Psychosocial risk assessment in Hospital

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Abstract

This paper proposes a psychosocial risk assessment case in a hospital in Rome, according to the criteria provided by the Work Health and Safety Act. Those involved in the assessment may comply with the rule without caring about the client request, the management and employees' expectations, the usability of the results. For a psychologist this means moving from producing documents to activating interest and development in the context of intervention. The article analyzes two social representations of the employee, conveyed by the work health and safety act: as a person with specific motivations that negotiates the rules in the workplace or as a physically and mentally vulnerable individual. This determines different visions of the assessment: analysis of the organizational relationships or diagnosis of individual malfunctions. We will analyze the assessment process developed with the protection and risk prevention Service responsible in the hospital: the relation between the consulting function and the technical one in the Service, how to enable the hospital strategic management, the coordinators and the 2000 employees' participation. The results of the research show significant levels of risk linked to the conflict with the strategic management, to the pressure made by patients and their relatives, to the health workers' lived experience of isolation despite complaints to the magistrates, thus showing the limits of defensive medicine. Then we present the training work with the first aid and emergency service workers carried out with the aim of intervening on the high level of risk noticed and on the sentinel events linked to the aggressions within that unit.

Keywords: work related stress; psychology and work health and safety; hospital culture; sentinel events; psychological intervention in the first aid service; psychological intervention in the hospital.

Introduction

We propose a report of a psychosocial risk[1] assessment intervention carried out at San Filippo Neri hospital in Rome. We dealt with this intervention firstly during our training as specializing students at SPS[2], then as consultants for the Hospital SPPR, Servizio Protezione e Prevenzione Rischi (Protection and Risk Prevention Service).
The assessment is an employer's duty, as provided by the Work Health and Safety act. Within this frame the psychologist consultant may risk to uncritically translate the client requests, in a duty based application of techniques within the obligation provided by law. In this case the chance to think with the client about a possible use of the assessment may be lost. Furthermore, the psychologist may suggest diagnosing and healing aspects of the organizational behavior, such as absenteeism or non-cooperative conduct. Alternatively the psychologist may care about the demand, the symbolic dimensions experienced by those taking part to the organization, thus giving a contribution to a thought about the relation between the organization and the employees belonging to it.
In the present case we worked within the partnership between SPS and SPPR, in a project oriented at creating, from the normative constraints, a development chance for the hospital context. In this paper we analyze the demand we were made at the hospital as a psychological intervention case within an organization that is coherent with our psychotherapeutic background. In particular we refer to the possibility that the psychological function may support organizational contexts in the development of the skill at thinking emotions.

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1 It is also defined as work related stress; in this paper we chose to use the definition psychosocial risk and we will explain the reasons later on.
2 SPS, Studio di psicosociologia, a School of Specialization in Psychoanalytical Psychotherapy that teaches to intervene with psychotherapy within context like the hospital.

The work of the psychologist within normative mandates: between duties and development

In the assessment of psychosocial risk, the psychologist and the client encounter by the necessity to comply with a law. The widespread habit to produce documents to solve in name only, therefore in a false way, law obligations that should face critical issues is a symptom of the distrust in the possibility to intervene on problems, in particular on those problems arising from the collapsed collusions within the organizational relation[3]. The requests to take care about the problems may be answered with conformist acts, that perpetuate usual relational modalities; in this way it is avoided giving sense to collapsed collusions, whose interpretation may take to new ways of relation in the working system. Adhering collusively to a task based culture, the psychologist and the client do not see the resources that are potentially at their disposal: for example laws introducing measures that can improve unease situations are not interpreted as opportunities.

If we just comply with the normative mandate, we can say that the intervention exists because there is a duty to be followed. According to common sense, law is a sufficient condition to determine expected behaviors. We think however to critical cases, such as the difficulty to promote the use of individual safety devises like gloves or helmets in a sector with a high amount of accidents like building trade. According to a psychological perspective, decisions, choices, behavior are translations in actions of the collusive culture that people share. The transition from law to its implementation requires to deal with the collusive dynamics of the consent; the word consent, from Latin *consensum*, feel together, agree, may evoke relations that are very different from an asymmetric dependence that takes the adherence to the requirements of a power for granted. It requires a project to redefine the value purposes in pragmatic objectives, as well as the comprehension of the cultural sense that the implementation of a law takes within a specific context. In the hospital we firstly thought about the sense that adapting to the management demands or complaining against them could have for health workers.

A cultural analysis of legislation on work related stress. Fragmentation of social object.

In Italy the legislation on safety has been reorganized as a consequence of the European Council requests[4]. The first element we may notice in the Italian translation of the European indications is the shifting from a perspective oriented at improving workers' conditions to a health protection dimension. In European pact for mental health of 2008 we read: "Action is needed […] to utilize the unused potential for improving productivity that is linked to stress and mental disorders". We may see here a reference to the productivity improvement request connected to workers' psychological condition. Furthermore, cultures and direction styles are cited along with more individualistic categories (drug abuser, alcoholism, mental patients). In Italy the decree 81/2008 connected the work related stress to categories such as women and men, pregnant women, foreigners, old and young people. The assessment presents itself as a sum of diagnosis that has to be accomplished on default social categories and that creates a fragmentation which is unlikely to provide exploratory criteria to understand the entire phenomenon. In our opinion this fragmentation is influenced by the technicalities culture that explains an object by segmenting its internal mechanism, but that does not catch the relations between the object itself and the reference context, even when it deals with social object. The psychological function may provide with reading models of the outlined problems, which are alternative to the division in numerous sub-categories and attentive to the relation.

[3] In our work we use a model of analysis and intervention on relations whose conceptual assumptions, that refer to a psychoanalytical theory of social relation, may be found in Carli & Paniccia, 2011.
[4] The change has been made firstly with decree 626/94, then with decree 81/2008, finally with decree 106/2009.

The medicalization of the conflict

If we explore the legislation on the relation between work and safety, we see two different images: on one side the image of the worker as a vulnerable, at risk person, on the other side as a person with dignity, that is the state of moral nobility which is given to man by his level, his intrinsic qualities, by his own nature[5]. The use of the word dignity is a characteristic of the '70s: we find it in the workers' statute. That is the phase when the economic boom and the industrialization contributed to develop strong conflicts regarding work issues, until "hot autumn" of 1969[6]. A person with dignity claims his/her rights. The workers asked to intervene on the agreement about work hours and salary[7]. There was then in the Italian history a period of deep mistrust in changes and of gradual negation of the social conflict potentialities, till the present *a-conflictuality*[8] valorization, meant as "a relation modality that is based on social conformism, i.e. on the claim to duly comply with law, with rules laid down by an indisputable power, and with no space for autonomy and thoughts" (Baraldi *et al.,* 2011, p. 66). By *a-conflictuality* we mean the mode of relating based on social conformism, or on the expectation that one dutifully sticks to a norm, to rules dictated by an unquestionable power which allows no space for autonomy and thought.

We can see this transition in law 81/08: workers' health issue is mentioned, the problem is medicalized, disconnected from organizational relations and confined to the worker's body. In the relationship between employer and employees, the rules negotiation is substituted by a medicalized vision[9] that changes the conflict in stress, in a phenomenon that is inside the worker's body or mind, in a pathology to treat or to remove, a vice that makes the employee dangerous, unproductive, ineffective. The medicalizing attitude that changes social conflict in individual illness may be interpreted as the attempt to make health promotion an alternative to facing negotiation dynamics[10].

In such a cultural scenario the employee is now considered as a person with no negotiation power and no skill at taking part to a production process. If in the relational dynamics of the conflict it is expressed the contrast between people having interest and contending power quota for a third and verifiable object, such as productivity, development and excellence, the cultural shifting on the health/illness concept moves the conflict on an object that is not verifiable anymore since it is a very general, linked to values and potentially with no limits purpose. The representation of social phenomena as disease produces sick subjects, isolated from the organizational system. At the same time, talking about illness in our culture seems to lead to hope, to trust in treating actions.

[5] Treccani dictionary (www.Treccani.it).

[6] In September 1969 Francesco De Martino, socialist party leader, said in Parliament: "The autumn may be very hot". In those months there were following strikes and assemblies in the main Italian factories in connection with the renewal of employment contracts. Beside workers requests, students asked for a greater protection of the right to study. The expression "hot autumn" has been used by the media also in September 2011 with regards to demonstrations against Mr Berlusconi's government.

[7] See Crainz, 2005, p. 188.

[8] On the concept of non-conflictuality, see Carli, 2010, pp. 1-3.

[9] With regards to the concept of medicalization, see Di Ninni (2011): "the medicine discourse pervaded our culture, providing and at the same time imposing traces of its logic to man's main issues, intervening on birth, death, pleasure, in a word producing a medicalization of life (…). The transition from listening to symptoms to the certainty of the pathogenesis through tissues observation, makes medicine oriented at illness investigation rather than at the patient. In short, the meaning demand linked to a suffering experience comes down to a health service request" (p.39).

[10] With regards to the critics about health concept in psychology, see Carli & Paniccia (2010): "It was sustained the limitedness of a psychology vision relegated to the individual, the ambiguity and the indefiniteness of health concept, if applied to psychology. We consider also the great ambiguity and the misleading value of the welfare construct if applied to psychology. What does "request for welfare" mean? When can any of us say to be in a welfare condition or to strive for it? […] If organizational systems aim to development, innovation, efficacy, do they need to pursue well-being or to achieve goals? We may continue and see how the word well-being, hinting at something positive, is historically untied from any possible psychological, sociological, economical, historical, political or religious interpretation of the phenomena characterizing co-existence and its conflicts, people's, nation's, social groups' events in their context" (p. 7).

The assessment of work related stress has this intrinsic ambivalence, that we believe useful to consider for the psychological function requested to deal with it.

The case of the Hospital: use of individualistic techniques or intervention on culture

We now consider how the project of assessment starts in the Hospital. It is the Protection and Risk Prevention Service (SPPR), an operating unit within the strategic management, that has to deal with it[11]. The SPPR psychology requests a collaboration to SPS to develop an intervention plan realizing what is provided by law and creating a chance to promote the organizational skill of those working in the hospital. The first suggestion in the relationship with those who commissioned the work, is reconsidering in a critical and reflective way the law obligation dimension and exploring the symbolic dynamics that substantiated the request for intervention.

At this stage we were part of the work group that was activated ad hoc within the Specialization Course and devoted to build hypothesis on the problem that it was intended to detect. The work group, to which SPPR and SPS consultants took part, shared the idea that the stress problem was not related to single individuals, but to specific cultures: the psychosocial risk has its reference and study center in the relationships developed among the different parts of the organization (Carli, 2012). In the clinical psychological interpretation, the stress phenomenon regards collusively shared experiences, ways in which people operating in an organization symbolize the work relationship. In the literature on stress this construct is defined in physiological, universal and recognizable terms by ostensible symptoms' presence, regardless of the context. In the clinical psychological proposal the stress concept is contextualized to catch its "local" sense. Intervening on stress in these terms implies promoting the skill at mentioning problems and relations with new categories. We suggested then to name stress as psychosocial risk; with this expression on one side we referred to the historical roots of the psychoanalytical perspective adopted by SPS, the French psycho-sociology, on the other end we used words that are immediately evocative and facilitate the relationship with the client. The aim was stimulating a real use of the assessment as a chance to understand the Hospital problems with regards to work risks.

The assessment of psychosocial risk: the intervention research

The assessment was developed in two phases. In the first one the SPPR psychology, together with the specializing students of SPS, created focus groups involving different professional figures and asking them to talk about work issues perceived as problematical in 15 operating units representative of the main activity lines in the Hospital. The focus group text was analyzed by AET, Analisi Emozionale del Testo (Emotional Text Analysis)[12], which allowed a first explorative analysis on the collusive processes that organize relationships in the Hospital. In the second phase all the UUOO (operating units) of the Hospital were involved using a ISO[13] questionnaire created ad hoc according to the results of the first phase as well. The assessment results show 3 areas of risk[14].

[11] On the role of SPPR and its organization see Atzori (2010, pp. 1-4).

[12] The method of Emotional Text Analysis allows to create knowledge on the emotional aspects that characterize a text. Here with text we refer to the discourse produced by people taking part at the same context, relating to the same object. In other words, AET allows to notice and analyze the collusive processes that organize coexistence in different contexts. For a deeper analysis, see Carli & Paniccia (2002).

[13] "ISO tool (organizational development indicators) is a questionnaire based on three elements: SPS models pool for the organizational analysis, population/problem specific expressions obtained through AET, client purposes. The use of AET and/or ISO tool is linked to the client-population characteristics and to the client purposes" (Cavalieri, 2003, p.3). For a deeper analysis, see also Carli, Paniccia & Salvatore, 2004, p. 30.

[14] See in the same journal issue: "Psychosocial risk in San Filippo Neri Hospital. Psycho-sociology study for the prevention and risk protection service".

First psychosocial risk area – The relation with the hierarchy managing the hospital
Two cultures are in contrast in this area. The first one complains about the lack of managerial skill in the hierarchy management: it is thought that those heading the Hospital are not interested in promoting development, improving results, pursuing hospital's goals. They proposed a discouraged dependence where they feel to be at the mercy of somebody else, but at the same time they give the responsibility of the organizational problems to the hierarchy they believe incompetent. On the opposite side, they describe the hospital as "the best possible world", where everything works well, where they are satisfied about their work, where they feel to be managed by a friendly hierarchy devoted to promote collaboration and to offer greater and greater development opportunities. The opposite ways to be in relation with the hierarchy heading the Hospital are in evident contrast in the difficulty to develop shared hypothesis on the organizational problems of the Hospital.

Second psychosocial risk area – relation with work dynamics
The second area as well is divided in two different ways of experiencing work in relation to the internal dynamics of the work itself. On one side an encirclement experience emerges. The workers live the job in the health area as subjected to looming and inevitable threats. They perceive the relationship with sick people and their relatives, as well as the work organization in hard shifts, as threatening; they fear the magistrates' intervention. On the other side it seems that the health workers find an antidote for stress in the solidarity and trusting relationships with their colleagues. Critical situations are always present, but the skills at communicating, at collaborating and at working in team offer a compensation to the stressful conditions.
This second risk area appears to be less problematical than the first one because, if on one side it shows critical elements, on the other side it refers to possible resources in the health work.

Third psychosocial risk area – relation with the health context specific problems
The third risk area is characterized by the awareness of the difficulties connected to the work in hospital, that puts into contact with difficult diseases, with death and the impossibility to treat. The problems mentioned, however, are in contrast with the valorization of workers' actions in the hospital. They trust their professional skills and they think that activities can be organized in an efficient way in the unit they belong to. They aim at pursuing the organization's goals, at working hard, they consider being innovative and showing interest for the patients as success' factors.
In short, it is about a way to live work in the hospital that plays on the efficacy and professional skills' feeling to compensate the stress connected to dealing with serious diseases. In this culture only few signs of psychosocial risk are noticed.

The protection and risk prevention service: between technical function and consulting one

We started the training at SPPR during the first phase of intervention-research, creating relationships with the Service's workers and with the hospital management. Our goal was using the meetings and exchanging opportunities with the service's workers to contribute making the actions connected to psychosocial risk talkable and then thinkable. We refer to the possibility of defining a problem[15] from the experience recognition. In this case it was about associating each assessment phase planning with reflection moments that allow to name the problems faced.

One of the first issues brought out during the training interviews with the tutor, the psychology of the Service, related to SPPR characteristics. It's a cross-service that, after the approval of the decree 626/94, supports the hospital management for the employees' work health and safety. It has been developed with two intervention areas: the first one, where doctors and nurses work, deal with the health monitoring service, i.e. with the employees' health protection from risks connected

[15] In the theorization of social representations, Moscovici says: "what is anonymous, nameless, cannot become a communicable image or be immediately connected to other images […]. In other words what was denied before now is allowed" (Moscovici & Farr, 1989, pp. 52-53).

to their specific tasks; the other one is mainly oriented at risks assessment and at the arrangement of adequate preventive measures. Psychology intervention takes place in the second area, characterized by the presence of different professional skills (medical, psychological, of the security staffs).

The evolution of law related to work safety stimulated the promotion of a strategic intervention logic within “the shift of safety perceived as a problem (because it is alien to the productivity process) to safety interpreted as a management project” (Atzori, 2010, p. 1).

With regards to this change, we noticed an integration demand between actions and functions made by the service’s employees. The first step supposed with the psychologist was proposing actions that promoted the involvement of the entire SPPR in the assessment project. We started from sharing the meaning the intervention was beginning to have: through psychosocial risk assessment SPPR was offering a consulting service to the hospital. This offer needed the involvement of the strategic management and of the health workers’ groups to be imaged and organized.

In particular the exchange with safety staffs allowed us to collect important information about the culture and the practices popular in the Hospital. Furthermore, it allowed noticing an interest to understand a hospital cultural dimension: how to put together actions connected to technical dimensions with actions centered on relational dimensions, such as the integration between objective and subjective risk indicators.

Another relevant aspect we dealt with was the involvement in the assessment of the entire staff of the hospital through the use of the ISO questionnaire. A great attention was paid to the way to activate the entire Hospital: how to convene and most of all motivate the UUOO? Actually the second intervention phase started with the proposal to have meeting to release and discuss the results of the first explorative phase. It was not about just showing data, but creating an implication starting from the data, keeping the assessment experience alive and promoting reflections about the hospital organizational functioning from the knowledge of its culture. We delivered the ISO questionnaire to all Units, finding in each of it representatives coordinating the data gathering in their own unit. The answer was more than satisfactory: we collected 956 valid questionnaires filled in by different professional figures, about 60% of the people working at the Hospital.

Who the results belong to?

When we finished delivering the questionnaire, our tutor had to leave for some months. We agreed with her that during her absence we would have continued the assessment interacting with the other SPPR functions. A new possibility to share criteria and strategies within the Service was about to be outlined, though the different technical and functional skills, starting from the common interest in realizing the psychosocial risk assessment that for the first time the Service was trying to undertake. We started a more direct dialogue with the director, to organize the phase of releasing the assessment results within the Hospital. In our conversation with the director an interest in taking actions that could keep the assessment process alive and make the assessment results not just “a document in a drawer”, but a resource to understand problematic aspects of health workers’ daily experience becomes apparent. It seems that the first solution could be giving to the Hospital hierarchy concrete indications, precise technical suggestions to deal with the problems noticed. Along with it, we regain the management’s interest, especially from the Health department and the UUOO staff, with regards to some issues perceived as relevant in the hospital work. This interest might leverage to talk firstly with the Strategic Department management as consultants, making the assessment a tool to highlight and deal with organizational problems.

We suggested to the director that it could be useful to have meetings to discuss the results with the whole SPPR and to elaborate the data before delivering them outside the Service. She told us she would have convened the meeting with staffs, doctors and nurses. It seemed to us that was a good

result of the exchange with her. The assessment results were activating exchanges about the emotions experienced in the workplace.

We prepared the invitation to the meeting talking with the Prevention Service workers, with which we had a greater cooperation during the previous months. During the conversation we start noticing more clearly the contacts among the various activities that were being carried out at SPPR: the research on accidents and the structural problems' detection on one side, the intervention on cultures on the other side. The internal SPPR meeting, addressed to all professional figures and oriented at a shared reflection on the present work, was also a first way to verify the results with a group of the hospital's health workers.

The hierarchy's implication: Hospital's Strategic Management, UOC (complex operating unit) directors , head of UOS (simple operating unit) and technical and nursing coordinators.

The Service director in a meeting with the General and Health Department directors agree to convene Directors and heads of UUOO and technical and nursing coordinators with the aim of returning the results. During the exploratory phase it was useful to meet Directors, Heads and Coordinators to share the assessment meaning: many representatives recognized themselves in the cultural representation SPPR was offering them. Then, with SPPR we arranged meetings with SAIO Servizio Assistenza Infermieristica e Ostetrica (Obstetric Nursing Assistance Service), CTSR Coordinamento Tecnici Sanitari e della Riabilitazione (Rehabilitation and health technician coordination), technical and nursing coordinators, administrative unit directors, informing them about the levels of psychosocial risk, but mainly about the issues perceived as problematic by the various functional areas.

In this phase SPPR invests particularly on a dialogue with the Administrative Management and this choice allows to deepen the relation between healthcare culture and management culture in the Hospital[16]. Often in the hospital culture we noticed a preeminence of the medical function on the administrative area, that includes the entire technical staff, from electrician to cooks. SPPR, along with the activities carried out with the aim of involving the administrative area, was planning an intervention on individual risk areas in collaboration with SPS.

In this phase as well it has been possible to work through the involvement and motivation of the various functional areas. A result of this dialogue was the possibility to notice a training and consulting request for the hospital workers both in the medical and in the administrative sectors. The exchange with the administrative units' directors was intense and promoted a request to develop skills at managing work groups. On the basis of the research data and of the gathered information, it was suggested an intervention addressed to four UUOO oriented at discussing with the staff how the groups they belong to work. The hypothesis is that deepening the knowledge of the dynamics one is absorbed in is itself an intervention oriented at promoting changes. We proposed to each Unit a seminar divided in two meetings: the first one devoted to the reflection on the conflicting and cohesive dynamics within work groups, the second one used to start analyzing critical events experienced by the staff in the ward life.

The seminars with First Aid and Emergency service Unit staff

[16] In the assessment experience we are reporting we noticed the problematic nature of the division within the hospital organization between a part that pursues medical goals and another one attentive to management aspects. In this regard it is important to remember that corporatization processes promoted in health care structures the rationalization in the resources use and in the goals definition. The ability of the hospitals to specialize and avoid inappropriate admissions is a strongly appreciated aspect in the healthcare politics in the last years.

We started encountering the staff of First Aid and Emergency service unit (MUPS) [Medicina d'Urgenza e Pronto Soccorso]. The staff of the unit was divided in four groups and each group assembled a work team. Two meetings of two hours each have been held about a month apart with each group. Here we report the issues discussed in the relationship with the staff.

What is this training work useful for? The participants asked this question at the beginning of our meetings. An issue noticed is a dyscrasia between our perception as consultants to be in the middle of a process made of barely planned and realized phases, and the staff's perception to join meetings that take place in the hospital life almost by chance. Many of them told us they did not remember to have filled in the questionnaire or that in their unit the preliminary assessment focus groups might have not taken place. We faced a breaking up of the contacts, of the activities, although we invested on and worked on the coordination functions. We thought about the hospital context, where everyone gets involved in emergency and in doing without memory, and we asked ourselves how it would have been possible to create a story, a process, a continuity. We kept the question open in the prosecution of the meetings with MUPS staff analysis. With regards to our propose to exchange views about the cultures appeared in the assessment, some members of the staff asked if we would have mediated in the communication with the Management, otherwise talking would have been vain. Some others connected the training meetings with the recent aggressions, even very violent, they have been subjected to by patients or their relatives. There are two fronts, the hierarchy and the patients, between which the staffs feel crushed. We faced a contrast with regards to our propose to think about their work style, based on being anchored to facts. If we could not intervene on those facts, talking was not useful. An important goal was facilitating the shifting from acting out the relationship without any recognition of the experiences to the possibility of seeing and thinking about the relational modalities taken in the work at the Hospital. For example, we noticed that the conflict between them and the patients was not only feared, but in its repetitive and stereotyped aspect it could also be a reassuring relational modality because of its predictability and because it allows the avoidance of relationships. The aggressions could be interpreted as actually dangerous and distressing failures in this avoidance.

The meetings with the staffs allowed us to focus on their representation of the Unit, described as a crowded, confused and disorienting context. The complaints centered on aspects on which each staff, as well as we consultant, has little or no power of intervention, thus confirming the feeling of impotence made clear in the request to talk directly with the management. Where acting prevails on the possibility to think, it seems not possible to organize events in a story, in a process. We worked on this aspect with regards to a critical event[17], that in the hospital culture is defined as sentinel event[18]: the aggressions some staffs were subjected to during the last months. In a first moment the aggression was described as an unpredictable event: "Things happen: it's just a moment and you find yourself to be subjected to violent acts". In the most recent case, the staffs talked about an aggression made by a problematic patient that, after having waited for several hours in the first aid ward, hit a doctor, a nurse and an auxiliary. The staffs start to retell the event, how it developed during the hours the patient was under observation. A problematic aspect can be noticed: the patient didn't understand they were taking care of him, he felt ignored, abandoned. It is gaining ground the hypothesis that the need to be welcomed and informed is so fundamental in the hospital context that patients intensify their actions till a physical conflict to become finally visible. Recognizing the role played by the aggression in the dynamics has been useful to understand how to work with major room for predictability and safety for themselves and the service offered.

[17] A critical event is "an event that determines a crisis in the structures' functioning, and therefore can induce the Service to rethink about the relation it sets up. We propose this construct as a criterion that allows to deal with problems emerging in the structures connecting them to the specific goals the structures themselves pursue. Patient's acting or acute crisis, staffs' impotence or a failure experience, may give attention to the structure-clients relation, promote a check of the work done and lead it to the structure's goals.

[18] From the Health care Ministry: "Sentinel events are those seriously adverse events that cause death or severe harms to the patient and that determine a lack of trust in the healthcare service from the citizens' side. The surveillance of sentinel events, already in place in other Countries, is an important action of public health, representing an indispensable way to prevent such occurrences and promote patients' safety".

The crisis of the reception function

The staffs talked about the impossibility to give attention to patients because of their hard workload. At the same time, they experience situations of great conflict with the patients and their relatives. We suggested thinking the present work organization as a cultural product, connected to the evolution medicine has made in the past decades. The possibility to access information about health and disease, the birth and the development of organization such as Tribunale per i diritti del malato [patients' rights court][19] contributed to create a deep re-organization of the relationship between doctors and patients. Health workers do not feel predictably safe in a relationship that demands reliance. A difficulty to acting according to the triage[20] emerges, and it is perceived in particular by nurses and auxiliaries. We saw that triage regards not only the assessment phase, but also the reception one to the First Aid ward: during the meetings it became evident that it is fundamental to develop staffs' skills at welcoming, at establishing a relationship, at communicating attention, care and interest. We may say that the aggression replaces other communicative actions perceived as impracticable. Aggressing (in Italian "aggredire" from Latin *aggredi*, from *ad-* = to and *gradi* = walk) may refer to going to somebody; it seems a desperate action that resorts to violence to escape from the feeling of being ignored. The patient that lays hands on the doctor reverses what usually happens: it is the doctor to act on the patient's body and not vice versa, and he/she does so to treat the patient, not to harm him. This brought to think that MUPS users may not be easily assimilated to the *patient* category. The patient is a person that submits himself/herself to medical care, accepting to have a dependent role. The first aid ward, as a borderland between the territory and the Hospital with its own rules and its dependence expectations, clearly shows the necessity to develop a skill at dealing with relationships, at managing the anxiety of those that, before becoming patients, are citizens waiting for a service.

Treating/Taking care

In the training work we started discussing the problematic nature of a culture based on conflict between the medical act believed as essential and the attention to the relationship considered just as a frame. If this is the feeling, when it is not possible to treat a patient, it seems that reference points and actions' priority disappear. Doctors say to experience a difficulty to face cultural changes, connected also to scientific developments, that nourished the fantasy that treating is always possible. They say that the relationship with patients and their relatives deeply changed compared to the past; they get involved in the request to solve with efficacy even the most compromised situations and they complain about patients becoming more diffident. They always feel to be in the eye of the storm because of patients' and their relatives' aggressiveness. The feel they have to defend themselves, trying to avoid aggressions and complaints. We think about defensive medicine, that organized medical practice in actions that have the aim to protect the doctor from possible responsibilities connected to the treatment given. We are noticing that at the center of the conflict there is a progressive predominance of a defensive conduct that interferes with treatments.

In the 2010-2012 Health care plan of Lazio region, we can read: "It is often noted the healthcare workers' inclination to reduce communication to a simple tool, vehicle of bare information, that nourishes patients' dissatisfaction". Why do health care workers have such a poor and not

[19] From www.cittadinanzaattiva.it: "The Tribunale per i diritti del malato [Patients rights court] is an initiative of Cittadinanzattiva started in 1980 to protect and promote the citizen's rights with regards to assistant and medical services and to contribute to a more human, effective and rational organization in the national healthcare system. TDM [Patients rights court] is a net set up by common citizens, but also by health care services' staffs and by professionals that work voluntarily (almost 10000)".

[20] It is a procedure followed in First Aid ward that allows to organize patients' access according to the evaluation of the seriousness/emergency of their conditions.

adequate communication with their clients? On one side it seems that the difficulties are linked to the fact that communicating is not a skill the Hospital is provided with: in particular doctors complain about having not been trained for such aspects. On the same time they recognize to be part of a cultural change process, therefore the doctor is not obviously considered as *friend*. They ask: how to communicate a person's death to a relative? How can they foresee the reaction of the people they encounter in the wards? How can they face the relationship with the patients or with the relatives that sometimes thank, some others give hugs crying, and some others insult and threaten them?

At the end of the training meetings, SPPR psychology discussed about the critical areas with SPS consultants, UOC Director and nursing coordinators. A will to continue the work carried out emerged, in particular with the aim of developing Fist Aid ward's skills at managing the relationship with clients, i.e. with patients and their relatives. SPPR, in collaboration with SPS, proposed a project in order to point out critical events in the First Aid ward communication and then to start an exchange with UO work groups. At the present two SPS specializing students are involved in the project achievement[21].

Which hypothesis on psychosocial risk prevention?

The work carried out with MUPS staffs allowed us to focus on how stressful experiences that are connected to an organizational culture characterized by a reduced attention to relationships. We think about internal relationships, with the hierarchy and the colleagues, and to those involving the clients, i.e. patients and their relatives. The hospital work organization, if thought in terms of techniques' use, then in terms of single actions that are invariably repeated, produces separation and isolation. In patients and their relatives it produces the feeling of losing control on what is happening, they feel at the mercy of the doctor's intervention. The work of reconstruction and reflection on the relational models acted by the staffs may have a preventive value, also with regards to the health care workers' or patients and their relatives' violent conduct. We saw how the health workers tend to take the comprehension of the hospital rules from the patients and their relatives for granted. When patients and their relatives do not act as expected, they underline the necessity of good manners: "Who enters has to know how to act!". We think also to the issue of leaving someone with no information: it may create distress, disorientation, paranoid experiences that make people acting against healthcare workers. Making people in the hospital be guided and feel that they are cared means having a containment function. It is about understanding that the hospital, besides giving medical services, receives people in crisis with regards to their condition. In a cultural scenario where dependence, functional to the health intervention, is not easily accepted anymore, a necessity may emerge to develop a skill at building a relationship with patients and their relatives based on trust and reliability.

Conclusions

Working at the hospital we experience how the assessment can be used to underline and deal with problems, often perceived as difficult to manage. The main point for the psychological function is the choice between the possibility to promote participation and development of a new culture

[21] With regards to the changes connected to the culture related to doctor-patient relationship, see Aries (1978, pp. 228-229): "But, if then phthisis was fatal as cancer is today, either the patient not his/her relatives wanted to know the nature of the disease. There was no obsession for diagnosis, not because they fear the result, but because they were uninterested in the disease's peculiarity, in its scientific aspect. The patient suffered, he/she was treated by the doctor and the surgeon (the bleeding), but he/she didn't ask them any information, even though the disease evolution could be easily inferred from the diagnosis. It was necessary a great effort to make the concept of a specific disease, such as phthisis, enter patient's mental universe […]. In his/her correspondence, he never cited his/her disease: he/she is not interested in; it a specialist's matter".

indicated by law or to demand dependence as technical executors of actions provided by law. We think that the risk assessment can not be just a specialist technique application, but it requires a clinical psychological skill useful to deal with duties. In our paper we underlined the various moments when the assessment, if considered just as a technical action, may have been interrupted, modified or trivialized. For example, the project may have been interrupted due to the conflict between subjective and objective dimensions or due to the collusion that the obligation was sufficient to make health workers take part to the training activities.

The use of the assessment as a tool to analyze the functioning of the protection and risk prevention service first, and of the entire Hospital then, allowed to give continuity to the work and to intervene on cultures at risk. In this sense, in the case we reported we noticed not a technical request, but the Protection and risk prevention service's demand to be supported in an assessment project that could be an opportunity, a tool to deal with staffs' problems in the work organization.

The issue is anything but specific and peculiar of the Hospital context we intervened on. We refer an analysis on the matter appeared in a recent paper[22] where INAIL, the Istituto nazionale per l'assicurazione contro gli infortuni sul lavoro [the Italian National institute for insurance against industrial injuries], (2011) underlined the difficulty of realizing a work related stress assessment: "The data about complaints is much more lower than the one emerging from the researches on stress made through questionnaire where a subjective perception may bear. […] It's more difficult to receive complaints for this kind of disease since the worker fears to come into conflict with the Company". The diagnostic method, focusing on the individual, may not give instruments to deal with the social problem that law indicates. The psychological function that suggests individualistic intervention in this scenario may not understand the dangerousness to become the employer's long arm in making problems not be expressed or attributable just to a few stressed individuals, or to be invested of a union function in acting as a spokesperson for the workers. We proposed a psychological function that deal with the organization, promoting the use of the assessment as a tool to understand the relationship between the organization and its internal and external clients.

We suggest thinking sentinel events as critical events that may lead in the hospital context to interpretation which create connections between parties. The aggression and violence may be read as the patients and their relatives' need to become visible to the blinded staffs that demand the technical action to be auto-evident and able to indicate that they are taking care of the patient. We noticed how in the hospital context the lack of attention to the reception function, in particular with regards to the relatives that are not in a dependence position, may create conflicts that are hard and risky even for the staff physical safety. The prevention of the psychosocial risk to which health workers are exposed may pass through the skill at understanding relationships, which is alternative to an approach that individualizes and medicalizes organizational problems.

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[22] See Sarubbo in this issue of the journal (2012): "The psychological function in the Protection and risk prevention service: comply with law or develop organizational skills?".

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