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Review Article

Sacred and Profane Space in the Therapeutic Encounter: Moving Beyond Rigid Distinctions

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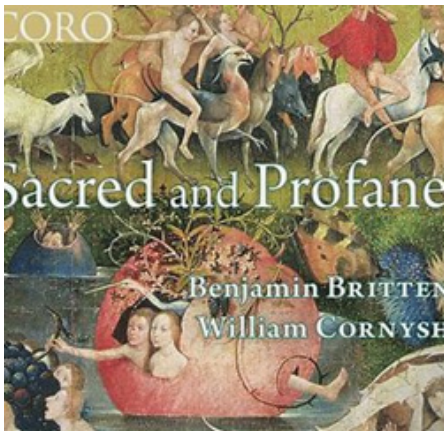
ABSTRACT

This article examines the therapeutic relationship between physician and patient through the lens of sacred and profane space. Drawing on anthropological, sociological, philosophical, and theological frameworks, we analyze how the rigid distinction between sacred and profane domains creates unnecessary tensions within healthcare settings. By reconceptualizing the therapeutic encounter as a liminal zone where these categories blend and transform, we offer healthcare practitioners a framework for understanding and improving patient-provider relationships. The metaphor of "patient as sacred text" is explored as a hermeneutic approach that respects both the scientific basis of medicine and the interpretive nature of the clinical encounter. The article concludes with practical implications for clinical practice that acknowledge both the technical and relational dimensions of healthcare.

KEYWORDS

Therapeutic relationship, Sacred space, Medical hermeneutics, Physician-patient relations, Liminality, Embodiment, Patient as text, Narrative medicine, Clinical ethics, Upaya.



Introduction

The therapeutic relationship occupies a unique position in contemporary society, simultaneously embodying scientific rationality and deeply personal human connection. While medical training primarily focuses on the technical aspects of healthcare delivery, practitioners routinely navigate complex social, emotional, and spiritual dimensions of patient care [1]. This multifaceted nature of healthcare creates tensions that can be productively understood through the conceptual framework of sacred and profane space.

The theoretical distinction between sacred and profane originates with Durkheim, who characterized the sacred as that which is set apart, protected by prohibitions, and invested with special significance [2]. In contrast, the profane encompasses the ordinary, everyday dimensions of life. While this distinction has proven analytically useful, its rigid application has created problematic separations in many domains of modern life, including healthcare [3]. This article explores how the therapeutic relationship transcends the sacred/profane dichotomy and functions as what anthropologist Marcel Mauss called a "total social fact" - a phenomenon that simultaneously involves juridical, economic, religious, and aesthetic dimensions [4]. By examining how these boundaries are negotiated in clinical encounters, we offer healthcare practitioners a framework for understanding the complex dynamics of the therapeutic relationship. The practice of medicine has always involved interpretation of symptoms, diagnostic data, research evidence, and patients' stories. This interpretive dimension positions medicine as a hermeneutic practice, where clinicians must "read" both medical evidence and the patient as texts requiring careful interpretation [5]. The concept of the "patient as sacred text" represents an emerging framework that explicitly draws on religious hermeneutics to suggest that patients should be approached with the same reverence, care, and interpretive rigor traditionally given to sacred texts. Beyond this hermeneutic framework, we can also understand the therapeutic space through theological concepts of divine presence and concealment: "In the space between the caregiver and the patient is a matrix depending upon your worldview of emptiness, presence (I-Thou) or divine presence". This perspective invites us to consider whether the therapeutic encounter is merely an empty void, a human relationship, or potentially a site of sacred presence that transcends both participants while joining them in meaningful connection.

The Therapeutic Space as a Liminal Zone

The modern clinical encounter exists in what anthropologist Victor Turner would identify as a "liminal" space - a threshold between different social states [6]. Within this space, several key dichotomies manifest, including the tension between evidence-based practice and patient-reported experience. Next the simultaneous expression of vocational calling and professional livelihood and the balance between patient autonomy and professional responsibility. Finally the negotiation between personalized care and public health imperatives. These oppositions create what Durkheim termed "anomie" - a condition of normlessness that can lead to alienation and disconnect in the therapeutic relationship [7]. As physicians and patients navigate these tensions, they often experience the clinical encounter as fragmented rather than holistic.

Arnal and McCutcheon argue that such rigid categorical distinctions function primarily as structures of power, masking their constructed nature while presenting themselves as natural or inevitable [8]. In healthcare, the categorization of certain knowledge as "scientific" and therefore sacred, while relegating patient experience to the realm of the profane, exemplifies this dynamic. This categorization has real consequences for how care is delivered and experienced.

Sacred Space in the Therapeutic Encounter

Mircea Eliade's seminal work on sacred space offers profound insights that can deepen our understanding of the therapeutic relationship. For Eliade, "For religious man, space is not homogeneous; he experiences interruptions, breaks in it; some parts of space are qualitatively different from others" [22, p. 20]. This heterogeneity of space resonates with the clinical environment, where certain areas operating rooms, intensive care units, even the examination room are set apart from ordinary space and invested with special significance.

The creation of sacred space in traditional societies, according to Eliade, involves a "break in the homogeneity of space" that "reveals the fixed point, the central axis for all future orientation" [22, p. 21]. In healthcare settings, we see similar processes at work. The hospital or clinic becomes what Eliade might call an "imago mundi" a microcosm reflecting the ordered universe in contrast to the chaos of illness and suffering. Just as traditional societies established sacred centers through rituals, healthcare institutions create their own centers through architectural design, professional rituals, and symbolic elements that distinguish medical space from the outside world. Eliade notes that "the threshold separates the two spaces" and represents "the limit, the boundary, the frontier that distinguishes and opposes two worlds" [22, p. 25]. In healthcare, thresholds abound the entrance to the hospital, the door to the examination room, the curtain around the bed each marking a transition from one mode of being to another. These thresholds function as what Turner [6] identified as liminal spaces, where patients transition from ordinary individuals to bodies under medical scrutiny.

Dualism in Healthcare

The sacred/profane dichotomy in medicine has deep roots in Western philosophical tradition. Susan Handelman traces how the Greek philosophical tradition, particularly Platonic thought, established a dualistic worldview that separated sacred from profane, mind from body, and theory from practice [5]. This dualism has fundamentally shaped Western intellectual approaches, including medicine's separation of the physical body

from the metaphysical person. Handelman contrasts this Greek-influenced Western approach with the Hebraic interpretive tradition, which she characterizes as more holistic and relational: "In the rabbinic mind, interpretation is not the recovery of some meaning which lies behind the text... interpretation is the text of life itself" [5]. Applied to healthcare, her insights suggest that healing requires an interpretive relationship rather than simply diagnostic categorization a dialogue between practitioner and patient rather than subject-object analysis. It demands the practitioner listens closely and "reads" the patient's biography of illness as he would a sacred text allowing for polysemous voices to emerge in the analysis. Much as the work of midrash in interpreting the biblical text and softening its rigid plain meaning through intertextual strategies and the use of fictional narratives and parables. The rigid diagnostic box categories of illness need a softening through multifarious voices bearing down on the simplistic reductionism of human pain and suffering into neat diagnostic categories.

This interpretive approach resonates with the therapeutic relationship as a site where rigid distinctions between sacred and profane might be overcome. The physician becomes not merely a scientific observer but an interpreter of the patient's embodied text, while the patient participates in constructing the meaning of their illness experience.

George Herbert Mead's social psychology offers another valuable perspective on how the therapeutic relationship navigates the sacred/profane distinction [9]. Mead's understanding of the self as fundamentally social and formed through symbolic interaction provides a framework for seeing the clinical encounter as a social process that transcends mere biological intervention. For Mead, the self emerges through taking the attitude of others toward oneself, internalizing social expectations while maintaining the capacity for novel response [9]. In the therapeutic relationship, both physician and patient engage in this process of role-taking, navigating between subjective experience and objective social roles. Mead's concept of the "generalized other" is particularly relevant to understanding how sacred/profane distinctions operate in healthcare. The physician embodies the "generalized other" of medical science - representing objective, rational knowledge that has traditionally been granted sacred status in modern society. Yet the physician must simultaneously engage with the patient's subjective experience, which has traditionally been relegated to the profane realm of the merely personal.

Divine Presence and Concealment

The concepts of divine presence and concealment from Jewish mystical thought offer a profound framework for understanding the therapeutic relationship. Drawing on the kabbalistic concept of tzimtzum (divine contraction or concealment), I have explored how the apparent emptiness between practitioner and patient might actually be a space filled with sacred potential [10]. This perspective provides a theological dimension to our understanding of sacred and profane space in healthcare settings.

Tzimtzum describes the paradoxical process by which the Infinite (Ein Sof) "contracts" or "conceals" itself to make space for finite existence. In the context of the therapeutic relationship, this concept suggests that the space between clinician and patient is not truly empty but rather contains divine presence in a concealed form: "A purely scientific doctor (Spinoza's model) sees healing as biological processes useful but emotionally distant. A mystical doctor (Reb Nachman's model) would recognize that the interaction itself is transformative, and divine presence is always there".

Different interpretations of tzimtzum parallel different approaches to the therapeutic relationship. The "literal" interpretation (tzimtzum kipshuto) suggests that God actually withdrew from a certain "space" to allow creation to exist independently. Applied to healthcare, this would view the therapeutic relationship as a primarily human encounter in which both participants retain their autonomy and separateness. The "non-literal" interpretation (tzimtzum lo kipshuto), favored by Hasidic thinkers, maintains that tzimtzum is only an appearance from our perspective God remains fully present but concealed. In therapeutic terms, this suggests that the seemingly empty space between provider and patient is actually filled with potential for connection and transformation. Rabbi Nachman of Breslov's concept of "double concealment" (hester betoch hester) offers particular insight for healthcare practitioners working with patients in spiritual or existential crisis. Not only might patients feel disconnected from meaning or purpose, but they may not even recognize this disconnection as a spiritual problem: "A patient suffering from illness may feel God is absent, but healing comes when they realize God is still there, even in the silence. A physician can embody this divine presence through deep listening, kindness, and faith".

This perspective transforms our understanding of the therapeutic relationship from a mere human encounter to a potentially sacred space where concealed presence can be revealed through compassionate care. It suggests that clinicians engage in a form of tzimtzum themselves creating space for the patient's experience while remaining fully present: "Doctors are 'co-creators' with God they engage in tzimtzum by making space for healing". The theological concept of divine presence and absence offers a framework for understanding not only the spiritual dimensions of healthcare but also the phenomenological experience of suffering and healing. Patients often experience illness as a form of absence or abandonment by their bodies, by others, or by meaning itself. The therapeutic relationship can transform this experience from one of emptiness to one of presence, even when cure is not possible. These mystical concepts complement and deepen the anthropological and philosophical frameworks discussed elsewhere in this article. Together, they suggest that the therapeutic space exists at the intersection of sacred and profane domains, requiring approaches that honor both the technical aspects of healthcare and its profound existential dimensions [10].

The Patient as Sacred Text

The metaphor of "patient as sacred text" represents a hermeneutic

framework that explicitly draws on religious interpretive traditions to reconceptualize the clinical encounter [5]. In this approach, patients should be approached with the same reverence, care, and interpretive rigor traditionally given to sacred texts. This framework builds on earlier approaches to medical interpretation but adds a distinctive dimension of reverence, suggesting that the patient's body and story contain wisdom that transcends the clinician's expertise, requiring an approach of humility rather than mere technical proficiency.

The patient-as-sacred-text metaphor draws particularly on religious hermeneutical traditions, which involve careful attention to textual details, recognition of multiple layers of meaning, and understanding that texts speak across time and contexts [5,11]. Just as sacred texts are approached with the understanding that they contain manifold levels of meaning requiring different interpretive strategies, patients must be "read" with attention to multiple dimensions of meaning biological, psychological, social, and spiritual. This interpretive approach aligns with Daniel's fourfold hermeneutic model for clinical decision-making, which draws explicitly from medieval biblical exegesis [12]. Daniel adapts the medieval fourfold sense of scripture literal, allegorical, moral, and anagogical to create a comprehensive framework for clinical interpretation. He describes a literal level where the objective facts of the patient's body and the literal story told by the patient. Next he outlines a diagnostic level (allegorical) where determining the diagnostic meaning of the literal data is the focus. H then moves to the praxis level (moral) where therapeutic decisions emerge from the diagnosis. Finally, the holistic level (anagogical) the space where transformation occurs in both patient and clinician through the clinical encounter. The patient-as-sacred-text metaphor implies several interpretive principles derived from religious hermeneutics [5,11,13]. These include careful attention to context and detail and simultaneous recognition of multiple layers of meaning accompanied by an interpretive humility open to multiple perspectives and a recognition of connections between seemingly disparate elements (intertextuality).

This approach positions clinical interpretation as an ethical responsibility rather than merely a technical skill. As Bruns notes, hermeneutics has historically been concerned not just with understanding texts but with "the ethical problem of how to relate to what is other than oneself" [14]. The patient-as-sacred-text metaphor emphasizes that how clinicians interpret patients has profound ethical implications.

Upaya and Skillful Communication

The Buddhist concept of upaya (skillful means) offers another valuable framework for understanding how sacred and profane dimensions intermingle in the therapeutic relationship. Upaya refers to the tailoring of communication to the specific needs and understanding of the recipient. As von Unwerth explains: "Upaya means speaking in the language of the other, intuiting what is meaningful to them and motivating to them, and presenting the message in those terms" [8].

The concept originated in the Lotus Sutra, a foundational Buddhist text, which illustrates upaya through parables. One such parable describes the Buddha encountering a gardener and, instead of using esoteric language to convey enlightenment, simply handing him a flower communicating through the medium the gardener knew best. This approach recognizes that "every person sees, feels and experiences the world differently, through his or her own lens, determined by his or her own cultural, historical, family and individual experience" [8].

Von Unwerth draws parallels between upaya and psychoanalytic practice, particularly the concept of "analytic listening" or "free-floating attention." This practice involves hearing beyond a patient's explicit words to discern recurring themes, idiosyncrasies, and omissions that reveal deeper preoccupations. In this form of listening, "everything becomes significant" [8] from breaks in thought to repetitions of certain themes or unusual emotional responses to particular topics.

The application of upaya to clinical practice suggests that clinicians should adapt their approach to each individual patient, "speaking in the language of the other" rather than imposing a predetermined framework. This approach allows for the creation of what psychoanalyst Donald Winnicott called a "holding environment" a safe space where patients feel seen, heard, and responded to in ways that facilitate healing. This parallels the mother-infant relationship, where the mother serves as the infant's "first translator of the world" [8], helping the child interpret both external stimuli and internal sensations. The concept of upaya complements the patient-as-sacred-text metaphor, with both frameworks emphasizing the need for reverent, attentive, and adaptive approaches to patients. While the sacred text metaphor emphasizes the inherent dignity and wisdom of the patient, upaya focuses on the clinician's responsibility to communicate in ways that honor the patient's unique understanding and needs.

Gift Exchange

One productive way to reconceptualize the therapeutic relationship is through Mauss's framework of gift exchange [4]. The medical interaction contains elements that are "voluntary, apparently free and without cost, and yet constrained and interested" [4]. The physician provides care that is simultaneously a professional obligation (bound by oath and contract) but also a voluntary service (expressing personal commitment to healing). There results a self-interested exchange (receiving payment and professional status) at the same time an altruistic gift (providing care beyond contractual obligations).

This framework illuminates what Durkheim called "the noncontractual element in the contract" [7] the moral dimension that transcends yet permeates the explicit agreement between provider and patient. Beyond the formal exchange of payment for

services lies a deeper moral obligation that enables genuine healing to occur.

In "The Art of Medicine as Translation," I explored how the clinical encounter involves a complex exchange that goes beyond technical services: "The physician offers not just technical expertise but also a form of attention that recognizes the patient's full humanity; the patient offers not just payment but also trust and vulnerability" [15]. This mutual exchange creates what is essentially a "covenant of care" that transcends the merely contractual aspects of the relationship. From a theological perspective, this covenantal understanding parallels my exploration of theism and pantheism in the therapeutic space [10]. While a purely theistic approach might emphasize the separateness of clinician and patient (with the clinician as a kind of divine agent bringing healing from outside), a pantheistic approach might recognize the unity underlying both participants. I suggest a middle path akin to panentheism which acknowledges both the separateness that allows for genuine exchange and the unity that makes healing possible: "The best approach is a physician who integrates both: rational science and a deep awareness of the sacredness of the encounter" [10].

This understanding of gift exchange provides a framework for transcending rigid sacred/profane distinctions. As Mauss describes, "common distinctions such as altruism and egoism or freedom and obligation become mixed up in gift exchange, and also how the separation between juridical, economical, religious, and political institutions no longer holds" [4]. In the medical encounter, this "mixing up" of distinctions suggests a therapeutic relationship of deep complexity. As Kirmayer notes, "The effectiveness of any health care system depends on meanings and relationships that cannot be completely rationalized, standardized, or commodified" [16]. This dimension of healthcare resists neat categorization as either sacred or profane, suggesting instead a blending of categories that more accurately reflects the lived experience of both providers and patients.

Spatial Dynamics of Sacred and Profane

The physical spaces of healthcare embody the blending of sacred and profane elements. Eliade observes that "the founding of a world" begins with establishing a fixed point a center around which meaningful space can be organized [17]. Hospitals and clinics establish such centers through architectural features that distinguish them from surrounding spaces. Consider:

The examination room: A space that is simultaneously ordinary (containing mundane furniture and equipment) and extraordinary (where intimate examination and life-altering diagnoses occur). Eliade would recognize this as a heterogeneous space that combines profane elements with the sacred function of healing.

The Hospital: With both mall-like public areas (cafeterias, gift shops) and sanctified spaces (chapels, birthing rooms, hospice suites) where, in Eliade's terms, "communication with the transcendent" becomes possible [22, p. 26].

The waiting room: A liminal space where patients transition from ordinary citizens to bodies under medical authority what Eliade might call a "threshold" that marks "the distance between two modes of being, the profane and the religious" [22, p. 25].

In "Therapeutic Space as Sanctuary," I attempted to articulate how clinical environments can be designed to facilitate healing by deliberately blending elements traditionally associated with both sacred and profane domains [18]: "When we enter a hospital or clinic, we cross a threshold that separates ordinary space from a domain where life's most profound transitions birth, healing, dying take place. This liminality requires architectural and design elements that honor both the technical requirements of modern medicine and the human need for sanctuary" [18].

The concept of tzimtzum (divine contraction or concealment) offers another perspective on healthcare spaces. Just as God paradoxically creates space for finite existence through self-contraction, the therapeutic environment must create space for the patient's experience while maintaining supportive presence [10]. This simultaneous presence and withdrawal mirrors the delicate balance required in clinical encounters, where the provider must be both fully present and capable of stepping back to allow the patient's autonomy and agency.

These spaces function like what Foucault termed "heterotopias" - real places that simultaneously represent, contest, and invert other real sites within a culture [19]. The hospital is both a site of scientific rationality and of profound human vulnerability, a space where life's most sacred transitions (birth and death) occur within highly structured institutional frameworks.

Like the Jewish spaces described by Nosenko-Stein, these medical spaces frequently experience "inversion of Ours and Theirs" [20]. The physician's office becomes temporarily "the patient's space" during consultation; the operating theater becomes "sacred ground" where only the initiated may enter:
"the most healing environments are those that acknowledge the patient's need for both scientific intervention and human sanctuary" [18]. This dual awareness informs the design of healthcare spaces that integrate technological sophistication with elements that evoke safety, dignity, and transcendence natural light, views of nature, privacy, artwork, and spaces for reflection and conversation.

The concept of the therapeutic space as sanctuary represents a deliberate blurring of the sacred/profane distinction, creating environments that acknowledge both the technical demands of medical care and the human dimensions of healing: "The most effective healthcare environments are neither purely technical nor purely spiritual but thoughtfully integrate elements of both domains" [18].

Beyond Mind-Body Dualism

The patient's body represents a primary site where sacred and profane dimensions intersect in healthcare. In Western medicine, influenced by Cartesian dualism, the body has often been treated as a mechanical object separate from the self a profane entity subject to technical intervention. Yet this approach fails to acknowledge how patients experience their bodies as integral to their identities and as sites of profound meaning.

Eliade's observation that "for religious man, the body shares in the dignity of the 'cosmos'" [17] offers a corrective to this mechanistic view. Just as traditional cultures understood the human dwelling as a microcosm reflecting the sacred structure of the universe, the human body can be understood as a dwelling place for the self that mirrors cosmic order.

In "Beyond Cartesian Dualism: The Body as Sacred Territory in Healthcare," I argued that "the body is not merely an object to be manipulated and fixed, but rather a sacred territory where the drama of human existence unfolds" [21]. This perspective helps explain why patients often experience medical examinations as boundary-crossing events that require ritual preparation. The established protocols of medical examinations disrobing, draping, systematic touching function similarly to what Eliade describes as the "foundation rituals" that transform ordinary space into sacred territory [22, p. 52]. These rituals acknowledge the transition from body-as-self to body-as-object-of-examination and back again.

Handelman's [11] contrast between Greek and Hebraic traditions is particularly relevant here. The Greek philosophical tradition, with its separation of form and matter, facilitated the conceptualization of the body as distinct from the self. The Hebraic interpretive tradition, by contrast, understood meaning as embodied rather than transcendent. This latter approach aligns with contemporary efforts in healthcare to overcome mind-body dualism and recognize the embodied nature of human experience. The paradox of the body in healthcare simultaneously sacred (as the vessel of personhood) and profane (as biological mechanism) parallels what Sagiv [22] describes as the ambiguity of divine names that can be both sacred and not sacred depending on context. Just as the ancient interpreters developed sophisticated hermeneutical frameworks for navigating this ambiguity, healthcare providers must develop frameworks that acknowledge both the technical and sacred dimensions of the human body.

Frank identifies the potential conflict between two ways of experiencing the body during illness: "a duality of sensibility, a conflictual experience of the body as, simultaneously, an object to be known, and the subjectively felt collection of sensations which we alone experience as ourselves" [23]. This tension between the body as scientific object and the body as lived experience highlights the need for interpretive approaches that can bridge this gap:

"when clinicians approach the body as sacred territory, they bring a reverent attentiveness to physical examination that acknowledges both its technical necessity and its boundary-crossing significance" [21]. This dual awareness allows clinicians to maintain the technical precision required for accurate diagnosis while honoring the patient's embodied experience.

Theological Dimensions of the Healing Relationship

The theological dimension of sacred space provides a valuable framework for reconceptualizing the therapeutic relationship. Just as Eliade notes that "religious architecture simply took over and developed the cosmological symbolism already present in the structure of primitive habitations" [22, p. 58], modern healthcare settings have inherited ancient healing traditions and their associated cosmologies.

The Temple in Jerusalem, as Eliade describes, was understood by Flavius Josephus to symbolically represent different cosmic realms: "the court represented the sea (i.e., the lower regions), the Holy Place represented earth, and the Holy of Holies heaven" [22, p. 42-43]. Similarly, the modern hospital contains distinct zones with varying degrees of sanctity from public areas to increasingly restricted spaces culminating in the operating theater, where life-altering procedures occur in a space accessible only to the initiated.

This symbolic ordering helps patients and providers navigate the complex emotional terrain of illness and healing. Just as sacred architecture creates what Eliade calls a "break in plane" that enables "communication with the transcendent" [22, p. 26], the structures of modern healthcare create spaces where ordinary reality is suspended, and transformative healing becomes possible. The theological distinction between sacred and profane also illuminates the concept of calling in healthcare professions. Despite increasing secularization and commercialization, many healthcare providers continue to experience their work as a vocation a sacred calling rather than merely a profession. This sense of calling echoes what Eliade describes as the religious person's desire "to live in a pure and holy cosmos, as it was in the beginning, when it came fresh from the Creator's hands" [22, p. 65]. Healthcare providers often seek to restore patients to wholeness, to a state that precedes illness or injury.

Sagiv's [22] analysis of how rabbinic traditions distinguished between sacred and non-sacred divine names offers a parallel to how healthcare providers must discern when they are engaged in routine tasks (the profane dimension of care) and when they are participating in profound healing moments (the sacred dimension). This discernment is not about rigid categorization but about maintaining awareness of how these dimensions interrelate and transform one another.

Cross-Cultural Perspectives

Understanding the sacred/profane dynamics of the therapeutic relationship has several practical implications for clinical practice. Nosenko-Stein's observation [20] that "profane space plays the role of the sacred one" in certain contexts offers a valuable lens for

understanding how meaning is created in healthcare settings. Just as Jewish communities developed sacred spaces within ordinary environments, healthcare providers can create healing spaces within seemingly mundane clinical settings.

The multicultural dynamics observed in urban settings have direct parallels in healthcare environments. Janev [24] describes how "ethno-politics determine the social and physical boundaries between members of different ethnic groups" in urban settings. Similarly, in healthcare settings, individuals from diverse backgrounds must navigate institutional spaces that often reflect the values and assumptions of dominant cultural groups.

For those from marginalized communities, navigating the medical space can involve what Blumen and Tzafrir describe as "wavering experience of time–space expansion and compression" [25]. The patient may simultaneously feel the expansion of new possibilities through medical intervention and the compression of their identity into biomedical categories that fail to capture their lived experience.

An integrated hermeneutic approach to clinical practice would recognize that clinicians must interpret both medical evidence and patients, with different interpretive skills required for each [5]. Links' analysis of how physicians' approach medical literature describes three interpretive stances fundamentalist, conservative, and liberal each representing different ways of relating to evidence-based medicine [12]. A fundamentalist approach treats evidence as "law, a series of 'sacred texts' that are to be applied literally," while a liberal approach "sees the literature as a guide, establishing principles that need to be applied to specific situations" [12]. These different stances toward evidence significantly influence clinical decisions. Similarly, different interpretive approaches to patients themselves shape the therapeutic relationship. The metaphor of patient-as-sacred-text and the concept of upaya both emphasize the ethical dimensions of clinical interpretation. By suggesting that patients should be approached with reverence and that communication should be tailored to each individual's unique understanding, these frameworks highlight the moral responsibility inherent in the clinical encounter.

These understandings suggest several practical approaches for clinicians:

Recognize the ritual dimensions of clinical encounters: Practitioners should acknowledge how clinical routines function as rituals that structure the patient experience. The white coat, the stethoscope, and the systematic review of systems are not merely functional tools but symbolic elements that establish the therapeutic relationship [26]. Eliade reminds us that rituals of foundation "re-actualize the paradigmatic work of the gods" [22, p. 29] in medicine, these rituals connect practitioners to the healing traditions that preceded them.

Attend to transitional spaces: The spaces where patients transition from ordinary citizens to bodies under medical authority (waiting rooms, intake areas) deserve particular attention. These threshold spaces, in Eliade's terms, mark "the paradoxical place where those worlds communicate, where passage from the profane to the sacred world becomes possible" [22, p. 25]. How might these spaces be designed to honor both the technical requirements of healthcare delivery and the human dignity of patients [27].

Cultivate reflexive awareness: Practitioners should develop awareness of their own interpretive stance toward both evidence and patients [5]. Daniel's observation that "the quality of care and efficacy of therapy are directly related to the care taken in interpretation" underscores the practical significance of these hermeneutic approaches [12]. Personal conscious and unconscious biases need to be acknowledged.

Create space for narrative: The rigid separation of sacred and profane can be bridged through narrative practices that validate patient experience while integrating it with biomedical knowledge [28]. Charon's narrative medicine approach emphasizes that physicians must develop skills in "close reading" similar to those used in literary analysis [2]. This attention to narrative structure complements but differs from a focus on interpreting medical evidence.

Address power dynamics explicitly: The sacred/profane distinction often masks power differentials. Practitioners should develop comfort in explicitly addressing how social status, cultural background, and institutional authority shape the therapeutic relationship [29]. As Arnal and McCutcheon argue [8], categorical distinctions often function as structures of power, masking their constructed nature while presenting themselves as natural or inevitable.

Create a holding environment: Von Unwerth's discussion of the mother-infant relationship as the prototype for all caregiving relationships provides a developmental foundation for understanding the clinical encounter [8]. The creation of a safe space where patients feel seen, heard, and responded to in ways that facilitate healing represents a core ethical responsibility in the clinical relationship.

Conclusion: Beyond Rigid Distinctions

By placing the therapeutic relationship within these anthropological, philosophical, and theological frameworks, we see how the rigid sacred/profane distinction has created unnecessary alienation in healthcare. The therapeutic relationship need not be constrained by rigid sacred/profane distinctions. The problem lies not in separation itself, but in "the kind of separation that makes it impossible to separate. The boundaries that shape our social life become a problem for our self-realization and solidarity if they cannot be changed, destroyed, or reappropriated" [3].

The diverse hermeneutic approaches discussed in this article from Links' analysis of interpretive stances toward medical literature to

the patient-as-sacred-text metaphor to von Unwerth's application of upaya need not be viewed as competing frameworks but as complementary perspectives illuminating different aspects of medical practice [8]. An integrated approach recognizes that clinicians must interpret both medical evidence and patients, with different interpretive skills required for each.

The theological concept of tzimtzum (divine contraction or concealment) adds a profound dimension to our understanding of the therapeutic relationship. As I suggest, the apparent emptiness between physician and patient may not be empty at all but filled with concealed presence [10]. This perspective transforms our understanding of clinical care from purely technical intervention to participation in a sacred process of revelation and healing. "True healing, is not just physical but also spiritual, existential, and relational" [10]. The therapeutic relationship becomes a space where the apparent absence of meaning can be transformed into presence through compassionate attention.

Daniel's fourfold hermeneutic model offers a systematic approach that helps integrate these diverse perspectives [12]. His progression from literal data to diagnostic meaning to therapeutic action and finally to transformation of life-worlds provides a structure within which various interpretive methods can be situated. This model recognizes that interpretation in medicine is not merely technical but involves a progression from scientific observation to human meaning-making and ethical action. For the therapeutic space to become truly healing, it must allow for fluidity between the sacred and profane, permitting both healthcare providers and patients to recognize what Durkheim called "the noncontractual element in the contract" [7]. The moral dimension that transcends yet permeates their exchange. As Eliade reminds us, what makes a space sacred is not its inherent qualities but the "break in the homogeneity of space" [22, p. 21] that establishes connection with a deeper order of meaning. This approach resonates with what Nosenko-Stein observed in Jewish spaces where "profane space plays the role of the sacred one" [20]. In healthcare, this might mean recognizing how seemingly mundane aspects of care listening attentively, acknowledging suffering, respecting dignity constitute the sacred dimension of healing work. The rabbinic tradition's evolving interpretations of sacred and not-sacred names, as documented by Sagiv [22], demonstrate how the rabbinic tradition's evolving interpretations of sacred and not-sacred names, as documented by Sagiv [22], demonstrate how communities can reframe inherited distinctions without abandoning them entirely. Similarly, healthcare can honor its spiritual and scientific heritage while developing more integrated approaches to the therapeutic relationship.

Drawing from both Handelman's critique of Western dualism and Mead's understanding of the social self, we can envision a therapeutic relationship that transcends the sacred/profane division not by eliminating boundaries entirely, but by making them permeable, negotiable, and responsive to the needs of the healing encounter [5,9]. Such a transformation would not only enhance the quality of care but would reconnect healthcare to its fundamental purpose: creating spaces where human flourishing becomes possible.

In an era of increasing technological sophistication and specialization, these hermeneutic approaches remind us that medicine remains fundamentally an interpretive practice [5]. By developing interpretive skills traditionally associated with humanities and religious studies, clinicians may enhance their ability to provide care that addresses both the biological and existential dimensions of illness: "By acknowledging the divine within the doctor-patient relationship, medicine moves beyond science into the realm of emunah (faith) and tikkun (rectification)" [10]. This recognition transforms both participants in the therapeutic encounter, creating what von Unwerth describes as "an altering of the conventional balance of the communication, where one listens and responds and is devoted to the other" [8]. This devotion to listening and responding to the other represents the common thread that unites all hermeneutic approaches to medicine.

By reconceptualizing the therapeutic relationship as a space where rigid distinctions between sacred and profane are suspended, practitioners can create clinical encounters that honor both the technical expertise of modern medicine and the deeply human dimensions of healing. In such encounters, we can witness what Mauss describes as "numerous people, and forces in motion, adrift in their environment and in their feelings" [4] a space where healing occurs not despite the blurring of categories but because of it.

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