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VSEBINA / INDICE GENERALE / CONTENTS

Janez Mlinar: The Role of Ironmaking in a Premodern Rural Community. The Example of the Weissenfels Lordship 117
Il ruolo della siderurgia nella comunità rurale di premoderna.
L'esempio della signoria di Weissenfels
Vloga železarstva v predmoderni ruralni skupnosti.
Primer gospostva Weissenfels

Gašper Oitzl: Migrations and Identities in Ironmaking in the Slovenian Territory during the Late Middle Ages and Early Modern Period 133
Migrazioni e identità nella siderurgia
in Slovenia tra tardo Medioevo e prima
età moderna
Migracije in identitete v železarstvu na Slovenskem
v poznem srednjem in zgodnjem
novem veku

Sabine Rutar: Mining as Maritime History? The Coalmine in Sečovlje from Fascist Beginnings to the Early Cold War 151
L'estrazione mineraria come storia marittima?
La miniera di carbone di Sicciole (Sečovlje, Slovenia)
dagli esordi del fascismo ai primi anni della guerra fredda
Rudarstvo kot pomorska zgodovina?
Premogovnik v Sečovljah od fašističnih začetkov do
zgodnje hladne vojne

Andrea Negro: On the Side of Production Waste: Doctors and Occupational Medicine in Support of Sick Miners between Belgium and Italy	177
<i>Dalla parte degli scarti di produzione.</i>	
<i>I medici e la medicina del lavoro a sostegno dei minatori malati tra il Belgio e l'Italia</i>	
<i>Na strani proizvodnih odpadkov.</i>	
<i>Zdravniki in delovna medicina v podporo bolnim rudarjem med Belgijo in Italijo</i>	

Resul Babaoğlu, Emin Alp Malkoç & Feyza Kurnaz Şahin: “A Coal Stain Is Hard to Remove”: Türkiye’s Mining Agenda f rom the Perspective of the Humor Magazines	197
<i>“La macchia di carbone è difficile da rimuovere”:</i>	
<i>il programma minerario della Turchia dalla prospettiva delle riviste umoristiche (1960–1980)</i>	
<i>»Madež od premoga je težko odstraniti«:</i>	
<i>turška rudarska agenda z vidika humorističnih revij (1960–1980)</i>	

Jan Babnik: Visual Economy of Sameness: Photography of Miners and of Mining Labor in Slovenian Photoreportage of the Twentieth and Early Twenty-First Centuries	241
<i>Economia visiva dell’uniformità: la fotografia dei minatori e del lavoro minerario nel fotoreportage sloveno del XX e dei primi decenni del XXI secolo</i>	
<i>Vizualna ekonomija istosti: fotografija rudarjev in rudarskega dela v slovenski fotoreportaži 20. in zgodnjega 21. stoletja</i>	

ON THE SIDE OF PRODUCTION WASTE: DOCTORS AND OCCUPATIONAL MEDICINE IN SUPPORT OF SICK MINERS BETWEEN BELGIUM AND ITALY

Andrea NEGRO

University of Padua, Via VIII Febbraio, 2, 35122 Padua PD, Italy

e-mail: andrea.negro.1@phd.unipd.it

ABSTRACT

This article explores the toxic legacy of the 1946 Italo-Belgian agreement that sent thousands of Italian workers into Belgian coal mines, many of whom later suffered from severe occupational diseases. Drawing on the author's doctoral research on the return of sick miners from Belgium to Italy, it focuses on the long-term bodily, social, and institutional consequences of mining work after the decline of the Belgian coal industry. Through two case studies – one centred on a widow in Liège seeking posthumous recognition of her husband's illness, the other on socially engaged occupational physicians in Slavia Friulana/Beneška Slovenija, the Slovenian-speaking area of Friuli-Venezia Giulia, the article examines how medical knowledge, diagnostic practices, and compensation systems could reproduce or challenge migrant workers' exclusion. Combining oral history, medical and judicial documents, and sources from associations and welfare institutions, it argues that occupational health was not only a field of suffering, but also a terrain of conflict over recognition, responsibility, and justice. Ultimately, it shows how medicine could become part of a broader dynamic of social discard, but also a tool for resisting it.

Keywords: Italian migration, Belgian coal mines, silicosis, occupational medicine, Slavia Friulana/Beneška Slovenija

DALLA PARTE DEGLI SCARTI DI PRODUZIONE. I MEDICI E LA MEDICINA DEL LAVORO A SOSTEGNO DEI MINATORI MALATI TRA IL BELGIO E L'ITALIA

SINTESI

L'articolo analizza l'eredità tossica dell'accordo italo-belga del 1946, che portò migliaia di lavoratori italiani nelle miniere di carbone belghe, molti dei quali in seguito furono affetti da gravi malattie professionali. Attingendo alla ricerca di dottorato dell'autore sul ritorno in Italia dei minatori malati dal Belgio, l'articolo si concentra sulle conseguenze a lungo termine – fisiche, sociali e istituzionali – del

lavoro nelle miniere dopo il declino dell'industria carbonifera belga. Attraverso due casi di studio – uno incentrato su una vedova di Liegi che cercava il riconoscimento postumo della malattia del marito, l'altro su medici del lavoro socialmente impegnati a Slavia Friulana/Beneška Slovenija, nell'area di lingua slovena del Friuli-Venezia Giulia – l'articolo esamina come le conoscenze mediche, le pratiche diagnostiche e i sistemi di indennizzo potessero riprodurre o contrastare l'esclusione dei lavoratori migranti. Combinando testimonianze orali, documenti medici e giudiziari, nonché fonti provenienti da associazioni e istituzioni di assistenza sociale, l'articolo sostiene che la salute sul lavoro non fosse solo un ambito di sofferenza, ma anche un terreno di conflitto in materia di riconoscimento, responsabilità e giustizia. In definitiva, mostra come la medicina potesse diventare parte di una più ampia dinamica di emarginazione sociale, ma anche uno strumento per opporvisi.

Parole chiave: L'emigrazione italiana, le miniere di carbone belghe, la silicosi, la medicina del lavoro, Slavia Friulana

A LONG LEGACY OF TOXICITY

In 1946, the Italian and Belgian governments signed a protocol that organized the recruitment of Italian workers for the Belgian coal mines in exchange for Belgium's commitment to sell coal to Italy. This agreement must be situated within the broader political economy of post-war reconstruction. Italy faced unemployment, poverty, social unrest, and a severe energy shortage, while Belgium needed to increase coal production rapidly in order to restart its industrial system (Alberti, 2016; De Clementi, 2010). The agreement therefore turned migration into an instrument of economic policy: Italian workers were recruited for Belgian mines through promises of wages, housing, and social protection, while their labour became part of a wider exchange between manpower and energy. Within this framework, once they arrived in Belgium, Italian migrants soon realized that the promises made to them by their government and the Belgian Coal Federation actually masked an agreement based on the exploitation and commodification of labour, workers, and, above all, human beings. The bitter realization that they had been 'sold for a sack of coal' is perhaps one of the most recurring themes in the hundreds of testimonies, interviews, autobiographies, diaries, and memoirs that have been produced over the years by the migrants themselves or collected by scholars, associations, and other organizations (Franciosi, 2024). In fact, we now know a great deal about issues related to migration in the strict sense and

the first twenty years following the protocol. I am referring to aspects such as the dynamics of departures and arrivals, the difficult living conditions of the early years when Italians were assigned the barracks built a few years earlier by the Nazis, the brutality of the work, the deaths in the mines, the Marcinelle disaster, racism, but also aspects such as the export of Italian culture to Belgium or the sense of community that formed among migrants.¹

Another central issue in this story is that of occupational diseases. It did not take long before the miners began to feel the effects of exposure to toxic dust in the mine. The theme of disease recurs constantly, both in direct testimonies and in literature. In the latter, however, compared to elements such as those mentioned above, it has received less attention, except in a few very significant cases, considering the importance of the issue.²

Broadening our view, we can consider occupational diseases as one of the effects of Italian-Belgian policies, one of the most tragic, but not the only one: the protocol of 1946 set in motion a long trail of toxicity that has spread through time and space, reaching the present day and producing material, bodily, environmental, social, and political effects. The interpretive framework adopted here is in dialogue with Marco Armiero's concept of the Wasteocene, understood as a system of wasting relationships that renders socially and politically subordinated people, bodies, and places expendable for the prosperity, security, and capitalist enrichment of others (Armiero, 2021, 19–24, 99–103), and with Daniele Valisena's notion of 'coal metabolism', which connects Italian migration to Wallonia to the extractive, social, and bodily costs of coal production (Valisena, 2026).

In this sense, the miners' bodies were among the places where the toxic legacy of coal extraction, migration policy, and industrial decline was deposited and made visible. Several effects can be mentioned: environmental contamination, which in turn poisons the bodies that cross and will continue to cross the landscape even fifty years and more after the closure of most mines; the long list of deaths at work, adding to the number of miners who died of disease, and to the related social, economic, community, and family impact; the psychological repercussions and memories that remain difficult to process today. I conclude this partial list with the social effects of deindustrialization that have afflicted and still afflict former mining areas and, for the most part, now also former steelworks.³

This article presents selected findings from my doctoral research, entitled *Deindustrialized Bodies. The Return of Italian Miners from Belgium: Occu-*

1 This is in fact a very prolific field of study; I will limit myself to citing a few examples: Morelli (1998; 2004), Morelli & Verschueren (2018), Ricciardi (2016), Salsi (2013), and Franciosi (2024), as this is a very prolific field.

2 Regarding occupational diseases and their recognition in the Belgian mining context, cf. e.g. Geerckens (2009; 2014), Rossini (2006), and more recently Valisena (2026), who addresses the topic from an environmental history perspective, should be mentioned.

3 On Belgian steel deindustrialization and on the social history of Walloon industrial decline and mine closures, cf. Francq & Lapeyronnie (1990), Cammarata & Tilly (2001), and Verschueren (2013).

pational Diseases, Assistance, and Mobilization (1957–1980).⁴ The research reconstructs the return of Italian miners who had emigrated to Belgium after the 1946 protocol, focusing especially on the 1960s and 1970s and on illness as one of the central forces shaping their return.

I propose here an overview of my research to highlight some insights into the experiences of sick miners, framing on the one hand the impact that mining work and the policies promoted by Italy and Belgium had on them, and on the other hand the forms of resistance and reaction to the toxicity that pervaded bodies, communities, and society, both by the miners themselves and by various figures who were involved in assisting and helping sick migrants in various capacities. Specifically, this article focuses on one specific thread: the encounter between sick migrants and medical knowledge, and the ways in which doctors and occupational medicine could reproduce or contest the institutional mechanisms that transformed occupational disease into a private burden. The two cases analysed below do not exhaust the complexity of miners' illness, return, and assistance; rather, they make visible, at different scales, how medical practices, diagnostic thresholds, and individual choices became part of a struggle over recognition and justice.

Methodologically, the article combines oral history with archival and printed sources. I conducted around fifty interviews and informal conversations with former migrants, descendants, widows, physicians, *patronato*⁵ workers, and other actors involved in return, illness, and assistance. These voices are read together with institutional, hospital, welfare, trade-union, *patronato*, and associational records, private judicial and medical documentation, printed sources, and ego-documents. Rather than treating interviews as transparent containers of factual information, following the approach of Alessandro Portelli (1991), I use them as part of a mosaic of voices through which experience, memory, silences, and meanings can be reconstructed. In this framework, the cases selected here are not exhaustive, but representative and analytically dense fragments that allow different uses of medical science – exclusion, recognition, care, and resistance – to be observed in concrete situations.

PRODUCTION WASTE

[My husband] worked in the mines for eleven years, then two years in a factory, in coke ovens where they made coal dust balls, [...] then he went to work here in the zinc furnaces, twelve years in zinc furnaces at 1,600 degrees, twelve years breathing burnt gases [...] he already had bits of coal in his lungs and his illness began to develop. When he coughed, when he spat, pieces of coal came out too.

4 *Corpi deindustrializzati. Il ritorno dei minatori italiani dal Belgio fra malattie professionali, assistenza e mobilitazione (1957–1980)*.

5 A *patronato* is an Italian welfare-assistance institution, often linked to trade unions or social organizations, that provides free support with pension, social-security, and occupational-disease claims.

*There are miners who died immediately, after two months of breathing coal in the tunnels, and those who fell ill later. And then there are all the other jobs they did afterwards that [made them ill].*⁶ (Carmela M.)

With these words, Carmela M., a witness I interviewed during one of my research trips to Belgium, told me the story of her miner husband. Eighty-nine years old at the time of the interview and living near Liège, she had moved to Belgium in 1956, a few months after the Marcinelle disaster, where she met the man who would become her husband a few years later, Giuseppe C.⁷ Originally from northeastern Italy, he also moved to Belgium at the same time to work in the mines, where he remained for over ten years before following a path common among Italian migrants, namely moving into the metallurgical and steel industry, where he worked until retirement, changing companies and jobs several times. The excerpt reported here is taken from an interview during which the witness spoke at length about the suffering endured by her husband due to the illness he developed as a result of exposure first to coal dust and then to toxic fumes from steelworks and foundries, an illness that ultimately led to his premature death after many years of increasingly intense suffering. I have chosen to include these excerpts not because this story is representative in every respect, but because it brings into view several elements that recur in the trajectories of Italian migrants who fell ill in Belgium: prolonged exposure to toxic environments, diagnostic neglect, the difficulty of obtaining official recognition of the occupational origin of the illness, and the decisive role that individual doctors could play, either in reinforcing or in challenging institutional exclusion.

I was so tired of washing the overalls by hand... washing [my husband's] work overalls covered in coal, [...] when he came home, his eyes were still black with coal, and when he went to bed at night, he would get up because he was always hot. You could wash the sheets as much as you wanted, but they were always dirty with coal... but he... his body, you would have said he had tatouage⁸, so marked was his skin [...] but the real damage was what was [forming] inside, in his lungs. [From his early years working in the mine] he had some bronchial problems. Then his illness developed later, in the early 1970s, but until he died

6 Translated from the original Italian (All interview translations are by the author). [Mio marito] undici anni di miniera ha fatto, poi due anni li ha fatti alla Cockerill, in fabbrica, ai forni a coke dove facevano le palle della polvere di carbone, [...] dopo è andato a lavorare qua ai forni a zinco, 12 anni di forni a zinco a 1600 gradi di calore, 12 anni a respirare i gas di bruciato... aveva già i pezzettini di carbone nei polmoni e ha iniziato a svilupparsi la sua malattia. Quando sputava, quando tirava fuori, uscivano anche pezzi di carbone, ci sono minatori che sono morti subito, dopo due mesi a respirare carbone nelle gallerie e quelli che si sono ammalati dopo. E ci sono anche tutti gli altri lavori che facevano dopo eh che [li facevano ammalare]. Interview with Carmela M., aged 89, province of Liège, 19 October 2023.

7 At this stage of my doctoral research, and in agreement with the witnesses, I have decided to anonymize them, referring to them only by first name and surname initial.

8 From French: 'tattoos'.

they treated him for allergic asthma... but he didn't have allergic asthma, the doctors were treating him wrong. Then, two years before [he died], I was the one who made him change doctors, [because] when the other specialists were treating him... there was the lung specialist who was following him... but don't tell me he didn't see what was wrong with him... he wasn't interested in having him apply for occupational disease benefits, because he wanted to defend the fund. And the family doctor, on the other hand, [said]: 'You're always the same, Mr. C.,' gave him an injection, and left. At first, he seemed to be getting better, but then the disease progressed... and when I couldn't stand seeing him suffer anymore, but the doctors told him he was still the same... then I decided to change doctors: 'You won't see me anymore: a person who feels ill, who is ill, and you always tell me that there's nothing wrong with him?'. For many, many years, he was treated badly. For many years, I couldn't even stand to see the doctor who came to visit him... I told him: 'change doctors' every time, and not once did he tell us that my husband was dying... he was racist towards Italians. I still know people whose husbands died a month later, and he told them they had nothing wrong with them. Doctors did that to Italians... many people I know had husbands [who died, and their doctors] hid the fact that they had died from the mine... the certificate signed by the doctor said that he had died of bronchitis or cancer, but what had caused those diseases?⁹ (Carmela M.)

Coal leaves traces on the body. Some are visible, such as the spots on the skin, the 'tattoos' Carmela talks about, others are invisible, at least initially,

- 9 *Io ero talmente stufo di lavare a mano le tute... di lavare le tute di lavoro piene di carbone. [...] Quando veniva a casa aveva ancora tutti gli occhi neri di carbone e quando si metteva a letto di notte si alzava perché aveva sempre caldo, le lenzuola potevi lavarle quanto volevi ma erano sempre sporche di carbone... ma lui... il suo corpo, avresti detto che aveva dei tatouage, talmente era segnato sulla pelle. [...] [Già dai primi anni di lavoro in miniera] aveva un po' di problemi ai bronchi. Poi la sua malattia si è sviluppata dopo, in principio degli anni Settanta, ma fino a prima di morire lo curavano per l'asma allergica... ma non aveva l'asma allergica, non ce la faceva più, non vedeva l'ora di prendere la pensione talmente stava male, ma i dottori lo curavano male. Dopo, due anni prima [che lui morisse], sono stata io che gli ho fatto cambiare dottore, [perché] quando lo curavano gli altri specialisti... c'era quello dei polmoni che lo seguiva... ma non venire a dirmi che non vedeva quello che aveva... non gli interessava fargli fare la domanda per le maladies professionnelles, perché voleva difendere il fond. E il dottore di famiglia invece [diceva]: "Sempre uguale, signor C., lei è", gli faceva la puntura e se ne andava. In principio sembrava che stava meglio, ma poi la malattia avanzava... e quando io non ne potevo più di vederlo soffrire ma i dottori gli dicevano che stava sempre uguale... allora mi sono decisa a cambiare dottore: "Non mi vedrete più: una persona che si sente male, che sta male e lei mi dice sempre che non ha niente". Tanti... tanti anni lo hanno curato male, tanti anni che il dottore che veniva a visitarlo non potevo neanche vederlo... gli dicevo "cambia dottore" tutte le volte, e mai una volta che ci abbia detto che mio marito stava morendo... e io questo dottore lo vedo ancora a messa... sai quando si scambia la mano in segno di pace? Il Signore Gesù dice di perdonare e io gli do la mano... ma lui era un razzista con gli italiani. Conosco ancora gente che [i mariti] un mese dopo sono morti e lui gli diceva che non avevano niente. I dottori facevano così con gli italiani... tanti che conosco hanno avuto i mariti [che sono morti e i loro dottori] hanno nascosto che erano morti per la mina... il certificato marcato dal medico diceva che era morto di bronchite o di tumore, ma cosa aveva causato quelle malattie? Interview with Carmela M., aged 89, province of Liège, 19 October 2023.*

such as the dust that settles in the lungs. When you think of mining, the first disease that comes to mind is silicosis, one of the most widespread occupational diseases worldwide between the nineteenth and twentieth centuries.¹⁰ It is an irreversible and incurable disease caused by the accumulation of silica particles in the lungs, which causes permanent scarring of the lung tissue. The effects of this disease can appear shortly after exposure or many years later, leading to progressive deterioration of the respiratory system and ultimately death.¹¹ What Italian miners commonly called *silicosi* or *pussiera*¹² was, from a medical point of view, a form of pneumoconiosis: a disease caused by prolonged inhalation of toxic dusts. Depending on the composition of the dust and the type of lung damage, this condition could be classified more specifically as anthraco-silicosis or pure silicosis, categories through which coal-dust exposure, silica exposure, and eligibility for compensation were negotiated (Rossini, 2006; Geerkens, 2014).

In Belgium, silicosis was officially recognized as an occupational disease only in 1963, almost twenty years after the Italo-Belgian agreement, thanks to a period of worker struggles in which Italians played an important role (Valisena, 2026).¹³ It is impossible to estimate how many people died from silicosis before this date (Geerkens, 2009): too many death certificates do not mention a correlation between work and death (Rossini, 2006, 20–35).

Within the extractive system that Daniele Valisena defines as the ‘coal metabolism’, Italian workers were recruited and exploited and were ultimately treated as production waste by a hostile institutional, health, and social security system (Valisena, 2021). Starting in 1963, the situation changed, allowing workers affected by silicosis and their families to obtain at least some compensation in exchange for the health that had been taken from them. Yet the official recognition of silicosis as an occupational disease did not put an end to the mechanisms of exclusion built into the Belgian system: compensation remained tied to narrow diagnostic categories, proof of exposure, and the capacity to navigate a system largely controlled by employers, experts, and compensation authorities. Firstly, recognition occurred only in advanced and severe forms of pneumoconiosis, as defined by the criteria applied by medical experts and compensation authorities. The early stages of the disease made visible by X-rays, although characteristic of the initial stages of silicosis, were disregarded. As Valisena has shown, the boundary between compensable silicosis and other respiratory conditions was contested rather than medically self-evident. The interpretation of X-rays, symptoms, and functional limitations – and the point at which a worker was considered ‘sick enough’ to qualify for compensation – was negotiated

10 On silicosis as a global professional disease, cf. Rosental (2017).

11 Regarding the medical debate, and partly the historical one, about silicosis and its complications, the key reference text in Italy is Minoia et al. (2019).

12 *Pussiera* was an Italianized form used by migrants for the French word *poussière*, literally meaning dust. In mining contexts, the related term *poussier* refers more specifically to fine coal dust.

13 Regarding the situation prior to silicosis recognition, cf. Geerkens (2009).

among medical experts, political authorities, trade unions, and coal companies (Valisena, 2026). Furthermore, even in severe cases, sick workers who wanted to obtain a disability pension had to prove that they had worked in a company where they had been exposed to silica or other elements and proof of exposure had to be provided by a certificate issued by the employer, even if the disease occurred years or even decades after exposure, with all the difficulties, and often the impossibility, of finding the documentation (Pitzalis, 2019, 24). It should also be added that silicosis, although the best known and most widespread, was not the only disease contracted by miners, who also suffered from other more or less serious diseases, such as other types of pneumoconiosis, bronchopneumopathy, chronic bronchitis, tuberculosis, various forms of pulmonary fibrosis, lung cancer, and obstructive respiratory diseases. Furthermore, silicosis itself can have outcomes that differ from those most easily recognizable and known to doctors at the time, outcomes that are still the subject of study and discussion in medical and academic circles (Minoia et al., 2019, 149–264). Therefore, even after the recognition of silicosis as an occupational disease, an event that had a significant impact on the funds of the Belgian *Fonds des maladies professionnelles* (Occupational Disease Compensation Fund),¹⁴ the Belgian system retained a hostile and obstructionist attitude, granting disability pensions only when the outcomes of silicosis were obvious and irrefutable according to the criteria applied by medical experts and compensation authorities, while denying them for other pathologies and outcomes not recognized as occupational diseases. To paraphrase environmental historian Marco Armiero, the burden of proving that one is ill and that the illness was caused by work fell entirely on the worker, who found himself facing an adversary holding all the power and often having an entire system protecting his interests (Armiero, 2021, 32–55). This story, like many others, clearly highlights how obstructionism within the Belgian medical and social-security systems operated both at the institutional level and in the attitudes of individual doctors who treated Italian patients. In many cases, this obstructionism was reinforced by widespread racism towards Italians, a structural dynamic that has emerged widely from testimonies and historiography. In this sense, diagnostic uncertainty did not function only as a medical problem: it could also become an institutional and political instrument through which recognition, care, and compensation were delayed or denied.

When I saw that he was dying [in the early 2000s], I made up my mind, because I'm a fighter! Many people didn't even pursue their claims after their applications were rejected... but I swore to the Virgin Mary that I would see it through to the end, because it was the right thing to do. [...] And I changed... I called the new doctor, who was the one I already had and who was also good with Italians, and I said to him: 'Listen, doctor, can you come

14 Broadly comparable to INAIL in Italy.

to my house to examine my husband? He's always ill.' He came here, looked at the X-rays and did this [gesture of bringing his hands to his face], and said: 'How much money do you get per month from the Fonds de le maladies professionnelles? Mr C., you have more than eighty percent disability, I'll send you to a specialist' [...] and we went to Professor Bartsch who, when he saw all the medicines he was taking and the X-rays, also did this [gesture of bringing his hands to his face] and also asked: 'How much pension do you receive per month?' and I said: 'Nothing.' 'What do you mean, nothing? You have more than eighty percent disability!' He also sent us to another cardiologist, but every time we went [for check-ups] with [my husband], I argued with him, but later [shortly before he died], he regretted not having changed doctors sooner.¹⁵ (Carmela M.)

What made the difference in this circumstance – which, as Carmela herself states, was certainly not common or representative in its final outcome – was her resourcefulness, her tenacity in pursuing the recognition of her husband's illness. She stood alone against a system capable of protecting itself through figures such as doctors, court-appointed experts, and the *Fonds des maladies professionnelles*. It is precisely for this reason that, in order to confront such an unequal struggle, the support of an insider – someone who knows the system's inner workings, who knows how to navigate them, and who, for ethical or political reasons, chooses to side with those seeking justice without having the means to obtain it – is essential. In this case, the first such person was a doctor who, after years of misdiagnoses and mistreatments, needed only a single examination of Carmela's husband and a look at his X-rays to grasp the seriousness of his condition. But it was above all Pierre Bartsch, a prominent pulmonologist and professor at the University of Liège, who played a decisive role. After examining the patient, Bartsch identified a severe pulmonary fibrosis initially classified as idiopathic and argued that, in this case, it was a consequence of silicosis and silica exposure, rather than allergic rhinitis, for which the man had been incorrectly – and quite plausibly in bad faith – treated for years. Achiev-

15 [Q] uando io ho visto che ormai stava morendo, mi sono decisa, perché io sono battagliera eh! Tanti non hanno neanche insistito quando hanno rifiutato le loro domande... io invece ho giurato alla Madonna che sarei andata fino in fondo, perché era giusto. [...] E ho cambiato, ho chiamato il nuovo dottore, era quello che avevo già io ed era bravo anche con gli italiani, e gli ho detto: "Ascolti dottore, può venire a casa mia a visitare mio marito? Sta sempre male [...]". E lui è venuto qua, ha visto le radiografie e ha fatto così [gesto di portarsi le mani alla faccia], ha detto: "Quanti soldi avete voi al mese dal Fond de le maladies professionnelles? Signor C., lei ha più dell'80% di invalidità, vi mando io da uno specialista". [...] E siamo andati dal professor Bartsch che, quando ha visto tutte le medicine che prendeva e le radiografie, anche lui ha fatto così [gesto di portarsi le mani al viso] e anche lui ha chiesto: "Quanto prendete di pensione al mese?" e io: "Niente". "Ma come niente? Avete più dell'80%!". E lui ci ha mandato anche da un altro cardiologo, ma io ogni volta che andavamo [a fare le visite] con [mio marito] ci litigavo, ma poi più avanti [poco prima di morire] si è pentito di non averli cambiati prima. Interview with Carmela M., aged 89, province of Liège, 19 October 2023.

ing justice nonetheless took many years, with numerous rejected applications, expert reports, and court hearings. It was only in 2013, nearly a decade after the former miner at the centre of this story had passed away following decades of suffering, that the *Tribunal du travail de Liège* (Liège Labour Court) finally recognized that his death had resulted from conditions linked to exposure to mine dust.¹⁶

RETURNING ILL

As recalled by Carmela M., many miners died from occupational diseases without these ever being officially recognized as the cause of death. Likewise, a great number were left without pensions or received pensions insufficient to compensate for their inability to work. My second case follows the experiences of a group of sick migrant workers who, having found themselves in this latter situation, decided to return to Italy, just as thousands of their compatriots did.¹⁷

No longer able to work with damaged lungs, many migrants were forced to decide whether to remain in Belgium or return to Italy – a decision influenced by numerous factors such as the degree of familial rootedness in Belgium, the severity of the illness, the possibility of continuing to work or relying on other sources of income, and, of course, pension entitlements.

This passage from Belgium to Italy also changed the scale at which illness could be contested. In the Belgian mining and industrial districts, Italian miners were not merely isolated victims: many were inserted into politicized and unionized worlds, shaped by Catholic and Communist associations, trade unions, *patronati*, and collective struggles over work, housing, safety, accidents, and illness (Morelli, 2004; Di Stefano, 2015). Return and disease often fragmented this collective fabric. Once back in Italy, especially in marginal villages and mountain or border areas, the struggle for recognition was frequently displaced into a more individual dimension: the sick miner, weakened by respiratory disease, had to face doctors, pension offices, certificates, X-rays, medical files, and social isolation.

Under pressure from the growing visibility of miners' occupational diseases and from the political consequences of Marcinelle, Italy began, from the first half of the 1960s, to provide forms of disability pension for individuals who had worked in the Belgian mines. This had been made possible by the Law no. 1115/1962, promoted by the Communist senator Renato Bitossi, which explicitly recognized silicosis contracted in the Belgian mines.

16 Personal archive of Carmela M., Tribunal du travail de Liège, Case Vve M.-C./FMP, judgment and expert report by Dr Pierre Bartsch, 22 October 2013.

17 The return of migrants to Italy has received little attention from historians of emigration. For some relevant work on the subject in general and specifically on Friuli, cf. Cerase (2001) and Saraceno (1981).

The pension application process, although not comparable to the challenges migrants faced in Belgium, still presented numerous difficulties and disparities (Rossini, 2006, 51–53).

Returning home sick meant carrying in one's body – damaged by the same industrial process that had transformed the mining landscape of Wallonia – the toxic effects triggered by the Italo-Belgian agreement and symbolically disseminating them throughout their regions of origin. These were typically marginal and peripheral areas, often depopulated due to both internal and international migration, now forced to confront the long-term consequences of national policies enacted thirty or forty years earlier. Slavia Friulana/Beneška Slovenija was one of these regions: a historically Slavic (Slovenian)-speaking area in Friuli in north-eastern Italy, within the administrative region of Friuli-Venezia Giulia and bordering Slovenia, where several hundred ill migrants returned from Belgium in the second half of the 1970s. This territory had become part of the Italian state following various adjustments to the eastern border. It comprises about 300 square kilometres divided into a dozen small municipalities, the most prominent of which is San Pietro al Natisone/Špeter Slovenov. The region is characterized by a constellation of small settlements scattered between the valleys of the Natisone/Nadiža River and surrounding hills, many of which remain isolated, poorly connected, and difficult to reach.

In the context of a long and dramatic postwar period that saw Friuli become one of Italy's most economically depressed regions, Slavia Friulana experienced an even deeper underdevelopment. This was further exacerbated by the marginalization of its inhabitants, who had already suffered under fascist Italianization policies and were after the Second World War still subject to ethnic, linguistic, and political prejudice, when Slovenia was part of communist Yugoslavia. In the first three postwar decades, emigration flows halved the local population, decreasing it from 60,000 to between 30,000 and 40,000. Departures from Slavia Friulana were among the most significant in the region, making Udine one of the Italian provinces that provided the highest number of labourers to Belgian mines (Micelli, 2012, 32).¹⁸

For this reason, Slavia Friulana is not only the local background of the second case study. It is one of the places where the toxic afterlife of Belgian mining work was reinscribed into a borderland already marked by depopulation, economic marginality, and the fragile position of a historically Slovenian-speaking community within the Italian state. The return of sick miners therefore allows the relationship between occupational disease, minority status, territorial marginality, and access to medical and welfare institutions to be observed together (Clavora & Ruttar, 1985; 1990; Clavora

18 Cf. Clavora & Ruttar (1990, 47–79). For a historical, social, cultural, and migratory perspective on Benečija cf. Clavora & Ruttar (1985), and Clavora & Pignat (2017).

& Pignat, 2017).

It was within this already highly complex context that, during the 1970s, as the Walloon mining era was drawing to a close, hundreds of migrants from Slavia Friulana returned from Belgium. Upon their return to Friuli, their primary concern was to undergo medical examinations to assess their health and begin the process of applying for pension benefits, either in Belgium or Italy. The designated facility for residents of Slavia Friulana was the Social Hygiene Dispensary (*Dispensario di igiene sociale*)¹⁹ in Cividale del Friuli, where several young physicians, recent graduates from the University of Padua, worked at the time. This detail is crucial for understanding the medical approach these physicians adopted in facing the wave of returning miners. To understand who these doctors were and why they acted as they did, it is necessary to shift the focus for a moment to Padua, an important university city with a long-established medical faculty and then one of the places where new ways of thinking about medicine, work, and health were taking shape. In the period of the 1968 movement, the University of Padua underwent a period of cultural and political ferment that also affected the medical faculty, fostering a climate of sociopolitical renewal. With respect to occupational medicine, this translated into a desire among certain professors and students to promote a practice that moved beyond the rigid frameworks of their predecessors – practices they viewed as mechanical and impersonal. Instead, they sought to develop a more socially engaged and multidisciplinary approach, one attentive to the needs of workers.

In parallel, another crucial moment for the formation of new ideas and practices was the Hot Autumn (*Autunno caldo*), a period of intense labour struggles that followed the 1968 movement and placed particular emphasis on the right to health. In those years, several experiences of medicine with a strong critical and social orientation were emerging across Italy, in organized forms such as Democratic Medicine (*Medicina Democratica*) and in less formal practices rooted in universities, workplaces, local health services, and political activism. The aim was to redefine the role of occupational medicine in a participatory and preventive sense, rather than merely as a reactive response to disease. Places such as Padua became important centres of this culture; after completing their studies, some Friulian doctors brought these ideas and practices to the periphery, pursuing different paths within various institutions but remaining united by the motivation to introduce a different medical practice to Italy's far northeast (Carnevale, 2019). During

19 The *Dispensario di igiene sociale* was a local public-health outpatient facility devoted to prevention, diagnosis, and follow-up of socially relevant diseases, especially tuberculosis and respiratory illnesses; in this case, it operated within the network of the Provincial Anti-Tuberculosis Consortium.

the late 1970s, they carried out numerous investigations in Friulian factories, working as closely as possible with workers, factory councils, and trade unions. In some cases, they found cooperation from companies; in others, they faced resistance, suspicion, or outright obstruction from employers. Some of them, through the Provincial Anti-Tuberculosis Consortium (*Consortorio provinciale antitubercolare*), were assigned at different times to the *Dispensario di igiene sociale* in Cividale del Friuli, where, as mentioned, they had to manage the return of ill miners (mostly from Belgium, but not exclusively).

The recollections of one of these doctors, Guglielmo Pitzalis – whom I interviewed on multiple occasions and who has written about the events – vividly highlight the complexity of the situation:

They were still young, but already ill and disabled, living in a state of double marginalization. In their home villages, they no longer found peers or youths, only the elderly. They did not know how to perform any other job: unlike carpenters or masons, miners do not possess transferable skills, and the old trades no longer served any purpose in now-empty villages. Thus, they became foreigners in their own homeland. (Pitzalis, 2019, 78)²⁰

Thanks to the approach they had developed during their years in Padua – and to their conviction that medicine is not a neutral science but deeply embedded in social dynamics – these doctors understood that illness itself needed to be considered within the broader context of the marginalization and isolation affecting Slavia Friulana. Around the respiratory illnesses there clustered a host of other issues that could not be ignored: psychological difficulties, loneliness, depression, poor environmental hygiene, degradation, alcoholism, smoking, and, more generally, a passive acceptance of disease.

Many of the patients treated at the Dispensary were men over forty, still of working age, mostly unmarried, incapable of engaging in physical labour, lacking transferable skills, and without prospects. They were confined to their native settlements, where the fabric of small artisanal trades had disintegrated following emigration (Cont & Pitzalis, 1983, 28–33). The doctors thus attempted to devise tailored, multifactorial intervention paths. First, they launched a survey to better understand the medical and social situa-

20 *Io li vedevo quando rientravano: erano ancora giovani, ma già ammalati, invalidi e vivevano una doppia marginalità. Nei paesi non trovavano più né coetanei né giovani, ma solo vecchi; non sapevano fare un altro lavoro: il minatore, diversamente dal carpentiere o dal muratore, non porta con sé una professionalità spendibile e i vecchi mestieri, nei borghi ormai vuoti, non servivano più. Così diventavano stranieri nel loro stesso paese. (Pitzalis, 2019, 78)*

tion, administering questionnaires to patients that included questions about their migratory and occupational history, living conditions upon return, and current health status. This investigation revealed over 350 cases of silicosis in various stages and levels of severity, as well as other forms of pneumoconiosis and other effects of mine dust exposure, many of which were not recognized as occupational diseases either by Belgian compensation authorities or, after the miners' return, by Italian institutions.²¹ There were also 208 cases of chronic bronchitis, many cases of liver disease linked to alcohol use, and numerous cardiovascular issues, some directly related to work, others to living conditions.

Second, they initiated collaborations with the National Institute for Assistance to Farmers (*Istituto nazionale di assistenza ai coltivatori*, INAC), a *patronato* office in Cividale, with the Union of Slovenian Emigrants of Friuli Venezia Giulia (*Zveza slovenskih izseljencev Furlanije Julijske krajine*), with the General Federation of Belgian Labour (*Fédération Générale du Travail de Belgique*, FGTB), and with clinics and doctors both in Friuli and Belgium who could treat the aforementioned issues and support the social reintegration of former miners. Since not all former migrants sought out the Dispensary on their own initiative, they also organized participatory conferences and information sessions in the villages of Slavia Friulana. These events addressed pension and health matters and emphasized the importance of visiting the clinic, as can be seen in the words spoken by Pitzalis on one such occasion:

Before concluding, I must say to those who have not yet visited the Dispensary: come not only for the sake of our statistics. From the statistics,

21 The Italian Law no. 1115 of 27 July 1962, promoted by the Communist senator Renato Bitossi, extended the economic, medical, and welfare benefits provided by Italian occupational insurance legislation to Italian citizens residing in Italy who had contracted silicosis in Belgian coal mines and had not been compensated under Belgian legislation. It thus placed them, in principle, on the same footing as workers who had contracted the disease in Italy. After the Belgian Law of 24 December 1963 on compensation for damage resulting from occupational diseases and their prevention recognized miners' pneumoconiosis as an occupational disease, however, INAIL adopted a restrictive interpretation and considered the effects of the Italian Law no. 1115 as exhausted with regard to applications submitted after the Belgian legislation entered into force. This interpretation was contested by the *patronati* and repeatedly challenged in court, since the Italian law provided for the cessation of INAIL benefits only when the individual worker had actually obtained comparable or higher benefits from the competent Belgian institutions. The issue was addressed only much later by the Italian Law no. 780 of 27 December 1975, promoted through bills presented by the Communist deputy Giovanni Bortot and the Christian Democratic deputies Enea Piccinelli and Franco Foschi. In particular, Article 6 of the law expressly provided an authentic interpretation of the Italian Law no. 1115/1962, extending its benefits to eligible survivors of workers who had died from silicosis contracted in Belgian coal mines (Rossini, 2006, 51–53; Bortot, 2015, 140–143).

we try to extract something that can help improve your quality of life. This is not only a medical issue – it is a social issue: alcoholism, the loneliness of the unmarried, hygiene conditions, etc. We want to give you the opportunity to carry out some small activities. Many of you, before becoming miners, were craftsmen, farmers, or woodworkers, and with a bit of willpower and commitment – from the public authorities, and from us doctors – we could consider reviving some of these trades. (Cont & Pitzalis, 1983, 61)²²

Pitzalis's reflections written in 2019 are partially different. He recognized the value of the Dispensary's work, which, for many isolated and ailing individuals, offered the possibility to resist, struggle, and imagine a more dignified coexistence with illness than the degradation into which they had fallen upon their return. However, he also revealed a heightened awareness of the devastating impact that mining work and the Italo-Belgian agreement had on the miners of Slavia Friulana:

In our illusion of changing the world – and for them, we did change it a bit – we imagined, together with local authorities, that some might resume the artisanal activities they had abandoned when emigrating in search of stable wages. Our work began in 1976 and lasted until 1981. [...] By sharing experiences and studies, we were better able to confront certain complications: tuberculosis could be treated and cured, and thus it could be communicated and experienced with more serenity; chronic obstructive pulmonary disease could not be radically cured because it did not respond to medication, but rehabilitation was possible. Doctors approached these illnesses with a new sensitivity to quality of life and felt more personally involved. In the last years, I no longer worked in Cividale, but I continued seeing these people; I maintained an emotional connection with them. Many managed to obtain recognition of their occupational disease – silicosis – in Belgium, some even in Italy, perhaps also for noise-induced hearing loss or serious musculoskeletal disorders. Unfortunately, several of those who lived long enough died of lung cancer, which we were never able to get recognized – neither in Belgium nor

22 *Prima di concludere devo dire a chi non è ancora stato al dispensario, di venire non solo per il gusto della nostra statistica. Dalla statistica noi cerchiamo di ricavare qualcosa che possa essere utile a migliorare la qualità della vostra vita. Non è solo un problema medico, è un problema sociale quello dell'alcool, della solitudine dei celibi, delle condizioni igieniche, ecc.; vogliamo dare la possibilità di svolgere qualche piccola attività. Molti di voi, prima di fare i minatori, o erano artigiani, o contadini o lavoravano il legno e quindi con un po' di buona volontà e di impegno, anche da parte delle autorità pubbliche, anche da parte nostra come medici, si potrebbe rivedere di riprendere alcune cose. (Cont & Pitzalis, 1983, 61)*

in Italy – as the ultimate consequence of their working conditions in the mines. (Pitzalis, 2019, 80–81)²³

CONCLUSIONS

I have chosen to dwell on these two cases, because they are particularly eloquent with respect to two aspects that are highly relevant for studying Italian migration to Belgium from the perspective of what happened after the mines closed.

The first element is the dynamic of discard, the wasting relationship, triggered by the 1946 Italo-Belgian protocol. This was an agreement that produced deep toxic effects, spread across both space and time. This legacy, which has been partially addressed in specialized literature and emerges from interviews, diaries, and similar sources, still needs to be fully understood in all its facets by tracing its histories, stories, and dynamics. In this regard, testimonies such as that of Carmela M. and the investigation promoted by the Friulian occupational physicians represent invaluable documents. The investigation, in particular, by virtue of the approach adopted by the physicians and the human attention they brought to the task, though it remains a localized case, allows us to understand both quantitatively and qualitatively the outcomes of these processes of marginalization. It also prompts us to ask how many thousands of other individuals may have experienced similar trajectories without ever being included in any statistics, and it underscores how important it is to follow the individual and collective stories of these people.

The second element stems from the observation that medicine and health policies played a fundamental role in this story, not only, as several studies have already shown, in the first twenty or thirty years following the 1946 agreement, but also in the later decades, up to the present day. The cases discussed here – there are many more – serve as a window through which we

23 *Nella nostra illusione di cambiare il mondo, e per loro un po' l'abbiamo cambiato, ipotizzavamo con gli enti locali che alcuni avrebbero potuto riprendere le attività artigianali abbandonate per l'emigrazione alla ricerca di uno stipendio sicuro. Il nostro lavoro cominciò nel 1976 e durò sino al 1981. [...] Condividendo esperienze e studi, alcune complicanze si sono potute affrontare [sic] meglio: la tubercolosi si poteva curare e guarire, e quindi poteva essere comunicata e vissuta con più serenità; la broncopneumopatia cronico-ostruttiva non poteva essere curata in senso radicale perché non rispondeva ai farmaci, ma si poteva fare la riabilitazione; i medici guardavano a queste patologie con un occhio più attento alla qualità della vita, portavano una diversa sensibilità e loro stessi si sentivano più coinvolti. Negli ultimi anni non lavoravo più a Cividale, ma continuavo a vedere queste persone, tenevo un legame affettivo con loro; molti riuscirono ad avere il riconoscimento della rendita per la malattia professionale – la silicosi – in Belgio, qualcuno in Italia, magari anche per l'ipoacusia da rumore o malattie osteo-articolari importanti. Purtroppo diversi, i pochi che riuscirono a invecchiare, morirono per neoplasia polmonare, che non siamo mai riusciti a far riconoscere né dal Belgio né dall'Italia come conseguenza ultima delle loro condizioni di lavoro nelle miniere.* (Pitzalis, 2019, 80–81)

can observe how medicine is not a neutral science and how, depending on the practices and uses to which it is subjected, it may wield the power either to include or to exclude.

Before drawing the final conclusions, one clarification is crucial: the decisive issue is not national belonging. In both Italy and Belgium there were physicians who used scientific expertise to minimize disease, delay recognition, or translate suffering into non-compensable categories, and others who mobilized the same expertise to support miners, reopen files, challenge diagnostic thresholds, and make sick bodies legible as evidence of industrial injustice. This contrast should therefore be understood through institutional positions, compensation systems, professional cultures, political trajectories, and individual ethical choices. Precisely for this reason, another relevant theme emerging from both cases is that it is not only state policies that make the difference – though these clearly remain a fundamental factor to consider – but often also the spaces of agency that individual physicians choose, and manage, to carve out for themselves within those frameworks. What separated these positions was the decision either to participate in the dynamics of discard or to resist them: to use medicine as a filter that excluded sick migrants from recognition, or as a practice of justice and inclusion, choosing to see the people before them as human beings before seeing them as miners, migrants, or Italians.

NA STRANI PROIZVODNIH ODPADKOV. ZDRAVNIKI IN MEDICINA DELA V PODPORO BOLNIM RUDARJEM MED BELGIJO IN ITALIJO

Andrea NEGRO

Univerza v Padovi, Via VIII Febbraio, 2, 35122 Padova PD, Italija

e-mail: andrea.negro.1@phd.unipd.it

POVZETEK

Ta članek obravnava strupeno dediščino italijansko-belgijskega sporazuma iz leta 1946, v okviru katerega so tisoči italijanskih delavcev odšli v belgijske premogovnike, kjer so mnogi kasneje zboleli za hudimi poklicnimi boleznimi. Na podlagi doktorskih raziskav avtorja članka o vrnitvi bolnih rudarjev iz Belgije v Italijo, se članek osredotoča na dolgoročne telesne, družbene in institucionalne posledice rudarstva po zatonu belgijskega premogovništva. Skozi dve študiji primerov članek proučuje, kako so medicinsko znanje, diagnostične prakse in sistemi odškodnin lahko utrjevali ali pa izpodbijali izključenost delavcev migrantov. Prva študija je osredotočena na vdovo v Liègeu, ki si prizadeva za posmrtno priznanje bolezni svojega moža, druga pa na družbeno angažirane delovne zdravnike v Beneški Sloveniji. Na podlagi kombinacije ustne zgodovine, medicinskih in sodnih dokumentov ter virov iz združenj in socialnih ustanov članek pokaže, da zdravje pri delu ni bilo le področje trpljenja, temveč tudi prizorišče sporov glede priznanja, odgovornosti in pravičnosti. Nazadnje članek prikazuje, kako je medicina lahko postala del širše dinamike družbene izključenosti, pa tudi orodje za upiranje tej izključenosti.

Ključne besede: italijanska migracija, belgijski premogovniki, silikoza, medicina dela, Beneška Slovenija

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