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RESEARCH ARTICLE



Like ticking time bombs. Improvising structural competency to ‘Defuse’ the exploding of violence against emergency care workers in Italy

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ABSTRACT

While violence against health care workers is being progressively recognised as a serious problem in the healthcare industry, it remains an under-studied area of enquiry in global public health. Anthropologists have long observed that violence toward patients is tied to institutional care practises in multiple ways, including repression, misrecognition and silencing. But research on health care staff’s experience of violence is still lacking. This article aims to address this literature gap by providing research on the daily experience of vulnerability to violence that health care providers face during their work. To do so, the paper ethnographically explores the effects and perception of violence against health care workers in an emergency department (ED) in northern Italy, a place with a dramatic escalation of violent incidents. The article illustrates how the ED staff attended to the experience of suffering of potentially violent patients. In so doing, ED professionals shifted the responsibility of violence against them from violent individuals to violent structures shaping health inequities. The paper thus argues that ED professionals display a structural competence perspective when dealing with violence.

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Introduction

The World Medical Association has recently defined violence against health workers as ‘an international emergency that undermines the very foundations of health systems and impacts critically on patients’ health’ (WMA, 2020). Violence against health care workers takes diverse forms: from physical assaults or sexual harassments, to verbal threats and psychological pressure. All of these kinds of violence increasingly seem to be a daily presence within healthcare settings, with important effects on the quality of healthcare delivery and on health care workers’ wellbeing, as well as job satisfaction (Brophy et al., 2018).

Since they were often believed to be carriers of SARS-CoV-2, health care workers have become even more vulnerable to ostracism, stigmatisation and physical attacks. Abuse of health care workers has reached alarming levels since the beginning of the pandemic. Incidents are reported daily across the world, from Mexico to the Philippines, the USA, and increasingly in Europe and Italy (Vento et al., 2020).

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International literature from occupational health (Brophy et al., 2018; Gacki-Smith et al., 2010); global public health (Devi, 2020; Vento et al., 2020) and nursing studies (Chapman & Styles, 2006; Davids et al., 2021; Hodge & Marshall, 2007; Saines, 1999) tends to highlight circumstantial causes of violence, underscoring individual responsibility for threatening and aggressive behaviour. They all neglect to analyse the effect of upstream structural conditions, such as healthcare and welfare underfinancing, care fragmentation and hospital overcrowding that make violence more likely to happen (Bhatti et al., 2021; Foghammar et al., 2016; Hillman, 2016; Krug et al., 2002; Pasquini, [under contract](#)). Such tendency reinforces what scholars of the 'structural competency' framework have defined as a general lack of understanding among medical students and professionals on how structural factors shape health and illness (Joshua et al., 2020; Salhi et al., 2019).

Anthropologist Helena Hansen and sociologist Jonathan M. Metzl have introduced structural competence as the capacity – of both health professionals and policy-makers – to recognise how structural factors create health inequities (2014). Avoiding the use of cultural factors to explain health inequities across ethnic distinctions, structural competence highlights how differences between groups are created and upheld by upstream factors such as, for instance, immigration laws, limited access to healthcare, food and housing security (Harvey et al., 2022). Structural competence has gained particular traction in scholarly debate about the reform of medical education in the US to address students and professionals' unfamiliarity with the effect of upstream forces that may result in poor health outcomes, or even harm and mistreatment of patients (Bourgois et al., 2017; Holmes et al., 2020).

However, the tension between individuals' responsibility for violent acts against health care workers and the effect of structural forces on the phenomenon is key to ED professionals' experience. A strong tradition of scholarship within the sociology of professions, and health and illness has focused on the categorising of ED patients as 'bad' (Dingwall & Murray, 1983), 'deviant' (Jeffery, 1979) or 'problematic' (Mannon, 1976). These labels are particularly used in reference to frequent ED users, who are addressed by global public health literature as the people who are the most likely to turn violent against health care professionals (Grover & Close, 2009).

Sociological literature demonstrated the importance of nurses and doctors' categorisations of patients as a way of defining the legitimacy of people's requests for help and dealing with care resource shortages and ED overcrowding (Dodier & Camus, 1998; Hillman, 2014; Johannessen, 2018; Vassy, 2001). Categorisation, though, often causes a gatekeeping of healthcare that mirrors social hierarchies outside the hospital venues (Hillman, 2016; White et al., 2012). Patients from vulnerable strains of the population are most often categorised as 'deviant': either uncompliant or potentially violent. They are more likely to receive rushed care assessments, possibly leading to misdiagnosis or mistreatment (Hillman, 2016; Holmes et al., 2020). Besides beliefs and values of health care professionals (White et al., 2012), sociological literature showed how patients' categorisation in the ED is tied to organisational necessities (Dingwall & Murray, 1983; Vassy, 2001); to staff concerns with institutional accountability (Hillman, 2016); to their professional interest in the case (Dodier & Camus, 1998); or to patients and caregivers' framing of their request for help and their perceived 'reasonableness' (Hillman, 2014; Wamsiedel, 2018).

Departing substantially from such analysis, anthropologist Mara Buchbinder argued that sociological literature has overconcentrated on the 'restrictive' and 'disciplining' aspects of gatekeeping, creating a distorted picture of ED work (2017). Illustrating the positive rather than negative effects of gatekeeping, Buchbinder describes such practise as a referral system to redirect patients toward welfare services that can better support people facing specific structural difficulties, such as poor access to primary health or social services (2017). Buchbinder thus argues that rather than an unjust moralising practise, gatekeeping in the ED can, at times, turn out to be a form of structural competence (2017; Wamsiedel, 2018).

I build on Buchbinder's work to expand our understanding of improvised forms of structural competence in emergency services. I ethnographically explore how violence against health care practitioners – a problem traditionally linked to individual aggressions and developing in the

stigmatisation of patients – can instead be addressed in productive structural terms by ED practitioners.

To do so, I will illustrate how some of the central competencies that constitute structural competence are mobilised to prevent and address violence against health care workers in the ED (Harvey et al., 2022; Metzl & Hansen, 2014).

In an attempt to prevent potential violence, (1) ED staff recognised the structures that shape people's health and illness. (2) Nurses and doctors reflected on staff positionality and agency, practising structural humility, and (3) acted on 'the causes of the causes' of people suffering by improvising structural solutions. All of which in a context like Italy, that offers an important example of how upstream structural conditions of health care delivery influence the trends of violence against health care staff.

Context & method

Being an emergency services nurse in Italy is a dangerous affair. According to the Italian Nursing Union, Nursing Up, '4% of nurses who work in ED have been held at gunpoint at least once during their career' (Nursing Up, 2019, p. 7).

The rate of violence against health care workers in the Italian Healthcare Service has steeply increased since 2010, when budget cuts to public healthcare were applied as a response to the 2008 financial crisis (Ramacciati et al., 2019). The consequent dramatic decrease in the number of hospital beds, nurses and medical specialists such as psychiatrists, has meant that individuals who cannot afford to turn to private practise and who are dependent on the national healthcare system for their care needs have increasingly turned to the ED – a service that is always open, and accessible to everybody. Individuals also refer to the ED out of convenience, due to the limited office hours of General Practitioners (usually 10–20 per week in Italy), incompatible with long working hours or the impossibility of taking time off work (Johannessen, 2018). Newspaper and television exposés frequently sound the alarm that one third of the Italian population visits the ED at least once a year, and 70% of those patients are assigned either low-priority or non-urgent care codes (Italian Association of Emergency Medicine, SIMEU, 2016). In other words, Italian EDs are full of people who the health care staff think do not belong there.

With ever-decreasing available alternatives, many people in Italy increasingly seek out the ED as a kind of refuge to receive medical attention. They return to this refuge frequently – some people go back to the ED as many as 60 times a year. As the ED is not designed to sustain the long-term care provision that people increasingly demand of it, this kind of revolving-door frequency significantly impacts on the tenor of care interactions that unfold there. The ED has consequently become a place of increasing friction.

A study of nurses in Italian emergency services between 2010 and 2017 revealed a dramatic national picture in which 35% had been victims of physical violence during their work. 90% had experienced verbal violence (Mamo et al., 2020). 64% of all the victims of physical violence are women, either nurses or doctors (National Institute for Insurance against Accidents at Work, Inail, 2020). And almost one out of ten (9%) of all work-related illnesses in the public healthcare sector in Italy are due to either physical or psychological violence against health care workers (Mamo et al., 2020).

Since the beginning of the pandemic such numbers have skyrocketed. Having to face the pandemic with inadequate resources, regional public health authorities in Italy often had to cut down on other fundamental services such as basic healthcare provisions of primary care (Anelli et al., 2020). As frustration and waiting times for basic care increased, so did violence against health care professionals, particularly in areas that had been hit hard by the coronavirus epidemic, like the Emilia Romagna region where my ethnographic fieldwork took place.

Located in the north of Italy, the ED in which I conducted my fieldwork between 2017 and 2018 is one of the main emergency hubs in the Emilia Romagna region, an area known for its civic

tradition and dynamic grassroots political activism (the city of Bologna is its regional capital, and it includes cities like Parma to its north, and Rimini to its south). The ED receives between 40 and 110 patients every day with a staff that works eight to twelve-hour shifts, composed of two to four physicians and five to six nurses (depending on whether it is a daytime or a night shift). The hospital serves a provincial area of around 700,000 inhabitants, but patients also travel from far away to reach this ED to access the high-quality specialised care that is offered there.

The aim of my ethnographic fieldwork was to immerse myself completely in the rhythm and work of the ED (cf. Mulla, 2014; Varma, 2020). I worked the same full shifts as the emergency nurses I was following (eight to twelve hours). For twelve months, between 2017 and 2018, I spent five to six days per week working morning, afternoon and night shifts.

For this research, I received ethical clearance from both the University of Uppsala's committee and the committee of the hospital in the Emilia Romagna region, where I carried out my fieldwork. Even though I had to wear a lab coat for hygiene purposes, I always introduced myself as a non-medical researcher and took time to explain who I was and what I was doing, making sure I disambiguated my presence in the ED as much as possible.

My position in the ED was divided into two basic methodological moments. First, I shadowed emergency nurses and their in-patient procedures (meaning I followed them around with a notebook and a digital recorder). I observed, discussed and asked for explanations, which most nurses and doctors gladly gave me, treating me like a young nurse or medical student in training.

Second, I sat in the external waiting room with patients and caregivers. I provided them with answers to questions like 'Where am I on the patient list?', 'Who should I ask about X?', 'What's happening now?'. I conducted 86 interviews inside and outside the ED venues, of which 21 were with nurses, 7 with physicians and 57 with patients, on topics that ranged from overcrowding, to conflicts and violence. Moreover, I audio recorded care interactions (94 recordings overall). I also mapped the space of the ED and its flux of people and resources by using in-site drawing as an ethnographic method. The final corpus of interview transcripts and field notes comprehended about two thousand pages. Following grounded theory guidelines, data was processed by open, axial and selective coding with NVivo 12 (Bryant et al., 2010). Overall, I collected 90 complete case studies concerning people seeking help in the ED that I followed throughout both nurses' and doctors' examinations. Comparing the interactions that occurred in such cases, I singled out common conversational patterns between patients and the ED staff (Sidnell & Stivers, 2014). This set of tools allowed me to describe in close detail the unfolding of interactions while focusing on conflicts in ED daily practise.

Findings

The staff told me numerous stories about times they were shouted at, threatened, kicked or hit by intoxicated or agitated patients. But violence can also be more serious, such as when one outraged patient threw a fire extinguisher at a nurse, or another tried to stab a nurse with a knife after having been forced by the police to come to the ED.

Episodes of violence mostly occurred in the reception desk area because this was where patients were crowded together, waiting for medical attention in the ED. Families and friends of the most urgent patients were in the waiting room nearby, and they sat there anxiously awaiting news. Because the ED lacked an alternative space for speaking to them, a patient's passing or other distressing news often got communicated there.

Even more than its actual occurrence, the potential that violence might erupt made health care workers pay attention to particular gestures and attitudes of patients. Potential violence constituted an event that had to be anticipated and, ideally, prevented by the ED staff. People who were considered by the medical staff as more likely to turn violent were approached as '*bombe a orologeria*', ticking time bombs, ready to explode. The person-bomb metaphor was widespread in the ED to convey the high unpredictability of a person's behaviour.

The main perpetrators of unpredictable violent reactions were well-known by the ED staff to be (1) drug addicts (particularly users of drugs such as cocaine, methamphetamines and heroin); (2) individuals with mental illnesses; (3) openly belligerent people; (4) elderly people suffering from dementia or Alzheimer's; or (5) alcohol intoxicated loners. In addition, there was always danger when people arrived at the ED in the aftermath of violence such as physical fights, car accidents, any sort of harassment, suicide attempts, or crimes such as murder.

Attention to the 'bomb people' had a strongly gendered dimension. In the stories the ED staff told, perpetrators were mostly male. The assailants or potential assailants were often sturdy and scary, either semi-unconscious from drugs or alcohol intoxication, or simply aggressive and nasty.

Similarly, to be the victim of violence often carried a component of femininity. Female members of the staff were statistically more likely to be victims of violence, even though I personally witnessed more than one male nurse and male doctor being punched or kicked by female patients. And when male nurses or doctors were subjected to assault, they not infrequently asserted their masculinity by saying something like, 'If that had happened outside the ED, I would have really let them have it'.

As explained above in the context section, violence against health care workers was often tied to overcrowding by patients who returned to the ED multiple times. Such patients established a diverse kind of relationship with professionals from the one the ED was designed to have with incoming people. Interactions between the staff and patients were supposed to last between 5 and 12 min and unfold between complete strangers. But in particular with patients deemed as 'ticking time bombs', this was often not the case. The fact that many of the people considered to be potentially violent were well-known to the staff, allowed the creation of particular relations, enabled by a profound knowledge of the other's living conditions. Such relations were often deployed to prevent violence against health care workers. In ward jargon: '*disinnescare*', defusing violent intents. The following is an example that shows how the high frequency by which frequent users came to the ED changed the way in which potential violence was experienced by health professionals.

A muscular man in his late thirties, a leather biker's jacket draped over one arm, lavish black tribal tattoos displayed on the other, strides with a swoosh through the sliding glass doors of the ED entrance. It is a crowded, freezing Monday morning in late January. The man plants himself in the middle of the waiting area – a large, barren room with eighty plastic seats, garishly lit by neon lights, painted pale institutional green. He waves a broken glass bottle neck in his right hand, glares in the direction of the nurses' reception area across the room, and shouts, 'I want to see a psychiatrist right now or I'm going to slit my wrists!'

Instead of alarm, this threat is greeted with jaded good humor. The tattooed man, a regular visitor to the ED, is well known to the ED staff. 'Go on, do it!' Nurse Giovanni – a gruff professional who that morning is seated at the reception, typing another patient's name and symptoms into his computer – hollers back through the thick glass wall that divides the nurses' reception desk from the external waiting area. 'We'll stitch you up. You know we can do it'.

The man stands staring at nurse Giovanni. 'Fine!', he yells. 'Then I'll cut my chest open and stab myself in the heart!'

Nurse Giovanni laughs. 'Good luck with that! If you can manage to pierce your sternum with a piece of glass, I'll give you a round of applause (*ti faccio pure l'applauso*)!'

The tattooed man snorts and looks around, visibly frustrated. Then he turns and strides out through the sliding glass door, just as purposefully as he had entered. (*fieldnote*, 18/01/2018)

Nurse Giovanni knew Valerio, as I later discovered the tattooed man was called, well enough to conclude that the broken bottle wasn't intended to hurt anybody, including the man himself. Instead, having a good understanding of the man's living conditions, nurse Giovanni later told me that he was convinced that Valerio had caused a scene to try to up the ante of the urgency of his demand for help. Valerio habitually claimed madness in order to skip the long waiting list for primary mental health care. He came so often to the ED, he once told me himself, because he had an 'urgent need to talk to someone' (*un bisogno urgente di parlare con qualcuno*). Clearly

feeling abandoned by the underfinanced Italian healthcare system, and desperate, Valerio's was far from being an isolated case.

1. *Recognising the structures that shape people's health and illness*

Other than being objectified as dangerous, people categorised by the ED staff as 'ticking time bombs' also required particular techniques. These techniques were geared toward deterring potentially violent patients from harming themselves and others, and preventing them from hindering care activities. Such techniques were not part of the ED staff's formal training, but they were widely shared.

These techniques involved distraction. Potential 'bomb-people' were offered a coffee, or a cigarette to smoke outside the hospital facility. Occasionally troublesome patients were invited to have a brief chat so that a nurse could '*disinnescare*', defuse potential violence by gathering knowledge about their living situation and thus connect with them, making them feel attended to. Chats about hobbies served this function, as did questions about vacations or favourite music. Another such technique was to isolate the 'bomb-person' in a strategic spot in the inner waiting area, where staff were able to watch them; for example, near the reception desk, where Valerio was often placed. Much as a professional explosive defuser would tinker with a prospective bomb, staff in the ED tinkered with people, to switch off potential violence.

Such techniques at times resulted in the alienating of a patient, as shown by the sarcastic replies given by nurse Giovanni to counter Valerio's violent threats. Nevertheless, the '*disinnescare*' of potential violence more often involved a timely foreshadowing of biomedical concerns, to foreground recognition of the different exposure to harm and suffering that people experience due to upstream structures.

The case of Massimo, a man in his early forties who appeared through the ED entrance one dazzling spring morning, provides a relevant example of how health professionals uncovered the upstream structures responsible for people's suffering by using techniques to switch off potential violence. He was escorted to the ED in the aftermath of a brutal fight with his mother, after attempting suicide by hanging himself with a bathrobe belt. While waiting in the ED his fists were clenched, his eyes fiery, red and angry. Nurse Patrizia, the emergency nurse I was shadowing that day, immediately regarded him as potentially violent, a ticking bomb.

Instead of making them wait outside, patients believed to be potentially violent were often fast-tracked by nurses into the doctor's office, even if the specialist they needed had not yet reached the ED (in Massimo's case a psychiatrist). This is an important improvised technique that the staff used in their dealings with individuals they regarded as potentially violent. Besides granting urgency, this arrangement also facilitated a considerably longer time for examination; precious time that the doctor could use to better understand a potentially problematic patient's living conditions.

In fact, having enough time to articulate his situation, Massimo argued that he did not need another psychiatrist to take care of him. His real trouble stood in his relationship with his mother. Encouraged by the doctor to articulate what he meant, Massimo's words flowed swiftly, telling the story of his mother: she was the daughter of a woman who had been constantly beaten and raped, who was forced to marry her rapist after she fell pregnant, to repair her family's shame (an Italian practise known as *nozze riparatrici*, 'repair marriage') toward the end of the Second World War. Massimo's mother ferociously hated all men: especially her father and her only son, in whom she saw her own rapist father.

Massimo told the doctor he had spent his life trying to gain his mother's respect; respect which he said was withheld even now, when he alone was taking care of her, because her mobility and independence had increasingly declined with age.

Massimo's mother preferred his sister who, he said, did not care about her and frequently asked for money, which his mother gladly gave her. Mother and son argued continually about his sister's behaviour. That morning, the morning of the altercation, in a dispute about his sister, Massimo's

mother had challenged him, shouting: ‘*Cupem! Cupem!*’ meaning ‘Kill me! Kill me!’ in the local dialect, implying that since Massimo would never succeed in changing his mother’s mind about his sister, he might as well murder her.

Massimo almost took his mother up on her dare. He beat her badly, leaving her lying on the floor of his apartment. Horrified at what he had done, he called an ambulance and locked himself into the bathroom. He took five doses of his antidepressant medication and attempted to take his own life with his bathrobe belt.

Massimo’s mother – who had been sent by ambulance to the other hospital in the city – was expected to recover from her injuries, and she decided not to press charges against her son. Alerted by the ED staff, the social services prioritised the procedure to find alternative accommodation for Massimo and a caregiver for his mother. Massimo was also referred to a local self-help group for perpetrators of violence against women. So as not to further fragment his relationship with the healthcare services, the doctor called Massimo’s own psychiatrist and negotiated a follow-up appointment with her.

Such organisation of the ED care response can be interpreted as an improvised form of structural competence. It shifted the grounds for engaging Massimo’s case in the ED, reframing the focus from being on him as a threat to the ED staff to his compelling narrative, which addressed why the tools available to the staff were of little help to address a family context of suffering that seemed to encompass almost a hundred years of violence. The relevant relations went far beyond diagnostic labels and ED-specific ideas of who was thought to be dangerous. Massimo’s relationship with his mother, as he described it, superseded the category of perpetrator and victim. It assumed the shape of an ambivalent kinship relation of hate, violence and dependency. His needs could not be addressed using a biomedical approach. Instead, they were symptoms of a violent normality of social abandonment that needed to be addressed in structural terms.

2. Being reflexive over staff positionality and agency

Improvised techniques of caring all pointed at what experienced professionals called the importance of ‘*disinnescare*’, defusing, violence in order to understand people’s suffering more fully, and to productively negotiate care. To switch off potential violence required a certain degree of reflexivity, not only upon the structures that shape patients’ health but also upon health care staff’s possibility to address them.

Indeed, not all professionals were equally good at defusing potential violence, and their subjectivity (i.e. gender, ethnicity, class, and personal experience) was a central component in their capacity to relate to potentially violent patients. For instance, emergency nurse Lidia told me that handling unpredictable patients means that ‘You need to be humble. You have to recognise when your presence or what you can do is not helpful, and then you have to call someone else who might be able to connect with the patient. For instance, I have never experienced any trouble with male patients, but once I could not find a connection with a woman who was angry with all good-looking ladies, including myself.’

As many members of the ED staff described it, defusing violence implied an exclusive relationship between a health care worker and a patient that was based on a shared experience of vulnerability to particular structural forces. The exposing of staff subjectivity and positionality among structural forces (i.e. gender, ethnicity, class, and personal experience) was effectively used as a tool to relate to people considered potentially violent.

To explain this mechanism, nurse Lidia provided me with the example of a South American woman in her thirties named Isabel who had just badly hit two male police officers. ‘The police locked her in the doctor’s office where I was working. Isabel threw anything she could find at me, she desperately wanted to hurt me. I didn’t have much information about her apart from the fact that she was visibly drunk and outraged. The cops had just told me that Isabel had had some love trouble with a man. So, I looked straight at her and made it clear whose side I was

on: “You are right to be angry. Men are all assholes!” And that was our click. I started talking shit about men and she visibly calmed down.’

The solidarity expressed by nurse Lidia toward her patient shifts her positioning from the role of a professional providing care to a fellow woman struggling to find her way in a world governed by men. By pushing forward the power structure of patriarchy as a relevant object of concern for patient’s health, nurse Lidia achieved the kind of connection and understanding that is described by emergency workers as being able to defuse violence. After this contact had been established, Isabel explained her situation to nurse Lidia. She was found attempting suicide after a brutal fight with her male partner during which they had beaten each other up. The story of partner’s violence produced an organisation of emergency care around her possibility to reach out for financial support in order to be able to move out of her partner’s apartment.

The reflexivity implied in *‘disinnescare’* potential violence is arguably a form of structural humility that develops as a key tool in dealing with potentially violent patients in the ED. In the case described by nurse Lidia, it helped to mobilise her positionality, as a woman, to reach a mutual understanding with her patient. This made it possible to first switch off violence and second uncover the structures influencing the woman’s health. The ability to defuse potential violence in the ED is thus tied to the experience of being exposed to the influence of similar structures. Another common example of how such a connection was achieved is the use of local southern Italian dialects to display a shared regional origin. Local dialect signalled that both patients and staff were subject to the same kind of discrimination as internal migrants from southern Italy. Again, structural humility – as the acknowledgment of the staff’s possibilities and positionality – develops as a technique to prevent violence and create a relation based on shared living conditions.

3. Improvising structural solutions

The ED staff improvised with a wide set of alternative care arrangements in order to face people’s structural conditions. For instance, ED staff granted people who were believed to be dangerous more privacy. They gave them medications that they would otherwise have had no access to through primary care. Or in the case of homeless patients, health care workers allowed them to rest on a stretcher in a secluded corner of the ED, where they could recover from the fatigue of life on the street. What such makeshift solutions often achieved were alternative ways to conceive of care in structural terms, turning staff’s attention away from biomedical criteria and toward people’s biographies and their living conditions.

Such care arrangements were furthermore ‘structural’ as they directly addressed what the ED staff envisioned as root causes of the increasing potential for violence within the healthcare organisation itself. Revealing the effect of ED overcrowding, ED strict biomedical focus and the limited time health professionals could spend with patients, alternative care arrangements were a daily attempt to bring about healthcare-service structural change.

Efforts to change were manifested in the ED through the peculiar relationship achieved with people identified as ‘ticking time bombs’. Such relations underscored the necessity of overcoming financial shortages and hire more staff in the ED. It highlighted the need for spaces where privacy could be granted to patients in need of in-depth listening and fast-tracking from the waiting room to more appropriate care settings like the doctor’s office. This relationship also foregrounded the diversity of the ED staff’s social background as a resource that can be used to achieve a meaningful relationship with people considered potentially violent. It gave value to knowledge about the structures that influence people’s health and the improvised solutions adopted to address those structures. Even though such knowledge was just passed on informally among nurses and physicians in the ED, the daily dealing with violent patients helped remind everyone of the importance of attempting to defuse violence by achieving a meaningful care relationship with people.

Moreover, an official referral system to address the upstream sources of people’s suffering was implemented on the basis of needs emerging from daily relations with patients dubbed as ‘ticking

time bombs'. The referral system included a network of local NGOs addressing, for instance, violence against women, financial aid, mental health rights, and elderly patients and caregivers support. For example, both Massimo and Isabel were referred to other services for support in the face of considerable structural difficulties.

Needless to say, the process of re-adapting ED instruments to people's experience of suffering, and promoting structural change in the healthcare-service organisation, required proper resources, time and staff that simply were not there. It is worth noting that such re-adaptation would have to coexist with the ED's dedication to clinical urgency. The extensive attention granted to individuals like Massimo or Isabel could not possibly be granted to everyone who came to the ED. Many of the patients who came regularly to the ED had to endure long waits and received little response to their needs connected to the influence of upstream structures that superseded biomedical intervention. Some of these patients erupted into violence.

Discussion

People recognised as 'ticking time bombs' created a paradox within ward practise. They were not only objects of stigmatisation and discrimination. In fact, ED staff dealing with people considered potentially violent illustrates structural competence.

On the one hand, ED professionals immediately connected aggressiveness with specific categories of patients, objectifying them as 'ticking time bombs'. Talk of sudden bomb-like-people's reactions at once alienates patients and undervalues the magnitude of violence against health care staff as a recurring global phenomenon. Health care practitioners' focus on the risk of violence produces a narrative that consolidates, and hence normalises, who is supposed to be the victim of violence and who is the perpetrator (Mulla, 2014). By constructing such boundaries daily, war metaphors, which are already entrenched in the emergency care environment, become even more prominent (Varma, 2020). Such findings are in line with sociological literature on gatekeeping in emergency services, where patients are dubbed by the staff as 'deviant' (Jeffery, 1979); 'problematic' (Mannon, 1976); or 'ticking time bombs' in our case.

On the other hand, in contrast with such sociological tradition, staff also tried to attune their attention to people's perceived needs in the attempt, first, to defuse violence and, second, to tailor care to people's specific conditions. As demonstrated by the examples of Massimo and Isabel, defusing violence involved assessing needs, not against a biomedical standardised body – as nurses were supposed to do in the ED – but by letting them emerge in the course of interaction by disclosing the structures affecting people's health. ED staff tinkered with different ways to care for, and connect with, patients identified as potentially violent. Such a process highlighted sameness rather than the power asymmetry entailed in acts of violence (between perpetrator and victim); care delivery (between provider and recipient of care), and war metaphors entrenched in daily ED activities.

Practically speaking, the effects of such practise were far reaching and meant that care in the ER shifted from being 'anonymous', i.e. based on risks connected to a standardised body, to instead being focused upon people's different living conditions (Stevenson, 2014). Defusing potential violence foregrounded the diversity of people's exposure to harm, and the unequal embodiment of violence in their lives (Bourgois et al., 2017).

As anthropologist Mara Buchbinder described, ED staff's gatekeeping did not restrict access to care to potentially violent patients (2017). Rather staff's gatekeeping importantly created an external referral system that can be understood as a form of structural competency that nurses and doctors deployed to better support people's facing upstream difficulties. But, differing from what is described in Buchbinder's work, the relation between ED staff and people dubbed as 'ticking time bombs' did not only reveal the structural vulnerability of people reaching out for help. Instead, violence in the ED directly questioned the way in which the ED was set up. The dealing with 'ticking time bombs' exposed how the very organisation of healthcare contributes to daily conflicts.

Allowing the creation of a space of reflexivity on ED daily practise, the relationship with ‘ticking time bombs’ allowed a series of improvised tools to emerge. These tools directly targeted overcrowding and the limited time staff could spend with patients as root structural causes of violence in the ED. Improvising structural changes with their limited agency, staff tried, first, defusing potential violence by referring people to other services and local NGOs for daily support. Second, ED professionals struggled to create dedicated space and time where people could rest, grieve, and where their suffering could be granted comfort and a sympathetic ear. Third, the staff advocated for increasing the dedicated health care staff to diminish waiting and enable time to listen to patients’ concerns revealing structural problems. Particularly in cases of frequent ED users like Valerio, Massimo and Isabel, which are also defined by international literature as the most likely to resort to violence, such people could be provided with alternative support from the ED and thus avoid returning so often, preventing conflicts due to long waits and overcrowding.

In conclusion, whereas most international literature revolves around condemning and deterring individual violence against health care workers (portrayed as somewhat passive receivers of violence), the ‘*disinnescare*’ of violence in the ED actively shifted the staff’s attention from individual aggressive behaviours to the upstream causes of overcrowding and understaffing, that made the occurrence of violence against them more likely.

Techniques of ‘*disinnescare*’ involved (1) recognising the structures that shape people’s health and illness. (2) Being reflexive over staff positionality and agency, practising structural humility and (3) acting over ‘the causes of the causes’ of people suffering by improvising structural solutions (Harvey et al., 2022). Comprising many of the core competencies that make up structural competence, ‘*disinnescare*’, defusing, is a set of caring techniques the staff mobilised to struggle toward equity of treatment and social justice. Emerging as a productive response to the threat of violence, ‘*disinnescare*’ contributes to our understanding of gatekeeping practises of the ED staff. It provides us with a valuable example of how the experience of health care professionals illuminates the potential application of structural competency to prevent violence in the ED.

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