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COVID-19 and Safety on the Job: a Perspective from Sociology of Health

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Abstract

The pandemic situation caused by COVID-19 has characterised the mindset, kick-starting a multidisciplinary thinking, in order to cope with a situation that has affected the entire world. A completely new scenario, such as the one in which we found ourselves working during the peak of the health emergency, leads to a more difficult control of information and a sharing of it that is sometimes not sufficient to overcome the perceived sense of uncertainty, fear and therefore emotional stress.

Keywords: COVID-19, social distancing, health, risk management, social policies

Riassunto. *Covid-19 – Come sta cambiando la società*

La situazione pandemica causata dal COVID-19 ha caratterizzato il modo di pensare rimettendo in moto un pensiero multidisciplinare per far fronte a una situazione che ha colpito l'intero mondo. Uno scenario inedito come quello in cui ci si è ritrovati a lavorare durante il picco dell'emergenza sanitaria, ha portato ad un controllo delle informazioni più difficoltoso e ad una condivisione delle stesse a volte non sufficiente a colmare il senso di incertezza percepito, la paura e quindi lo stress emotivo.

Parole chiave: COVID-19, distanziamento sociale, salute, gestione del rischio, politiche sociali

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1. Introduction

The pandemic situation caused by COVID-19 has undoubtedly characterised not only the beginning of 2020 but also the mindset, kick-starting a multidisciplinary thinking of fundamental importance, in order to cope with a situation that has affected the entire world. Everyone, at this particular time, can and should discuss how COVID-19 has changed our lives – and will change them again – aspects of social relations, health and illness (Corposanto, 2007).

Health has become a social problem, which is why sociology has shifted its focus from illness, medicine, and social services to health, which in the past was not the subject of reflection or social intervention because it did not represent a socially recognised issue: it constituted a hidden dimension of social life, since it is illness and not health that manifests itself. When we talk about illness, three different actors come into play: the sick person, the

medical institution with its professionals, and society as a whole. The onset of illness creates a triadic system of social interaction involving the three above-mentioned actors.

From society's point of view, illness is first and foremost a problematic social condition, potentially dangerous, other than onerous, to the social order, which raises awareness of the importance of disease prevention and health promotion.

There are many definitions of prevention and health promotion. These concepts are constantly evolving and need to be reflected upon, especially in terms of the effects of the interventions implemented. The understanding of the functioning of the health sector is no longer based just on a theoretical reasoning, it is based on actual performance and observed costs. It is becoming increasingly clear that, in addition to remedial or rehabilitative action, it is necessary to act in advance and prevent the appearance of the disease. This action is necessary in order to avoid some of the subsequent problems and prevent the health system from collapsing (Brown, 2020).

Synergistic action is needed to live better. Prevention and health promotion cannot be limited to health education alone. Through sound public policies, it must act both on individuals to promote healthy lifestyles, but also on the existential conditions, social, economic and environmental factors that are determinants of health. Health promotion and disease prevention is the responsibility of most actors within the economic system, but also of all those acting in favour of sustainable development. The intervention of private actors is unquestionable, but the state cannot ignore its responsibility and assume its role, which is fundamental. Health promotion is positive, and numerous interventions have demonstrated their effectiveness.

Investments in health promotion improve the health status and quality of life of individuals. They can promote the independence of the elderly, prevent or delay dependency on care and ensure a more differentiated use of the services offered by the healthcare system, thereby curbing the long-term rise in costs.

This is because what is spent on health promotion and prevention is often a profitable investment for society as a whole and, depending on the case, saves those who finance it money.

2. Historical evolution of the Sociology of Health

Every society, in order to subsist, must fulfil four functional prerequisites: Adaptation to the environment from which the social system must draw the physical resources from which to obtain goods and services; the selective pursuit of aims, which for society is resolved in the political function of the institutions; social integration, that is, the diffusion of values and norms that must be socially shared and internalised, from which also the search for motivational consensus for adherence by members to the constituent and functional social roles of society; latency, otherwise known as societal control of tensions and behavioural deviances from social role expectations. Talcott Parsons (1964) can be defined as the founder of Medical Sociology, but he was certainly not the first sociologist to be interested in the binomial health/disease; Émile Durkheim, in his main works, deals with the dichotomy between normal and pathological, anticipating Medical Sociology but above all paving the way for structural-functionalism in sociology. Authors such as Ramazzini (at the end of the seventeenth century) and Virchow, although belonging to other disciplines, can be considered proto-sociologists of health because of their studies aimed at underlining the social impact of some health interventions (or lack of interventions) (Durkheim, 1895, p. 65). Returning to Parsons, his thought has been superseded, like structural-functionalism, by other sociological currents that have criticised the functionalist idea of the social system (conflict theorists and radical sociology), focusing their attention on micro-systemic aspects (phenomenology), and using the concept of health in a holistic sense (correlational model).

Conflict theorists (Marxists, Marxian and radicals) have adopted as their epistemological basis the critique of the social system of the functionalist type, promoting the abolition of present things in order to cope with a system less dependent on the economic-political context of the liberalist type. Medicine is also criticised because it determines forms of social control and it is also an appendage of the economic structure; it is «regarded as an ideology of social control, that is, as a false consciousness spread by those social groups that derive particular advantages from certain practices» (Donati, 1983). The focus is therefore on the class conflict between those who own the means of production (capitalist

bourgeoisie) and those who sell their labour power, thus generating differences, inequalities and injustice. Health is therefore conditioned by the social system that generates discrepancies between a narrow elite that holds coercive power and the mass of individuals. The doctor/patient relationship, therefore, also presents a dichotomy in which there is a one-sidedness of the relationship between the doctor and the patient: the doctor acts using his knowledge on a body, whose individual is unaware of his real condition.

Unidirectionality (not to say dominance) is also dictated by the fact that doctors belong to the highest social class, while patients are predominantly 'exploited' proletarians. Karl Marx never wrote anything about health or illness. His thinking in this respect can therefore be traced back to his model of structure and superstructure. Friedrich Engels, on the other hand, co-author of the Manifesto of the Communist Party, wrote at a very young age a study entitled The Condition of the Working Class in England. A work in which the very young Engels describes in a detailed and precise way the life of the English proletariat and sub-proletariat in the mid-nineteenth century: a faithful reproduction of the real consequences on the masses of the change produced by the wild industrialisation of lifestyles, the cause of an increase in certain morbidity and mortality that had hitherto been little noticed.

The main difference between the two currents is that for the latter, alienation does not derive mainly from economic capitalism but from an industrial and bureaucratic cultural model; the health/disease dichotomy is read not only in economic-political terms but following Enlightenment and existentialist typologies. Ivan Illich, an Austrian sociologist, argues that the power of medicine in industrial societies is undermining the freedom and ability of individuals to take responsibility. He sees modern medicine as literally a sickening force that actually creates disease (Illich, 2005). Illich is a leading exponent with his concept of iatrogenesis, by which he means an illness caused by the secondary effects of treatment in industrial societies where the subject is helpless before the mass of persuasive and suggestive stimuli aimed at consumerism, biomedical and pharmaceutical dominance in the field of health, etc. Phenomenology, on the other hand, has 'revolutionised' the way of reading and understanding health and illness, since it has attempted, and in some ways succeeded, to overcome the anachronistic Cartesian dichotomy between res cogitans and res

extensa, thus unifying the two dimensions. Phenomenologists, in their different schools, focus their interest on the concept of self (Illich, 2005).

Goffman is a Canadian-born scholar of some relevance to anyone working in sociology, but particularly in the sociology of health and illness. In two of his works, Stigma and above all Asylums, the American sociologist makes an accurate reconstruction of the so-called total institutions. Goffman uses this term to define not only prisons and asylums, but a whole series of institutions, such as, for example, cloistered religious orders, although the ideal-type of total institutions are those that are coercive, where the individual assumes the role of an inmate. The stigma is the mark left by the cross on the wounds of Christ (stigmata), it is the branding on the skin of slaves (Goffmann, 2003). In social life, stigmatisation lingers on the traces of an illness or accident, on the signs of alcoholism, on the behaviour of drug addicts, on the skin of the black man, on the star of the Jew, on the customs of the homosexual, etc. A chronic or reversible illness is a stigma. A chronic or reversible illness is therefore stigmatised insofar as it leads to partial or complete exclusion from social life. The environment creates a malaise in the person suffering from any kind of impairment, which is not only biological but also affects their performance and abilities. Medicine, therefore, cannot disregard the patient's 'individuality' and must establish an empathic relationship that facilitates the patient's well-being. It is in this perspective that authors such as Twaddle (and later Maturo) make explicit the three dimensions of illness: disease, illness and sickness, which are at the basis of Narrative Based Medicine (Maturo, 2007). Phenomenology is not enough to solve the epistemological problems of sociology at the end of the 20th century. In recent years the correlational approach is advancing. Connectionism is «a multidimensional and interdisciplinary perspective, which considers and embraces various analytical levels, coordinating and interacting with them in a logic of theoretical, cultural and methodological co-integration, which favours the plurilateral comparison between different proposals and between different conceptual levels» (Bertolazzi, 2004). Correlativism is based on a correlational logic in which the link that is established between the different variables in play, the connection that joins them and the co-variation that is produced, deny heuristic legitimacy to both Platonic constructivist idealism and Aristotelian positivist realism

(Giarelli, 1998). According to Costantino Cipolla, every authentic knowledge becomes correlation in the measure in which it is co-produced, co-instituted, co-constructed according to a plurality of interconnected analytical levels that imply the assumption of the multiple, of the variability, of the change, of the multidimensionality of one's own universe of relevance (Giarelli, 1998). With the correlational approach health sociology was born. The founder of this branch of sociology in Italy was Achille Ardigò, one of the most important Italian sociologists who dedicated a significant part of his research activity and reflection to the theme of health. He placed the health system at the centre of a quadrilateral, the corners of which contain four constituent elements, the interweaving of which can explain the characteristics that over time have given rise to the main interpretative paradigms of human reflection in this field: nature external to man, nature internal to man, the social system and individual psychic reality (Giarelli, 1998). The interweaving of scientific discoveries, therapeutic and organisational progress in health care and phases of sociological thought thus led to the development of a new series of steps in human thought on health, which, according to Ardigò's schematisation, are dominated by the considerations between the social system and the individual subject as a psychic entity. Ardigò intends to highlight precisely the weight of the psyche and social factors in determining the study of health phenomena, and their explanation, in the period closest to us. Everything that has taken place from the end of the 1970s to the present day, and which is described by Ardigò, is decisive for the birth of the modern sociology of health, that discipline with which, for the first time in the modern era, illness and treatment are explained not only and not so much in the light of their organic causes, but also and above all in relation to the relationships pertaining to the social and psychological determinants, and to the more specifically immaterial ones that exist between patient and doctor, with all the evident connections with the anthropological and economic dimension of existence (Ardigò, 1997).

3. COVID-19 and social distancing

Today, COVID-19 has made us discover again the meaning of social distancing and physical distancing. Communication is increasingly influenced by technology, just think of neo-languages, the imperative presence of technology brings about a radical change in the way we communicate. For example, communication used to be by handwritten letters, but nowadays we use e-mail. In reality, there are two types of change: a more superficial one, that of waiting, and a more profound one, that of the loss of time and space. Before, we knew where the letter was written (just think of Leopardi's poems), whereas today we have lost the place that is so important for human reflection, so we need to reconstruct the contexts, the places that help interpretation. In his work, Corposanto has managed to explain how the term social distancing now does not refer to reality, since globalisation and the new tools for communication, which were different until a few years ago, manage to eliminate distances, thus changing the term from social distancing to physical distancing. This paves the way for the sociology of health, which does not focus on a particular social sub-system but attempts to analyse aspects of health from a multidimensional, multidisciplinary and multifunctional perspective (Corposanto, 2020). The sociology of health, as a branch linked to the cardinal themes of the discipline of sociology, has assumed an important role in the processes of development and consolidation of the welfare system and in particular of health and social services.

COVID-19 made us discover new conditions of life of the person, but also new social relations. The social determinants of health are analysed, social research or project/intervention management is undertaken. The sociologist of health, in particular, will have to operate his or her interventions with priority on certain areas, such as: social factors and relations of the individual that produce health/disease, that promote well-being and quality of life; social factors and relations that produce health/disease, ease/discomfort, social inclusion/exclusion, that promote well-being and quality of life in different environmental contexts, in groups, etc.; system of social relations that produce health/disease, ease/discomfort, social inclusion/exclusion, that promote well-being and

quality of life in different environmental contexts, in groups, etc. the system of social relations that produce health/disease, ease/discomfort, social inclusion/exclusion, that promote well-being and quality of life, through the relationship between the network of social actors of welfare, social/health services, organisations/institutions, groups, citizens and the territory; communication and relational systems, organisational models, planning, management and evaluation processes within the network of social actors of welfare and social/health services. The health sociologist has finally become an observer who suspends his knowledge linked to the cognitive and affective dimension, does not act on the body but on the system of representations of the person, evaluates the life experiences of the patient from birth onwards (Rhodes, Lancaster and Rosengarten, 2020).

The contribution of sociology to the health system in general is oriented towards quality assessment, a useful contribution for optimising the management of both medical and organisational management interventions. A significant means of evaluation for efficient quality assessment is user satisfaction and the collection of "life stories". Sociology, and by extension the sociologist of health, by opening up to other sciences, combines its methodology with statistical, epidemiological and economic methods; its knowledge intersects with medicine, law and even fiction. This is an excellent way of assessing the structure/process/outcomes of social and health service provision (Rhodes, Lancaster and Rosengarten, 2020). Today, as never before, the road to the sociology of health is open to us, which focuses not on a particular social sub-system, but attempts to analyse aspects of health from a multidimensional, multidisciplinary and multifunctional perspective.

4. COVID-19 and Safety at Work

In this time of particular difficulty and change, it seems necessary and proper to focus research on the study of psychosocial risk factors, with particular reference to their outcomes, has expanded over time and led to significant developments in occupational safety research (Rossiterand and Godderis, 2020).

The level of awareness within companies about the prevalence of such risks is highlighted by European data from the European Agency for Safety and Health at Work (EU-OSHA) survey on new and emerging risks, which recently confirmed that psychosocial risks are perceived as among the most challenging by European employers/managers (Hassard e Cox, 2010; Hupke, 2015)

Currently, it is the EU-OSHA that has been providing data on the identification, prevention and management of psychosocial risks and work-related stress, and a European opinion poll on occupational health and safety reveals that about half of workers believe that the problem of work-related stress is common in the workplace (European Agency for safety and health at work, 2014).

The latter identifies which working conditions may lead to the risk of work-related stress:

- excessive workloads;
- insufficient time available to complete tasks;
- conflicting demands and lack of clarity on roles (matching worker skills and job requirements);
- discrepancies between the job requirements and the worker's competence (including under-utilisation of skills);
- lack of involvement in decision-making processes affecting workers and lack of influence on the way work is done;
- inadequate management of organisational change and its processes (working time arrangements, degree of autonomy, job insecurity);
- ineffective communication (uncertainty about job expectations, employment prospects...);
- lack of support from colleagues or superiors (emotional and social pressures, feelings of inadequacy, perceived lack of support);
- environmental working conditions (exposure to noise, heat, dangerous substances...);
- psychological and sexual harassment, third-party violence (mobbing, bossing, etc.);
- difficulty in reconciling work and private commitments (Hassard e Cox, 2010).

In the light of this survey, a preventive, holistic and systematic approach to the management of psychosocial risks was found to be the most effective.

It is important to emphasise that psychosocial risks should not be confused with a healthy working environment that, while challenging, supports and stimulates workers, encouraging their development and performance to the maximum.

EU-OSHA's 2019 Survey of Enterprises on New and Emerging Risks (ESENER) examines how psychosocial risks are perceived and managed in European enterprises, as they also suffer from negative effects including low overall profitability, increased absenteeism and staff turnover (absences tend to be longer than they should be) or even presenteeism (continuing to go to work even when you are sick but at the same time not being efficient), an increase in the rate of accidents and injuries at work leading to a highly significant increase in costs for businesses and companies, estimated at billions of euros at national level (European Agency for safety and health at work, 2020a; 2020b), of which EUR 240 billion per year is for mental disorders (including those not directly related to work).

Less than half of these costs are direct costs, such as medical care, while about 136 billion euros are related to lost productivity for companies, including sick days (Hassard *et al.*, 2014). On the other hand, as far as we are concerned, data from the EU-OSHA survey (2014 and 2019) were confirmed by the results of the National Survey on Occupational Health and Safety (INSuLa) of INAIL (National Institute for Occupational Accidents Insurance) showed a prevalence of work-related stress risk among the health risks perceived as most pressing by most of the sample of workers interviewed (over 8,000 workers representative of the Italian production system).

At the level of occupational safety research and prevention, these risks represent one of the main challenges to be faced, also in view of the significant socio-economic costs associated with them for companies and society as a whole (Iavicoli *et al.*, 2011).

The impacts of such risks on workers' health, company productivity and society are obvious.

It is more evident than ever at this particular time caused by a global epidemic, the need to raise awareness and find practical tools to facilitate the treatment of work-related stress.

By adopting the right approach, it is possible to effectively prevent and manage psychosocial risks and work-related stress, regardless of the characteristics or size of the company, or to address them in the same logical and systematic way as other occupational health and safety issues (European Agency for safety and health at work, 2020c) .

Although it is the employer's legal responsibility to ensure that risks at work are properly assessed and controlled, it is also essential to involve workers, who, together with their representatives (RLS), best understand the problems that can occur in the workplace (European Agency for safety and health at work, 2020b).

They have the right and the duty to share this knowledge with managers and employers, so as to help draw up a plan and implement solutions.

However, worker participation cannot be limited to a simple feedback from the bottom of the hierarchical pyramid: it requires a two-way dialogue between employers and workers, in which both sides (European Agency for safety and health at work, 2012):

1. communication
2. listening to each other's concerns
3. sharing opinions and information;
4. taking joint decisions.

Worker involvement is particularly important for successfully addressing stress and psychosocial risks in the workplace because, by consulting workers, managers help to create a climate of trust in which workers will feel comfortable reporting any problems. Involving workers can ensure that the development of preventive measures is appropriate and effective will also improve overall morale and ensure that the measures put in place are both appropriate and effective (Health and Safety Executive, 2007).

At the same time, however, they have a general obligation to comply with the preventive and protective measures established by the employer himself. The management of work-related stress problems is carried out within a general risk assessment process, through a separate stress policy and/or specific measures aimed at identifying stress factors.

Measures to prevent, reduce and eliminate work-related stress problems may be collective, individual or both, and should be implemented and monitored by experts in the workplace (Rangel *et al.,* 2020).

It is crucial to understand which dimensions of analysis and interpretation of work situations are most useful for making choices that are more congruent between production objectives and workers' well-being perspectives. Once in place, anti-stress measures should be regularly reviewed to assess their effectiveness, whether they are making the best use of resources, and whether they are still appropriate or necessary. Such measures could include, for example: establishing behavioural protocols, referring to the so-called "socially ethical business" (art. 2, paragraph 1, of Legislative Decree no. 81/2008) (Psicologia del lavoro, 2019), to the social responsibility of companies themselves and to ethical codes to protect rights and dignity (also by inserting contractual clauses), which at the same time envisages stimulating a cultural change that stigmatises vexatious behaviour, changing leadership styles, tackling "organisational dysfunctionality", improving corporate communication, taking care of communication and management measures, such as clarifying the objectives of the company and the role of each worker, ensuring adequate managerial support for individuals and groups, combining responsibility and control at work, improving the organisation and work processes, the working conditions and environment, promoting total quality management, etc. (Rulli, 2010).

All this is summed up in two words, "promotional activities", according to the provisions of art. 11 of Legislative Decree no. 81/2008, in order to make the prevention activities of companies concrete and facilitated, funding is provided to companies for investment, training and activity projects.

Increasing the competences of occupational physicians (also family doctors, psychiatrists and psychologists), identifying health impairments through health surveillance (art. 40, l.d. 81/2008) involving medical checks targeted at specific workplace exposures and conditions and/or biological tests (including biomonitoring) for specific risk indicators, in order to train managers and workers to increase awareness and understanding of stress, its possible causes and how to deal with it and/or adapt to change.

Improving information and training (raising awareness of the need for protection) of all those who must contribute to creating the safe enterprise: employers, supervisors, competent doctors, RSPP, consulting workers and/or their representatives (RLS) in accordance with EU and national legislation, practices and collective agreements (ETCU, UNICE, UEAPME, CEEP (2004).

The effective intervention approach, as far as workers themselves are concerned, on the other hand, is one that allows women and men, with the specificities of the case, to detect perceptions of their own state of health and, at the same time, to work on empowerment, i.e., first of all, on the development of skills of self-awareness and self-mastery, motivation, empathy, resilience («the ability of an individual to cope with and overcome a traumatic event or a period of difficulty»), coping («adaptation strategy»), social skills, i.e. the emotional competences with which he/she tries to control events that he/she considers difficult or beyond his/her resources and the effects they have on the individual and the organisation, in other words understood as expected professional competences (Schön, 1993).

5. Towards a new organisation

A completely new scenario, such as the one in which we found ourselves working during the peak of the health emergency, inevitably leads to a more difficult control of information and a sharing of it that is sometimes not sufficient to overcome the perceived sense of uncertainty, fear and therefore emotional stress.

On the other hand, the lack of dynamism may lead to souring the relationship between colleagues or to a loss of respect for one's job role (Rossiterand and Godderis, 2020).

Most of the time, it is not possible to tackle all causes of stress in a decisive way because they are very diverse and subjective; however, an analysis of workers' behaviour and perceptions, if carried out in depth, can at least help to identify the most relevant causes of work-related stress, allowing early intervention to contain its symptoms and reduce its

levels. To this end, it is important to promptly put in place different intervention strategies, not only at individual level, but also at organisational level.

On this front, providing for a system of constant health surveillance and a review of work organisation that considers the needs of workers and their state of well-being, is the key to managing stress and the operational and behavioural patterns of workers, both at work and in relations between colleagues.

A healthy and peaceful working environment, which puts people at the centre of all organisational and management rationale, helps to contain cases of discontent, increases individual satisfaction levels and improves perceived quality of life.

A modern organisation must necessarily adapt to the challenges imposed by the external context and must know how to manage its human resources (in terms of motivation, talent development, professional growth and also health protection) and technical-productive resources (technology, company know-how) while guaranteeing high levels of productivity, effectiveness and efficiency. According to Lawrence and Lorsh (1967), there is no one organisational model that is valid for every situation, since models change from time to time according to the goals to be achieved and environmental changes.

Since the organisation is embedded in and in constant relationship with the environment, it must have a variety of regulatory mechanisms at least equal to the variety that characterises the environment, otherwise it could not manage environmental challenges.

Commendable was the adaptation of the hospitals and the services rendered by the medical staff during the COVID-19 emergency, where the recognition of individuality, creativity, responsibility and sacrifice as well as the usefulness of teamwork emerged.

It is important to remember that whatever the starting point, an organisation can change its structure, as well as the goal to be achieved and/or the means to be employed, and a striking example of this is represented by single-specialist or general hospitals, for example, transformed during the COVID-19 emergency into "covid hospital" structures by making changes to the premises, equipment, type of personnel and their training (De Sio *et al.*, 2021).

It follows from the above that an organisation based on Taylor's mechanistic theory, with its rigid procedures and the passivity of people not encouraged to take on more responsibilities than those precisely allocated to them, would face serious difficulties in dealing with new situations (Mykhalovskiy and French, 2020).

An increasingly integrated approach to health problems requires all the 'non-medical' health professions (nurses, physiotherapists, radiology and laboratory technicians, etc.) to act in concert and as a team, in harmony with the other health professions (doctors, psychologists, biologists, etc.).

Within all professions, there is an emerging need to establish leadership-based co-ordination and management roles in order to use one's own skills to activate the potential of others, motivating them to give their best in the organisation for which they work.

6. Conclusions

The pandemic has awakened practitioners from a deep sleep, reminding them that there have been so many changes over a hundred years and now, as never before, the sociology of health is supporting a new model of health management by promoting social wellbeing and tackling illness, disability and malaise. Its aim is to study the relationships between points of view, between social actors, between groups, between institutions in relation to the social construction of well-being aimed at improving the health and quality of life of individuals and populations. In conclusion, it becomes necessary to draw up a contingency plan while waiting for a vaccine where the fundamental objective will be to guarantee the continuous improvement of the quality of the service. The health sociologist will have to further explore the issue of health/disease in a holistic and non-particularistic sense. His work must again be based on an additive logic capable of overcoming the induction/deduction dichotomy.

The methodology and social research techniques to be adopted will ensure that the work product of the health sociologist will be a valuable tool for micro-macro structural investigations in the various subsystems of society (Rossiterand and Godderis, 2020).

In recent years the welfare system, and in particular the national health service, have proved to be very representative contexts in which both the identity and knowledge of sociology have been able to express themselves concretely, and the skills of the professional sociologist have been used in operational terms. The world has changed, society has changed, we have to accept change.

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