Essays

Towards a Systemic Social Medicine: Epistemological Foundations and Operational Perspectives

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WELL-BEING AND DISEASE IN THE FIELD OF AESTHETIC SURGERY. OVERCOMING THE DICHOTOMY AND THE ROLE OF THE PHYSICIAN

ABSTRACT: In recent years, renewed attention has been devoted to the epistemological and operational foundations of Social Medicine. Building on contributions to Global Social Medicine and critical analyses of the political economy of healthcare, this article advances the notion of Systemic Social Medicine. Grounded in complexity theory and systemic epistemology, this framework transcends reductionist paradigms and repositions health as an emergent property of interrelated biological, social, and political determinants. Four epistemic axes are proposed relationality, conscious and cooperative reduction, transcendence of knowledge, and global relationality aiming to reconfigure both clinical reasoning and public health practice within a genuinely systemic perspective.

KEYWORDS: Systemic social medicine; epistemology of complexity; relationality; global health; evidence-based medicine

1. Introduction

In recent years, scholarship has increasingly sought to reconsider the theoretical and practical foundations of Social Medicine. Pentecost and colleagues[1] have advanced the notion of *Global Social Medicine* as a framework that reasserts, at the international level, an agenda oriented to-

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[1] M. PENTECOST, V. ADAMS, R. BARU, C. CADUFF, J.A.GREENE, H.HANSEN, *Revitalising global social medicine*, in *The Lancet*, 398, 10300, 2021, 573-574.

ward the promotion of human rights and social justice. This perspective forms part of a broader movement toward the decolonization and democratization of knowledge production and circulation in public health, building on earlier contributions by Adams et al.[2] (2019) and later by Abimbola and Pai.[3]

Concurrently, Anderson and Smith,[4] through a critical analysis of the political–economic trajectory of Western medicine progressively governed by "market rationality" have articulated a model of Social Medicine attentive to three structural dimensions: (a) the decisive impact of socio-economic conditions on medical practice; (b) the recognition of collective health as a matter of social relevance; and (c) society's responsibility to promote well-being at both individual and community levels.

The concept of social determinants of health, long regarded as the backbone of Social Medicine, is itself undergoing critical reassessment. This reappraisal responds to their increasing stratification and to the challenge of adapting them to contemporary geopolitical diversity.[5] Within this context, the political dimension of Social Medicine has assumed growing significance, particularly with respect to the active role of health professionals in medical intelligence[6] and in safeguarding or reinforcing democratic processes.[7]

We argue that attention to the political dimension of medicine in general, and of Social Medicine in particular, represents a theoretical and operational concern of crucial importance. As we have underscored elsewhere,[8] the practice of science and medicine, if it is to be genuinely meaningful and transformative, requires direct engagement with social life through observation, listening, and continuous encounter with pressing issues such as violence, poverty, corruption, addiction, and the many forms of social pathology that shape everyday existence.

For this reason, science and Social Medicine cannot be confined within an abstract, pre-systemic logic detached from lived reality. Real problems are inherently complex and multilayered; understanding and addressing them requires a medical paradigm capable of integrating such complexity. It is precisely in this domain that Social Medicine may assume a pivotal role in facilitating the transition of clinical reasoning from a pre-systemic mode to one that is genuinely systemic.

Within this perspective, the present contribution seeks to outline several elements for the theoretical and operational constitution of Systemic *Social Medicine*. The discussion unfolds as follows: we begin by providing a conceptual framework, followed by an epistemological proposal consistent with the current model of Evidence-Based Medicine (EBM). We then present four epistemic directions that we consider

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[2] V. Adams, D. Behague, C. Caduff, *et al.*, *Re-imaging globl health trough social medicine,* in *Glob Public Health*, 14, 10, 2019, 1383-1400.

[3] S. Abimbola, M. Pai, *Will global health survive its decolonization?,* in *The Lancet*, 396, 10263, 2019, 1627-1628.

[4] M. Anderson, L. Smith, V.W. Sidel, *What is social medicine?*, in *Monthly Review*, jan 01, 2005.

[5] E. Borde, M. Hernandez, *Revisiting the social determinants of health agenda from the global South*, in *Glob Public Health*, 2019, 14, 6-7, 847-862; Q. Eichbaum, S. Reid, A. Coly, *et al.*, *Conceptualizing medical humanities program in low-resource settings in Africa*, in *Acad Med*, 94, 8, 2019, 1108-1114.

[6] A.C. Vilasi, *Medical Intelligence and Public Health in the complexities of contemporary societies. The role of FBI in The United States*, Security Science Journal, 5, 2, 2024.

[7] V. Tambone, P. Frati, F. De Micco, G. Ghilardi, V. Fineschi, *How to fix democracy to fix health care*, in *The Lancet*, 399, 10323, 2022, 433-434.

[8] G. Ghilardi, L.L. Campanozzi, M. Ciccozzi, G. Ricci, V. Tambone, *The political nature of medicine*, in *The Lancet*, 395, 10233, 2020, 1340-1341.

fundamental to the development of systemic Social Medicine and conclude with a brief reflection intended as an open invitation to critical debate.

2. An Ethical Rationality for a Medicine of Complexity

When Baruch Spinoza entitled his major work *Ethica ordine geometrico demonstrate,*[9] he explicitly declared already on the title page his intention to construct a rigorous philosophical system modeled on the axiomatic structure of Euclidean geometry. The entire architecture of the work unfolds according to a stringent logical sequence: definitions, axioms, propositions, demonstrations, corollaries, and scholia. What might appear as a purely formal exercise is, in fact, the coherent expression of an ontological premise in which reality is conceived as a unified, rational, and necessary system. The universe is neither fragmented nor ruled by chance or arbitrariness; it constitutes an interconnected whole, intelligible through the use of reason.

From this standpoint, the *Ethics* is not to be understood as a set of subjective moral prescriptions, but as the outcome of an adequate comprehension of being. A good life coincides with a rational life: the ethical subject is one who recognizes their position within the order of truth, including their relation to the web of necessities that structures nature. Ethics and ontology thus converge inseparably; to understand what is, simultaneously means to understand how one ought to act. This is a form of thought that does not merely describe the world but immerses itself within it, seeking to transform it through awareness and the coherence of action.

In this light, the so-called naturalistic fallacy identified by G.E. Moore[10] may be read, on the one hand, as a logical fracture between knowing and acting, and on the other, as one of the theoretical roots of modern anti-ecological attitudes, which deprive nature and its laws of any normative force.

Despite the historical distance, this approach retains a striking relevance today. It can be traced, in renewed form, within contemporary medicine, particularly in those strands most attuned to complexity. In this respect, a medicine that seeks to define itself as social and systemic appears to recover precisely that demand for order, rationality, and interconnectedness that Spinoza ascribed to reality. The idea of a systemic Social Medicine emerges from the need to overcome specialist and technicist reductionism, in order to construct a form of knowledge capable of reassembling what has been fragmented, integrating rather than separating, and inquiring beneath the surface of phenomena into the deeper conditions that generate them.

Research that aspires to a systemic knowledge of reality can, and indeed has, followed two very different paths. On the one hand, it seeks a "theory of everything" capable of formalizing existence through axiomatization. On the other, it advances through an open dynamic, aware of the limitations inherent in knowing a multidimensional reality and, for this very reason, open to the cooperation of multiple forms of knowledge.

[9] B. Spinoza, *Ethica* ordine geometrico demonstrata, 1677.
[10] G.E. Moore, *Principia ethica*, 1903.

3. From Formalization to Complexity: An Epistemological Turn

Over the course of the twentieth century, the project of a fully formalized science founded on a few first principles and capable of deducing every truth axiomatically reached its apex in David Hilbert's program.[11] The aim was to reduce the entire corpus of mathematical, and ideally scientific, knowledge to a coherent, complete, and logically grounded system. Yet this ambition encountered a radical limit in Kurt Gödel's incompleteness theorem,[12] which demonstrated that within any sufficiently powerful formal system there exist propositions that, while true, cannot be demonstrated within the system itself.

From this turning point onward, science has been compelled to acknowledge the constitutive limit of immanence: no system of knowledge can ever be entirely closed, exhaustive, or self-sufficient. Rationality, therefore, is not negated but transformed from a foundational and immanent logos into an open, dialogical, and, in a certain sense, transcendent process.

Concurrently, the emergence of systems theory[13] and the rise of the sciences of complexity[14] introduced new epistemological paradigms, which challenged classical notions of linear causality, explanatory reductionism, and predictive determinism. These developments suggest a new approach: circular and open causality, a conscious and cooperative reduction, and a prognostic capacity only partially amenable to formalization.

Within this new horizon, knowledge is no longer constructed through the analysis of isolated parts but tends toward the comprehension of open, dynamic, and interconnected systems. Phenomena can no longer be interpreted through mere analytical decomposition, as they arise from complex relations, unstable equilibria, feedback processes, and mechanisms of self-organization. Reality thus takes shape as *emergent reality*, a totality qualitatively distinct from the simple sum of its components.

From this perspective, medicine may evolve toward increasing specialization in the search for deep biological evidence, while interpreting such evidence clinically through a systemic paradigm. The growing availability of data and their processing through advanced algorithms does not mark the end of interpretation; on the contrary, it constitutes its point of departure. These data must be read through a systemic and personalized lens, capable of restoring complexity and clinical meaning. This dual interpretation personalized and systemic could form the epistemological foundation both of future clinical medicine and of systemic Social Medicine.

The foundational element of this transition is represented by the dynamic interplay between correlation and interpretation. The former, supported by Artificial Intelligence, enables a semantic refinement of data; the latter, acting upon this same product, reintegrates it within a systemic context of meaning, thereby arriving at increasingly veridical and thus effective formulations, both at the individual and collective levels.

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[11] G. Israel, A. Millan Gasca, *The World as a Mathematical Game: John Von Neumann and Twentieth Century Science*, Science networks Historical Studies, Birkhäuser, Basel, 38, 2009, 219.

[12] Gödel first presented the incompleteness theorem at a roundtable following the Second Conference on the Epistemology of the Exact Sciences in Königsberg in 1930. The theorem states that any consistent formal system of mathematics, sufficiently expressive to represent the structure of the natural numbers with addition and multiplication, admits the construction of a well-formed statement that is true but neither provable nor refutable within that system itself.

[13] L. Von Bertalanffy, *General System Theory. Foundations, Development, Applications*, New York, 1968.

[14] I. Prigogine, *Introduction to thermodynamics of irreversible processes*, 1955.

This dynamic is not merely cooperative; it possesses a complex and circular nature in itself: it simultaneously becomes a site for the fine-tuning of Artificial Intelligence and an epistemic space in which the constitutive dynamic relations of reality unfold. In this perspective, the social medicine of the future must be conceived as systemic medicine, engaged not only in understanding biological physiology and pathophysiology but also and perhaps more importantly the physiology and pathophysiology of relationships.

4. Reductionism and Complexity: Towards a Systemic Evidence-Based Medicine

Such an epistemological shift carries significant implications for the life sciences and, in particular, for medicine. Linear, deterministic, and predictive models have undoubtedly yielded important results in the diagnosis and treatment of diseases. However, they today exhibit clear structural limitations, especially when confronted with phenomena such as chronic conditions, multimorbidity, psychosocial suffering, or when approached from the integrated perspectives of One Health and Global Health.

Every clinical condition is embedded within a dynamic and transformative context biological, psychological, cultural, environmental, relational, political, that cannot be dissociated from the other dimensions with which it constantly interacts. Moreover, these interconnections are subject to temporal changes that elude representation through linear statistical models or classical probabilistic logic.

In light of this, it appears inadequate to continue defining medicine as a merely probabilistic science. It is, in our view, more appropriate to conceive of it as a systemic science, akin to other practical sciences—and, one might add, even theoretical sciences. This does not imply the adoption of a single scientific method across all disciplines, as already noted by Popper.[15] Each science must retain its methodological specificity, while acknowledging that every form of knowledge represents, at best, a reduction of reality: a partial truth within a broader network of meaning.

Consequently, there arises the need for conscious and cooperative reduction:[16] an epistemological stance that recognizes the partiality of knowledge and actively seeks interdisciplinary collaboration to construct a systemic and shared vision of the object of study. Such a vision maintains structural openness, both in terms of epistemic completeness and operational applicability.

Adhering to a linear framework entails perpetuating a partial and potentially misleading understanding. An authentically scientific medicine today must integrate ontological and epistemic transcendence into its method, transitioning from traditional Evidence-Based Medicine (EBM) to what we might term Systemic Evidence-Based Medicine (SEBM), which is more faithful to the complexity of reality.

This implies that every act of knowledge must transcend mere empirical evidence, interrogating the deep causal relationships, emergent levels, and latent dynamics that structure phenomena not only in space and time, but also within multiparametric configurations, as suggested by chaos theory.

[15] D. Antiseri, K. Popper, *Protagonista del secolo XX*, 2002.

[16] V. Tambone, G. Ghilardi, *Aware and cooperative reduction*, in *La Clinica Terapeutica*, 163, 3, May 2012, e133-e143; G. Ghilardi, V. Tambone, *Per una fondazione ontologica della riduzione consapevole e cooperante*, in *Medicina e Morale*, 64, 5, 2015; G. Ghilardi, V. Tambone, *Per una fondazione ontologica della riduzione consapevole e cooperante*, in *Medicina e Morale*, 2015; 64, 5.

An exemplary reference in this context is provided by the dimensional ontology developed by Viktor Frankl[17]. According to the first law of this theory, "a single and identical phenomenon, projected onto lower dimensions than its own, gives rise to different and mutually contrasting figures." The example of the cylinder is emblematic: projected onto a horizontal plane, it generates a circle, whereas on a vertical plane, it produces a rectangle. Two irreconcilable figures yet arising from the same object.

Applying this concept to the human being, if one observes a person solely in their biological dimension, somatic phenomena will emerge; if seen only in the psychological dimension, psychic aspects will surface. Although both perspectives concern the same reality, they may appear irreconcilable or in conflict.

Frankl's second law states that "different phenomena, projected onto the same lower dimension, may appear similar or ambiguous." Here too, the geometric analogy is illuminating multidimensional phenomena, observed through a single reductive perspective, lose their specificity and risk being misinterpreted or confused.

Numerous thinkers have anticipated or developed a similar multidimensional vision: from Edwin A. Abbott with *Flatland,*[18] to Ken Wilber with his Integral Theory; from classical psychoanalysis (Freud, Jung, Hillman) to the theories of Carl Friedrich von Weizsäcker, according to whom the world is constituted not by objects but by informational structures articulated across ontological levels. In the physical sciences, one can recall Michio Kaku's extra-dimensional theories, or the quantum perspective advanced by Niels Bohr, Werner Heisenberg, and David Bohm, for whom the very behavior of matter depends on the observer (principle of complementarity), with non-local and interconnected levels of reality (entanglement), so that the universe can be viewed as interconnected, holistic, and composed of overlapping layers of reality—much like Frankl's dimensional ontology.

This leads naturally to systems thinking (Systems Theory and Cybernetics) with authors such as Ludwig von Bertalanffy, Gregory Bateson, Edgar Morin, Humberto Maturana, Fritjof Capra, and Joanna Macy. Within this framework, existing phenomena including human beings are open complex systems composed of hierarchical and interdependent levels. Each system possesses emergent properties that cannot be reduced to the sum of its parts (for example, consciousness). The human being is seen as a node within a network of biological, social, cultural, and ecological relationships, which can be progressively understood, but whose main characteristic is to serve as an ontological and transcendent interpretive key, possessing its own dialectic with a persistent level (which may be termed substance, self, or otherwise) that actualizes its potential in a becoming already present as a project (sometimes described as passive potentiality). This predefines the acting subject even before its development and thus enables the relationship, which becomes a prerequisite for any co-relation.

"Relationship" must therefore be observed at a multiparametric level: an immanent dimension (relation to oneself), a horizontal dimension (relation to peers), a global dimension (relation to the mineral, vegetal, and animal worlds), a vertical dimension (relation to one's formal and ultimate cause), a historical dimension (relation to memory), and additional dimensions such as the technological (relation of reinforcing alteration). The subject and their relationships thus constitute the genetics of a systemic interpretation of reality.

[17] V. FRANKL, *Man's Search for Meaning: The classic tribute to hope from the Holocaust*, Vintage Pub, 2004.
[18] E.A. ABBOTT FLATLAND, *A Romance of Many Dimensions*, Independently published, 2025.

It is in this direction that the proposal for systemic social medicine develops, grounded on four constitutive axes: relationship, conscious and cooperative reduction, transcendence of knowledge, and global relationship as an operational guide.

5. Four Epistemic Axes for Systemic Social Medicine

5.1. Relationship

The concept of relationship that we aim to propose goes far beyond its traditional applicative forms, such as the physician-patient, physician-society, physician-politics, or physician-economy relationships. While these manifestations are important, they represent partial expressions of a more radical truth: every individual reality is intrinsically relational. Relationship, therefore, is not a mere accessory to existence but constitutes a foundational, existential, and dynamic element.

In human beings, relationality manifests in forms that are partially involuntary and partially voluntary; it may be comprehensible in its effects or elusive and unpredictable; sometimes physiological, sometimes pathological; it can present as reception or as offering. Beyond these forms, however, relationship is primarily the means through which the human subject constructs both self and world. Here, we will focus particularly on the voluntary dimension of relationships, the one that implies awareness and responsibility.

Voluntary acts, in fact, do not merely modify the environment; they primarily transform the actor. According to the ancient principle that "man becomes what he does", the one who steals progressively constitutes himself as a thief, the one who writes as a writer, and so on. This phenomenon signals the presence of a primary immanent relationship, internal to the subject, articulated in the dynamic between intellect, will, and passions. If the will chooses to act in accordance with the judgment of the intellect, which has recognized the good to be done, action will be rational (*kata logon*), and over time the subject will strengthen their capacity for rational action. Conversely, if the will is drawn toward what contradicts the intellect's directive, behavior will be irrational and, over time, will tend to weaken rational faculties.

The structure of this immanent relationship profoundly influences the quality of transcendent relationships: these may be rational and constructive, or irrational and destructive. In the first case, one speaks of physiological relationality; in the second, of pathological relationality.

Without delving further here, we can affirm that systemic social medicine should adopt as its primary objective the study, promotion, and support of physiological relationality, as well as the diagnosis and treatment of its pathological forms. In this sense, it must address risk behaviors, interpersonal violence, ecological challenges, social responsibilities, and many other areas central to public health, all starting from and through the foundational category of relationship.

In line with the thought of Ivan Cavicchi, who defined medicine as an "incomparable science"[19] due to its irreducible complexity, we consider it urgent to move beyond an approach based solely on biological facts toward a relational paradigm, capable of integrating the biological dimension with the social, systemic, and global dimensions, while recognizing that "biological facts" are themselves relational.

[19] I. CAVICCHI, *La Scienza impareggiabile*, 2022.

Applied examples of relationality in systemic social medicine

1. Human-technology relationship (bio-techno-relational domain):
   - Biological effects of new technologies on the central and peripheral nervous system.
   - De-skilling phenomena, particularly the loss of critical and reflective thinking.
   - Use of personalization algorithms and implications for freedom of choice.
   - Mental health in relation to the use of conversational interfaces (chatbots).
2. Relationship with political-economic dynamics (socio-political-relational domain):
   - Impacts of public health within the context of surveillance capitalism.
   - Psychopolitics and forms of behavioral modulation.
   - Distorted meritocracy and unequal access to education.
   - Longtermism and the crisis of democratic participation.
3. Pathological abusive relationships (deviant-relational domain):
   - Bullying and gratuitous violence;
   - Gender-based violence;
   - Institutional violence and latent states of war.
   - Sexual violence and extremes of bondage.
4. Relationship with nature (One Health and beyond):
   - Overcoming G.E. Moore's naturalistic fallacy.
   - Science for humanity vs. transhumanism.
   - Ecological urban planning and environmental sustainability.
   - Human ecology as a critical development beyond deep ecology.

These examples far from exhaustive demonstrate how systemic and social medicine must address relationship in a transversal, multidimensional, and interdisciplinary manner.

5.2. Conscious and Cooperative Reduction

In contemporary scientific thought, method is often considered the cornerstone of rationality. However, this methodological emphasis can easily degenerate into a form of epistemological reductionism, in which only the scientific method is deemed legitimate for producing valid knowledge of reality.

This stance found its most complete expression in the twentieth-century formalism of David Hilbert, who sought to ground mathematics on perfectly coherent and complete axiomatic foundations. His second problem proving the internal consistency of the real number system represents the apex of this vision. However, Hilbert's dream was shattered by Kurt Gödel's incompleteness theorems (1931), which established the impossibility for any sufficiently complex formal system to prove its own consistency from within. This failure sparked a profound crisis in scientific reductionism.

In the second half of the twentieth century, an alternative epistemological orientation emerged, aimed at reaffirming the irreducible complexity of reality. Holism was its first expression, supported by authors such as Fritjof Capra and David Bohm, who promoted an interconnected view of phenomena. However, even holism can degenerate into a mirror form of reductionism, in which parts are absorbed into the whole, losing their specificity.

A genuine overcoming of this polarization was offered by complexity theory, which rejects both reductionist simplification and holistic universalism. It recognizes the existence of multiple levels of reality, each of which cannot be reduced to the others. The concept of emergence is central here: the properties of a complex system such as a symphony or a culinary dish cannot be deduced from its individual parts but emerge from nonlinear relationships and higher-order organization.

The science of complexity therefore proposes a new epistemology: interconnected, transdisciplinary, and cooperative. The interaction between different bodies of knowledge is no longer optional but an epistemic necessity. Every phenomenon, to be adequately understood, requires the contribution of multiple disciplines, each carrying a fragment of truth.

However, it is equally necessary to recognize that every act of knowledge entails a reduction. To observe, analyze, or interpret inevitably involves selecting, simplifying, and cutting through the complexity of reality. The epistemic error does not lie in reduction per se, but in the failure to recognize it as such. Reduction is legitimate only if it is conscious, provisional, purpose-driven, and open to revision.

From this perspective emerges an epistemology of conscious and cooperative reduction, grounded in the dialogical integration of different forms of knowledge. Scientific knowledge thus becomes a collective, self-critical, and asymptotic endeavor: never definitive, always revisable. The multidimensional approach, also theorized by Viktor Frankl, restores the complexity of the person and the world, honoring the diverse dimensions of human suffering.

Applied to medicine, this principle translates into clinical practice based on temporary and directed reductions, capable of integrating into a systemic reading of the human condition. The clinician, from this perspective, is not an isolated technician but an actor within a dialogical and collaborative network. Every diagnosis becomes an interpretative hypothesis to be verified, integrated, and, if necessary, reformulated.

A systemic social medicine founded on this epistemology will therefore have the courage to recognize the limits of its own reductions and the wisdom to embrace interdisciplinary cooperation as the primary path toward a more humane, more accurate, and more effective understanding of health and care.

5.3. Knowledge as Necessarily Transcendent

As previously observed, Gödel's incompleteness theorems indicate the impossibility for any sufficiently complex formal system to exhaustively encompass the totality of truth it claims to represent. Authentic knowledge, therefore, can never be fully contained within a closed system; it always requires reference to dimensions that transcend it. This transcendence should not be understood merely in hierarchical or organizational terms, but as an openness to a further systemic level that allows phenomena to be interpreted in their circular dynamics, according to both top-down and bottom-up causality.

In the medical field, this need for transcendence is particularly evident in the approach to clinical complexity. For instance, understanding an oncological pathology requires integrating molecular biochemistry with the patient's immunological profile, individual genetics, existing comorbidities, expected therapeutic responses, and much more. However, to fully comprehend the immune profile itself, one must consider the subject's nutritional status, possible substance abuse, quality of habitat, presence of domestic animals or environmental pathogens, and so on. Furthermore, to adequately assess nutritional status, one must examine the socio-economic and geopolitical context in which the patient lives, as well

as potential psychopathological conditions such as an eating disorder which, in turn, point to an additional causal level, namely familial, affective, social, and friendship relationships.
In each of these articulations, a central principle becomes evident: the cause can never be entirely immanent to the phenomenon but must necessarily transcend it, as only what is external can determine it.
From this perspective, scientific knowledge recovers its etymological root: *scire per causas*. To know is to investigate the deep causes, not to remain at the surface of the data. In medicine, this entails recognizing that the object of knowledge health, disease, body, mind can never be reduced to the observable but always lies beyond the symptom, the lesion, and the parameter.
The recovery of the Aristotelian causal model which includes material, formal, efficient, and final causes—allows medicine to reclaim its authentic therapeutic status: not merely treating effects but interrogating the deep causal structures of clinical phenomena. Systemic medicine thus constitutes a critical and reflective knowledge, capable of transcending the specialist and sectoral perspective to address suffering in all its existential and contextual density.
Even dysfunctional behaviors individual or collective must be read as systemic symptoms, indicators of relational or environmental dysfunction rather than mere anomalies to be corrected. Authentic diagnosis thus becomes an hermeneutics of complexity and therapy an act of reconnection and rebalancing.

5.4. Global Relationship as Operational Evidence

In a famous passage from his essay *Physics and Reality* (1936), Albert Einstein states that "the theory determines what we can observe." This observation both overturns and complements the classical empiricist view: it is not observation alone that generates theory, but theory itself that guides, selects, and structures what is observed. Data, therefore, is never neutral, but mediated by a pre-existing theoretical horizon.
From this follows a fundamental implication for medicine: the necessity of adopting a global theoretical horizon capable of guiding clinical observation in a broad, contextual, and systemic manner. Medicine has always been an integrative knowledge: anamnesis, semiotics, and epidemiology are tools that seek connections among phenomena, not mere mechanical correlations.
From a systemic perspective, this integrative vocation must be carried to its extreme consequences: the patient is not an isolated organism but a person-in-relationship, embedded in complex networks—familial, social, cultural, environmental, economic. The patient is not a static being but a historical subject, in whom past experiences, memory, and current choices contribute to defining both the present and the intentional direction of existence. For reasons we will not elaborate here, we understand the historicity of the human being as a combination of permanence and dialectic. It seems incorrect to reduce it solely to the dialectical dimension, as this would strip it of meaning in the same way that, in nihilism, ideas detached from generative ideas lose significance. The permanence of relationship resides in the person and manifests at linguistic, legal, historical, ethical, clinical, and even biological levels.
For this reason, the dialectic and dynamic to which we refer is not a dialectic of negation and overcoming, as seen in contemporary deconstruction à la Derrida,[20] which proves fallacious and unsustainable. Rather, we refer to a dialectic or dynamic of construction when oriented toward the purpose of the per-

[20] AA.VV., *Su Jacques Derrida: Scrittura filosofica e pratica di decostruzione*, in *LED*, 2012.

son, or to a dynamic of deconstruction when contrary to the purpose of the subject. Indeed, dynamics or dialectics are not inherently positive or negative; they are characterized according to their relation to the goal of the acting subject. Here, the material dimension must be combined with the psychological and spiritual dimensions in a dynamic of personal construction. This combination represents the deepest multiparametric dimension.

This historicity is also reflected on the biological level. The intellectual-volitional dimension of the human being as vividly illustrated by Viktor Frankl affects not only existential capacity but also personal biochemistry. Spiritual interiority is not reducible to a psychological epiphenomenon; rather, it constitutes a multiparametric openness capable of generating powerful existential attractors that orient choices, behaviors, and bodily states.

Within this framework, relationships are not a mere corollary of clinical practice but a primary operational evidence. Every medical intervention, treatment pathway, and public health strategy must be conceived and implemented within a relational logic. Systemic social medicine thus postulates that only a theory capable of embracing complexity as a structure of reality can underpin a clinical practice adequate to contemporary human and social realities.

6. Conclusion: Dwelling in Complexity, Living Relationship

Systemic social medicine does not propose itself as a new specialization, nor as an ideological alternative to existing medical knowledge. Rather, it represents an epistemic transformation: a shift in the very way of conceiving knowledge, observation, diagnosis, and care.

Far from rejecting science, it radicalizes its demand for truth, assuming complexity not as an obstacle to knowledge but as an original condition to inhabit. Medical knowledge, in this view, becomes reflective, dialogical, and open: it rejects the linear paradigm, exposes itself to the encounter of multiple levels of reality, and is nourished by disciplinary plurality and epistemic cooperation.

Ultimately, systemic social medicine is also ethics: not in the normative sense of a behavioral code, but as an ethics of epistemic and clinical responsibility. It is an ethics of well-executed work, of embodied rationality, of cooperative awareness. It is a practice that recognizes the value of relationships as a structural condition of care.

In a world marked by fragmentation of competencies, knowledge, and relationships systemic social medicine reminds us that to know is to correlate and interpret, and to care is also to heal relationships. Health is not merely the absence of disease but a fully realized form of lived relationality. Dwelling in complexity and living relationship: this is the horizon of the medicine we envision.