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Introduzione/*Introduction*

> *“Dr. House’s assistants waste no more time than him in chatting to the patient: while doing an encephalogram and monitoring a lady, first from behind a glass wall and then from a computer screen, at a certain time they notice that her heart-rate flat-lines. They leap up, worried that she may have arrested, and only then notice that she is no longer in the room!”*
> *(Cappi, in this volume)*

Subject

This volume presents some reflections on modern medicine by scholars of various disciplines. The *leitmotiv* of the various contributions is the focus on the dimensions of “cure” and “care”.

In Italian, the term *cura* describes both the elimination of the cause of a disorder or disease and a combination of procedures that refer to the informal form of assistance based on elements such as attention, encouragement, support, compassion. The English language, however, uses two different words to indicate the processes described above: cure and care. The first draws on the wealth of knowledge of scientific medicine and thus concerns the therapeutic methods that allow physicians to treat patients from an exclusively technical point of view; the second refers to the wealth of knowledge and practices which entail the personal involvement of the person administering the treatment with the person who is suffering.

Thus, curing and caring are, by definition, medical practices par excellence but, historically, the two concepts have taken different forms and have not always gone hand-in-hand. In the pre-scientific age, it was care that prevailed, so much so that healing, if and when it occurred, depended essentially on the recovery capacity of the patient’s organism and on the level of care of whoever provided

assistance: women, within the family; slaves, in the "valetudinarian" of ancient Rome; monks in medieval monasteries. From the late 1700s, care began to be accompanied progressively by cure: starting in hospitals within or in the vicinity of monasteries, in which various figures were alternated, of different training and social extraction (physicians, surgeons, barbers and assistant barbers) and later, with the emergence of clinical medicine, in structures in which systematic patient observation and scientific experimentation were practised[1].
In the modern days, cure, benefiting from powerful diagnostic and therapeutic instruments, increasingly accentuated knowledge specialisation and new and sophisticated digital applications, guarantees certain and effective results for a large number of medical problems. The area of care, however, is much more restricted than in the past: it is to be hoped for but it is not taken into consideration in the biomedical standard that dominated medical science nearly all the way through the 1900s. In fact, in this model – which presumes the clear separation of mind and body – disease is a deviation from the biological norm; the suffering of a patient can only refer to physical and biological causes; consequently, physicians must act on the disease and not on those who are suffering as a cause of the disease. Today, this "scientific" vision of medicine is widely perceived as "dehumanising". Anthropologists, philosophers, physicians, educationalists, sociologists and historians agree on the observation that the passage from anamnesis and physical examination to a medical procedure dominated mainly by science and technology has not just brought the benefits of more effective results against diseases, but also a new attitude in considering the patient. In fact the patient is an "organism" that can be "measured" and studied in detail right down to the very last cell. In this model, the traditional doctor-patient relationship – in which the one who cures does not just cure but, by combining the clinical dimension to that of an anthropological nature, "takes care", in the wider sense, of whom is not well

– is transformed into an encounter between therapist and disease, understood in the purely biological sense of the word. The patient as an individual almost disappears from the physicians' viewpoint, insofar as, in the treatment methods, identifying and understanding in-depth the psychological and social elements of his medical history (who is the person that needs to be treated, what are his background, his preferences, his expectations) is irrelevant. And that is not all. If the doctor-patient relationship is not a direct exchange between two subjective entities but only the encounter between an object (the diseased organ-patient) and a subject (the physician), it is inevitable that the professional expert also becomes the unique repository of knowledge and power.

It is not by chance that the asymmetry of knowledge/power of the doctor-patient relationship has been highlighted by several sociologists, especially in the years in which the biomedical paradigm was universally accepted. Talcott Parsons (1951 e 1954)[2], for example, focusing on the social function of physicians (protecting society from disease or, in functionalist approach, neutralising the pushes towards deviancy) and on certain features of medical practice (the right to access the human body, to prescribe medicines, to carry out surgical operations and to sign death certificates), "justifies" the asymmetrical relationship between professional expert and patient based on the former's specific skill and on the commitment/disinterest that he/she injects into his/her working practices. Erving Goffman (1961)[3], however, takes a different standpoint, linking the asymmetrical condition of the relationship between the one who cures and the one who is cured to the fragile situation of the individual entering the role of "sick person": in the exchange with the physician, the ill person appears helpless, demoralised by the feeling of having lost part of their identity. Both in Parson's and Goffman's reflections, therefore, the theme of power is of central importance: the physician exerts an explicit power on the patient which is supported by the purpose behind it, i.e. the wellbeing of the sick individual. In relation to this purpose, he can establish a diagnosis, indicate the treatment he believes suitable and carry out that treatment. All that the patients can do is "to trust" and "to entrust": they can only presume that, given that the national authorities have granted physicians the monopoly over the practice of medicine, they must really be the most competent figures in the field of treating illness.

Care, cure and a typology of doctor-patient relationships

In the 1970s, Eliot Freidson[4] hypothesised the shattering of medical dominance, that is to say the traditional medical power, starting with the presumption that the doctor-patient relationship can also be conflicting, insofar as it may reflect, within, all the social conditioning of the actors involved in the relationship deriving from the networks to which they belong. This means that, in the treatment relationship, the patient may become the "active" subject, that is to say acquire more "power", as far as to make the relationship conflicting.

The interactionist sociologist, following Thomas Szasz and Mark Hollander's typology of doctor-patient relationships[5], notes that

> *Under some circumstances -as in surgery and electroconvulsive therapy- the patient must be thoroughly immobilized and passive, wholly submissive to the activity of the physician. The work itself requires such minimal interaction […] This model for interaction Szasz and Hollander call activity-passivity. In it, the patient is a passive object. The second treatment situation […] is one in which the patient's consent to accept advice and to follow it if necessary […] Since he suffers […] he seeks help and he is ready and willing to "cooperate". When he turns to the physician, he places [him] in a position of power […] The interaction is expected to follow the model of guidance-cooperation […] The patient […] assumes a less passive role than if he were anesthetized but a passive role nonetheless […] Finally, there is the model of mutual participation, found where patients are able or are required to take care of themselves -as in the case […] of some chronic illnesses like diabetes […] Here, "the physician does not profess to know*

> *exactly what is best for the patient. The search for this becomes the essence of the therapeutic interaction". Obviously, some forms of psychotherapy fall here. Szasz and Hollander's scheme, however, is defective logically and empirically […] Logic and fact do, however, require recognition, and they dictate the suggestion of two other patterns of interaction -one in which the patient guides and the physician cooperates, and one in which the patient is active and the physician passive. [While] it is difficult to imagine an empirical instance of the latter possibility […] For the former instance, however, we may find empirical examples in a fair number of the interactions in client-dependent practices, particularly where the practice is economically unstable and the clientele of high economic, political, and social status*[6].

This last situation reminds us, curiously, of the "London stage" of Dr Manson in *The Citadel*, the famous novel by Cronin[7]. In London, as well as the financial aspects, Manson becomes aware of the status or prestige that the profession can bestow. He has the chance to meet the best established physicians in the city: those who have their practices in the richest areas and have their enormous salaries ensured by wealthy, hypochondriac patients. Very soon, however, he realises that his training counts for very little with his new, wealthy patients. First of all, because these patients visit their physician even for insignificant malaise (or presumed illness); then because such patients demand of their physician qualities including some of a not exactly professional nature, such as, for example, elegance of dress and luxury waiting rooms. In short, we are faced with, as Freidson would say, a classic system of client-dependent "profane reference", which maximises the offer of care, perhaps in a not entirely disinterested manner.

Freidson's observations coincide, more or less, with the diffusion of the bio-psycho-social model in the field of medicine, which perceives disease as related to the individual experience of the person. Basically, in this model, the condition of illness is not simply equated to a biological imbalance, but is influenced by psychological and social elements that can condition patient reactions and, therefore, their pathway to recovery. Indeed, among the key elements of the bio-psycho-social paradigm, explicit reference is made to the way in which the doctor-patient relationship must develop: the professional experts cannot limit themselves to the identification of the symptom and, thus, of the correct diagnosis, but they must also give the patients enough room to articulate their worries, expectations, achieving a shared understanding of the patients' narrative, with the patients. And, as we will see further on, the only area in which this seems to occur is in psychiatry, where the narrative method represents a way of curing and caring. Only after having listened to the patient's point of view, his direction in life, can the physician formulate a diagnosis and treatment plan[8]. For this reason, the bio-psycho-social approach is also defined as *patient-centred*, because is characterised by the shift to a more equal doctor-patient relationship, in which the sick person is considered an active subject in his own recovery. In effect, with the advent of this new paradigm, the *compliance*, which presumes an act of absolute faith in the physician - because the patient does not have the knowledge to deal with the situations deriving from the disease from which he is suffering - becomes *concordance*, i.e. the involvement of the patient in the decisions regarding health and, above all, in the management of chronic and debilitating diseases[9]. Going back to Freidson, and his revisitation of Szasz and Mark Hollander's work, the bio-psycho-social approach is nothing other than the model of "mutual participation".

The shift from one medical model to another also implies a change in *care* and *cure* dimensions. In the biomedical model, everything is centred on the disease and on the expert who is treating the disease, considered to the sole repository of knowledge and power. The content of the communication between physician and patient is limited, in fact, to the biological dimension of the disease and the role of the sick person is that of passive receiver of the decisions of the physician. In short, there is not much room for *care*, meant as listening, encouragement, support, compassion. In the bio-psycho-social paradigm, instead, the patient is actively involved because, to the physician, both the disease and the patient's experience of living with the disease are important. In taking on board the patient's history, the direction of life, the physician is inevitably personally involved with the person who suffers from a certain disease.

The in-depth analyses found in this volume are not designed to "measure" the diffusion of one paradigm as compared to the other, but aim at broadening our vision of *cure* and *care*, from different scholarly viewpoints.

In-depth analyses

In the first paper Benedetta Gambacorti-Passerini and Lucia Zannini mainly focus on the transformations which the clinical practice has undergone, thanks to whom the concept of "taking care" of the patient has gained increasing attention. The two authors begin with the observation that the concept of "cure" dates back to the origins of Western culture and refers to symbolic dimensions that universally invest the existence of man. Thus they remind us of one of the fables of Igino (1st century. B.C.)[10], in which the story goes that Cure, whilst crossing a river, saw some mud and used it to create and model man. A quarrel then broke out over the paternity of man, between Jupiter, who had infused his spirit and Earth, who had provided the raw material. Saturn, Time, was given the task of resolving the issue and he ruled that the spirit of man, upon his death, should go to Jupiter, and his body to Earth. "But because it was Cure who had first shaped this being, he shall belong to Cure for as long as he lives"[11]. In this respect, going back to that conveyed by the fable, Heidegger presents an extremely significant aspect of cure: it is not just a method of acting and interacting between men, but is also a structural and founding feature of existence itself.

In particular, to highlight the different meanings of “cure”, it is useful to explore the different “clinical” attitudes adopted by western medical science over the centuries. The term “clinical” (from the Greek noun *klinè*, bed, and by the corresponding verb *klinèin*, bend over) originally indicates the typical action by the doctor of bending over the patient on his bed to perform a “check-up” and establish a therapeutic relationship: this clinical relationship involves the creation of particular knowledge, which requires both the technical skills and the capacity of the physician to create a compassionate relationship.

The Birth of the Clinic[12], in which Michel Foucault presents the development of the medical *regard* (gaze) in western science, is exemplary in order to understand the evolution of the concepts of “clinic”, “cure” and “treatment/therapy”. Western medical practice has its origins in Hippocratic medicine[13], focused on the ethics of overall care of the individual[14], and Foucault demonstrates how far this has been gradually built based on a “gaze” that aims to break up the body into its parts in search of a disease. In this respect, therapeutic relations aimed at curing the individual have shifted, over the centuries, towards curing the disease, the diseased organ. Foucault’s main reference, in this regard, is François Broussais, who, around 1820, introduced the concept of disease, to replace the diseased body, as a subject of medical science. This change also implied a renewed perception of death: through the study of corpses, in fact, death became a positive foundation on which to build further knowledge.

Thinking of cure as “care”, instead, leads the thought to take on a more educational dimension: educational care, indeed, is basically acting towards the development of existential planning, the genuine interest of man in the development of another man. Education and educational therapy can make a particular contribution to the activity of the physician with regard to interpretative and significant skills[15] because educational care reveals significance opportunities for every man, with a strong interest in the stories of lives being built: “If a situation is classified within an ‘already given’, you can’t encourage the opening up of a ‘still possible’. This need for meaning is the opening up of the project of oneself”[16].

Such aspects are revealed to be particularly relevant for those physicians involved in long-term and continuous treatment of patients, thus acting on diseases that affect people’s existence and daily lives.

In the second chapter Valentina Cappi asks herself how is care represented on television. Is it depicted in a univocal or heterogeneous way? Are care and cure represented as exclusive or complementary activities? Who is attributed predominantly certain skills (technical or relief support) or the position of carer (doctors, nurses, patients themselves or their relatives)? It is important to answer these questions for many reasons, particularly because television is identified by Italians as the third most important source of health information[17].

In order to grasp what kinds of representations of care are broadcast to Italian spectators on a daily basis, she constructed a sample from two days of digital terrestrial programming in March 2015, picking one weekday and one from the weekend, at the distance of a fortnight. By consulting the listings of the most popular networks in the weekly magazine *Film TV*, she identified those programmes that had explicit health and medical themes, recorded them via a Sky HD decoder, and watched them back at a later moment.

One common feature emerges from a brief examination of the selected programmes: healthcare, as far as health professionals are concerned, appears predominantly as a mode of *curing*, as therapeutic techniques, rational actions that aim to repair the body and interventions from a kind of medicine that “has conceived of itself as a science, albeit an applied science, that is practical and professional: it is ‘knowing what to do’ when facing disease, imbalance, disability”[18]. On the other hand, healthcare intended as *care* - its personal dimension that refers more to the ability to take care of others, to “provide answers that are not necessarily and not only of a technical nature"[19] – is barely hinted at. Care does not appear to feature within the primary responsibilities of healthcare professionals (doctors or nurses) and for that reason is entrusted to groups of peers, affected family members or via the self-cure of the patient.

At the end of this overview of programming, it is possible to maintain that care and cure are aspects of medicine that are depicted with different grades of complexity according to the genre of the programme in which they feature. In scientific-informative shows *Elisir* and *Medicina 33* cure and its related aspects prevail. The only emphases of the show relating to care are those which address prevention, that in any case call for the patient to adopt their own responsibility. Care is thus not presented as a prerogative, instrument or objective for health professionals. In medical dramas and documentaries, references to care are frequent, despite the fact that it is often one aspect of a hospital setting in which cure doubtless dominates. Professional care is a fundamental element of the healing process in the medical documentary *Mystery Diagnosis*, just as the professionalism of the midwives of *One Born Every Minute* is a quality that is taken for granted. Ultimately care is not excluded from televised representations of medicine, but the context in which it is most often portrayed is that of the fictional medical drama, the domain of the plausible but not of the real.

In the third chapter Ekaterina Borozdina considers how social and political changes in contemporary Russia have influenced professional project of midwives after the dissolution of the Soviet Union. The research is based on analysis of secondary data and on interviews with 15 midwives from three Russian cities.

Many distinctive features of contemporary Russian maternity healthcare are inherited from the model that Soviet medicine took by 1960s and doctor-patient relations in this context took a form of triangle: doctor-patient-state[20]. Physicians, unlike their American counterparts, lacked control over conditions and content of their work. Moreover, as a result of devaluation of health care professionals in Soviet society, "feminization" of medical profession was very high. Obstetrics and gynaecology (along with pediatrics) constituted the most clear indicator of this trend. In early 1970s women in these fields reached 90%[21]. At the same time, the state guaranteed medical dominance through preference to obstetrical care. There was no higher education for midwifery in the country and midwives were not allowed to attend deliveries without doctor's supervision or to consult women during pregnancy.

Structure of state maternity healthcare was based on a two-tier system. Women's clinics (*zhenskaya konsul'tatsiya*) provided services for gynecological patients and pregnant women, while birthing hospitals (*rodil'niy dom*) took care of births. Such division also had a negative impact on midwives as a professional group. Fragmentation of maternity services led to the fragmentation of midwives' skills and knowledge, and split the midwifery profession. However, in early 1980s a homebirth movement began in the country. Ideology of the movement differed from ideology of western midwifery and patients' movements in two crucial ways. First, as the vast majority of Russian obstetricians were women, no opposition was constructed between a male-doctor and a female-midwife[22]. Second, technologization of childbirth and extensive medical control over it were not the main targets of the critique put forward by Soviet homebirth proponents. Movement's agenda was grounded in parental discontent with low quality of medical services and state bureaucratic control over childbearing and childrearing.

After the dissolution of the Soviet Union in 1991, Russian healthcare experienced a chain of reforms oriented to market principles. System of health insurance was introduced. State expenditures on healthcare were cut down, but the government allowed for private medical practice and for provision of commercial medical services in state hospitals and clinics. This created a window of opportunity for those midwives who aimed at gaining more professional autonomy answering to the demands of those wealthy clients who wanted to make informed decisions about childbirth (including the choice of childbirth assistant) and that remind us the situation of “mutual participation” in the Szasz and Hollander’s typology of doctor-patient relationships[23]. One of such services introduced in hospitals was a so-called “individual delivery”, in the frame of which a woman was able to choose an obstetrician and a midwife, who would help her during labor. In some hospitals women, who opted for “individual delivery”, could decide to give birth with a midwife alone, with a doctor being nearby in case of emergency.

In mid 2000s another stage of the development of Russian maternity healthcare begun. It can be described in terms of restoration of extensive state control over the sphere and its subsequent politization. This trend reflected pronatalist policy orientation, seen as the solution for the “demographic crisis”[24]. Thus, while the general trend in healthcare organization was oriented to market criteria, authorities tried to make reproductive healthcare services available and free of charge for almost all categories of women.

Midwives who have experience of work at late-Soviet period emphasize that changes provoked in healthcare by liberal reforms have contributed to the diminishing of the midwife’s role in hospital labor. As we have already described above, authority of a midwife rests on negotiations with a doctor. But in the context of healthcare liberalization and restoration of state control over the maternity care, adherence to official rules and formal distribution of responsibilities becomes more and more prominent. Thus, relational logic of care[25] is being replaced at birthing hospitals by the logic of law, which is not in midwives’favor.

The Russian scholar concludes that the formation of welfare states and dramatic changes in gender order which occur in modern societies have led to institutionalization of care practices and have provided a basis for jurisdictional claims of caring professions. Moreover, when the state supports medicalized approach to childbirth, the ability to achieve some extent of professional autonomy at micro-level is crucial for the development of the midwifery profession. This process can be facilitated or, on the contrary, obstructed by wider socio-political context. During the first decade of liberalization of Russian healthcare, midwives had better position for negotiations with doctors and hospital administration. Restoration of extensive state control over the reproductive health in mid 2000s has weakened midwives' standpoint and limited further development of midwifery autonomy.

In the fourth paper Barbara Sena and Alessandro Stievano outline that the nursing profession in Italy has undergone significant changes over the past 20 years, moving from a work characterized by tasks exclusively devoted to the care of a patient, to a health profession with skills, autonomy and specific responsibilities. The basic principle of nursing, which is to "take care" or "to care" of people in sickness and in health, seems to embed some forms of cure (forms of advanced care, drug therapy). This points to crossing old cultural models linked to the dominance of a single profession (medicine) and is favoured by the increase of technical and diagnostic capabilities, acquired either through new paths of university education, started in Italy with the reforms of 1990s, or with new programs of social and health integration. Today the activities of a nurse vary from performances that require high technical skills (as in the case of nurses working in surgery or intensive care or operating rooms) to activities where are required few technical skills but much more human and relational abilities (such as in geriatric or palliative care). Thirty years ago the nursing profession was perceived as a figure in charge of performing manual tasks specifically addressed to the assistance of sick people. Although this corresponded only partially to the true activities, in the eyes of patients, nurses professional identity consisted essentially in this[26]. The Second National Survey on Nursing by the Centre of Excellence for Nursing Scholarship Ipasvi showed a different picture and an evolution in a relational way of the epistemological core of the caring activities and of this identity. The most of respondents believes that the relational aspects are very important (74,4%). Then the relational dimension, which consists of interpretational, emotional and communicative skills with patients and caregivers, has become a prominent feature in the nursing field. Through this relationship, in fact, the nurses are able to pursue humanistic and emphatic objectives, while conveying their professional values. The role of nurses in contexts outside the hospital, as in the three main areas of the social-health integration: family health nursing, nursing homes and nursing home care, is beginning to grow, even if slowly, because this makes possible the development of alternative methods of care, consistent with the new health needs of the population (e.g. the increase of chronic degenerative diseases, related to population aging). Sena and Stievano conclude that in the current context the distinction between cure and care has not, perhaps, the same significance of some years ago. At that time, nurses demanded strongly the specificity of their care activities. Now, it is clearer that cure cannot exist without care and there are not so specific and clear distinctions anymore. This new and wide form of "care" is itself "cure" and vice versa.

In the fifth chapter Adia Harvey Wingfield considers how most of the research on gendered occupations fails to consider how also racial minority status affects working performance. Drawing from a larger research on the organizational changes in medicine for black professionals and from another study consisting of interviews with 17 black male nurses in USA, she examines the interplay between gender and race in shaping the ways that caring and curing are done in gendered occupations of nursing and medicine.

The American scholar starts with reminding us that nursing and medicine are two clear examples of occupations that carry with them distinctive ideas about suitable workers, tasks, and responsibilities. The nursing profession is predominantly white and female, instead, even despite a recent influx of women into this field, medicine remains a predominantly white male profession. These differences extend to job expectations, where (mostly female) nurses are frequently tasked with and expected to be caring, nurturing, and deferential to doctors; while (mostly male) doctors are expected to cure and take on primary responsibility for many aspects of patient wellness[27].

Wingfield goes on to consider how race and gender work together to complicate these occupational expectations. Specifically, she examines how black men in nursing and medicine negotiate gendered job expectations that are attached to their occupations. Black men are in the minority in both fields due to race, but are in the gender majority in the medical profession. Though previous studies assert that gendering occupations privileges men in various occupations, additional research indicates that this gendering is a racialized process. That is, minority men often do not benefit from the unspoken gendered expectations, while these gendered norms are subtly racialized in ways that primarily advantage white men.

In previous studies of black men working as nurses, Wingfield has shown that in contrast to their white counterparts, these men rarely describe adopting or benefiting from traditional displays of masculinity. Black male nurses did not shun their female counterparts or the femininity associated with their profession. They also contended that, due to the gendered racism they encountered in nursing, they endorsed the femininity associated with nursing because it allowed them to access their caring side and prove that they really were capable, qualified, and good at nursing. They also reported that racial tensions made it difficult to perform masculinity by seeking close ties to (mostly male) doctors[28].

The findings of Wingfield's researches show that for black men in healthy professions, racial dynamics contextualize in many ways their experiences: from interactions with colleagues and patients, to motivations for working in health care, to understandings of their role in the medical field. It is within this racialized context that gender informs the ways that they engage in caring and curing.

Distancing and marginalization were frequent for black male nurses but not exclusive to them. Black male doctors also discussed ways they felt isolated from their coworkers. Unlike white men nurses who are routinely assumed to be doctors, it was not uncommon for patients to assume black men nurses filled lower status roles[29]. This process occurred for black male doctors as well. Many noted that it was a common practice for patients to assume they were orderlies or that they were unqualified for their jobs.

The racial challenges that black men encountered in nursing, a predominantly white, gender-segregated occupation, meant that caring took on additional significance. It became a way to show their qualifications and fitness for the work and allowed them to behave in ways that were consistent with the occupational norms of the field. The racial dynamics present of being in the numerical minority, coupled with the fact that they worked in a culturally feminized occupation, meant that caring became an integral and important component of the ways that these men did the labor associated with their jobs.

In contrast, black men in medicine engaged in the process of *curing* by working to reduce racial health disparities. They did not highlight the importance and need for caring as a strategy towards proving occupational competence, because they saw a major part of their role in medicine as the ability to improve health outcomes so reducing health disparities for underserved and black populations.

Wingfield concludes that it is not just working in a gendered occupation, but the racial context of that experience that sets the stage for how labor is done by black professionals in the health sector.

Moreover, her research has relevant implications for changes that are under way in the American health system. At the time nursing is experiencing a critical shortage due to a rapidly aging population and a declining number of workers trained to enter this profession, it might be beneficial to consider making nursing a more inclusive field for underrepresented minorities so that caring becomes simply part of the job rather than a strategy for demonstrating competence. Similarly, given their interest in curing as a way for reducing racial health disparities, black male doctors' priorities with regards to curing should be encouraged in and of itself rather than functioning as a coping mechanism in a somewhat hostile environment.

In the sixth chapter Guido Giarelli considers the need to reconnect care and cure in the specific conditions of Alzheimer's disease (AD), a widespread disease which affects 44 millions of people in the world and 4.1% of the people aged 65 or more in Italy[30]. He begins with recalling two main ways the persons with AD are considered and their illness is treated[31]. The first is the dominant conventional biomedical approach which portrays sufferers as "lost" to disease, considered as a pathology of the brain, whose irreversible and upsetting effects are the depersonalization and the loss of self. In this frame dementia is considered as a syndrome, resulting from a number of underlying brain pathologies.

The second approach to AD and dementia is the psycho-social one, which questions the biomedical's portrayal of sufferer as a passive victim of a relentless deterioration of mental and physical capacities making the existence a "living death", i.e., a biologically alive but mentally and socially dead condition[32]. This opinion contends that, notwithstanding this deterioration, the sufferer is a *person*, even though a *different* one, whose selfhood has become elusive and ostensible. Understanding this different person requires, according to this approach, a subjective and social contextualization of the illness.

There is another version of the psycho-social approach, the symbolic interactionist analysis of the problem of the dementia sufferers' social disconnectedness and interactional incapacity[33]. On the basis of Goffman's dramaturgical theory[34], sufferers' increasing inability to honour societary conventions for ordinary interactions is considered in terms of their spoiled identities as the result of their failure to meet culturally and situationally defined ordinary expectations by others and of the discredit and stigma this attach to them.

The concept of "existential labour", Giarelli goes on, has been proposed to refer to the discursive work involved in articulating, realizing and managing the unique selfhood of dementia sufferers in an attempt to play down the potentially discrediting implications of their unconventional behaviours and implement restorative and socially inclusive actions[35].

Then Giarelli asks himself to what extent have contemporary health care systems taken into account the need outlined above of a strict interconnection between cure and care. And he answers that in the last decades, given the increasing concern for "chronic health conditions"[36], various more comprehensive approaches and models of intervention have emerged which call for raising "the gaze of health care from the disease to the person and the population"[37]. Among those approaches, one of the most comprehensive is certainly the Chronic Care Model (CCM). It is grounded in the idea that care for people with chronic conditions requires not only ongoing medical knowledge and appropriate cure, but also time for physicians and other health professionals to have meaningful conversations with them and their caregivers. The CCM has been implemented in several countries; in Canada, in particular, an expanded version has been developed. If in the original CCM improved functional and clinical outcomes ideally resulted from interaction between teams and patients, in the expanded CCM improved health of population results from interactions and relationships among community members, healthcare professionals, organizations, individuals and community groups.

On the basis of this expanded CCM, an experimental project among the University "Magna Græcia", the Regional Center of Neurogenetics of Lamezia Terme and the Local Health Authority of Catanzaro has been carried on. The main aim was to pursue a proactive community approach to dementia and AD involving patients, caregivers and professionals in order to prevent and anticipate the development of the disease and of its complications by slowing its progression.

The conclusions regarding the results of the quality of life (QoL)-AD project are somehow paradoxical. Giarelli and his colleagues adopted this research tool to assess whether the set of integrated interventions of cure and care envisaged by the CCM could improve the QoL of the patients with AD. Instead, they found that the levels of self-rated QoL worsened significantly over time. The second paradoxical outcome has regarded the relatives caregivers: their evaluation of the QoL of their family member with AD improved quite significantly. On the whole, the most significant result appears the patient-caregiver disagreement regarding their evaluation of QoL. These outcomes seem to tell that AD is a biunique illness, affecting not only the sufferers, but also their family caregivers, in a sort of "cognitive dissonance" related to the different perception of the illness and of the ways it affects sufferer's QoL. The need to reconcile this discrepancy between sufferer and caregiver is, according to Giarelli, one of the biggest challenge we face, if we believe that "caring for the incurable" is the only chance we have to accompany the persons suffering from AD in their inexorable decline into the unknown.

The reflection proposed by Palmieri and Speranza in the seventh chapter retraces the most important stages that have led surgeons to the affirmation of their "jurisdiction" and, therefore, of their own identity. The thinking of the two authors starts from the idea that *care* and *cure* have not always walked hand in hand and that the changing of the figure of the surgeon is doubly linked to the expansion of the dimension of *cure*. In pre-modern times medicine was, in fact, essentially *care* that, imbued with Christian values, was capable of giving comfort and relief to people suffering, but far from ensuring the healing of the sick.

The sphere of the "care practices" was instead given to figures without specific training (such as barber-surgeons, apothecaries and phlebotomists), which occupied a socially inferior position to the doctors with a formal education. Subsequently, the *care* began to lose a little of its "religious connotations" and the *cure* started to strengthen its cognitive basis and its effectiveness: the observation and the "profanation" *cum ferro et igne* of the human body are progressively allowed, and ill and dead bodies become doctors' main study material. In this changed perspective, the surgeons become essential: it is thanks to their manual skills that the interior of the bodies can be examined and the mechanisms that have led to injuries and diseases reconstructed with precision.

In the contemporary world, finally, thanks to the progressive refinement of the diagnostic and therapeutic tools, which have revolutionized the entire medical work, the scope of the surgery has also become the one wherein the results are more numerous, tangible and obvious. This has led to a consequent revaluation of surgeons not only in the medical arts but also in the social stratification with the surgeon becoming, thanks to the contribution given by cinema, television, literature and media, the most popular medical figure among people.

According to Palmieri and Speranza, therefore, the cure has received a significant boost from the surgical practices which make it possible to remove, replace and reconstruct with high precision parts of the human body and lead to the identification of the root causes of diseases. The space of *care*, on the other hand, is more restricted than in the past and generally associated with those skills and healthcare professionals (eg, clinicians and nurses) who interact face to face with the patients, taking care of their needs.

But what is the nature of the ties that link the various medical specialties to feel more or less close to *cure* or *care*? To answer this question, the authors use the results of a qualitative research carried out on clinical practitioners and surgeons that support the hypothesis that those who practice surgery are less caring of those who deal with clinical medicine.

In general, all the clinical practitioners interviewed believe that *care* is an important part of their medical practices and, indeed, the relationship with their patients is on top of their identification processes and it is markedly affected by the altruistic expectations most people identify doctors with. What surgeons are most interested in are the results of the scalpel, of the hand: they do not interact at all or they just interact in part with the patients (most of them are asleep during the operation); they do not take care of patients in a holistic way (as, almost by definition, they busy themselves with only a "part" of the patient care); their tasks are not flexible but extremely precise and limited. At the top of surgical practices and, therefore, of their identification process, there is, in fact, an emphasis on the operating room and its functioning based on action, speed, drama, strength and resistance[38].

In the final chapter Antonio Virzì et al. try to show that narrative medicine in psychiatry is a way to care and cure at the same time. They start to remark that psychiatry, in the last sixty years, has undergone a profound evolution characterized by definition of guidelines, development of new pharmacological therapies, new psychiatric rehabilitation programs and mental health institutions. Initially, without valid therapies, the only treatment was "taking care" of patients. Different instruments and theories, coming from sociology, philosophy, human science, have been gradually developed and adapted to psychiatry to better treat and understand patients needs.

In 1978 in Italy asylums were closed by the law 180 and mental health services were reorganized. Mental Hospitals, within General Hospitals, were created for acute patients, almost entirely treated with pharmacological therapies, and rehabilitation communities, home treatment teams and social support completed the set of new mental health services. Therefore the difference between curing, more linked to pharmacological treatment, and caring, linked to various instruments and health services, becomes clearer. More recently narrative medicine has been identified as a versatile way to care and also to help psychiatrists to cure patients.

In fact, psychiatry, historically, has always been based on an interpretation of each patient's past and, therefore, has always paid attention to their histories and to their meaning, aiming at listening and the creation of a significant relationship, although this approach has gradually decreased with the development of the "neuroscientific" system. Narrative medicine is based on the patients' histories and it allows to look at the psychiatric disease from different points of view: the clinicians', the health care workers', the patients' and their relatives'.

Virzì et al. stress that in psychiatry the true revolution is that of substituting the traditional taking care of the patients with "giving them back" the capacity of taking care of themselves. On a closer inspection, this situation reminds the model "of *mutual participation*" in the typology of doctor-patient relationships developed by Szasz and Hollander and taken up by Freidson. "Obviously, some forms of psychotherapy fall here"[39]. Moreover, the narrative paradigm assumes particular value in the approach to subjects with chronic diseases and disabilities, where the subject and his family take on full-time roles as leading and supporting actors in the treatment path. In such a respect, narrative medicine is not just a useful supplementary approach for better understanding the patients and their diseases, but it becomes an essential element both in diagnosis and cure.

The changing boundaries of caring and curing

After having reviewed all the contributions to this volume, what next? On one hand there is the conventional wisdom. Curing and caring are medical practices by definition but, historically, the two concepts have not always gone hand-in-hand. Often they have been considered as two mutually exclusive terms and therefore alternatively connected to different social actors. Nursing and medicine have been seen, and in many ways still are, as two classical examples of professions with opposite attitudes towards caring and curing. Or, to continue to consider the physicians, clinicians are traditionally more associated with caring and surgeons with curing. But profession and specialization are not the only variables involved in shaping caring and curing attitudes, other variables are concerned. Therefore, on the other side, this volume was meant to try to open a scenario as wide as possible and to consider how race, gender, projects of professionalization of old and new professions, even different kinds of sickness, social and political changes, national peculiarities (just to give an idea of the complexity of the variables involved) *work together to complicate* the unilateral occupational expectations. In order to see how it works let us pick up three variables starting with the national peculiarities.

As it concerns the early 1980s homebirth movement in Western countries, we are used to think that midwifery socially constructed an opposition between a male-doctor and a female-midwife, but this was not the case in the Soviet society where, as a result of devaluation of health care professionals, “feminization” of medical profession was very high (90% in obstetrics and gynecology, in early 1970s).

As for different kinds of sickness, a more comprehensive approach has emerged, grounded in the idea that care for people with chronic conditions requires not only appropriate medical expertise and cure, but also time for physicians and other health professionals to have caring conversations with them and their caregivers. This is rather clear in the appealing title (*Caring for the incurable*) of a chapter presented in this volume.

As for the projects of professionalization, it has been emphasized that nowadays the distinction between cure and care does not have, perhaps, the same significance of a few years ago, when nurses claimed the specificity of their care activities. Today, it is clearer that cure cannot exist without care and there are not so specific and clear cut distinctions anymore. Narrative medicine in psychiatry, for instance, is a way to care and cure at the same time. The boundaries between caring and curing are changing.

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40. This introduction is the result of a mutual and cooperative work of the authors. However, A. Palmieri wrote paragraph 1; L. Speranza wrote paragraphs 3 and 4; both authors wrote paragraph 2.

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