# Navigating the contradiction: balancing patient care and caregiver protection. From heroes to victims

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The COVID emergency has accelerated professional and organizational transformations, prompting a re-signification of activity systems, routines, professional visions. An unforeseen scenario emerges, highlighting elements of uncertainty and discomfort linked to the challenge raised towards the professional identities of the various players, called to deal with the new organizational constraints. On the other hand, the challenge refers to the possibility of achieving a good balance between offering services aimed at the promotion and protection of health and guaranteeing working safety and security conditions, in increasingly complex contexts in which tensions and contradictions coexist with reduction of resources and requests for more effective services. At risk is the possibility to cope with increasing situations of social conflicts and events such as those related to the aggressiveness of patients, the verbal and often physical aggression against the health professionals, exposure to the temptation to abandon work and devote oneself to something else. At stake is the lacerating dilemma between the identification with a service that must take charge of the needs of a patient and the need to protect one's own and others safety conditions to be able to fulfill the professional task to which one is called.

We tell you a story, and as it should be when you tell a story… Once upon a time in central Milan, there existed a SerD, a Service within the Department of Mental Health and Addiction. This SerD specializes in the comprehensive diagnosis and treatment of Substance Use Disorder and Gambling Disorder. A diverse group of professionals, including doctors, nurses, educators, psychologists, and social workers, formed the multidisciplinary team, ensuring a holistic approach to personalized care. The story we wish to share revolves around this team, a significant historical period, and the presence of traumatic events.[1]

On February 20th, 2020, the team at this SerD comprised 23 dedicated professionals, but by February 20, 2023, the number had reduced to 17, widely expected, due to the retirement and/or burn out of many unreplaced SSN (National Health System) medical workers.[2]

The period we will delve into spans from February 20, 2020, to February 20, 2023. The traumatic events: the COVID pandemic and the disruptive violence caused by an individual known as P.

COVID-19 sweeps over everything and everyone, leaving no aspect untouched. Relational spaces undergo a complete transformation, and institutional care settings experience radical changes. Social workers, educators, and psychologists find themselves working remotely, through smart working arrangements.[3,4] The boundaries between work and personal life blur as professional obligations invade the private sphere for the first time. Patients now enter the intimate spaces of bedrooms, kitchens, and living rooms, bridging the physical distance but bringing unsettling proximity: they are both far away and too close. While doctors and nurses continue their on-site presence, medical visits are restricted to what is strictly essential. Toxicological monitoring activities come to a halt, the interaction spaces become broader with a minimum distance of "at least 2 meters." Masks, gloves, and disinfectants become indispensable tools, but they also contribute to the loss of genuine human contact. The problem of violence in the healthcare environment is certainly not new and widely described,[3-11] but the current difficulties of the SSN mentioned above have meant that it is increasingly out of control.

We find ourselves thrust into an unforeseen and restrictive new setting, devoid of clear protocols, leaving us to endure rather than process it. Just as during Italy's football matches, where we unite as a team against the adversary, we now stand together—caregivers and patients—facing the external threat as one supportive group. The once-frustrated tones, sometimes amplified by patients struggling with emotional management and demanding instant gratification, have now faded to a minimum. Aggression is absent and balanced on a level playing field. We all adapt to some extent, reassuring ourselves that everything will eventually be alright.

Our ability to navigate increasingly complex and demanding

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situations and environments is put to the test. Our work objective becomes challenging, ever-shifting, and shaped by constant redefinition: use Skype, avoid Zoom, opt for Teams, rely on WhatsApp; FFP2 or perhaps no, only surgical masks, no, ffp3; toxicological tests postponed, with uncertain future rescheduling. The guidelines fluctuate, causing uncertainty: maintain a distance of 1 meter, wait, make it 1 and a half meters, actually, now it's 2 meters between us and the patients. The ever-changing color-coded zones confound us: red, orange, ah, even dark orange... the cycle continues.

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As COVID continues its relentless assault in waves, we find ourselves juggling a delicate balance between solidarity and paranoia. Our colleagues begin to depart, some anticipating retirement, others resigning, and some seeking transfers. We strive to remain committed to our work, but uncertainty looms, making it challenging to look beyond the current month.

The future remains uncertain, casting a shadow over our unity in the face of the external threat. We yearn for a return to pre-COVID normalcy, searching for the comfort of familiar routines. However, pre-Covid garments are no longer suitable. Instead, we don post-COVID attire, which bears a striking resemblance to its predecessor but is tinged with a hint of hypomania, a survivor's mentality ("We endured, who can defeat us?"). The boundaries between us blur as pseudo-intimacy and alliances forged during the harshest lockdowns seep into our interactions. ("We were allies, scared together, you used to give me methadone supplies for long periods, you gave me bottles for two weeks, now you can't go back, now you can't tell me that I have to come 3 times a week, COVID made me more trustworthy?"). Now, patients demand greater control over their therapies, blurring the line between doctor and patient. It is within this context that our service grapples with an escalation of patient aggression, often expressed through insults hurled at the staff, reaching its pinnacle with P.

P. is a 43-year-old man who has spent a significant portion of his life behind bars due to multiple criminal offenses, accumulating almost 20 years of imprisonment. With no stable residence and limited connections, his sole and powerful attachment lies with substances. Our acquaintance with him dates back to 2019 when he began receiving specialized pharmacological treatment for a severe addiction to high-dose opiates. P. has never been one to remain calm; his street life has taught him to demand rather than ask. Nonetheless, the SerD has managed to handle and contain his outbursts to a considerable extent, at least until the phase of transitioning back to pre-COVID routines. Over the course of three months, P.'s behavior takes a distressing turn. He screams relentlessly each week, violently bangs his head against wardrobes, hurls insults, engages in stalking behaviors, and even threatens harm to the professionals and their families. Physical aggression towards objects within the Service becomes a regular occurrence. P adamantly insists on having full control over his drug treatment, seeking self-management.

We are afraid and this triggers the most disparate reactions. Some choose to downplay the danger ("Yes, it makes a lot of noise, but it's just a scene… It doesn't scare me at all"), and others experience overwhelming anguish that creates an instinctual urge to escape ("I'm trying to figure out if I can leave, if I can be moved to another office... I no longer take the same route to work in the morning"). The feeling of isolation surrounding us engenders anger, as we realize that even contacting the authorities yields no intervention. The dilemma of reporting arises, knowing that divulging personal details exposes us to potential risks. Despair looms, extinguishing hope, ("Anyway, nothing will ever change..."). How distant those comforting words of "everything will be fine" now appear.

The team finds itself following a familiar pattern, reminiscent of the response to COVID-19, as it unites against the common adversary, P. This alliance, too, serves as a defense mechanism. However, P possesses an extraordinary strength, not in his aggression or violence, but in the role he embodies as a patient. It is this very role that swiftly undermines the defensive team alliance, as it calls into question the representation of their professional and institutional responsibilities. The internal conflict arises: "He must be removed!... But he is our patient... Yes, but he must be removed, we are not safe… But he is one of our patients, he requires treatment." The presence of a patient within the care of the Service, exhibiting aggressive behavior that exceeds sustainable thresholds, repeatedly prompts the staff to request police intervention. However, the police can only provide containment measures in the absence of a formal complaint against P. "It seems that P has got us by the balls". We are paralyzed. Nevertheless...

We become proactive, implementing various measures to address the situation. Firstly, we establish a fast-track system involving police, enabling us to swiftly respond to incidents. We prioritize the protection of our most vulnerable specialists, ensuring they receive adequate support. Additionally, we started utilizing incident reporting forms more frequently and consistently, raising an initial alarm at the organizational level. The Director takes a hands-on approach, consistently being present on-site and directly addressing the situation. Furthermore, we leverage the benefits of organizational supervision, a preexisting structured space that the team had conceived before February 2020. This dedicated space allows us to address these events effectively, recognizing that acts of violence against operators reflect an underlying organizational structure that requires remodeling. In team meetings, the recurring question arises: "How do we welcome a violent patient? Should we even welcome them at all?" We grapple with the realization that violence is part of the patient's pathology, posing a complex dilemma.

Supervision plays a crucial role in providing order and meaning to our actions. It enables us to take direct action with the Company (Hospital), urging them to send personnel to assess the situation and determine appropriate measures. Initially, we relied on individual operators' complaints, but eventually, the Company (Hospital) expressed its willingness to take legal action independently, thus avoiding further risks to its personnel. This transition is facilitated by the involvement of trade unions to which we have reached out for support.

Simultaneously, we establish conditions to transfer the patient to another SerD. This initiative aims to alleviate the anxiety and concerns present in our place, lightening the overall burden.

## Reflective insights

These recurring situations give rise to understandable fears and patterns of avoidance or expulsion. These reactions stand in clear

contrast to the service's mission and the staff's commitment to caring for every patient in need. Consequently, we find ourselves in a state of impasse, feeling disenchanted, powerless, and inclined to give up. However, the only way to overcome this impasse is to confront the delicate balance between the threshold of our limits and the limits of those thresholds.

The presence of such patients brings to the forefront a fundamental question: under what conditions can we justify assuming responsibility for a patient, and when is it appropriate to recognize that their acceptance is not feasible?

The working group succumbs to a sense of depression as a loss of purpose pervades their lives, leading to the question, "Are we truly here to make a meaningful difference?" We find ourselves demoralized, and this emotional atmosphere inevitably affects the patients as well. Amidst the perplexity of the working group, following the initial wave of COVID-19, the patients' requests and demands intensified. Alongside the disruption of the service's functioning, the significance of the protocol, which establishes the framework, becomes blurred. Any opportunity becomes an excuse to deviate from the protocol, and we witness a fragmentation of the established setting. In areas where gaps appear, the patient becomes restless as the containment they relied upon dissipates. Before 2020, the team already displayed a lack of consistently effective containment capacity, and COVID-19 served as a catalyst, exacerbating this team dynamic.

The protocol serves as a ceremonial practice (composed of schedules and guidelines) designed to contain anxiety, as rituals help manage human aggression. During the COVID era, doctors and patients find themselves united, and this unity seems to make patients accountable: overdoses are avoided, aggression diminishes, and solidarity prevails, exerting a profoundly impactful emotional influence on the group. However, as the COVID phase subsides, the previously loose rules are shattered, leading to changes in the protocol and an inevitable accentuation of power dynamics.

When clear rules are in place, individuals can make choices and assume responsibility, establishing a system for restraining human aggression. Within a structured system with defined rules, the needs of those in positions of dependence can be transformed into rights, thus imparting responsibility. In chaotic situations, the most vulnerable individuals tend to exhibit heightened unruliness due to fear and a sense of being lost. In the absence of rules, they often form subgroups that may serve criminal purposes or instigate conflicts resembling gang warfare. In fantasy, the doctor can even be envisioned as the jailer figure.

Moreover, during the intervals between waves, the vaccine emerges as the third dividing factor, in psychological terms. It not only separates but also fosters splits. Gradually, what was once a fragile split becomes increasingly entrenched. We encounter two distinct groups: the vaxes and the no vaxes, those who subscribe to conspiracy theories and those who delve into the history of viruses dating back to the Stone Age. Some believe that being on the side of health necessitates opposing the economy, while others argue that supporting the economy requires opposing health measures.

A lacerating dilemma arises when confronted with the conflicting demands of serving the needs of users/patients and ensuring the safety of oneself and others (including other patients) to fulfill the professional duty. This impasse was vividly expressed by a participant who said, "He's got us by the balls..." capturing the sense of helplessness and deadlock experienced by healthcare professionals. By exploring the interplay between containment, setting limits, tolerable thresholds, and managing reciprocal aggressiveness, we delved into the patient's interpretations and representations ("Is he/she behaving like a/is he/she a criminal or a severe drug addict?" or "Both?"). Central to this issue is a fundamental contradiction between the mission of protection, attentiveness, and fostering emancipatory paths that professionals in social and healthcare identify with, and the legitimate need to safeguard themselves personally and physically against criminal behavior. Therefore, it becomes necessary to navigate the conflict between meeting the user's needs through active listening and recognition and establishing dynamic thresholds and limits that ensure sustainable and feasible relational containment.

The potential to view ourselves as an emancipatory boundary, steering clear of fantasies of expulsion and rigid regulations, has led to a collective decision for a systemic alliance. This alliance enables us to address both genuine concerns regarding personal security and the exploration of our defensive mechanisms when confronted with external aggression.

Consequently, there arises a call for cohesive and expeditious professional hybridization processes to confront the inherent contradictions of daily organizational encounters and the pressing need to imbue them with significance. This entails exploring fresh avenues of action that are intertwined with the unfolding of our daily activities.



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