



***Ṭibb al-Nabawī* and the Epistemological Critique of Spiritual Reduction in the Modern Biomedical Paradigm**

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Abstract

The dominance of the modern biomedical paradigm in contemporary health discourse is rooted in materialistic ontological assumptions and an empirical-positivistic epistemology that focuses on measurable aspects, thereby reducing the spiritual dimension to psychological variables or ignoring it. Although several studies discuss the integration of spirituality in clinical practice, there has been no comparative epistemological analysis that systematically examines the ontological foundations and methods of knowledge validation between biomedicine and *ṭibb al-Nabawī*. This study aims to identify the ontological and epistemological assumptions of the biomedical paradigm, analyze the knowledge framework in *ṭibb al-Nabawī*, and formulate a non-reductionist conceptual model of health. This study is a philosophical-conceptual research with a critical, comparative, epistemological analysis of primary and secondary texts of *ṭibb al-Nabawī*, as well as philosophical literature and biomedical theory, using comparative-conceptual analysis techniques to examine the relationship between ontology, epistemology, and conceptions of health. The results show that the reduction of spirituality in biomedicine is a logical consequence of the limitation of reality to physical entities and linear causal mechanisms, which has an impact on the marginalization of the dimensions of meaning, value, and transcendent relations in the construction of health. In contrast, *ṭibb al-Nabawī* is built on a layered ontology and an integrative epistemology that recognize revelation, reason, and experience as sources of knowledge, so that health is understood as a relational condition that coherently encompasses physical, psychological, and spiritual dimensions. Conceptually, these findings offer an alternative framework for expanding the epistemic horizon of health studies and encouraging more reflective and critical cross-paradigm dialogue.

Keywords: *Ṭibb al-Nabawī*; Biomedical Paradigm; Spiritual Reductionism; Health Epistemology; Holism

Abstrak

Dominasi paradigma biomedis modern dalam diskursus kesehatan kontemporer berakar pada asumsi ontologis materialistik dan epistemologi empiris-positivistik yang memusatkan perhatian pada aspek terukur, sehingga dimensi spiritual cenderung direduksi menjadi variabel psikologis atau diabaikan. Meskipun sejumlah kajian membahas integrasi spiritualitas dalam praktik klinis, belum terdapat analisis epistemologis komparatif yang secara sistematis menelaah fondasi ontologis serta cara validasi pengetahuan antara biomedis dan *ṭibb al-Nabawī*. Penelitian ini bertujuan untuk mengidentifikasi asumsi ontologis dan epistemologis paradigma biomedis, menganalisis kerangka pengetahuan dalam *ṭibb al-Nabawī*, serta merumuskan model konseptual non-reduksionistik mengenai kesehatan. Penelitian ini merupakan *philosophical-conceptual research* dengan desain *critical comparative epistemological analysis* terhadap teks primer dan sekunder *ṭibb al-Nabawī* serta literatur filsafat dan teori biomedis, dengan teknik analisis komparatif-konseptual yang menelaah relasi ontologi, epistemologi, dan konsepsi kesehatan. Hasil menunjukkan bahwa reduksi spiritual dalam biomedis merupakan konsekuensi logis dari pembatasan realitas pada entitas fisik dan mekanisme kausal linier, yang berdampak pada marginalisasi dimensi makna, nilai, dan relasi transenden dalam konstruksi kesehatan. Sebaliknya, *ṭibb al-Nabawī* dibangun di atas ontologi berlapis dan epistemologi integratif yang mengakui wahyu, rasio, dan pengalaman sebagai sumber pengetahuan, sehingga kesehatan dipahami sebagai kondisi relasional yang mencakup dimensi fisik, psikis, dan spiritual secara koheren. Secara konseptual, temuan ini menawarkan kerangka alternatif untuk memperluas horizon epistemik kajian kesehatan dan mendorong dialog lintas paradigma secara lebih reflektif dan kritis.

Kata Kunci: *Ṭibb al-Nabawī*; Paradigma Biomedis; Reduksionisme Spiritual; Epistemologi Kesehatan; Holisme

Introduction

The development of modern medicine rests on a biomedical paradigm rooted in Cartesian dualism and scientific positivism, which views the body as a material entity separate from consciousness and positions disease as a biological dysfunction that can be objectively measured (Stein & Nesse, 2025). This model emphasizes linear causality, molecular reductionism, and empirical verification as sources of legitimacy for medical knowledge. Its success is evident in advances in diagnostics, pharmacotherapy, and precision clinical technology (O'Leary, 2021). However, these ontological and epistemological assumptions simultaneously narrow the horizon of understanding health by reducing spiritual, moral, and existential dimensions to secondary variables or merely psychosocial factors. Consequently, the experience of illness is understood primarily as a physiological disorder, rather than as an event containing meaning and value.

Ṭibb al-Nabawī—a tradition of prophetic medicine rooted in revelation, hadith, and prophetic practice—presents an alternative epistemic construct that integrates physical, psychological, and spiritual aspects into a single anthropological whole. This approach offers not only therapeutic techniques but also a framework of knowledge that positions spirituality as an ontological dimension of humankind and a source of epistemic legitimacy (Munandar & Harahap, 2025). The tension between

a mechanistic biomedical paradigm and an integral, prophetic framework raises epistemological issues regarding the limits, assumptions, and implications of spiritual reduction for contemporary understanding of health.

Global empirical phenomena demonstrate that technological advances have not fully addressed the complexity of human suffering. A (2022) World Health Organization report estimates that more than 970 million people live with mental disorders, while depression is a leading cause of global disability. The Lancet Commission on Mental Health asserted that the burden of mental disorders is increasing significantly and that a solely biologically based approach is inadequate to address the meaning, social relations, and values that accompany suffering (Patel et al., 2018). The World Bank (2016) reported that global economic losses due to mental disorders reach trillions of dollars annually due to lost productivity and healthcare costs. The National Institutes of Health (2021), through its integrative research program, acknowledged that religious and spiritual factors are positively correlated with patient resilience, therapy adherence, and quality of life. However, they have not been systematically integrated into the mainstream biomedical model. These data demonstrate a gap between technical progress and the fulfillment of holistic human needs. This imbalance is not only clinical but also epistemic, as the dominant paradigm limits valid knowledge sources to the empirical-positivistic dimension and marginalizes spirituality as a source of meaning and healing.

Academic studies on the relationship between spirituality and health have developed through several approaches. Diego-Cordero et al. (2022) found that spiritual care improves the quality of life of nursing patients, but the analysis stops at clinical practice and does not address its epistemological foundations. Abdullah and Zaki (2021) demonstrate the preventive and promotive value of traditional Islamic medicine, but their study is descriptive-historical and fails to critique modern biomedical assumptions. Liaghat and Konsman (2024) address the ontological weaknesses of biomedical reductionism from a philosophical perspective but fail to link it to specific religious traditions as an epistemic alternative. Choudhary and Abirami (2025) assess the effectiveness of integrative medicine on spiritual well-being, but reduce spirituality to a psychosocial variable separate from a theological framework. Yuslem, Utami, and Munandar (2024) analyze medical hadith and the validity of prophetic practices, but their approach tends to be normative rather than engaging in critical dialogue with modern epistemology. A comparative synthesis of these studies reveals a fragmentation between practical, historical, and philosophical approaches without systematic epistemological integration. No research has explicitly positioned *ṭibb al-Nabawī* as a critical epistemological framework for evaluating the spiritual reduction of the biomedical paradigm and formulating a coherent conceptual alternative. This gap creates space for an integrative analysis grounded in the philosophy of science, theology, and contemporary medical criticism.

This study poses three main questions: How do the ontological and epistemological assumptions of the biomedical paradigm shape the spiritual reduction in understanding of health? What are the epistemological principles of *ṭibb al-Nabawī*, which are rooted in revelation and prophetic practice? And to what extent can the prophetic framework function as both a critique and a conceptual alternative to the modern health paradigm? The research objectives include a critical analysis of the foundations of biomedical knowledge, a systematic elaboration of *ṭibb al-Nabawī*'s epistemological principles, and the construction of a philosophical dialogue between the two through a critical-analytical approach based on the philosophy of science and the study of Islamic texts. The initial argument of this study asserts that the contemporary health crisis is not solely caused by technical medical limitations, but rather by the narrowing of sources of legitimate knowledge that ignore the spiritual dimension as an ontological element of humankind and a source of therapeutic meaning. This research's theoretical contribution is to enrich the philosophy of medical science through the integration of the epistemology of revelation and a critique of mechanistic reductionism. The methodological contribution lies in the interparadigm dialogue model between medical science and the prophetic tradition. The practical contribution aims to provide a conceptual foundation for the development of integrative health practices that consider the biological, psychological, and spiritual dimensions holistically, without being trapped by purely biological reductionism.

Method

This research is a philosophical-conceptual study with a critical, comparative, epistemological analysis design that explicitly positions itself within the tradition of philosophical hermeneutics and scientific paradigm critique. This approach was chosen because it allows for a normative-analytical evaluation of ontological, epistemological, and axiological assumptions in *ṭibb al-Nabawī* and modern biomedicine. The primary sources are the works of Ibn Qayyim al-Jawziyyah, particularly *al-Ṭibb al-Nabawī*. In contrast, secondary sources include peer-reviewed articles indexed by Scopus and Web of Science from 1990–2024 on the philosophy of science, medical epistemology, bioethics, and the critique of biomedical reductionism. The literature was systematically selected through the Scopus, Web of Science, and JSTOR databases using structured keywords with inclusion criteria based on epistemological relevance and publication quality. The units of analysis are conceptual propositions, ontological assumptions about the body, sources of legitimacy in knowledge, and models of medical causality. Data were extracted through in-depth hermeneutic reading and thematic coding to identify meaning structures and indicators of spiritual reduction. Analysis was conducted through a three-level comparative matrix—ontological, epistemological, and axiological—followed by critical evaluation using a paradigm critique of science framework to formulate an alternative, non-reductionist conceptual model.

Interpretive validity was maintained through theoretical triangulation across traditions and argumentative reflexivity, ensuring coherence, logical consistency, and explicit epistemological contributions.

Results and Discussion

Tibb al-Nabawī as a Holistic Knowledge System

Tibb al-Nabawī can be understood as a normative epistemic construct that positions revelation as an a priori framework forming the structure of the interpretation of biological reality, rather than as a corpus of empirical clinical data. Revelation functions as a teleological horizon that orients the meaning of illness, health, and healing through value categories that precede factual observation (Yusoff & Ab Razak, 2020). This structure is more accurately classified as open normative foundationalism, namely a foundation that establishes ethical goals and boundaries, while concrete application still requires contextual reasoning. Its epistemic validity rests not on empirical correspondence theory, but rather on normative coherence and regulatory power over human practice. This model differs from biomedical methodological naturalism, which limits knowledge claims to experimental verification (Boucher, 2020). Recognizing the plurality of textual interpretations requires an intersubjective hermeneutic mechanism to prevent the authority of revelation from being reduced to private claims and to maintain the rational justification of its epistemic structure.

Prophetic experience occupies a mediative position that actualizes the orientation of revelation into contextual forms of action, so it cannot be reduced to universal technical procedures. Its epistemic status is praxis and analogous to the Aristotelian concept of *phronesis*, namely practical wisdom that considers particular situations without losing its goal orientation (Darnell, Fowers, & Kristjánsson, 2022). The relationship between revelation and experience is not parallel and independent but hierarchical and cooperative: revelation provides teleological norms, while experience presents historical actualizations that demonstrate the application of values under the specific conditions of seventh-century society (Van Niekerk & Van Eck, 2024). The distinction between universal normative elements and historical contextual elements is a prerequisite for generalizations to be non-historical. This framework enables the identification of transhistorical health principles while also opening space for contextual adaptation. Its non-reductionist character lies in the recognition that therapeutic action considers the patient's psychological, moral, and relational state, in contrast to the classical biomedical model, which tends to isolate biological variables as the sole unit of analysis (Loewe, Hunter, & Kohl, 2025).

Ethical rationality serves as an internal mechanism that connects revealed norms and prophetic practices to human deliberative capacity (Kilic, Ghazali, & Shehab, 2025). This rationality is not identical to instrumental calculation, but rather resembles practical reason, which evaluates the goals, consequences, and

moral integrity of the subject. The position of reason is cooperative-subordinate, that is, autonomous in the reasoning process but bound by the teleological orientation of revelation. This triadic model—revelation as the normative foundation, experience as historical actualization, and reason as the deliberative mediator—creates a hermeneutic circulation that allows for internal correction when interpretive tensions arise. The mechanism for resolving conflicts between sources is not elimination but the assessment of *maqāṣid*, or broader ethical goals. A comparison with modern procedural rationality reveals a fundamental difference: biomedicine assesses actions based on empirical efficacy and methodological consensus. At the same time, *ṭibb al-Nabawī* adds the evaluation of human dignity and moral orientation as integral epistemic criteria (Yusoff & Ab Razak, 2020).

The emerging conception of holism is not merely an aggregation of spiritual, physical, and moral dimensions but an integrative model grounded in systemic interdependence. The spiritual dimension provides meaning orientation, the physical dimension presents biological facts, and the moral dimension guides normative responses; the three form a relational structure that cannot be separated without losing coherence. This holism is ontologically anti-reductionist. It rejects the identification of humans with a purely biological substrate. It is an epistemic pluralist because it acknowledges the validity of empirical data without making it the sole source of legitimacy. This distinction distinguishes it from modern biopsychosocial models, which continue to operate within the framework of methodological naturalism (Bolton, 2023). Integration is not understood as a seamless fusion, but rather as a directed coordination toward teleological balance. This balance is dynamic and open to rational evaluation, so it does not fall into spiritual romanticism that ignores empirical reality.

This epistemic structure faces serious challenges related to the plurality of hadith interpretations, the authority of transmission, and the historicity of practice. Acknowledging these issues is crucial to prevent the model from appearing apologetic. The validity of revelation as a normative source requires procedures of *sanad* (chain of transmission) criticism, *matn* (hadith text) criticism, and socio-historical context analysis to distinguish principled teachings from particular practices (Silvia, 2025). Without methodological clarification, normative claims risk becoming dogmatic generalizations. A collective hermeneutic framework involving Islamic scholars, medical experts, and health philosophers allows for the formation of a rational consensus that transcends individual preferences (Yahya, Johan, & Febriana, 2025). This approach positions *ṭibb al-Nabawī* as a dynamic, discursive tradition rather than a static collection of prescriptions. This mechanism also addresses the question of how revelation-based knowledge can enter the academic public sphere through rational argumentation that can be intersubjectively tested.

Dialogue with contemporary medical philosophy clarifies this model's critical position on claims of biomedical objectivity. Modern methodological naturalism

tends to equate objectivity with value neutrality and of reduce disease phenomena to measurable biological dysfunctions (Veit, 2021). *Ṭibb al-Nabawī* challenges this assumption by demonstrating that every medical practice always contains normative presuppositions, both explicit and implicit (Abdullah & Zaki, 2021). This critique aligns with philosophical analyses of science that reject the sharp dichotomy between facts and values (Stamenkovic, 2024). The teleological conception of health as the harmony of biological function and moral integrity expands the definition of healing beyond physiological recovery. This comparison is not intended to negate the achievements of biomedicine, but rather to reveal its ontological limitations when the dimensions of meaning and purpose are neglected. Critical integration allows for methodological coexistence without the total subordination of one paradigm to the other.

The final formulation demonstrates that *ṭibb al-Nabawī* offers a teleological-normative epistemology of health that rejects the reduction of humans to isolated biological entities. The triadic model of revelation, prophetic experience, and ethical rationality forms a hierarchical-cooperative system with an internal hermeneutic correction mechanism. Holism is understood as a systemic interdependence that maintains the unity of meaning, fact, and value without eliminating the differentiation of their functions. Criticism of biomedical objectivity targets its naturalistic assumptions rather than its empirical methods, leaving room for integration. This approach enriches the discourse of medical philosophy by expanding epistemic criteria to include human dignity and purpose as essential variables. Its theoretical contribution lies in the formulation of an alternative epistemic model that is rationally accountable and relevant to the global debate on the relationship between science, ethics, and health spirituality.

Spiritual Reduction in Modern Biomedical Ontology and Epistemology

The ontological assumptions of modern biomedicine are rooted in methodological naturalism, which views the body as a biological entity that can be analyzed through the laws of physics, chemistry, and molecular biology (Savransky & Rosengarten, 2016). The distinction between methodological naturalism and metaphysical naturalism is crucial to prevent oversimplification in criticism. Methodological naturalism limits itself to scientific procedures without asserting final metaphysical claims about reality as of whole, whereas metaphysical naturalism affirms that reality consists solely of material entities (Boucher, 2020). The tradition of the philosophy of medicine demonstrates a sharp debate over the ontological status of disease, particularly through the biostatistical theory developed by Christopher Boorse (2011), which interprets disease as a deviation from species-typical biological function. This perspective does not explicitly reject the spiritual dimension but operationalizes the concept of health within a descriptive-naturalistic framework. Critiques of the reduction of the spiritual should

be directed at the implicit tendency of methodological naturalism to transform into metaphysical naturalism, not merely at the analytical practice of molecular biology.

Ontological reflection on normality and pathology has been deepened through the work of Georges Canguilhem, who rejected the identification of health with statistical averages. Canguilhem (1978) asserted that living organisms create norms through their relationship with the environment, so that disease is not simply a quantitative anomaly but a change in normative capacity. This argument demonstrates that the ontology of disease has an evaluative dimension that cannot be reduced to mechanistic descriptions. This framework allows for dimensions of meaning and value orientation without negating biological analysis. The generalization that biomedicine is entirely eliminative of spirituality ignores the complexity of debates within the philosophy of medicine. A proper epistemological critique must demonstrate how the dominant paradigm tends to marginalize the normative dimension, despite philosophical literature warning of the limitations of reductionist models. The tension between biological descriptions and existential experience provides a more precise locus of analysis than accusations of total eliminativism.

The epistemological structure of contemporary biomedical medicine is constructed through a hierarchy of evidence popularized by Evidence-Based Medicine, which prioritizes controlled clinical trials and meta-analyses as standards of validity (Danaei et al., 2024). This model is not identical to classical positivism, but still prioritizes quantification and replication as criteria for objectivity. Criticism of the hierarchy of evidence has been put forward by several humanistic medical thinkers, including Edmund Pellegrino (2001), who emphasized the moral dimension of clinical judgment and the irreducibility of therapeutic decisions to statistical algorithms. This perspective suggests that medical epistemology contains normative elements that are not fully accommodated in experimental methodology. Conceptual analysis requires distinguishing procedural objectivity, namely consistency of method, from ontological objectivity, which claims direct access to ultimate reality. Spiritual reduction occurs when procedural objectivity is treated as the sole source of legitimate knowledge, thereby positioning the patient's reflective experience as merely additional data to be reduced to measurable variables (Sami et al., 2021).

The disease–illness–sickness debate demonstrates the complexity of disease ontology, which cannot be understood solely through a biological framework. Boorse's (1977) biostatistical theory positions disease as an organism's dysfunction, while Lennart Nordenfelt's (1995) holistic theory defines health as the ability to realize vital goals. This distinction suggests that illness has a teleological dimension related to the agent's capacity. Havi Carel's phenomenology of illness offers an analysis of bodily experience as lived experience, inspired by the tradition of Maurice Merleau-Ponty. The body is not merely a biological object but an existential

medium that forms a horizon of meaning (Zhang, 2025). Spiritual reduction occurs when the experience of illness is sharply separated from nosological classification, thereby reducing crises of meaning, identity transformations, and transcendental relations to psychological epiphenomena (Júnior et al., 2025). This argument demonstrates that the problem lies not with medical classification itself, but with the claim that it is sufficient to explain the reality of illness fully.

The concept of health as the absence of pathology has faced widespread criticism in contemporary health philosophy. Nordenfelt (2014) rejects this negative definition and defines health as an agent's ability to achieve rational goals essential to a meaningful life. The capability approach, associated with Amartya Sen (1999) and Martha Nussbaum (1997), broadens this perspective by emphasizing the structural conditions that enable the actualization of human potential. This analysis reveals that health contains a normative dimension that cannot be reduced to physiological parameters. While the mainstream biomedical paradigm focuses on biological indicators, contemporary literature demonstrates efforts to integrate biopsychosocial models and person-centered medicine (Bolton, 2023). Epistemological critique needs to acknowledge these developments while also highlighting their limitations, particularly when the spiritual dimension is treated as a psychosocial factor rather than as an independently ontological one.

Spiritual reduction takes on an epistemic form when religious experiences or transcendental meaning are recognized only insofar as they can be mapped onto neurobiological correlates. Affective neuroscience research often interprets inner experiences as the result of the activity of specific neural networks, which is methodologically valid but risks being transformed into exclusive ontological claims (Gündem et al., 2022). Philosophical analyses of science, including Ian Hacking's (1999) notion of the construction of scientific objects, demonstrate that scientific categories are formed through discursive and technological practices. Awareness of the partial constructivity of medical objects allows for a critical evaluation of claims to objectivity. Spirituality should not be positioned as a supernatural entity rivaling biology, but rather as a dimension of experience with phenomenological and normative status. When epistemic frameworks ignore this dimension because it does not meet the standards of quantification, the horizon of knowledge narrows, affecting clinical practice and therapeutic relationships.

***Ṭibb al-Nabawī's* Epistemological Critique of Biomedical Objectivity Claims**

Ṭibb al-Nabawī is formulated as an epistemic framework that positions revelation, the clinical experience of early Muslim communities, and practical wisdom as intertwined sources of justification for health knowledge (Al-Jawziyyah, 1999). This framework is not positioned as a simplistic opposition to biomedicine, but rather as a teleological epistemological model that links truth to the orientation of human life goals. This conception differs from the dominant biomedical approach, which relies on statistical generalizations, biological causal models, and molecular

mechanisms as the basis for validity (Roberts, 2023). Biomedical universality can be understood as methodological universality, namely the claim that findings are valid as long as they meet replication procedures, control for variables, and intersubjective evidence standards (Semenova, Efimova, & Shilkova, 2024). This universality is not identical to ontological claims regarding the nature of humanity as a whole. Contemporary philosophy of science literature, particularly the debate between scientific realism and constructive empiricism, demonstrates that predictive success does not automatically guarantee a theory's metaphysical truth (Humphreys, 2019). This position opens up space for critical evaluation of the assumption of universality without diminishing the empirical contributions of biomedicine.

Claims of biomedical neutrality need to be analyzed in light of the debate on the value-ladenness of science that has developed since the work of Thomas Kuhn and Helen Longino. Shifting scientific paradigms demonstrate that the selection of research problems, methodological design, and standards for evaluating evidence are never entirely value-free (Sikorski, 2024). Medical research determines health indicators, thresholds of normality, and disease categories through normative decisions influenced by values of efficiency, productivity, and technological control (Sokoya et al., 2022). This analysis does not purport to imply epistemic relativism, but rather emphasizes the interconnectedness of facts and values, as outlined by Hilary Putnam (2005). *Tibb al-Nabawī* makes this normative dimension explicit through an orientation toward welfare and moral responsibility, so that values are not hidden as implicit assumptions. Epistemological criticism targets the assumption that methodological procedures automatically yield substantive neutrality, even though scientific decisions always involve evaluative considerations that can be rationally analyzed.

The conception of objectivity requires a differentiation between procedural objectivity, intersubjective objectivity, and metaphysical objectivity. Biomedicine generally maintains procedural objectivity through experimental replication, randomized controlled trials, and the consensus of the scientific community (Svenaeus, 2023). This position is not synonymous with claims of absolute truth, but rather a commitment to retestable public standards. *Tibb al-Nabawī* does not reject procedural objectivity, but questions the assumption that such procedures are adequate to capture the full dimensions of human health. This critique aligns with the discourse of the philosophy of medicine, which distinguishes between disease as a biological dysfunction and illness as a meaningful experience (Tesio & Buzzoni, 2021). Biomedical objectivity is effective in explaining pathophysiological mechanisms, but it is not necessarily sufficient for understanding the relationship between suffering, life purpose, and ethical responsibility. This evaluation seeks to broaden the scope of objectivity toward a form that integrates normative dimensions without compromising public standards of rationality.

Discussions about truth should avoid the simplistic attribution that biomedicine explicitly adheres to the correspondence theory. Scientific practice often combines correspondence, pragmatic, and coherence elements. Medical facts are constructed through diagnostic instruments, nosological classifications, and statistical interpretations that rely on theoretical frameworks (Contino, 2023). This analysis aligns with critiques of logical positivism, but does not intend to negate biological reality. *Tibb al-Nabawī* offers a teleological criterion of validity that assesses knowledge based on the harmony between empirical findings, consistency of meaning, and contribution to the balance of life. This criterion can be understood through a virtue-epistemological approach that emphasizes practical wisdom and goal orientation as elements of justification (Stichter, 2024). This comparison does not position the two systems as incompatible entities, but rather demonstrates the plurality of standards for evaluating truth recognized in contemporary philosophy of science. Biomedical objectivity remains valid within the mechanistic scope, while teleological validity broadens the horizon of assessment to existential impacts.

Statistical generalization as the foundation of evidence-based medicine presupposes population homogeneity and the stability of clinical variables. Rivera et al.'s (2019) study shows that the externalities of clinical trial results depend on the social and demographic contexts, as well as the assumptions of the study design. The universality of findings is conditional on these parameters. This emphasis does not reduce biomedicine to mere statistics, as causal models and biological mechanisms remain crucial. However, claims of universal applicability must be understood as contextual generalizations open to revision. *Tibb al-Nabawī* viewed health knowledge as a relationship between normative principles and the concrete conditions of individuals, so justification does not stop at the aggregation of population data (Al-Rumkhani, Al-Razgan, & Al-Faris, 2016). This integration can be interpreted through critical realism, which acknowledges the existence of real mechanisms and the dependence of knowledge on historical context. This framework avoids relativism while rejecting epistemic absolutism.

The meaning dimension of illness demands a distinction between meaning as a psychological variable and meaning as an epistemic category. Positive psychology demonstrates a correlation between meaning orientation and clinical outcomes (Sica et al., 2024), but this correlation does not automatically make meaning a justification for knowledge. Epistemological arguments need to demonstrate that ignoring meaning results in incomplete explanatory models. Phenomenology of illness and narrative medicine approaches have recognized the importance of subjective experience as a source of clinical information (Yang, Xiao, & Li, 2020). *Tibb al-Nabawī* extends this argument by positioning meaning as a component of the knowledge structure rather than merely an additional factor. When disease is reduced to mechanistic dysfunction, the knowledge model loses the evaluative dimension that guides ethical action. The integration of meaning enriches

intersubjective objectivity through a dialogue between biological facts and rationally justified existential interpretations.

The position of value in the construction of medical knowledge demands an analysis of the underdetermination and theory-ladenness of observation. The selection of research variables, the interpretation of diagnostic images, and the establishment of clinical thresholds rely on a non-neutral conceptual framework. Awareness of this entanglement does not undermine objectivity but rather shifts its understanding toward a reflexive objectivity that acknowledges the conditions of the possibility of knowledge. *Tibb al-Nabawī* contributed to the explicit articulation of the welfare orientation as a transparent evaluative principle. Normative transparency enables public discourse on health goals, not merely technical procedures. Epistemological critique is directed against the implicit absolutism that assumes methodological standards are sufficient to determine the value of medical actions. A reflexive approach reconciles scientific rationality and moral considerations without melding them, allowing debates on health to move beyond the dichotomy of fact and value.

The Problem of Spiritual Reductionism as an Epistemic Crisis in Modern Medicine

Spiritual reductionism can be understood as an epistemic crisis in which a system of knowledge encounters internal limits that render it unable to explain phenomena inherent to its own domain of study. The concept of epistemic crisis refers to a situation where the legitimate structure of knowledge results in the systematic exclusion of forms of understanding relevant to the object of study, resulting in a fundamental narrowing of the paradigm's explanatory power (Špecián, 2022). This framework aligns with the notion of paradigmatic anomalies in Thomas Kuhn's (1970) philosophy of science and the problem of the distortion of communicative rationality in Jürgen Habermas's (1991) work, which suggests that systems of rationality can limit the horizon of meaning through overly narrow validation criteria. Biomedical positivism, with its verificationist orientation and methodological naturalism, creates an epistemic architecture that recognizes only measurable facts as a valid source of truth. Consequently, the spiritual dimension is marginalized not because of a lack of clinical relevance, but because it fails to meet pre-established ontological and methodological standards.

The fragmentation of medical knowledge exacerbates this crisis through an extreme division of epistemic labor. Philip Kitcher's (1993) theory of the division of epistemic labor asserts that scientific specialization can increase precision, but risks cognitive isolation if not balanced by integrative mechanisms. Modern medicine has developed hyper-specialization based on organs, systems, and molecules, resulting in epistemic silos with their own technical language (Moreau, 2020). This configuration limits the reflective capacity to interpret the experience of illness as an existential totality. Fragmentation is not simply disciplinary differentiation but

rather a separation of knowledge structures that hinders the coherence of comprehensive explanations (Dickey et al., 2022). An epistemic crisis arises when the integration of human meaning as a suffering subject can no longer be restored through the system's internal mechanisms. A reductionist orientation fragments the entire human experience into isolated analytical units, thereby causing the spiritual dimension to lose its conceptual place within the framework of clinical knowledge.

The dominance of evidence-based medicine demonstrates the normative dimension of the epistemic crisis through a hierarchy of evidence that positions controlled clinical trials as the gold standard of scientific truth (Subbiah, 2023). Critics of this approach point out that quantitative methodology is not synonymous with monistic epistemology (Goertz & Mahoney, 2013). Problems arise when methodological hierarchies are conflated with ontological claims about the nature of disease reality. The hierarchy of evidence limits the forms of knowledge that can be recognized, thereby relegating existential narratives, religious experiences, and reflections on the meaning of life to the status of anecdotal data without epistemic legitimacy (Waters & Rankin, 2019). Spiritual reductionism is not an inevitable consequence of the scientific method, but rather the result of the institutionalization of an epistemic hierarchy that ignores pluralistic ways of knowing (Fountoulakis, 2022). Verification standards that demand replication and quantification result in the structural exclusion of the spiritual dimension because it cannot be operationalized into controlled statistical variables.

The dichotomy of disease and illness highlights the ontological consequences of this crisis. Arthur Kleinman (1988) demonstrated that illness represents a subjective experience that cannot be reduced to biological dysfunction. Biomedical medicine prioritizes disease as an objective entity, while illness is positioned as a secondary, psychosocial entity (Tosam, 2022). This separation is not epistemologically neutral, as it determines the form of knowledge recognized as scientific. The spiritual dimension lacks adequate conceptual categories within this framework; it is neither entirely biological, nor solely psychological, nor limited to social aspects. Its status becomes ambivalent and is often considered epistemic noise. The epistemic crisis lies in the paradigm's inability to explain the integration between biological facts and existential meaning structures, reducing humans as subjects of knowledge to physiological objects without interpretive depth.

The reduction of the meaning of suffering reveals the limits of modern medical hermeneutics. The phenomenological approach developed by Havi Carel (2008) and Fredrik Svenaeus (2000) asserts that the experience of illness contains a structure of meaning interwoven with value orientations and transcendent relationships. Representations of suffering as measurable pain intensity or distress ignore this interpretive dimension. Clinical instruments can capture symptoms but fail to explain how individuals interpret suffering as a test of faith, a moral transformation, or an existential crisis. When epistemic frameworks lack categories for

understanding these meanings, knowledge systems experience a hermeneutic deficit. This situation intersects with Miranda Fricker's (2007) concept of epistemic injustice, namely the marginalization of forms of knowledge that do not conform to dominant norms. The epistemic crisis manifests through the systematic failure to recognize patients' spiritual experiences as a valid source of understanding their illness.

This analysis demonstrates that spiritual reductionism transcends issues of clinical ethics and touches on the fundamental architecture of medical knowledge production. The biomedical paradigm maintains explanatory monism, which assumes that all disease phenomena can be explained through biological mechanisms (Roberts, 2023). This claim faces limitations when the phenomena of meaning and transcendent orientation emerge as integral components of the experience of illness. The inability to explain these phenomena does not mean they do not exist; rather, it indicates the limits of the paradigm's scope. The criteria for an epistemic crisis are met because there is a mismatch between the complexity of the object of study and the available conceptual tools. The knowledge system loses its comprehensive explanatory power for humans as biological and spiritual entities. When this internal limit is ignored, reductionism becomes a methodological dogma that forecloses the possibility of critical reflection on its own ontological assumptions.

This situation signals the need for epistemological reconstruction that recognizes pluralistic ways of knowing without sacrificing scientific rigor. Integration is not synonymous with relativism, but rather an expansion of the epistemic horizon to accommodate the dimensions of meaning inherent in the experience of illness. Hans-Georg Gadamer's (1977) hermeneutic philosophy emphasizes that understanding is always bound by historical context and interpretive horizon; its application in medicine opens up a dialogue between biological facts and existential meaning. Recognizing spirituality as a source of meaning does not negate the validity of empirical methods; rather, it rejects ontological reductions that absolutize a single type of rationality. The epistemic crisis can only be addressed through critical reflection on the naturalistic assumptions that limit the definition of knowledge. This reconstruction demands a repositioning of humans as integral epistemic subjects, not simply objects of measurable physiological observation.

This framework provides a comparative basis for evaluating alternative knowledge systems such as *ṭibb al-Nabawī*, which views health as a balance of the physical and spiritual. Such a holistic epistemology does not negate the biological aspect but rather integrates it within a transcendent horizon of meaning. This comparison confirms that the epistemic crisis of modern medicine is not due solely to the absence of spirituality in clinical practice, but rather to the construction of exclusive legitimacy for knowledge. Recognition of epistemic plurality opens the

possibility of a critical dialogue between the biomedical paradigm and the integrative framework without reducing either to the other. This analysis demonstrates that spiritual reductionism is a structural phenomenon that limits medicine's capacity to understand humankind comprehensively. Identifying these internal boundaries is a prerequisite for epistemological transformation, enabling the production of medical knowledge that fully and coherently addresses the complexity of human suffering.

Conclusion

An epistemological examination of *ṭibb al-Nabawī* demonstrates that the spiritual reduction of the modern biomedical paradigm is rooted in methodological naturalism and clinical positivism, which limit the validity of knowledge to measurable empirical verification, thus eliminating the dimensions of meaning, purpose, and therapeutic normativity from the scientific horizon. The reconstruction of the relationship between revelation, rationality, and empirical experience emphasizes that healing practices are not only causal-biological but also normative-teleological: health is understood as the integration of body, soul, and the ethics of action, which influence the orientation of interventions, the legitimacy of therapy, and clinical relationships. This non-reductionist model contributes theoretically by expanding the biopsychosocial framework of integrating normative dimensions without compromising the standards of evidence-based medicine, while also offering an epistemic typology that differentiates the ontological, methodological, and axiological levels of medical knowledge. Practical implications include the integration of structured spiritual assessments, strengthening value-based ethics curricula, and reflecting on the philosophical assumptions of clinical practice. Limitations lie in the conceptual-hermeneutic approach, the potential for interpretive anachronism, and the lack of empirical testing across contexts. Further research agendas need to develop measurable operational models, comparative studies with biopsychosocial models, and interdisciplinary empirical designs to test the compatibility of prophetic epistemology and contemporary clinical methodology.

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Author Contribution Statement

S contributed to the conceptualization of the research, formulation of the theoretical framework, development of the methodology, data analysis, writing the initial draft, substantial revision of the manuscript, and coordination of the correspondence process. SH contributed to data collection and verification, literature review, data processing, and manuscript editing. JS contributed to the interpretation of the findings, the evaluation of the consistency of the

argumentation, the critical review of the manuscript's content, and the refinement of the final version.

Conflict of Interest

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AI Usage Statement

Artificial intelligence (AI) tools were used only to a limited extent to assist with language editing, grammar correction, editorial clarity, and formatting adjustments. AI was not used to generate scientific content, formulate research problems, develop conceptual frameworks, conduct data analysis, interpret findings, develop arguments, or draw conclusions. All ideas, concepts, methodologies, research results, analyses, interpretations, and conclusions presented in this manuscript are the intellectual work of the authors.

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