NOTES

News

In the double digits. "Salute e Società" ten years later

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Salute e Società is now 10 years old. During these years *Salute e Società* has reached many goals and has become the most important scientific journal in the field of the Sociology of Health in the national context. In this article, we analyze the philosophy of *Salute e Società*, its editorial structure, and the collaborative relationship between academic and professional medical sociologists which has led to the realization of each of its issues. An analysis on the journal's contents by T-Lab software is provided. In addition, we point out that the coordination of the referees; the decision to publish all the articles both in Italian and in English and the attention for all the innovations required in order to obtain the Impact factors are the most demanding aspects of a high-quality level scientific journal.

Key-words: Internationalization, Scientific journal, Referee, Impact factor, Sociology of Health, Società Italiana di Sociologia della Salute.

1. The Manifesto of *Salute e Società*, ten years later

After ten years, reading over the first editorial of *Salute e Società* – edited by prof. Costantino Cipolla, scientific editor in chief of the journal – arouses a complex of emotions and satisfactions.

At that time, the relevance of topics such as the Citizen's role, health care humanization and personalization, and

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the quality of health and social services (just to list some of the topics which were foundational to this journal) was increasing within the scientific community and the political arena thanks in part to the pioneering work of Achille Ardigò (President of scientific board until his death). Doubtless, those ideas were passionately debated ten years ago, while they are fundamental aspects of our health care systems today. *Salute e Società* cut across these arguments, and sped up and consolidated these changes through hundreds of papers written by academics and professionals.

Speaking about the future of the journal, Costantino Cipolla explained *Salute e Società*'s Manifesto and recalled some of its fundamental principles: honesty and civil courage, scientific rigor, continuity and international openness. These principles have been developed through the content (monographic topics) and the form (volume structure and processes) of the journal. Honesty and civil courage have come to the forefront in discussions of topics which are sensitive and complicated from an ethical point of view such as the medicalization of life (Maturo, Conrad, 2009), the roles of bio-technologies (Giacca, Gobbato, 2010), the living will (Clemente, Cersosimo, 2011), just to give some examples. Furthermore, the discussion of these topics has been alimented through the journal's dedication to giving space to critics in each volume (think about the section Comments which follows the Debate);in some volumes this aspect is done very explicitly (Marradi, Nigris, 2010; Cipriani, 2011). Scientific rigor is an obvious and essential requirement of the journal, which we seek to guarantee through the practice of double-blind peer review. The continuity of the journal's publication is not only respected, but we've even reinforced it by publishing many supplements (nine in ten years) to ensure authors the possibility of finding a space for important intellectual debates and scientific observations. Finally, internationalization has been fostered through the use of new channels and forms: the number of international correspondents and foreign authors has increased, and the journal is always published in Italian and English (always available online, sometimes also in print).

Salute e Società is at the core of many collateral activities concerning health sociology. In the first editorial the scientific editor cited some initiatives related to our journal, such as the Specialization School of Health Sociology (University of Bologna), founded by late prof. Ardigò and directed by prof. Cipolla. The Italian university reform has suppressed these schools, but many new initiatives linked to our journal have been launched. From an educational point of view, bachelor, masters and postgraduate courses have been promoted[1]. From an intellectual prospective, many workshops and con-

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[1] These degree courses include – now cancelled due to the university reform – "Sociology"; a master's degree in "Wellbeing, safety and health sociology"; a master's degree in "Sociology and social and health policies" ("Facoltà di Scienze Politiche R. Ruffilli" at Forlì, Bologna University): For postgraduate education: master's of first level "e-Health, electronic health dossier and social networks" (previously "Social and health quality evaluation") and an Advanced Training Course in "Social planning: new tools for social and health services"). In the past, the following courses were promoted: "Welfare State and Citizenship: gay, lesbian, bisexual, trans (Glbt)"; "Methodology of social and epidemiological research in the drug sector"; "Health sociology and complementary medicine"; "e-Health, Electronic Health Dossier and social network".

ferences have been organized[2]. A new interdepartmental research center, called Ce.Um.S[3] (*Centro Studi Avanzati sull'Umanizzazione delle Cure e sulla Salute sociale* – Research Center for Care Humanization and Social Health) have been established: sharing the basic principles of our journal, it aims to promote and coordinate studies and research on human and relational aspects of health and disease. Furthermore, as you note from our editorial, *Salute e Società* is indexed in the main bibliographic research platforms (Ebsco Discovery Service, Google scholar, ProQuest Summon/Sociological Abstract, Casalini Digital Library) and has an h-index calculated by Publish and Perish. Obviously, *Salute e Società* has many other features which are discussed in the Editorial of this volume.

In brief, *Salute e Società* has assumed a leading role in promoting the international debate both through its articles and through many initiatives that are closely connected to the journal.

2. Contents organization of Salute e Società

Compared to other scientific journals, *Salute e Società* takes an original approach to organizing its articles. Typically, the contents of a journal comprise an introduction and some articles followed by reviews. *Salute e Società* has a more complex structure. In addition to the Introduction, written by the editors of the issue, each volume includes an Editorial. The Editorial is always written by a prominent scholar on the scientific topic proposed in the volume. In fact, *Salute e Società* takes a monographic approach to arguments, thus every volume is dedicated to a specific subject and the articles are related to it. The Editorial is usually a brief comment about the centrality of the topic and does not describe the articles of the volume (though the Editorialists has the opportunity to read them, of course). The articles are divided into two main sections: Theory and Research.

Articles which are published under the section "Theory" have theoretical connotations, while those in the Research section usually give an account of empirical research that has been carried out. There is also a third kind of article entitled, until recently, "International Perspective", which is commented on by two experts. From its start in 2002, *Salute e Società* has included a foreign article in every volume. We have always been convinced that internationalization needed to be concretely pursued and not left as an abstract principle. There have been many discussions among the editorial board about the contents of the comments section. At first, we thought about having a pro-comment and a con-comment, but eventually we decide to give the commentators the freedom to express more nuanced opinions.

As a rule, the foreign articles we include have not been published elsewhere, exceptions are made only for articles which have created resounding debate in the scientific community. In

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[2] It's impossible to list all them here for reasons of space. Nevertheless, we should mention the conference to celebrate the five-year anniversary of our journal (Forlì, 19th 21st-April 2007). More than 200 people replied to our call for papers. After the conference, many speakers wrote papers and the essays were published in both *Salute e Società* and the series which has the same name (FrancoAngeli).

[3] The Center's statute has been published in the section Note of *Salute e Società* (see vol. 1, 2011).

these cases, *Salute e Società* pays the fees for the right to translate them (which are not always merely symbolic). Recently, the title International Perspectives has been changed to "Debate". The reason why this shift occurred is simple: as in many volumes the number of foreign articles is high, the internationalization of *Salute e Società* is well established and there is no reason to emphatically underline it. Indeed, *Salute e Società* is also published in English (always in the on-line version, often in the printed version). *Salute e Società* also has a section called Discussion in which experts debate about the topic of the volume.

The Board of *Salute e Società* is responsible for the Reviews and the Notes (which comprises News, Opinions, Letters to the Editor, Health online, Glossary, In memoriam). It can therefore be said that the editorial efforts go far beyond the typical editorial work of coordinating referees and monitoring translations.

3. Editors and the relation between academics and professionals

As the *Manifesto* declares, the journal *Salute e Società* aims «to advance social sciences knowledge about health in its various forms» from a sociological perspective. Forms that are presented by the journal not only through the many different subjects covered during its ten years of publication, but also offering different and multiple points of view, sometimes coexisting and completing each other, sociology of health being the starting point, but with other related disciplines included. It could be stated that the Journal has provided a relevant "surplus" for the discipline of health sociology which studies possible ways to intervene on vital and organizational areas undergoing changes.

This goal has been reached through the contributions from academics who have shown their high expertise on the subject considered by each Journal issue as well as professionals who also possess knowledge of whom has "dirty hands", due to the work they are performing on a daily basis. So, in several issues professionals and "pure" scholars are talking together on the same subject. The perspective presented by the Journal does not put in contrast two kinds of knowledge, but rather aims to build a shared platform able to drive epistemologically the sociology of health. Applying this strategy is extremely useful in order to avoid not only social researches based solely on bureaucratic and administrative priorities, but also social actions empty of praticability.

Our approach follows the direction of innovation. It stretches out to new epistemological and methodological worlds within the sociology of health, constantly rebuilding the areas of knowledge occasionally forcedly defined. The aim is to restore the contrast between "academic" and "professional" sociology, an aim which again affects the ground of its definition as social science.

The reason of this division between academics and professionals is probably the nature of health sociology's paradigms and theoretical and methodological constructs – which differs from the distinctive features of traditional human sciences. Notwithstanding, scientific knowledge is grounded on empirical evidence, historically defined, and it reduces the absolute property of logic constructs and every time it forces the sociologist to verify the theory in the world of reality (Minardi, 2012).

For this reason, health sociology has to be perceived as a logical and analytical perspective on the social worlds. Its heuristic power is not emptied with the rigor of its assumptions, but constantly refers to the dimensions of the social reality.

The ongoing contrast between the two dimensions, academic and professional, in several scientific and operating frameworks strengthens criticism and negative comments about the sociology of health, which in the end turns into a question of inadequacy of our discipline among the social sciences, on one hand, and among the applicative techniques of its analytic models, on the other. That leads to a separation which is responsible for the lack of prestige experienced by the sociology of health and which has to be overcome through the reassembling of the approaches, of their analytical and diagnostically functions with regard to the social complexity faced by the health sociology.

3.1. *Academics, professionals and miscellaneous*

A look at the editors of the *Salute e Società*'s issues published during the last 10 years immediately reveals the richness of its planning with contributions from academics, as well as professionals, and sometime both.

Let us start by considering the first case, namely the contributions from "pure" academics to *Salute e Società*. Firstly, it could be represented by the issue on the *Narrative-based medicine* edited by professor Roberto Cipriani (a. IX, n. 2, 2010), head of the Educational Science Department of Roma Tre University, who has been chairman of some important Italian and foreign associations of sociology and who is experienced in facing theoretical and methodological issues, having conducted several theoretical and empirical researches. Another academic who edited an issue of the Journal is Marco Ingrosso, professor of sociology at the Ferrara University where he leads the "Laboratory of Social Studies on Health and Wellness Paracelso", working on several subjects such as education, health promotion and communication, social wellness and treatment. The issue edited by Ingrosso treats the topic of communication on health concerning networks and relations (a. VI, n. 1, 2007).

The contribution of the professional sociologists of health is equally relevant to our discussion and widely participated to the breathing space offered by the Journal. The contribution given by the Italian Society of Health Sociology (Società Italiana di Sociologia della Salute - SISS), an association which aims to the integration between the academic and the professional knowledge can't be neglected. SISS edited two Journal issues: the first one was edited in 2004, entitled *The Sociology of Health in Italy: Topics, Approaches, Praticability,* the second issue, entitled *Being and Practicing the Sociologist in Italy*, was edited in 2009. On both occasions SISS had chance to define its guidelines in order to put together and harmonize two souls of the health sociology, aiming to develop a strategy able to strengthen consciousness, to widen knowledge and to suggest instruments of integration (a. VIII, n. 3 - Supplement, SISS 2009). The combination of the academic and the professional perspectives presente in the issue edited by SISS testify readers about the evidence of a knowledge at high level, that can be assimilated to other scientific disciplines. A distinctive feature of this knowledge is its ability to convey elements of transformation and improvement discovered on the social reality, offering an opportunity to put into comparison and exchange the "sociologies of health" (a. III, n. 3, SISS 2004).

Besides that, concerning the topic of new transformations involving the organizational system of health (relations between health professionals, doctor-patient relation, treatments, etc.) Andrea Gardini, head of the Hospital of the Ferrara University, edited *The Hospital in the XXI Century* (a. VI, n. 3, 2007). In this issue Gardini analyzed the organizational situation of the hospital at present offering possible scenarios of its evolution in the future. He assumed about the implementation of innovative strategies, considering topics like the rationalization of resources and the relation between new technologies and health, as well as ethical problems, showing the ability to explain clearly the phenomenons from the professional perspective.

Moreover, concerns about the enhancements of the biological research are not only a matter of discussion among the academics. The task of discussing the effect of new biotechnologies on the quality of human life and health was assigned to Carlo Antonio Gobbato, executive sociologist at the Hospital of the Udine University and president of SISS, with the support of Mauro Giacca, head of the International Centre for Genetic Engineering and Biotechnology of Trieste. The issue edited by them, entitled *Genetics Polis and the society of the future* (a. IX, n. 3, 2010), offers several consideration about the social legitimation, the genetic selection and the manipulation of life.

One cannot deny that several topics could be discussed from a sociological perspective putting together both points of view, the academic and the professional. During its ten years of publication, *Salute e Società* kept an open space for this kind of contributions.

Turning to the question of the the reorganization of health care system due to the innovation technologies, the reflection produced by Mauro Moruzzi, head of CUP 2000 – a company belonging to the Emilia Romagna Region working with the e-health and e-care systems –, who joined his pioneering experience in this field and the scientific understanding of the relevance of this topic projected onto the future, was proposed in two Journal issues: *e-care and health* (Moruzzi, Maturo, a. II, n. 2, 2003) and *Telemedicine* (Moruzzi, Cipolla, a. III, n. 3 - supplemento, 2004).

Although *Salute e Società* is keen on modern topics concerning the organizational health care system, there has been some long lasting matters of contention on the health sociology's horizon. The approach recently adopted by the Journal combines academic and professional points of view. Accordingly, the issue *Social inequalities in health. Problems of definition and measurement* was edited by two professors – Giuseppe Costa, who teaches at the Medicine and Surgery Faculty of Torino University and who is head of the University Health Care Centre of Asl To3 in Piemonte, and Cesare Cislaghi, who teaches Health Economy at the Milano University and who is head of the National Agency for Regional Health Services – and a statistic, Nicola Caranci (a. VIII, n. 1, 2009). Similarly, *The health care of citizens*, was edited by Leonardo Altieri, professor at the Bologna University and expert in evaluation of health services and social policy as well as citizens' participation, together with two professionals: Maria Augusta Nicoli, director of the Community, Equity and Participation Section at the Health and Social Agency of the Emilia Romagna Region, and Vittoria Sturlese, coordinator of Laboratory for listening and involving of citizens and professionals working in the Health and Social Agency of the Emilia Romagna Region (a. X, n. 2, 2011).

As a final point, rolling the Journal's indexes the reader can find elements of bridging, which link the two worlds, integrating the one with the other. The CERFE Group, the coordinating agency of three non profit associations working in the field of social research – Cerfe, Citizenship' Sciences Laboratory and the Women assembly for the development and the fight against social exclusion (ASDO) – edited the issue *For an active interdependency between North and South of the planet* (a. I, n. 3, 2002). It comprehends and interprets health's transactional dimension through an analysis of the theoretical and methodological fundaments of our discipline. Finally, Cleto Corposanto, professor of Sociology at the Catanzaro University, edited an issue on theoretical, empirical and methodological aspects of the evaluation research (a. VI, n. 2, 2007) discussing the problem of social participation and governance related to health and social services. It is clear from the above that the professional experience with the setting up of indexes, sociological informants and measuring systems should go along with the elaboration of scientific guidelines.

3.2. *The two legs of health sociology*

If is true that «the integration is the pearl of almost every action» (Cipolla, 1997: 2252), part of the quality of *Salute e Società* lies on the attention to operational areas of sociology of health in order to enhance our discipline by scientific legitimation. In fact, if on one hand it can be said that the science gives rules to the profession, a knowledge circumscribed by time and space and resilient under certain conditions; on the other hand, the profession conserves its self-sufficiency with regard to the scientific knowledge because is a method that gives feedback and operationalization that controls[5].

In conclusion, a journal such as *Salute e Società*, which aims to spread a specialized knowledge strengthened by practical feedbacks and operational values, liberated from conceptual vanities and closer to the things of the world (Cipolla, 1997), has to be open to the different voices of health sociology belonging to the academic field as well as to other correlated disciplines, and also to those who handles the same issues from a professional point of view.

4. Content Analysis of the articles in *Salute e Società* from 2002 to 2012

4.1. *A methodological note on content analysis using the T-Lab software*

The indices of the journal have been subjected to an in-depth analysis using T-Lab software, whose results are presented here. This software employed a "photographer-like" strategy, selecting which words to give greater focus to in light of the conceptual categories used by the magazine. These calculations, which allow you to produce enlargements of some key concepts of the journal — those that emerge more frequently in the series — are designed to capture the different semantic fields in which the journal's contributions have moved over the last 10 years through a statistical analysis of language. T-Lab consists of a set of linguistic and statistical tools for the analysis of texts that can be used in the following research

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[5] For further conceptual details, see the terms *Accademia* and *Professione* in Cipolla C. (1997), *Epistemologia della tolleranza*, FrancoAngeli, Milano.

practices: Semantic Analysis, Content Analysis, Perceptual Mapping, Text Mining, Discourse Analysis. The texts analyzed with T-Lab can be either a single text (e.g. an interview, a book, etc.) or in our case, a collection of texts (ie, many interviews together, websites, newspaper articles, answers to open questions, phrases, etc.). In particular, the T-Lab tools allow you to carry out three types of analysis: A) – analysis of co-occurrences of keywords, B) – thematic analysis of the context units, C) – comparative analysis of the corpus.

In this study we used analysis of co-occurrence that allows the calculation of the overall word associations (between 184 keywords). The selection of the words present in the image is carried out through the calculation of an Association Index (Cosine). This tool allows T-Lab to test how the contexts of co-occurrence determines the local meaning of keywords. In the radial plots, the lemma is selected in the center and connected with others which frequently accompanied it. The words that are distributed around it are those that occur together, that occur closer to one another throughout all the text fragments (the fragment is a cross between paragraph and sentence), each at a distance proportional to its degree of association. The significant relationships are, therefore, of the type one-to-one, between the central lemma and each of the others.

4.2. *Interpretation of output*

Thanks to the use of T-Lab software, it was possible to analyze the titles of the Journal's articles published over the last 10 years.

In particular, we have defined the number of occurrences (tab. 1) and various associations between the most important words (figg. 1, 2).

With regard to the first analysis, the occurrence is the number of times that every lexical unit (single or multiple words) is present in the unit of context, which is the portion of text in which the corpus that we analyze can be subdivided (Lancia, 2002).

The occurrence, in this case, is the frequency of words that appear in the titles of papers of every number of the Journal from 2002 to 2012.

Table 1 reports the words with a frequency equal to or greater to 19; the word with the most occurrences is "health", repeated 108 times. This word is one of the most important subjects in the journal *Salute e Società* and is based on the WHO's definition (1948): health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

In the journal, health is always considered in its totality and multidimensionality, as personal, organic, social and relational fact with objective, subjective and relational dimensions (Cipolla, 1997).

Tab. 1 - Most words frequent

Words	*Frequency*
Health	108
Health field	62
Medicine	53
Social	44
Sociology	32
New	31
Research	28
Public health	26
Medical	24
Service	22
Body	21
Perspective	21
Quality	21
Italy	20
Net	19

Let's explore some of these words and, in particular, "health field" and "social" with a frequency, respectively, of 62 and 44 times.

These words are associated with others and the outcome of these links is the diagram reported in fig. 1 and 2.

The word "health field" is connected to different words but, with some of these, the association appears stronger and closer, as is demonstrated by the distance between them and the center of the diagram.

"Health field" is very close to: health, service, system, and integration. We can deduce that this word is related to health system in which in recent years is moving toward to a process of integration with the social system.

Health system is considered by the Journal as a pluralistic concept because it is not limited to an institutionalized system of medical care but includes a wide range of resources related to different medical traditions (biomedical, alternative, folk…) existing in a society (Giarelli, 2004).

The second word whose associations we analyze is "social"; it is closely associated with the concepts of health, new and vulnerability.

The strong association with the word "health" highlights the importance of the "social" factor in regard to overall well-being totality, and provides important resources for moving in this direction; moreover, together with bio-organic and psychic aspects,

Fig. 1 - "Health field" and its associations

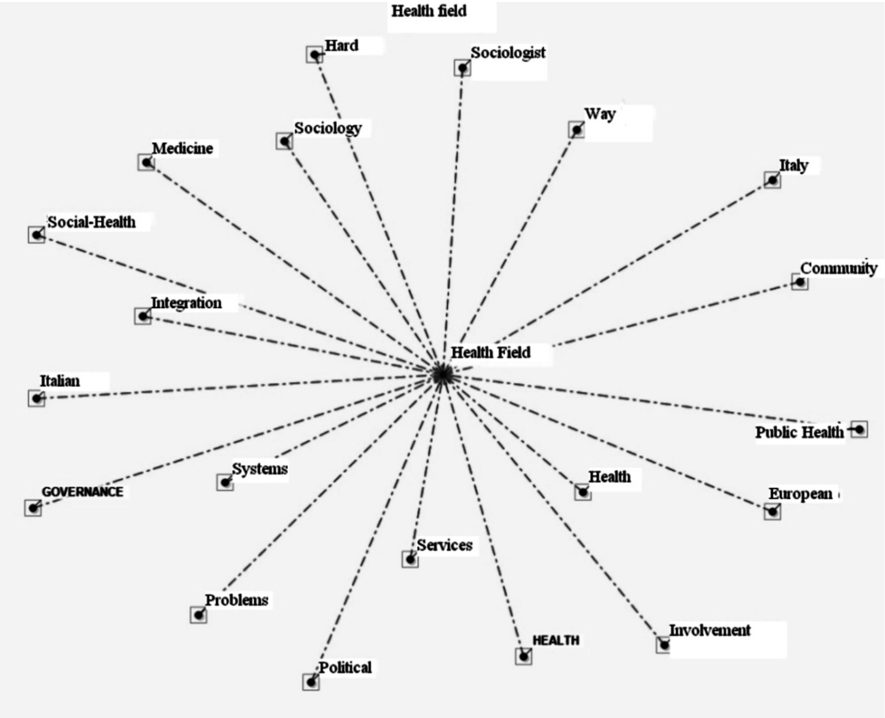
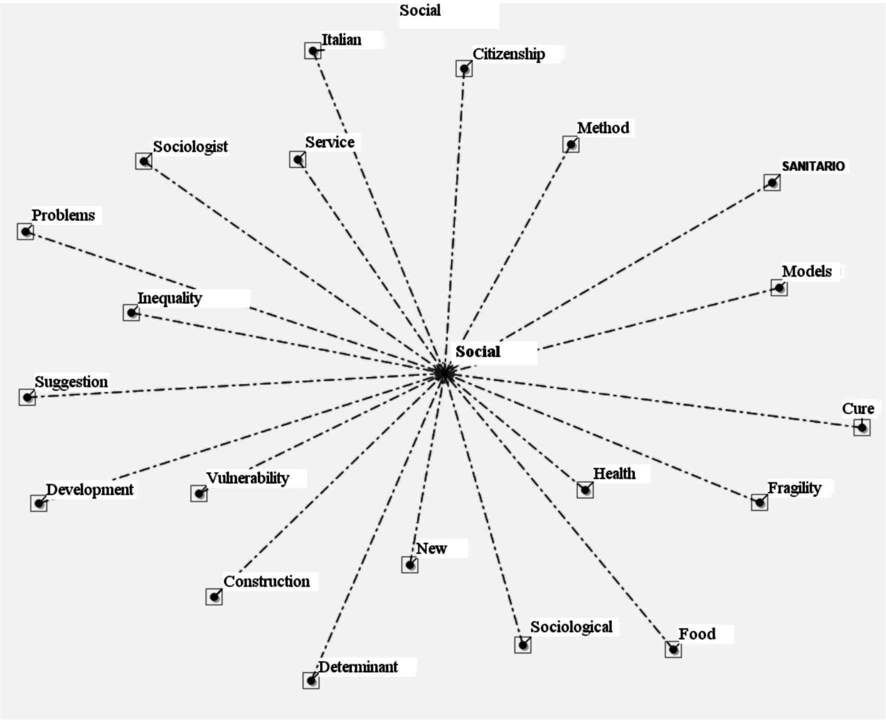


Fig. 2 - "Social" and its associations



the social dimension co-institutes the concept of health. It is, therefore, a new way of thinking, interpreting and analyzing the word "social", acknowledging a role that in a strictly biomedical perspective, has been often overlooked and from which the Journal "Salute e Società" has distanced itself by moving to a multidimensional, pluralistic and integrated approach.

Following this analysis, we can argue that the numerousness, the diversity and the distance, at least in appearance, of words that appear in the titles of the Journal's articles, allows us to support the claim that *Salute e Società* is based on and engaged in a sociology understood as a discipline which specializes in many areas (Cipolla 1997), a discipline which is always open to dialogue and interdisciplinarity.

5. A glance at the future: online innovation

A journal that, from the start, has aimed to look toward the future, must give ample consideration to technologies which accompany health and social transformation processes.

The *Information and Communication Technology* (ICT) applied the health system promotes the use of tools capable of responding to the challenges of today's society, such as the spread of new pathologies, the process of population aging, the need for cost containment. These shifts, increasing the demand for continuity in assistance and electronic care for patients, can reduce the gap between health services and citizens by improving efficiency, timeliness, quality and user satisfaction even if such discussions should not go without a consideration of the relationship between these technologies and patients in terms of care humanization and personalization.

During the last ten years, four volumes have been completely dedicated to health technologies: Mauro Moruzzi and Antonio Maturo are the editors of *e-Care and Health* (II, n. 2, 2003), in which experts describe and analyze recent developments in health technologies considering also the risks of social marginalization for people who have fewer cultural and symbolic resources. Mauro Moruzzi and Costantino Cipolla have edited *Telemedicine* (III, n. 3 - Supplement, 2004) in which new assistance scenarios – closely connected to the telematics platforms – have been investigated considering their pros and cons. Francesca Guarino and Licia Mignardi are editors of *Network technologies for health and care* (VI, n. 2 - supplement, 2007): this volume discusses the need to include the technological dimension in the debate on institutional welfare reform. Lastly, Ilaria Iseppato and Simona Rimondini are editors of *The admission network for health and care assistance* (VIII, n. 1, 2009) that presents and gives a preliminary evaluation of cutting edge e-Care projects which are underway.

In addition, *Salute e Società* includes a thematic area called "Online health" that gathers various types of contributions, for example: comments about websites and tools that concern matters of health (see, for instance, contributes by Alessia Bertolazzi and Luca Mori in vol. 1 - 2002 or by Maresa Berliri, Marina Cacace and Maria Letizia Coen Cagli in vol.3, 2002); online evaluation resources about specific topics (see Rossana Giacomoni, *Social-economic determinants. A research about world wide web* in vol. 2, 2002; Antonella Guarneri, *A review of websites on immigration* in vol. 2, 2004); descriptions of e-Care projects on-going (see, for example, Cinzia Pizzardo, *Telemedicine: home care's origin and its application* in vol. 3, 2003); finally, papers about the basic dimensions of web research in the field of health (see Enrico Marchetti, *Health websites: norms and quality criteria* in vol. 1, 2007).

Conclusions

Since we have given a description of the accomplishments of *Salute e Società*, we will not provide any Conclusion at this point. We just would like to emphasize the fact that people have worked hard in these year in order to have *Salute e Società* in regular circulation. Beside the usual editorial work, most of the time has been dedicated to overseeing the English translation, to coordinating the referees, to making the necessary updates in order to appear in the international indexes and to be credited according to the various measurements of the Impact factor (see the Editorial in this volume). However, we can look back on the last ten years with some pride. We have built a strong foundation for facing the challenges of the future, challenges which are exciting and deserve to be faced with our usual enthusiasm.

References

Altieri L., Nicoli M. and Sturlese V., eds. (2011). La sanità dei cittadini. *Salute e Società,* X, n. 2

Berliri M., Cacace M. (2002). Informazione e conoscenza in rete. *Salute e Società*, I, n. 3

Bertolazzi (2002). Un software intelligente per la selezione delle informazioni sanitarie. *Salute e Società*, I, n. 1

Cipolla C. (1997). *Epistemologia della tolleranza*, 5 voll., FrancoAngeli, Milano

Cipriani R., ed. (2010). Narrative-Based Medicine: una critica. *Salute e Società*, IX, n. 2

Clemente C., Cersosimo G., eds. (2011), La fine pre-scelta. Forme e disposizioni sulla propria morte. *Salute e Società*, X, n. 1

Corposanto C., ed. (2007). Sulla valutazione della qualità dei servizi sociali e sanitari. *Salute e Società*, VI, n. 2

Costa C., Cislaghi C., Caranci N., eds. (2009). Le disuguaglianze sociali in sanità. *Salute e Società*, VIII, n. 1

Gardini, ed. (2007). L'ospedale del XXI secolo. *Salute e Società*, VI, n. 3

Giacca M., Gobbato C., eds. (2010). Polis genetica e società del futuro. *Salute e Società*, IX, n. 3

Giacomoni R. (2002). *Le determinanti socio-economiche della salute. Una ricerca sul* world wide web. *Salute e Società*, I, n. 2

Giarelli G. (2004). "Il sistema sanitario: modelli e paradigmi" in Cipolla C., ed., *Manuale di sociologia della salute. I. Teoria*, Milano: FrancoAngeli

Gruppo CERFE, ed. (2002). Per una interdipendenza attiva tra Nord e Sud del pianeta. *Salute e Società*, I, n. 3

Guarino F., Mignardi L., eds. (2007). Tecnologie a rete per la salute e l'assistenza. *Salute e Società*, VI, Suppl. n. 2

Guarneri A. (2004). Rassegna mirata di siti dedicati all'immigrazione. *Salute e Società*, III, n. 2

Ingrosso M., ed. (2007). Fra reti e relazioni: percorsi nella comunicazione della salute. *Salute e Società*, VI, n. 1

Iseppato I., Rimondini S., eds. (2009). Le reti dell'accesso per la Sanità e l'assistenza. *Salute e Società*, VIII, n. 1

Lancia F. (2004). *Strumenti per l'analisi dei testi*, FrancoAngeli, Milano

Marchetti E. (2007). I siti web della salute: aspetti normativi e criteri di qualità. *Salute e Società*, VI, n. 1

Marradi, Nigris D., eds. (2011). Evidence-Based Medicine: una critica. *Salute e Società*, IX, n. 1

Maturo, Conrad P., eds. (2009). La medicalizzazione della vita. *Salute e Società*, VIII, n. 2

Minardi E. (2012). "Sociologia accademica e sociologia professionale", in Cipolla C., ed., *L'identità sociale della sociologia in Italia*, Milano: FrancoAngeli

Mori L. (2002). "Dalla rete: idee e servizi online". *Salute e Società*, I, n. 1

Moruzzi M., Cipolla C., eds. (2004). Telemedicina. *Salute e Società*, III, n. 3 - supplement

Moruzzi M., Maturo A., eds. (2003). e-Care e Salute. *Salute e Società*, II, n. 2

Pizzardo C. (2003). "Telemedicina: le origini e le applicazioni nell'home care". *Salute e Società*, II, n. 3

SISS, ed. (2004). La sociologia della salute in Italia: temi, approcci, spendibilità. *Salute e Società*, III, n. 3

SISS, ed. (2009). Essere e Fare il sociologo in sanità. *Salute e Società,* VIII, n. 3 - supplement

www.saluteesocieta.com

(Bad)Health System's victims between a quest for health and a quest for justice. The response of mediation-conciliation

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The raising conflict in the relationship between doctor and patient and, on a different level, health system and citizen, is nowadays very diffused also in our Country, this having serious consequences for the whole system, too. From this point of view, it seems really necessary starting to improve not-judiciary means for conflict resolution, although it could appear something absolutely new for the Italian way of thinking. The D.Lgs. n. 28/2010 goes in this direction, considering the rebuilding of trust and the mutual reconnaissance among the proceedings' social actors the fundamental turning point of that intervention.
Key-words: malpractice, victims (of the health system), trust, reconaissance, mediation, D.Lgs. 28/2010.

1. Conflict in health care: an insight into the Italian situation

In Italy, the subject of litigation in health care, while not experiencing immediate attention from public institutions or agencies like the U.S. Institute of Medicine, has nevertheless found a significant compliance in some studies[1] which have captured the characteristics and peculiarities of the phenomenon. In particular, it was investigations to highlight the possible dynamics assumed by the dispute between doctor and patient, or between the hospital and the citizen, and surveys have also asked to reflect on possible measures to limit – partially – the more negative outcomes of the conflict, knowing that the cost of that will inevitably reflect on the patient, the medical facility and the community at large. But without forgetting, it should be noted that «some litigation can be considered almost physiological and cannot be eliminated» (Cipolla, 2010, p. 23) as always while dealing with issues related to the human and social dimension.

As mentioned, in our Country the growth of this conflict is attested by numerous factors. First of all the increase in complaints to be counted in the civil field, which resulted, in the last fifteen years, in an increase of over one thousand per cent of the premium for medical care "RC", and this compared with an increase of two hundred percent of the number of claims reported on ASL and individual physicians (Manzato, 2011). This is a number that, though obviously showing fluctuations from year to year, shows a trend in strong and steady growth. As reported by R. Manzato (Director of Life and non-car damage ANIA) at a recent conference[2], the amount of complaints and their openings practices

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[1] See on this subject C. Cipolla, ed. (2004), *Il contenzioso socio-sanitario. Un'indagine nazionale* (Milano: FrancoAngeli), and the following work again edited by C. Cipolla (2010), *Il contenzioso sanitario visto dai pazienti* (Milano: FrancoAngeli).

[2] At the meeting *"La conciliazione, un'alleanza rinnovata tra medico e cittadino"*, held in Rome in May 2010 by Fondazione Previasme. The documents have been published in January 2011, in the interesting book edited by B. Lomaglio, with the same title.

resulting from accidents in the medical area increased from 9,567 cases in 1994 to 29,543 in 2007, presenting an increase of two hundred percent. This increment could be intended to be as much as three hundred and sixteen percent if we would consider the doctors alone. The number is impressive, and in fact comes to cover as much as the thirty-nine percent of the entire branch of the Italian civil liability insurance. According to ANIA data, the premiums paid to ensure the medical liability of health facilities in 2007 were over 270 million per year. It is obvious that this is a charge to fall on the citizen as a taxpayer, and this feeds a more general discontent against the system. Thus, as said by G. Mosca (2011), president of the Fondazione Previasme, «the number of claims grows, the amount of reimbursements increases and so does the share of health expenditure to cover the risk. But the level of services is not growing and the level of satisfaction of the people who access to the healthcare system is not growing either» (p. 15).

As regards the behavior of insurance companies, it follows the inevitable – as consistent with the objectives of their profit sector – increase in the amount of premiums charged to policy holders, which, in some cases, are extremely high. Currently in Italy the situation is very varied, approximately, a family doctor operating within the national health service (important distinction because things change if the doctor is a freelance) pays a minimum of 350 euros for 500,000 euros of maximum coverage and 500 euros for 2,000,000 euros of maximum coverage, while a surgeon can pay around 3,000 euros for a maximum of 2,000,000 euros[3]. This means that we are approaching with great strides the English model, where the insurance premium for a general practitioner is currently about 5,000 pounds. Not surprisingly, the United Kingdom plays a central role in the Medical Defence Union (MDU), a mutual association founded in London in 1885 which today has about 200,000 members, whose purpose is to help to overcome – as positive as possible – the phase of heated conflict between doctors and patients. The (also) conciliatory approach used by this Association invests the two areas of prevention and defense – key points of the system – as already seen in the telephone medical-legal counseling service, available for the members and operating 24 hours a day, that is supported by the work of thirty-four doctors and sixteen lawyers. This service has the conflict management and its containment as targets, with the aim of directing the adoption of more effective strategies of repairing the damage[4].

Moreover, as regards the position of the accused doctor, it is possible to make several considerations. In fact, if it is recognized a liability or even a prosecution in the event, the financial damage resulting from the costs of the proceedings must be added to the expected decrease in work capacity and the economic outcomes of the sentence. Moreover, the painful damage to the personal and moral profile would be prejudicial with regard to the social image and professional reputation. As underlined by a study published some years ago in the British Medical Journal (Ashok, 1999), becoming the target of a complaint for medical malpractice

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[3] Here to underline that the maximum is the higher amount that the insurance company pays on an insurance policy. We are talking about approximate amounts because, since operating in a competitive market, each insurance company can decide which fare to apply.

[4] See the website www.the-mdu.com

could cause a lot of legal reactions by the accused doctor[5]. Receiving a notification of the Court often results in severe stress, usually accompanied by feelings of anger towards the person who filed the case. Then, that feeling turns to anger and aggressiveness, opening to a conflicting dimension that gets worse as the esteem of the subject diminishes. The consequences at the personal, social and professional level are not slow to become evident, so that recently we are driven to compare such symptoms to those that characterize the post-traumatic stress disorder (PTSD). Finally, the decision to embark on a journey – whatever its nature is – aimed at resolving the dispute, coincides with the assumption, more or less conscious, of professional attitudes that can be described as defensive, directed to all patients. In extreme cases, it is possible to come to the abandonment of the profession, if we consider the image of professional and social events inevitably compromised by the trial and the media exposure. It should also be noted that adopting a defensive attitude does not represent a strategy used only by the physicians who are directly involved in judicial proceedings, or made subject of a report, but it is something that can be extended to the whole category, thanks to a widespread sense of insecurity and – as symmetrically occurs in patients – increased vulnerability. For these reasons, a doctor belonging to a particular category, experiencing the questioning of their knowledge and their own role, may decide to engage in acts of closure in order to communicate an explicit distance from the patient and to underline his "specificity". Or can consciously choose to employ strategies of defensive medicine. This "remedy", however, must be regarded with concern because it can influence the choice of therapies to be undertaken. In fact, the acts of defensive medicine seem more built to protect the doctor, rather than to respond to the actual needs of the patient in care, thereby opening up to forms of irresponsibility masked by the physician – for instance by requiring invasive procedures but not strictly necessary or administering unnecessary drugs, or using the informed consent in a distort way. These attitude lead, at a later time, to the increase of the citizen's sense of distrust as well as the tensions and conflicts towards the system.

From this point of view, the establishment in 2002 of the *Associazione Medici Accusati di Malpractice Ingiustamente* (*Association of Doctors Unjustly Accused of Malpractice)* (AMAMI) can be understood as an indicator of malaise; a general malaise, transverse to all the categories considered here that, frequently, is nourished by information that are not always correct. The climate of widespread distrust that has recently invested the health service and the medical profession, is the subject of a conflict through a capillary action to counter unfounded allegations to the doctors (the so-called "frivolous lawsuit"): these which would depend on unstable assumptions in at least two out of three cases, representing the outcome of the process of increased visibility of medical errors that led to the (inevitable?) consequence of the proliferation within the media space and to the trend, now increasingly common, of creating trials on virtual public squares, crowded with a belligerent public opinion, much ear-

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[5] Confront on this subject the considerations proposed by emeritus speakers during the debate "*Il danno cagionato al medico quando l'accusa è infondata*" available on the website of the AMAMI Association, www.associazioneamami.it

lier than in courtrooms (accomplices, perhaps, the time indeed too long of our justice system).

On the other hand, the (not so many) data we have on the subject of litigation in health care, as well as the reports about medical malpractice *tout court*, tell stories designed to produce a lot of concern in the citizens[6]. It is necessary to recognize the importance of the analysis carried out by *Cittadinanzattiva - Court for Patients' Rights*, in particular those related to spontaneous reports made by patients about the quality of the practices and of the health services. Although described by some as a sort of "containers of discontent", these annual reports contain interesting food for thought. In particular, as we take a closer look at the data emerging from the last report, the PiT Health 2010[7], published on the occasion of the thirtieth anniversary of the Tribunal for Patients' Rights. It offers some wider considerations from reports received from the advice, information and protection service PiT Health from 1996 to 2009. In this period of time, approximately 228,000 reports have been collected in the field of health, an average of 16,000 per year, reflecting the same obvious different distribution between national headquarters and local offices. The reports briefly recalled here, however, are solely those managed by the National Health PiT, amounting to 66,712, which were interpreted with reference to five basic rights in the Health sector: the right to security, the right to information, the right to access, the right to time and the right to humanization[8]. It must be noted that, during the period under consideration, as much as 28% of reports adhere to the security of health services, the following is information (as in 25%), intended primarily as a lack of information. Moreover, 20% of them concerns problems related to the access to health care and welfare, while 10% regard the lack of respect for the right to time. Finally, 8% of reports relates to the question of humanization, making a very significant reference to the behavior of doctors and medical staff to patients. Analyzing the investigation, the safety of health services see growing reports of malpractice in particular as regards the field of oncology and orthopedics. The errors reported are mainly diagnostic and therapeutic[9],

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[6] It must be noted that, up to now, it is not available a national informative system able to collect, analyze and provide more reliable data «on the number of adverse events that occur to patients during the caring process or at least during the hospitalization, on the number of "avoidable" adverse events ascribable to medical or organizational malpractice, on the number of adverse events that generate cases of conflict in the health field and on the characteristics of the patient that file (or do not file, even if the event was really avoidable) a law suit for the reparation» (Porcu, 2010, p. 14). So, since this resources are not available, resorting to "alternative" resources appears inevitable, still recognizing the partiality of the adopted point of view .

[7] The PiT Health Report 2010 "*Diritti: non solo sulla carta*" can be found on the website www.cittadinanzattiva.it

[8] While the first four points can be found within the "*European Chart of Patient's Rights*", the last one is a sort of a summary based on some other points of that Chart, such as the right to a free choice, the right to avoid suffering and pain, the right to a personalized treatment, the right to privacy and confidentiality and the right to receive quality standards.

[9] In the year 2009, the suspected wrong diagnosis regarded more the oncology field: it is clear that, since we are talking about a person with a tumor, both a not well-timed diagnosis or a wrong one could be fatal.

and the citizen is, above all, exasperated by the lack of attention and communication experienced at facilities, as well as during the direct relationship with the doctor. An important role in this sense is also played by the discovery of gaps and shortcomings in the practice of informed consent, and, again, the "lightness" caught during the compilation of medical records by the doctors. What emerges, then, and will return in the subsequent data is the clear perception of the patient not to be taken into account either as to the requests made, nor – and indeed much less – as a person. So it is in the sense of powerlessness and frustration experienced by the patients, that we can find the root of the decision to report in order to achieve an inspection (and a penalty...) about the possible liability. The fact that the practice of informed consent can be reduced to mere practice of acquiring a "piece of paper" signed by the patient (i.e. if you are already in the operating room, in a state of obvious vulnerability), constitutes an incomprehensible conduct[10], if not as an attempt of extreme lack of responsibility with regard to possible future risks. The infections acquired within healthcare facilities are subject to frequent reports too – significantly those relating to contaminated blood transfusions – while the departments most at risk appear to be those of intensive care and transplantation, i.e. departments where hospitalized people are already really weak. A second area that deserves attention is the one dedicated to the right to information, which created – in the years covered by the report – about a quarter of the reports received. We speak here of a lack of information concerning, for example, the social and health services, (not) provided by general practitioners or operators of the mental health area, and, after that, the complaints are related to deficiencies regarding the respect of welfare benefits for the disability pension and the right to exemption from the payment of the ticket. These are areas whose reflections, mainly economic, most often fall on the most disadvantaged sections of the population consisting of elderly, disabled and handicapped people. One – fifth of the reports received regards the access to care, and here the biggest problem is the improper discharge from hospital. It should be noted that even if the increase in fees is paid, quite paradoxically, it resulted in a reduction in the length of stay – so that patients who do not completely stabilize are at risk of being discharged prematurely – in the absence of structures capable of managing patients with complex clinical pictures. This is a "new" type of error, perhaps due to recent changes in the health system that suffered numerous economic cuts. The Anglo-Saxons, with sharp irony, suggest a mechanism characterized by the logic of "*quicker and sicker*" describing the condition of a patient that, being discharged from the facility too much fast, has to "deal" with the inevitable deterioration of his/her med-

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[10] It must be noted that this represents the patient's point of view. From the informal confront had with some medical personnel emerges how this is mainly the result of organizational lacks. For example, since the doctor doesn't have enough time to provide explanations to the patient, this work should be done by the hospital nurses or briefly done with the help of papers prepared by the Hospital administration but that are not those provided for the law. The problem of how to deal with emergency cases still remains. It must not be forgotten that, from the doctors' point of view, the filling of papers has a secondary importance, since it is not an essential part of the medical treatment.

ical condition. There are also many reports on refused hospitalizations, particularly in those regions that do not have enough specialized structures. Even the right to time, defined as the (long!) waiting lists for specialist visits, clinical examinations and surgery, is an issue of complaint. The bewilderment and irritation, however, are destined to rise when the citizen discovers that waiting average of six months expected contacting a structure through the CUP can move significantly faster, always within the same structure, if you pay the fee. Endless expectations are those for the recognition of civil disabilities and special needs. Finally, the humanization of care, sticking and transverse point, in the research Report. Although the reports in this area represent about 8% of the total, should be recognized that the consequences of the conduct (whether these actions, omissions or acts of insensitivity) recorded under this heading are intended to leave deep wounds in patients, and – should not be neglected – in those who assist them. "Invisible wounds" because intangible, but no less painful or easier to forget. The reported cases concern medical and health personnel who appoints the patient with the number of the bed (instead of his/her own name), who is not polite or shows little impatience when questioned, that ignores the suffering – perhaps because in a hurry, or busy with bureaucratic questions, or because of the "*habit*" – and who is incapable of making a gesture of comfort and hope. We talk about negligence and carelessness of the staff, but also about the infliction of unnecessary suffering and privacy violations. In each of the considered conducts it is central the lack of attention and patients' "care", thereby helping to exacerbate the state of exasperation and grief that already marks the time of the disease. The lack of respect for the person's dignity, for his/her state of weakness and fragility, for experiences of suffering also going to persist over time, are conditions that feed, day after day, suffering after suffering, the conflict within the health system, and this makes easier than in the past, to react to a condition perceived as unfair.

In this perspective, further reflections emerge from the data reported by the Parliamentary Commission of Inquiry on the errors in the Health system and regional health deficits[11], chaired by Leoluca Orlando. The data, related to a period of just less than two years (end of April 2009 – the beginning of April 2011), report of 409 cases of malpractice, of which 276 led to the death of the patient because of structural deficiencies, inefficiency or medical and health personnel failure. The geographic concentration of episodes also shows some worrying problems: in fact, 89 cases occurred in Calabria (region, unfortunately, even on the top sad ranking of the deaths), while 81 occurred in Sicily. Other regions have many problems, and although that the situation may seem better in the North, we must not forget that even Lombardy, Emilia Romagna and Tuscany, whose health system is often cited as a model, attend to this list.

As stated by Hon. G.M.S. Burtone during a session at the Chamber of Deputies (ibid.):

> too many errors were committed, and have also led to the death of patients. Saying this does not mean wanting to negatively stigmatize our health system, not at all. (…) However, we need to understand, to know better and to conduct an inquiry regarding

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[11] See the documents available on the website www.camera.it

> the state of the health system in Italy (…). There is no doubt, in fact, that very often the errors are not caused only by men, but they are determined by the structures. I remember that we have crumbling structures, especially in the South.

2. A matter of trust

Why did the level of attention to the errors in health care and episodes of bad health increase? Which are the most influent factors in these dynamics, designed to reflect heavily on the doctor-patient relationship? Mainly, in the opinion of the writer, we can refer to two reasons. First, the unprecedented increase in health information, easily accessible to "non-experts". To this days, the patient is more informed and aware, and therefore decides to reclaim an active role and participate in the system of care. The more technical knowledge can be easily approached through the web, which offer detailed news depending on the demands placed by the user. If this is the background, it seems inevitable that the traditional mechanisms of recognition of the doctor's authority specifically, and more generally of the world of healthcare, entered a crisis, being hit by transformations that are not easy to handle – as revealed by the figure of the "*challenging patient*". On the other hand, the enormous progress made by medicine in the recent years have heightened the expectations of its possibilities, and seen his power as unlimited, but it goes without saying that, if the medicine is considered «virtually all-powerful, or nearly so, the problem could be the technician who applies it bad, because he is not updated or is not able to apply the latest techniques, or is the system that is unable to rebuild the unity and uniqueness of a patient preparing for each one of them an individual clinical path of excellence» (Vaccaro, 2011, p. 41). More specifically, there are many reasons that can promote or push the patient towards the vindication of the rights violated by some form of medical error, suggesting a complex web of subjective dimensions, social and relational, as correctly noted by C. Cipolla (2004, pp. 20-21):

> greater attention and public awareness of the issue; greater visibility or severity (perceived) of the damage suffered; greater strength of the primary networks, lower disposable income, more advanced juridical and associative culture; better quality of the facilities that provide services (it is ironic but true); less confidence or empathy in the doctor-patient relationship, more pressure or availability of the media around the subject, the presence of a larger legal and insurance system, less personal and environmental quality communication, less advanced government (reports, complaints, etc.) of the citizen's (and his entourage) path of protest, more social expectations about the difficulty of healing.

And thus, the increase in litigation in the health field is quite obviously due (also) to a matter of trust. Or rather, the gradual erosion of that more general feeling of confidence which should be based on the community, and, in particular, of that most ancient relationship of trust that once linked doctor and patient, as well as health institutions and citizens. A relationship focusing on (mutual) trust that begins from the recognition of the centrality of the informative-empathic dimension. The latter, attesting and remarking the authority of the medical expertise – so difficult to judge from the "profane" – combining this with a sense of human participation in the events that helped the patient to accept the outcome of the disease, even when lethal. This is the sense of the term "compassionate care": to keep in mind, first of all, the person, a bundle of flesh and feelings, impalpable hopes and real suffering, so that the act of "taking care" of the human exceeded that of "taking care" the symptom or the disease. The question of the erosion of the trust, the fact that it less present today also in the health field, emerges in the interesting qualitative work recently made by C. Cipolla and his collaborators (2010). In fact, what seems to push the parties involved to work to see the harm suffered recognized, in particular – beyond the seriousness and severity of the injury itself – is having experienced a sense of abandonment, a lack of interest, complained of profound disregard for the problem by the doctors or by the health facility that were specifically aimed to help and care. Relational aspects, therefore, seem to have a central position for the subsequent decisions, even having considered the difficulties that will mark the judicial process. And it is this feeling of betrayed trust, of non-compliance, of offense and humiliation of the dignity that acts as a detonator, triggering a spiral of conflict which is intended to reflect not only on "that" specific patient-physician relationship, but on the many relationships that characterize and structure the health system. So, what is trust? Which aspects are affected by its loss, its disappearance? And which are the consequences of such erosion for the subject and the community? In the sociological perspective, the concept of trust essentially pertains to three core dimensions related to the building of personal and social identity (Misztal, 1996). These are the basic trust (or familiarity), latent and based on the "constituent expectations" of everyday life that can ensure a certain degree of predictability and reliability in the existence of the subject; after that, personal trust (or interpersonal), granted voluntarily by the individual to all those with whom he/she has emotional relationships or confidentiality and intimacy, and, finally, institutional trust (or systemic), consisting of positive expectations in relation to the "normal" (because fair, equitable) operation of social institutions and subsystems that operate to protect the person and its multiple relationships. The first type of trust allows the social order thus to be perceived as stable, rising to a common ground generated by routine practices. These represent the background where the daily interactions move; the requirements of predictability, intelligibility and reliability are, firstly, the element capable of sustaining the social order and, second, the factor can reduce the subjective perception of complexity and uncertainty related to the environment (Luhmann, 1989). In this perspective, the first threat to this type of trust involves the facing – with the limited cognitive resources available to the human being – the sense of contingency yet no longer avoidable. This can cause the disorientation of the subject asked to measure up with not familiar dynamics because they are ruled by insecurity. At this level of reality, therefore, the act of trust should be seen as something necessary and inevitable, otherwise we will face the most complete immobility; in fact G. Simmel, at the beginning of last century, reflecting on the impossibility of not trusting in modern age, remembered that the daily challenge of the risk of being deceived becomes the necessary arrangements to ensure the continuity of relations, while recognizing that relationships with others – often marked by a superficial knowledge – only admit trust acts paradoxically imbued with mistrust (1989). The second dimension of trust, the interpersonal trust, is constructed from a set of social practices that take place within the family, in loving relationships or friendships and in the professional or community relations. These practices play a reinforcement of the feeling of inviolability of the person, through the establishment of relations between the individual and significant others. So it is a type of trust strongly influenced by expectations regarding future actions of others, as well as by a sense of authenticity given off from interpersonal ties. As argued by H. Garfinkel (2004), in everyday life the subject tends to consider his interlocutors as *bona fide* members of the group, assuming an action-oriented by fairness and by the ability to manage the interaction in cognitive terms. Therefore, when the relativity of the taken for granted becomes manifest, the choice is between the subject re-definition of the situation and the withdrawal from the social scene. The consequences of this decision are fundamental, implying a new reading of the situation itself, and yet we must not forget that such a choice may have, in extreme cases, even dramatic implications, such as the isolation of the subject, the call to the Courts for the imposition of a penalty or, sometimes, the escape into private revenge. Finally, the strength of the third kind of trust, the institutional one, is put into question all the time that the agencies appointed to the care of the subject, to its preservation and protection, betray the expectations, thus putting into question the contents of the same (implied) social contract on which we base today the relationship between rulers and ruled. In this way, institutional trust is eroded whenever the person who has suffered an injury knows a process of denial of his condition, made by the institutions themselves, which causes even more suffering. Insomuch as, in other fields of study, this process is called “secondary victimization” (Vezzadini, 2006).

3. Mediation and reconaissance: the introduction of D.Leg. 28/2010

If you can say that the above also relates to the dynamics of health care, the central question concerns the restoration – at least partial if not total – of the trust links between doctor, patient and health care system in order to avoid, on one hand, a dangerous and difficult way to manage the *impasse* in the system, but also, on the other hand, an uncompromising, resentful and eventually helpless closing by the all the subjects differently involved in the dispute. Prerequisite for the reconstruction of breached fiduciary expectations is the mutual *reconaissance* between the parties: a *reconaissance* that, well before the economic and financial concern (such as damages), looks to the feelings and to emotional experiences of the social actors. We are talking about feelings of fragility and weakness, helplessness and humiliation, but also shame and dishonor, guilt and personal failure and even anger, frustration, torment. Emotions which, though produced at different times, end up more often uniting existential paths of the conflicting parties, setting up an “emotional soil” on which to start a shared comparison and reflection. This in order to identify, together, non-destructive solutions (in material and symbolic terms) of the other; an “other-enemy” which is charged with all the experienced malaise. It was P. Ricoeur (2005), in one of the last works written shortly before his death, who stressed that this *reconaissance* is nourished by a dialectical approach, focusing on the idea of mutuality that has its basis not in a formal identity, but in the asymmetry of the concrete existence. Thus, the dialectical element confirms the irreducibility of the dimension of the *reconaissance* to the one of knowing, since the first transcends the latter, giving rise to an open structure in which the action, although related to the identity dimension of the cognitive processes, is in constant relationship with the other in a dimension permeated by constant and reciprocated exchange.

Now talking about mutual *reconaissance* as a dialogue, as listening to others, as a dialectic confront, is exactly what is proposed by the practice of mediation-conciliation, which aims to support and guide those involved within a conflict to a resolution that takes into account the different points of view, even when mixed. The mediation-conciliation, now provided in Italy for the *D.Leg. 28/2010* that implements the reform of the civil trial, is finally – after years of requests – a form of not-judiciary conflict resolution in the health field. In fact, the decree provides for its mandatory application in relation to compensation for damages resulting from medical liability, becoming an alternative mode of recognition and management of conflicts within the complex relationship physician-patient-health care facility, representing a fundamental resource that is central both in the realization of the principle of citizen participation and in the development of policies for improvement of the social-health context. The main merit of mediation-conciliation, in the opinion of the writer, is to promote new logic of communication, opening up a process in which two or more individuals are turning to a neutral third party, the mediator[12], in an attempt to make it easier to face the causes and the effects of the conflict, allowing the reopening of those communications channels which were previously blocked (Bonafé Schmitt, 1992; Ceretti, 2001; Morrone, 2011). Although from the outset, on the operational side, have been some objections to this practice – primarily concerning the mode of action, it must be said[13] – it is still possible to claim a certain satisfaction with the inclusion of mediation in the health context. In fact, despite being quite obvious that the same could not serve as a *panacea* to the (many) evils that plague the health care system in our Country, nev-

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[12] A lot has been written on the role of the mediator, for a deeper insight, that here cannot be done, refer to J.P. Bonafè Schmitt (1992), *La médiation: une justice douce* (Paris: Syros Alternatives); J. Faget (1997), *La médiation. Essai de politique pénale* (Ramonville Saint-Agne: Erès); J. Morineau (2000), *Lo spirito della mediazione* (Milano: FrancoAngeli); M. Esposito, S. Vezzadini, eds., (2011). *La mediazione interculturale come intervento sociale* (Milano: FrancoAngeli).

[13] Among the critics to this instrument, we must remember the concerns over its mandatory application that is something that contradicts what can be defined as the guiding principles of the practice itself (voluntary and free participation in the first place). Particular attention was also paid to the training of the mediator, who, by definition, is not a judge or arbitrator and therefore requires a specific store of knowledge. Based on this observation, it should be noted how, in a very short period of time, many courses have flourished in our Country, aimed at providing the right tools to this new profession: do not overlook the fact that such person is called to work in the extremely delicate context of health. Finally, an important issue is to understand which parties should be involved in the mediation process itself: what should be the role of defense lawyers, for example? And what about the role of the insurance companies (which, as you might guess, would have more than one interest in attending)? And if the doctor belongs to a hospital, who should intervene? In fact, over-expanding the participation, make the risk of tainting the process of mediation-conciliation quite concrete.

ertheless it provides an opportunity to promote a significant change in the attitudes. In this perspective, promoting the management and the overcoming of the conflicts through the strengthening of the dialogue is of fundamental importance, because this approach focuses on the concept of openness to others. And perhaps here lies the opportunity for redemption for a health system in trouble, and at the same time, for a patient more and more discouraged and therefore bound to fall back on a knowledge, found on the *web*, which is falsely exhaustive. In an age in which we have partly forgotten that the vocabulary of care involves the idea of *reconnaissance of* the Other (of his suffering and fears, but also of his inability in front of the imponderable and his human frailty) the rediscovery of this value may – perhaps – create new relationships which will be able to avoid future threats and opening new horizons of meaning.

References

Ashok J. *et al*. (1999). General practitioners' experiences of patients' complaints: qualitative study, *British Medical Journal,* 318:1596

Cipolla C., ed. (2004). *Il contenzioso socio-sanitario. Un'indagine nazionale*. Milano: FrancoAngeli

Cipolla C., ed. (2010). *Il contenzioso sanitario visto dai pazienti*. Milano: FrancoAngeli

Esposito M., Vezzadini S., eds. (2011). *La mediazione interculturale come intervento sociale*. Milano: FrancoAngeli

Garfinkel H. (1963). A Conception of, and Experiments with, 'Trust' as a Condition of Stable Concerted Actions. In: Harvey O.J. (edited by), *Motivation and Social Interaction*. New York: Ronald Press (trad. it.: *La fiducia. Una risorsa per coordinare l'interazione*. Roma: Armando Editore, 2004)

Lomaglio B., ed. (2011). *La conciliazione. Un'alleanza rinnovata tra medico e cittadino. Atti del Convegno*. Roma: Ethos

Luhmann N. (1989). Familiarità, confidare e fiducia: problemi e alternative. In Gambetta D. , ed., *Le strategie della fiducia. Indagini sulla razionalità della cooperazione*. Torino: Einaudi

Manzato R. (2011). L'assicurazione RC sanitaria: stato dell'arte e possibili varianti. In: Lomaglio B., ed., *La conciliazione. Un'alleanza rinnovata tra medico e cittadino. Atti del Convegno*. Roma: Ethos

Misztal B. (1996). *Trust in modern societies*. Cambridge, UK: Policy Press

Morrone A. (2011). Servizi socio-sanitari e mediazione transculturale. In: Esposito M., Vezzadini S., eds., *La mediazione interculturale come intervento sociale*. Milano: FrancoAngeli

Mosca G. (2011), Presentazione. In: Lomaglio B., ed., *La conciliazione. Un'alleanza rinnovata tra medico e cittadino. Atti del Convegno*. Roma: Ethos

Paltrinieri A. (2004). Dall'errore medico al contenzioso. Temi ed ipotesi della ricerca. In: Cipolla C., ed., *Il contenzioso socio-sanitario. Un'indagine nazionale*. Milano: FrancoAngeli

Porcu E. (2010). Introduzione. In: Cipolla C., ed., *Il contenzioso socio-sanitario. Un'indagine nazionale*. Milano: FrancoAngeli

Porcu E. (2010). Il contenzioso dal lato dei pazienti. In: Cipolla C., ed., *Il contenzioso socio-sanitario. Un'indagine nazionale*. Milano: FrancoAngeli

Simmel G. (1908). *Soziologie. Untersuchungen über die Formen der*

Vergesellschaftung. Berlin: Duncker & Humblot (trad. it.: *Sociologia*. Milano: Edizioni di Comunità, 1989)

Rapporto PiT Salute 2010 *"Diritti: non solo sulla carta"*, disponibile al sito www.cittadinanzattiva.it

Ricoeur P. (2004). *Parcours de la reconnaissance. Trois études*. Paris: Stock (trad. it.: *Percorsi del riconoscimento*. Milano: Raffaello Cortina, 2004)

Vaccaro K. (2011). L'ars medica ieri e oggi. In: Lomaglio B., ed., *La conciliazione. Un'alleanza rinnovata tra medico e cittadino. Atti del Convegno*. Roma: Ethos

Vezzadini S. (2006). *La vittima di reato tra negazione e riconoscimento*. Bologna: Clueb

In memoriam

Harold Garfinkel (1917-2011): reflections on his contributions to the sociology of health

Barbara Sena*

April 21st, 2011 marked the death, at the venerable age of 93, of the most controversial sociologists of the 20th century, Harold Garfinkel, known as the father of ethnomethodology, a sociological current whose development began in the United States in the 1960s and then spread to several countries, especially in Anglo-Saxon areas.

In Italy, his writings, but especially the approach he created, are not very well known and diffused among the sociological *establishment*; indeed, the approaches attempted by some scholars up to now have been sporadic and mostly theoretical[1]. Nevertheless, Garfinkel's contribution to contemporary sociology is now recognized internationally and, therefore, deserves to be remembered here, given his recent death.

My aim in the following pages is to present briefly some aspects of this sociologist's life and work, which may be considered significant for the remembrance of his intellectual path and, more specifically, his interest in the topics related to the sociology of health.

First of all, it is worthwhile presenting some stages of Garfinkel's intellectual formation.

In 1946, after doing his *Master's degree* in sociology at the University of North Carolina, where he had the opportunity to delve into the phenomenology of Husserl, Schutz and Gurwitsch, and after taking part in World War II, Garfinkel arrived at Harvard. There, in 1952, under the supervision of Talcott Parsons, he obtained his Ph.D. with a thesis about the social order, criticizing Parson's

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[1] As is known, ethnomethodological bibliography studies analyze the methods that the members of a social group use to make their daily activities comprehensible and organize them (Garfinkel, 1967). For those who wish to deepen theoretical principles there is now a vast literature, especially in English. Among the contributions on ethnomethodology in Italy see: Fele (2002), Giglioli, Dal Lago (1984), Muzzetto (1997 and 2010), Muzzetto, Segre, (2005), Ruggerone (2000) and Sena (2011).

theory of action and opposing to it some elaborations of Schutz's phenomenology.

We can say that, starting with the critique in regard to Parson, a "protoethnomethodology" (Lynch, 1993) begins to develop that will have an impact on Garfinkel's research focused on medical-health care[2].

After the period at Harvard, Garfinkel embarks on his career as a sociologist. In 1954, he begins to teach in the Department of sociology and anthropology at the University of Los Angeles, California, where he remained for his entire academic life and stayed active as a Professor Emeritus from 1987 (the year he formally retired) until his death.

Although Garfinkel was a long-lived and brilliant sociologist until his death, it cannot be said that he has produced many publications. For years this author's only book, which also contained some previously published contributions, was *Studies in Ethnomethodology*. Published in 1967, this book is a kind of "bible" for the ethnomethodologists, which today is still the primary reference text for all ethnomethodological investigations.

In 2002 Garfinkel published another book: *Ethnomethodology's Program. Working out Durkheim's Aphorism*, in which essays written in the 1980s and 1990s are grouped and developed. This volume marks the passage from the "radical ethnomethodology," which had characterized the 1960s and 1970s, to the "neoethnomethodology," based on the program of respecification of sociology and science in general. It is not surprising that this phase coincided with ethnomethodology's final passage from being a subversive movement in the field social sciences to its statute as a sociological movement formally recognized by the academic world[3].

In recent years, thanks to the curatorship of Anne Rawls, other two volumes of Garfinkel's unpublished writings, however, from the 1940s and 1950s, have been published: the first, which dates back to 1948, *Seeing Sociologically. The Routine Grounds of Social Action* (2006); and the second, containing some of Garfinkel's writings from 1951-1952, bears the title *Toward a Sociological Theory of Information* (2008).

Apart from these books and some short essays written in collaboration with other ethnomethodologists, not much more of Garfinkel's research and study has been conserved.

Although his works are not numerous, Garfinkel's studies dealt with many issues of contemporary sociology, including medical and health care.

In the 1950s and 1960s, Garfinkel participated for several years in research carried out at the psychiatric clinic of the University of Los Angeles (UCLA) Medical Center. The results of this study compose notably two chapters of *Studies in Ethnomethodology* (hereafter: *Studies*) that we will now briefly consider.

In the first chapter, which represents the sixth chapter of *Studies*, written in collaboration with Egon Bittner, Garfinkel is interested mainly in the question, typical of ethnomethodologi-

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2. Parsons is considered one of the first sociologists who took interest in the doctor-patient relationship, in the 1950s, a question to which he dedicated a chapter of *Il Sistema sociale* (1951) (cfr. Carricaburu, Ménoret, 2007). Garfinkel, who certainly knew both both Parsons and his work well, quite probably took it into account in his studies of medical contexts, although without making any explicit references to this.

3. For a discussion of the life of Garfinkel and ethnomethodology's evolution since its inception, see among others: Rawls (2000), Lynch (1993) and Ruggerone (2000).

cal research, the fact that the work of a competent member in a certain field of activities, e.g. a doctor or a nurse in a hospital, depends in many ways on local, "nonofficial" skills, i.e. not formalized on the general and institutional levels. It is no accident that Garfinkel gives this chapter the title *"Good" organizational reasons for "bad" clinic records*. It emphasizes the contrast between a researcher's external criteria and the internal one's of the medical staff (i.e. the well-known problem in social sciences of *etic-emic* distinction) with regard, on the one hand, to interpretation and, on the other, to the compilation the medical records of the patients visited. Garfinkel noted how «the records *consist of procedures and consequences of clinical activities as a medico-legal enterprise*» (Garfinkel, 1967, p. 198). By defining the medical records as "bad" and the organizational reasons as "good", Garfinkel intended to point out that the problems researchers have in reading and correctly interpreting the records compiled by the staff physician actually derive from a "normal and natural" trouble. This expression refers to the fact that the ways in which the staff report, in the different clinical documents, the activities performed on their patients, are applied reflexively and routinely, often not according to the rules or formalized procedures (*ibidem*, p. 191).

Analyzing medical records produced in a psychiatric clinic, Garfinkel also underlines how they can to be read in two different ways: on the one hand, as "actuarial" folders (in the mathematical sense) and, on the other hand, like folders indicating a sort of "therapeutic contract" between the health staff and the patient. The term contract, here, refers to the fact that «the contents of clinic folders are assembled with regard for the possibility that the relationship may have to be portrayed as having been in accord with expectations of sanctionable performances by clinicians and patients» (*ibidem*, p. 199).

Unlike the actuarial folders, such as those that constitute bank accounts, the medical records do not presuppose a "standard" reading, since they contain material that can build a "documented representation", which depends primarily on practical considerations of the reader rather than on objective characteristics of the situation in which the folder was written.

These contractual considerations are certainly not the only ones taken into account by those who write the medical records; but according to Garfinkel they have priority over the others, since they involve medical and legal liability that in most cases finally prevails over other considerations.

On the basis of these observations and others, Garfinkel concludes that «the folder contents much less than revealing an order of interaction, presuppose [by the researcher] an understanding of that order for a correct reading» (*ibidem*, p. 201).

Unfortunately, despite the originality with which the issue of the doctor-patient relationship, like the composition and understanding of clinical documents – as objects of modern sociology of health (cfr. Cipolla, 2004) –, was addressed, it one cannot be said that Garfinkel's work was well documented on the methodological level. In fact, it seems that his comments concern the problems he personally encountered in reading the medical records, rather than an empirical study explicitly aimed at documenting the activities of a hospital (Have, 1995). In any case, this work is full of interesting ideas typical of ethnomethodological investigations, e.g. *membership*, i.e. participation of specialists in professional contexts that determine *routinized* practices, taken for granted by the members, but also the reflexivity between the activities and *accounts* used by members to describe them and make them comprehensible to themselves and to others (cfr. Sena, 2011).

Further on, in chapter 8 of *Studies*, under the title *Methodological adequacy in the quantitative study of selection criteria and selection activities in psychiatric outpatient clinics*, Garfinkel continues and broadens the considerations begun in the previous chapter. Even here, he uses the results of the survey carried out at the psychiatric clinic of the University of Los Angeles, trying to understand on the basis of what criteria patients are selected for therapeutic treatment.

In an analysis of existing literature about the influence of socio-economic factors in the selection and discrimination of patients in psychiatric clinics, Garfinkel observes how, in reality, the results published by the various statistical surveys alone do not allow the researcher to determine the criteria according to which patients are selected; this presupposes direct knowledge of the various social structures in which the doctors who makes these selections work (Garfinkel, 1967, p. 211). In this study Garfinkel criticizes the various parameters that scholars take into account for their own assessments with respect to the selection criteria, stressing, in this case, that we cannot generalize the characteristics of "populations" of patients of different hospitals. For the author, in fact, the specific conditions of patients cared for in a health facility and the ways in which the facilities are managed by medical personnel in a "located" and "legitimized" process that differs from one clinic to the next, cannot be overlooked[4].

These points, like others presented in the pages of *Studies*, constituted the basis for the creation of a current of "medical ethnomethodology" (Have, 1995), which is interested in different aspects of the sociology of health, e.g. doctor-patient interaction, the organization of medical work, the international language used by the medical staff, the way in which people live with diseases such as physical or mental disability, therapeutic treatments, and the practices related to health policies[5].

Certainly, in this field, as in many other into which the ethnomethodological studies have extended, Garfinkel's writings are a reference that serves as the starting point for analysis but not as theoretical guide and practical prescriptive, given the general character of the principles set forth in *Studies*.

In other words, as Garfinkel himself said several times when he was called the father of ethnomethodology, his paternity has spawned a community of "bastards" offspring; he thus indicated the freedom with which the ethnomethodologists apply and interpret the principles he expressed, without

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[4] Garfinkel's analysis is very articulate and complex, using both mathematical formulas and statistics tables as well as clinical documents collected in the field in order to criticize the methods used up to that time by researchers. Here, however, we will not go deeply on this analysis but limit ourselves to mentioning some elements.

[5] Ethnomethodological literature in the field of medicine and health now has hundreds of references that cannot be quoted here for the sake of brevity. For a fairly complete overview see site on ethnomethodology and conversation analysis, edited by Paul ten Have, which also contains a specific section dedicated to the bibliography of ethnomethodology in the area of medicine and psychotherapy (cfr. www.paultenhave.nl/medbib.htm).

ever denying their membership in the ethnomethodological movement.

References

Carricaburu D., Ménoret M. (2007). *Sociologia della salute*. Bologna: il Mulino (or. ed.: *Sociologie de la santé*. Paris: Armand Colin, 2005)

Cipolla C., a cura di (2004). *Manuale di sociologia della salute* (3 voll.). Milano: FrancoAngeli

Fele G. (2002). *Etnometodologia. Introduzione allo studio delle attività ordinarie*. Carocci, Roma

Garfinkel H. (1967). *Studies in ethnomethodology*. Englewood Cliffs: Prentice-Hall

Garfinkel H. (2002). *Ethnomethodology's program: Working out Durkheim's aphorism*. Lanham: Rowman & Littlefield

Garfinkel H. (2006). *Seeing sociologically. The routine grounds of social action*. Boulder: Paradigm Publishers

Garfinkel H. (2008). *Toward a sociological theory of Information*. Boulder: Paradigm Publishers

Giglioli P.P., Dal Lago A. (eds.) (1983). *Etnometodologia*. Bologna: Il Mulino

Have P. Ten (1995). Medical Ethnomethodology: an overview *Human studies*, 18, 2-3: 245-261

Lynch M. (1993). *Scientific practice and ordinary action*. New York: Cambridge University Press

Muzzetto L. (1997). *Fenomenologia, etnometodologia. Percorsi della teoria dell'azione*. Milano: FrancoAngeli

Muzzetto L., Segre S. (2005). *Prospettive sul mondo della vita. Sociologia fenomenologica ed etnometodologia: materiali per un confronto*. Milano: FrancoAngeli

Parsons T. (1951). *The social system*. New York: Free Press

Rawls A.W. (2000). Harold Garfinkel. In: Ritzer G. (ed.), *Companion to major sociological theory*. Boston: Basil Blackwell, pp. 545-576

Ruggerone L. (2000). *Parlare per vivere. Linguaggio ed esperienza nell'etnometodologia*. Milano: FrancoAngeli

Sena B. (2011). *Etnometodologia e sociologia in Garfinkel. L'indicalità inevitabile*. Milano: FrancoAngeli

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The social culture of health needs. Filippo Barbano's reading

Donatella Simon*

Filippo Barbano, who died in Turin in July 2011 at the age of 88, was among the leaders of Italian sociology renaissance after World War II, the so called by Him "second sociology", after the first historical phase in the positivistic age, between the XIXth and XXth century. To these phases of sociology He dedicated several studies, as well as to political sociology, already in the Fifties. In the Sixties He promoted in our country the sociological work of Robert K. Merton, representative of critical functionalism and of 'middle range' as well as student of the sociology of science, field that interested also Barbano. He taught sociology and history of sociological thought both in Trento and always in Turin, where His cultural activity was very

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lively, open in different fields and directions. Upon one of these I would like in this "In memoriam" to write.

Between 1977 and 1980 Filippo Barbano developed some fruitful intuitions in the *cultural field of assistance and health needs*. He fitted them into a perspective non only of therapeutic support, but also into a far-reaching existential point of view (*care needs)* and this at two levels: that of the Object-Subject of the intervention (the assisted person, the sick person) and that – above all – of the *education* of the social and medical workers within complex organizations.

The material opportunity for these considerations was a Seminar ("University and Territory" – 1977) focused upon different themes, among which that of *Health*. Preliminary to that section was a draft (*The health need)* written by Barbano but raising from internal discussions in a group-work of the Institute of Political Science in Turin University.

These were the years in which tasks and functions in order to implement the National Health Service were transferred to Regions: a very relevant chance for sociological reflexion, confronted by organizational dimensions, the sanitary way of functioning and the restructuring of both contexts within the territorializing process (Local Sanitary Units).

At stake was finally the effort to recompose the interventions, with regard to the problem of education and participation, around the Subject-person who is in hospital, the *patient* or the *sick person*. As far as these two notions are concerned, one must consider the 'status' (the objective condition) and the subjective perception of the one who is unwell or unhealthy.

More than with organization (despite the positive effects of 'departmentalization' with regard to results of scientific research), Barbano concerned himself with the medical work. He made reference to the territorial culture which was well developed by the medical officers in the XIXth century. They had been in fact engaged in prevention, above all with physical and hygienical education, the last one favoured by the bacteriological revolution.

Barbano mentioned – with sociological refinement – the 'crisis of identification' of the medical role. This was connected not only with the rapid evolution of scientific and technological knowledge, but also with the *social and cultural meaning* of its working: experience of sickness (diagnostic capabilities), of health as a whole of organization and functions (division of labour), of security needs, with reference to 'what' health means. *A latere* he was also the question of 'paramedical' personnel and relative needs and that of its relationships with medical personnel, from a hierarchical, functional point of view and from that of the meaning of the service, not only as organization but also for the professional conscience. Barbano underlined that both medical and non medical personnel were to be conceived as *social operators*. This notion implies manifold considerations of historical, scientific, technological, economical, sociological nature.

The relationship which ties both types of operators has three aspects: a) separation (deriving from the division of labour); b) subalternity (power relationships); c) unification (as a tendency toward the 'unique role' or at least to strict complementary roles). Education is professional but also 'social', also in the sense of team work.

Barbano wrote in that draft that the locution 'social operator' meant two things: a socializing function (human aid to the sick person) and a participating function (in the sense of sharing choices of health policies) which go further the technical roles.

As to *education* Barbano noted the arising 'culture of prevention' so that if the sickness was no longer a 'social accident', then the doctor, and also an auxiliary well-prepared operator, must interest themselves also in the social and psychological aspects of their role-functioning.

Really – Barbano underlined – the 'medicalization of disease' (its appropriation by the technical and scientific culture) coped with its socialization, that is with the diffusion of a 'health culture', a process initiated with medical positivism (end XIXth – beginning XXth centuries) in our country. To all this, for Barbano, had to be added the growing field of team-work, which really transformed technical operators (doctors, nurses, other personnel) in 'social operators' and even , from another point of view, in 'collective operators'.

This – historically – ties up to the birth of the clinique (the great debates in the XIXth century in the medical schools, the French ones especially), which represents a collective subject working inner side the hospitals and integrates the charismatic, personalistic competence of the 'Magister'. In other words: the clinical équipe socializes both scientific and assistential competences.

The general question is that of *health need* with regard to *institutional model*. Barbano already in those years underlined the necessity of verifying the efficiency of the services: calling upon the means at disposal of the medical culture (*latu sensu*) to evaluate its condition and the results of its operations but also taking into consideration the proceedings, the exigencies that show themselves into the social in order to control their validity. It' s a general problem of the 'quality' of the socio-sanitary services, which is urgent today because financial resources are much less than before.

In those years – as said – a culture of prevention began to diffuse, also at legal level, and Barbano urged for a new awareness: that of (depreciable?) polarity between the 'territorial dimension' of needs only quantitatively conceived and the 'institutional dimension' of services designated to their satisfaction. The distorted problem, then, was the hospital, with its clinics, its personnel, its functions, its roles (hierarchical division of labour), and the social image of disease, so that all that was conceived as 'morbid' fell into the former along technical lines of competence. Idem for the assistential institutions which always along even legal areas of competence circumscribed the needs into categories: handicap, minority, marginalization, etc. It was a logic of isolation, not of 'territoriality' of needs sustained with strength by Barbano.

He considered in fact the *territoriality* as a priority variable in order to programme, maintain and verify the quality of the services.

The territory – He affirmed – was not a container of 'quantitative' needs, nor a whole of geographic areas to be controlled by the institutions. For Him the territory was first of all the 'subject' of social health needs. Not market relationships, therefore, (pure logic of cost/benefits), not bureaucracy: on the contrary historical-cultural relationships (scientific competence) and political-social ones (level of choices and priorities).

In Barbano's reflexion was therefore very important the 'social factor'. Within a growing tendency to consider reciprocal interactions between conditions and causes, so that, for example, epidemiological factors stay near pathological factors, social situations stay near individual situations, in His point of view one had to ask: "social situations", what does it mean?

It was not only a 'sum' of factors within a circumscribed milieu, around a mere technical conception of preventive medicine: general data, even generic ones, and therefore unproductive.

The 'social' – for Barbano – was strongly conceived as 'territoriality'; a place where needs are transformed, also health needs, going further the borders of a 'local community' thought as mere statistical-demographical place of residence.

It is also the problem of the 'net' of services, able to recover concentrations of sickness despite a possible dispersion of the affected persons beyond the limits of the zone. This demands means of information and analysis and also an articulation of the intervening structures. It was the innovative moment, also at normative level, of the Local Sanitary Units.

Therefore, for Barbano, the problem was not only statistical and morphological (territory as 'container' of needs), but also of participatory politics (territory as ''expression' of needs, perceived and denounced by the bearers themselves). In other words: participation conceived as 'conscious riappropriation of the cycle: health- disease', beyond mere specialism and (also bureaucratic) technicism.

Again and differently: the role of operators and of their education, which had not to be only technical, but also including a 'cultural' redefinition of their practice. For Barbano, it was an integration between technics and professional culture which could go further the cumulative effect resulting from the weaving between operations at different levels and status/power connected to these.

Obviously, in the field of education, it was also question of the university (reform of the faculties and programming) and of the extra-university milieu (territorialisation and relative 'liaisons', as well educational recycling with regard to scientific, social and cultural transformations, in the sense also of the 'awareness of people').

With reference to these problems, for Barbano one was entering into a third phase of major strategies of education.

A first phase corresponded to the free market of competences, within the encounter between an answer, from singles or groups, and a response which was fundamentally privatistic and elitist.

A second phase furnished functional and 'ad hoc' responses with bureaucratical operators prepared to cope with predefined needs, both private and public.

The third phase – for Barbano – had instead to preview public programming and therefore a politics: this called upon the Regions, along with the lines of the new health reform (L-833).

One had to assure an adequate level of knowledge and permanent education of the operators with regard to territory, however without thinking that political-technical problems (like prevention) could be resolved by more instrumental interventions.

Afterwards, in 1980, Barbano developed the idea and insisted upon the fact that education and sanitary consciousness are not only tied to learning but also to interests and practices which form a *social culture of health*. Its components are the historical context and the social structures (institutions, families, groups and social strata).

It is an anthropological-historical-sociological feature which consents the comparison of different ages and cultures and of which, in this case with reference to health, *transformations* may be noted.

In that historical phase Barbano underlined the voluntary effort in order to reappropriate health, both in the form of participation to political choices, and at a level of awareness about which the problems are and how to cope with them.

For Barbano there was a strict connexion among 'integration' of socio-sanitary services, professional consciousness and cultural education of the operators, who became really 'social', unity of interventions (prevention and cure), autonomous participation ('being part' and above all 'having part') and finally territoriality.

Leading point was the patient, or the sick-Person: the patient as a problem of identity, social and cultural problem, of self-determination, not mere 'object of overwhelming medical specialization'.

Barbano proposed a sociological meaning of 'mental Hygiene': a problem of imagination, not psychological but in fact sociological, as ability to think and to project the change, in the light of this new and diffused cultural awareness. Then technical use would be moulded by the emergent culture: that of transformation and territoriality, as already said.

Then also the institutional dimension of medical work had to assume a fuller social characterization: the relationships doctor-auxiliary personnel-sick person is a *social relation* and in this sense also the specialistic education had to be reoriented. The hospital had to fulfil collectivity needs but also more diffused 'community needs', without however thinking to affective connotations in the parsonsian sense.

The social relationship of the sick-person to the structure and its personnel is of 'involuntary dependence', 'voluntary submission' (to be hospitalized), scientific (the sick – person is an observed object), therapeutic and finally social.

Barbano wrote that the production of health is production of services by means of social relationships: to this I could add, in a weberian way, that these relations are rationally oriented towards the 'aim' (prevention and cure) and toward the 'value' (the Persons: ethics of cure and *care*). Beyond therefore the mere institutional and bureaucratical rationality (dysfunctional, if the above mentioned one is not considered).

Relations are crossed over by urgent needs of *communication*, which interfere with institutional and territorial dimensions.

And then the 'time': of operators, often burn-out, but also of the illness (objective) and of the sick-person (subjective), fast along a phenomenological line.

And more also the experience of pain: physical and psychical, objective, fast measurable, and subjective, interior, itself source of transformation.

Therefore Barbano's itinerary underlines historical paths (diseases become scientific and medicalized), institutional and organizational, educational, communicational paths and ways of experience. This was done by synthesis, which was his main characteristic, which is often hint, not further developed remark: this is typical of a polyvalent intellectual, very curious and human for the people' needs, but who then lets himself attract by other interests, explores always new fields, gives rise to sociological imagination. This was his most distinctive quality.