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Commentary on Mario Perini's article 'On violence in healthcare. On violence against caregivers and violence in care'

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Mario Perini's article is interesting and full of suggestions for further investigation. In my contribution I will try to highlight, by points, some relevant lines for health care, postponing the analysis of the recent murder of psychiatrist Barbara Capovani to other writings (Pellegrini, 2023a; 2023b).

a) The correct distinction between aggression and violence must take into account the bridging role played by hate speech. An attack on 'political correctness', which is non-violent and respectful of differences, asserts priorities of various kinds and shows little tolerance for conflict and dissent. Violence, which has always been intrinsic to society, is less understood in its multiple determinants and at the same time, its use is legitimized both to assert itself and as a response to aggression and violations. A line that separates 'us/them', 'friends/enemies', totally unlike the line of 'zero violence', which tends towards the encounter, mediation, and self-control in order to build together health and social well-being, the quality of life of a community that includes all living things.
   A change in the social pact has been taking place for some time. In fact, while our Constitution outlines a set of rights and duties, in reality, we can see how these are 'emptied', stated but not demanded or respected, and therefore, often filled with rules placed outside a general vision. For example, when facing perceived insecurity, the extension of the concept of legitimate defense and the possibility of the ownership of weapons.
   Health and social services are instruments for making rights effective and must be ensured for each of us in the interests of the community. If the instrument is weakened, the rights and the very concept of the state itself will suffer. This then changes from being the expression of a living democratic community to being an abstract entity that must ensure public order and dispense bonuses or privileges without posing the problem of sustainability to the citizens who are no longer held accountable and are

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sometimes infantilized. By privatizing suffering, the market will regulate social relations. This is more relevant now that we are in the syndemic due to the association and complication of several crises: health, social, economic, climate, peace.

b) In the health sphere, the pandemic was tackled with a depressive, restorative experience that was only partly reflected in public opinion, which, on the other hand, maintained a 'schizoparanoid' attitude, *i.e.*, one centered on projection, vindication, the search for culprits and the demand for compensation for 'unjust damage'.

   The pandemic marked the return of medical power owing to the regulations imposed on people in every walk of life and upset the order of health priorities.

   It should have been an opportunity for an inclusive model of development, a new relationship with the environment and all living things on the planet, fostering ecological and digital transitions and addressing 'social determinants'.

   Health workers were at first idealized then rapidly devalued, forgotten, and neglected. When heroes do not die in action, they tend to become annoying veterans, wounded and complaining, struggling to cope with waiting lists, millions of backlogged visits and operations, psychological and psychiatric suffering with ever fewer resources available for dealing with them.

   The crisis in human and economic resources is leading to fragmentation, burnout, disinvestment, and flight in the face of the increasing professional and ethical impossibility of responding adequately to people's suffering. Nevertheless, the single operators and patients give daily proof of resilience, providing a silent testimony that keeps the system going. Despite this, there are protests, grievances, aggression, as well as resignation and abandonment of care. The words of professionals and citizens fall on deaf, violent indifferent ears and are papered over by empty assertions. The phenomena of fragmentation of the employment relationship (with cooperatives, atypical contracts, temporary work) undermine fairness and teamwork.

   Healthcare depends on and is at the service of the economy. This is a process that has been going on for some time, in which the demands of a universal public welfare have been incorporated into an 'individual demand' welfare. We are moving towards an insurance system with residual public welfare for the poor. A very bad prospect given that private systems increase costs and litigation, and do not guarantee the right to health for everyone.

   The public service is universal, but those who have the financial means can 'also' turn to the private sector. This is made easier by the absence of verification of access titles to the system (tax-compliant?) and the uncertainty of the essential levels of care.

c) The caring relationship has changed from a paternalistic one to a more

egalitarian one, to a 'demanding' one where it is the person who demands and protests if he or she encounters obstacles. There are undoubtedly institutional limits in responding to needs and operators in creating a dialogical and collaborative climate, but the problem is more complex. We have moved from the obligation of means and not of results, to the demand for predictable average outcomes on the basis of criteria and a risk/benefit assessment made explicit in guidelines. This affects healthcare liability, defensive medicine, and litigation. What is needed is the decriminalization of the medical act and the overcoming of the position of guarantee in favor of therapeutic privilege.

Overly high or unrealistic expectations are brought about by overly positive communication, even to the point of therapeutic omnipotence, which does not highlight limits or difficulties. Granted that, it is necessary to keep hope alive, this makes it difficult to accept negative or inauspicious outcomes.

The inclusive mandate sees fragmented, closed, exclusionary, and sometimes racist communities unable to act on the social determinants of health reduced to a health issue through the psychiatrization of distress. Requests for the neo-institutionalization of deviants, the disturbed, but also the elderly, the disabled, and migrants, are on the rise. A psychiatry that should be at the service of public order and create 'worlds apart'.

d) Limited knowledge of the scientific approach is evidenced by the low uptake of vaccinations even in children, of cancer screening (60%), and recommended or evidence-based therapies. Limited compliance (50-60%) is found in the treatment of chronic diseases (diabetes, *etc*.) not only in patients with mental disorders. There is therefore a widespread tendency not to follow medical guidelines and knowledge, both in the area of pathology, prevention, and lifestyles, suffice it to consider the case of tobacco smoking and the use of alcohol, the damage of which is well documented. The use of sorcerers and occult practices also remains widespread in our society.

   While consent, freedom, and self-determination are fundamental ('nothing concerning me without me'), the limits and conditions of care must be made explicit, which means motivation and responsible participation of the person are essential. Within this framework, 'compulsory' and 'coercive' practices, even though residual, need to be better regulated, providing rights and guarantees. A very delicate point in respect of which there should be an improvement in safeguards involving tutelary judges, lawyers, support administrators, trustees, guarantors for persons deprived of their liberty. An ambience of dialogue, of listening to the different needs (social, educational, income, work, home) must avoid solely a health and psychiatric response.

e) To Mario Perini's proposals, which I agree with, I would add the need for interinstitutional collaboration between health, justice, and security, involving citizens, associations, and drastically reducing the circulation of

weapons. We need to extend clinical governance and safety of care by acting on all structural, organizational, resource, and technological factors.
On a legislative level, the criminal code needs to be revised by changing the rules on chargeability (Articles 88 and 89).
In Italy, there has been a steady fall in serious crimes (318 homicides in 2022 versus 1916 in 1991) with a rate of 0.6 homicides per 100 thousand inhabitants versus an EU average of 1.03. The number of feminicides has been relatively stable over the years. For crimes such as theft and robbery, Italy is in seventh place and in sixth place for house break-ins. The suicide rates in prisons are 15-20 times higher than that in the general population, and the data on the main critical events (assaults, acts of self-damage, protests) are worrying, which urges us to reflect on the relevance of overcrowding as well as of isolation, relational, affective, sexual deprivation associated with the absence of hopes, prospects, rights, and opportunities.
Finally, it is unrealistic to consign all evil to one place. Evil is part of man and will always be present in families and communities. Its reception, processing, and meaning may differ. The illusion of coercion and custody can distance us from complexity, and create false solutions and reassurances.

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