Medicine, like other modern systems, privileges some people and ways of seeing over others. Some researchers and clinicians are trying to help people who are marginalized by poverty or stigma to benefit from modern medicine. Others are developing ways of being with patients that restore the patient’s right to his or her narrative, including questions of meaning, suffering, and personal growth. Most importantly, perhaps, although modern medicine has official sanction in most countries, patients often seek solutions elsewhere, in healing that is biological, magical, social, or religious.

Medicine in historical context

Medicine is the craft of healing a human being. The practitioner has an understanding, often implicit, of what a human being is, and how to help a human being to become healthy, or whole. Medicine is therefore innately spiritual. However, schools of medicine differ radically in their models and techniques.

In medieval Christendom and Islam, a human being was body, soul, and spirit. Purification of the soul could allow a person to fulfill their humanity and experience eternal pleasure, in the Divine presence. Soul-healing was done by holy people, often in holy places. People were also asked to work on their own souls by following spiritual ways of life that could be understood as extensions, or expressions, of religion (Ghazali 2014, Kempis 1952, Thomas 1971, Wilson 2000).

Bodily healing was part of the soul’s journey. A healthy body could do good and serve others; but illness also had value. It could help the soul to mature, by, for instance, teaching patience and acceptance of God’s will; it could also act as a heaven-sent correction to waywardness and selfishness. Until the soul was purified, suffering was inevitable: holy people taught others how to suffer gracefully. They might also be empowered, by God, to heal miraculously when a person was spiritually ready to receive such healing; or to exorcise evil influences from the patient. Holy people also taught the use of natural medicines, particularly herbal medicines (à Kempis 1952, Ghazali 2014, Suyuti 2015, Thomas 1971, Wallis 2010).

In addition to holy people, the medieval world had magicians. Some made alliances with fairies or demons. Other, more reputable forms of magic were natural magic, in which the magician sought to work with the souls of things, and celestial magic, a development of astrol-
ogy. But, in general, magic was suspect: in contrast to the spiritual seeker who sought to submit to God's will, the magician sought to control nature, or other people. The selfless magician was rare. But magicians, perhaps masquerading as holy people, might nonetheless be consulted for healing (Flint 1991, Thomas 1971, Vickers 1991, 1994, Wilson 2000).

Medieval scholarly medicine, in Christendom and the Islamic world, was Greco-Arabic. Hippocratic and Galenic teachings were developed and revised by physicians such as Hunayn ibn Ishaq (Joanitius; died circa 873), Ibn Sina (Avicenna; died 1037), Ibn Rushd (Averroës; died 1198), and Moshe ben Maimon (Maimonides; died 1204). From the late 11th century, Constantine the African, Gerard of Cremona, and others translated the writings of leading physicians from Arabic to Latin, allowing scholarly medicine to spread to western Europe and be taught in the newly emerging universities (Porter 1997, Wallis 2010).

The body at this stage was a biological organism. It was influenced by its environment, including the climate and heavenly bodies; it had phases, was animated by life forces, and had a soul. A healthy body, like a healthy life, was perfectly balanced. Imbalance led to illness, and the physician's job was to restore balance: by changes of diet or lifestyle, as well as by the prescription of medicines often derived from herbs (Glick et al. 2005, Siraisi 1990).

Such a medicine was consistent with Jewish, Christian, or Islamic spirituality. In medieval hospitals, physicians and nurses would apply the latest medical knowledge about the body in a religious atmosphere: pills and salves were accompanied by prayer and sacraments. However, a physician did not have to be an expert on religion: in Chaucer's Canterbury Tales, the Physician's "studie was but litel on the Bible": he favored natural and celestial magic. To some extent, a dual medicine developed, with people's spiritual needs being taken care of by religion, and their physical health being attended to by the physician; although, in practice, many people rarely or never saw a physician (Arikha 2007, Chaucer 2008, Moseley 1987, Wallis 2010, Wilson 2000).

Several leading physicians were also influential natural philosophers. Ibn Sina and Ibn Rushd argued that philosophy could arrive at truth separately from theology. Ghazali (died 1111) wrote that this was an illusion. Any true knowledge must be free from the distortions caused by vanity and selfishness: hence, knowledge began with self-knowledge, which, in turn, required a pure soul. Spiritual healing was essential to objectivity (Guillaume 1931, Ghazali 1998, 2000, Leaman 1988, Sheikh 1982).

Ghazali's ideas were widely accepted in the world of Islam. In Christendom, however, inaccurate translations of Averroës inspired philosophers, initially in Paris, to argue that philosophy could reach coherent, stable truths different from those of religion (Guillaume 1931, Leaman 1988, Tarnas 1996). In the mid-15th century, Marsilio de Ficino translated into Latin the magical texts known as the Hermetic corpus. Echoing the Hermetic corpus, Francis Bacon outlined a plan for converting knowledge to power, restoring man to the sovereignty over nature that he had enjoyed before the Fall (Bacon 1870, Thomas 1971).

In the Renaissance, nature was still full of souls. However, writing in the 17th century, Descartes and Hobbes described a mechanical nature without souls—except, for Descartes, the soul of man (Hobbes 1651, Schouls 2000). Modernity, almost by definition, came to mean a world in which souls did not exist: or, if they did, they were inessential to knowledge. Science was, in many ways, natural magic without the souls (Chittick 2007, Illich 1981, Shumaker 1989, Vickers 1991). The biological medicine of the medieval period was gradually replaced by mechanical medicine (Table 23.1).

Mechanical medicine required the patient to be visualized as a body to be engineered. It therefore used an anatomy based on dissection, and a physiology based on fluid mechanics. The pioneer anatomist Vesalius (died 1564) had difficulty obtaining corpses, partly because of lingering beliefs that human dissection was loathsome and unnecessary; some of the bodies he was
dissecting proved to be alive. In Enlightenment England, demand from medical schools led to a cadaver shortage, and a thriving bodysnatching industry, addressed by the Anatomy Act of 1832. The new physiology led to much vivisection, which was sometimes justified by the depiction of animals as automata (Carlino 1999, Illich 1982, May 1639, Wootton 2006).

However, mechanical techniques did not necessarily lead to therapies that worked. Until the mid-19th century, much treatment in western Europe was still Greco-Arabic. But much of the subtlety of the discipline had been lost. The small-scale, selective bloodletting of the Greco-Arabic physicians had become an almost indiscriminate exercise that tended to harm the patient; techniques of pulse diagnosis were dismissed as mythical by physicians who could not use them. The patient was no longer a biological organism but an animated physiological corpse, in whom many Greco-Arabic treatments seemed inexplicable; and perhaps the squalor and mayhem of the Agricultural and Industrial Revolutions took away not only much traditional knowledge but the facilities and environments patients needed to heal (Polanyi 2001, Rahnema and Bawtree 1997, Thomas 1971, Wilson 2000, Wootton 2006).

Understandably, therefore, Greco-Arabic treatments were found to be useless (Wootton 2006). The first modern drug is sometimes said to be Kairin, synthesized from petrochemicals in a German laboratory in 1882 (Burch 2010); medical imaging with x-rays was pioneered at the end of the 19th century. The 19th-century doctor was given technology and measuring equipment in the form of a stethoscope and thermometer: even the use of these tools was debatable, since the stethoscope was more decorous, but not necessarily more effective, than putting an ear to the body; and the numbers on a thermometer could not substitute for skilled and sympathetic observation (Illich 1995, Mendelsohn 1979, Needleman 1992). But by the 21st century, the patient would be a machine, surrounded and assessed by machines; even the doctor would be a machine, a corporate employee doing standardized tasks in a standardized way, and replaceable, at least in principle, by a robot or computer program.

### Table 23.1 Medieval Medicine versus Modern Medicine

<table>
<thead>
<tr>
<th>Medieval medicine</th>
<th>Modern medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body has a soul and, in religious teaching, a spirit.</td>
<td>Body may not or may not have a soul or spirit, but can be treated as though it does not.</td>
</tr>
<tr>
<td>Consciousness is experienced through the soul.</td>
<td>Consciousness is experienced through the mind, which is an epiphenomenon of the brain.</td>
</tr>
<tr>
<td>The sick body or soul is out of balance, which can be restored.</td>
<td>The sick body or mind is broken and should be fixed.</td>
</tr>
<tr>
<td>Patient viewed as part of community or ecosystem.</td>
<td>Patient tends to be viewed in isolation.</td>
</tr>
<tr>
<td>Patient can be affected by ordinarily unseen beings: demons, fairies, elves, jinns.</td>
<td>Patient can be affected by ordinarily unseen beings: bacteria, viruses, fungi.</td>
</tr>
<tr>
<td>Hospital is run by religious order.</td>
<td>Hospital is run by state or corporation.</td>
</tr>
<tr>
<td>Medicines are grown, harvested, or mined, and often cooked.</td>
<td>Medicines are synthesized from petrochemicals in the laboratory.</td>
</tr>
<tr>
<td>Diagnosis by dialogue, observation, and examination of the living person (and his excretions).</td>
<td>Diagnosis by patient's history and examination of the body, ideally with scans and laboratory tests.</td>
</tr>
<tr>
<td>Physician required to be a skillful and idiosyncratic practitioner.</td>
<td>Physician requires the best technology to obtain standard results.</td>
</tr>
</tbody>
</table>
The current practice

Spirituality still exists in medicine: but it is, in many ways, the spirituality of modern economics. The body is material: the object of medicine is to fix the broken machine so that it can work again. Indeed, doctors decide who is, and is not, capable of economic activity. Physical soundness and work are taken to be good in themselves: their ultimate purpose is rarely questioned. The machine will fail in the end: so medicine, if it works, is a postponement of failure.

Since medicine relies on the manipulation of matter, it can be dominated by people who have the economic and social power to control matter. The independent doctor is now a rarity: the doctor’s education, training, validation, practice, treatments, and equipment are determined by state and corporation. The only medicines that can legitimately be prescribed are made in factories, usually by multinational corporations; they are often paid for by the state.

The removal of suffering from patients is still considered a worthwhile and meaningful act. However, because the patient is, scientifically, a machine, to relate to the patient as a human being can be seen as a low priority (Relman 2014, Rosenhan 1973): unethical, indeed, when time and resources are scarce. This approach has been particularly damaging in cases where malfunctions cannot be rapidly cured and need to be addressed with sensitivity and creativity; or where mechanical malfunctions do not exist, as in much of psychiatry (Davies J 2013). When a patient is defined as “mad”, his or her narrative is especially vulnerable to being overruled, with devastating results: the failure to uncover abuse, the prescription of treatments with disabling side-effects.

Casual inhumanities are excused on the grounds that medicine works: randomized controlled trials demonstrate that treatments are effective. Or do they? Trials are selectively designed; and trial databases are of questionable value when around half of all trials, generally those with unwelcome results, are never reported (Glasziou and Chalmers 2017). Even when a trial is reported to show that a treatment works, it nearly always shows, on closer examination, that the treatment is more effective than placebo, for a restricted outcome, in a small minority of patients.

Moreover, trial results are, like the rest of science, provisional. Between 2001 and 2010, the New England Journal of Medicine, perhaps the world’s most influential medical journal, published 363 studies that assessed clinical practices previously supported by research: 138 upheld the practice and 146 found it unhelpful or harmful (Prasad et al. 2013). In preclinical studies, around half of published findings cannot be replicated, often because they were arrived at through improper selection of data or because they represent chance findings. Influential and striking findings may be particularly unlikely to be replicated. Some studies give rise to widespread further research before their essential falsity is discovered (Begley and Ellis 2012, Button et al. 2013, Prinz et al. 2011).

The increase in life expectancy since the Industrial Revolution seems to have much less to do with specific medical treatments than with sanitation and the eradication, or displacement, of extreme poverty (McKeown 1979, Porter 1997, Wootton 2006). Despite the vast growth in medical technology, misdiagnosis remains common (Kingsford 1995, Roulson et al. 2005). When doctors go on strike, in general, death rates stay the same or decrease (Mendelsohn 1979, Metcalfe et al. 2015). Although medicine now costs around 10% of a rich country’s annual budget—the equivalent of the medieval tithe to the church—nearly everybody is classified as sick (McGrail et al. 2016).

Materialist medicine, perhaps almost by definition, is an economic good, with infinite want and limited supply. Objective assessment of need is almost impossible, unless need is equated with potential restoration of capacity, and assessed in a crude and actuarial fashion. In practice, lobbying, fashion, and influence often determine how resources are allocated. Culturally
“less-worthy” patients often endure conditions that would be deemed intolerable for others (Whitaker 2010). In Germany, the squalid conditions of asylums in the 1930s helped ideologues to argue that psychiatric patients were barely human (Burleigh 1994): when World War Two began, they were systematically exterminated, and the resulting resource savings publicized (Proctor 1988).

Internationally, no pretense of equity exists. People in poor countries are denied basic treatment on cost grounds. In 2015, the only antivenom safely effective against all African snakebites was withdrawn on the grounds of inadequate profitability, despite each treatment costing at least $280 (Lancet Editorial 2015). Ironically, simple, cheap treatments such as mosquito nets and eye ointments are often far more effective than fashionable drugs. Similarly, clean water, adequate food, good drains, and land rights can achieve far more than many ostensibly medical measures (Bhutta et al. 2013, Davis 2006, Mara et al. 2010, Marmot 2015, Woodman and Grig 2007).

Inequality is exacerbated by the “inverse care law”: healthcare staff are less likely to work where they are most needed, because conditions and pay are better elsewhere (Moosa et al. 2013). Practitioners are encouraged to leave poor countries to fill healthcare rotas in rich countries, who thereby avoid the expense of training their workers. Even within countries, cosmetic surgery and the latest drugs are available to some, while others sicken for want of food. Poor people are, however, at the forefront of medical experimentation, sometimes without adequate consent (Elliott 2010, Pappworth 1969).

In a way, doctors are doing what they always have done: attending to the patient, while leaving questions of meaning and purpose to the experts. But the world around them has changed, as has the basis of medical knowledge. For many thinkers, before the “Averroist” revolution (Averroës was not an Averroist), natural philosophy could be understood only in the light of theology: which, in turn, was relevant only inasmuch as the student’s own soul was prepared to receive and understand truth (Chittick 2007, Ghazali 2015, Illich 1981, 1993, Tarnas 1996). Modernity has brought with it a fragmentation of knowledge. Theology can be understood as an academic discipline, without reference to its practical application; philosophy has been separated from theology, the humanities from philosophy, and science from the humanities. Since science has become the dominant way of seeing, medicine has become a branch of science. It can be justified in scientific terms, without being shaped by knowledge of the soul, philosophy, the humanities, or aesthetics.

The discipline of medical ethics does exist, but tends to act as a discussion of what medicine should be allowed to do, rather than an analysis of what medicine is for. Limits recommended by medical ethicists tend to be systemically overcome, as what was once deemed grotesque or inhuman is thought justifiable because it works. Even if it does not work, it will one day, if enough resources are put into it: or should, because it is scientific.

Similarly, although the hospital chaplain often provides real comfort and support to patients, he is not there to shape the medical encounter. He can, in fact, act as a safety valve, turning dissent into a question that cannot challenge the doctor. Rather as the medieval doctor was a visitor in a hospital dedicated to the sacred, the chaplain wanders corridors that resemble, and symbolize, the inside of a machine.

In the absence of a widely acknowledged religious framework, the doctor’s pastoral role is, potentially, wider than ever before, and the ethical responsibilities more onerous. Doctors abort fetuses, terminate the lives of elderly or sick people (often in fact, if not in law), allocate animals for sacrifice, and decide what kinds of suffering can legitimately excuse someone from wage labor. Doctors also counsel people about their family lives and lifestyles, and police the boundary between sin and sickness. The psychiatrist, not the priest, hears confessions and helps people cope with extreme distress. In the 20th century, as church attendance declined, doctors took on the white coat, echoing the priest’s robe as well as the vivisector’s gown.
Yet doctors receive little support to bear this burden. Occasional ethics classes and clinical discussions are no substitute for a reflective, insightful perspective on the art of suffering. Clinical training cannot, on its own, help a doctor to relate sincerely and creatively to the patient. As the pressure to rationalize medicine becomes ever heavier, discussions and relationships are being replaced by processes and guidelines (Greenhalgh et al. 2014), the white coat by surgical scrubs. Yet this does not prevent the doctor from having to take on people’s grief and confusion, or from being marked by it.

The doctor is trained to transmute suffering into illness, which becomes disease, which can be treated with a drug or surgery. The doctor is, on the whole, not encouraged to be a human being, with weaknesses, idiosyncrasies, and personal insights. Doctors often work grueling hours under stressful conditions: their rates of mental illness and suicide are high (Brooks et al. 2011). Although many doctors intuitively recognize ministering to people as a spiritual act, the impact of medicine on the doctor’s soul is rarely acknowledged. The Hippocratic Oath, a prayer, is understood as a professional pledge: ethical practice is a professional duty, not a spiritual craft.

However, like other institutions, medicine is shaped by the mores and values of society. These include, to varying extents, compassion, which often filters into the consulting room; and Darwinian ruthlessness, that can be applied when allocating scarce treatments, or, indeed, medical careers. Medical and social hierarchies do not always encourage attractive personality traits. Physicians were around seven times more likely than other employed men to join the Nazi party (Read and Masson 2013, Seeman 2005).

In contrast, some doctors consciously take an ethical or spiritual stance: which can mean working for a human-rights organization, or where the need seems to be greatest; or campaigning for equitable access to health, or for people to be given the conditions necessary for health: clean water, good food, sanitation, access to markets, fair working conditions, an absence of violence.

**New developments**

One of the most striking features of modern medicine is its uniformity. In Canada, Korea, Kyrgyzstan, or the Congo, hospital design, equipment, staffing, and the training and practice of the staff will be essentially the same. Any differences are more likely to be determined by finance than by radical differences of worldview. This does not just reflect colonialism, or other forms of globalization, but the fact that modern medicine is rooted in a way of seeing that has become almost universal (Illich 1978, 1995).

However, modern medicine is not ubiquitous or, in practice, entirely dominant. Every culture has other ways of dealing with illness: spiritual, biological, social, magical. These tend to be used when modern medicine is seen to be inadequate, or unavailable; or when non-modern beliefs and practices have not lost their perceived power. Sometimes, the juxtaposition is quite stark. On a British psychiatric ward, nurses may pray (when senior colleagues are not looking) in congregation for a patient; in the courtyard of an Indian hospital, patients bring gold, and animals for sacrifice, to a dreadlocked woman through whom the goddess of death (or, perhaps, a jinn) is said to speak (Prasad 2016).

Although modern medicine intrudes ever more into people’s lives, it is also increasingly seen as inadequate. The years 1900 to 1980 saw the apparent conquest of bacteria by antibiotics; the successful replacement of joints and organs; and conception outside the womb. But much suffering remained untouched: rates of mental illness, for instance, increased, in a way not merely attributable to diagnostic practices.

The wonder drugs of the 20th century now seem, in general, a mixed blessing: powerful if taken by the right patient, especially in the short term; often harmful if used at length. 85% to
90% of new drugs offer little or no advantage on old ones (Light and Lexchin 2015), even if trial results funded by their manufacturers are to be believed. Tricia Greenhalgh and colleagues (2014) wrote in the *British Medical Journal* that evidence-based medicine is, "increasingly, a science of marginal gains—since the low-hanging fruit (interventions that promise big improvements) for many conditions were picked long ago".

Having been widely seen as a general good, modern medicine is now increasingly depicted as a system that is difficult to sustain. In the USA, China, and India, many people find healthcare difficult to afford. Even in countries where the state guarantees healthcare, overworked staff struggle to attend to emergencies, or to keep patients safe and clean. In England, perhaps around a third of hospital patients are malnourished (Ray et al. 2014), and staff often do not have time to ensure that frail patients eat the food they are given; although drugs, like a sacrament, are faithfully administered.

Much of the money diverted to healthcare is swallowed up by administrative costs and profit. In the US alone, $82–272 billion was lost in 2011 to medical embezzlement (Jain et al. 2014). Perhaps around a sixth of all drugs worldwide are fake (Cockburn et al. 2005). Procedures and drugs can be charged at many times cost price (Brill 2013); drug prices are sometimes multiplied manifold overnight (Pollack 2015). Companies that provide healthcare are mainstays of modern finance. Finance, rather than clinical need, determines the design and interpretation of much of the science that underlies healthcare (Crews 2007, Davies S 2013, Goldacre 2012, Gotzsche 2013, Horton 2004).

Richard Horton, editor of the *Lancet*, remarked,

> The case against science is straightforward: much of the scientific literature, perhaps half, may simply be untrue. Afflicted by studies with small sample sizes, tiny effects, invalid exploratory analyses, and flagrant conflicts of interest, together with an obsession for pursuing fashionable trends of dubious importance, science has taken a turn towards darkness.

*(Horton 2015)*

Marcia Angell, former editor of the *New England Journal of Medicine*, has written,

> It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor.

*(Angell 2009)*

Some academics ask that trials be better designed and more fully disclosed (Goldacre and Heneghan 2015). But this would not necessarily ensure that studies are honestly conducted and reported. In the USA, in 1973, spot checks were done of clinical trials of new compounds conducted by doctors. A third of the checks showed that the trial had not been done at all; another third showed that the trial had not been done according to the established protocol (NW 1973, Special Commission on Internal Pollution 1975).

Doubts about medical science are not confined to leading academics. People in rich countries are increasingly using alternative medicine: which is typically called “complementary” medicine, acknowledging the social and legal power of modern healthcare systems. As long ago as 1997, people in the US spent about as much on alternative medicine as on physicians; alternative medicine has, in general, become more popular and widespread since, especially among women.
“Complementary” medicine draws on existing spiritual, biological, and magical techniques. As well as helping to spread modern medicine, globalization has led to the diffusion of other schools of medicine. In the UK, for instance, a small town can contain a wide variety of healers, as well as a pharmacy and health center. Healers are often eclectic: which reflects not only the wide variety of contacts made possible by globalization, but the harmonies between various disciplines. A practitioner of Greco-Arabic medicine, for instance, can quite easily absorb techniques from Ayurvedic or traditional Chinese medicine, which are conceptually essentially similar; and may well have an interest in spiritual healing. A Buddhist healer may find much that is familiar in the beliefs of a Sufi patient. Quite often, the specific technique is less important than the healer’s expertise and insight. People seem to follow intuition and personal preference in deciding which healer is right for them; although ultimately, a healer can only be judged by experience.

Having been very much a minority interest in academia, spirituality-in-medicine has recently become slightly more fashionable. In 2012, *The Oxford Textbook of Spirituality in Healthcare* was published; a year later, Harvard University launched an Interfaculty Initiative on Health, Religion, and Spirituality, uniting theologians and doctors in research. Some academics try to infuse medicine with the meaning they feel it has lost: to use their own humanity to open a dialogue with the patient that allows compassionate, reflective, and constructive attention to suffering. The patient is, once more, a person with hopes, fears, and dreams, rather than a mere diagnosis. Various writers and clinicians advise practitioners on how to recognize, and work with, a patient’s beliefs and spiritual needs (Koenig 1998, Puchalski 2006, Sulmasy 2006).

Other academics try to show that spirituality has an instrumental value: that practices such as prayer and meditation can lead to increased life expectancy or a faster recovery from illness. Many studies have shown positive health effects of spiritual practices, and the effect sizes are sometimes quite large (Koenig et al. 2012): some writers argue that if prayer were a drug, it would be lucrative and widely prescribed. But, as with drugs, researchers must exercise caution when assessing the results of trials. Some scholars argue that prayer is not supposed to have scientifically predictable results: that would be reducing God to the level of a mechanism, and a method for soul purification to a nostrum.

**Conclusions and ways forward**

Like all empires, modern medicine consists of an infrastructure and a set of beliefs. Both of these seem fragile. Being based on the manipulation of matter, medicine requires matter to drive it: metals and, above all, petrochemicals, for plastics, fuel, and drugs. These raw materials are, by definition, becoming scarcer: beyond a certain point, they will be too rare, or expensive, to be widely used. Already, access to medicine is far from equal.

More importantly, perhaps, modern medicine is seen to have only a limited view of human nature: its physiological reductionism is very helpful in some instances, and starkly inappropriate in others. Modern medicine has produced many brilliant successes, but has had a limited impact on human suffering.

Future approaches to medicine will be more successful if they have a more complete view of humanity: seeing people not only as machines, but as biological, cultural, social, and spiritual beings. Spirituality is always at the heart of medicine: if consciously examined, it can allow questions of value and justice to be properly addressed, and provide healing that is deep and of lasting value to the patient and the clinician.

Relaxation of medicine’s current belief system could help doctors to acknowledge the limits of the physician’s role and confess where healing might more suitably be provided by a priest,
grandmother, or café; or, indeed, by a healer in a “complementary” tradition; or, simply, by the age-old techniques of being with the patient in expert companionship. The avoidance of over-medication could lead to improvements in public health. For working doctors to be intellectually free and transparent, however, the current structures of medicine would need to change. Administrative and financial systems would be based on the needs of patients and clinicians. Trials would be designed with the patient’s wellbeing in mind, and fully and honestly reported. The less avid use of profitable but largely useless medicine could free resources for genuine clinical care.

Historically, patients have lacked access to information about diagnosis and treatment. For those who have internet access, this is no longer the case: but selecting reliable information can be problematic. The website thennt.com, established by clinicians, gives, for many treatments, the “number needed to treat”: the number of patients who, on average, need to receive a treatment for one person to benefit more from the treatment than from the placebo. In October 2017, the NNTs for the first 10 treatments classified as the “best you can get”—the most unambiguously supported by research—were 125, 67, 100, 18, 4, 22, 4, 8, 3, 20, 11, 16, 79, 143, 50, 333, 77, 200, 42, 20, and 100 (some treatments had more than one NNT).

Medicine is a universal human activity: although, in hindsight, much medicine, and not just in the modern tradition, has been on a spectrum between optimistic and imaginary. Medicine survives not just because of its effectiveness at healing disease, but because it consists of people sharing their humanity with each other. If doctors, patients, and policymakers choose to see themselves, and each other, as human beings, with all their different dimensions and potentials, then a truly humane medicine can be established, with spirituality at its heart.

Notes

1 The words “soul” and “spirit” are often used interchangeably. The Oxford English Dictionary notes that St Paul used the Greek word psyche (transliterated via Latin as psyche) to refer to “the lower or merely naturalistic life of man, shared with other animals” and pneuma for “a high element due to divine influence supervening upon the original constitution of unregenerate human nature”. Psyche covers a similar set of meanings to the Hebrew nephesh, Arabic nafs, and Latin anima: it is usually translated into English as “soul”. Pneuma is roughly equivalent to Hebrew ruach, Arabic ruh, Latin spiritus, and English “spirit”. Following Galen’s use of pneuma, Hunayn ibn Ishaq described the body as having life-forces, or ruhs: these became the natural, vital, and animal “spirits” of Greco-Arabic medicine (Rocca 2012, Wallis 2010).

2 Not all medicine is the same. Provision of emergency medicine, for instance, may save lives (Metcalfe et al. 2015).

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Spirituality in medicine


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