Weaponised Concern: Moralised Discourses of Care as Mechanisms of Regulation in Professional Nursing

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Abstract

Workplace bullying in nursing is commonly defined through overt hostility, yet less visible forms of regulation often operate through the language of care itself. This paper examines how discourses of concern, kindness, and professionalism can function as mechanisms of moral regulation within professional nursing. Drawing on feminist critical theory, we introduce the concept of weaponised concern to describe how ostensibly benevolent expressions of worry about a colleague's well-being or coping may redirect attention away from substantive critique and toward the presumed psychological state of the speaker. In doing so, dissent is reframed as instability, and professional disagreement becomes pathologised rather than engaged. Situated within gendered expectations of emotional regulation and relational harmony in a predominantly female profession, these practices contribute to collective silencing, reputational harm, and the erosion of professional voice. Digital professional spaces further intensify these dynamics by amplifying and preserving insinuations framed as care. We argue that confronting workplace harm in nursing requires a critical examination of how moral virtues can be mobilised as instruments of control, shaping whose knowledge is legitimised and whose speech is disciplined within the profession.

Workplace bullying and psychological violence in nursing are most often conceptualised through overt behaviours such as intimidation, exclusion, or abuse. Bullying is widely recognised as a pervasive problem across healthcare organisations globally, with evidence linking it to organisational culture, hierarchical power relations, and institutional responses to conflict (Bashir & Oetzel, 2025). However, in many professional nursing contexts, harm is enacted less through visible hostility than through discourses of concern, kindness, civility, and professionalism. These discourses carry significant moral authority within nursing and are therefore uniquely positioned to regulate behaviour, delimit acceptable speech, and silence critique (Jackson et al., 2026). When mobilised in response to dissenting voices, these discourses can be weaponised. In such instances, they function not as ethical practices but as disciplinary tools that delegitimise professional work while preserving the appearance of care. We introduce the concept of *weaponised concern* to describe how discourses of care may operate as mechanisms of psychological violence and moral regulation within the workplace. This paper presents a feminist critical theoretical analysis, drawing on existing scholarship and recurrent discursive patterns within professional nursing to examine how moralised concern functions as a mechanism of regulation. Weaponised concern operates through a discursive sequence that serves as the analytic anchor for this paper. First, a moral reclassification occurs. A professional critique is shifted from argument to attribute, such that the individual's emotional state, for instance "not coping," becomes the salient object of evaluation. Second, this classificatory move constitutes a form of symbolic violence because it mobilises professional virtues such as kindness and composure as ostensibly neutral criteria that mask underlying power relations and render the reclassification reasonable. Third, this shift produces testimonial injustice. The speaker's credibility is diminished and their knowledge claims are discounted. Finally, these effects

promote compliance, either through managerial containment such as support, referral, or removal, or through anticipatory self-censorship. Together, these steps convert the language of care into a technology of governance. The outcome is not overt punishment but forms of reputational and epistemic regulation that narrow who can speak and be heard.

Theoretical Lens

This paper adopts a feminist critical theoretical orientation to examine how moralised discourses of care function as mechanisms of professional regulation within nursing. This perspective highlights how gendered power relations are embedded within organisational norms, professional expectations, and everyday practices. Rather than treating power as a possession held by individuals, feminist scholarship conceptualises power as socially organised and relational, shaping credibility, authority, and the boundaries of legitimate conduct.

Organisations are patterned by implicit assumptions about bodies, comportment, and authority (Acker, 1990). Even within female-dominated professions such as nursing, institutional norms may reproduce broader gendered hierarchies. Nursing has historically been shaped by ideals of altruism, self-sacrifice, and relational harmony, which have become intertwined with professional standards of kindness, civility, and emotional restraint. Women are routinely required to manage affect in ways that preserve institutional equilibrium and prioritise the comfort of others (Hochschild, 1983). Within nursing, emotional regulation is integral to professional identity (Bolton, 2000). Competence is therefore often interpreted through affective comportment. Visible frustration or refusal to acquiesce may be read as excess, instability, or an inability to cope.

The ‘double bind’ described in feminist scholarship further illuminates this dynamic. Women who speak assertively risk being perceived as aggressive or unprofessional, while those

who temper their speech risk being dismissed or marginalised (Jamieson, 1995; Jackson et al. 2025). Within such conditions, expressions framed as concern about a colleague's well-being acquire regulatory force. When dissent is redirected toward the presumed emotional state of the speaker, the substantive content of critique is displaced. The focus shifts from what is being said to how the speaker is perceived. Professional disagreement is thus relocated into a moral register in which emotional composure becomes evidence of legitimacy.

Analysis is also informed by scholarship on epistemic injustice, which describes harms that occur when individuals are wronged specifically in their capacity as knowers (Fricker, 2007). Testimonial injustice arises when credibility is unjustly diminished due to prejudice, including gendered assumptions about emotionality or instability. In healthcare contexts, these dynamics are intensified by of clinical language (Carel & Kidd, 2014). Informal speculation about a colleague's coping, resilience, or psychological stability may function as a credibility-reducing move, reframing critique as symptomatic rather than substantive. Language associated with therapeutic assessment can thereby migrate into informal professional surveillance, with consequences for voice and participation. Feminist analyses of affect further clarify how institutional norms regulate dissent. Ahmed (2010) argues that those who disrupt organisational harmony by naming injustice are often positioned as the source of disturbance rather than its diagnosticians. Attention shifts from the conditions being critiqued to the person who speaks. Within nursing, moralised concern may function similarly by repositioning dissenting practitioners as emotionally compromised while preserving the appearance of care.

Situating weaponised concern within feminist critical theory allows it to be conceptualised as a patterned practice that polices professional boundaries. Moralised discourses of concern shape subject positions, redistribute credibility, and stabilise existing hierarchies

while remaining framed as ethical conduct. This analysis shifts attention from individual intent to structural effects and foregrounds the profession's ethical responsibility to interrogate how its most valued virtues may be mobilised in ways that constrain rather than sustain professional voice.

Symbolic Violence and Epistemic Injustice in Tandem

Weaponised concern operates at the intersection of symbolic violence and epistemic injustice. These concepts illuminate distinct but complementary dimensions of harm. Symbolic violence refers to the subtle imposition of dominant norms and classifications that are misrecognised as natural, legitimate, or benevolent. In professional nursing, standards of emotional composure, resilience, and relational harmony are treated as neutral markers of professionalism. When a nurse's dissent is reframed as evidence of not coping, these norms function as classificatory tools. The individual is repositioned within a deficit-based interpretive frame that appears compassionate yet reinforces existing hierarchies. The violence lies in the naturalisation of this shift from interlocutor to subject of concern.

Epistemic injustice names the harm that follows this reclassification. When credibility is diminished because a speaker is implicitly positioned as emotionally unstable or insufficiently resilient, testimonial injustice occurs (Fricker, 2007). The substance of critique becomes secondary to judgements about the speaker's capacity. In healthcare contexts, where clinical language carries institutional authority, informal speculation about coping further erodes credibility (Carel & Kidd, 2014). The nurse is therefore not only morally repositioned but epistemically discredited. Thus, symbolic violence explains how the reclassification becomes socially intelligible and difficult to contest, while epistemic injustice clarifies the damage to credibility and knowledge participation. Weaponised concern, therefore, operates both morally

and epistemically, reshaping how individuals are perceived and evaluated. As the discourse is framed as care, resistance risks confirming perceptions of instability, deepening both forms of harm.

Weaponised concern as moral regulation

Weaponised concern operates by redirecting attention away from substantive critique and toward the perceived emotional or psychological state of the person advancing them. Statements framed as worry about a colleague's well-being, professionalism, or "coping" are rarely passive or neutral. Instead, they reframe critical engagement as a personal problem, casting the target's contributions as suspect while shielding the speaker from accountability. Because such expressions are socially sanctioned and often aligned with nursing's moral identity, they are difficult to contest without the targeted person appearing defensive, unstable, or unprofessional. In this way, concern becomes reputational harm enacted under the guise of ethical responsibility. Similar dynamics have been described in nursing academia where formal organisational processes, including complaints mechanisms, may be strategically mobilised as instruments of professional harm rather than mechanisms of justice (Cleary et al., 2026).

Such moralised practices do not operate in isolation. Rather, they are collectively enacted through mobbing, a patterned and sustained process of psychological aggression in which an individual is progressively undermined through alignment, silence, rumour, and reputational narrative-building (Yildirim & Yildirim, 2007). This interpretation is consistent with recent systematic review evidence showing that workplace bullying and horizontal violence in intensive care nursing commonly involve exclusion, isolation, gossip, hostility, silencing, and other patterned behaviours that progressively undermine the target within the workplace (Zhang et al., 2025). Workplace gaslighting and mobbing frequently coexist, with evidence indicating a

positive association between these forms of mistreatment in clinical work environments (Atta et al., 2025). Within mobbing processes, weaponised concern and performative kindness provide moral cover that allows collective harm to unfold without appearing overtly hostile. Recent review evidence also shows that bullying in nursing is frequently sustained by organisational cultures in which harmful conduct is normalised, insufficiently challenged, and embedded within broader patterns of leadership failure, subgroup formation, and workplace stress (Zhang et al., 2025).

Experiences of workplace gaslighting are strongly correlated with mobbing behaviours, suggesting that manipulative and collective forms of workplace harm may reinforce one another within professional environments (Atta et al., 2025). Withdrawal of support, quiet warnings to others, and informal reputational questioning may be justified as protective or caring acts, even as they erode professional credibility and isolate the targeted individual. In this way, mobbing functions as the mechanism through which moralised concern becomes durable and distributed, producing sustained professional harm.

“Coping” as judgment disguised as care

Within mobbing processes, the language of coping occupies a particularly powerful position. To state that a colleague is “not coping,” “struggling to cope,” or “having difficulty coping” appears, on the surface, to signal empathy. However, when used outside a legitimate therapeutic relationship, and without invitation of appropriate assessment, such language functions less as understanding and more as judgment rendered from a position of professional authority. In this way, it reflects forms of symbolic violence enacted through ostensibly benevolent discourse (Contandriopoulos et al., 2024).

In nursing, coping is not a neutral descriptor; it is a clinically laden concept embedded within assessment frameworks, care planning, and diagnostic reasoning. To speak authoritatively about another person's coping implicitly positions the speaker as the evaluator and the colleague as the subject of assessment. Unlike genuine support, which is centred on listening, consent, and responsiveness, statements about coping often bypass the substance of a colleague's work or critique. Instead, they recast professional disagreement as evidence of personal inadequacy or emotional fragility.

Epistemic Injustice and the Credibility Deficit

The reframing of professional dissent as a problem of coping can be further understood through the lens of epistemic injustice. Fricker (2007) conceptualises testimonial injustice as the unjust diminution of a speaker's credibility due to prejudice. In professional contexts shaped by gendered expectations of emotional regulation, women who speak persistently, critically, or forcefully may be assigned a credibility deficit grounded not in the substance of their claims but in assumptions about emotional excess or instability. When a nurse's critique is met with informal speculation about her coping, the shift is epistemic. The focus moves from evaluating the knowledge claim to evaluating the knower.

Such credibility reduction is rarely explicit. It does not require direct accusation or formal sanction. Instead, it operates through insinuation and gradual narrative reframing. Once the possibility of "not coping" is introduced, subsequent contributions may be filtered through that interpretive lens. The speaker's arguments become suspect not because they lack merit, but because the speaker has been repositioned as emotionally compromised. In this way, weaponised concern functions as a credibility-diminishing move that produces testimonial injustice while maintaining the appearance of collegial care.

Within healthcare settings, this dynamic is intensified by the authority of clinical language. As Carel and Kidd (2014) observe, epistemic injustice in healthcare often arises where interpretive authority is unevenly distributed. When clinical terminology migrates into informal professional evaluation without consent or an appropriate relational context, it can reinforce existing power asymmetries. The invocation of coping thus becomes more than a metaphor. It becomes an epistemic tool that redistributes authority and narrows the range of knowledge recognised as credible.

Affective Regulation and the "Problem" of the Dissenter

Feminist analyses of affect illuminate how institutional cultures regulate dissent through expectations of emotional harmony. Ahmed (2010) argues that those who disrupt collective comfort by naming injustice are frequently repositioned as the source of disturbance. The figure of the "killjoy" captures this dynamic. Those who identify structural problems may themselves be reframed as the problem because they unsettle the atmosphere of collegiality.

Within nursing, moralised concern can perform a similar affective redirection. Rather than engaging the critique itself, attention shifts to the tone, persistence, or emotional intensity of the speaker. The dissenter becomes the site of scrutiny. Expressions of worry about coping operate to restore affective equilibrium by repositioning the speaker as in need of management rather than a participant in professional deliberation. Institutional priority shifts toward maintaining relational smoothness rather than interrogating structural inequity. This affective reframing has disciplinary consequences. When professional legitimacy becomes tethered to emotional composure, nurses learn that visible urgency or sustained critique carries reputational risk. The expectation of kindness and civility, while ethically meaningful in patient care, may be extended in ways that constrain legitimate professional disagreement. In such contexts,

weaponised concern functions not merely as interpersonal discomfort but as a mechanism of affective governance that regulates whose dissent may be voiced without moral penalty.

From Coping to Compliance

The cumulative effect of these epistemic and affective shifts is the production of compliant professional subjects. Once dissent is recoded as coping difficulty, the appropriate response becomes support, management, or quiet containment rather than substantive engagement. This transformation is subtle yet powerful. It converts a structural or ethical concern into an individualised matter of resilience. The nurse who persists risks further confirmation of instability, whereas the nurse who withdraws restores equilibrium. Silence becomes adaptive. Such adaptation may also take the form of disengaged compliance. Recent research among nursing and midwifery academics found that greater mobbing exposure was associated with stronger quiet quitting attitudes, suggesting that workplace hostility may produce not only distress but also forms of muted professional withdrawal (Bilgiç et al., 2025).

Through this process, the language of care is reoriented toward preserving institutional stability. What appears as compassion may simultaneously function as containment. Recognising this duality does not negate the importance of genuine collegial support; rather, it requires discernment about when concern is invited and when it displaces critique. Naming this dynamic is a necessary step in protecting professional voice and the integrity of nursing knowledge.

The power of the term lies in its ambiguity. “Concern about coping” can be voiced without overt accusation, yet it carries clear implications of diminished resilience, impaired proportionality, or compromised professional capacity. Once introduced, the label “not coping” can circulate through informal conversations and reputational narratives, becoming detached from any specific behaviour and attached instead to the individual. In this way, coping becomes

shorthand for undermining credibility without evidence while maintaining the appearance of care.

Importantly, this dynamic also reflects a misuse of nursing knowledge and professional scope. The assessment and interpretation of psychological functioning require appropriate context, competence, and relational boundaries. Informal speculation about a colleague's coping, particularly when framed as concern and shared with others, extends clinical reasoning into forms of professional surveillance. This is not care, but rather a form of epistemic and moral overreach that mobilises clinical language to produce reputational harm.

Within mobbing processes, assertions about coping often operate alongside more explicit diagnostic labelling. Colleagues may be described as "burnt out," "obsessive," "on the spectrum," or "showing early cognitive decline," frequently without substantiation and framed as sympathetic observation. Such labels draw on stigmatised understandings of mental health and neurodivergence to recast dissent, persistence, or critical engagement as pathology. The effect is not support but delegitimisation. The individual's work is no longer engaged on its merits because it has been reframed as a symptom of personal difficulty.

Gender, power, and alignment

These dynamics cannot be understood outside the gendered context of nursing. As a predominantly female profession, nursing is shaped by expectations of emotional regulation, niceness, resilience, and self-sacrifice. Women who speak assertively, persist in critique, or challenge authority are more likely to be perceived as difficult, emotional, or unstable (Jackson et al. 2025). Weaponised concern capitalises on these stereotypes by repositioning dissenting women as subjects of concern rather than interlocutors in professional debate.

Mobbing rarely requires overt coordination. Instead, it escalates through silence, alignment, and withdrawal. Colleagues may disengage, avoid association, or quietly accept prevailing narratives in acts of self-protection. Over time, the targeted individual becomes increasingly isolated, while the harm remains diffuse and difficult to trace. This collective character renders mobbing resistant to intervention, as accountability is distributed across everyday interactions and sustained by the pressure to remain aligned with perceived professional norms.

Mobbing as Collective Credibility Erosion

While mobbing is often described as sustained psychological aggression, its operation within professional nursing frequently relies less on overt hostility than on cumulative credibility erosion. Through repeated insinuations, alignments, and strategic silences, the target's epistemic standing is gradually destabilised. Earlier research examining avoidant leadership in nursing has shown that when nurses raise concerns about wrongdoing, managerial responses may shift attention away from the issue itself and toward the complainant, who can become positioned as the problem rather than the concern they attempted to raise (Jackson et al., 2012). Rather than confronting ideas and issues of concern directly, collective discourse shifts toward questions of temperament, stability, or coping. This redirection functions as a distributed form of testimonial injustice (Fricker, 2007), in which credibility is incrementally withdrawn without formal accusation.

Importantly, such erosion does not require coordinated intent. It unfolds through everyday interactions, including raised eyebrows, careful distancing, quiet disclaimers, and subtle narrative framing. As reputational doubt circulates, others may align not out of conviction but for self-protection. The result is a moral consensus that appears organic. The targeted nurse is

not publicly condemned; they are gently repositioned as unreliable, emotionally excessive, or professionally strained. Organisational procedures themselves may also become implicated in such reputational processes. Research in nursing academia has shown how formal complaints mechanisms can be weaponised to pursue retaliatory agendas or to discredit colleagues under the appearance of procedural legitimacy (Cleary et al., 2025).

Gendered Alignment and the Preservation of Harmony

Feminist theory clarifies why mobbing may be especially difficult to interrupt within feminised professions. Organisational cultures structured around relational harmony and emotional composure create powerful incentives for alignment. Open disagreement risks not only professional isolation but also moral judgement for disrupting collective harmony. Women, in particular, are socialised to preserve relational equilibrium and to avoid being positioned as the source of conflict (Jamieson, 1995). Within such environments, distancing oneself from the targeted individual may be framed as prudent rather than punitive.

This dynamic does not reduce mobbing to interpersonal rivalry. Rather, it situates collective withdrawal within gendered expectations of niceness, loyalty, and self-preservation. When dissenting voices are reframed as emotionally unstable or "not coping," alignment with that voice becomes risky. In this way, mobbing functions as a mechanism through which gendered norms of emotional containment are collectively enforced.

Affective Atmosphere and Moral Containment

Mobbing also operates at the level of affective atmosphere. Institutional environments are shaped not only by formal hierarchies but by shared emotional norms regarding what is appropriate to feel and express. When a nurse persistently raises uncomfortable issues, such as inequity, unsafe practice, or power imbalance, she may be experienced as introducing tension

into a space oriented toward smooth functioning. As Ahmed (2010) argues, those who disrupt collective comfort by naming structural problems are often repositioned as the disturbance itself.

Within this framework, mobbing can function as a form of moral containment. The collective response seeks to restore affective equilibrium by marginalising the dissenter. Concerned whispers, gentle questioning of coping, or quiet exclusion may serve to re-establish a climate of calm. Mobbing thus becomes less about overt aggression and more about the regulation of atmosphere, in which institutional stability is prioritised over critical engagement.

Distributed Power and Plausible Benevolence

One feature that renders mobbing resistant to intervention is its distributed nature. Harm is enacted across multiple actors, none of whom may perceive themselves as aggressors. Expressions of concern appear individually defensible. Silence may be framed as neutrality, and alignment as professionalism. Because each act is modest, and often benevolent in tone, the cumulative effect becomes difficult to recognise and contest.

This diffusion of responsibility shields the collective from accountability. Unlike overt bullying, which can be clearly identified and sanctioned, moralised mobbing operates through plausible benevolence. The targeted individual is left navigating reputational decline without a singular event to contest. The absence of visible hostility can intensify psychological harm, as the experience of exclusion is paired with the expectation that concern be received as kindness.

Digital amplification and the permanence of reputational harm

The psychological harms experienced by targets of cyberbullying are well documented. Research consistently demonstrates increased anxiety, depressive symptoms, stress, and suicidal ideation following incidents of cyberbullying, with females at higher risk of suicidal ideation than males (Yang et al., 2021). Despite this, cyberbullying is still often framed as an adolescent

phenomenon, with comparatively limited attention to its manifestation in professional and academic contexts (Bansal et al., 2024). Contemporary studies of workplace cyberbullying among healthcare workers and nurses indicate that even low prevalence is associated with heightened symptom burden, psychological distress, and intention to leave the profession (Zhang et al., 2025). In professional settings, digital harassment and reputational attacks are frequently embedded within discourses of concern, performance, and collegiality rather than overt threats.

Digital professional spaces intensify the dynamics outlined earlier in this paper. Cyberbullying and doxxing, defined as the use of digital platforms to harass, intimidate, or publicly expose individuals, are increasingly recognised as forms of workplace violence in healthcare (Wilson & Zwang, 2024). Digital communications are persistent, searchable, and easily amplified. A single insinuation framed as concern can circulate widely and remain accessible long after the initial exchange. In this way, moral reclassification and credibility erosion become archived rather than transient.

Digital environments also collapse boundaries between professional and personal domains. Speculation about a nurse's mental health, competence, or stability may extend beyond organisational contexts, shaping reputation, employability, and psychological safety. Even in the absence of explicit doxxing, the possibility of public exposure functions as a form of surveillance. Anticipatory self-censorship becomes a rational response. In these digital spaces, weaponised concern is not confined to private conversations but may be publicly performed, indexed, and preserved, magnifying the reach of reputational and epistemic harm.

Consequences for professional voice and ethical practice

The cumulative effect of weaponised concern, mobbing, and diagnostic labelling is the erosion of professional voice. Emerging evidence suggests that mobbing may foster forms of

withdrawal and disengagement from professional work, with recent research among nursing and midwifery academics linking mobbing exposure to stronger quiet quitting attitudes (Bilgiç et al., 2025). Exposure to workplace gaslighting is also associated with reduced career entrenchment among nurses, suggesting that such dynamics may weaken nurses' professional commitment and attachment to their work (Atta et al., 2025).

Nurses who observe colleagues being undermined in these ways quickly learn which forms of speech invite scrutiny and which ensure safety. Silence becomes a survival strategy. Over time, this silencing undermines ethical practice, as critical dialogue about power, inequity, unsafe systems, and professional accountability becomes increasingly constrained.

For mental health nursing, these dynamics are particularly paradoxical. A profession committed to reducing stigma, supporting psychological well-being, and advocating for vulnerable populations may simultaneously tolerate practices that mobilise mental health language in ways that harm colleagues. This contradiction reflects a failure to interrogate how professional virtues and clinical knowledge can be redirected into instruments of control.

The implications extend to compassion itself. Mental health nurses, trained to recognise and respond to psychological distress in others, may not extend the same discernment to colleagues whose "non-coping" is discursively constructed rather than clinically assessed. This selective blindness parallels patterns identified in compassion fatigue research, where sustained exposure to suffering can erode empathic attunement (Marshman et al., 2022). Ironically, practices most closely associated with compassion may become vulnerable to reinterpretation and misuse.

Weaponised Concern as Epistemic and Ethical Problem

The analysis presented here reframes weaponised concern not as a failure of interpersonal kindness but as an epistemic and ethical problem within professional nursing. When dissent is redirected toward questions of coping, the profession risks committing testimonial injustice by diminishing credibility on the basis of gendered assumptions about emotional stability (Fricker, 2007). The harm is not only reputational but epistemic. Knowledge claims about unsafe systems, inequity, or power imbalance are displaced by informal assessments of the speaker's resilience. In this way, the language of care may contribute to the silencing of professional voice.

Recognising weaponised concern as epistemic harm shifts attention from intent to effect. Individuals may sincerely believe they are expressing care, yet the structural consequences may include erosion of credibility, social isolation, and anticipatory self-censorship. The profession's ethical responsibility, therefore, extends beyond discouraging overt hostility. It requires sustained critical reflection on how clinical language and moral virtues are mobilised in everyday interactions. Such reflection is essential if professional dialogue and dissent are to remain legitimate components of nursing knowledge production.

A feminist critical lens underscores that nursing's most valued virtues, including kindness, civility, resilience, and relational harmony, are not inherently oppressive. They are ethically meaningful in patient care. However, when these virtues become moral standards against which professional legitimacy is measured, they can also function as regulatory mechanisms. Nurses who speak with urgency, refuse accommodation, or persist in critique may be positioned as violating the affective norms of the profession. The resulting double bind constrains the conditions under which dissent can be voiced without penalty.

Addressing this tension requires feminist reflexivity within nursing leadership, education, and scholarship. Reflexivity entails interrogating how gendered expectations shape evaluations

of professionalism and how informal speculation about coping may redistribute authority. It also requires distinguishing between invited support grounded in relational consent and unsolicited psychological framing that displaces critique. Such discernment is essential if care is to remain ethical rather than disciplinary.

Protecting Professional Voice

Research synthesising evidence across healthcare professions consistently identifies organisational culture, hierarchical power relations, and institutional responses to conflict as central drivers of bullying behaviours in healthcare settings (Bashir & Oetzel, 2025). If nursing is to uphold its ethical commitments, it must safeguard not only patient well-being but also the epistemic integrity of its practitioners. Professional voice is foundational to safe practice, quality improvement, and moral accountability. When reputational narratives about instability circulate unchecked, they signal that critique carries risk. Silence may become a rational adaptation, but it is not a neutral outcome. The erosion of voice undermines the collective capacity to identify and address systemic harm.

Naming weaponised concern as a patterned form of moral regulation is therefore a step toward safeguarding professional dialogue. This does not negate the importance of genuine collegial support. Rather, it calls for clarity about when concern is appropriate and when it functions to contain dissent. A profession committed to compassion must also be committed to justice, ensuring that the language of care does not become a vehicle for silencing those who challenge inequity within its own ranks.

Reframing the problem

Weaponised concern is not a benign interpersonal misstep. It is a socially sanctioned mechanism of professional regulation that, when embedded within mobbing processes, allows

slander, rumour, and diagnostic labelling to function as tools of exclusion while appearing as the language of care. These practices do not merely harm individuals; they shape the epistemic and moral boundaries of nursing itself by influencing whose voices are heard, whose knowledge is legitimised, and whose dissent is pathologised.

What remains underexplored is the profession's ethical responsibility to confront these dynamics directly. Addressing mobbing and weaponised concern requires more than policies against bullying or exhortations to be kind. It requires critical interrogation of how professional virtues such as kindness, civility, and concern may be mobilised as instruments of harm. Naming these practices is a necessary step toward restoring professional integrity, psychological safety, and ethical practice within the profession. Such work also requires vigilance not only against overt aggression but also against the subtle transformation of care into control and concern into constraint.

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