Report 5 – The function of psychology in the hospital context as the competence of thinking about relations: a risk prevention and protection service

by Elena Lisci

The talk I am going to give is about my practical training experience, which lasted two years and is almost over, at the Risk prevention and protection service in the hospital of an Italian town. The Service was created in 1994 in response to Legislative decree n°626 about the protection of workers' health and safety, which has been updated with the modifications to the law, until the present inclusion of the assessment of psychosocial risk. From a beginning that stressed the structural aspects of risk – it is no coincidence that similar services in other hospitals are managed by engineers – there has been the gradual inclusion, in an increasingly explicit way, of aspects concerning the culture of the organisation.
The Service has two specificities: it is run by doctors and includes a head psychologist. It is therefore to be remembered that in it there are medical and psychological competences side by side, with their different models. Moreover, in line with the development of interest, from mainly structural aspects to the inclusion of cultural aspects, a transition is taking place from a mainly inspectorial controlling role to a role related to organisational consultancy.
In this change the psychological competence in the service is taking on a particularly important role. It in fact allows for a response to the law that is not a mere discharge of duty, but performs an assessment of psychosocial risk using models that give real knowledge of the relations in the hospital and an intervention on their dysfunctional components that constitute a risk for people's emotional and mental health.
In hospital culture the model of relational organisation that tends to clearly prevail is the medical model. Relations that serve as a framework for the relation between the technical expertise of the doctor and the sick part of the patient tend to be neglected or ignored. This translates into a frenetic, stressful behavior, characterised by the experience of urgency that accompanies work that has not been thought out and is not organised with criteria and strategies, where the numerous cases produced are perceived as being single and exceptional, and at the same time always the same. This culture often calls on psychology to take on the burden of the problematic aspects connected to relating, bringing back unwilling individuals, such as patients, to the relational model serving the medical intervention. Instead of colluding with this demand for intervention with the individual, the psychological function of the Service presents itself as the competence to think about relations and to promote change within them. Relations with patients, but also those between staff members in a working team, or between Operative Units.
This year the psychology manager of the Service – which is directed by a doctor – saw the new obligation to carry out psychosocial risk assessment as a possible pretext for sounding out the usefulness for the hospital of spaces for reflecting on one's own work. I was involved in the project, which was an important element in promoting the activity of consultation offered by the service, and benefited from a considerable contribution by the trainee psychologists. Previously, with the mainly inspectorial role of the service, trainees were rarely seen as a true resource.
The clinical psychology hypothesis underlying the assessment of psychosocial risk in the project is that risk is created when the motivations, expectations, and experiences of those working clash with the goals the organisation wants to achieve. Symptomatic of such a clash between culture and goals is the lack of attention to the client's demand, meaning by client both the internal (the staff) and the external one (patients and their families who come to the hospital). Later I will present a case that exemplifies this conflict.
There are four psychologists working on the project: the tutor and three trainees from the school of specialisation in psychotherapy of which I am part. It envisages an exploratory phase, during which we are working with 16 Operative Units chosen with the Health Service Management, representing the various functions and services offered by the hospital.
Initially two interviews are held, one with the manager and one with the coordinators of the various professional roles present in the Operative Unit, in order to agree on goals and start

to understand the Unit. This is followed by a meeting of feedback to the manager and the coordinators together. Then two focus groups are held with some representatives of each professional category, chosen by their head as representing different modes of approaching the job. The focus groups launch discussion and reflection on the issues encountered in their working activity, with special attention to the more problematic matters.

I will now talk about a meeting I took part in with a Complex Operative Unit. This Operative Unit has a role that cuts across the other Units, and is in charge of guaranteeing the hygiene and safety of services provided to the citizenry, and to promote their quality and efficiency. It carries out functions of guidance, coordination and control through the constant updating of procedures and operative protocols, of which it must also guarantee the homogeneity in the various Units. In the initial interview with the director of the Unit, conducted by the head psychologist who is also my tutor in the practical training, and at which I was present, the most important thing seemed to be to show, through a detailed non-stop description of the activities, a high level of organisational efficiency, and to communicate that in the Unit nothing was improvised. I felt bored, I could not concentrate, and I felt like walking out. I felt ignored; I didn't understand, but I didn't feel that I could ask for clarifications. What could I do with those feelings?
An aside is needed here. In this phase of the intervention my function was to help with the reporting of the meetings, both those with the heads and those with the focus groups. The school of specialisation I attend lays great store, in our training, on the methodology of reporting as a competence to re-organise an experience in which one has participated emotionally, using categories of interpretation that allow feedback to the people one is working with so as to encourage the possibility of thinking of the emotionality involved in the work, instead of acting it out. This emotional experience, reorganised by categories, is an essential source of knowledge about what is being done. Thinking over the emotions I felt during the interview with the head, while I was involved in reporting, proved very useful for starting to form some hypotheses on the collusive dynamics typical of the Operative Unit.

Before talking about these hypotheses, let me add a few comments deriving from the subsequent interview with the coordinators of the administrative staff and of the nursing staff and from the two staff focus groups. A problem situation is presented to us. The Unit we are talking about has a twofold purpose. On the one hand, it provides organisational consultancy whenever the Units that are its clients cannot achieve the desired quality. On the other, it is supposed to check that everything necessary is being done to pursue quality. The coexistence of consultancy and control creates a conflict, not thought out by people, but acted out. This results in various seemingly contradictory experiences. A relationship of collaboration with the client Units is hoped for, in awareness of the fact that appearing like "exacting task-masters" is not a successful strategy. At the same time, one would like to have more severe ways of sanctioning. Frustration emerges at the lack of respect for the protocols created by the Unit, in a continual effort to pursue excellence through activities of study and research. A highly problematic event is that of the handing over of clinical records
The client Units are supposed to send the patients' clinical records to the Unit in question within ten days of their release (at the cost of not achieving the budget goals), so that they are available to patients asking for them. In actual fact this does not happen. It follows that relations with the patient who does not obtain the records to which he is entitled, become very strained. The staff member contacted by the patient often takes the protesting patient to his coordinator, creating an obvious situation of conflict and difficulty. Another critical event is the seemingly insoluble stymying of the plan to create a centralised reception service that serves as the only way into the hospital. The project, championed for years by the Unit and supported by Emergency, is strongly opposed by the client Units, which continue to keep their own waiting lists, parallel to those of Emergency.

Let us get back to my feelings of being denied as an interlocutor and placed in the role of a buyer of a perfect product, which already existed in its entirety before relating with me, and to which the only possible responses seem to be unconditional acceptance or rejection. In

fact the meetings with the Unit showed that ignoring the client is the source of their problems. The Unit, ignoring its relations with the client, seems to believe that the responsibility for conflict is to be placed completely on the client's shoulders. The client should therefore simply be kept under control in getting correct information, in being better informed and in extreme cases, sanctioned.
Feedback on these aspects was given to the psychologist in charge at the Unit, starting from the analysis of what happened in the relationship between the psychologists and the Unit, from the very beginning. It was a symptomatic case. At the first meeting, all the people identified by the Management were present (except one who was on strike). They had no idea why they were there. All they had been told was to make sure they were free at that time, and they had been told to attend. In view of the absence of one of the people expected, all the others suggested talking to the Director about the wisdom of having the meeting and after a short discussion, they came back with the order to postpone it. The meeting, on the invitation of the head psychologist, was held all the same, and work proceeded, starting from the analysis of what was happening. It was a matter of following what had been agreed so strictly that the agreement lost validity. The Unit's staff had had a violent reaction, aroused by feeling they were being given orders; the same reaction that the Unit causes in its clients and that I myself had experienced in my relations with the Unit. Remember the way they came to the meeting: ordered to come, without knowing what they were to do there, seemingly totally compliant. A debate began on the difficulty of applying the procedures if they are seen to represent controllers and bureaucrats that impose behavior, the sense of which has not been agreed on. It emerges that they are said to always go to inspections in pairs, like the police. Above all, they are considered lacking in the ability to think critically, possessed by the same experience of unthinking compliance that they want to see from others. A comment directed at them is reported: "If your boss tells you to jump out the window, do you do it?" We dealt with the possibility of constructing and sharing the meanings of what is done, in the belief that this is useful for the prevention of psychosocial risk.