

## **Post-pandemic perspectives in social care. Toward the end of medicine?**

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### **Summary**

The debate about residential institutions for the elderly with disabilities (RSA) is back current in the last two years, as a result of the pandemic, which highlighted its structural limitations. However, consideration should be given to the problem of reforming these institutions bearing in mind the clinical and psychosocial dimension of users, which is constantly evolving thanks to advances in medicine. Otherwise, the changes would be technocratic and detached from the needs of users and their families.

### **Riassunto**

Il dibattito sulle istituzioni residenziali per anziani disabili (RSA) è ridivenuto attuale, nel corso degli ultimi due anni, a seguito delle note vicende pandemiche, che ne hanno messo in evidenza i limiti strutturali. Tuttavia, bisogna tenere presente che mettere a tema la problematica di una riforma di tali istituzioni prescindendo o comunque subordinando a essa la dimensione clinica e psicosociale degli utenti, in costante evoluzione grazie ai progressi della medicina, rischia di generare cambiamenti tecnocratici sostanzialmente avulsi dai bisogni degli utenti e delle loro famiglie.

### **Key words**

RSA, health care quality, disability, assessment

### **Parole chiave**

RSA, qualità delle cure mediche, disabilità, valutazione

### **Introduction**

The question of the future of senior residential facilities in post-pandemic western societies has increasingly been discussed. These contributions to the debate, in Italy as well as elsewhere, are mostly found - although not exclusively - within media internal to the social welfare sector. <sup>1,2</sup>

It is not a question here of contributing to the technical aspects of this debate, with regard to possible new configurations of these structures and institutions. Rather, it is a question of drawing attention to some preliminary questions, from a neuropsychiatric point of view, on the process of institutionalization of persons with disabilities and of the elderly in particular, and on what is at stake for the quality of health care in these institutions. <sup>3</sup>

### **Ambiguities of institutionalizations**

When proceeding to institutionalize (a process that is always complex and often unavoidably confused), a “multifactorial” point of view is usually adopted. In this perspective, an important role is played by resource management. It is fairly proven that a definitive institutionalization (temporary institutionalizations remain, despite official

projections, more or less the expression of a hope) is not decided merely (and often not even primarily) on the basis of medical or clinical reasons (contrary to hospitalization, at least in theory) but on the basis of a complex of factors, partly health-related but mostly psychological and social, which results in a loss of autonomy. Let it be noted, in passing, that in the past such a loss of autonomy could be due simply to poverty, as witnessed by that masterpiece of Italian baroque architecture that is the Bourbon Hospice for the Poor of Place Carlo III in Naples.

Until approximatively after World War II, those situations of loss of autonomy in which the clinical/medical component was due to neurological or psychiatric issues (in the past, the distinction was no doubt fluid) found their "natural" solution in the asylum. <sup>4</sup>

### **Post-pandemic perspectives**

The new post-pandemic era that, whether we want it or not, is upon us in developed countries will inevitably bring with it a debate about the institutions that care for the elderly, who are, and in particular those among the elderly that are most fragile, the principal target of the virus. In Italy, considering the serious and well-known organizational problems that have complicated the first phase of the pandemic, the time seems to have come to interrogate ourselves on what configuration to give to the structures tasked with serving the needs of the elderly population, commonly called RSA (residenze sanitarie assistenziali).

Within the recent discussion, we go from the views of those who reject them entirely, deeming it possible to replace them completely with home-care services, <sup>5</sup> to the proposed policies of down-sizing, associated with a greater modularity. <sup>6</sup> These stances generally share the same concern, more or less explicit, with "demedicalization". When talking about the RSAs, we are no doubt dealing with a heterogeneous reality, considering also, among the many elements (such as their juridical status, for example), the fact that these structures have been "draining", since at least twenty or thirty years, from other sectors, such as psychiatry <sup>7</sup>, intellectual disability <sup>8</sup> or again neurological and/or rehabilitative care of chronic/degenerative diseases <sup>9</sup>.

Even if a reconsideration of the RSAs appears inevitable, it ought to be clear that to concentrate primarily on those institutions represents a political and ideological choice, which incidentally goes in the opposite direction to that pursued (maybe in a utopian fashion) by contemporary social psychiatry. Speaking of recent countertrends in psychiatry, we could cite the more and more casual use that is made, by the media and by others, of the acronym CHT, compulsory health treatment), a medical procedure in psychiatry that has always been strictly regulated, so as to guarantee the preservation of individuals freedoms.

At any rate, as far as the "structuralist debate about the RSA is concerned, as we could call it, we can observe that in framing the discussion primarily in terms of the containers, we run the risk of feeding the false idea, or at least the ideological presupposition, that constructing good containers represents the solution of the problem, according to the managerial dogma that is today the dominant faith of our time.

## **Subsidiarity**

Instead, it is necessary to start from people and their needs (if possible, expressed rather than interpreted) and, as a consequence of these, from the skills of the technicians and from what society (from the community if you prefer) is able to create with bottom-up. Those who argue that Italy has (for a change) a delay to make up for in terms of the institutionalization of the elderly, probably incurs an error of perspective. In fact, a relatively low percentage of institutionalized elderly people (especially in the South) means that the family and society still have a strong substitute role (Italy has less than half of the beds available in France, with a distribution by region ranging from 4.1 beds for every 100 elderly residents in Piemonte to 0.7 in Campania) <sup>10</sup>.

Maybe, we should rediscover a logic of subsidiarity, especially since in Italy there is a considerable plurality of actors throughout the social welfare sector, represented above all by private social institutes or foundations, whose very substantial contribution should be further enhanced. At least some of these realities have Medical Directions, and therefore a philosophy of care that for simplicity will be called traditional, which allows to maintain a link with the clinic that otherwise could be easily lost, as the French medical-social context shows. quite clearly.

As has rightly been noted, thanks to advances in medicine, more and more chronic patients are called to accept severe neurological patients with potentially algogenic pathologies, which need to be known and accompanied, starting from different professional skills <sup>11</sup>.

Not only amyotrophic lateral sclerosis or minimally conscious states <sup>12</sup> but also other neurodegenerative diseases that can associate themselves with neuropathic pain such as, limiting myself to anecdotic cases I have been able to observe personally, metachromatic leukodystrophy and Friedreich Ataxia (FA), or even Mitochondrial recessive ataxia syndrome (MIRAS). A solid link with clinicians, so as to guarantee adequate access to care for these patients, even just for a routine electromyography, remains fundamental, but could become in practice quite problematic.

## **Conclusions**

We ought in summary to safeguard as much as possible the specificity of the care needed by a given person; one should just think of the pioneering philosophy adopted in the Swiss French equivalent of the RSAs, the so-called EMS <sup>13</sup>, historically differentiated into geriatric and psychogeriatric, as if recognize the complexities in the management of the mental health of elderly persons, for whom - as it is well known - the algological aspects play a key role.

In other words, we should, preserving as much as possible the clinical (and rehabilitative) dimension, maintain the paradox of an attitude that is meta-institutional, if not exactly anti-institutional, that is an attitude that sees the institution as a means and not a solution in itself, without the fear of words (nursing homes, hospice, old people's home, chronic care nurses) replacing in time a cosmetic bureaucracy that delineates, or plans, with acronym after acronym a reality, that remains forever virtual.

It is not a question of demedicalizing (whatever we might mean by that term) but of protecting the rights of individuals to medical care. To avoid a dangerous drift into a sort of purely administrative health-care system, strongly biased against physicians (according to the wish expressed by Carlson in his well-know and dystopian text, expressly alluded to in the title of this piece) <sup>14</sup> and, precisely for this reason, also antiscientific.

### **Conflict of interest**

The authors certify the study was conducted without conflict of interests.

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### **Bibliografia**

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