Governo clinico e salute di Comunità. Comunità di cittadini e cittadine e Comunità di professionisti

Giorgio Simon

Gli spunti di riflessione

- Clinical governance
- Professione
- L’azienda
- Curare a casa
- Stigma
- **Confini**
- Le disuguaglianze
- La diagnosi
- Cittadini o consumatori

The new

NHS

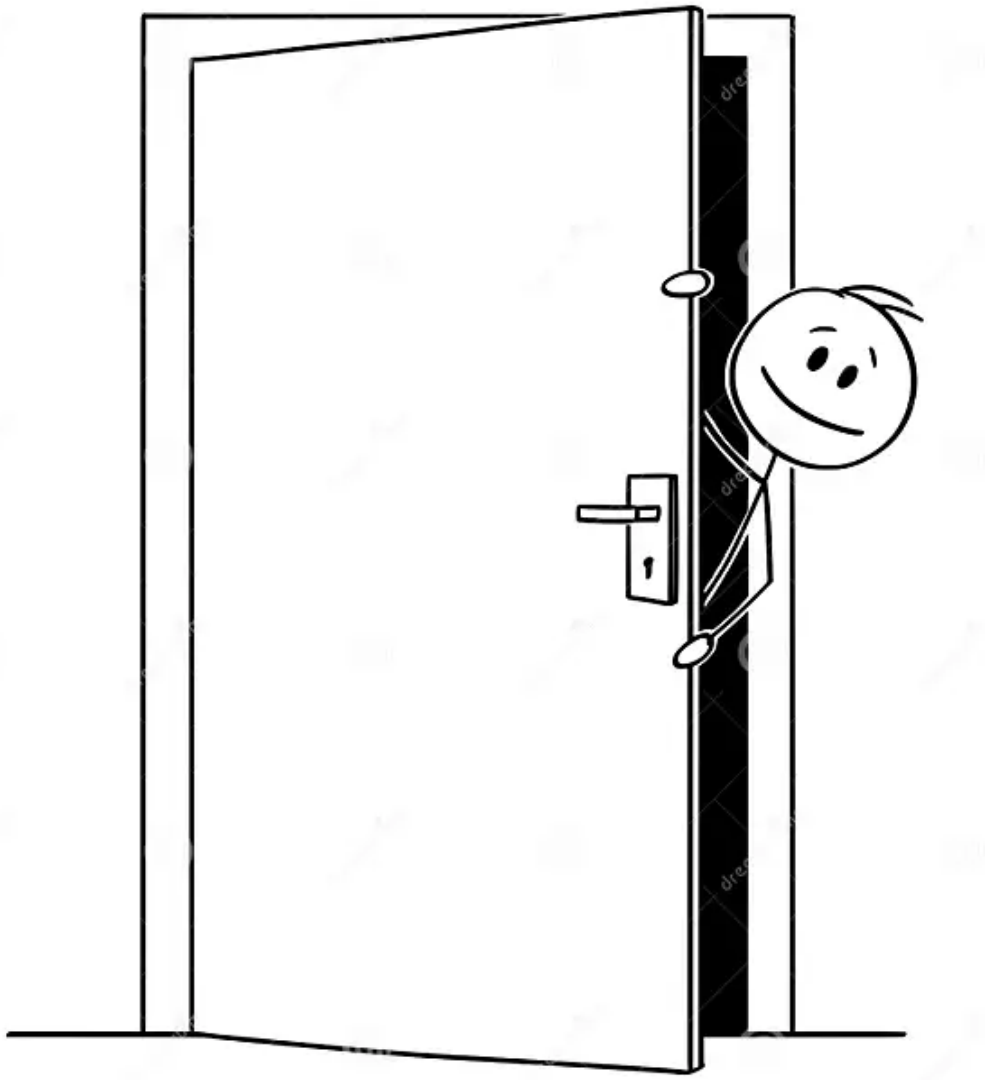
Modern · Dependable

Servizi territoriali
COMUNITA’

Cosa c’è “fuori”?

Quali professionisti?

Quali
rischi/opportunità?



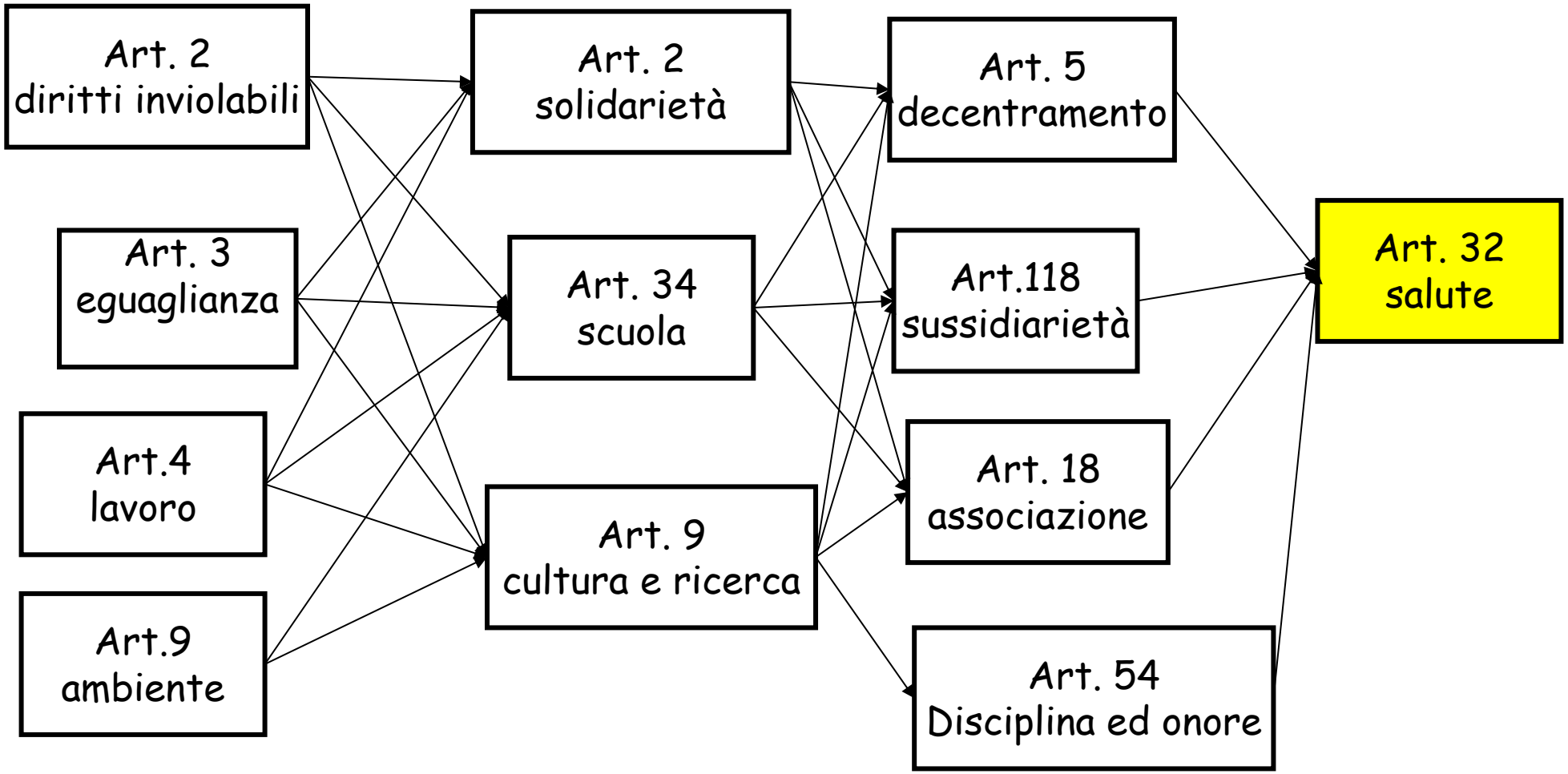
Articolo 54

Tutti i cittadini hanno il dovere di essere fedeli alla Repubblica e di osservarne la Costituzione e le leggi.

I cittadini cui sono affidate funzioni pubbliche hanno il dovere di adempierle con disciplina ed onore, prestando giuramento nei casi stabiliti dalla legge.

La professione

«DISCIPLINA»
Costituzione, sanità pubblica e Servizio Sanitario Nazionale
DIRITTO ALLA SALUTE



professione

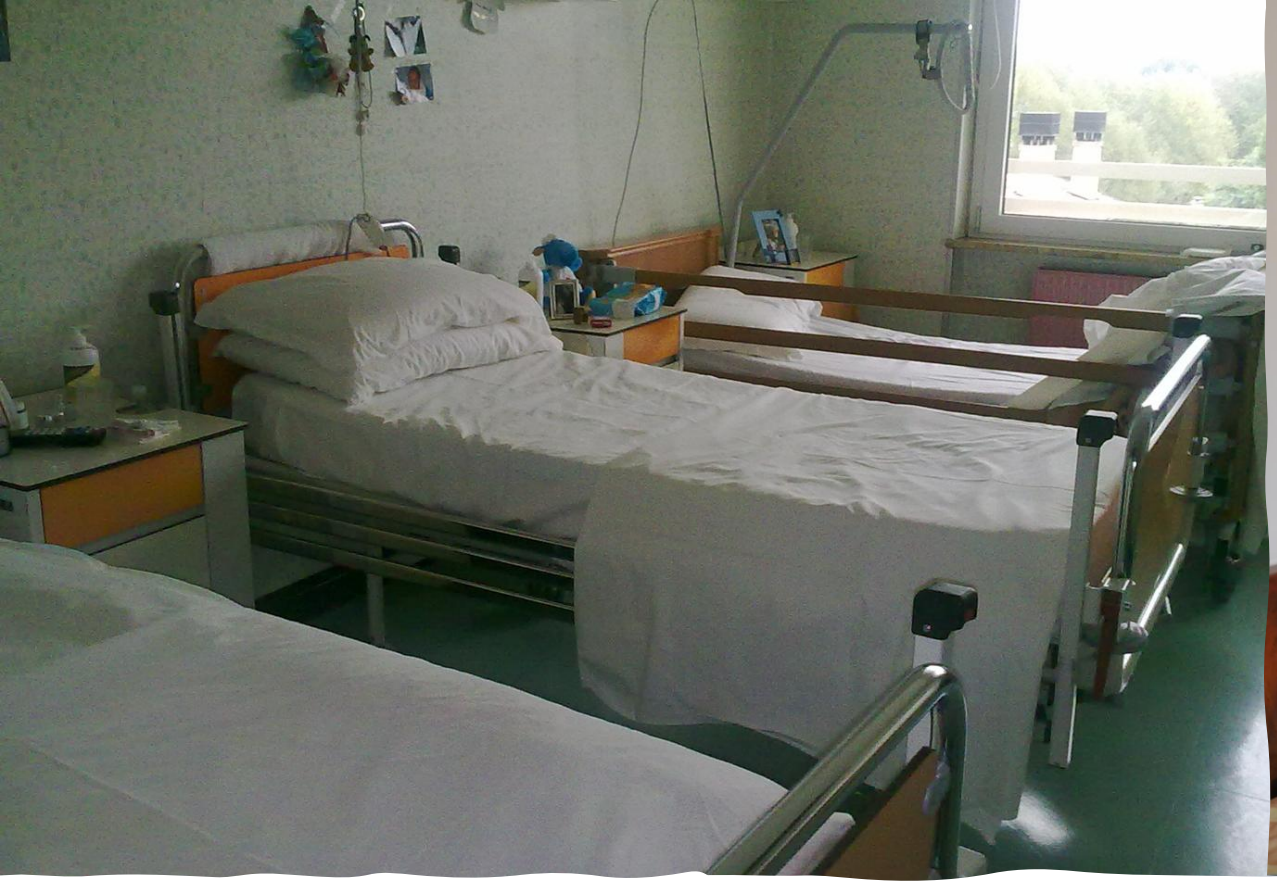
- Ruolo di sapere
- Ruolo civile
- Ruolo di comunità

L’istituzione azienda

che presenti in Parlamento).

Rimettere al centro del dibattito sulle istituzioni la loro natura di Cosa pubblica significa ribadirne la funzione di civiltà e in particolare il fatto che la loro vocazione è di essere allo stesso tempo *di tutti e di ciascuno*. Un’istituzione deve in sostanza porsi al servizio di un territorio e di una collettività senza, come si dice, lasciare indietro nessuno: pur rispondendo alle necessità su larga scala di una certa fascia di popolazione – il bisogno di cure, di istruzione, di servizi –, non dovrebbe perdere di vista la specificità delle realtà che intercetta e dovrebbe, nei limiti del possibile, recepire la declinazione singolare della domanda, esplicita o latente, che ogni soggetto porta con sé. L’uso dei condizionali è d’obbli-

Lavorare nella comunità



Il luogo di cura e la cultura di cura

Il corpo

«Noi desideriamo che il nostro corpo sia rispettato, tracciamo dei limiti che corrispondono alle nostre esigenze, costruiamo un’abitazione al nostro corpo»

Franco Basaglia

«Il paradosso principale degli anziani fragili. Per noi vogliamo l’autonomia, per chi amiamo la sicurezza.»

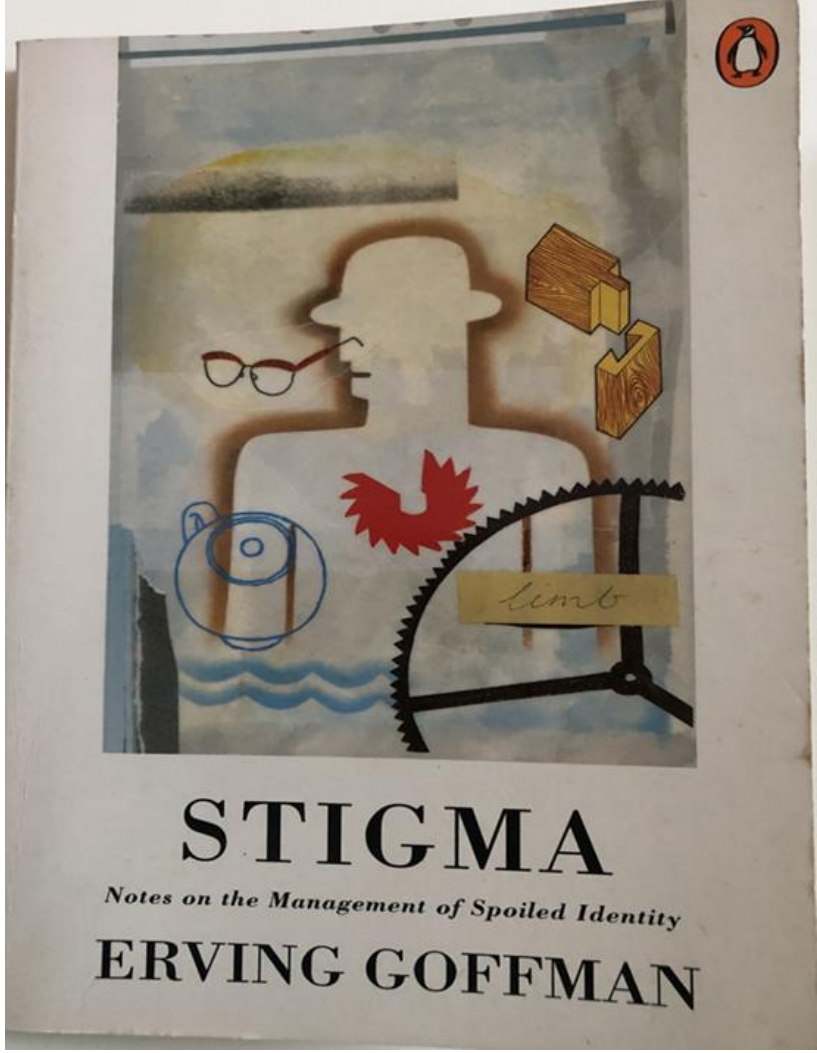
«Molte delle cose che vogliamo per chi ci è caro sono le stesse che noi rifiuteremmo categoricamente, in quanto violerebbero il nostro senso di identità.»

ATUL GAWANDE

ESSERE MORTALE

COME SCEGLIERE LA PROPRIA VITA FINO IN FONDO

Stigma



stereotipi (come pensiamo)
pregiudizi (come «sentiamo»)
discriminazioni (come agiamo verso le persone in base alle loro caratteristiche)

Stigma e situazioni /pazienti

Table 1. Frequent Physician Responses to Commonly Encountered Situations and Patient Types.

Situation	Physician's Emotional Response	Physician's Behavioral Response
Terminal illness/chronic incurable disease[9-11]	Sympathetic identification; feelings of inadequacy, impotence, lowered self-esteem, frustration	Denial, reluctance to discuss illness with patient, avoidance of patient and family
Patient in emotional crisis; physician lacks time or skill to treat emotional aspects	Feelings of helplessness, loss of control, inadequacy	Failure to obtain consultation or refer patient
Institutionally determined termination of relationship (rotation or completion of residency)[12]	Guilt, sadness	Procrastination or failure to inform patient
Patient Type		
Organic brain syndrome/dementia; language/cultural differences; inability to understand explanations of disease or treatment	Impatience, frustration	Hostility, rejection (abruptnes avoidance, minimizing seri ness of symptoms)
Hostile patient/borderline personality[13,14]	Taking patient hostility personally; hatred; feeling authority threatened	Reciprocal hostility, rejection (power struggle, derision, forced discharge)
Overly dependent patient[15]	Initial gratification, followed by resentment, anger, impatience, guilt	Hostility, abrupt distancing, coldness
Hypochondriacal patient[16]	Impatience, frustration, anger	Rejection (derision, avoidance, prescription given out of exasperation)
Antisocial/self-destructive patient	Disapproval, anger	Punitive hostility, rejection (neglect or overtreatment)
Noncompliant patient	Sense of loss of control, threatened authority; frustration; anger	Hostility, rejection, denial (power struggle, loss of interest)

SPECIAL ARTICLE

PHYSICIANS' REACTIONS TO PATIENTS

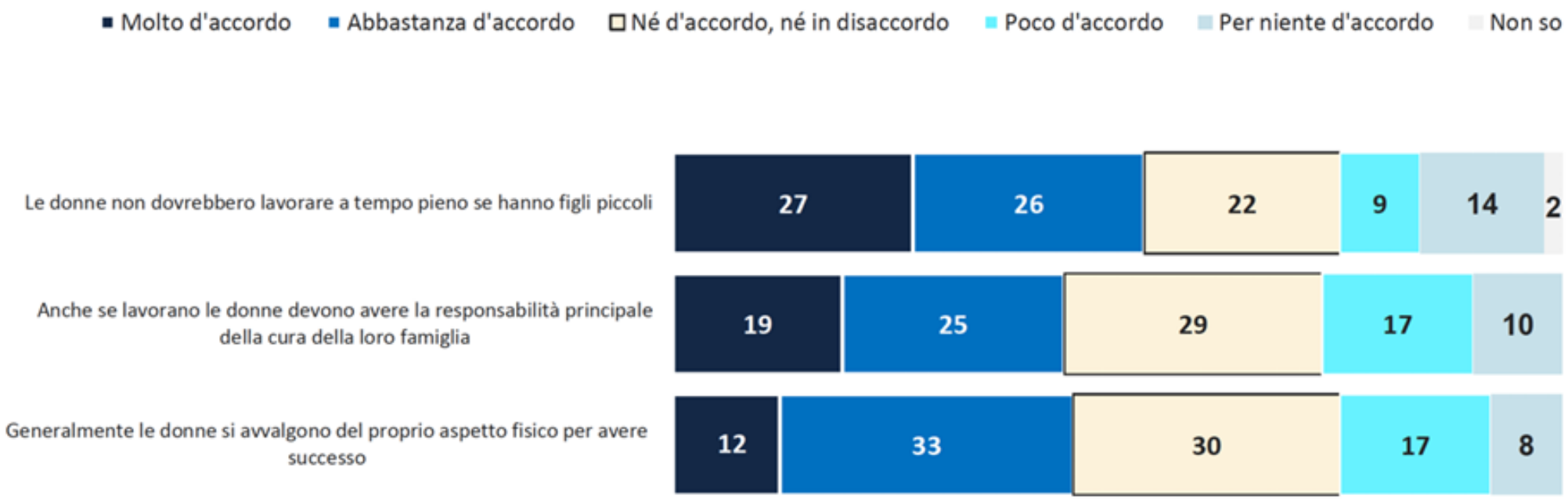
A Key to Teaching Humanistic Medicine

Richard Gorlin, M.D., and Howard D. Zucker, M.D.

Stigma e donne

LA SFERA PROFESSIONALE: LA DONNA NELL' IMMAGINARIO DEGLI ITALIANI

ST1. Indichi il suo grado di accordo con le seguenti affermazioni.



Salute mentale e mortalità precoce

Life expectancy and years of potential life lost in people with mental disorders: a systematic review and meta-analysis

Joe Kwun Nam Chan,[a] Christoph U. Correll,[b,c,d] Corine Sau Man Wong,[e] Ryan Sai Ting Chu,[a] Vivian Shi Cheng Fung,[a] Gabbie Hou Sem Wong,[a] Janet Hiu Ching Lei,[a] and Wing Chung Chang[a,f,]*

[a]LKS Faculty of Medicine, Department of Psychiatry, The University of Hong Kong, Hong Kong, China
[b]Department of Psychiatry, The Zucker Hillside Hospital, Northwell Health, Glen Oaks, NY, USA
[c]Department of Psychiatry and Molecular Medicine, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, NY, USA
[d]Department of Child and Adolescent Psychiatry, Charité - Universitätsmedizin Berlin, Berlin, Germany
[e]LKS Faculty of Medicine, School of Public Health, The University of Hong Kong, Hong Kong, China
[f]State Key Laboratory of Brain and Cognitive Sciences, The University of Hong Kong, Hong Kong, China

Summary

Background Mental disorders are associated with premature mortality. There is increasing research examining life expectancy and years-of-potential-life-lost (YPLL) to quantify the disease impact on survival in people with mental disorders. We aimed to systematically synthesize studies to estimate life expectancy and YPLL in people with any and specific mental disorders across a broad spectrum of diagnoses.

eClinicalMed
2023;65: 10
Published Onli
October 2023
https://doi.o
1016/j.eclinm
102294

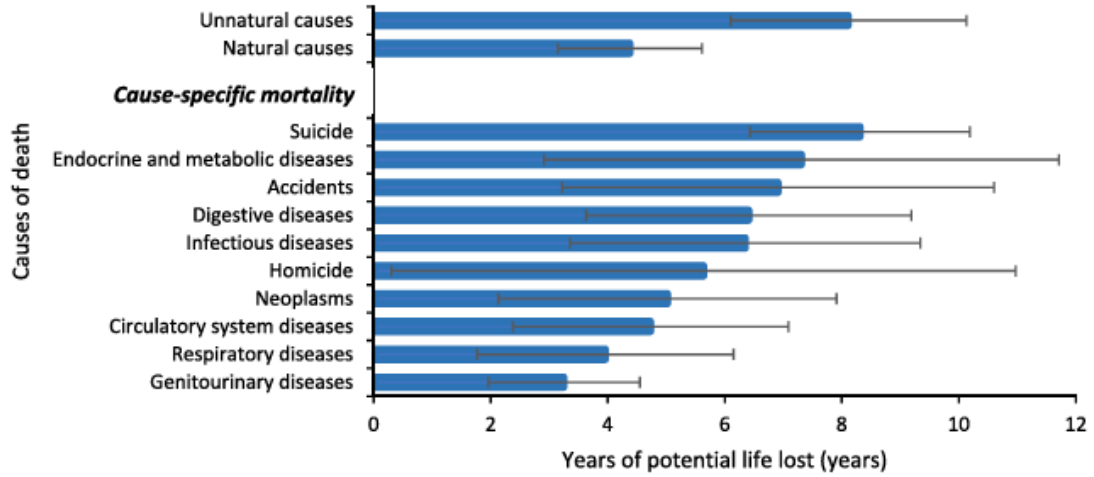


Fig. 5: Years of potential life lost (YPLL) of people with any mental disorders relative to the general population with same death cause.

Le disuguaglianze

«Perché curare le persone e riportarle alle condizioni che le hanno fatte ammalare?»

Michael Marmot 2018

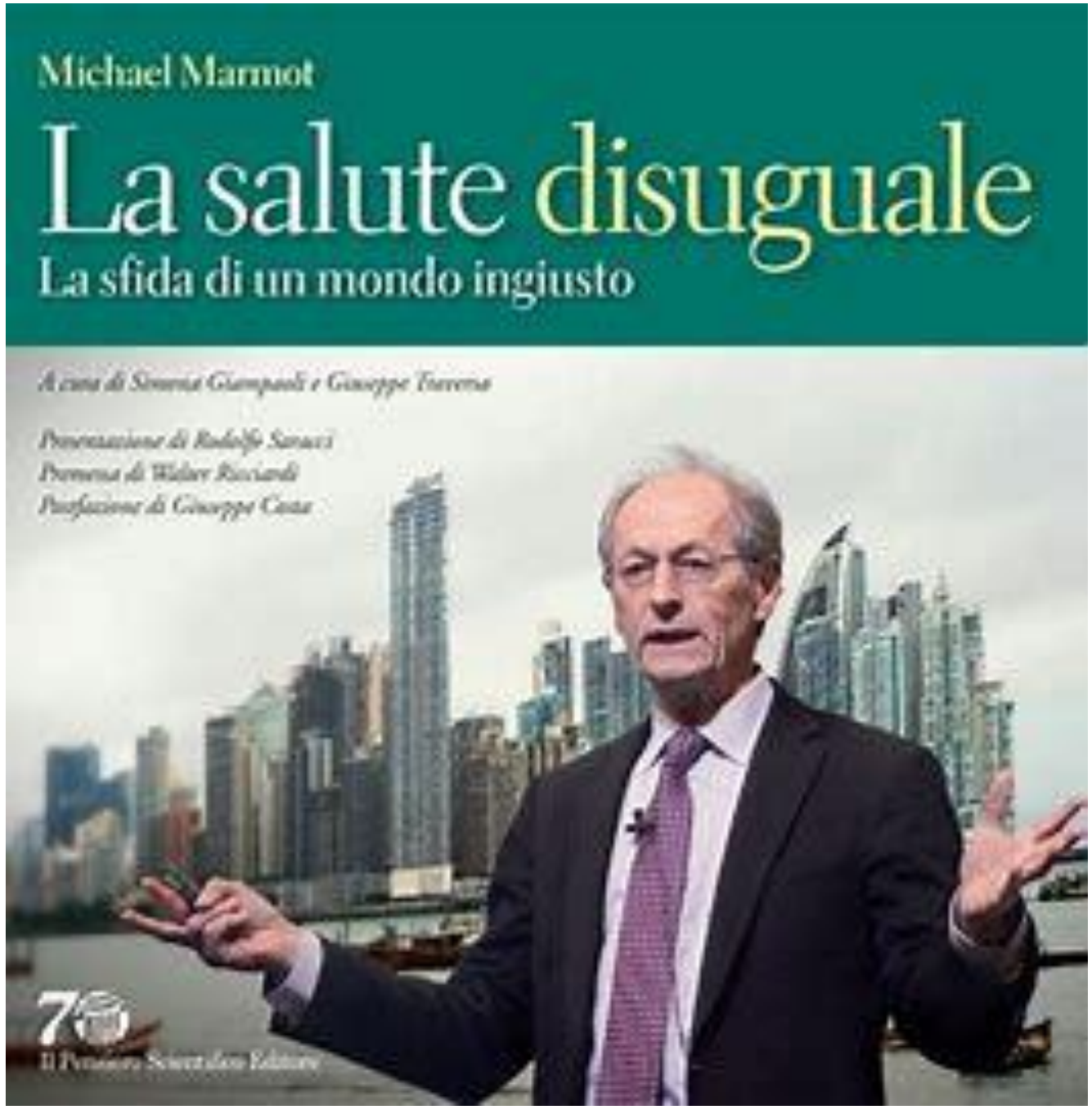
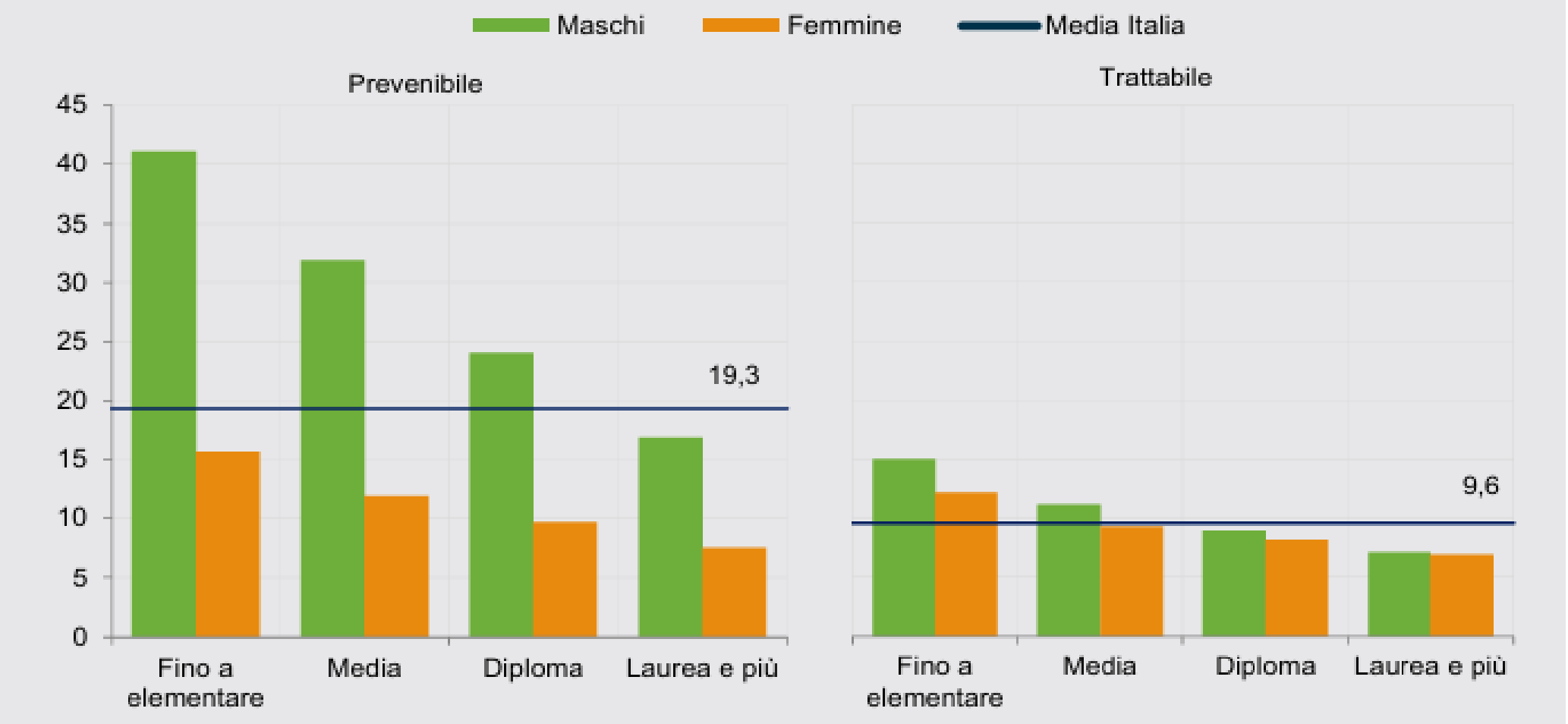
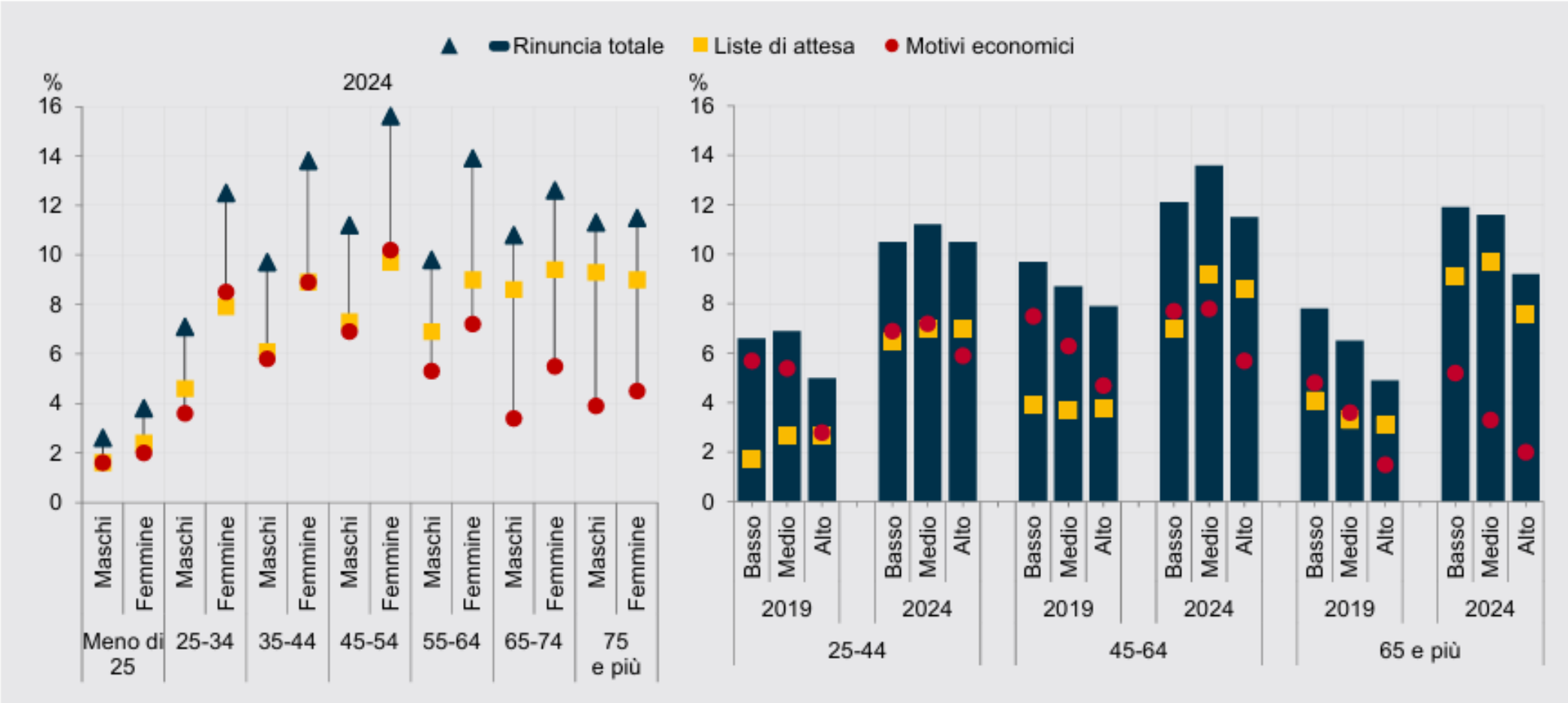


Figura 1 Tassi di mortalità prevenibile e trattabile per titolo di studio e sesso. Anno 2021
(decessi per 10 mila abitanti)

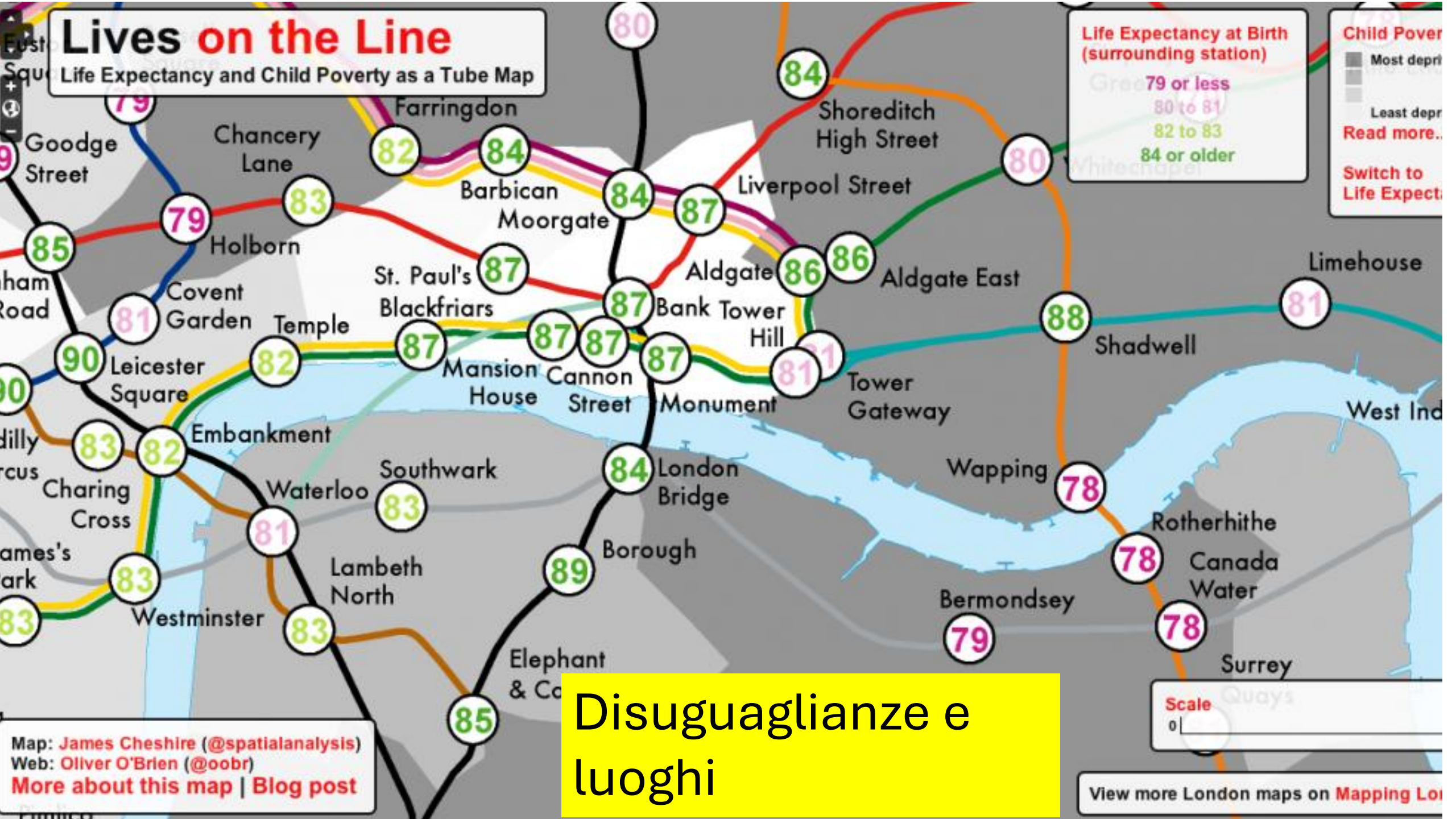


Fonte: Istat, Indagine su decessi e cause di morte

Figura 2.19 Persone che dichiarano di avere rinunciato negli ultimi 12 mesi a prestazioni sanitarie (visite ed esami specialistici) per motivo, classe di età e sesso (sinistra), e titolo di studio (destra). Anni 2019 e 2024 (valori percentuali)



Fonte: Istat, Indagine multiscopo sugli aspetti della vita quotidiana

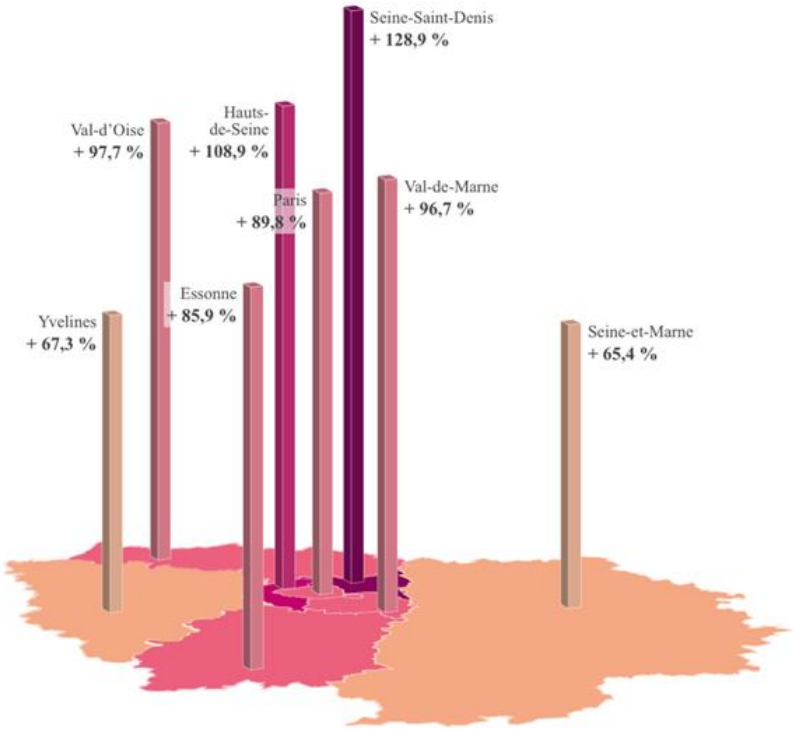

Lives on the Line
Life Expectancy and Child Poverty as a Tube Map
Life Expectancy at Birth (surrounding station)
79 or less
80 to 81
82 to 83
84 or older
Child Poverty
Most deprived
Least deprived
Read more...
Switch to Life Expectancy
Farringdon
Shoreditch High Street
Chancery Lane
Barbican
Moorgate
Liverpool Street
Goodge Street
Holborn
St. Paul's
Blackfriars
Aldgate
Aldgate East
Limehouse
Covent Garden
Temple
Bank
Tower Hill
Shadwell
Leicester Square
Mansion House
Cannon Street
Monument
Tower Gateway
Embankment
Southwark
London Bridge
Wapping
Charing Cross
Waterloo
Borough
Rotherhithe
Lambeth North
Canada Water
Westminster
Bermondsey
Elephant & Castle
Surrey Quays
Scale
0
Map: James Cheshire (@spatialanalysis)
Web: Oliver O'Brien (@oobr)
More about this map | Blog post
View more London maps on Mapping Lon
Disuguaglianze e luoghi

09:10 Dom 17 mag
32%
EN DIRECT

Le département le plus jeune et le plus pauvre de France paie un lourd tribut à la pandémie du Covid-19.

Taux de surmortalité départementale observé entre le 1er mars et le 27 avril

Evolution des décès cumulés du 1er mars au 27 avril 2020 rapportés aux décès cumulés du 1er mars au 27 avril 2019



Méthodologie : pour l'Ile-de-France, la surmortalité est représentée au département de résidence des personnes décédées. Pour la carte de la Seine-Saint-Denis, la surmortalité est représentée au lieu de décès de la personne (la donnée au lieu de résidence n'étant pas disponible) pour les habitants de ce département, les personnes résidant hors de Seine-Saint-Denis (mais y étant décédées) ont été exclues de ces calculs.

I numeri nelle città metropolitane

I divari nel reddito medio dichiarato (2023) e nei livelli di istruzione nelle 14 città metropolitane. A confronto i valori nel capoluogo (centro) e negli altri Comuni (periferia), con il dettaglio dei quartieri più ricchi e più poveri

I LIVELLI DI ISTRUZIONE

Laureati o dottori di ricerca ogni 100 abitanti

Fonte: elaborazione Sole 24 Ore su dati ministero delle Finanze, Istat e Scenari Immobiliari

Friuli Venezia Giulia - Anni di vita persi 2016-2020 per distretto -maschi

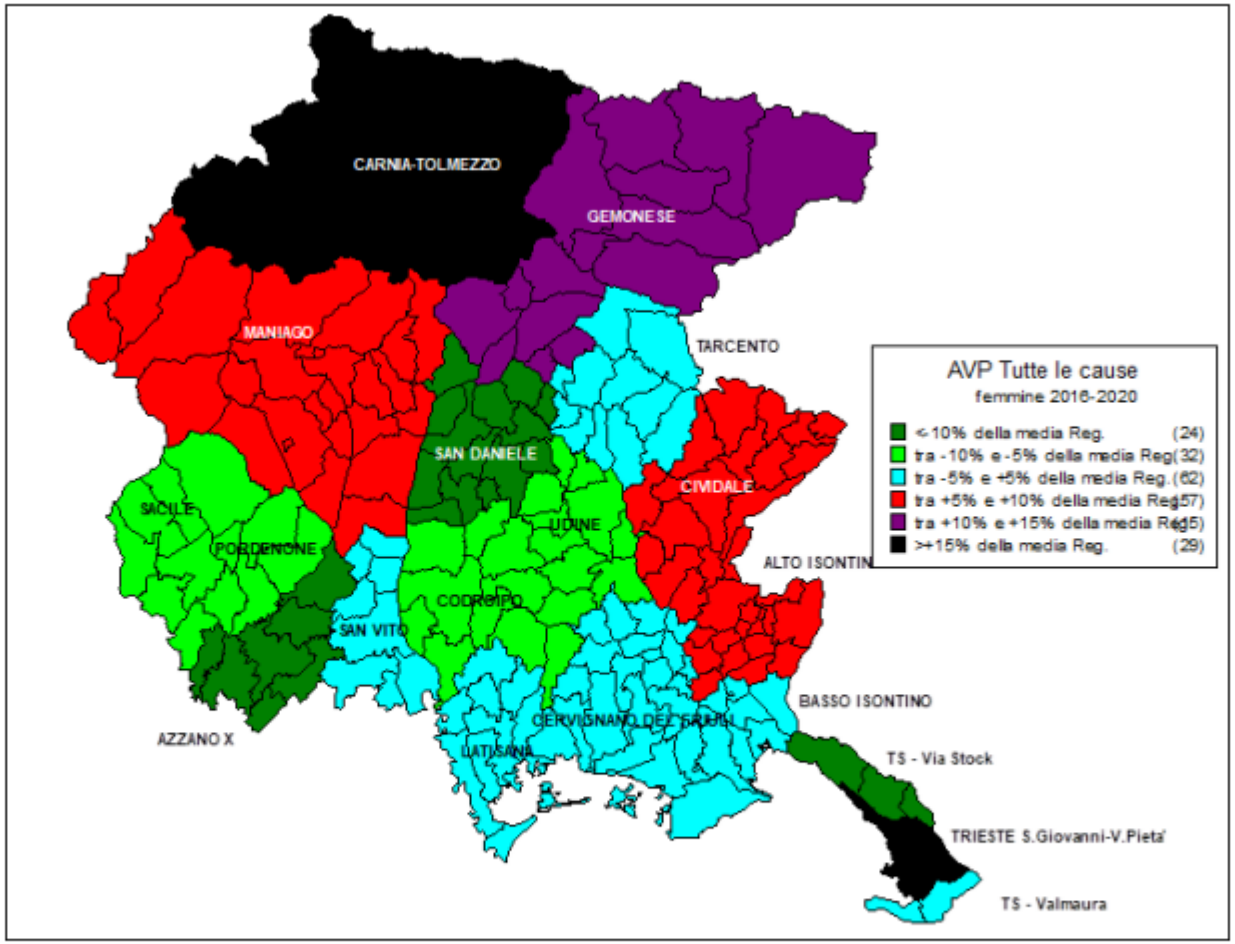


Figura 16: Tasso standardizzato di AVP per tutte cause per Distretto in rapporto al valore regionale. Quinquennio 2016-2020. Popolazione femminile.

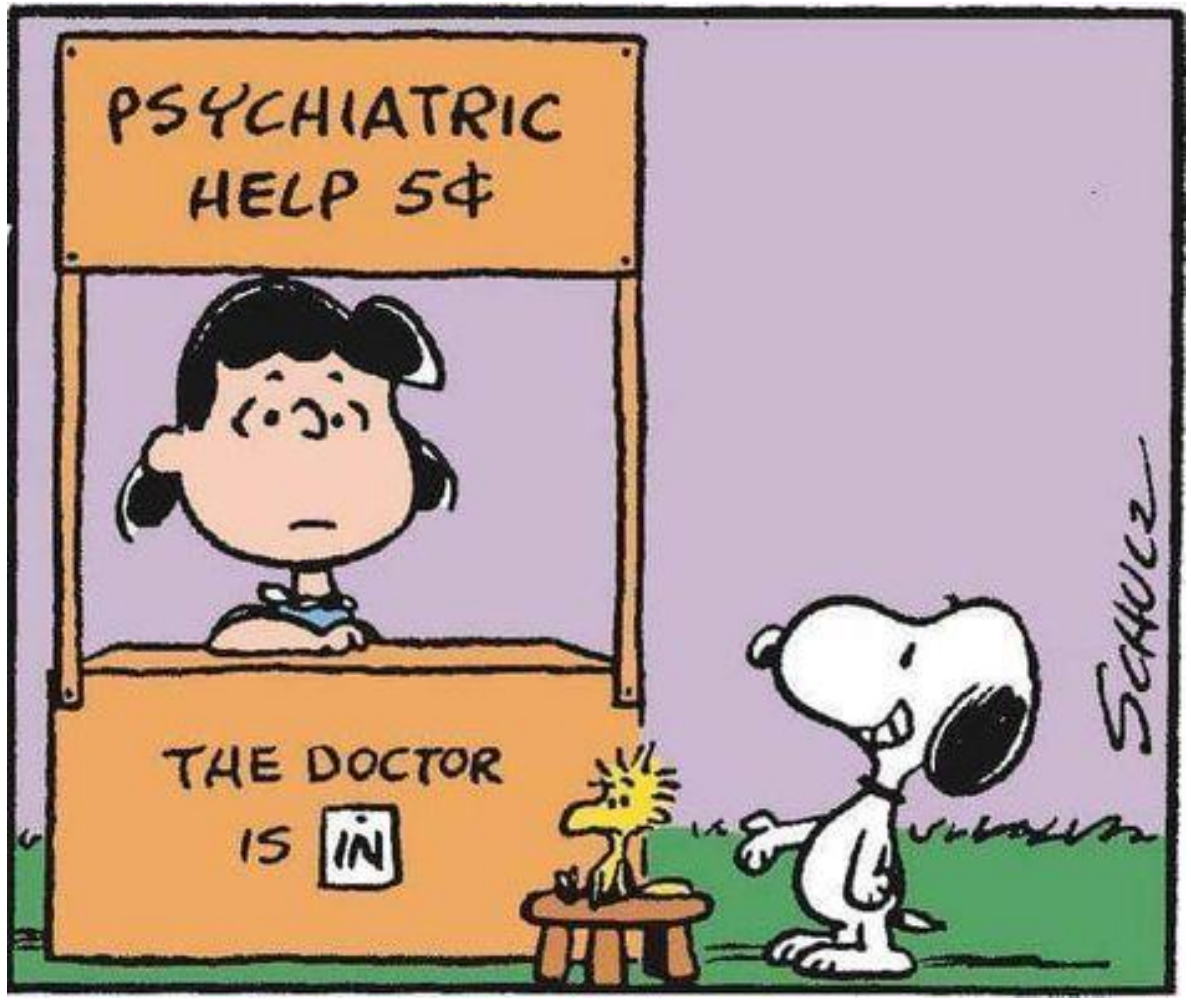
CONFINI

Gorizia
Settembre 1947

Silos vecchi e nuovi

- Servizi
- Professioni
- Culture
- PDTA
- Istituzioni
- Diagnosi
- Finanziamenti

La diagnosi

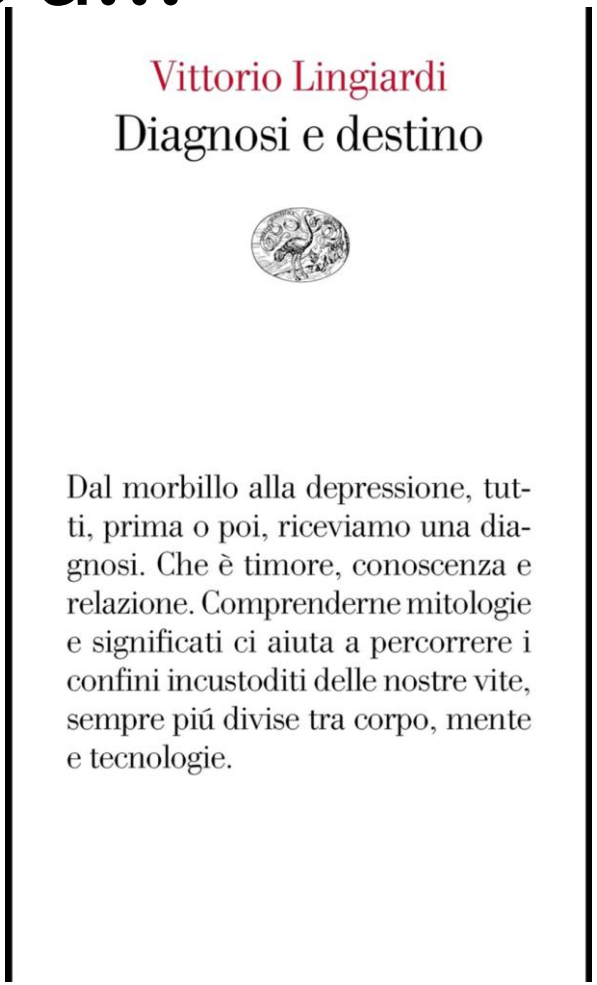


La diagnosi si usa per…

- Programmare la cura
- Fare prognosi
- Classificare
- Definire chi paga
- Erogare contributi
- Misurare
- Certificare

La diagnosi usata male può portare a…

- Stigma
- Resa
- Pregiudizi
- Semplificazione
- Errori
- Danni
- Separazione dei servizi



ARTICLE

On Being Sane in Insane Places

D. L. ROSENHAN Authors Info & Affiliations

SCIENCE • 19 Jan 1973 • Vol 179, Issue 4070 • pp. 250-258 • DOI: 10.1126/science.179.4070.250

7.530 1.298

Abstract

It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment—the powerlessness, depersonalization, segregation, mortification, and self-labeling—seem undoubtedly

L'ospedale psichiatrico St. Elizabeths Hospital, Washington, D.C., Stati Uniti d'America, uno dei luoghi dell'esperimento Rosenhan

L'ESPERIMENT0

PSEUDOPATIENTS AND THEIR SETTINGS

The eight pseudopatients were a varied group. One was a psychology graduate student in his 20s. The remaining seven were older and "established." Among them were three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife. Three pseudopatients were women, five were men. All of them em-

IL «COME»

After calling the hospital for an appointment, the pseudopatient arrived at the admissions office complaining that he had been hearing voices. Asked what the voices said, he replied that they were often unclear, but as far as he could tell they said "empty," "hollow," and "thud." The voices were unfamiliar and were of the same sex as the pseudopatient. The choice

IN OSPEDALE

Immediately upon admission to the psychiatric ward, the pseudopatient ceased simulating *any* symptoms of abnormality. In some cases, there was a brief period of mild nervousness and anxiety, since none of the pseudopatients really believed that they would be admitted so easily. Indeed, their shared fear was that they would be immediately exposed as frauds and greatly embarrassed. More-

LA DIMISSIONE

Despite their public "show" of sanity, the pseudopatients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia,[10] each was discharged with a diagnosis of schizophrenia "in remission." The label "in remission" should in no way be dismissed as a formality, for at no time during any hospitalization had any question been raised about any pseudopatient's simulation.

GLI SCETTICI

could be reversed. The following experiment was arranged at a research and teaching hospital whose staff had heard these findings but doubted that such an error could occur in their hospital. The staff was informed that at some time during the following 3 months, one or more pseudopatients would attempt to be admitted into the psychiatric hospital. Each

RISULTATI 2

Judgments were obtained on 193 patients who were admitted for psychiatric treatment. All staff who had had sustained contact with or primary responsibility for the patient — attendants, nurses, psychiatrists, physicians, and psychologists — were asked to make judgments. Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. Twenty-three were considered suspect by at least one psychiatrist. Nineteen were suspected by one psychiatrist *and* one other staff member. Actually, no genuine pseudopatient (at least from my group) presented himself during this period.

GLI «OSSERVATORI PRIVILEGIATI»

patients' sanity. During the first three hospitalizations, when accurate counts were kept, 35 of a total of 118 patients on the admissions ward voiced their suspicions, some vigorously. "You're not crazy. You're a journalist, or a professor [referring to the continual notetaking]. You're checking up on the hospital." While most

LE CONCLUSIONI

traits. Once a person is designated abnormal, all of his other behaviors and characteristics are colored by that label. In-

RESEARCH

OPEN ACCESS

Pathologists' diagnosis of invasive melanoma and melanocytic proliferations: observer accuracy and reproducibility study

Joann G Elmore,[1] Raymond L Barnhill,[2] David E Elder,[3] Gary M Longton,[4] Margaret S Pepe,[4] Lisa M Reisch,[1] Patricia A Carney,[5] Linda J Titus,[6] Heidi D Nelson,[7,8] Tracy Onega,[9,10] Anna N A Tosteson,[11] Martin A Weinstock,[12,13] Stevan R Knezevich,[14] Michael W Piepkorn[15,16]

BMJ: first
Prot

(BMJ 2017;357:j2813)

Metodologia dello studio

- Studio osservazionale su accuratezza e riproducibilità.
- 187 patologi da 10 stati USA.
- 240 biopsie cutanee (sovra-rappresentazione di casi difficili).
- Due fasi di valutazione a 8 mesi di distanza (stesso set biopsie).
- Classificazione MPATH-Dx (classi I-V).

Table 3 | Intraobserver concordance of 118 pathologists' interpretations of melanocytic skin biopsy lesions of the same case at phase 1 and phase 2 at least eight months apart*

Phase 1 diagnosis	Phase 2 diagnosis (No of paired interpretations)						Intraobserver concordance† % (95% CI)
	Class I	Class II	Class III	Class IV	Class V	Total	
Class I	**1155**	188	119	27	17	**1506**	77 (73 to 80)
Class II	170	**227**	182	37	28	**644**	35 (31 to 39)
Class III	91	120	**653**	169	58	**1091**	60 (56 to 63)
Class IV	20	37	147	**531**	105	**840**	63 (59 to 67)
Class V	14	16	44	105	**852**	**1031**	83 (80 to 85)
Total	**1450**	**588**	**1145**	**869**	**1060**	5112	67‡ (65 to 69)

Numbers of diagnostic interpretations with intraobserver agreement are emboldened.
*Concordance rates are influenced by case composition, which included larger proportions of cases in classes II-V than would typically be encountered in practice.
†Denominator is phase 1 interpretations and numerator is phase 2 assessments that agreed with phase 1 interpretation. Does not include participants who reviewed glass slides in phase 1 and digital images in phase 2.
‡Average κ for intraobserver agreement across participants is 0.57.

Concordanza intra- osservatore

67%

Table 4 | Interobserver concordance of pathologists' interpretations of melanocytic skin biopsy lesions. Pairwise comparison of interpretations by 187 participating pathologists in phase 1. Diagnoses for all possible ordered pairs of participants reading the same glass slide are included*

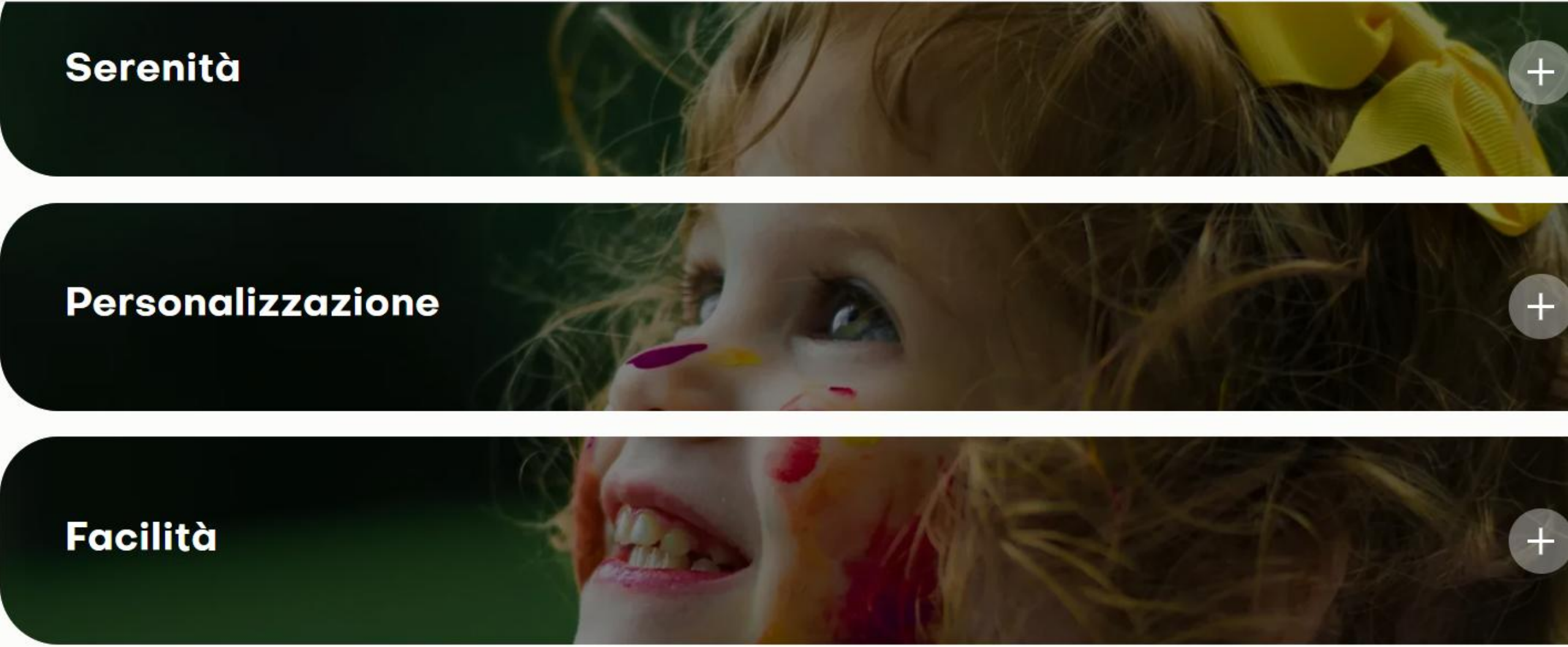
First pathologist's interpretation	Second pathologist's interpretation						Interobserver concordance % (95% CI)
	Class I	Class II	Class III	Class IV	Class V	Total	
Class I	**64 122**	15 082	11 223	2993	1773	**95 193**	71 (69 to 73)
Class II	15 082	**10 366**	11 028	3974	1903	**42 353**	25 (22 to 27)
Class III	11 223	11 028	**31 326**	12 675	4494	**70 746**	45 (42 to 47)
Class IV	2993	3974	12 675	**22 334**	8854	**50 830**	46 (43 to 49)
Class V	1773	1903	4494	8854	**50 926**	**67 950**	77 (75 to 79)
Total	**95 193**	**42 353**	**70 746**	**50 830**	**67 950**	327 072	55† (53 to 56)

Numbers of interpretations with agreement are emboldened.
*Average pairwise agreement is an unweighted average across all participant pairs. The number of first pathologist interpretations for a given diagnostic class varies across pairs. Concordance rates are influenced by case composition, which included larger proportions of cases in classes II-V than would typically be encountered in practice. There are 6814 distinct order participant pairs ×48 case interpretations per pair yielding 327 072 interpretations.
†Average κ for interobserver agreement across all participant pairs is 0.42.

Concordanza inter- osservatorì

55%

Da diritto alla salute e diritti del consumatore?



Velocità

Accedi a visite mediche ed esami in tempi brev

Chiamaci per l'acquisto

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I centri convenzionati sono relativi alle polizze acquistate tramite canale digitale.

Scopri i centri convenzionati

Toscana

Oltre 790 centri convenzionati disponibili in Tosca

Chiamaci per l'acquisto

Conclusioni

NEJM 2016 Nov 3;375(18):1713-1715

BECOMING A PHYSICIAN

Tolerating Uncertainty — The Next Medical Revolution?

Arabella L. Simpkin, B.M., B.Ch., M.M.Sc, and Richard M. Schwartzstein, M.D.

"At once it struck me what quality went to form a Man of Achievement . . . when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason."

— *John Keats, December 1817*[1]

These words penned by John Keats, who was a physician as well as a poet, remind us of the human struggle to live in a gray-scale space where uncertainty is rife — a space that is neither black nor white. Our quest for certainty is central to human psychology, however, and it both guides and misguides us.

Although physicians are rationally aware when uncertainty exists, the culture of medicine evinces a deep-rooted unwillingness to acknowledge and embrace it. Embodied in our teaching, our case-based learning curricula, and our research is the notion that iterative and evolutionary nature of clinical reasoning — is the very antithesis of humanistic, individualized patient-centered care.

We believe that a shift toward the acknowledgment and acceptance of uncertainty is essential — for us as physicians, for our patients, and for our health care system as a whole. Only if such a revolution occurs will we thrive in the coming medical era.

In medicine today, uncertainty is generally suppressed and ignored, consciously and subconsciously. Its suppression makes intuitive sense: being uncertain instills a sense of vulnerability in us — a sense of fear about what lies ahead. It is unsettling and makes us crave black-and-white zones, to escape this gray-scale space. Our protocols and checklists emphasize the black-and-white aspects of medicine. Doctors often fear that by expressing uncertainty, they will project

seem, intuitively, to be a tolerance for uncertainty and a curiosity about the unknown. Have we created a culture that ignores and denies that requirement? Could our intolerance of uncertainty, in turn, be contributing to the accelerating rates of burnout and the rising cost of health care? For there is no doubt that absolute truth and certainty are hard to come by in clinical medicine.

Great tensions are created by the conflict between the quest for

The Last Dose

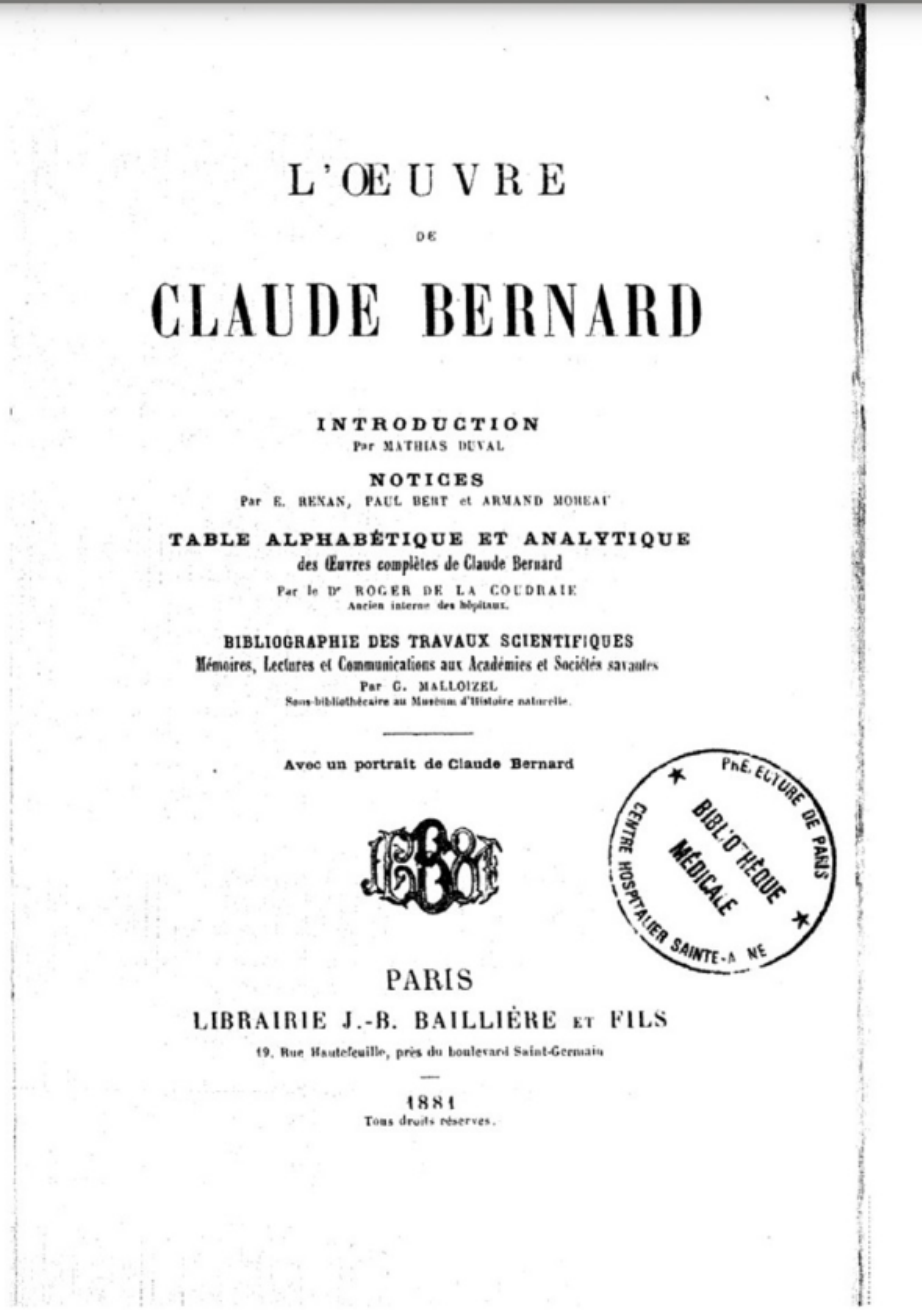
N ENGL J MED 392;18 NEJM.ORG MAY 8, 2025

David N. Korones, M.D.[1]

giving Zoila and his family the space to hope, but hoping with them, and doing whatever it took to get her that last dose. Looking back, I know that there was more than medicine in that little brown bag: there was hope.

«Quello che già conosciamo è il principale ostacolo alla crescita della conoscenza»

Claude Bernard



L'ŒUVRE

DE

CLAUDE BERNARD

INTRODUCTION

Par MATHIAS DUVAL

NOTICES

Par E. RENAN, PAUL BERT et ARMAND MOREAU

TABLE ALPHABÉTIQUE ET ANALYTIQUE

des Œuvres complètes de Claude Bernard

Par le Dr ROGER DE LA COUDRAIE

Ancien interne des hôpitaux.

BIBLIOGRAPHIE DES TRAVAUX SCIENTIFIQUES

Mémoires, Lectures et Communications aux Académies et Sociétés savantes

Par G. MALLOIZEL

Sous-bibliothécaire au Muséum d'Histoire naturelle.

Avec un portrait de Claude Bernard

PHÉ. ECTURE DE PARIS
BIBL·O·THÈQUE
MÉDICALE
CENTRE HOSPITALIER SAINTE-A NE

PARIS

LIBRAIRIE J.-B. BAILLIÈRE ET FILS

19, Rue Hautefeuille, près du boulevard Saint-Germain

1881

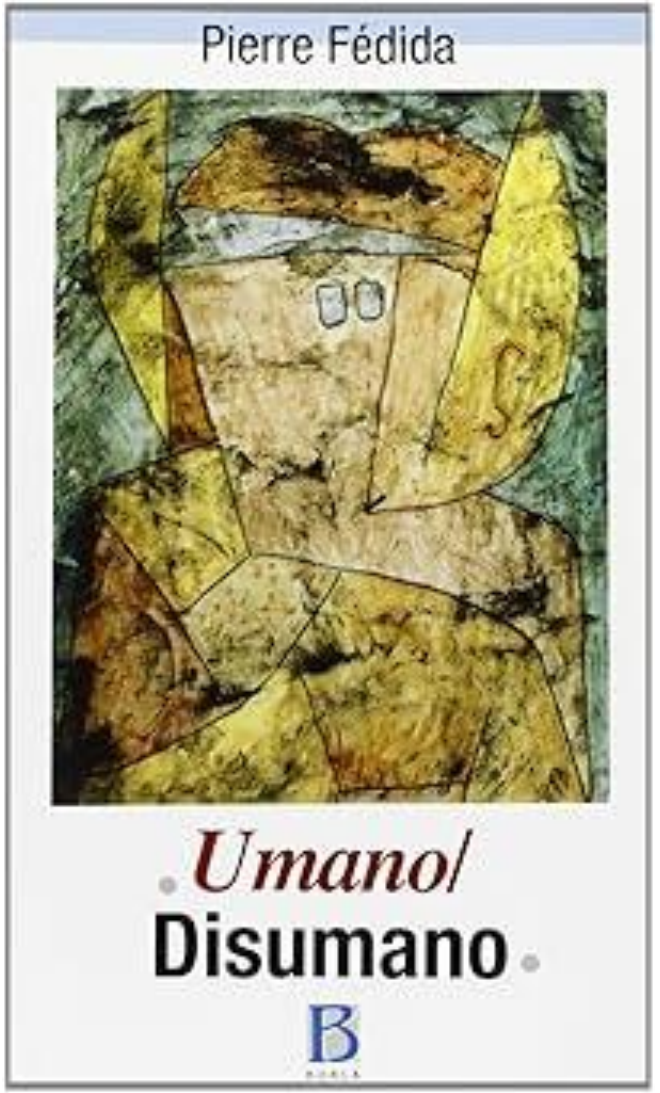
Tous droits réservés.

Key message

«Vi è un’età in cui si insegna ciò che si sa; ma poi ne viene un’altra in cui si insegna ciò che non si sa: questo si chiama cercare»

«Finché è possibile sognare non ci avranno»

Pierre Fédida



Articolo 54

Tutti i cittadini hanno il dovere di essere fedeli alla Repubblica e di osservarne la Costituzione e le leggi.

I cittadini cui sono affidate funzioni pubbliche hanno il dovere di adempierle con disciplina ed onore, prestando giuramento nei casi stabiliti dalla legge.

Grazie dell’attenzione