

The “No-Visitor Policies” Among Lonely Patients, Powerless Caregivers, and Exhausted Health Professionals

Pedagogical Perspectives to Rebuild a Fractured Alliance

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Le politiche di restrizione delle visite tra pazienti soli, caregivers arrabbiati e operatori esausti: prospettive pedagogiche per ricostruire un'alleanza incrinata

One of the most unexpected effects of the epidemic on our society was the closure of hospitals and other health services to visitors. Preventing the spread of infection was the main reason for these decisions in the early days of the pandemic when there was no clarity about the means of transmission and the origin of the virus. Nevertheless, in view of the persistence of the restrictions to date and the numerous negative consequences they have had on the professional and personal quality of life of doctors, nurses, patients and carers, the aim of this article is to analyse in depth the reasons why these decisions have been and, above all, are still being applied, also considering the hypothesis that the choices made so far in the training of health professionals should be questioned. The persistence of restrictions, the constant reduction of human and economic resources in the face of an increase in the demand for care have exacerbated the distance between health professionals and users, to the point of escalating into actual acts of violence and aggression. According to the Critical Pedagogy approach, pedagogists can play a central role in activating formative and collaborative strategies, such as maieutic groups, to rebuild an alliance between those who today find themselves on opposite sides: health professionals on the one hand, and patients and families on the other.

Una delle cose più imprevedibili che la pandemia ha portato nelle nostre società è stata la chiusura degli ospedali e di altri servizi sanitari ai visitatori. La prevenzione della diffusione dell'infezione è stata la ragione principale per cui queste decisioni sono state applicate nei primi giorni della pandemia, quando non c'era chiarezza sui mezzi di trasmissione e sull'origine del virus. Tuttavia, data la persistenza delle restrizioni fino ad oggi e le numerose conseguenze negative che hanno avuto sulla qualità della vita professionale e personale di medici, infermieri, pazienti e caregiver, questo articolo si propone di analizzare in profondità le ragioni per cui queste decisioni sono state e, soprattutto, sono ancora applicate, considerando anche l'ipotesi che siano da porre in discussione le scelte fatte fino ad oggi nella formazione dei professionisti della salute. Il perdurare delle restrizioni, la continua riduzione delle risorse umane ed economiche a fronte di un incremento delle richieste di assistenza, ha esacerbato la distanza tra operatori sanitari e utenti, fino a sfociare in veri e propri atti di violenza e aggressione. Secondo l'approccio della Pedagogia Critica, i pedagogisti possono svolgere un ruolo centrale nell'attivare strategie formative e collaborative, come i gruppi maieutici, per ricostruire un'alleanza tra coloro che oggi si trovano su fronti opposti: i professionisti della salute da un lato e i pazienti e le famiglie dall'altro.

Keywords: No-visitor policies; Medicine and power; Training; Critical pedagogy; Maieutic group.

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1. Introduction

One of the most unexpected effects of the epidemic on our society was the closure of hospitals and other health facilities to outside visitors, including friends and family of inpatients. Said closure was accepted by everyone during the acute phase of the infection’s propagation which coincided with the lockdown periods. This incident occurred among many other unfathomable events, such as the restriction of personal freedom or the cessation of various work or commercial activities, all of which were simply unthinkable just a few months before. During these months of widespread anxiety and fear, everyone was prepared to accept any compromise so as to prevent infection. The ban on visitors, along with other restrictions, were then deemed as necessary and unavoidable. This passive acceptance may seem questionable, but nonetheless transpired. Nevertheless, given the consequences of such a decision on the lives of millions of people, and especially given that “no-visitors policies” are still in place in many health units today, when the spread of infection is minimal and most people are vaccinated, it is time to better analyze how and, above all, why it happened.

The aim of this paper is to analyze the following three questions: first, why this decision was adopted at the start of the pandemic; second, the consequences of the “no-visitor policies” for patients and their relatives, as well as for doctors and nurses; and third, why these policies are still so prevalent in our Italian health system. Finally, given the evidence that the epidemic has shattered a relationship that had taken nearly half a century to build, to explore the hypothesis that a potential underlying reason could be that something has gone wrong in the training of health professionals over the last thirty years. If this hypothesis is correct, it is our duty as pedagogists, to understand how this happened and how subsequent recruitment can become possible.

2. The reasons why the decision was taken

Caution about the spread of infection was the main reason why “no-visitor policies” were implemented everywhere during the early days of the pandemic, when there was no clarity or certainty about the means of transmission and the origin of the virus, and it seemed best to avoid any contact between infected people and healthy people. However, as numerous scholars have argued, there is no scientific proof, either then or now, that these measures achieved the intended effects. (Jefferson *et al.*, 2020; Munshi *et al.*, 2021). Moreover, many hospitals and health services in Italy, as in many other countries, implemented such decisions without reference to any specific state regulation (Sudai, 2021). In Italy, there is no specific mention of the absolute ban on hospital visitors in the several laws and decrees enacted by the Prime Minister and the Government throughout the two years of the pandemic.¹ In every DPM

1. For example, there is no ban on visitors in both the Legislative Decree (LD) n. 23 of February 2020 and in the Decree of the Prime Minister (DPM) of 25 February 2020. The first reference to restricting the access of visitors in the hospital units appears in the DPM of 01 March 2020, art. 2, sections J and K, which cites only the words: “J) restrictions of visitor access to in-patient areas, by hospital health managements; k) strict limitation of visitor access to guests in nursing homes for the non-self-sufficient”. In the DPM of 04 March 2020, art. 1, sections L and M, section L specifies: “accompanying persons of patients are forbidden to stay in the waiting rooms of emergency and admission departments and emergency departments (DEA/PS), unless specifically indicated otherwise by the healthcare personnel in charge”, under section M “the access of relatives and visitors to hospitality and long-stay facilities, assisted healthcare residences and residential facilities for the elderly, whether self-sufficient or not, is limited only to the cases indicated by the health management of the facility, who is required to take the necessary measures to prevent possible transmission of the infection”; the same words are present in the following DPM of 08 March 2020, art. 2, sections P and Q. In the DPM of 09 March 2020 there are no references and in the LD of 25 March 2020, art. 1, section Z, bb e cc the words “are forbidden” are replaced by “specific prohibitions or limitations” for the accompanying persons of patients accessing to emergency area; for the long-stay facilities, for self-sufficient or not, the concept is expressed with different words but the content remains the same. The following year, with the LD n. 221, art. 7, comma 1 and 2, the situation changed: comma 1 states “as from 30 December 2021 and until the termination of the state of epidemiological emergency by COVID-19, the access of visitors to residential, socio-medical and hospice facilities [...] is only permitted to subjects with a green COVID-19 certificate, issued following the administration of the booster dose following the primary vaccination cycle”; under comma 2: “access [...] is also permitted to persons in possession of a COVID-19 green certificate, issued following completion of the primary vaccination cycle or the successful recovery [...] together with a certification attesting to the negative result of the rapid or molecular antigenic test, performed in the forty-eight hours preceding the access”. The law n. 11 of the 2022, in the annex A, simply confirms that visitors will have access to hospitals and elderly homes if they have had a vaccination or immunisation since they had the infection.

(Decree of the Prime Minister) or LD (Legislative Decree) issued during those months, the only words used are “specific limitation”, not “ban”, and even when the word “ban” is used, it only refers to the carers of infected patients on first access to emergency rooms or relatives and friends who would have access to retirement homes. Yet visitors, whether or not in possession of a green certificate, have been banned everywhere and are still banned from far too many places.

Beyond an excess of caution, it would be interesting to attempt to understand why it happened: perhaps one of the hypotheses underlying these decisions could be rooted in the defensive approach that medicine has taken in recent years. Defensive medicine, according to Tancredi and Barondess (1978) is “the use of diagnostic and end-treatment measures explicitly for the purposes of averting malpractice suits”; thus, clinical choices, before curing patients, would have the aim of safeguarding the clinician against litigation arising from some adverse outcomes of their decisions (Bester, 2020). Tancredi and Barondess claim that defensive medicine is responsible not only for the increased costs of the healthcare systems, but also for a human cost to patients, who are often subjected to unnecessary procedures with significant and avoidable risks and discomforts. Since, according to Bester, a particular kind of defensive medicine known as Negative Defensive Medicine (NDM) is oriented towards avoiding “patients or clinical situations to reduce the risk of such lawsuits or complaints”, it could be argued that the overuse of restrictive measures in relation to family access to wards and care rooms during and after the pandemic is the result of an original, previously overlooked, expression of NDM. Restricting family members’ access might reduce the risk of infection and, thus reduce risk of additional deaths being attributed to errors or medical malpractice. In fact, the fear of death affects not only “the patient, but also the doctor, because if the former sees it as a threat to his/her own life, the latter cannot fail to see it as a threat to his knowledge and skills” (Galimberti, 1987, p. 99).

One final argument for the “no-visitor policies” could be the necessity to reduce healthcare costs by providing visitors with the necessary PPE (Personal Protective Equipment, such as ffp2 masks, etc.) in order to prevent contagion, which results in a considerable cost for healthcare organizations.

In any case, the access restriction policies were accepted by patients and families because they were persuaded that it was and still is necessary in the service of a greater good (Sudai, 2021). And yet that is not the case: whether the reason for the “no-visitor policies” lies in caution, defensive medicine or the reduction of costs, these measures are nowadays completely out of place. If the lack of scientific evidence of its efficacy does not suffice, consider the implications it has had and continues to have on patients and families, as well as doctors and nurses.

3. The consequences

3.1. Consequences for patients and families

It is common knowledge that the presence of relatives close to patients during hospitalization has numerous benefits for the healing process, primarily because visitors can provide psychological support and concretely help inpatients when they are too weak to care for themselves autonomously; they can additionally assist patients when they have to decide on the best treatment among the various options proposed by doctors. Conversely, it is readily apparent that the main impact of the no-entry policies has been and continues to be felt by inpatients: whether one is a child, adolescent, adult, or, even more so, an elder, the experience of hospitalization is alienating, but having to face it alone, without the comfort of known and loved ones, becomes extremely painful. According to some studies carried out during and after the pandemic, the drastic restriction of visitors made inpatients feel isolated, helplessness, and anxious; feelings of distress and uncertainty were frequently encountered (Honarmand & Mehta, 2021) as well as an increase of perceived body pain, loneliness, and depressive symptoms (Hugelius, Harada & Marutani, 2021; Iness *et al.*, 2022). Inpatients’ loneliness can turn into a sense of helplessness, leading to exhaustion and fatigue, which can interfere with the healing process, if not cause long-term trauma (Zeh *et al.*, 2020), especially for certain types of hospital experiences (e.g., hospitalization for surgery, hospitalization involving children, long stay in home for the elderly, hospice or intensive care units).

All of these consequences are understandable because “when we are sick, it is not possible to escape the experience of loneliness, which leads us to take the uncomfortable and often avoided paths of our

interiority” (Borgna, 2011, p. 131); during this kind of experience, it is no longer possible to disguise our vulnerability, and the gap opened up between our physical body and our lived body becomes evident to us: while the latter continues to desire, the former is arrested and it arrests that desire (Borgna, 2011, p. 135). According to Galimberti (1987), the body is open to the world, it inhabits the world, and this inhabiting does not just mean knowing the world, but feeling at home, hosted by a space that is familiar since it holds us without ignoring our will and our wishes. Our lived body lives among things that can narrate our experience because they are the object of our making sense processes: we transcend their pure objectivity to take them out of anonymity to become the things in themselves that are meaningful (Galimberti, 1987, p. 124). But when we are ill, the world loses its physiognomy because our body has been transformed into an obstacle which blocks any form of human intentionality (Galimberti, 1987, p. 133). Moreover, the affective atmosphere in which people are immersed can influence their personal experiences (Bruzzzone, 2022, p. 115 and p. 121), and it becomes evident that the places of care are frequently dense with anxiety, anguish and fatigue, negativity that can influence even the tone of any relationship that can be established there (Bruzzzone, 2022, p. 126). Patients, feeling lonely, seek a foothold on which to anchor their humanity, to restore purpose to their being, and relatives and friends can be that turning point. According to Frank (2013), the ill person needs to talk about their story because they need to “give voice to the body, so that the changed body can become once again familiar” (p. 2): as a result, the loneliness that patients were forced to endure during the pandemic prevented them from understanding themselves and the experience they were living. To restore map and destination, stories have to repair the damage that illness has done to the ill person’s sense of where he/she was, and where he/she may be going (Frank, 2013, p. 53), and if the interrupted voice remains silenced (Frank, 2013, p. 58), the self cannot be formed in what is told (Frank, 2013, p. 55). To be human, to be a person, patients require a relationship, the opportunity to experience security, safety, closeness, and being worried about, to feel like a who and not just a what: what patients require to remain a person is an elective contact that ensures they can feel loved and valued by someone (Van Manen, 2015, pp. 112–116). This kind of relationship may exist exclusively between parents and children, daughters and sons, lovers, and friends, not between professionals and patients. In addition to the confusion caused by their vulnerable state, patients need someone to assist them in their attempt to relearn everything, to first learn to live with and accept a new identity, to calm their fear of what they are losing, to understand that they have not lost themselves forever. In other words, they need to be accompanied, but only by someone who can and will listen to them (Bobbo, 2020), not by people they are unfamiliar with and are unsure if they can share their fragility with, who are frequently focused on other things. They need to be free to tell without fearing to be blamed (Frank, 2013, p. 54). Relatives and friends could possess an intuitive knowledge of the patient and thus, without rethinking or pondering the optimal course of action, know how to act (Van Manen, 2015, p. 81) using an attentive attunement of their entire being to the experience of the world of the other (Van Manen, 2015, p. 83). As a result, the relationship must be personal and loaded with intentionality, which is impossible between patient and professional, who are often two distinct human beings meeting for the first time in the midst of a confusing and painful experience.

The consequences of relatives banning have also been studied, and it has been reported that parents, sons and daughters, as well as partners and friends of inpatients, experienced profound distress, uncertainty, helplessness and anxiety, exhaustion, and psychological sequela when their relative’s disease reached a critical phase (Honarmand & Mehta, 2021).

Vice versa, the presence of relatives near inpatients during hospitalisation gave them the opportunity to discuss and negotiate with clinicians about the patient’s treatment, when he/she was too weak or too ill to express his/her opinion or simply speak. Their forced absence frequently led to an increased distrust of the care team and a decreased satisfaction with the therapy (Honarmand & Mehta, 2021).

Another consideration may be that many individuals were not present when a loved one died in a hospital, which was a devastating event for relatives and friends, resulting in feelings of powerlessness and unbearable guilt. These kinds of situations, which can still occur, subjected relatives and friends to a complicated grief which can only currently be mitigated by the possibility of holding a funeral at all (Zeh *et al.*, 2020).

Mother and fathers, sisters and brothers, friends and lovers feel as they have lost the opportunity

to do what ethically and morally they feel they should do. This deprivation causes people to lose the meaning of their relationship, the significance of their role in that relationship, and a key part of their identity. They may believe they are inadequate fathers, sisters, lovers, or friends, and this perception may represent a genuine, profound, and pervasive suffering.

3.2. Consequences for physicians and nurses

According to some authors, health professionals confronted with “no-visitor policies” experienced three types of consequences: first, they were asked to provide more psychological support to patients, the same support that relatives could have provided if they had been admitted; second, they had to increase their workload by providing information to the inpatients’ relatives by telephone and managing contact between them and inpatients by video calls; third, they were frequently subjected to a so-called moral injury, meaning that they were forced to do something with which they did not agree ethically; in other words, they regarded themselves as forced to go against their own ethical principles (Hugelius, 2021). These experiences resulted in an increase in health professional fatigue, distress and exhaustion (Iness *et al.*, 2022; Sudai, 2021).

Every healthcare professional realized how important it was for patients to have human contact with their loved ones, since the experience of others may be grasped by looking at the other, seeing the expressiveness of their face, and the movements of their body (Bruzzone, 2022, p. 95). Not having the time to spend even a moment at the bedside, and (during the worst months of the pandemic) even fearing for their own health if they got too close to the infected patients, they felt guilty because these situations affected their sensitivity based on a principle of solidarity. When they saw what the patients needed and were unable or unwilling to provide it, they felt hurt since within their relationship, whether chosen or simply defined by circumstances, self-consciousness loses its primacy to make way for an intense awareness (of the other) through which each can perceive the awakening of their own humanity and, beyond that, their responsibility. Humanity does not reside in a person’s powers, but in his or her awareness of responsibility towards others; Lévinas (1998) states that “it is the other who is first” (p. 146), and each person, in doing something for the other, discovers the deepest ethical root of care (Bruzzone, 2022, p. 33). Lévinas (1998) additionally reiterates that

the death of the other calls me into question, puts me in question, as if I, with my possible indifference, become an accomplice to this death, invisible to the other who is exposed to it; as if, even before I am chosen, I must answer for this death and not leave others alone in their mortal solitude. The others are my neighbour precisely in this call to my responsibility through the face that summons me, that demands and reclaims me (p. 183).

Such responsibility undoubtedly contains the secret of sociality (Lévinas, 1998, p. 186). Caught between the impulse to help ethically, the fear for their own safety and the rationality that led them to understand the logic of the restriction policies, they found themselves in the middle, having to silence the emotions that drove them to accept the patients’ (sometimes silent) requests with an overload of emotional labour (Bobbo & Rigoni, 2021).

4. Exploring the reasons why the no-entry policies are still applied

None of the above justifications can explain why the no-entry regulations remain in place. Few people appear to consider the detrimental effects that such practices have on those directly affected by the disease, even to the point of violating the fundamental precept of the medical and nursing professions, *non-maleficere*. There must therefore be something more, something that goes beyond prudence, beyond ethics, beyond everything. Something that has to do with a psychological, but also cultural dimension of illness and care, and which could be better understood by stepping back in time.

Fifty years ago, a letter published in the *Corriere della Sera* wrote,

I am the mother of a two-and-a-half-year-old boy, and I had the misfortune of having to admit my son to a hospital in a northern Italian city. I was struck by the fact that, despite

being preschool-aged, hospitalized children are not permitted to have any family members near them except during visiting hours. Thus, children left alone exhibit clear hysterical reactions: the only remedy is to tie them to their beds until they have become accustomed to this state of abandonment. This attitude reveals a tendency to consider the child only from a physical point of view with no regard at all for the possible psychic trauma.

This was just one of the numerous expressions of disappointment and dissatisfaction that in the mid-1970s of the 20th century, drove a number of doctors and researchers, such as Giulio Maccacaro, Giorgio Bert, and Massimo Gallio, among others, to establish the Democratic Medicine Movement, whose main goal was to change the relationship between patients and physicians hitherto based on a power dynamic. The various contributions collected in the book series “Medicine and Power”, edited by Maccacaro, attempted to analyze this type of dynamic and the worst consequences on patients it brought about in different fields of medical practice, such as paediatrics, psychiatry, and so on. The findings of these studies were very interesting: firstly, they demonstrated that a “hospital regulates its operation and the provision of its services in order to optimise the management of itself as a moment of a larger enterprise ... and not in order to optimise the actual care of the infirmities and needs of the patient” (Maccacaro, 1976, p. XV); moreover, hospital rules place patients in an unfamiliar environment, so that the sick person has to face a process of adaptation (Bert, 1975, p. 90) accepting a mental habit of dependency (Bert, 1975, p. 94). Secondly, the study highlighted that doctors attempt to carry out a process of reducing patients into things, so that they can treat patients as mere objects of scientific interest (Maccacaro, 1976, p. 37). Thirdly, according to those authors, this reduction enables the doctor to assume, according to tradition, the role of the affectionate or perhaps gently severe father (Bert, 1975, p. 43). Fourthly, according to Pollack (1972), family members represent the only link the sick person has with the real world, with his/her world, and can contribute towards making the institution more tolerable by bringing food, drink and linen. They are, however, considered disturbing elements and are removed as soon as possible (Pollack, 1972, p. 142).

Perhaps, it may be too much to speak of an exercise of power in the case of the “no-visitor policies” since the rationale behind their setup is clear and perhaps understandable, but when trying to understand why they persist, the concepts evidenced by these authors can be useful. What is happening now becomes clear if it is hypothesized that during the pandemic period, doctors and nurses had the opportunity to savor in some ways how much easier it is to work only with the patient, as if turning back time fifty years was possible: working only with a weak and defenceless human being, often unable to fully express his or her feelings and needs, unable to oppose any kind of decision made by others, debilitated not only in physical strength but also in his or her identity as an autonomous and self-determined person, is indubitably easier than working with a healthy person in full possession of all physical, psychological and cognitive faculties. The ill person’s self-efficacy can be compromised especially when hospitalisation coincides with a new serious or chronic diagnosis when patients may experience a sense of “loss of self” (Charmaz, 1997, p. 11), which results in losing any ability to be an authoritative defender of his/her own rights. As a result of the loss of self that the alienating experience of hospitalization fosters, patients are unable to significantly influence the definition of the meanings inherent in the relationship between themselves and the medical staff, allowing others to decide who and what they should be in every moment of the hospitalization: a person or a thing, or even simply a diagnosis (Bert, 2007). Left alone, they became passive observers of the therapeutic process they underwent. Sporadic contacts (a few minutes that seem infinitely insufficient) with one’s loved ones are of no use, especially if they occur in virtual mode. Some of the comforts which today’s hospitals come equipped with (though not all of them and not entirely) appear to be of no use as well.

Once the devastating moment of the pandemic had passed, once the months when deaths were no longer countable and work shifts appeared exhausting and unbearable ended, seeing routines restored, doctors and nurses may have realised that the absence of families and friends could be an essential corollary, not necessary but convenient to making their work easier and, perhaps, even compensating them for the fatigue of those days: a way to clear their spaces, to avoid having to face someone who, being healthy and worried, constantly demands accountability for every decision, action or word they may express. So why not continue as such, in the name of an ostensible prudence, even when this is nowadays no longer justifiable?

The pandemic has taken many lives and caused much suffering, but it risks leaving a very serious legacy: the undoing of fifty years of struggles for the rights of the sick and for the claim of a subjectivity of the suffering person who has the right to have beside him/her those who not only confirm his/her identity as a person, but also support him/her in facing what is completely unmissable for him/her in those moments. The hypothesis put forward in this paper is that the continuation of the policies of not allowing visitors is the result of an unspoken decision, rather than the result of an explicit negotiation with the patients or of a clinical or scientific evaluation. Namely, it appears to be the effect of an inertia stemming from the unacceptable desire to be able to work more easily, to regain the authority and freedom to act, to regain the solitude of a weak patient who is simply incapable of attacking, refusing or withdrawing any therapeutic choices, all things and actions that his/her relatives can do and often do. If this means reducing or abolishing the policy of democratisation and the ethical imperative of humanising the hospitals, it makes little difference. No one has explicitly said that prohibition on visits is still necessary, and no one has explained why, even in the face of a state laws that explicitly authorizes visits, they are nevertheless restricted if not prohibited; things continue simply as before...

We are aware that this is an appalling hypothesis, yet it is difficult to find another explanation for what is happening. It looks as if we had suddenly gone back a hundred years and recovered the Cartesian idea of a total distinction between body and mind, as if it were possible to distinguish between a sentient, lived body and an object body, a materiality that can be handled and known:

the doctor's gaze does not meet the patient but his/her disease, and in his body he/she does not read a biography but a pathology, where the patient's subjectivity disappears behind the objectivity of symptomatic signs that do not refer to an environment, to a way of life, to a set of contracted habits, but only to a clinical picture (Galimberti, 2010, p. 95).

According to Bruzzone (2015), doctors and nurses are led to deny their own emotions in order to defend themselves, to hide those that drive them from the depths in order to see and pity the suffering of others (p. 133), but as the same author points out, emotional superficiality corresponds to inauthenticity, to the emptiness of any ethical value of the profession (p. 139). Therefore, the defence seems worse than the evil it is supposed to eliminate. The arid coldness, the technological ideology that dominates the character of modern medicine seems to be oblivious to the fragility of others, who instead cry out for attention (Borgna, 2011, p. 135). The spreading individualism can erode the social bond which dissolves under the blows of a fierce defence of the ego's well-being, even losing all empathic bonds with others (Bruzzone, 2022, pp. 41-42). However, as educators, we know that the self can be understood as becoming human in relation to others, and that the self can only remain human by living for others (Frank, 2013, p. 15).

5. Some implication for the work of pedagogists

If the above hypothesis is correct, it is conceivable that the pandemic has exacerbated an already existing malaise among the operators, who are increasingly overworked and less and less respected for their competence. The numerous cases of aggression, violence, if not outright murder, against doctors and nurses by patients and their families represents perhaps the real crux of the matter. Indeed, doctors and nurses were already under pressure before the pandemic and still remain squeezed today (little has changed...) between the demands of the company they work for on the one hand and the demands of being constantly kind, listening, sensitive, and humane towards patients and their families on the other; squeezed in this impasse, they simply decided, if not consciously and certainly not rationally calculating the consequences of these decisions, that they could no longer go on like this. And when one cannot go on, one tends to retreat. To return to old habits. Perhaps we also made a mistake as educators, asking before, during the basic university training, to acquire the most complex and updated technical competences, and after, as professionals, to do something completely different and which they could not afford: to be doctors and nurses of humanity in an organisational environment governed by the market laws, cost efficiency, the cutback of everything that managers and economists say can be reduced, including operators. Perhaps, once again, we have acted as academics unable to keep in touch with the reality of the

facts and places of care. This is a criticism of the system, specifically of our health and education systems. Trained and sensitized by people who perhaps did not really listen to their difficulties, perhaps being themselves incapable of articulating them, exhausted by a profession that has replaced an ethic of solidarity with a market ethic, they made themselves insensitive to any request and sought every means to protect themselves from any suffering that was not necessary to carry out their technical work, to save and cure sick patients. The deep and vital need to feel and be respected by others has led them to decide, once again irrationally, to push away those who had the strength not to respect them, leaving only those who, weakened by disease, no longer have this strength.

What can we do as educators to remedy this and rebuild a relationship that has been forged over fifty years of battling for patients' rights and training for the humanization of care? Medicine can no longer be a mode of power; we have the awareness and the knowledge to prevent it. Yet we are living in a period when institutions are being questioned rather than simply accepted because they have lost their authority, a time when the social covenant is being broken because the ethic of individualism is stronger than anything else (Ritchie, 1891). Thus, as educators, we should strive towards forging a new alliance, and in order to do this we must convene all the actors of this human set: doctors need patients as much as patients need doctors, and both cannot make sense of their wounded existences without the help of the other.

Perhaps, this is what pedagogy is called to do, to create the conditions for rebuilding an alliance, not in the same way as in the past, but in a new way. It is up to the actors to decide because the new alliance between patients and health operators cannot be built on the rule of the dynamics of power and obedience between those who decide and those who execute these decisions: patients are no longer willing to relinquish their rights in exchange for a competent but only technical performance. Their access to education, to information, their knowledge of their rights as human beings beyond being purely ill individuals prevents them from being the same kind of patients who in the last century were willing to submit to the doctors' wishes. What they can understand are the rights that other people have and their obligation to respect them, including the rights of doctors and nurses. But in order to do this, they need to know what being a healthcare worker means in these times, to know that the myth of our healthcare system as a perfect system, the envy of all, is simply an illusion, because it does not correspond to the truth. To understand, also, that the scientific myth of medicine which can care for any kind of disease is another illusion, because it sometimes fails. Patients, especially the suffering ones, cannot be emphatic with the operators, but even in that case, they can comprehend their predicament. Physicians and nurses, on the other hand, need a time-space to express all their malaise having lost the sense of their profession (Bobbo & Ius, 2021), having seen their own vocation eroded little by little by continuous requests of efficiency in every aspect of their work. The new alliance can be based on the opportunity for both parties to get to know each other and their needs and wishes. This hypothesis is fully consistent with the paradigm of critical pedagogy, according to which everyone has the right to speak, to express his or her point of view, to exercise a power of action and choice within his or her community of life, in order to transform that community into a place of empowerment of the self through help and sharing with others (Giroux, 2017, p. 93; McLaren, 2007, pp. 301–302). According to this paradigm, in order to overcome the distance that separates two actors who have ended up on opposite sides and who can now only see each other as a possible threat, a maieutic group must be created, which Danilo Dolci has described as a small research community: a group of people where everyone has the opportunity to talk to and listen to someone else, because the mask of the role is taken off and new ways of being with others can be discovered; when the conflicts and mistreatments of current social relations are suspended, re-establishing authentic social bonds, person to person becomes possible (Vigilante, 2011, p. 105).

To do this, what we as pedagogues can do is to make these encounters possible and moderate them because in order to start talking to each other, physicians, nurses, patients and caregivers need someone who knows that it is possible to grow as a human being through an encounter with the other, however different that other may be from us (Buber, 1970). A pedagogue, moreover, recognizes the patients' discomfort, and what physicians and nurses are trained for. First, he/she is aware of the biographical disruption (Bury, 1982) that patients face after diagnosis and the limbo of despair they can fall into, as well as the erosion that compassion fatigue can cause in the carer's life of a health care professional; secondly, he/she knows how doctors and nurses have been trained to be perfect technicians, shielding them from

any emotions that might impair their judgment. As a result, they frequently lack the knowledge and abilities necessary to handle any situation pertaining to the vulnerable human relationship. In addition to teaching them how to achieve greater self-awareness and understanding of others, the pedagogue can also help them establish the practical framework needed for conversation.

The maieutic group, that is according to Habermas the first, concrete realization of his theoretical public sphere (Mayo, 2017; Vigilante, 2011, p. 103), represents the best context for this dialogue, as it is described as a meeting of different human beings needing to solve common problems, through discussion and negotiation, where everyone can express their needs and difficulties and propose and negotiate potential solutions. Several examples can be found in Italy, often carried out by a pedagogue, as the COS² of Aldo Capitini and the School of Barbiana of Don Lorenzo Milani (Catarci, 2012; Scuola di Barbiana, 1967). In these groups of people, the person whose opinion might carry more weight has to speak last. Each member then assists the others in seeking the truth, which arises from the dialogue itself and does not fully exist in each individual (Vigilante, 2011, p. 102).

6. Conclusion

Pedagogists should organize and oversee numerous small-scale maieutic groups that could be formed in various hospital contexts or continuing education settings as opportunities for change and learning: these small communities of research can start by reflecting on relational dynamics and, in particular, on the forms of violence, explicit and implicit, direct and structural, that characterise them, establishing themselves as a single body capable of mobilising for change (Vigilante, 2011, p. 86; McLaren, 2007).

Just as after a war, peace must be restored and people must learn again to embrace the other: it is not through domination and imposition, but only through cooperation, development, and transformation of the mutual perspective that it becomes possible to create a new sociality, so that the enemy can become an ally again (Capitini, 1971). Pedagogists could and should play an important role in this rebirth.

2. COS were Centres for Social Orientation, an experiment of a fortnightly meeting for discussion, open to all, on all administrative and political problems, which party leaders, administrators, experts of all tendencies were invited to listen and speak. According to Capitini, COS gave people the opportunity to understand what democracy is (retrieved November 11, 2023 from <https://www.nonviolenti.org/cms/rubriche/i-volti-della-nonviolenza/aldo-capitini/>).

References

- Bert, G. (1975). *Il medico immaginario e il malato per forza*. Milano: Feltrinelli.
- Bert, G. (2007). *Medicina narrativa. Storie e parole nella relazione di cura*. Roma: Il pensiero scientifico.
- Bester, J. C. (2020). Defensive practice is indefensible: how defensive medicine runs counter to the ethical and professional obligations of clinicians. *Medicine, Health Care and Philosophy*, 23, 413–420. <https://doi.org/10.1007/s11019-020-09950-7>
- Bobbo, N. (2020). *La diagnosi educativa in sanità*. Roma: Carocci.
- Bobbo, N., & Ius, M. (2021). *Lavoro di cura, educazione e benessere professionale*. Padova: Padova University Press.
- Bobbo, N., & Rigoni, P. (2021). Il lavoro emotivo tra gli studenti di infermieristica: dagli studi nell'ambito delle neuroscienze alle implicazioni per la formazione emotiva dei futuri infermieri. *Giornale Italiano di Educazione alla Salute, Sport e Didattica Inclusiva*, 2(5), 364–375. <https://doi.org/10.32043/gsd.v5i2.361>
- Borgna, E. (2011). *La solitudine dell'anima*. Milano: Feltrinelli.
- Bruzzone, D. (2022). *La vita emotiva*. Brescia: Morcelliana.
- Buber, M. (1970). *I and Thou* (Vol. 243). New York: Simon & Schuster.
- Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, 4(2), 167–182. <https://doi.org/10.1111/1467-9566.ep11339939>
- Cameron, J. I., Chu, L. M., Matte, A., Tomlinson, G., Chan, L., Thomas, C., et al. (2016). One-year outcomes in caregivers of critically ill patients. *New England Journal of Medicine*, 374(19), 1831–1841. <https://doi.org/10.1056/NEJMoa1511160>
- Capitini, A. (1971). *Teoria della nonviolenza*. Verona: Edizioni del Movimento Nonviolento.
- Catarci, M. (2012). La pedagogia della nonviolenza di Aldo Capitini. *Studium Educationis*, 1, 37–50.
- Charmaz, K. (1997). *Good Days, Bad Days: The Self in Chronic Illness and Time*. New Brunswick (NJ): Rutgers University Press.
- Domingo, P. (2011). «Ciascuno cresce solo se sognato». Nonviolenza, sogno e liberazione nella pedagogia di Danilo Dolci. *Educazione Democratica*, 2, 13–22.
- Frank, A. W. (2013). *The Wounded Storyteller* (2nd Edition). Chicago (IL): Chicago University Press.
- Galimberti, U. (1987). *Il corpo* (Vol. 5). Milano: Feltrinelli.
- Giroux, H. (2020). *On Critical Pedagogy*. London: Bloomsbury Academic.
- Honarmand, K., & Mehta, S. (2021). Consequences of visitor restriction policies in the intensive care unit during the COVID-19 pandemic. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*, 68(10), 1465–1470. <https://doi.org/10.1007/s12630-021-02048-5>
- Hugelius, K., Harada, N., & Marutani, M. (2021). Consequences of visiting restrictions during the COVID-19 pandemic: An integrative review. *International Journal of Nursing Studies*, 121. <https://doi.org/10.1016/j.ijnurstu.2021.104000>
- Iness, A. N., Abaricia, J. O., Sawadogo, W., Iness, C. M., Duesberg, M., Cyrus, J., & Prasad, V. (2022). The effect of hospital visitor policies on patients, their visitors, and health care providers during the

- COVID-19 pandemic: A systematic review. *The American Journal of Medicine*, 135(10), 1158–1167. <https://doi.org/10.1016/j.amjmed.2022.04.005>
- Jefferson, T., Foxlee, R., Del Mar, C., Dooley, L., Ferroni, E., Hewak, *et al.* (2008). Physical interventions to interrupt or reduce the spread of respiratory viruses: Systematic review. *British Medical Journal*, 336(7635), 77–80. <https://doi.org/10.1136/bmj.39393.510347.BE>
- Lévinas, E. (1998). *Tra noi. Saggi sul pensare all'altro*. Milano: Jaca Book.
- Maccacaro, G. A. (1973). *Il bambino è dell'ospedale?* Prefazione a J. Robertson, *Bambini in ospedale*. Milano: Feltrinelli.
- Mayo, P. (2007). Critical approaches to education in the work of Lorenzo Milani and Paulo Freire. *Studies in Philosophy and Education*, 26, 525–544.
- McLaren, P. (2007). *The future of the past: Reflections on the present state of empire and pedagogy*. In P. McLaren, & J. L. Kincheloe (Eds.), *Critical Pedagogy: Where Are We Now?* (pp. 289–314). Lanham: Peter Lang.
- Munshi, L., Evans, G., & Razak, F. (2021). The case for relaxing no-visitor policies in hospitals during the ongoing COVID-19 pandemic. *Canadian Medical Association Journal*, 193(4), E135–E137. <https://doi.org/10.1503/cmaj.202636>
- Polack, J. C. (1972). *La medicina del capitale*. Milano: Feltrinelli.
- Ritchie, D. G. (1891). Contributions to the history of the social contract theory. *Political Science Quarterly*, 6(4), 656–676. <https://doi.org/10.2307/2139203>
- Scuola di Barbiana (1967). *Lettera a una professoressa*. Firenze: Libreria Editrice Fiorentina.
- Sudai, M. (2021). Not dying alone: The need to democratize hospital visitation policies during COVID-19. *Medical Law Review*, 29(4), 613–638. <https://doi.org/10.1093/medlaw/fwab033>
- Tancredi, L. R., & Baroness, J. A. (1978). The problem of defensive medicine. *Science*, 200(4344), 879–882. <https://doi.org/10.1126/science.644329>
- Van Manen, M. (2015). *Pedagogical Tact: Knowing what to do when you don't know what to do*. Oakland (CA): Left Coast Press.
- Vigilante, A. (2011). Maieutica reciproca e sviluppo comunitario. *Educazione Democratica*, 2, 80–123.
- Zeh, R. D., Santry, H. P., Monsour, C., Sumski, A. A., Bridges, J. F., Tsung, A., *et al.* (2020). Impact of visitor restriction rules on the postoperative experience of COVID-19 negative patients undergoing surgery. *Surgery*, 168(5), 770–776. <https://doi.org/10.1016/j.surg.2020.08.010>

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