Editorial

Social Medicine for Global Health Equity

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For some time now, health has been recognized not only as an individual asset but also as a social one, and its protection as both a right and a duty of the individual.

Rapid scientific and technological progress-particularly in the last thirty years-has generated unprecedented scenarios in the field of healthcare. This continuous evolution has raised complex organizational, ethical, moral, deontological, and medico-legal issues, broadening the horizons of knowledge within a multidisciplinary context.[1]

Social Medicine explores, analyses, and studies the features and dynamics of social phenomena in their constant evolution, particularly those with medical relevance or repercussions on human health. Its work in the service of social life is vast and necessarily draws on profound scientific understanding of biological, pathophysiological, physical, and chemical processes inherent to medicine. At the same time, it must remain an attentive observer of those events that can be traced back to sociological dynamics and the social sciences.

In practice, Social Medicine seeks to adapt medical-scientific advances to the evolving needs of society, moving away from the traditional individualistic approach of clinical medicine: the individual exists only as a person integrated within the community-family, workplace, association, and so on and as such is both a holder of rights and a bearer of duties. This concept is enshrined in the social pact underlying our society, namely the Constitutional Charter, which in Article 32 states: *"*The Republic safeguards health as a fundamental right of the individual and as an interest of the community*"*.[2]

No other right except the right to health protection is defined as *fundamental* by our Constitution.[3] Through Article 32, it clearly expresses four foundational principles: a. universality of beneficiaries; b. comprehensiveness of services; c. equality of treatment; d. respect for human dignity.

Health, as an inviolable human right of paramount importance among all rights guaranteed by the legal system, has what may be called a *transversal nature*. This means that all other rights must be regulated and realized in ways that do not harm or conflict with the needs that arise from it. It follows that, in its broadest sense, the right to health cannot be fulfilled solely through the healthcare system or through medical acts. Every social, environmental, or legal phenomenon that may affect human health must be governed in such a way that health is safeguarded and promoted.

For example, since 1987 the Italian Constitutional Court[4] has interpreted the right to health as encompassing the right to a healthy environment an understanding that today, more

[1] S. Ricci, *Social Medicine between science and biolaw,* in *PanMinerva Medica*, 2014, 56, 1-12.

[2] S. Ricci, *Atto Medico. Evoluzione e Valore sociale*, Rome, 2000, 1-169.

[3] Right to health is the only right explicitly defined as "fundamental" by the Constitution. The judiciary, in order to emphasize its importance, has also characterized it as a "primary" ("primario") right. Cfr. Italian Constitutional Court, 26 July 1979, n.° 88, in *Foro It.*, I, 1979, 2542 and 18 December 1987, n.° 559, in *Riv It Med Leg*, 1990, 227.

[4] In Decision no. 617/1987, with regard to provisions aimed at protecting the environment and at preventing situations of environmental harm, the Court acknowledged the special nature of the interest at stake, defining it as «a primary good of absolute value, constitutionally guaranteed to the community» («un bene primario e di un valore assoluto costituzionalmente garantito alla collettività»).

than ever, is perceived as requiring greater protection.[5] It is clear that the right to health takes precedence over other rights because it pertains to the right to life, the quality of life, and public well-being.[6]

The possibility of inducing changes in the natural processes of life and even of death calls for profound reflection on the limits of lawful human intervention. Such limits cannot be defined solely in biological or medical terms. The *legal phenomenon* must also be considered, since it represents the instrument through which the needs of collective life are addressed and regulated.[7,]

It was not so long ago that Jules Guérin (1848) urged physicians to assume "the role of intermediaries" between divided interests and conflicting social elements between medicine and legislation.[8] Over time, Social Medicine has evolved along multiple paths, yet always in harmony with its foundational aims and attuned to the social realities of each era.[9]

There are areas within the biomedical sciences that are especially delicate and of pressing relevance, which cannot be left to individual initiative or to market forces. Consider, for instance, the control or modification of the beginning and end of life through interventions in natural generative processes; the potential of genetic engineering to alter the chromosomal makeup and thus the biological identity of present and future individuals; the protection of privacy and human dignity in the face of automated data processing; and, finally, the globalizing impact of new technologies. What, then, are the limits of lawful human intervention in life?[10]

In daily practice, healthcare professionals frequently face situations that inevitably involve ethical dilemmas. Even when the law prescribes specific conduct, the fact remains that legal

[5] B. Pezzini, *One Health e Corti supreme: le coordinate di un paradigma,* in *Corti supreme e salute*, 1, 2025, 191-216.

[6] S. Ricci, A. Miglino, *Medicina e Società. Dalla tutela dell'integrità fisica al diritto alla salute,* Rome, 2005, 1-97; M.V. Rosati, A. Sancini, F. Tomei, C. Sacco, V. Traversini, A. De Vita, D.P. De Cesare, G. Giammichele, F. De Marco, F. Pagliara, F. Massoni, L. Ricci, G. Tomei, S. Ricci, *Correlation between benzene and testosterone in workers exposed to urban pollution,* in *Clinica terapeutica*, 168, 6, 2017, e380-87; T. Archer, S. Ricci, F. Massoni, L. Ricci, M. Rapp-Ricciardi, *Cognitive benefits of exercise intervention,* in *Clinica Terapeutica*, 167, 6, 2016, 180-85; F. Tomei, M.V. Rosati, C. Di Pastena, G.F. Tomei, G. Giammichele, F. De Marco, S. Corsale, A. Suppi, P. Ricci, C. Sacco, S. Ricci, C. Monti, *Urinary Nichel and Progesterone in Workers Exposed to Urban Pollutants,* in *Journal of occupational and environmental medicine*, 63, 10, 2021, e660-e666; M.V. Rosati, C. Sacco, A. Mastrantonio, *et al.*, *Prevalence of chronic venous pathology in healthcare workers and the role of upright standing,* in *International Angiology*, 38, 3, 2019, 201-10.

[7] M. Gulino, M. Martelli, P. Ricci, S. Marinelli, G. Montanari Vergallo, *How can euthanasia and assisted suicide regulation guarantee patient health and autonomy? Lesson from nine European countries,* in *Ethics, Medicine and Public Health*, 33, 2025, article 101131; F.M. Damato, P. Ricci, R. Rinaldi, *Informed consent and compulsory treatment on individuals with severe eating disorders: a bio-ethical and juridical problem*, in *Clinica Terapeutica*, 174, 4, 2023, 365-69.

[8] W.E. Nicoletti, *Argomenti di Medicina Sociale,* Rome, 1991, 1-380.

[9] A. Beretta Anguissola, *Medicina Individuale e Medicina Sociale,* Rome, 2, 1982, editoriale; Id, *Le ragioni storiche della Medicina Sociale, principi ed obiettivi*. *La Medicina Sociale e le Politiche sociali e sanitarie in Italia,* Rome, 1995, 15-20.

[10] E. Sgreccia, *La bioetica, nuova disciplina: limiti e prospettive. La medicina sociale e le politiche sociali e sanitarie in Italia*, Rome, 1995, 33-39; G. Montanari Vergallo, M. Gulino, P. Ricci, A. Pastorini, G. Bersani, R. Rinaldi, *Psychiatric advance directives (Ulysses Contract): the need for a specific law and a criteria proposal for its introduction,* in *Rivista di Psichiatria*, 58, 5, 2023, 241-48; L. Ricci, B. Di Nicolò, P. Ricci, F. Massoni, S. Ricci, *The exercise of rights beyond therapy: on Human Enhancement,* in *BioLaw Journal*, 1, 2019, 497-512.

norms should never override ethical norms. Hence the need for an educational project that profoundly shapes professional identity one in which ethics, legal objectives, and deontological principles are harmonized through the practice of moral virtue.

Ethics and morality, when compared with the administrative, civil, and criminal frameworks of the State, give rise to the codes of ethics, which establish rules of conduct drawn up by professionals themselves and to which each practitioner must adhere. Yet when deontological conduct alone fails to adequately protect certain fundamental human values, it becomes the legislator's duty to intervene. The State must act to safeguard everyone from judicial distortions that could undermine the legal institutions on which civil coexistence is founded.[11]

Professional categories and especially those in healthcare require clear and equitable laws that explicitly define what is permissible and what is not. Nevertheless, legislation can never encompass the entire moral dimension of human behavior. Ethics must therefore complement the legal system. Fulfilling one's legally defined duties does not exhaust professional responsibility: acts may be performed that, though not punishable by law, still merit an ethically grounded judgment of illegitimacy.

For these reasons both scientific and practical Social Medicine has risen to the status of a full medical discipline, with a distinct scientific framework and clear practical aims.[12]

Going through the centuries, we can already find in the works of Hippocrates clear evidence of the social dimension of medicine, just as the *Regimen Sanitatis Salernitanum* unmistakably promotes the defense of public health.

The stages of medicine's social evolution over time are numerous and irrefutable. The examples could extend across many centuries, with a long list of works that confirm this distinctive feature.

The need to provide free care for the poor and to combat infectious diseases such as cholera, plague, and smallpox that devastated entire populations, generated the first efforts to establish organized healthcare systems. Within this framework shaped by the State's growing interest in the health of its people the seed of Social Medicine was sown in seventeenth-century Italy through the works of two great physicians: *Quaestiones medico-legales* by Paolo Zacchia and *De morbis artificum diatriba* by Bernardino Ramazzini.

Zacchia's work marked a decisive step forward, affirming the community dimension of medicine. Thanks to this eminent scholar, the social character of medicine found its first concrete expression one that was then deepened and systematized by Ramazzini. Indeed, Ramazzini can be considered not only the founder of Occupational Medicine, but also a pioneer of the medico-social interpretation of public health problems. His thought was pervaded by a remarkable social sensibility, exceptional for his time, and extended to the entire community without distinction of social class.[13]

The eighteenth century was dominated by the figure and work of Peter Frank, a great physician–politician. In the following century, the social mission of medicine was reaffirmed by other enlightened physicians such as Giacomo Barzellotti, Francesco Puccinotti, Guido Baccelli, and Angelo Celli.[14]

[11] A. MIGLINO, L. RICCI, S. RICCI, *The right to hearth as a liberty of self-determination,* in *Panminerva medica*, 56, 2014, 13-24.

[12] F. ANTONIOTTI, *Corso di Cultura in Medicina Sociale,* Rome, 1971, 1-481.

[13] *Ibidem*.

[14] W.E. NICOLETTI, *op. cit.*

The twentieth century, however, proved especially fertile ground for the development of discipline. Three main factors contributed to its growth: the rise of industrialization, scientific and technological advances in medicine, and the emergence of social insurance systems.

Although the inherently social nature of medicine is beyond dispute, the profound economic, social, and structural transformations of the modern era and especially the rise of welfare systems and organized public assistance made it clear that medicine required its own specific instrument. This instrument, on both the scientific and educational levels, was to serve as a link between medicine and society, addressing the new and evolving relationship between the doctor and the citizen.

From a historical perspective, therefore, Social Medicine represents the *modus agendi* of medicine its way of acting as both science and practice in response to the deep social transformations of the past two centuries and to the needs arising from the protection of public health in a community undergoing continuous social and cultural evolution.[15]

As an academic discipline, Social Medicine was first introduced in 1963 at the University of Sassari (under the chairmanship of a professor from the Roman School) and was subsequently established in many other Italian universities, including Rome from 1968 to the present (professors C. Gerin, F. Antoniotti, W.E. Nicoletti, S. Ricci). For over forty years, it has also been taught in the Faculty of Law. It has always held an autonomous position within the University Competition Sector of *Legal and Occupational Medicine*.

Its unique scientific and doctrinal identity now places it at the forefront of efforts to safeguard *good health* understood in its most modern and comprehensive sense and as a promoter of all the rights inherently connected to the human person. Over time, these rights have acquired peremptory and universally recognized status.

Given its doctrinal, historical, cultural, and methodological foundations, Social Medicine, as a discipline within the broader area of Public Health, rightfully stands as Global Social Medicine, a fully autonomous field equipped with its own specific research methods and theoretical framework.

The arguments elaborated underline how it must now be admitted that the "right to health" must interface with the awareness that there is also a "duty to health", which is revealed as an individual responsibility towards society.[16] In truth, the relationship between the protection of citizens' health and the economic interests of organized communities have generated social needs and discrepancies in response such that the doctor before any other professional must face on a daily basis. This can only be calmly addressed if, on the one hand, the professional has a holistic view of the problem, but on the other hand, the user has sufficient education to understand its meaning[17]. Adherence to the principle of collective responsibility to protect social and health safety is the only way in which the objective of promoting health in the sense of a positive meaning of the concept can be achieved.[18]

The experience of recent years has shown the existence of a worrying trend towards growing

[15] F. ANTONIOTTI, *op. cit.*

[16] G. LOMBARDI, *Contributo allo studio dei doveri costituzionali,* Milan, 1967; F. POLACCHINI, *Doveri costituzionali e principio di solidarietà,* Bologna, 2016, 1-353.

[17] Art. 4.2. of the Principles of European Medical Ethics, approved in Paris on 6 January 1987 by the European Conference of Medical Associations and Bodies with Similar Functions.

[18] S. RICCI, A. MIGLINO, *Persona e Diritti*, Roma, 2009, 1-57.

international instability with an incipient request for help coming from many parts of the planet, which risks becoming a serious problem for the near future. The problem is to identify the most effective way to provide the life of international relations with adequate centers (references) of universally recognized authority and power, which can peacefully manage this request for aid in the health field. The principle of humanitarian intervention, which is increasingly pressing, in our opinion must be institutionalized not according to the logic of emergencies, but according to that of development, for a correct and useful humanitarian policy.

Clearly, the rapid changes in society of our time are also reflected in the cultural and institutional environment within which health services are provided and make us feel the need to operate new theoretical and systematic options, which can coherently organize the continuous acquisition of knowledge. Paradoxically, while the progress of science and technology offers new tools for the protection of health, the resources necessary for everyone to benefit from the best medical activity are becoming scarce.[19] Today's society marginalizes many groups of people, the so-called weaker groups, who are often marginalized because they have health problems that involve the entire family unit (think, for example, of autism).[20] It is therefore natural to ask whether the right to health can be interpreted in such a way as to derive indisputable criteria for the acquisition and rational management of financial resources intended for the health sector. This is clearly not possible. Nevertheless, in practice, the content of health legislation, even when it is endowed with an intrinsic logical rigor, finds its legitimacy in the principle of the balancing of interests, on the basis of which a constitutionally protected right can be limited to protect a right of equal degree.[21]

Today, social medicine must, on the one hand, be able to bring out the salient aspects of this dynamic phenomenon and, on the other, make the appropriate evaluations so that objectives are pursued that protect the personality and rights of the citizen to the highest degree. This gives rise to the need to highlight two essential elements in the operational system: reaffirming a global vision of the behavioral frameworks of medical activity; seeking to recompose the mental process of synthesis in the face of circumstances that simultaneously require technical and scientific skills and therapeutic performance tempered by the legitimacy and humanity of the act performed. The defect of our times to break everything down analytically, sometimes to excess, often translates into cultural by-products of confusion and intellectual

[19] N. Diridin, E. Caruso, C. Rivoiro, *Universalism and budgetary constraints in health protection: a political issue, even before a financial one,* in *Social Policies*, 3, 2014, 387 ff.

[20] R. Ferrara, L. Iovino, M. Di Renzo, P. Ricci, *Babies under 1 year with atypical development: Perspectives for preventive individuation and treatment,* in *Frontiers in Psychology*, 13, 2022. 1016886; R. Ferrara, L. Ricci, P. Ricci, L. Iovino, S. Ricci, F.M. Damato, G. Cicinelli, R. Keller, *How autistic women are aware of their body and take care of their health? Focus on menstruation cycles and gynaecological care*, in *Clinica Terapeutica*, 175, 3, 2024, 168-175; G.M. Troili, R. Businaro, F. Massoni, L. Ricci, L. Petrone, P. Ricci, S. Ricci, *Investigation on a group of autistic children: Risk factors and medical social considerations*, in *Clinica terapeutica*, 164, 4, 2013, e273-e278; R. Ferrara, F.M. Damato, L. Ricci, L. Iovino, S. Ricci, P. Ricci, M.C. Laznik, G. Cicinelli, *Parents-children co-regulation as therapeutic variable and target in autism spectrum disorders. From observation of drive to need of cooperative parent-mediated therapy.*, in *Clinica Terapeutica*, 174, 6, 2023, 537-44.

[21] H. Rebscher, *Social medicine and healthcare economics. The framework for future forms of healthcare,* in *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 51, 5, 2008, 552-7.

uncertainties, which in our environment unfortunately turn into the suffering of interpersonal relationships.

The risks of such a delicate profession, the achievements attributable to current scientific achievements (think of genomics, predictive medicine, translational approaches, etc.) and technological capabilities (Artificial Intelligence, Robotics, etc.) and the responsibilities arising from them and connected to them, highlight today more than ever the need for a relational alliance between doctor and patient supported by institutions.[22] An underestimation of the past was perhaps that (particularly in our country) of setting up university education by favoring a model of care with purely specialist-hospital characteristics.[23] It is therefore essential that a powerful reorganization of territorial social and health care is carried out with the aim of enhancing resources in respect of the quality of life and making the figure of the general practitioner central

Global Social Medicine can now exert catalytic action to raise awareness of the healthcare needs of the community and also stimulate a new approach to university teaching based on medicine that is practiced outside hospitals but coordinated with them. Let us consider the growing interest in unconventional medicine (traditional Chinese medicine: acupuncture, herbal medicine, etc.).[24]

To achieve concrete results, responsibility, self-sacrifice and a real willingness to measure oneself in an equal role with other countries (including intercontinental ones) are needed, COVID has taught us this.[25]

[22] S. Ricci, F. Massoni, *Privacy e professione sanitaria*, Roma, 2014, 0-47; G. Montanari Vergallo, L.L. Campanozzi, M. Gulino, L. Bassis, P. Ricci, S. Zaami, S. Marinelli, V. Tambone, P. Frati, *How Could Artificial Intelligence Change the Doctor–Patient Relationship? A Medical Ethics Perspective,* in *Healthcare*, 13, 18, 2025, 2340.

[23] C. Calvaruso, *Quali bisogni informativi e formativi in medicina sociale*. *La Medicina sociale e le politiche sociali e sanitarie in Italia,* Roma, 1995, 181-186; E. Garaci, *Il ruolo dell'università nei processi di formazione di medicina sociale. La medicina sociale e le politiche sociali e sanitarie in Italia,* Roma, 1995, 187-189; S. Ricci, W.E. Nicoletti, *Docenza universitaria e servizio sanitario nazionale nell'evoluzione dei sistemi: rapporti, compatibilità ed incompatibilità,* in *Difesa Sociale*, 4, 1996, 1-8.

[24] S. Ricci, A.Miglino, E.Onofri, *Aspetti medico legali dell'agopuntura,* in *Annali di Medicina Sociale*, Roma, 2000, 103-12.

[25] P. Ricci, M. Pallocci, M. Treglia, S. Ricci, R. Ferrara, C. Zanovello, Pl. Passalacqua, F.M. Damato, *The Effect of Physical Exercise during COVID-19 Lockdown.* Healthcare, 11, 11, 2023, article 1618 open access; G. Montanari Vergallo, P. Ricci, M. Gulino, *Palliative care and covid-19 pandemic between hospital-centric based approach and decentralization of health services: a valuable opportunity to turn the corner?*, in *EuroMediterranean Biomedical Journal*, 18, 7, 2023, 34-39.