Reflections on the relationship between health and society in the contemporary Italian context

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Abstract
Focusing on the social management recommended by the 1978 Conference of Alma-Ata, the present study aimed to reflect on how Italian family doctors experienced the relationship between health and societies in the experience of their practices. A field study with a qualitative approach and exploratory-descriptive nature, carried out) in 2007, in the province of Rome, Italy, with Italian family doctors. Performed according to the perspective of everyday bioethics, the analysis revealed that the anthropological-social dimension in the experience of the Italian family medical practice depends on the context in which such practice occurs, and that (risk) social risk management, in the individual sphere, is a common constitutive aspect. It could be concluded that, when dealing with the relationship between health and societies, from a moral dimension towards an ethical practice, it sets the possibility of fulfilling the ideal of making Primary Health Care the center of national health systems..

Key words: Health. Society. Family and community medicine. Bioethics. Italy.

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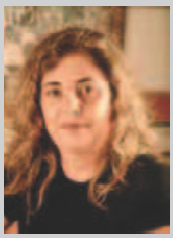

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At the conceptual level, the expressions adopted to designate the current capitalist societies are manifold: complex societies, post-industrial, post-material, late-capitalist [1,2]; society of fluid modernity [3]; interval society; paradigmatic transition society [4]; modern reflexive society [5]; modern society [6,7], and risk society [5,8].

Understanding these societies as comprehensive systems based on information, the Italian psychotherapist and sociologist Alberto Melucci recognized in the 80's, the decline of the conception of society as a whole to demarcate the sociocultural specifics circulating in the micro-spaces of everyday life as a structural element of the new social configuration [1].

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One of the characteristics identified as a hallmark of capitalist societies today is a contradiction: on one hand, a dizzying production of information and symbolic resources, which support the individualization, in its eagerness, to build *reliable terminals for information networks* from autonomous individuals; on the other, the submission of individual's internal processes to control of a symbolic order that regulates the space on which the experience and motivation to act are modeled. Thus, contemporary societies would produce and intervene themselves from the process of individualization and regulation [1].

In the same direction and historical time, Ulrich Beck, German sociologist, shared the idea of depletion of the design of society as a whole, pointing to the emergence of a new society format, which opened paths to a reflexive modernity. Understanding reflexivity as *awareness of the need to confront the risks* [5], Beck signals that in this society broke out irreducible ambivalences and an autonomous stage: the *risk society*, in the dynamics of which *risk* cohabits with *existence*.

In the context of public health in capitalist societies, the reliable terminals of information networks, described by Melucci [1], as well as Beck's notion of reflexivity [5] may be recognized as strategic resources of primary health care (PHC) to enable *social management* [7], in self-managed health modality. Among the goals of *social management* [7] recommended in the *Informe de la Conferencia Internacional sobre Atención Primaria de Salud*, of 1978, stand out: 1) the requirement of fostering individual and social consciousness for self-determination and self-responsibility, signaling that the management of health problems would be addressed from the management of individual singularities, contributing thus, the particular attributes of self-determination and self-responsibility the role of social means

for achieving the highest level of health; 2) commitment to the principle of cooperation to promote national self-responsibility and fairness, among others [9].

In 2008, the Commission on Social Determinants of Health (CSDH) of the World Health Organization (WHO) reaffirmed the goal *La atención primaria de salud, más necesaria que nunca* [10]. Since then, there was a call of the scientific community for PHC consolidation, for investment in autonomous communities, responsible governments, and external support [11].

Considering family doctors as structuring part of the social management within the PHC, this article seeks to develop a reflection on how Italian family physicians experience the relationship between health and society in their practices experience. Part of the understanding of health as a universal good [12], a value common to all and available to be exercised or enjoyed by all people. As a universal value in essence, health manifests itself in various ways and is achieved through the ability of humans to face daily challenges, the margin of tolerance that they have to overcome the infidelity of the environment. The disease, in turn, is designed hereto as a state of the individual in which there is *less margin of tolerance for infidelity of the environment, a state of living in a different medium* [13], which produces interferences in biological dynamics.

The discussion is guided by everyday bioethics, an applied ethics benchmark proposed by Giovanni Berlinguer. This theoretical hallmark is committed to related human issues and tensions produced in daily relations in their political, cultural, and social contexts. Everyday Bioethics is a complex field of knowledge that needs to be approached with pluralistic approaches, secular and multi-disciplinary, because we understand human phenomena as the production of daily social heterogeneity that to move forward and put itself at the service of a fairer world, demands a shared ethical process [12].

Italian family medicine and its relationship with the State: a brief retrospective

Giorgio Cosmacini states that the first moves to build the Italian family doctor, originally called *condotto* (municipal) physician, was observed in the seventeenth century. This medical category remained state-related until the 20th century [14].

From the Lorenzo-Garavaglia Health Reform, that in 1992 established a regionalized model of governance, the *status* of the category has changed: through its union, family medicine decided for private medical practice, giving rise to the private health care system, maintained by the system [15,16]. One effect of the Reform was the removal of the State's commitment to prioritize the PHC instituted by the *Servizio Sanitario Nazionale* (SSN) in 1978. The regionalization choice ended up weakening the territorial medicine.

In 2007, the Council of Ministers, the collegiate body that makes up the government, approved the project for the territory medicine called Winning Health, which consisted of a program of universal health protection, agreed between government and institutional levels. The aim was to promote healthy lifestyles and behavioral changes targeted to individual coping with major risk factors (smoking, alcohol, poor diet and physical inactivity), in order to ensure sustainability in efficiency and effectiveness of health services [15].

In 2008, in Rome, a conference sponsored by the Ministry of Health with the participation of the regions, health workers, social forces and residents' associations, aimed to propose a collective discussion on the territory medicine ministerial draft. Conceived in 2006, the House of Health provided for the construction of a territorial clinical government [15], which actually had been designed in the 60's in a similar format and presented to the Italian Parliament: the Berlinguer Plan, for decentralization of the system [14].

The conference proposed to family medicine a covenant of rights and duties: transform the PHC into a territorial (district) clinical government system formed by district physicians, outpatient specialists, nurses, social workers, district administrative staff and communities. The House of Health would be a set of interdisciplinary activities focused on social health needs, especially focused on programming for home care and education of self-care, operating 24 hours/day[15].

However, there was already a state home program, albeit in a smaller range: the Center for Home Care (CHC), established in the 90's and made effective in 2000. It consisted of a systematic proposal of free choice of family medicine, aimed at residents of rural areas, disabled in their locomotion for social, physical, or psychological reasons. Of territory jurisdiction, the CHC has district headquarters and the family physicians are responsible for the assessment of the registered people. According with the needs, they request support from social workers, nurses, physiotherapists, and medical specialists [15].

Because of these multiple discussions and initiatives, family medicine was actually revived in Italy at the beginning of the 21st century, as a specialty clinic for primary health care. Thus, it came to represent the main structure of the *Servizio Sanitario Nazionale*. According to the European Society of Family Medicine (*Wonca Europe*), the practice includes longitudinal care and humane approach. It is centered on the subject in its multiple dimensions, physical, psychological, social, cultural and existential, and oriented to the individual, family and community [15].

The definition of family medicine of *Wonca Europe* meets the experience of family physicians in Italy. As a health director reported, when interviewed about one of the contexts covered in this research, the family physician of that country should be considered a real filter in the first two levels of care: level 1 – collective preventive actions and; level 2 - district health care actions.

In general, the link starts at six years old, but there is freedom for the child to continue under the care of a pediatrician (who, despite being an expert, is part of the PHC personnel) until 14 years old and, in case of justified family request, until 16 years old [15].

Care is given in private practice and at home. People have the right to choose the family doctor they want in any municipality belonging to the district they live in, with no need for the medical choice to be connected to the city of residence. O delineamento *per capita* da prática da medicina de família dá-se sob o teto máximo de ≀1.500 pessoa/medico. The *per capita* outline of family medicine practice takes place under the maximum ceiling of &1.500 person/physician. Thus, the number of physicians contracted to SSN/municipality is related directly to the number of inhabitants. The salary of the category in 2007 was set at four euro per patient, whether or not the subject had requested medical care. Both the practitioner and user can cancel the agreement at any time. It is worth mentioning that the family doctor, while an independent professional, also conducts private medicine, but in Italy the contract with the public sector predominates [15].

The methodological course

This is an empirical, qualitative, and exploratory-descriptive study conducted in 2007, approved by the Ethics Committee (CEP) of the Federal University of Santa Catarina/UFSC. Participated seventeen general practitioners contracted to SSN, active in Rome Province, Lazio, Italy, graduated in medicine from 1975 to 2000. All of them had expertise in other medical fields, but practiced only family medicine, in the form of group medicine

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The survey was conducted in three different Province of Rome contexts: metropolis, urban-industrial city and urban-agricultural city. The metropolis, with over 2.5 million inhabitants, holds rich historical and architectural heritage, has had population growth in recent years and the pace of life is indeed one that characterizes fast societies. The urban-industrial context corresponds to a young city, geographically extensive, with a population of approximately 100 thousand inhabitants.

Designed by architects and strategically founded in the twentieth century, to support the industrial development of the Province of Rome, the activities of family physicians in that city generally follow the frantic pace that characterizes the Italian Roman daily life. The third context of Latin, Etruscan and Volsci origin is an urban-agricultural land which has 50 thousand inhabitants and has the sixth century as a landmark of its historicity. In the Middle Ages, it was one of the few autonomous cities of the Lazio region to preserve independent life. It proclaimed the Republic in the eighteenth century, was destroyed by World War II, rebuilt itself with courage and today presents itself as a beautiful, tranquil and welcoming city, the urban area of which is a veritable open

museum and the rural area is primarily agricultural[15]

The application process and authorization to study at the institutional level as well as the selection of participants, took place through the region's district managers, the health directors. The survey was not submitted to the Italian ethics committee, since for Italy it was a research with suitable subjects with cognitive faculties that had signed the informed consent of participation. The anonymity of the subjects was ensured by the use of code names of filmmakers, builders and followers of the Italian neo-realism.

To the semi-structured instrument, built to guide the search for likely ethical implications of the discourse of family physicians on the subject's autonomy and solidarity in PHC, was added the following question: *how can family medicine contribute to addressing the obstacles that life imposes on people nowadays?*

After reliable transcription, the data was organized, processed and analyzed using content analysis techniques, the dynamics of which is guided by systematic procedures to describe the content of speech [17]. In the organization stage, a reading was carried out to learn the nuclei of meanings containing relevant meanings to the object of study. The nuclei were cut in themes that constituted the recording units, which when treated and coded resulted in the analytical category presented as follows.

Prescriptive family medicine *versus* person's family medicine

The data analysis expressed that the anthropological and social dimension in the experience of practicing Italian family medicine depends directly on the context in which the practice occurs and that the social management of risk within the individual scope is a common constitutive element.

In the metropolitan context, the practice of persons medicine proved to be a bleak experience. Bureaucracy, the speed of modern life, the presence of more significant social disarticulation, the availability of countless technological resources and the absence of coexistence and mutual recognition in the social fabric eventually flow into the exercise of an anonymous family medicine. Thus, there is a tendency to prescriptive practice, which leads to an undermining the dialogue potential that address the unique ways in which people perceive, experience, feel, and think about health as well as its relationship with the living conditions, as revealed in the speech of interviewees: "...*I said to myself: I cannot exercise the profession* [according to my values] *in the capital or I'll go crazy, the pace is too hard and I'm not a manager* [...] *it's prescriptions all the time in addition to the social disarray* [...] *here people tend to seek the experts* (De Robertis)".

The statement above shows a genera

health condition that is devastating the process of living in contemporary, capitalist societies: the construction of an accelerated temporality. Especially in big cities, characterized by fast real and/or virtual daily transits, most people are being conditioned to construct an accelerated temporality, embedded in everyday life as a constitutive element of social dynamics and, therefore, essential in order to act in such spaces. From the perspective of the Beck theoretical-conceptual model [5], we can start to infer that such acceleration behavior is a reflection of the industrial society option that in the reflexive modernization does not find space for reflection (thought), but for manifestation.

In any society there are two essential factors in the induction of social dynamics: time and space, which determine the social structure, influencing both the society itself, while structure and process, and while each one is in everyday life in the same society. The model of capitalist social organization has produced changes in the perception of temporality, distancing itself from a "natural" order of time (marked by diffuse perceptions of the passage of time that arise from geographical and cosmic notions) and inserting a fragmented perception of temporality (expressed in hours, minutes and seconds). The historical effect of this cultural construction of temporal order has been the acceleration in the perception of temporality.

This trend is materializing, creating its - system of meanings, and producing antagonistic inscriptions.

Currently, it is observed that the accelerated pace of life created a daily struggle in people to dominate the time, concurrent with the desire to overcome the limits of their scarcity in face of the multitude of daily duties imposed by capitalism. In parallel, there is also the inevitable submission to this hectic pace, measured in seconds, which is prevalent in large cities, but not limited to them, producing a feeling of loss of direction and control over one's own life. Individual attempts to consolidate in daily life this temporality imposed as universal, and thus immanent to pertaining to capitalist societies and globalized economies, have generated anger and anxiety, as reflected in the speech of some interviewees, who often fail to bring in their daily personal and professional temporality that they consider necessary to produce values that underpin their own morality and world view [18].

Far from thinking that the present time demands a return to an atavistic time, it is worth pointing out that human relations, based on this timing, have been similar to contractual relations, bureaucratic, fleeting, and governed by their mutual benefit, resulting in the human movements [18] and consequently, on the social production of health. For daily bioethics, the last decades have shown that it is people's perspective which has redrawn the boundaries of ethics [19] and that one way to improve

"human subjects" through the cultural way is to increase the moral awareness [20].

Closer to Melucci [1,2] and Beck's [5] sociological approach it was possible to recognize the antagonism in the conflict presented in the above report: *that of not being able to pursue family medicine, according to their own values, in a big center so as not to go crazy*. In this speech, we can identify the dichotomy security/insecurity, moving between disposition for an integrative medical practice and adjusting the power to do so. This type of conflict makes up the functioning of current capitalist societies, in which process there is a mismatch between the potential for integrative action and the ability to act integrally [1].

The issue that arises from the perspective of everyday bioethics [13,21], is that somehow this mismatch generates disconnection with the probable result that "the choice not to engage in the practice according to the personal worldview " may trigger, for example: the unsatisfactory process of work resulting from the denial of genuine abilities.

The report notes that in contrast to that disposition, the logic of the discourse seems internalized as fruitful, the society *with time/without time* suggests recognizing the benefit of the relationship when it is established quickly, prescriptive or punctual: turning to the expert. Returning to Garcia[20], it is important to mention that there is no insurmountable walls about the cultural possibility of creating a new everyday culture in which *time is owned by the self*, used and controlled by the societies. Put another way, it is possible to deconstruct and reverse positions, putting the time in a submissive position to active participants of a transforming society. Towards a healthy social production (and reproduction). This seems to have been the choice of the interviewee in question, as is clear from her speech.

Still related to the experience of practicing family medicine in the context of the metropolis, reports stated that people with limited economic resources tend to establish greater trust with family medicine, unlike the wealthier classes, to the point of projecting on the professional the understanding that the economic vulnerability can increase the bond and encourage the exercise of a practice *with time* to consider specifics.

However, we also observed that, in general, the tendency to bond does not exempt the most suffering classes in more developed centers to require the prescriptive demand.

There is still a reality in which people with poor material conditions tend to deposit their care in the relation with family medicine because: "...*going to the specialist creates costs of transportation and ticket.* (De Robertis)".

Ticket represents the co-participation of society in the system. With regional variations, there is a tax paid by the Italian productive sector to ensure the average complexity for categories whose

annual family income is below the exemption level determined by the State; for retirees with pension and their dependents (not fiscally independent); for the unemployed (for license or dismissal) and family (not fiscally independent); disabled civilians and due to labor accidents, among others [16].

According to the *Gazzetta Ufficiale*, the Italian state has decided on this model of co-participation by a decree signed in 1989. Later, this decree was modified and was regulated by Law No. 537/93, enacted one year after the regionalization of the system. Since then, consultations with experts and laboratory tests are paid by citizens and the governmental justification was the need to curb abuses in the use of non-essential specialized services and the indispensability to increase the financial side of system, seeking access equity to average complexity [16].

In the urban-industrial context, created to support the development of the capital, there are similarities in the shape of the rhythm of life in relation to the mertopolitan, but the experience of the practice of family medicine transits between dark mismatch and illuminated relational encounter between subjects: "...*the demand of patients, sometimes, exceeds our capacity and we do not always have time* (Germi)"; "...*prescriptions and repetition of prescriptions is something we have more and more* (Rosselini)"; "...*My large family of 1,500 patients grew with me and we are getting older together, it's beautiful* (Castellani)"; "...*I see people as a whole, know their fears and how is their life* (Felini)".

When reporting on daily life, family physicians revealed border elements for a practice that may include social and cultural specificities of everyday life, generated by the existing social order: the tendency of the society to require a prescriptive practice in parallel with the fact that the income of the medical profession is tied to society itself. However, they also expressed a commitment to the person, embodied in the dialogue about their personal/social relationships and in the reproduction process as well as in the respect for their values and historical-cultural constructions.

For daily bioethics, the submission of the experience of medical practice to prescriptive logic, anxious to avoid the risk of *losing* the person who, at the end of the month, guarantees revenue, is morally questionable, because the human issues and tensions related produced in daily relations in their political, cultural and social contexts need not *submission* but a shared ethic process, fueled by the disposition for a harmonious relationship between moral and material life.

Moreover, returning to the issue of today's order of time and the universe of possibilities for the emergence of active social actors mentioned by Garcia [20], in light of everyday bioethics, at all times

and in every space people can make themselves ethical people in everyday relationships. They can occur socially with ethical bases, upon the deconstruction of what is in place and that it is not good for the good life in society and through deconstructions and reconstructions of value systems and aspirations [13,21]. It is possible to infer that the prescriptive practice is materialized through the language of biomedicine. This language is an instrument of utilitarian rationality oblivious to the personal awareness carried by the subject about feeling healthy or unhealthy, because it is grounded in field management of another from the internalization of purely biologicist, fragmented and Cartesian values and projections.

Understood by Laplantine [22] as ontological model, this form of language has been the basis of medical objectivism of contemporary society. Considering that, the ontologization of the disease as a nosologic entity relates to something that exists regardless of where it (disease) grows, the ontological model is recognized in the logic that there is a *being* of the disease [23]. Such a perception has been fostered by the tendency of humans to naturalize what they have to deal with technically [1-3], that is, treating hypertension is less strenuous than caring for the subject with hyper-tension. Moreover, this focused view promotes a secondary gain: it reduces the investment of time, to suit relations of a contractual type. It does not presuppose a meeting of relationship, nor recognition of cultural construction: it is enough to evaluate the entity hypertension, categorize it in etiological terms and just to prescribe.

In the wake of everyday bioethics, health is universal and historically achieved in a context called *culture* [24]. From this perspective, what ethical sense can assume the biomedical model in the process of living if it operates in the absence of motion to explain reality? What ethical sense this model may have that denies the *bridge to the past* that allows the encounter with the cultural roots of the direction of human actions, in the course of time? [21] What possibilities of overcoming the infidelities of the environment can be glimpsed in the insistent scenario where *being* disease becomes increasingly ontological?

These considerations about the values involved in professional practice, as well as the effective possibility to overcome the limitations imposed by the environment, seem to reflect on the career choices of some respondents. In the urban-industrial context, family doctors have brought to light a separate model of family medicine, a person's medicine, as previously demonstrated in the speech of a man who sees beauty in the historical construction of his universe of 1,500 people; a beauty that in the ethical and aesthetic sense of the work process can be understood as determining general health status and resource potential for a medical practice that meets, in fact, the individual.

It is appropriate at this time, to comment on a peculiarity of the urban- industrial context: this context that resembles an

an appendix to the metropolis, has a large land area, but its population is available not in a crowded, but fractionated, way. There are neighborhoods in relatively distant hills, more difficult to access, with a slower pace of life and neighborhoods more linear, of frantic dynamics, near the industrial districts. According to the data collected, it was found that family physicians who work in places far from downtown and industrial districts tend to have a practice more interconnected with the anthropological and social dimension than those ahead of a most industrial daily life

The peculiarity suggests that physicians working in less economically developed regions, less subject to emerging social stimuli, tend to make available more of their time, as if to them the future conditioned and determined to a lesser extent the present time. This experience, which still seems to reside in the calm of living, appears to be healthy for both subjects: strengthens autonomy and satisfaction with life.

The experience of the personal medical practice was evidenced in the urban agriculture context. Unlike the trend for the hegemony of the model of prescriptive practice, observed in the metropolis and in parts of the urban-industrial context, the practice model signaled in the urban-agricultural context is supportive. This happens because the professional recognizes he is not standing before an *ontological being illness or the sick*, but a subject in its entirety, with joys and sorrows, sweetness and harshness with which he establishes a relationship in the dominion of freedom, considering it a moral dimension for an ethical practice[25]. In Laplantine's view this supportive model corresponds to the *relational model*, which fits the perspective of health and illness of the study [14].

In this context, in which it seems that life *speeds in a slow way*, family physicians have demonstrated to recognize the relationship between health and society as the essence of medical practice. While such social choice does not release these professionals from new types of boundaries, conflict and probable movements of the concession, it was noticed that they still resist the charms of the biomedical model. They demonstrated that by recognizing themselves in the social fabric, feeling part of the community, they can expand the range of possibilities of family medicine for the construction of a dense social fabric. A more satisfied and therefore more productive social fabric, thus contributing to the wishes of the Conference of Alma-Ata, from 1978: promoting a *level of health* that ensures a socially and economically productive life.

The reports below express contributions to the image of a happy life: "...*I help him to put himself in the process of life* [...] *I open windows* [...] *try to dig his life, family relationships, work relationships without judgment of any value* [...] *people are sick for attention"* (Tornatore)*; "... the family doctor in a big center sees you in your illness* [...] *we hear your fears* [...] *if you lost your job, has been betrayed by your husband, if your son was a drug addiction*" (Ingrao).

Regardless of the context in which they live, family physicians have demonstrated health education as the potential for a strategic tool for training the person, especially in increasing their capacity for self-determination and self-responsibility in care management, as noted in the speech: "...*if we could*

explain in elementary school how the body works, how to make self-management of the difficulties,what is a healthy diet, we would solve future problems [...] *in a role like that of a mother"* (Bertolucci)

Health education is a paternalistic way of education, which sees in normative orders, for example, in unified indicators of the field of epidemiology, the way to measure "levels of health" of a collectivity.

It is therefore a cultural construct driven by epidemiology, field of knowledge that in the second postwar moved from its position as a complement to the clinic, in the search for prophylactic and preventive measures for diseases of the historical moment, to a position in which was attributed to it the task of measuring the *complete whole* [26], as the *Declaration of Alma-Ata* had expressed in its concept of health: *a state of complete physical, mental and social wellbeing* [10].

Since this *complete whole* [26] is full of subjectivities, popular knowledge, new standards and human riches, considering that health is linked to satisfaction /suffering, possibilities/tolerance/resilience, the exhaustive searches [27] to measure it happen (and have happened) in a non-transparent way: referring health indicators for treating collective disease indicators, in the representation, particularly, of risk indicators [26].

Reports indicated the biopolitics of risk prevention as the image goal of health education. Recognized as the politicization of *bare life* [28], or as the phenomenon resulting from the state choice of giving to biological life itself a central position in political life, biopolitics has been operating on the persistent state of exception, to which capitalist societies are subject.

Converging on Melucci's[1] sociological analysis, risk prevention biopolitics seems to be a galvanic regulator of such *reliable terminals of information networks*, to the extent that these are groupings of individual dimensions subject to a *collective code*, set up to normalize the daily reproduction and from there, to promote economic and social development. Individuals are confined in a single category that universalizes particularities. In this process, the regulator systematically blames the individual for deviant cases, resulting from individual choices.

Thus individualized societies are built that are sufficiently capable of emptying the human relationship of its moral character. That is, ethical values are annihilated in their ability to normalize social life:

> *"...my logic moves along two binaries: to show the patient that he is the one who must manage his health and disease and must be aware of what means to smoke, drink, eat and [...] exempt myself from the problem, if he telsl me he does not want to heal because we don't have the obligation to heal, but to provide means and opportunities for healing " (Bertolucci); "... after I talked a lot about the importance of exercise, diet control, ideal weight [...] at night I go to the restaurant [...] and find my diabetic patient eating a nice pizza" (Puccini).*

Weaving considerations

The study sought the relationship between health and society in the discourses of medical professionals in three different contexts in an attempt to demarcate the anthropological dimension of social experience in the practice of family medicine in Italy. In times of inaccurate theoretical constructs about societies, at times lacking in moral-philosophical questioning about the concept of health; in times of *Atención primaria de salud, más necesaria que nunca* [11]*;* in times of reflexive global order of submission of the present to colonization of the future; in contingent times, times without times, the initiative to bring to Brazil a clip of another capitalist reality resulted from the understanding that the discussion on health and society, this form of social organization, has no boundaries.

The analysis showed distinct guideposts in the context of social reality in the experiences of family medicine practices and social management of risk at the individual level, as a category common to such practices. Family phisicians demonstrated they recognize their role in the social fabric of action from two models: prescriptive medicine and medicine of the person. Highlighting the contradiction as a mark of contemporary societies, cited by Melucc[1], it is in the context of greater technological boiling, of alleged possibilities of social arrangements promising economic "social" development, that the family medicine practice tends to be less developed, from the human perspective: a basically prescriptive one, where the anthropological and social dimension is on the sidelines.

In contrast, in an environment where life *slowly speeds up* the person's medicine sits down, the social conditions and cultural constructions gain voice in the practice of primary health care. As if in this context the *reliable terminals of information networks* [1] were produced from a network that, at least, is not subject to a total subjection, networks that are still able to share the *normal state that the* [other] *wants to restore* [14].

In the analysis of this study, the urban-rural context showed that there are family doctors who see themselves as individuals responsible for shaping the social fabric, which enhances the tolerance range of people to confront and overcome the infidelities of the environment and heats the caring relational practice . The speech signaled that in this type of arrangement of everyday life the impact of the temporality of modern society is less clear, prevailing still the traditional perception, directly associated with the production conditions of the agricultural environment.

However, the social management of risk, within the individual context, presented itself as a common constitutive element of the experience of practice in the studied contexts, marking a major

contradiction, a major antagonistic conflict in times of social order of *Atención primaria de salud, más necesaria que nunca* [11]: on one hand, a global call for commitment to the health of the peoples, on the other, the order to foster self-determination and self-responsibility in a global reality of deep inequities

It is imperative to reflect that if the object society is uncertain, if the understandings of the object health in the sanitary field are contingent, reality is not. It is alive and pulsating: marked by deep and unjust social inequalities, the confronting of which seems to be the goal of WHO and its agencies

Here some questions arise: the search for the universality of particular attributes and dependent on external and internal conditions, such as self-responsibility and self-determination in inequitable societies, is not generating an increase in inequalities? He who does not achieve such a feat is excluded? Blamed on his limitations? And what is the health of the peoples, but their inclusion in the "agenda" of social life?

Such concerns anchor in the reflection of Giovanni Berlinguer on the risk of disease. The author notes that the distancing of the State of the causes of diseases - the social and economic structure - and the re-approximation of individual guilt in the process of illness can lead to the risk of the care been denied to those *victimized by themselves* [29].

Furthermore, considering that the production of the relationship between health and society occurs in the context of *communication processes* [1,2,9], the primary goal of the *Atención primaria de salud, más necesaria que nunca* [11] must be powered by the will of governments to mediate conflicting interests: putting itself in conformity is not with the orthodox status – the *unambiguous instrumental rationality* – but with a willingness to discuss, *practice and integrate the ambiguity and ambivalence* [...] *bettering* (so) *the preconditions for political action* [5].

Resumen

Reflexiones sobre la relación salud y sociedades en el contexto italiano contemporáneo

Volviéndose hacia la gestión de lo social recomendada por la Conferencia de Alma-Ata, en 1978, el presente trabajo recogió desarrollar una reflexión sobre cómo médicos de familia italianos vivencian la relación salud y sociedades en la experiencia de sus prácticas. Se trata de un estudio de campo, de abordaje cualitativo y carácter exploratorio-descriptivo, realizado en 2007, en la Provincia de Roma, Italia, con médicos de familia italianos. Realizado en la perspectiva de la bioética cotidiana, el análisis reveló que la dimensión antropológico-social en la experiencia de práctica de la medicina de familia italiana está en la dependencia del contexto en la cual la práctica se produce, y que la gestión social del riesgo, en el ámbito individual, es un elemento constitutivo común. Se descubrió que al tratar la relación salud y sociedades con miras a una dimensión moral, para una práctica ética, crea la posibilidad de alimentar la utopía de hacer de la Atención Primaria de Salud el centro de sistemas nacionales de salud.

Palabras-clave: Salud. Sociedade. Medicina de familia y comunidad. Bioética. Italia.

Resumo

Reflexões sobre a relação entre saúde e sociedade no contexto italiano contemporâneo

Voltando-se para a gestão do social recomendada pela Conferência de Alma-Ata, em 1978, o presente trabalho buscou desenvolver uma reflexão sobre como médicos de família italianos vivenciam a relação saúde e sociedade na experiência de suas práticas. Trata-se de um estudo de campo, de abordagem qualitativa e caráter exploratório-descritivo, realizado em 2007, na Província de Roma, Itália, com médicos de família italianos. Realizada na perspectiva da bioética cotidiana, a análise revelou que a dimensão antropológico-social na experiência de prática da medicina de família italiana depende do contexto no qual a prática se produz e que a gestão social do risco, no âmbito individual, é um elemento constitutivo comum. Apreendeu-se que ao tratar a relação saúde e sociedade tendo em vista uma dimensão moral, para uma prática ética, cria-se a possibilidade de alimentar a utopia de fazer da atenção primária de saúde o centro de sistemas nacionais de saúde.

Palavras-chave: Saúde. Sociedade. Medicina de família e comunidade. Bioética. Itália.

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Authors participation in the study

Rita de Cassia worked on conception, analysis, interpretation of the data and final writing of the text and Marta worked on conception and general supervision.