IF THE CURRENT PANDEMIC REMAINS A HEALTH COMMUNICATION ISSUE FROM AN INFORMATION POINT OF VIEW

Filippo Silvestri

Università degli Studi di Bari Aldo Moro, Italy

Abstract

COVID-19 is not only a virus that attacks our bodies and lives, but also a political information subject/object navigating global networks and shaping the new configurations of our political lives. Thus, the biological spread of the virus is, in a sense, mirrored by its mediatized dissemination. This article examines the information problems connected with COVID-19 within the larger analytic framework of "health communication." It takes the latter in its classical version, which relates to "normal" times, in so far as we can ever speak of normal times in the health sector, but certainly of late we have been experiencing an exception to these times. The article attempts to re-interpret the more or less consolidated models and variants of the doctor/patient relationship, which have become topical once more, ever since the pandemic brought health communication and its possible modalities to the forefront of the global political agenda. Today, the world's population in its entirety finds itself in the position/condition of 'patient,' a patient who must follow the doctors' orders, imposing a mass treatment, which has significant repercussions on the management of communal freedom. Confronted with this configuration, the study investigates whether it is possible to hand back a modicum of centrality to the patient/citizen, one that is the calibrated capacity of participation in the management of health within the public political spectrum that the health issue in question has recently raised.

Keywords: *COVID-19, health communication, the pater familias model, the consumer model, the role of patients, possible new political configurations*

1. A BRIEF INTRODUCTION TO THE OBJECT OF ANALYSIS

The time of our pandemics, those linked to COVID-19 and all the vaccines spurred therein, has, as is evident, measured once again the deep meaning of our "affective proximity" [1] to ourselves and our lives, to the lives of and with others, in the light of a different 'proximity' that is more akin to an *imminence*, that of the virus and its variants. To clarify, each of us has been put to the test of the pain/terror caused by the pandemic. Each of us has, in a more or less conscious fashion, confronted his/her willingness to "run a risk", a deadly one, for him/herself and his/her beloved ones [2]. Each of us has then developed, in an extremely short period of time, an open series of "adaptive responses" [3], based on a personal and widespread feeling of the *magnitude* and frequency of the risk, a risk that, it is worth stressing again, is deadly, conclusively, definite.

In short, each of us has taken stock of his/her *fatalism*, as he/she manages an incomplete tension that gradually and retroactively affects his/her behaviors. Mainstream and online (even niche) media have acted as amplifiers of the virus' communication/information. They have constantly referenced both a real and a "mythical" dimension, that of the pandemic, which, as in any other emergency, is charged with symbolic meaning that acts on our ability to make sense of the situation in both the short and long term. Talking about how things were going (and they were going badly), we have run the risk of "offsetting" the right alarm, at least in some cases, while events, in the constantly mediated deferment, often ended up vanishing from what we called our *mythical* horizon.

As we go through the vaccination phase today, but yesterday too at the time of maximum alarm over the spread of the infection, the feeling was, that each time, a certain clarity, a desirable precision, were required to give and circulate the news, if not to lend continuity to what would otherwise be fragmented and distracted listening. Here lies an inherent contradiction regarding the media. If, on the one hand, the uniqueness of the source of information cannot be ascertained for democratic reasons concerning such information, on the other hand, the multiplication of the sources and the apparent variations in reporting

the news, generated not only a certain confusion, but contributed to a progressive and widespread distraction. Every time, we ended up asking ourselves when the pandemic *event* would hit and with what degree of force: this is the logic regulating mass behavior at a moment of emergency. Yet, even in this case, each time we had the impression that the situation was at least partially under control and we ended up *loosening our grip*, dissipating the achieved results in a sort of uneven 'falling out.' But perhaps that is how it should have gone, although some reservation remains.

2. THE COVID-19 IS AN AMBIGUOUS AND VAMPIRE-LIKE PANDEMIC

Given this short premise, the pandemic's time was marked by such a saturation of information that we are tempted to say that *the telling/informing was not telling/informing us about anything,* anymore. The cold, numerical representation of the sick and the dead produced an effect of indifference to and then the "indifferentiation" of the victims. Like in a moment of overwhelming, revolutionary collective violence, we all went on a hunt for "scapegoats" [4], growing increasingly intolerant of the restrictions connected with a condition that (especially that of *others*) directly affected us. Then, at least at the beginning, as the epidemic spread from China, at least in the West, the European [5] and North American West, the fear of what comes from the East, the Far East, emerged again in the wake of a centuries-old tradition – the wild, zoophagous, infective, East, for yet another *clash of cultures*, for positions that repeated in a Manichean fashion. First and at the origin of everything was a small event, the first center of the outbreak, then its pandemic spread.

In any case, the time of the pandemic was characterized by widespread ambiguity, an almost 'demure' ambiguity of healthy bodies that still carried the disease, in a paradoxical reversal of differences that harbored a psychologically disquieting mix of different motifs of life, death, health, and sickness. In this shadow of things and men, a deadly and eerie shadow, in this shadow cone, ended the hospitals, and the houses of the isolated sick. Panic spread in a homogeneous/uneven way across the rest of society with only a few, public and private, political and geographic exceptions. The scenario opening in front of all of us, in our various capacities, has then been marked by constant fractures, constant thresholds of passage between the healthy and the ill, the vaccinated and those who had to wait to get the vaccine. Doctors, patients, scientists, politicians, reporters, and spectators gathered into multiple and different "hybrid collectives" [6] touched by an old/new language of duty, power, and powerlessness.

The space defined by these boundaries, between what you were and what you were not and were again (healthy and ill, infectious and not infectious), between those who could and could not, those who must and must not, ended mixing up with the missed geography of our belongings. In other words, the viruses spread all over, more or less unobstructed, crossing all available spaces, geographies, borders, following an invisible course of action, leaving traces of their passage everywhere, in the vampire-like forms of born-again Nosferatus – *a not-dead that carries nothing* [7]. The same viruses were hybrid and always anomalous, inside/outside of our bodies, this sickness in the guise of a "foreign sickness, arriving with foreigners" like a new Dionysus, the god of epidemics hailing from far away, carrying death from distant lands [8]. Taking all of this into account, only the necessary isolation saved us, as it was only the proximity of doctors and patients that ensured the margins for safety: all so close, all so distant. The sickness that washed over us thus laid claim to every space, real and virtual, physical and psychological, "saturating" and homogenizing it in a vortex-like spread that coincided with the virus' *appropriation* of our bodies. On the other hand, but not elsewhere, we were forced to attempt "concentrating" what was "spreading", except that we hoped not to find ourselves occupying the center of these spaces of "concentration."

3. WHY THE PATIENT-PHYSICIAN ENCOUNTER IS CENTRAL ONCE AGAIN AND NEVER TRIVIAL

When taken together, the problem is, in a way, trivial (although, of course, it is not at all trivial), because even in a pandemic dimension it is still a "patient-physician" relationship. If they do not understand each other, because they do not make themselves clear and understand each other, it is not only their

communication that fails, but, in such a dramatic moment as our present pandemic one, a whole plan/project of reaction/resistance comes undone. Today, the whole *governmental political subject* (Foucault) [9] has donned the uniform of the physician/scientist with the whole population in the role of patient.

In our exceptional, pandemic case, as in all the "normal" ones (assuming that a medical condition can ever be considered "normal"), the patient's health and improvement depend on the quality of the communication between the same patients (a plurality of persons) and their physicians (another plurality). Whenever we talk of communication, regardless of its normal or exceptional configuration, it is always a matter of "proximity" (a "proxemic" question), of knowing how to be close to each other to be able to understand and heal each other, even if this entails a mortal risk, since in these cases not understanding each other, being unable to grasp the other's problems, can be lethal. In pandemic times caring necessitates *proximity*, which relates to the ability to understand the languages of sick bodies and the symptoms that can be interpreted, given a necessary "distancing" that ensures a degree of social security. The safety of those who get ill depends on reducing the communicative (and non-communicative) distance between their bodies, the patients' bodies, and the hands and eyes of the physician/scientist. This is where the true fight is waged, a fight to translate the sickness into the forms of its healing, a biological and semiotic fight between the viruses and the vaccines that contrast them, to return a state of exception to "normality" (the following pages will show how certain war metaphors like those of "fight" and "strife" are not necessarily appropriate in health communication).

The question of the patient/physician relationship is never self-evident, since it is a matter of conscience, the conscience of things, is at stake [10]. Hence, and to phrase it differently and coming to the crux of the matter of those *knowing* and "operating," certainly the physician knows more than the patient, who is always, constitutively, in a minority position, a position of need and of wait. On the other hand, no one better than the patient knows how he/she 'feels' and the doctor's listening is, in all cases, decisive. The physician/patient's encounter is one of "belief," of each's belief, and the balance cannot be offset in a "paternalistic sense" in favor of the physician [11]. Further, the relationship, which must tend toward normalizing the patient's condition and normalizing the communication (and agreement) between physician and patient, should take into account its constitutive instability connected with personal variables that change from patient to patient and physician to physician, following the course of an illness that evolves according to often immeasurable variants. Never within a pandemic is it possible to offer a political understanding of such communicative configurations, because the human matter (of patients and practitioners) and that the virus are constantly evolving, giving rise to an agenda that needs constant update.

4. SOME THERAPEUTIC BALANCES ARE HARD TO ESTABLISH

The patient's role remains crucial: he/she is responsible for and participates in the therapeutic plan set in place by the physicians. He/she must collaborate, follow instructions, and yet, on his/her part, should be allowed to offer his/her contribution, also in innovative terms. We are here faced with a role play that has its own rituals and rules. In 1980 the psychiatrist Engel wrote: "…the most obvious fact of medicine is that it is a human discipline, one involving role- and task-defined activities of two or more people. Such roles and tasks are defined in a complementary fashion. Roles are based on the linking of the need of one party, the patient, with an expected set of responses (services) from the other party, the physician. […] The patient's tasks and responsibilities complement those of the physician. […] The term "patient" characterizes an individual in terms of a larger social system" [12]. The different spaces in which the patient/physician relationships take place – homes, medical practices, hospitals, as well as the various social contexts the physicians and patients come from – play a crucial and shifting role [13]. These circumstances explain, at least in part, why, to this day, we lack a globally shared theoretical approach to the problems connected with the successes and failures of health communication [14].

In any case, including in our pandemic situation, anyone who enters into a medical relationship is forced to push him/herself into a semiotic jump, meaning that he/she enters an unknown language that he/she does not control and that excludes him/her at the time the relationship is established. In other words, my

illness, or suspected illness, forces me to confront a world/language, a *semiosphere*, multiple semiospheres, that I do not understand, and it is from this experience of semiotic lack of control that I must entrust myself to the care of the physician, the physicians, accepting the therapeutic rules that they hand me, forcing myself into a constant personal translation of what I am told and I must know how to do it, adjusting to the things I am told. Having faith, or not, since this is about surrendering parts of my independence to a physician, who, in most cases, if not all of them, applies a protocol that has to neglect the particularities of my situation. During a pandemic, this sense of trust and at the same time of aloneness of the *citizen-global patient* from the physicians who include him/her in a protocol, is further aggravated.

It is, however, hard that a patient does not attempt to force the setting of the relationship, as it is just as hard that the physician does not find him/herself in a situation where he/she applies a therapeutic approach that leaves him/her with no time to figure out the various, subjective anxieties of the individual patient. The *paternalistic model* of the patient-physician relationship applies in many cases: the orders, which is exactly what they are, come from above and must be received because we must settle on a course, especially when, as during a pandemic, it is a matter of health and public order. We cannot underestimate the preeminent and prestigious social role of the physician and, even more so, of the scientist. It is not easy to question their authority. Besides, every communicative relationship is based on a missed balance between sender and receiver. In fact, communication, in one of its primary forms, is tasked with evening out these disparities and reaching an agreement. It is paramount to remind ourselves once more how hard this is in the patient-physician relationship and, even more so, in a pandemic marked by the rush and tension of finding a mass solution. This is to say that, often, there is no objective 'salience' to things when the patient focuses both his/her attention and the physician's on something that he/she claims is 'relevant.' But this constant tension between patient and physician does not allow for Manichean solutions that shift the balance exclusively on the side of the physician's rule in his/her therapeutic relationship with the patient.

5. TWO COMPARING MODELS: THE *PATER FAMILIAS* AND THE CONSUMER RELATIONSHIP

The contemporary pandemic has forced us, in the socio-political sense, into an exceptional patient/physician condition, because the whole society/world has become ill. In a matter of weeks, the illness and the death of threat that are connected with it turned into a universal condition, a pathologic planetary semiosphere: we are all facing the compulsory *medicalization* of our lives. Let us review it again: the patient-physician relationship is already, in its essence, a 'political relationship' characterized by substantial paternalism. As a patient, I go back to being an adolescent who is told what he can and cannot do, constantly called on to act responsibly and as an adult, substantially "prescribed", given advice for his sake and for the sake of his health, with a progressive reduction of his freedom of choice (think of all the recommendations that we receive for a diet about what and what not to eat).

Today physicians and scientists, those who have become the new protagonists of the political scene and media personalities, who already exercised for the above-mentioned reasons a prescriptive/coercive power, assert always, and once more, this power, but in a *state of exception*. In this situation of unbalance between patient and physician, aggravated by the widespread pandemic state and made necessary for many reasons, we need to establish a "therapeutic alliance" [15] between patients and physicians once more, which has limited room to be effected and it is not easy at the wider social and political level.

Hence, and once again, during a pandemic a *paternalistic approach* can have its positive effect and is certainly easy to adopt, although in the long run certain asymmetries regarding a failure to listen to the patient can determine an imbalance that will be hard to re-set. There is generally little available time to settle the most complex issues, in emergencies. The anxious need to find solutions does not leave ample margin for dialogue and listening to 'everybody.' Thus, the contradictions when it comes to therapy are almost immediate, because we are in a hurry to find some answers and because the subject/object illness mutates in the symbiotic exchange with the environment and the various bodies that it comes into contact with. These are, it is worth repeating, different from the other and therefore subject to unmeasurable

variables. I repeat myself once more, as this is a crucial aspect of the patient-physician relationship, especially in light of a discussion in a pandemic moment: most paternalistic models work in patient-physician communication. Of course, things are not easy, because the patients, on their part, uphold a "consumer" model (which they are mostly used to) that translate into a client (patient) physician (professional) consultant relationship, where the former demands from the latter a series of immediate responses, performances, and solutions on cue. This is based on the assumption that paying for a solution entails that you get it, which is, somehow, a way to curb the dominating paternalism, a sort of conquest of a space of listening and speaking up, which would otherwise be hard to conquer [16]. Now, in this way and even more so in a widespread public emergency, the patient-physician relationship does not work. The patient, as we have said, is used in most cases to the request/question and to the consequent, more or less satisfying, performance/answer, finding him/herself forced again into a minority position of dependence, reduced into a unilateral relationship because in this exceptional, pandemic case (but in general in any "normal" hospital situation), the physician cannot offer a service on request as he/she has no time, nor the chance to listen. After all, and this may seem trivial although it is not, the passage of information between physician and patient is never easy because of several semiotic barriers that are worth exploring [17].

Thus, during a pandemic, as in any normal patient-physician situation, we need to be sympathetic and empathetic and this is not only a task of the physician, but applies also to the patient overall, of his/her anxieties and urgent requests. It is all a game of expectations, of the physician and the patient, which we have already mentioned, that is a shared mind, which is to say that, beyond the paternalistic tones and the paid service, the potential (pandemic or not) patient must be engaged, he/she must perceive to be engaged and this applies in the long and short run, equally [18]. The public and private health, of the individual as well as of an entire population, is a shared mission. Given these premises, in normal and pandemic times, the patients themselves must be able to develop a good degree of autonomous self-management (the so-called "self-efficacy"). Further, the so-called "patients" (certainly all of us in a pandemic moment) must be *confirmed*, updated, re-oriented at the therapeutic level, included in the evolution of the instructions with which they are expected to comply, since they must never lose contact with the feeling and the conviction that what they are doing, the therapeutic regime that they are following, worked and is working again. In any case, the *top-down model* of health communication does not work anymore today, at the time of web 4.0. It works at the first, immediate, level of the mass media, but then it ends up 'diffusing' in myriad communication streams that are mostly online, with a variety of possibilities that can only be assessed via a dedicated semiotic analysis.

6. THE "SUBJECTS OF SPECULATION" AS MIDDLE FIGURES OF THE PANDEMIC NARRATIVE

Of course, in normal and pandemic conditions, everything hinges on the possibility that the patient might, as we have just said, have made his/her independent and informed research, acquiring essential data, considering them essential for the way he/she can behave, having a chance to assess all the variables that may appear "conflicted." Based on these circumstances, governance is never trivial, either at the level of the mass media, or at that of the personal relationship with the physician, or physicians, dependent on the patient's prediction of his/her suspected or certain illness, and thus the cures that may be more or less available at any moment in time. Finally, an aspect that is integral to the process that we have just described, the patient develops in the relationship that he/she manages to establish with the physician and physicians with whom he creates a relationship of trust, some *preferences* (a large and very concrete notion) that will lead him/her to make some choices [19].

These preferences, although apparently trivial, play a decisive role when the government of public health is at stake, as they involve the entire population, and it is here that each government must, from the beginning, anticipate some possible scenarios and share them with the population, securing its more or less satisfied acceptance. Today, the protagonists who can outline these horizons are, again, only few. This is because when we look at the media in their mainstream incarnation and beyond the Internet variants, which are still qualitatively the purview of patient and expert surfers, we have witnessed a significant reduction in the number of those who have been granted a 'narrative function' in our

exceptional-pandemic times – politicians, scientists, physicians, and witnesses. To be clear, these ‘middle figures’ occupying a middle position between the world of the sick and those of the healthy, two realms that often overlap, establishing the scene mentioned above, leading the dance, setting the political agenda, which is a health agenda, ‘giving an account’ of where things stand from a position that can be attributed to some ‘subjects of speculation,’ or however else we want to call them, always some *key figures* in the field of health communication. Who does materially stand in this middle Earth? Who are the scientists and the physicians that can help? The TV public, just like that of Internet users, does not make a great difference between an infectious disease specialist, a virologist, and an epidemiologist, although the first one sees his/her patients every day, the second one never sees them, and the third one only looks at statistics. Regardless of these differences, which are not at all evident, scientific information, with all its variants, has become a “totem,” without necessarily being a real source of knowledge and holding responsibilities. Certainly, an undeniable absence of classic political parties, an absence now consolidated in many European countries, coincided, even in this pandemic moment, with a lack of ‘makers of well-thought positioning,’ all to the benefit of a by-now consolidated trend toward recognizing leaders, whose opinions we have had to comply with, with the oscillations that this allocation of reliability entailed and will entail. That we could not *lend the tragedy the time of its truth* is a fact that cannot be managed in a condition of shared, mounting preoccupation. And yet, there has been an immunological informative consolidation, as if a quick *alphabetization consolidated regarding contagion*, since people have understood the public health communication more or less easily, as they are used to a kind of *media regimen* that safeguards their health online, on TV, and in newspapers. But whether, in our exceptional situation as in more normal ones, we are witnessing a real ‘cognitive improvement,’ or whether this knowledge exchange is fortuitous or it will take root, whether it is regenerative, leading to real awareness, or only incidental and thus alarmist, we do not know, although for health’s sake we should tend toward recognizing what might happen to us and how we should behave. Here, the discriminating factor shifts from that of an illness affecting a limited number of individuals to an epidemic involving everybody and entailing various degrees of awareness.

There was a widespread cognitive push, then, but what hold will it have? There certainly has been an increase in information consumption linked to a re-modulation of the lives of those who, before COVID, could not keep themselves informed as they were *at work* and therefore busy doing something else. In the field of information we have witnessed communication reduced to useful things, as if the protagonists of this scene were carrying out a ‘useful’ function. However, we are compelled to repeat that there remains doubt as to whether this effectively produced a cognitive improvement concerning the pandemic and other questions. Perhaps the isolation that we were forced to go into contributed somehow and at some moment to reconstructing the meaning of what was going on, when all of this was possible. Certainly, in the mass media sense, we witnessed a real overlapping between what really happened and the decisions that were made at the organizational, political, and health levels, which is to say, only in the face of decisions made we got a real grasp of what was happening, with the effect that we *delegated* recognizing the reality of the situation to governmental authorities, who decided, together with the medical and scientific community, that something was happening and that thus they all had to decide on what to do.

Beyond these distinctions, which may appear deceptive, but are so only up to a point, a ‘demand for institution’ grew exponentially – the demand for ‘someone’ that would address the emergency, publicly and politically, on behalf of everybody. The State, the States, have gone back to playing the States, except for giving way to the solution market (the pharmaceutical companies producing the vaccines, to be clear). It remains fairly evident how, in the fragile pandemic arena, the communicative scepter, for reasons connected with a widespread need for “truth,” immediately passed from the politicians to the physicians/scientists. Yet this passing of the baton of communication did not simplify the number of information problems, since when there is the need to persuade someone of the goodness of some solutions, logical arguments alone are not enough, because we must address people’s feelings and this must be a ‘political choice,’ to take in a conscious way and without false morality that would not work in a moment of difficulty. *Ethos, pathos, logos* necessarily go together, because it is never a matter of rationality confronting irrationality, but a persuasive, rhetorical journey toward a shared, common health and healthy best practice. In other words, health communication is always a *social and ecological*

problem of approaching persons [20], where individual/personal and collective traits cross each other and have to be regulated in a political fashion that knows how to score, since we cannot reduce such an issue to the mere management of focus groups, which might be differentiated from a therapeutic point of view. The pandemic is something that goes beyond the health communication applied in cases such as that of HIV-Aids that had easier social and communicative margins to manage, although they were never easy to govern.

The organization, and before that the existence, of multiple communities that might constitute the basis and the support for the circulation and functioning of health communication in an emergency situation, as in a normal situation of managing the *res publica* of health, are therefore crucial political elements. What counts is what in marketing is known as advocacy. Perhaps in the health sector we should look at how communities like the LGBT one has functioned and still function at the communication level of the shared safeguarding of health, of course keeping in mind the necessary distinctions and dimensions of the phenomena [21]. The right balance between the public spheres of intervention and the so-called social ones, which are basically "private," is advised to encourage the patient's participation (engagement) that we have mentioned. This can have a therapeutic effect in itself as it is likely to bring him/her out of a distanced position in which he/she might feel relegated, in a state of solitude that often coincides with a feeling of impotence. Working on old and new media-spheres and their 'social' features is a step to take and, if it has been done already, to further encourage: the more or less *educated* citizen can thus become a real agent of change.

7. SOME POSSIBLE CONCLUSIONS: HOW I CAN CONVINCE YOU TO DO SOMETHING FOR YOUR SAKE

In any case, in health communication, it is not enough to 'persuade that' something is true (as if we are dealing with a simple shift of knowledge), it is necessary to 'persuade someone to do something', encouraging him/her not only to *believe* in something, but also to carry out any actions required in a given moment. It is not enough for someone to recognize that something is 'evident': it is necessary to persuade that someone that it is *right* for him/her to do something as it is important for his/her life/health. To give an example, a good communication practice in the health sector may also entail the use of statistics, something that is widespread in the scientific and mass-media fields, at least in this pandemic moment, but this string of figures, graphs and tables would need to be accompanied by instructions explaining the patient/audience their concrete meaning. Or the use of metaphors should be regulated to avoid misleading interpretations. For example, war metaphors are not always effective [22]. We should be clear on this, reviewing prior points; in many cases a deficit model is destined to fail even in the medical field, which applies to the patient/listener as if he/she could not understand, occupying a passive and asymmetric position concerning the physician, doctor, politician who address him/her with the only expectation of handing him/her a packet of knowledge/prescriptions lacking any ethical and political considerations that would evaluate a "contextual model" in an informed way [23]. Hence, a "public engagement in science and technology" is important, which has at its main goal the "patient empowerment" [24], because it is a question of "healthy literacy" [25], that is of a widespread culture of health.

The political balance in the face of a health problem like our present one, is, as we have repeatedly stated, not easy to attain and preserve. The issue of public health and the one connected with governmental responsibilities come down to a somehow ruthless equation, which captures, at least in part, a pandemic situation that entails accepting a 'calculated risk,' recognizing a certain *vulnerability* emerging from the population's general health picture, as it is connected with problems relating to the public health education of the citizens. It is a question of working on, only to give a macroscopic example of our recent times, a sort of constant, almost commercial, "transaction" regarding the *pleasures* that can be recognized and the contextual and inevitable dis-pleasures. Nothing rings truer than this when you are about to go on a diet, given the right proportions, and nothing rings truer than during a pandemic, when it is about making some concessions without pushing the stressful consequences to their limits. The public and personal health imply this balance and this must be true at the global level to prevent the healthcare system to go bankrupt, which is a possibility that, for a number of reasons, is

always around the corner and not only during a health emergency. After all, this cannot be avoided in both ordinary and extraordinary cases, as it is a question of "diseases awareness," of understanding one's state of health and that of the population to which we belong, avoiding "over-diagnosing", because the border between what is and is not needed is hard to define and the waste of resources, which is also a psychological waste, is always a possibility.

REFERENCES

[1] Costa, PT Jr, McCrae, RR 2009, *The Five-Factor Model and the NEO Inventories* in Butcher J. N. (ed.), *Oxford library of psychology. Oxford handbook of personality assessment*. Oxford: Oxford University Press, pp. 299-322.

[2] Beck, U 1999, *World risk society*, Cambridge: Polity Press.

[3] Fornito A, Zalesky A, Bullmore ET 2016, *Fundamental of Brain Network Analysis*. London, San Diego, Cambridge, Oxford: Elsevier.

[4] Girard, R 1982, *Le bouc émissaire*. Paris: Grasset.

[5] Delumeau, J 1978, *La peur en occident*. Paris: Arthème Fayard.

[6] Teubner G 2015, *Ibridi e attanti. Attori collettivi ed enti non umani nella società e nel diritto*, Milano: Mimesis.

[7] Lancioni T 2003, "Il contagio e il suo doppio. Piccola riflessione sull'immaginario epidemico a partire da una lettura del film *Nosferatu* di Wilhelm Murnau" in Manetti G (ed.), *Il contagio e i suoi simboli. Saggi semiotici*. Pisa: ETS, pp. 121-151.

[8] Detienne, M 1986, *Dionysos à ciel ouvert*. Paris : Hachette.

[9] Foucault, M 2004, *Sécurité, territoire, population. Cours au Collège de France 1977-78*, Paris: Seuil/Gallimard.

[10] Street, RLJ 2013, "How clinician-patient communication contributes to health improvement: modeling pathways from talk to outcome", *Patient Education and Counseling*, vol. 92, no. 3, pp. 286–291.

[11] Taylor, K 2009, "Paternalism, participation and partnership - the evolution of patient centeredness in the consultation", *Patient Education and Counseling*, vol. 74 no. 2, pp. 150–155.

[12] Engel, G L 1980, "The clinical application of the biopsychosocial model", *The American Journal of Psychiatry*, vol. 137, no. 5, pp. 535–544.

[13] Lewis B, Lewis J 2015, *Health Communication. A Media & Study Approach*, New York: Palgrave; Bigi, S 2016, *Communicating (with) care*. Amsterdam, Berlin, Washington, DC: IOS Press, pp. 37-58.

[14] Mead, N & Bower, P 2000, "Patient-centeredness: a conceptual framework and review of the empirical literature", *Social Science & Medicine (1982)*, vol. 51, no. 7, pp. 1087–1110.

[15] Cross R, Davis S, O'Neil I 2017, *Health Communication Theoretical and Critical Perspectives*, Cambridge: Polity Press.

[16] Beisecker, AE, Beisecker, TD 1993, "Using Metaphors to Characterize Doctor--Patient Relationships: Paternalism Versus Consumerism", *Health Communication*, vol. 5, no. 1, pp. 41–58.

[17] Wasserman, RC, Inui, TS 1983, "Systematic analysis of clinician-patient interactions: a critique of recent approaches with suggestions for future research", *Medical Care*, vol. 21 no. 3, 279–293; Ong, LM, de Haes, JC, Hoos, AM, Lammes, FB 1995, "Doctor-patient communication: a review of the literature", *Social Science & Medicine (1982)*, vol. 40, no. 7, pp. 903–918.

[18] Cegala, DJ 1997, “A study of doctors’ and patients' communication during a primary care consultation: implications for communication training”, *Journal of Health Communication*, vol. 2, no. 3, pp. 169–194.

[19] Elwyn, G, Miron-Shatz, T 2010, “Deliberation before determination: the definition and evaluation of good decision making”, *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, vol. 13, no.2, pp. 139–147.

[20] McMurray A 2006, *Community Health and Wellness: A Socio-ecological Approach*, St. Louis: Mosby Elsevier.

[21] Dutta, M 2008, *Communicating Health: A Culture-Centered Approach*, London: Polity; Dutta M. 2011, *Communication Social Change: Structure, Culture, and Agency*, New York: Routledge.

[22] Segal, JZ 1997, “Public discourse and public policy: Some ways that metaphor constrains health (care)”, *Journal of Medical Humanities,* vol. 18, no. 4, pp. 217–23; Segal, J Z 2000, “Contesting death, speaking of dying”, *The Journal of Medical Humanities,* vol. 21, no. 1, pp. 29–44.

[23] Gross, JJ, Muñoz, RF 1995, “Emotion regulation and mental health”, *Clinical Psychology: Science and Practice*, vol. 2, no. 2, pp. 151–164.

[24] Castro EM, Van Regenmortel T, Vanhaecht K, Sermeus W, Van Hecke A 2016, “Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review”, *Patient Education and Counseling*, vol. 99, no. 12, pp. 1923-1939.

[25] Kindig David A 2004, *Health Literacy. A Prescription to End Confusion*, Washington: National Academic Press.