medical settings: Dynamics and consequences. BMJ Open 2021;11(7):e043256. doi: 10.1136/bmjopen-2020-043256.
11. Yerushalmi H. Stagnation in supervision as a result of developmental problems in the middle-aged supervisor. Clin Supervisor 1993;11(1):63–81. doi: 10.1300/J001v11n01_05.
12. Duradoni M, Gursesli MC, Martucci A, Gonzalez Ayarza IY, Colombini G, Guazzini A. Dark personality traits and counterproductive work behavior: A PRISMA systematic review. Psychol Rep 2023:332941231219921. doi: 10.1177/00332941231219921. Epub ahead of print.
13. Huffington C, Halton W, Armstrong D, Pooley J, editors. Working below the surface: The emotional life of contemporary organisations. Routledge, 2004.
14. Curk P, Gaitanidis A, editors. Narcissism: A critical reader. Routledge, 2007.
15. Hinshelwood RD, Skogstad W, editors. Observing organisations: Anxiety, defence and culture in health care. Routledge, 2002. doi: 10.4324/9780203135150.
16. Schruijer S. The role of collusive dynamics in the occurrence of organizational crime: A psychoanalytically informed social psychological perspective. Adm Sci 2018;8(3):24. doi: 10.3390/admsci8030024.
17. Srivastava R. Speaking up—When doctors navigate medical hierarchy. N Engl J Med 2013;368(4):302–05. doi: 10.1056/NEJMp1212410.
18. Weller JM, Webster CS. Normalising good communication in hospital teams. Br J Anaesth 2021;126(4):758–60. doi: 10.1016/j.bja.2020.12.036.
19. Sekar H, Dharmasena D, Gunasekara A, Nauta M, Sivashanmugarajan V, Yoong W. Understanding authority gradient: Tips for speaking up for patient safety (and how to enhance the listening response). Obstet Gynaecol 2022;24(4):272–80. doi: 10.1111/tog.12829.
20. Illing J, Carter M, Thompson N, et al. Evidence synthesis on the occurrence, causes, management of bullying and harassing behaviours to inform decision making in the NHS. National Institute for Health Research Service Delivery and Organisation, 2013. Available at https://durham-repository.worktribe.com/output/1632761 [Accessed 30 April 2024].
21. Gillen PA, Sinclair M, Kernohan WG, Begley CM, Luyben AG. Interventions for prevention of bullying in the workplace. Cochrane Database Syst Rev 2017;1(1):CD009778. doi: 10.1002/14651858.CD009778.pub2.
22 Maben J, Aunger JA, Abrams R, et al. Interventions to address unprofessional behaviours between staff in acute care: What works for whom and why? A realist review. BMC Med 2023;21(1):403. doi: 10.1186/s12916-023-03102-3.
23. Kirk B, Schutte N, Hine D. The effect of an expressive-writing intervention for employees on emotional self-efficacy, emotional intelligence, affect, and workplace incivility. J Appl Soc Psychol 2011;41(1):179–95. doi: 10.1111/j.1559-1816.2010.00708.x.

correspondence **ajgp@racgp.org.au**