



Spontaneous medical remissions from an epistemological perspective

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Article History

Received: 16.05.2025

Accepted: 11.07.2026

Published: 29.07.2026

Abstract: - The body of living beings (in particular that of man, to whom this note is dedicated) has its own “normality” (**health**), developed over the centuries by medical speculation. Alongside the standard, considered “*normal*”, anomalies, i.e. exceptions (**diseases**), appear in individual subjects.

Beyond the history of medicine, there is a phenomenon in which pathological cases seem to disappear without therapeutic reason (*spontaneous remission*). The speculative clinical argument is mostly entrusted to **meta-studies**, that is, observations born from the comparison of similar results in other pathological branches, without there being a common unifying framework. Due to their frequency and importance, spontaneous remissions require a separate medical branch that goes beyond the individual pathology.

In last decades, *information technology* (IT) and *artificial intelligence* (AI) have provided medical science with a revolutionary contribution in dealing with the patient, where diagnosis and therapy are built on the physiology of the individual subject. Their combination with statistics and graph theory has given rise to *network medicine*.

A convergence of these speculative approaches promises significant medical and scientific progress.

In addition, brief notes on the epistemology of medical and pharmacological science.

Keywords: meta-studies, spontaneous remission, evidence medicine, network medicine.



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1. Introduction

This brief note stems from the *patient* 's curiosity about the state of the medical art rather than from the *healthcare professional* 's observations.

Over the centuries (from the deities of health, to nature lovers, to Greek clinicians, to current researchers), medicine (from an empirical and thaumaturgic practice to a science of physical-somatic exploration) has undergone remarkable developments, particularly at the end of the last millennium. With adequate technology, today it is possible to insert a micro-catheter into a coronary artery, equipped with a balloon (*stent*), or to operate on the abdomen without cutting

the sternum (*laparotomy*) but by making holes, inflating it, and inserting a micro-camera and other equipment (*laparoscopy*).

The study of pathologies has allowed them to be grouped by somatic affinities, generating individual medical branches (cardiology, orthopedics, hepatology, ophthalmology, etc., each subdivided into *medicine* and *surgery*). In this vast sea float the **spontaneous regressions** or **remissions** or **healings**, described for the first time by Everson & Cole [1], that is, pathologies which, without any apparent reason, disappear from diagnostics. Of these, in addition to the specific description of the case under study, in order to arrive at a clarifying explanation of the clinical

Cite this article:

Animobono, N. U., (2026). Spontaneous medical remissions from an epistemological perspective. *ISAR Journal of Medical and Pharmaceutical Sciences*, 4(7), 27-32.

path leading to resolution, we essentially have **meta-studies** at our disposal, that is, observations (medical and statistical) obtained from the individual remission results in the specific pathological branches, in the hope of finding novelties and common interpretations.

What is missing in theoretical medicine is a *separate discipline* that takes charge of analyzing spontaneous remissions regardless of the somatic compartment involved and capable of identifying common physiological features among different remissions.

Nowadays it is common to use synonyms ⁽¹⁾ to indicate similar phenomena: **Remissions** of tumors of the hematopoietic system (*leukemias*), **Regressions** of palpable tumors (*neoplasms*),

Healings for non-oncological diseases.

2. Generality

2.1 Medical epistemology

Since the dawn of time, *philosophy* and *medicine* are a unique cultural world. *Philosophy* reflects the health of the *mind*, and *medicine* that of the *body*. Together, they experienced the same existential vicissitudes until very recently. Today's Hippocratic Oath takes us back to names like Aristotle.

Sciences are usually divided into *pure* and *applied*. *Mathematics* is among the former, *medicine* is among the latter. The philosophy of science, from an epistemological point of view, found its privileged cradle in exploring the foundations of mathematics. From mathematics, attempts were made to understand the logical laws that govern its demonstrative dialectic. This interpretative vision was later extended to the other sciences.

With new biological knowledge (*DNA*, *chromosomes*, *nitrogenous bases*, etc.) and recent technologies, engineering (*laser*, *CT*, *ultrasound*, *micro-catheters*, etc.) and information technology (*big data*, *AI* etc.), medicine acquires a leading role in the context of the philosophy of science, given the broad spectrum of inherent philosophical interests.

Medicine immediately showed itself to be a harbinger of broad philosophical interests (ethics: absent in mathematics, in medicine is decisive). Here we will touch upon a few aspects involved in medical-scientific philosophy.

2.2 Italy case

In Italy only in 1965 did the first in-depth work on medical rationality appear, edited by E. Poli [2]. And yet at the time in Italy the teaching of *Clinical methodology* inserted in the discipline of *Special Medical Pathology* [3]. Its main characterization was the distinction between

methodology and *method*: the first epistemological, the second as protocol guidelines. Then the progressive deepening of the individual medical branches generated super-specialties that did not communicate with each other, undermining the didactic need for *clinical methodology* ⁽²⁾. This absence was noticed and addressed not by clinicians, but by a couple of philosophers: Baldini [5] (1975) and Antiseri [6] (1981).

3. Methodologies

3.1 Metastudies

The body of living beings (particularly that of humans, to whom this note is dedicated) has its own "normality" (**health**) established over time by medical speculation. Alongside this model, considered *normal*, *anomalies*, that is, exceptions (**diseases**), appear in individual subjects.

The *medical science* has developed over the millennia (from magic to Hippocrates to today's findings), with acrobatic results. Herbal potions restore physiological regularity, surgical procedures remove tangles, and even modern chemical compounds block a pathology and reverse it until it disappears. Known and treatable pathologies usually stem from very few physiological abnormalities (chromosomal, glandular disorders, circumscribed syndromes, etc.), while cancer in general involves so many physiological aspects that medical research is still at a standstill. We call this form of science *conventional medicine*, founded on solid scientific, theoretical and empirical foundations (and databases such as *PubMed*).

In this chaos of pathological cases with the most diverse outcomes, some even disappear seemingly without reason (known as *spontaneous remission*). To arrive at a plausible explanation, these clinical situations follow a specific process based primarily on *meta-studies* (gathering information from clinical cases in the specific field). This insufficient and inadequate approach highlights the need for a further medical branch that directly studies the spontaneity of remission, examining the *etiology* (cause of disease) and its *semiotics* (objective *signs* and subjective *symptoms*) to narrow down the *diagnosis* (definition of the pathology), both in isolation and in the context of apparently different pathologies but with the same healing process.

At an international level, there is a *lack* of a unifying discipline that moves from the metaphysical to the physical plane. For thirty years, an important documentation work has been available, carried out (on behalf of IONS) by Hirshberg & O'Reagan [7]: it is still the largest existing database. Another indirect source is *PubMed*. Other *shortcomings* to be highlighted: **periodicals**, **national registers** and specific **university courses**.

Meta - studies emerge when conventional medicine is inadequate. In *medicine*, these refer to a horizontal

evaluation of the same medical episodes analyzed in different branches and summarized in a statistical-health perspective. Double-blind (or even triple-blind) placebo-controlled *trials* also fall into this category.

3.2 Network medicine

Another methodological aspect involved, the result of the current level of *IT* (*information technology*) and *AI* (*artificial intelligence*), is the newly born (2011) [8] **network medicine**, that is, having a large amount of health data (*big data*) for each clinical event.

In medicine, for each event, there is rarely a single prevailing reason ⁽³⁾, while the usual context is multi-disciplinarity. Coordinating all the clinical aspects involved involves the management of multiple medical branches, whose knowledge is fragmented among multiple professionals, often not intercommunicating [9].

Network medicine encompasses multiple disciplines, both medical and non-medical. For medicine, the newcomer is biotechnology (identified by the suffix *-omics*, e.g., genomics, transcriptomics (RNA), microbiomics, etc.). Outside of this, the computer analysis of complex systems and the mathematical-algebraic structure of connecting data in graphs provide medicine with an unexpected new investigative tool.

3.3 Evidence-Based Medicine (EBM)

Appeared under this name at the beginning of the 90s, it entrusts its knowledge to meta-theoretical aspects. From the analysis of a large number of similar cases, favourable results are identified: its pioneer (1972) was the epidemiologist Cochrane [10]. In his name, a group of volunteers created the *Cochrane Library*, where pertinent clinical cases are collected and evaluated, allowing decisions to be made on the basis of previous positive results. In Italy, since 1996, the *GIMBE* foundation has been present with similar aims ⁽⁴⁾.

The adoption of this clinical modality, based on positive experience, raises many doubts [12]: the precariousness of the reference system, subject to continuous integrations, involves the founding themes of epistemology. The Bayesian and *inductive attitude* of reasoning, adopted since *Baconian times*, is *supplanted* by the *Popperian* vision of interpretation (*hermeneutics*) and *falsifiability*. Clinical reasoning is, albeit hidden, hypothetical-deductive.

3.4 Prospects

Computer science, both hardware and software, now manages enormous quantities of data. Analyzing it manually would be unrealistically time-consuming and require unrealistic human resources. The time is ripe for medical epistemology to profitably embrace these methodological

approaches, alternatives to past paradigms.

4. Communicability

4.1 Doctor / patient

In general philosophy a dominant argument is the universality of concepts (Plato docet) from which *communicability* descends. The frequent stumbling block is *solipsism*. Between these two extremes we have the real world in which men, who do not know philosophy, substantially communicate ⁽⁵⁾.

In medicine, in the doctor/patient relationship, communication has an efficiently therapeutic role. A defense mechanism of the body is *pain* (in its various manifestations): knowing how to describe it well directs the doctor. Conversely, the answers to appropriate questions can exclude or catalyze the doctor's attention ⁽⁶⁾.

The emergency room is the typical healthcare environment where, for the first time, people who are strangers to each other meet. After hearing a few words from the patient, the doctor (after listening to the patient or a relative for a brief anamnesis) quickly starts with blood tests, various ultrasounds, x-rays, CT scans etc., trusting in these tests as *oracles*. He adopts standard methods, protocols, guidelines, trying to limit the reasons for the discomfort. The mnemonic and speculative lucidity of the *reliable* and *credible* patient is rarely evaluated, giving him the opportunity to express his observations. At times, the doctor arrogantly emphasizes their autonomy in devising the diagnostic procedure. The contributions of disciplines, such as psychology and sociology, are absent in the applied method. From these, *potentially* and if *used appropriately*, a rich vein of insights emerges that are very useful to the philosophy of medical science.

In this regard, integrating medical training with patient/caregiver etiquette is rewarding and beneficial for both parties.

4.2 Instruments

Another rich source of epistemological observations is provided, with an improper definition, by instrumental communication. Today technology makes available sophisticated machinery that often does not integrate but replaces medical diagnoses ⁽⁷⁾. An X-ray shows a pleural effusion, a CT scan an intestinal perforation, etc. providing timely treatment.

The theory of errors in instrumental measurements, a topic well known to physicists, is almost unknown among physicians. While the physicist extracts (temporarily) *universal* observations from the measurement of the phenomenon ⁽⁸⁾, the physician considers the machine tested and functioning (apart from clear evidence of lights bouncing like in a Christmas tree), and hardly raises the

doubt of malfunction. An example: the pulse oximeter ⁽⁹⁾. Another example: the flat EEG ⁽¹⁰⁾.

4.3 Pharmacological therapies

Once the state of malaise (*pathology*) has been identified, the hospitalization process concludes with the choice of treatment (*therapy*) aimed at eradicating the disease. Among the various treatment modalities, a prevalent form consists of medication.

Pharmacology generates a significant flow of epistemological observations in the philosophy of medical science. From this path, we highlight two *chance occurrences* that provide unexpected solutions.

A drug (*sildenafil*) studied for angina and hypertension, is effective for impotence; while drugs designed for diabetes have also found application for other conditions. *Liraglutide* (hereinafter: *semaglutide*) is effective for *obesity*; *dapagliflozin* is effective for *heart failure*.

5. Perspectives

Medical philosophy is rich in interactions from ethics (both individual and collective) and sociology to its own history: healthcare choices shape life choices.

5.1 Life path

Let's photograph three moments of human existence: *birth*, *development*, and *death*. These concepts, particularly the beginning and the end, cannot be hermetically defined. Literary narratives provide us with enchanting portraits of these moments. Biology and philosophy raise questions that border on hair-splitting. Once upon a time, birth was identified with the birth and the newborn's cry. Today, with current knowledge of reproduction, the timing is brought forward. Philosophy (and even more so, religion) takes its toll on the questionable moment of generation. Human beings (*ἄνθρωπος*) tend to drive stakes even into quicksand. Issues like abortion *become* divisive (ethical-religious judgment is put first, ignoring the underlying biology of the situation). Similarly, the *end of life*, which old housewives predicted by perceiving the gradual cooling from the feet upwards, is today delegated to non-univocal parameters ⁽¹¹⁾. In between, from the archaic biblical male/female schemes to current chromosomal knowledge, sexual situations arise that were once inconceivable ⁽¹²⁾.

5.2 Historical development

In the last century, science has generated revolutionary results. By limiting ourselves to mathematics, physics, and biology, transfinite theories, relativity and quantum mechanics, nitrogenous bases and genetics have emerged, overturning previous centuries-old knowledge. Galileo, Newton, and others have helped us understand the vitality of the cosmos; Einstein, approaching situations near the speed of light, has shown us a disrupted cosmic vitality. The

anatomical images created by Leonardo's hands have been replaced by propellers, graphs, and formulas, capable of highlighting physiological phenomena invisible to the naked eye. Scientific narrative now weaves two opposing canvases: the large and the small, the slow and the fast (*macro* and *micro*).

Philosophy itself has incorporated procedures that were once unclassifiable. (Being *and* non-being from pure ontology to concrete *existence* and non-existence). Knowledge (*gnoseology*) has incorporated investigative methods typical of science (*epistemology*). Eco-scans, chromosomes, EEGs, etc. have made it possible to circumscribe events such as birth, sex, and death.

6. Conclusions

Without being doctors, as simple epistemologists and curious to frame knowledge in a scientific method, here it has been underlined, however concisely, the need to catalogue, with new parameters, self-resolved pathogenic forms and not left at the mercy of miracle workers, homeopaths or various saints ⁽¹³⁾.

In this note, the epistemological aspect of medical-scientific research has been emphasized. The recent *Covid* has provided further insights into the philosophy of medical science: in particular, the distinction between *vaccine* and *drug*, with all the associated conspiracy controversies.

Medicine is likely an applied, ecumenical science: it pervades all known dialectical sectors, neglecting no part. Recalling the epigraph prefacing this brief, concise essay: ***philosophy and medicine are inseparable*** (paradoxically: a solid state of *entanglement*).

Spontaneity & Acknowledgements

The author declares no conflicts of interest or funding.

Notes

- (1) Often, alongside spontaneous remissions, there are *standard remissions*, which are a substitute for interventions and treatments, for which the non-recurrence has a suitable duration. For breast cancer, treated early (according to an appropriate protocol), when the aforementioned medical expectation exceeds five years.
- (2) Murri [4] already underlined, over a hundred years ago, the risk of the specialist privileging his own discipline to the detriment of clinical medicine.
- (3) In the history of medicine, when faced with a disorder, attempts have been made to identify the predominant anomalous element (e.g. for diabetes, excess sugar in the blood, through the measurement of *glycaemia* and *glycated haemoglobin*) or the single genetic variant (for *Crohn's disease*, the *nod2/card15* gene appears to be involved).
- (4) The libraries mentioned can be reached, respectively, at:

cochrane.org and gimbe.org.

(5) In *The Betrothed*, Manzoni, speaking about the *plague*, cites the figure of the intellectual Don Ferrante for whom the plague, being neither *substance* nor *accident*, did not exist. At which point Manzoni's lash: Don Ferrante died of the plague.

(6) Even the pediatrician and the veterinarian, even if they do not use speech, are able to communicate by perceiving the response.

(7) Diabetes mellitus was once diagnosed by dipping a finger in urinary fluid and tasting it. Today, a drop of blood prevents possible nausea.

(8) I remember cold fusion from palladium. In 1989 the physicists Fleischmann and Pons reported that they had achieved cold fusion using a palladium cathode and heavy water (I am omitting the details). The experiment, tested by many physicists, was never replicated. *Experimental replication, being a fundamental epistemological principle* in physics, was never achieved. Most likely there was an incorrect measurement of the heat produced at the origin.

(9) Every hospital patient, several times a day, is subjected to the control of some physiological parameters such as temperature, BP, saturation, etc. In some departments it is vital to keep *saturation under control*: it is actually a *litmus test* of the state of health. Its measurement is done using a *pulse oximeter*, a very schematic instrument. It is a thimble that wraps around the nail of a finger and passes through it with a beam of infrared light that intercepts the oxygen present in the haemoglobin. Many factors influence the measurement: length and polish of the nails, low temperature of the hand, micro capillaries, position of the patient, etc. Often, in the face of a low measurement, the patient is subjected to forced oxygenation and consequent therapies: an erroneous temperature measurement is promptly noticed, the pulse oximeter is pure gold.

(10) For the removal of organs intended for transplant, an ethics committee decrees the brain death of the donor after 6 hours of flat EEG (as well as other parameters). A more than legitimate threshold that leaves no room for any hypothetical awakenings. The definition of flat EEG is based on the absence of an electromagnetic field that can be generated by the donor's body. Yet a zealot, against donations, could argue that in the presence of more sophisticated machinery, an ephemeral electric field would still be measurable. Here too, the epistemological intertwining of physics, medicine, psychology, sociology, etc. provides an interdisciplinary approach to the philosophy of science.

(11) Michela Murgia, in a touching story [11], proposes an old Sardinian practice on the end of life, entrusted to a mysterious lady, defined *accabadora* (in Catalan: she who brings to completion), often associated with the figure of the

midwife (obstetrician).

(12) Morris syndrome (a recessive hereditary mutation of the maternal *X chromosome*, which modifies the androgen receptor) identifies subjects who are morphologically female, but without ovaries and menstruation and with endotesticles. This, unlike trisomy 21 (Down syndrome), which does not give rise to social controversies (indeed it promotes a social push towards the integration of the subjects who experience it), generates social conflicts that the philosophy of science, if appropriately made accessible, could resolve.

Indeed, to condemn certain behaviors, deemed *unnatural*, the execrated subjects are credited with the creation of a social theory born from the minds of the scandalized: *gender*. When religious dogma (*axiom*) becomes a rule of life (*morality*), it transforms into a steamroller over scientific knowledge. The geocentrism of the Inquisition crushed Galileo's morale. The so-called *surrogate womb*, from a medical practice (for women capable of conception but with a defective womb), was made taboo following alleged abuse. *Embryonic stem cells* were not used due to ethical obstacles. Even the collection of male sperm for health checks was subject to the use of a defenestrated (*punctured*) condom, so that the sperm could not be completely dispersed.

(13) One epistemological sector involved concerns the human attitude towards the incomprehensible. From prehistoric times, to the appearance of unexpected natural phenomena, an explanation has always been sought. The immediate one has always been of a *metaphysical, religious, divine nature*. Over time, with the growth of human knowledge, the aura of mystery has disappeared and metaphysics has given way to *physics*, astrology to *astronomy*, etc.

The inexplicable takes on different human dimensions depending on the historical context of the episode. At the popular level, beyond doctors, we have a plethora of healers, miracle-workers, holy men, gurus, and so on, who peddle supposed healings as a result of their physicality (in turn a conduit for some external therapeutic force). Religious literature depicts individuals capable of restoring speech to the mute, hearing to the deaf, sight to the blind, and walking to the lame. These individuals, as proof of their supernatural powers, not only heal but also transform water into wine, multiply loaves and fish, and so on. Literature defines all these phenomena as *miracles*. Alongside them, more subtle *prodigies are included* (among these is the multiple liquefaction of San Gennaro's blood, never subjected to spectrographic examination).

Even in medicine, we have the controversial *homeopathy*, which even some qualified allopaths swear by. Homeopathy, a nineteenth-century formulation by

Haemann, interprets a chemical solution dissolved in water that is always present, even if diluted several times, and water as having therapeutic memory. Regardless of future knowledge of quantum physics, the methodology used to date to explain it is inadequate according to current methodological standards.

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