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Medical Anthropology "at Home": a conceptual framework and the Italian experience

Tullio Seppilli

Sezione Antropologica, Dipartimento Uomo & Territorio, Università degli Studi di Perugia (Italy) / Fondazione Angelo Celli per una Cultura della Salute (Perugia, Italy)

1.1.

As our present Conference in Tarragona shows, the consolidation of the project to hold periodical European encounters of a *medical anthropology* defined as *"at home"* requires in my view further examination of what this formula means.

Everyone knows that the question was discussed during the inaugural day of the preceding Conference, the first one, held in Zeist (The Netherlands) between 16th-18th April 1998 (1): already on that occasion there emerged extremely heterogeneous positions, stemming moreover from heterogeneous reference parameters. So we were uncertain about the suitability of keeping the term in use and, therefore, of conceptually maintaining the opposed coupling that distinguishes between an anthropology "at home" and an anthropology "abroad".

Indeed, the specification "at home" is often used to refer to research carried out in what were once called the metropolitan countries, namely the European or more generally the Western industrialised ones. In those countries anthropology was born and for a long time produced the greater part of ethnologists and social and cultural anthropologists, trained to do in research largely "elsewhere" in "other", different contexts, in areas of the world defined as "exotic", "primitive", "pre-industrial" or, more explicitly, in the "colonial" or (today) the "developing" countries. As against this, anthropology "at home" should be related to the modern industrialised world in which most anthropologists live, i.e. the European or more generally the technologically advanced Western world, in so far as this is a particular research field characterised in effect by several specific common features. This is, therefore, a sphere of anthropological research defined

by its specific *object* (a certain type of society) and at least to some extent by a specific territorial reference point. We should talk, in this case, of a *[medical] anthropology concerning European societies* or, in general, *concerning "Western"* or *industrialised* (or *highly technologically advanced*) *societies*.

As we know, this anthropology, both medical and (more generally) sociocultural too, dedicated as it was to the study of the institutions and cultural dynamics of industrialised societies, developed very little until a few decades ago. The field was partially covered by sociological research, on the implicit assumption that anthropological disciplines, to a certain extent, should concern themselves only with "primitive" or "other" societies and not "Western" ones [(2)]. In an essentially evolutionist perspective, the only aim assigned to anthropology with reference to these "Western" societies was to reconstruct in the "backward folkloric" areas the impoverished survivals of previous more ancient periods of civilisation [(3)]. As a consequence, anthropological attention was focused at the beginning on the knowledge and practices of health/sickness processes almost exclusively on the medical traditions of "primitive" or in any case extra-Western peoples or on folk medicine in the West. Anthropology focused on knowledge and practices that were classified as "superstitions" and that were considered essentially irrational and ineffective. The aim, then, was, certainly, to document but above all to extirpate.

I have already underlined the importance of such limits, that involve at the same time both theory and object of study. «Maybe the most incisive quality jump, the one which radically released and transformed the *whole* disciplinary framework of medical anthropology, and which greatly extended its critical dimension, modifying its relationships with other research fields and changing its operative directions, consisted in the resolute widening of its sphere. When medical anthropology overstepped the study of a mere 'alterity', that is to say the study of European folk medicine or of the non-Western or in any case "heterodox" medical systems, and began increasingly to face up to official Western medicine, studied therefore as just *one* of the many different medical systems that have existed in the world. Western medicine appears as different, because it is based on the scientific method (with all the presuppositions and implications it involves), but it is also, like other systems, a *social institution* and a *power structure* and, in any case, like the other it is a *historically-determined cultural-ideological and organisational apparatus*» (Seppilli, 1996:XIV-XV) [(4)].

In this perspective, much of the research carried out in recent decades has focused on the anthropological study of biomedicine, that is the medical system we must consider, in the West, hegemonic and therefore "conventional".

However, is it meaningful today for us, as anthropologists, to define "at home" as a research sphere only because it focuses on realities in the West or, in any case, in industrial societies? For we are dealing with realities to which not only Western researchers but those from elsewhere are turning their attention, others who were trained in the West and stayed on to work there, or who were even trained elsewhere, given the well-known growth of training centres and institutions of professional anthropology outside its original boundaries. In such cases what sense would there be in defining this type of enquiry as having been done "at home"? And moreover is it still legitimate and heuristic in the framework of the current processes of planetary interactions, to distinguish anthropological research concerning the West from anthropological research carried out "elsewhere"?

1.2.

I believe, instead, that the indication "at home" should stand for something more profound, namely not simply an *object* but a *condition* which can actually occur not only in Europe or throughout the West (or at least in a specific part of the world or in a particular kind of society), but in any area of the world. In other words the fact *the researcher and the object of research* (and therefore also the problems that give rise to the research and the social consequences that its results pursue) *are rooted in one and the same social context*. Medical anthropology "at home", then, is *research carried out by medical anthropologists in their own country* (and if we want to specifically refer to Europe, as *research carried out by European medical anthropologists in their own country*).

What implications does a definition of this sort have? What does it mean, for an anthropologist, to do research – "fieldwork", in particular – *in their own country [at home]* rather than in a context that is "different" from the daily one in which they live? What is the substantial difference when in the research field the person who investigates and the one investigated are rooted in the same context?

Let us look at some preliminary answers to this question. We are dealing with the question of research carried out by anthropologists in contexts which are at least partly the same as those of their own daily life. Certainly the anthropologist has first acquired a specific professional knowledge/approach. But in any case, life horizons and the cultural system on which points of view, references to the past, hierarchies of values and a wide set of codes and conventions are based, are mostly the same – or quite similar –

for both the poles of the research (the anthropologist and his object of enquiry). As we know, all this allows the researcher to take advantage of a useful general framework of knowledge and of valid readings of the reality being studied but, at the same time, it masks as apparently "obvious" several manifestations and connections that an outsider observer would immediately see as glaring. And in some way, it also involves the researcher, even subjectively, in the network of judgements and tensions that characterises relationships and reciprocal images between the various social groups of his/her own context. What follows, then, for the researcher, is an approach to the reality investigated that is concisely indicated, as we know, by the expression "view from within", in contrast to the "view from afar" of researchers studying cultures and societies in extraneous contexts. To this there must be added that, once the work has come to an end, when the researcher lives in the same place in which he does fieldwork – as usually happens in "at home" researches – a situation of a persistent responsibility emerges. There is a state of "indebtedness" of the researcher, and equally of "expectation", on the part of those who have been the object of the research, who expect some subjective or objective "benefit" (caused or not by the aims of the project or the researcher's intentions). This situation, even beyond its ethical-deontological values, ends up by affecting the processing and diffusion of the data gathered, the operating results that the research eventually gives rise to, and the future possibilities of working "at home" for the researcher himself. All this obviously happens to a very minor extent when the researchers, at the end of his fieldwork "abroad", calmly (cynically?) returns to their own country, where the only concrete "dependence" is the one that may join them to those who "commissioned" the research.

If we want to proceed, we must first of all "dismantle" any possible residual representation of the anthropologist as abstracted from their material and cultural context, from its internal contradictions and from the hegemonic and power processes that take place within this context. We must do so because the anthropologists themselves are "historically/socially determined" persons and cannot but share, at least in part, the conception of the world and a certain hierarchy of values of their society (although in a critical and sometimes opposed form). Also, because they are intellectuals (and more specifically because of their scientific knowledge of social realities), the operational outcomes of their work must to some extent influence the mechanisms and equilibria of the social system of which they are part, or in which they have to operate professionally. With regard to such equilibria, in fact, the social use of the results of the research, and the

specific choice of the object of enquiry, are not at all socially "neutral": they largely depend on powers external to the anthropologist's merely "technical" field. This is why in stratified social systems anthropologists have (partly, at least, and more or less consciously) the "organic" function of providing specialist support to the goals and strategies of a specific social class, or in any case of a specific power formation. They furnish cognitive platforms about the social realities in which such a formation intends to operate and help create and increase the awareness and efficacy of its planning strategies and act as a producer of themes and as a cultural mediator within the processes of hegemony and circulation of ideas by which this formation develops its policies of social control [(5)]. However, even in this field, (medical) anthropologists who operate "at home" and those who operate "abroad" seem to work in largely heterogeneous conditions, on which it would be opportune to conduct a more detailed analysis. What are the power formations power involved and in what perspective? What are the effective strategies of intervention in which the research is situated and what are the social groups and, in their different ways, the environmental contexts involved? When and in what professional conditions is research carried out; to what extent and with what methods and mediations are the research results used and, realistically, what are thus their operational applications?

1.3.

Finally, it may be opportune here to refer to an epistemological question which involves the very bases of medical anthropology and which clearly reveals itself when the object of anthropological research is biomedicine, for us Europeans *our* hegemonic medicine.

Certainly biomedicine has to be examined just like any other medical system, as a historical product rooted in a concrete and specific typology of society and culture. Besides, we have already emphasised that biomedicine is *also* a social institution, a power structure, and an ideological-cultural and organisational apparatus. In any case, the paradigm of biomedicine, and the criteria by which it characterises and classifies pathological states, establishes their etiopathogenesis and constructs the very concept of "illness". For medical anthropology all this has the value of one "emic" model on an equal footing with those formulated by other medical systems.

However, at the same time, biomedicine necessarily assumes a particular value for medical anthropology which derives from its own status and is

traceable to the common matrix of both their epistemological bases, i.e. in essence to the general bases of "scientific thought". What I mean here is that the parameters within which biomedicine studies the factors of a certain syndrome, or the action mechanisms of a given drug (or those within which it evaluates the efficacy of that drug) are found on a methodological horizon which is undoubtedly historically determined but which just because of certain of its rules appears to guarantee with a certain degree of approximation the "reliability" of even the conclusions, provisional and partial as may be, that we call "scientific constructs".

Therefore, apart from the evident heterogeneity of the methodological construction of "natural sciences" on the one hand and "socio-historical sciences" on the other – which it is not the case to go into here – biomedicine and medical anthropology share a common general epistemological basis, which is the "scientific conception of the world".

In such a framework, if biomedicine often possesses an image of pathology which is limited biologistically just to *disease* – a well known theme, for us – the "cognitive deficit", which stems from it and which corresponds to an ideological and practical limit on its own scientificity, clearly indicates that the discipline is insufficiently open while, however, not annulling the substantial reliability of its conclusions in the strictly biological field. Further, it is precisely this limit on biomedicine that anthropological research contributes to overcoming by an examination (which equally aims at being scientifical) of *illness* and *sickness*, that is to say the dimensions of pathology constituted by its subjective experience and its socio-cultural correlations.

But here we are dealing with the convergent perspectives, in the light of a more comprehensive (and therefore more "correct") scientific representation of an object, pathology, to which both approaches contribute to investigating *by intertwining with each other*. Here it should be clear that the tendency of some medical anthropologists to exclude any reference to the biological reality of pathology as something radically extraneous to the anthropological approach, which should just concern itself with pathology in so far as it is *culturally perceived*, is a very serious theoretical and practical mistake. It is akin to asserting that an enquiry into how the various medical systems interpret and deal with, for example, plague epidemics, and with what success, does not need "to know" what the "real" etiopathogenic mechanisms are. That is to say, it does not need "to know" if the "real" correlation is with the wrath of God, or with a biological bacterium-flea-rat sequence, linked to particular events and environmental and socio-historical situations.

Thus, when medical anthropology investigates biomedicine – or, if one likes, the biological paradigm which is its cognitive basis – it studies an "emic" object which, at the same time, represents a very particular "case". In essence, then, the "anthropological knowledge" of the researcher and the "biological knowledge" which constitutes one of the characteristics of the object investigated, both to a large extent participate in one single epistemological basis and, at least in principle, cannot but integrate to constitute an "etic" point of view. In any case the one is existentially doubly bound to the other.

2.1.

Bearing in mind what has been said above, it seems to me of interest to examine the trends of development, the main topics and problems of a "national" medical anthropology such as that of Italy. This is an interest which is not only to be defined in its overall, early and in some ways original contribution to the growth of our studies but above all – and this is what we are most concerned with – in the fact that, different to what has happened elsewhere, Italian medical anthropology has in fact to a large extent been developed "at home", as a long and articulated succession of stages of research carried out by Italian researchers within their own country [(6)].

In this respect, it would be opportune to define briefly the steps of this research tradition whose historical development, while today definable in terms of "medical anthropology", have each had their own and in some senses autonomous methodological, thematic and operational configurations, and their own specific goals, ideals and socio-political horizons.

(*a*) The first phase, which we could define as pre-anthropological, concerned public investigations from which significant information emerged about orientations and cultural patterns relative to health in particular areas or particular social strata. I am here talking, for example, about the medical-epidemiological surveys, contained in detailed "reports", commissioned by the Health Judiciary of the Florentine State (Grand Duchy of Tuscany) in the early 16th century, and which provided precise detailed information regarding the Tuscan peasants' mistrust of medical examinations by the official physicians.

(*b*) The second phase is due to the Enlightenment and was therefore centred on the so-called "Napoleonic surveys or *statistics*", carried out in the various Italian States under French hegemony or direct French occupation

in the first fifteen years of the 19th century. In that period, very long, detailed and systematic surveys were carried out at successive levels, from the municipal to the provincial level to arrive at a synthesis at the State level. These surveys took into account many aspects of the territory and society, conditions of health and so-called "superstitions", with the aim of constructing a useful knowledge base so that well-grounded policies of "good government" could finally be put into effect. Let us give an example. Among the numerous and detailed information requested by the five weighty "questionnaires" carried out in 1811 throughout "napoleonic" Murat's Kingdom of Naples, there figured the gathering of data regarding prejudices against smallpox vaccinations (at that time rampant). The aim of this was to strengthen an intensive mass campaign of health education in the entire territory to support the practice of vaccination.

(*c*) After the fall of the Napoleonic States, Italy underwent a contradictory period of socio-political involution. At the same time there was a slow renewal of a unitary national identity, shown in the intellectual field by the ideals of Romanticism, and then by a progressive philological sensibility which was later to develop during the positivist period. At this time, in the context of a growing interest in "popular literature", the only significant contributions to medical anthropology in this domain are proverbs, the "living voice of the people", which are testimony throughout all parts of Italy, to the strong attention paid by the people to health matters and to their correlations with doctors and medicines, with nutrition, with lifestyle, and with the human life cycle.

(*d*) However in a certain sense the great explosion in research that we would today define as "medical anthropology" took place during the age of positivism, more or less between national Italian unity (1870) and the conclusion of the First World War. This was a time of great productivity in the sphere of human sciences, which may very briefly be characterised by:

(i) a strong secular orientation and open hostility to all "superstitions" and all forms of "obscurantism";

(ii) an intense promotion of science and its role in future human progress, and widespread confidence in the possibilities of a scientific approach to knowledge of man and his vicissitudes. This approach was however closely identified, as a consequence of Darwin's revolutionary discoveries and the progress of medicine, with the paradigm of the biological disciplines, hence a tendency, albeit with different emphases given to it by different authors, to attribute to biological factors a great number of phenomena determined

in actual fact by socio-historical conditions ("social Darwinism"), with serious theoretical and political consequences;

(iii) careful attention to the most varied psychic and/or behavioural styles linked in whatever way to what much later would be included under the heterogeneous "deviance" heading (madmen, criminals, bandits, rebels, anarchists, visionaries and religious reformers, and prostitutes etc.). They were carefully analysed but very often interpreted in biological terms such as "atavism" or "degeneration", and in any case grouped together in a limbo of some supposed "social danger" (even compulsorily and therefore blameless), which was defined in opposition to a "normality", which was identified with the operating parameters of a bourgeois society considered to be at the peak of evolutionary process;

(iv) the project to assign anthropologists, as "organic intellectuals" of the new political ruling class of a recently unified Italy, to construct innovative policies of social control and cultural homogenisation and modernisation.

In this perspective, and with the limits generated by the heavy biologistic distortions, the contribution of positivistic anthropologists to stimulating reflection and empirical research in every field of medical anthropology was truly enormous. They compiled the corpus of knowledge and practices of popular medicine in entire regions, areas or particularly interesting zones (7). There was assembled one of the greatest European collections of protective amulets (8). There was produced – despite the biologistic bias we pointed out above – a very wide documentation about madness (9). Hypnosis and suggestion mechanisms, mediumistic states and other "altered" states of consciousness were investigated (10). They raised the question of the real and contradictory social incidence of hospitals (11). In correlation with, among other things, legislative operations that tended to centralise every health care activity under the exclusive aegis of biomedicine, data were gathered from all municipalities in Italy on the possible presence of health workers whom we would define today as "non-conventional", in the context of a wide State-promoted survey of the "health and sanitary conditions in the municipalities of the Realm" (1885).

(*e*) In the following period, under the Fascist regime, anthropological production – for evident reasons of social control – came to an almost total halt, above all as far as fieldwork was concerned. For the same reasons, only two lines of research were encouraged. The first of these was a limited colonial ethnography, which also made some mention of Ethiopian medicine. The second, within the country, was folklore research directed at those aspects of the "popular arts" – above all of rural tradition – whose empha-

sis was functional to the ideological-cultural policies of the dictatorship (the myths of "rurality" and "race"). Therefore, in this framework there was little room for surveys that today would be considered as belonging to the sphere of medical anthropology "at home". However, we must mention the beginnings of the vast and systematic enquiry into popular beliefs and practices concerning pregnancy, birth and nursing, which Antonio Scarpa conducted throughout the entire country. This made use of the organisational structures of the National Organisation for Maternity and Infancy (*Opera Nazionale Maternità e Infanzia [ONMI]*), created by the Fascist regime itself in support of its intense policy of demographic increase. The investigation began at the end of the thirties but was completed and published only in the post-war period (1952, 1969). Equally, it is important to remember that in the second half of the thirties a scholar coming from the field of the history of medicine, Adalberto Pazzini, put together a wide-ranging collection of information, published and unpublished, regarding popular Italian medicine. After the publication of a first *Saggio di bibliografia di demoiatrica italiana* (1936) he published two wide-ranging volumes, the first during the Fascist period, and the latter after the end of the Second World War (1940 and 1948).

(*f*) With the fall of Fascism and the end of the Second World War, there began to develop a large movement to discover social reality and the great unresolved problems of the country, such as the so-called "Southern Question" and the persistent poverty of large masses of the people. With the help of broad combative political and trade union organizations, an extensive movement in the literary, artistic and cinematic fields, well-known as neorealism, was developed. In this ideologically complex and to some extent contradictory context, the social sciences and anthropology itself were reborn even though, for a number of reasons, the development of anthropology ended up by being quantitatively lesser than, for example, those of sociology and psychology. In this development, various influences came into play. On the one hand there was the influence exerted by United States cultural anthropology; on the other, there was the expansion of a cognitive approach to social reality produced in Italy by a renewed tradition of Marxist studies. And there was also in general an impetuous process of "updating" which came about thanks to scholars and publishers with regard to what, under the dictatorship, had been produced abroad in the whole sphere of human sciences. But undoubtedly, as far as anthropology and medical anthropology are concerned, the work undertaken by Ernesto de Martino (1908-1965) up to the time of his premature death is fundamental. He carried out an extremely extensive theoretical and empirical

research work, in which his origins in Benedetto Croce's historicism became increasingly more closely intertwined with methodological and thematic threads borrowed from psychoanalysis, from existentialism and phenomenology and, above all, from a Marxism greatly enriched by the contribution of Gramsci. His vast research activity, that as regards empirical fieldwork was to a large extent carried out in Southern Italy, was characterised by dissolving and overcoming of the old and narrow positivistic folklore methodology in a new perspective of wide historical horizons, with great attention paid to the dynamics of cultural circulation processes, to the network of class, hegemony and power relationships, and to the complex rooting of individual and collective subjectivities within the material conditions of existence in which humans live their life. In this context, the preceding interpretative patterns concerning magic, states of consciousness and popular therapies, were integrated with psychoanalytic and psychiatric contributions above all of a phenomenological nature, without however losing the concreteness of the socio-cultural framework in which the historically analysed objects are produced. Moreover, great attention was paid to the researcher's subjectivity and his reference contexts, to the need for making this explicit, and to its consequence and its constitutive meaning within the relationship between the researcher and whoever was in some way the object of the research itself. An "encounter" that must – on pain of the research losing its heuristic value – set itself the goal of achieving a new common perspective of awareness and deliverance. The main cornerstones of such a complex "methodological revolution" are the reflections regarding the meaning and the psycho-cultural function of the historic institution of magic (*Il mondo magico,* 1948, and *Magia e civiltà*, 1962), the enquiries into funeral laments (*Morte e pianto rituale nel mondo antico: dal lamento pagano al pianto di Maria*, 1958) and on the popular healers of Lucania (*Sud e magia*, 1959), historical-ethnographic research on tarantism (*La terra del rimorso*. *Contributo a una storia religiosa del Sud*, 1961) and the posthumous volume *La fine del mondo. Contributo alla analisi delle apocalissi culturali* (edited by Clara Gallini, 1977), to mention only the main volumes. And we can consider that such cornerstones are also fundamental reference points of current Italian medical anthropology and, so to speak, of its specific "national tradition". And the same book *La terra del rimorso* undoubtedly constitutes the moment of the birth of ethnopsychiatry in Italy, in the same years in which it was born in France and West Africa with the School of Dakar, in Canada and in the United States [12].

(*g*) We have now reached the present day and the new Italian medical anthropology – despite a number of significant researches and interven-

tions in Africa and Latin America – still seems to be mainly concentrated "at home", where it is developing with at an increasing pace, and its empirical research already covers numerous areas of the national territory [13]. Today de Martino's theoretical framework is being used, to a greater or lesser extent, by almost all the Italian medical anthropologists and, in the meantime, the methodological processes of many once separate research lines have been integrated (under the now acknowledged definition of "medical anthropology"). Some of the steps in this process may be considered the National Conference on "Health and pathology in the traditional medicine of the popular classes in Italy" ("*Salute e malattia nella medicina tradizionale delle classi popolari italiane*", Pesaro, 15-18 December 1983) and the special issue on *La medicina popolare in Italia*, linked to this Conference, in the journal *La Ricerca Folklorica* (October 1983); the constitution of the Italian Society of Medical Anthropology (*Società italiana di antropologia medica [SIAM]*) (Perugia, 18-19 May 1988); the publication of the collective book *Tradizioni popolari italiane. Medicine e magie* (1989); the first number of the periodical *AM. Rivista della Società italiana di antropologia medica* (October 1996); and the publication of the first volume of the "Series on medical anthropology" (*Biblioteca di antropologia medica*) (November 2000). I cannot but underline the impetus given to each of these initiatives by the so-called School of Perugia [14], in which de Martino's heritage may appear today more explicitly, integrated in the course of time by the main contributions elaborated in other countries. Starting from the mid-fifties, this school has confronted almost all the themes of medical anthropology 'at home'. These, certainly, were directed at comprehending contemporary processes, but at the same time were open to the exploration of more ancient historical periods. These fields have ranged from investigations of popular medicine, traditional healers in both the countryside and in the urban contexts, sacral thaumaturgies and therapeutic sanctuaries, to the recent expansion of "non-conventional medicines", from studies on amulets and apotropaic formulas to the cataloguing of ex-votos, from collecting proverbs which codify and transmit "popular knowledge" aimed at guaranteeing well-being and longevity to the critical examination of training courses for "official" medical personnel, from the ways in which health is dealt with within the home (the *autoatención* of Spanish language scholars) to the observation of the ways in which "therapeutic itineraries" are followed and of social relations within the hospital, from research into madness and its cultural perception to the so-called "writings from the asylum" to those about life in total psychiatric institutions and long-stay hospitals, from the analyses of health and medicine patterns propagated

by the mass-media to the cognitive contributions aimed at health education, from surveys about professional styles of therapeutic figures and about relations between patients and physicians, as well as between the health institutions and their users, to the evaluation of how the health services respond to the health requests of recent immigrant groups.

It is perhaps to this activity that I owe the invitation from the Scientific Committee of our Second Conference on Medical Anthropology "At Home" to give this introductory lecture. For this invitation I am very grateful and deeply honoured.

Notes

(1) See the extensive and very precise report that Ivo Quaranta wrote about the Conference: "Medical anthropology at home. A European Conference". *AM. Rivista della Società italiana di antropologia medica*, num. 5-6, 1998, p. 300-308.

(2) See Mariza G. S. Peirano ("When anthropology is at home: the different context of a single discipline". *Annual Review of Anthropology*, vol. 27, 1998, p. 105-128) for the complex and tortuous path through which anthropologists, little by little, went beyond the practice of doing research by exclusively focusing on the study of "exotic" populations, starting to direct their attention toward the Western world in which, moreover, anthropology itself developed as a discipline.

(3) Even today the never extinguished *querelle* regarding the field of the anthropological disciplinary corpus, regarding its internal partitions and their respective denominations – differently developed in different countries – is made more complex by the fact that when anthropology pays attention to the extra-European societies, it is generally understood as a "global" discipline, directed therefore to the whole social system examined as a global social setting of civilization – from its economic bases to its social and power structures, and thence to its symbolic and ideological constructs. Whereas when it turns its attention to societies improperly defined as "complexes", such as the European ones, anthropology is generally understood as being directed at focusing uniquely on the set-up of the institutions and cultural processes, and must therefore correlate with and integrate itself into a framework in which other socio-historical disciplines also converge.

(4) Tullio Seppilli, "Presentazione". In Donatella Cozzi and Daniele Nigris. *Gesti di cura: Elementi di metodologia della ricerca etnografica e di analisi socio-antropologica per il nursing*. Paderno Dugnano: Colibrì, 1996, p. XI-XXIII.

(5) About the notion of "organicity" see Antonio Gramsci, *Gli intellettuali e l'organizzazione della cultura*. Torino: Einaudi, 1949, p. 3-7 (Opere di Antonio Gramsci).

(6) The lack of development of an Italian overseas medical anthropology is not surprising. The main reason was the weak and late colonial policies of a State which was unified as a nation only in 1870 and which had only a few, unfortunate colonial vicissitudes.

(7) Antonio De Nino for the Abruzzi and Molise [1891], Zeno Zanetti for Umbria [1892], Giuseppe Pitrè for Sicily [1896]. Also Carolina Coronedi Berti for the territory of Bologna [1877], D. G. Bernoni for the city of Venice [1878], Giovan Battista Bastanzi for the Venetian Alps [1888], Caterina Pigorini Beri for the Apennine part of the Marche [1889 e 1890], Paolo Riccardi for Modena [1890]. For specific topics, see Angelo De Gubernatis, Paolo Mantegazza, Alfredo Niceforo, and many others.

(8) Giuseppe Bellucci [1870 to 1920].

(9) Cesare Lombroso, Enrico Morselli.

(10) Giulio Belfiore, Leonardo Bianchi, Cesare Lombroso, Enrico Morselli, Salvatore Ottolenghi, Pasquale Rossi, Giuseppe Seppilli, Scipio Sighele, etc.

(11) G. Vadalà-Papale [*Il darwinismo e gli ospedali*, 1884].

(12) Within this Italian ethnopsychiatry "at home", under de Martino's influence, research was carried out by numerous students: by anthropologists such as Vittorio Lanternari, Alfonso M. Di Nola, Mariella Pandolfi and Donatella Cozzi and by psychiatrists such as Giovanni Jervis, Michele Risso, Piero Coppo, Sergio Mellina, Roberto Beneduce, Giuseppe Cardamone, Salvatore Inglese and Virginia De Micco.

(13) Notwithstanding the heterogeneous nature and the different research directions, which cannot possibly represent in any way a large census of Italian medical anthropological production, we may cite Clara Gallini, Luisa Orrù and Nando Cossu for Sardinia, Elsa Guggino for Sicily, Luigi M. Lombardi Satriani for Calabria, Giovanni Bronzini, Miriam Castiglione and Annamaria Rivera for Puglia, Alfonso M. Di Nola and Emiliano Giancristofaro for Abruzzo, Mariella Pandolfi and Italo Signorini for the Campanian Sannio, Paolo Apolito and Gianfranca Ranisio for Campania, Gioia Di Cristofaro Longo for Lazio, Fabio Dei for Tuscany, Giancorrado Barozzi and Roberto Roda for Emilia-Romagna, Gian Luigi Bravo and Piercarlo Grimaldi for North-Western Italy, Glauco Sanga and Italo Sordi for Lombardy, Dino Coltro and Daniela Perco for the Veneto, Emanuela Renzetti for Trentino - Alto Adige, Gian Paolo Gri and Roberto Lionetti for Friuli - Venezia Giulia.

(14) I may be said to have set up this "school" shortly after beginning my academic work when, on coming to Perugia, I was able to establish in the local university the Institute of ethnology and cultural anthropology (*Istituto di etnologia e antropologia culturale*) (1956), which I was to direct until the end of 2000. My first writings – "A Contribution to the formulation of the relations between public health practice and ethnology" [*Contributo alla formulazione dei rapporti tra prassi igienico-sanitaria ed etnologia* (1956)] and "The Contribution of Cultural Anthropology to Health Education" [*Il contributo della antropologia culturale alla educazione sanitaria* (1959)] – date back to these initial years as do my first investigations about popular healers and folklore medicine and the organization, in Perugia and Rome (1958), of the exhibition of photographic documentation of the research into Lucanian healers directed in 1957 by Ernesto de Martino, to all intents and purposes my teacher. Ever since then, even while carrying out research in several other fields, I have continued to devote almost uninterruptedly my attention to medical anthropology, to the reflection on its epistemological basis and on its operational implications, to its teaching and to its instruments of scientific and professional organisation and, above all, to a great number of its own research objects, with particular reference to Italy. Since the beginning of 1999, the Institute of ethnology and cultural anthropology has become the Anthropological Section of the new and broader Department of Man and the Environment [*Sezione Antropologica del Dipartimento Uomo & Territorio*]. Moreover, for some years now our medical anthropology activities have been principally located in the Angelo Celli Foundation [*Fondazione Angelo Celli per una Cultura della Salute*], constituted by my father, a professor of public health, in 1987 and of which I am now president. The Foundation is also situated in Perugia, where the *Italian Society of Medical Anthropology [SIAM]* has its national headquarters. In this by now long journey through the disciplinary field, I have been supported by a growing group of pupils and collaborators of various "generations", the names of whom, at least, I would like to cite here: Alessandro Alimenti (†), Giancarlo Baronti, Carlotta Bagaglia, Paolo Bartoli, Andrea Caprara, Paola Falteri, Sabrina Flamini, Grazietta Guaitini, Lara Iannotti, Laura Lepore, Cristiano Martello, Massimiliano Minelli, Cristina Papa, Caterina Pasquini, Maya Pellicciari, Enrico Petrangeli, Giovanni Pizza, Chiara Polcri, Roberta Pompili, Riccardo Romizi (†), Pino Schirripa, César Zúniga Valle. Without them, very little of what has been done could have been brought to a successful conclusion.