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Research Article

Hermeneutic Medicine and Its Neighbors Medical Anthropology, the Anthropology of Morality, Science Studies, and Cultural Psychiatry

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Abstract

Hermeneutic medicine treats the patient as a sacred text and the clinical encounter as a sacred space of interpretation. A critical reading of my forthcoming monograph by Arthur Kleinman identified three linked deficits: reliance on his early work rather than his later moral and ontological turn; clinical vignettes too thin to carry the theory built on them, in which patients and families nearly disappear; and isolation from medical anthropology, the anthropology of morality, the history of science, and cultural psychiatry. This article accepts the critique and maps the neighborhood. It reads Kleinman's later work (What Really Matters, The Soul of Care, A Passion for Society, The Practice of Wisdom), Byron Good's explicitly hermeneutic Medicine, Rationality and Experience, Cheryl Mattingly's narrative phenomenology and first-person virtue ethics, the ordinary-ethics tradition of Veena Das, Michael Lambek and Jarrett Zigon, Annemarie Mol's praxiography of the body and of care, and Laurence Kirmayer's cultural psychiatry together with the DSM-5 Cultural Formulation Interview. For each, I state where hermeneutic medicine agrees, where it differs, and what it must change. The central conclusion is that the textual metaphor survives only if it is rebuilt as a shared, polyphonic and enacted reading, closer to the study partnership (havruta) and the many-voiced Talmudic page than to a solitary reader bent over a silent text. It then sets out a protocol for rebuilding the book's clinical cases and tests the author's own published papers against the same neighbors and criticisms, separating differences that are commitments from those that are defects.

Keywords

Hermeneutic medicine, Medical anthropology, Moral experience, Ordinary ethics, Narrative, Caregiving, Cultural Formulation Interview, Ontology, Kleinman, Good, Mattingly, Mol, Kirmayer.



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Introduction: the presence of absence

In October 2026 Arthur Kleinman read the manuscript of *The Broken Vessel: Hermeneutic Medicine and the Sacred Work of Healing* [1] and wrote to me with unusual candor (personal communication, October 2026). He found the scholarship in hermeneutics and Jewish theology impressive. He also found something he called the presence of absence. Three absences carried his argument.

The first was bibliographic and, more importantly, conceptual. I had leaned on *The Illness Narratives* [2], a book written almost four decades ago. Kleinman told me he had long since made an ontological turn and had abandoned the short paradigmatic patient vignette for a much deeper engagement with care. The second absence was clinical. My vignettes illustrated my approach, but they were too thin and underdeveloped to bear the theoretical structures I built on them; worse, they were one-sided, so that patients and families all but disappeared. The kind of meaning I sought was therefore unable to engage the real context of illness and care. The third absence was disciplinary. My work, he wrote, seemed cut off from medical anthropology, the anthropology of morality, the history of science, and cultural psychiatry, fields whose theories and findings bear directly on my topics.

I want to take this critique seriously rather than defensively. A reader who has spent half a century studying suffering across China, North America and the global health clinic has told me that my patients go missing in my own book. For a project that claims the patient is a sacred text, that is the gravest possible charge. A sacred text that cannot answer back, that has no family, no neighborhood, no insurance card and no history outside the consulting room, is not a sacred text. It is a projection.

Hermeneutic medicine, as I have developed it across a series of papers [3-5], proposes that the clinician approach the patient's history with the interpretive seriousness a tradition brings to scripture: patience with ambiguity, attention to what is concealed, humility before a meaning that exceeds the reader. Its theological vocabulary comes from Lurianic Kabbalah (contraction, shattering, repair) and its philosophical vocabulary from Gadamer and Ricoeur. Its closest public neighbor in North American medicine has been narrative medicine [6]. But the neighborhood is much larger than that, and I had not walked its streets.

This article does three things. First, it reads the six bodies of work that matter most for the project: Kleinman's later writing; Byron Good's *Medicine, Rationality and Experience*; Cheryl Mattingly's narrative phenomenology; the anthropology of ordinary ethics; Annemarie Mol's account of how practices enact the body; and Laurence Kirmayer's cultural psychiatry, including the DSM-5 Cultural Formulation Interview. Second, for each it states plainly where hermeneutic medicine agrees and where it differs, and whether the difference is a contribution or a defect. Third, it sets out a revision protocol for the book's clinical cases and tests my own published papers against the neighbors and against Kleinman's criticisms. My thesis is that hermeneutic medicine survives the encounter, but only in a changed form: the patient is not a text the physician reads alone, but a partner in a shared reading whose page carries many voices.

Kleinman after the Illness Narratives

From explanatory models to moral experience

Kleinman's early program gave clinicians the distinction between disease and illness and the habit of eliciting the patient's explanatory model [7,8]. *The Illness Narratives* [2] brought that program to the bedside through short, vivid cases. It is the book most physicians know, and it is the book I cited. But Kleinman's own trajectory has moved in a different direction, and the move matters for hermeneutic medicine.

In *What Really Matters* [9] the unit of analysis is no longer the illness narrative but moral experience: what is at stake for particular people in particular local moral worlds, under conditions of uncertainty and danger. Kleinman distinguishes this lived moral experience from ethics as an abstract, universalizing discourse, and he argues that the two must be brought into tension rather than collapsed. The book proceeds not by vignette but by extended portraits of lives followed across years, including his own and the life of the physician-anthropologist W.H.R. Rivers. The earlier work with Veena Das and Margaret Lock on social suffering [10] had already shown that suffering is distributed by social forces and cannot be read off the individual body.

Caregiving as moral practice

The Soul of Care [11] is a memoir of the years Kleinman spent caring for his wife Joan through early-onset Alzheimer's disease, joined to

a critique of a medical system that has made caregiving marginal to its self-understanding. Its claim is that care is a moral practice that makes both the giver and the receiver more human, that it is learned through doing, and that its core is presence, attentiveness and the willingness to remain. The same argument appears in compressed form in his essays in *The Lancet* and the *New England Journal of Medicine* [12-14], where he describes his own movement from illness as culture to caregiving as moral experience [13].

Two of these essays bear directly on my book. In "Caregiving: the odyssey of becoming more human" [12], Kleinman describes caregiving as a moral practice of empathic imagination, responsibility, witnessing and solidarity, learned by doing rather than from textbooks. He draws on a Chinese view that people are not born fully human but become so by cultivating themselves through their relations with others. In "From illness as culture to caregiving as moral experience" [13], he looks back on his own explanatory-model method with open ambivalence. Eliciting the patient's model, he observes, had often hardened into a mechanical task that ended conversations rather than opening them, and some admirers had turned illness narratives into free-standing stories, cut off from the economic, emotional and relational context of suffering. Caring for Joan taught him that the ordinary practices of daily care create meaning, rather than meaning coming first. That is, in essence, the criticism he made of my manuscript. A hermeneutic medicine that reads stories without their context repeats the error he spent the second half of his career correcting.

Social suffering and the social sciences

A Passion for Society, written with Iain Wilkinson [15], is a history and a manifesto. It recovers the origins of social science in a caring response to suffering, holds up Jane Addams and the settlement movement as models, and argues that social inquiry should again become a form of social care. It makes clear that the meaning of illness cannot be separated from poverty, policy and institutional neglect.

The practice of wisdom

Most recently, *The Practice of Wisdom*, written with Davíd Carrasco, Stephanie Paulsell and Michael Puett [16], grows out of a long-running Harvard course on religious, moral and aesthetic experience. It treats wisdom as a lifelong practice formed through caring for others and through solitude, ritual and art, drawing on Confucian ritual, Howard Thurman, William James, Toni Morrison and Paul Farmer. Kleinman's own chapter, on the quest for care, reflects on what Farmer and Joan taught him [17]. The authors explicitly refuse to offer a single wisdom; they hold that context and contingency make wisdom as various as the seekers.

Where hermeneutic medicine agrees

The agreements are substantial. Both projects reject the reduction of the patient to a disease entity. Both treat presence as the core clinical act; my own work on the doctor and chaplain as witnesses [18] and on caregiver grief [19] is close in spirit to *The Soul of Care*. Both locate the moral life of medicine in practice rather than in principles. Both indict the market's colonization of care, which I have addressed in work on a sacred economy of care, on Medicaid cuts and on precarity [20-22]. And *The Practice of Wisdom* legitimates something I had assumed would be suspect in anthropology: that religious traditions are resources of practical wisdom for the bedside, not merely objects of comparative study.

Where it differs, and what must change

The differences are sharper. First, Kleinman's later work is comparative and pluralist; mine speaks from inside one tradition. His remark that he is a non-observant Jew whose formation came through Chinese moral traditions, the subject of decades of his fieldwork and of Deep China, his collaborative study of how the moral person is being remade in contemporary China [23], is not biographical color. It is a methodological warning: a theology of the encounter must not presume that patients share the clinician's cosmology. My response is not to abandon the Jewish sources but to present them as one physician's hermeneutic resource, offered alongside others and never imposed, and to show their kinship with traditions Kleinman cites. Confucian ritual as Puett reads it, which creates provisional worlds in which people practice becoming otherwise, is a close cousin of halakhic practice, and the comparison should be made in the book.

Second, Kleinman's ontological turn moves attention from what illness means to what is at stake in being and in caring. Hermeneutic medicine has privileged interpretation. It must show that interpretation is itself a form of care, done with hands as well as eyes, and that it is answerable to what matters to the patient rather than to what fascinates the physician. The question *what really matters to this person, here, now?* should precede every theological elaboration in the book.

Third, Kleinman's caregiving is unmistakably plural: spouse, children, aides, nurses, physicians, friends. My encounters are dyadic. That is the deepest form of the disappearance he names, and I return to it in Section 9.

Finally, *The Illness Narratives* should be cited where it belongs, as a historical starting point, while the arguments of the book should be tested against *What Really Matters*, *The Soul of Care*, *A Passion for Society* and *The Practice of Wisdom*. Kleinman and Benson's critique of cultural competency (24), which proposes a mini-ethnography in the clinic built around the question of what is at stake, should replace the explanatory-model checklist wherever my text echoes it.

Byron Good: the closest neighbor

An explicitly hermeneutic anthropology of medicine

If one book had to stand beside *The Broken Vessel* on a shelf, it would be Byron Good's *Medicine, Rationality and Experience* [25]. Omitting it is the largest single gap in my manuscript, because Good had already done, in anthropological form, much of what I set out to do in theological form.

Good's work began with a cultural hermeneutic model of clinical practice, developed with Mary-Jo DelVecchio Good [26]. Its starting point was his study of "heart distress" in Iran [27]: a symptom is not a sign pointing to a lesion but a node in a semantic network that links bodily sensation to grief, family conflict, gender, fertility, poverty and religious meaning. To interpret a symptom is to unfold that network. The clinician's task is therefore interpretive in the full Gadamerian sense [28], and the patient's complaint is a text in Ricoeur's sense: meaningful action that can be read [29].

Medicine, Rationality and Experience extends that model in four directions that bear directly on my book. First, it criticizes the language of "belief" in medical anthropology, which assigns knowledge to physicians and mere belief to patients, and it argues that both are forms of world-making. Second, in its study of medical students, it shows how medicine constructs its objects: students learn to see, write and speak the body in new ways, and medicine thereby acquires something like a soteriological structure, a way of confronting suffering and death that functions as a secular salvation. Third, drawing on the phenomenology of chronic pain, it describes illness as an unmaking of the lifeworld, in which the body shifts from the medium of experience to its object. Fourth, through narratives of epilepsy in Turkey, it shows how stories of illness keep the future open by "subjunctivizing" it, holding several possible endings alive at once, including hopes for healing through religious means. The parallel collection *Pain as Human Experience* [30] carries the same phenomenology into the clinic.

Where hermeneutic medicine agrees

The agreements are nearly total at the level of method. Both projects hold that clinical knowledge is interpretation, not mere observation; that the body in illness becomes strange to its owner; and that the patient's story is a reading of experience, not a report of data. My papers on the patient history as a way of reimagining the body [31], on contextual errors in decision making [32] and on the social construction of clinical judgment [33] say, in different words, what Good said in 1994. The philosophical lineage is shared as well: the medical hermeneutics of Drew Leder [34] and Fredrik Svenaeus [35] are common ancestors.

Most striking is Good's claim that medicine has a soteriological structure. My book argues that the clinical encounter is sacred space. Good reaches the same threshold from the opposite side. He shows that secular medicine already behaves like a religion, with initiations, ways of seeing and promises of rescue. I argue that the sacred is genuinely present in the encounter. The two claims are not the same, but they meet, and the book should make the meeting explicit.

Where it differs

The differences are instructive. Good's hermeneutics is ethnographic: the interpreter is the anthropologist, the object is a cultural world, and the evidence is fieldwork across years in Iran, Turkey and Indonesia and in Boston. My hermeneutics is clinical and theological: the interpreter is the physician, the object is one patient, and the evidence is the encounter. Good can therefore show what my vignettes only assert, namely that a symptom's meaning is socially distributed. Heart distress meant what it meant because of mothers-in-law, contraception, poverty and mourning, not because of anything a solitary reader discerned.

Good's subjunctive narratives also correct a temptation in my work. Hermeneutic medicine likes the decisive reading, the moment when the hidden meaning of a patient's suffering is disclosed. Good's patients and families deliberately keep meaning unresolved, because closure would foreclose hope. Hermeneutic medicine should learn to honor the open text, the reading that is deliberately not completed. My own tradition supports this: the Talmud's refusal to close many questions (*teiku*) is a subjunctivizing practice.

What must change

The book should introduce Good in the introduction as the closest predecessor, position hermeneutic medicine as a clinical and theological extension of his anthropological hermeneutic and replace any implication that it is the first hermeneutic approach to the clinic. The chapter on the Cartesian split should engage his account of how medicine constructs its objects. The chapter on sacred listening should engage the semantic illness network as a concrete method: for each case, map what the symptom is connected to in the patient's world and show the map.

Cheryl Mattingly: emplotment, moral laboratories and the thin vignette

Narrative as the structure of clinical action

Cheryl Mattingly's *Healing Dramas and Clinical Plots* [36] begins from occupational therapists rather than physicians, and that choice is revealing. Therapists, she found, do not simply hear stories; they make them. They engage in therapeutic emplotment, shaping a course of treatment so that it has a beginning, a turning point and an end that matter to the patient. Narrative is not a report laid on top of experience but the structure of experience as people act it out. Some clinical moments become healing dramas, scenes in which patient and therapist together sense that something significant is happening. Her earlier work with Maureen Fleming on clinical reasoning [37] had already shown that practitioners reason narratively, not only procedurally.

The family as moral laboratory

In *The Paradox of Hope* [38] and *Moral Laboratories* [39], Mattingly followed African American families caring for children with serious illness and disability in Los Angeles for more than a decade, in clinics and in homes. Hope, she showed, is a practice rather than a feeling, cultivated in the clinical borderland where families, professionals and institutions meet across lines of race and class. Everyday family life becomes a moral laboratory: a place where people experiment, often under great peril, with how to live a good life and how to be a good parent, sibling or spouse. Against both rule-based ethics and the Foucauldian reading of ethics as self-fashioning within power, she defends a first-person virtue ethics in which the question is always *what should I do, now, as this person in this situation?* [40].

Why this answers the thin vignette

Mattingly is the most practical answer to Kleinman's criticism of my cases. Her method shows what a thick case looks like. It is longitudinal, so that interpretations are revised as lives change. It is multi-voiced, so that a mother's account, a child's behavior, a sibling's resentment and a clinician's plan are all on the page. It is situated, so that housing, schooling, transport and racism are part of the plot rather than background. And it is morally serious about the patient and family, who appear as agents working out the good under constraint, not as recipients of the clinician's insight.

My vignettes, by contrast, are mostly single encounters told by the physician, with a moment of disclosure in which the patient's hidden meaning comes into view. The structure is my own healing drama, and the patient's own plot is absent. Mattingly would ask: what happened next? What did the patient make of my reading? Did the family agree? What did the reading cost them?

Where hermeneutic medicine agrees and differs

The agreement is real. My work on the patient as parable [41,42] and on the patient's two accounts [43] treats narrative as a structure of meaning that the clinician must interpret rather than reduce, and my reading of the Joseph narrative as a paradigm of family conflict and bodily symptom [44] is an attempt to think illness through families. The mashal, the parable whose meaning the listener must work out, is a close cousin of Mattingly's emplotment: both make meaning an achievement of the hearer as much as the teller.

The difference is in who holds the pen. In hermeneutic medicine as presently written, the physician interprets the parable. In Mattingly's work, patients and families are themselves interpreters and experimenters. A first-person virtue ethics also clarifies something my theological vocabulary obscures: the patient is not only a sacred text to be read, but a moral agent trying to live well with illness, whose own interpretive work deserves the same reverence I give to the classical commentators.

What must change

The book should cite Mattingly in the introduction and in the chapter on narrative, adopt therapeutic emplotment as a description of what hermeneutic clinicians actually do, and rebuild at least three cases in her manner: followed across time, told from several positions, and carrying the patient's own reading of what happened. Section 9 sets out how.

The anthropology of morality and ordinary ethics

Three positions

Over the past two decades anthropologists have turned from treating morality as a set of social rules to studying ethics as it lives in ordinary speech and action. Three positions matter most for hermeneutic medicine.

Veena Das, in *Life and Words* [45], studied women who survived the violence of the 1947 Partition and families caught in the 1984 riots in Delhi. Her argument, built with Wittgenstein and Cavell, is that people do not recover from catastrophe by ascending to transcendent meaning. They recover, when they do, by a descent into the ordinary: by making tea, tending a household, saying or withholding certain words, slowly reinhabiting a world that has been poisoned. Ethics lives in this everyday labor of repair. In *Affliction* [46], she carried the same attention into the health care of poor neighborhoods in Delhi, where illness, debt, kinship and the practitioner's shop are inseparable.

Michael Lambek's edited volume *Ordinary Ethics* [47] proposes that ethics is intrinsic to speech and action, not a special domain reserved for dilemmas. We are always already judging, committing, apologizing and keeping faith, mostly without reflection. James Laidlaw's argument for an anthropology of ethics as freedom [48] shares this widening of scope.

Jarrett Zigon [49,50] offers a useful refinement. Most of the time, morality is an embodied, unreflective way of being in the world. Ethics in the strong sense appears at moments of moral breakdown, when that way of being fails and a person must consciously work out how to go on. The aim of ethical work is to return to an unreflective, livable every day.

What this means for the clinic

Illness is a paradigm case of moral breakdown in Zigon's sense, and the clinic is often where it is felt. But what Das and Lambek add is that the response to breakdown is mostly ordinary. The patient with a new neurological diagnosis does not need a revelation. She needs to know whether she can drive her grandson to school, whether her husband will stay, whether she will lose her job. Repair happens in such details.

Where hermeneutic medicine agrees

Hermeneutic medicine already shares the ordinary-ethics suspicion of rules applied from above. My critique of protocol-driven medicine, and my insistence that language in the clinic does moral work before any explicit ethical judgment [51], belong in this conversation. Das's Wittgensteinian attention to how words can wound or heal in ordinary use is very close to my own argument about the crisis of language in therapeutic practice. And my anti-theodicy, the refusal to explain suffering away [52], meets Das's refusal of redemptive narratives about violence.

Where it differs

The difference is one of altitude. Hermeneutic medicine tends to locate meaning at the height of the sacred: Shekhinah in exile, divine contraction, the shattering of vessels. Ordinary ethics locates it at ground level. This is not merely a contrast of temperament. Das's point is that the move to transcendent meaning can itself be a way of not seeing what a person is going through. When my vignettes lift a patient's suffering quickly into kabbalistic categories, they risk exactly this.

The tradition I draw on already knows the danger. Hasidic thought insists that the divine is found in eating, trading and talking, and

halakha is a discipline of the ordinary. The book should say so, and its clinical cases should dwell much longer in the ordinary before any theological reading is offered. My recent work on the patient who cannot be discharged [53], which attends to consent, access and release in concrete encounters, points in this direction.

What must change

Each chapter should test its theological claims against a simple question drawn from ordinary ethics: what did this patient and family actually do, day by day, to go on? Where the answer is not in the case, the case is not yet thick enough to carry the theology.

Annemarie Mol: the body multiple, the logic of care and the Cartesian split

Ontology in practice

Annemarie Mol's *The Body Multiple* [54] is an ethnography of atherosclerosis of the leg arteries in a Dutch university hospital. In the outpatient clinic, the disease is a patient's pain on walking a certain distance. In the pathology laboratory, it is a thickened vessel wall under the microscope. In the radiology suite, it is a narrowing on an angiogram; in the vascular laboratory, a pressure gradient. Mol's claim is not that one disease is seen from several perspectives. It is that different practices enact different objects, and that the hospital does constant work to coordinate them so that they hang together as one disease. She calls her method praxiography: the study of how reality is done.

The Logic of Care [55], based on diabetes clinics, sets the logic of care against the logic of choice. The logic of choice treats the patient as a customer or citizen who chooses among options. The logic of care treats living with disease as an ongoing, collective practice of attuning, adjusting and tinkering, in which professionals, patients, relatives, devices and food all take part. Good care is not respect for choice but persistent, practical attention to what works for this body in this life. The collection *Care in Practice* [56] extends this to homes and farms.

A counterpart to my critique of the Cartesian split

My book argues that Cartesian dualism still structures medicine, splitting body from person and treating the patient's subjective account as noise around objective data [57,58]. I have proposed instead an ontological account of the encounter, using the kabbalistic image of contraction to describe a clinician who withdraws to make room for the patient's reality [59] and I have used actor-network theory to criticize medical hierarchies [60].

Mol gives this critique an empirical spine that it lacks. She shows the split not as a philosophical error lingering in the background but as something done every day by specific practices: one department enacts the body as lived pain, another as tissue, and the institution coordinates them, usually by ranking the laboratory above the patient. Earlier anthropology had made a similar case through the idea of the mindful body [61] and Kirmayer's analysis of mind and body as metaphors carrying hidden values [62]. Charles Rosenberg's history of diagnosis adds the historical dimension. Over the past century, he shows, diagnosis has been tied ever more tightly to specific disease entities imagined as existing apart from any particular sufferer, and those entities now organize clinical decisions, bureaucratic administration and health policy, so that diagnosis mediates between individual experience and the institutions that manage it [63]. But Mol's account is the strongest because it is the most concrete.

Where hermeneutic medicine agrees

We agree that the patient's account is not merely subjective color laid over an objective disease. We agree that the hierarchy of knowledges in medicine is a moral and political arrangement, not a fact of nature. And Mol's logic of care, attentive, persistent, collective and unglamorous, is close to what I call presence.

Where it differs

Mol's approach also exposes a weakness in mine. The textual metaphor assumes that there is one patient to read, whose deep meaning lies beneath the surface. Mol suggests that there are several patients enacted in several sites, and that coordinating them is itself the work of care. If the patient is a text, it is a text with many editions, produced in the clinic, the imaging suite, the family kitchen and the insurance office. A hermeneutic medicine that reads only the edition produced in the consulting room misreads.

The tradition again offers a better model than the one I used. The printed Talmudic page places the Mishnah and Gemara at the center and surrounds them with commentaries from different centuries that disagree, cross-reference and correct one another. It is a coordinated multiplicity, not a single text. Reframed this way, the hermeneutic clinician is less a solitary reader than an editor of a many-voiced page, responsible for making the edition that the patient can live with.

There is also a difference in what each approach wants from the word ontology. Mol's ontology is practical and local: realities are made in practices. Mine has been theological: the patient's being exceeds any representation of it. These need not conflict. But the book must stop treating ontology as a synonym for depth and acknowledge that, in the anthropology Kleinman refers to, the ontological turn means attention to what practices make real.

What must change

The chapter on the Cartesian split should be rewritten in dialogue with Mol. For at least one rebuilt case, the book should show the same patient enacted in several sites, from the neurological examination to the MRI report to the family's account at home, and show how the clinician coordinates them, or fails to.

Cultural psychiatry: Kirmayer and the Cultural Formulation Interview

Kirmayer's cultural psychiatry

Laurence Kirmayer, working in the McGill tradition of social and transcultural psychiatry, has made three arguments that matter here. First, the familiar model of cultural competence is inadequate

[64]. It treats culture as a property of minority patients, reduces it to stereotyped traits and leaves the culture of biomedicine and of the clinician unexamined. What is needed instead is cultural safety and humility, and attention to the clinician's own culture and to structural inequality. Second, illness narratives are rarely the coherent stories that narrative medicine sometimes imagines [65]. They are often broken, fragmentary and metaphorical, and the clinician must be prepared to work with fragments rather than demand a plot. Third, healing works through meaning, metaphor and imagination as well as through mechanism [66]. Recent work with colleagues proposes an ecosocial approach that integrates neuroscience with culture, social context and the patient's lived world [67].

The Cultural Formulation Interview

The Cultural Formulation Interview (CFI), introduced in DSM-5 [68] and developed by Roberto Lewis-Fernández, Kirmayer and colleagues out of the earlier DSM-IV Outline for Cultural Formulation [69-71], is the most widely available clinical tool for doing what I call sacred listening. Its core version is a brief semi-structured interview of sixteen questions in four domains: the patient's own definition of the problem; the patient's understanding of its causes, context and supports, including the role of culture, religion and identity; the patient's own ways of coping and past help seeking; and the factors that bear on help seeking now, including the clinician-patient relationship itself. Supplementary modules extend it to explanatory models, spirituality, religion and moral traditions, social network, immigration, caregivers and other domains, and an informant version brings in family and caregivers. The interview is designed to be asked in ordinary language, not imposed as a checklist.

Where hermeneutic medicine agrees

My work on sacred listening [4,5,72] argues that the history should be taken as one would read a sacred text: slowly, without premature closure, attending to what is said and unsaid, letting the patient's own language set the terms. The CFI operationalizes much of this. Its first move, asking how the patient describes the problem in her own words and to her own people, is the hermeneutic principle of letting the text speak before the commentary. Its questions on religion and moral traditions open precisely the space in which my book works. And Kirmayer's insistence on examining the clinician's culture matches my long argument that the physician is not a neutral reader. My papers on religious trauma [73], on spiritual crisis and psychiatric diagnosis [74] and on race and health care justice [75] belong in this conversation.

Where it differs

The CFI is a tool; hermeneutic medicine is a stance. The CFI is deliberately agnostic about the content of the patient's world, while hermeneutic medicine brings a rich theological vocabulary to it. That vocabulary is both a strength and a risk. It is a strength because it gives clinicians a language for depth, mystery and the limits of explanation that biomedicine lacks. It is a risk because, as Kirmayer warns, a clinician's interpretive framework can override the patient's. If a patient describes her illness as a test, a punishment, bad luck or simply a disease, the hermeneutic clinician must not translate it into Shekhinah and exile. The patient's categories come first.

The CFI also corrects the dyadic shape of my cases. Its informant version and caregiver module bring the family into the interview by design. The thin vignette Kleinman criticized would have been thicker if I had asked the CFI questions of my patients and their relatives and reported their answers.

What must change

The book's chapter on sacred listening should present the CFI as its practical counterpart, show how each of its four domains maps onto hermeneutic principles, and include an appendix for the Instructor Guide in which students conduct a CFI and then write a hermeneutic reflection on what they heard. The Kirmayer critique of cultural competence should be used to sharpen my own critique of protocol-driven care, and the book should state clearly that the

Neighbor	Core claim	Where hermeneutic medicine agrees
Kleinman, later work (9, 11, 15, 16)	Moral experience in local worlds; caregiving as moral practice; wisdom as practice	Presence, care as moral act, critique of market medicine, religious traditions as practical wisdom
Byron Good (25)	Clinical knowledge is interpretive; symptoms sit in semantic networks; medicine constructs its objects	Hermeneutic method; illness unmakes the lifeworld; medicine's quasi-religious structure
Cheryl Mattingly (36, 39)	Therapeutic emplotment; families as moral laboratories; first-person virtue ethics	Narrative as structure of meaning; parable as clinical form
Das, Lambek, Zigon (45, 47, 49)	Ethics lives in ordinary speech and action; repair is a descent into the ordinary	Suspicion of top-down rules; language does moral work; anti-theodicy
Annemarie Mol (54, 55)	Practices enact multiple bodies; logic of care vs logic of choice	Critique of Cartesian split and of knowledge hierarchies; care as persistent attention
Kirmayer and the CFI (64, 68)	Cultural humility; broken narratives; meaning in healing; a practical interview	Sacred listening; patient's own words first; the clinician is not neutral

theological language is the clinician's resource for humility, not a frame to be laid over the patient.

The neighborhood mapped

Across all six neighbors, hermeneutic medicine agrees on the rejection of reductionism and differs on the same three points: who interprets, where meaning lives, and how far it may rise above the ordinary. The table summarizes the map and the change each neighbor requires.

Three conclusions follow from the map. First, hermeneutic medicine's distinctive contribution is real: none of the neighbors offers a theological account of why the encounter deserves reverence, or a vocabulary drawn from a living interpretive tradition for the clinician's own humility and self-withdrawal. Second, that contribution is currently purchased at the expense of the patient's agency and context, which every neighbor insists on. Third, the remedy is the same in every case. The reading must become shared, many-voiced, longitudinal and grounded in ordinary life.

Rebuilding the vignettes: a revision protocol

Kleinman's most consequential criticism is the clinical one, and it can be met concretely. The following protocol applies the neighbors' methods to the book's ten clinical cases.

Ten short cases should become three or four anchor cases, each developed to several thousand words and returned to across chapters, with the remaining cases shortened and clearly labeled as illustrations. Each anchor case should be followed across time: the first encounter, the months after, the turning points, and the outcome, including the outcome that disappointed. Mattingly's and Kleinman's portraits are persuasive precisely because time revises the first reading.

Each anchor case should contain at least three voices besides the physician's: the patient in her own words, a family member or caregiver, and another professional such as a nurse, therapist or chaplain. Where they disagree with the physician, the disagreement should stay on the page. Arthur Frank's call for patients to be tellers of their own stories rather than material for the clinician's [76] applies with special force to a book that calls the patient a sacred text. The model is the Talmudic page and the study partnership, in which the text is read by two who argue.

For each anchor case, the book should state what was at stake for the patient and family: work, money, insurance, faith, marriage, children, migration, dignity. This is Kleinman's question and the backbone of Kleinman and Benson's mini-ethnography in the clinic [24]. Structural forces such as insurance denials, Medicaid rules, transport and precarious work should appear as part of the plot.

The four domains of the Cultural Formulation Interview [68-70] should be used as a scaffold for each anchor case: how the patient named the problem, what she thought caused it and who supported her, how she coped and sought help, and what shaped her trust in the clinic. Where the case record lacks this information, the gap should be acknowledged rather than filled by inference.

At least one case should map the symptom's semantic network in Good's sense [25], and at least one should show the patient enacted across several sites in Mol's sense [54]: the examination room, the imaging report, the pharmacy, the home. The reader should see the physician coordinating these realities and sometimes failing to.

In each case, the narrative of what the patient did day by day to go on should come before any theological interpretation and should be at least as long. The theological reading should then be offered explicitly as the physician's lens, with the patient's own categories reported first.

At least one case should show hermeneutic medicine misreading a patient: a meaning imposed, a family excluded, a closure forced too soon. The book will be more credible, and more faithful to its own humility, if it shows its method making mistakes.

Cases should be presented with written consent where possible, de-identified, and marked when composite. The CARE guidelines for case reports [77] give a minimum standard. Better still, patients or relatives should read the rewritten case and comment, and the book should report what they said. This is the most direct way to ensure that the patient does not disappear, and it extends my argument that patients must be known by name and story rather than as anonymous cases [78].

Finally, each case should acknowledge who the physician is: a neurologist formed in a particular tradition, practicing in a particular community, with his own griefs and limits. My work on the hermeneutic clinician's self-emptying [79] and on the long formation of hermeneutic medicine [80] can be drawn into the cases themselves, so that the reader sees the reader as well as the text.

My own published work against the neighbors

Kleinman read the manuscript, not the papers behind it. A fair test is to read those papers against his three criticisms as well. They show that some of what he found absent from the book is present in the wider body of work, and that some of it is absent there too. Where a paper already meets a neighbor, the book should draw on it. Where a paper is exposed to the critique, the book should not repeat its move.

Context as clinical data. My paper on contextual errors [32] is built on Saul Weiner and Alan Schwartz's research (81), which defines patient context as everything outside the patient's skin that bears on planning care, and shows that physicians who miss it make plans that are biomedically correct and practically unworkable. The paper accepts, in so many words, Kleinman's point that context is not background but clinical data. Two cautions follow. It is a review of other researchers' evidence, not a report of my own cases. And

its closing section translates context back into the language of Shekhinah and divine contraction, which is exactly the upward move that ordinary ethics warns against (Section 5).

Social suffering and political economy. My papers on Medicaid cuts [21], on precarity [22], on the sacred economy of care (20) and on capitalism and health care [82] stand close to *A Passion for Society*. They treat suffering as produced by policy and markets, not only by disease.

Care as plural. My proposal for a therapeutic clinic [83] includes family rooms, community health workers, home visits, chaplains and therapists, and new-patient visits long enough for unstructured narrative. That is nearer to Kleinman's and Mol's picture of care than anything in the book's vignettes. But its two illustrative cases are explicitly hypothetical and told from the planner's point of view. They are the thin vignette in its purest form, and they show that the problem is in my method of writing cases, not only in this book.

More than one tradition. Papers on Eastern religious symbols in therapeutic practice [84] and on the Twelve Steps read alongside Ramchal's *Mesilat Yesharim* [85] show that the work already reaches beyond a single tradition. The book should say so, because it partly answers Kleinman's comparative point.

The clinician's own body. In "When the Body Breaks" [86] I wrote up my own fall down a flight of stairs as a case, read in four dimensions: physical, emotional, psychological and spiritual. It is the closest I have come to the first-person register of *The Soul of Care*. Yet even there, the other people who were present are missing. No one helps me up, no family member speaks, and all four dimensions are mine. The pattern Kleinman named runs through my own illness as well as my patients'.

Dementia and the genre of tragedy. This is the sharpest difference between Kleinman and me, and the book must face it. In "The Blessing of Dementia" [87] and its companion on memory loss [88], I proposed that dementia might be read, beneath its real suffering, as a sacred unburdening, a return of the soul toward its source. The paper acknowledges the suffering of patients and caregivers, draws on Tom Kitwood's relational account of personhood, and frames the blessing dialectically. Kleinman wrote about the same illness as the husband who fed, dressed and guided Joan. His essay on caregiving records her asking why God had done this to her and concludes that "the proper genre is tragedy" [12]. Das would add that a redemptive reading offered too early can be a way of not seeing [45].

I do not withdraw the theological reading. It belongs to a physician's private discipline of humility before what he cannot explain. But it must never be offered to a caregiver as consolation unless the caregiver reaches for it, and in the book it should follow, not precede, the caregiver's own account of what the illness has cost.

Autonomy as choice. My paper on patient autonomy and the design of healing environments [89] builds autonomy around control: patients adjusting light, sound, temperature and privacy, and choosing how much to engage. To its credit it includes family rooms and patient co-design. But Mol's logic of care [55] would ask whether the logic of choice has entered through the architecture. Good care, on her account, is not a menu of options but persistent, shared attunement. The book should state that the autonomy it values is relational, and that respecting a patient sometimes means tinkering together rather than handing over controls.

The clinician at the center. Papers on physician grief [90], on the hermeneutic clinician's self-emptying [79] and on the physician as witness [91] attend carefully to the healer's inner life. That is a real contribution; medicine neglects it. But in a book about the patient as sacred text, the healer's interior should not occupy the space where patients and families ought to speak. Kleinman's own memoir is about his inner life too, but Joan, their children and the aides are always on the page.

The solitary reader. The papers that founded the textual metaphor [3-5,41,42] are the ones most exposed. They describe a physician reading; they rarely describe a patient reading back. Section 9's protocol is the corrective.

Where I keep differing

Some differences are commitments, not defects. My work on the sacred epistemology of not-knowing [92] and on an anti-theodicy for the clinic (52) keeps meaning open in the way Good's subjunctive narratives do, but it grounds that openness in a theology of divine concealment rather than in ethnographic description. My paper on

Kleinman's criticism	Published work that already answers it	Published work exposed to it
Cut off from the neighboring fields	Contextual errors (32); actor-network critique (60); Eastern symbols (84); Twelve Steps and Ramchal (85)	Founding hermeneutic papers (3-5)
Thin, one-sided vignettes	Clinic model's plural care (83); first-person case (86)	Hypothetical clinic cases (83); own case without others (86)
Patients and families disappear	Caregiver grief (19); Joseph and family conflict (44)	Dementia as blessing (87, 88); healer-centered papers (79, 90, 91)
Meaning detached from context	Medicaid, precarity, economy of care (20-22, 82)	Context re-theologized (32); autonomy as control (89)

interoception and unconscious bias [93] argues from neuroscience for embodied clinical practice, converging with Mol's practical ontology and Kirmayer's ecosocial psychiatry from a different direction. And the claim that the encounter is genuinely sacred, not only structured like a religion, remains mine. The neighbors do not make it, and I do not expect them to. What I owe them is to make it in a way that keeps patients, families and their ordinary lives at the center.

Conclusion: from the solitary reader to the shared page

Kleinman's phrase, the presence of absence, names something every interpretive tradition knows. A commentary that never cites its predecessors is not original; it is unmoored. A reading that never lets the text answer back is not reverent; it is possessive. The critique I received is, in this sense, a call back to the best of my own tradition.

The neighbors converge on one lesson. Kleinman teaches that what matters is lived in local moral worlds and enacted in care. Good teaches that clinical knowing is already hermeneutic, and that meaning is distributed across a social world. Mattingly teaches that patients and families are interpreters and moral experimenters in their own right. Das, Lambek and Zigon teach that ethics lives in ordinary words and acts, and that repair is often a descent into the everyday. Mol teaches that the body is enacted in many practices and that care is the work of coordinating them. Kirmayer teaches that the clinician's framework is itself cultural and offers a tool for letting the patient's categories lead.

Hermeneutic medicine has something to give in return. It offers a vocabulary, drawn from a living tradition of reading, for the clinician's humility: for withdrawing to make room, for staying with what cannot be explained, for treating the encounter as worthy of reverence. *The Practice of Wisdom* (16) suggests that Kleinman himself now regards religious and moral traditions as sources of exactly this kind of practical wisdom. My task is to offer mine without letting it eclipse the person it is meant to serve.

The sacred text, in the tradition I come from, was never read alone. It was read aloud, argued over in pairs, surrounded on the page by voices from other centuries, and carried out of the study house into kitchens and markets. If the patient is a sacred text, then the patient must be read the same way: with others, over time, in the ordinary, and with the text itself free to disagree. That is the book I now need to write.

References

1. Ungar-Sargon J. The broken vessel: hermeneutic medicine and the sacred work of healing. Wilmington (DE): Vernon Press; forthcoming.
2. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books. 1988.
3. Ungar-Sargon J. Hermeneutic approaches to medicine: from objective evidence to patient as sacred text. EC Neurol. 2025; 17: 1-10.
4. Ungar-Sargon J. Applying hermeneutics to the therapeutic interaction: the act of interpreting the patient history as a sacred text-sacred listening as experiential encounter versus rational faith. Int J Psychiatry Res. 2025; 8: 1-6.
5. Ungar-Sargon J. The art of sacred listening: divine presence and clinical empathy in contemporary medical history taking. Rev Theol. 2025; 25: 85-97.
6. Charon R. Narrative medicine: honoring the stories of illness. New York: Oxford University Press. 2006.
7. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978; 88: 251-258.
8. Kleinman A. Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley: University of California Press. 1980.
9. Kleinman A. What really matters: living a moral life amidst uncertainty and danger. New York: Oxford University Press. 2006.
10. Kleinman A, Das V, Lock M. Social suffering. Berkeley: University of California Press. 1997.
11. Kleinman A. The soul of care: the moral education of a husband and a doctor. New York: Viking. 2019.
12. cct.umb.edu
13. Kleinman A. From illness as culture to caregiving as moral experience. N Engl J Med. 2013; 368: 1376-1377.
14. Kleinman A. The art of medicine: caring for memories. Lancet. 2016; 387: 2596-2597.
15. Wilkinson I, Kleinman A. A passion for society: how we think about human suffering. Oakland: University of California Press. 2016.
16. Harvard Book Store
17. news.harvard.edu
18. Ungar-Sargon J. Presence, witness, and meaning: the doctor and the chaplain in the therapeutic space. Med Clin Sci. 2025; 7: 055.
19. Ungar-Sargon J. Navigating the depths: a framework for caregiver's grief work. J Behav Health. 2025; 14: 1-9.
20. Ungar-Sargon J. Toward a sacred economy of care: reimagining healthcare through an integrative moral lens. Glob J Crit Care Emerg Med. 2025; 2: 1-13.
21. Ungar-Sargon J. Shattered vessels in the house of healing: the ethical and psychological devastation of Medicaid cuts through the lens of hermeneutic medicine and mystical theology. Am J Med Clin Res Rev. 2026; 5: 1-17.
22. Ungar-Sargon J. Poverty, precarity, and the fracturing of care: toward a new model of healthcare inequity. J Psychol Neurosci. 2025; 7: 1-13.

23. Kleinman A, Yan Y, Jing J, Lee S, Zhang E, et al. Deep China: the moral life of the person. Berkeley: University of California Press. 2011.
24. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med. 2006; 3: e294.
25. Good BJ. Medicine, rationality, and experience: an anthropological perspective. Cambridge: Cambridge University Press. 1994.
26. Good BJ, Good MJD. The meaning of symptoms: a cultural hermeneutic model for clinical practice. The relevance of social science for medicine. 1981; 165-196.
27. Good BJ. The heart of what's the matter: the semantics of illness in Iran. Cult Med Psychiatry. 1977; 1: 25-58.
28. Gadamer HG. Truth and method. 2nd rev ed. Weinsheimer J, Marshall DG, translators. New York: Crossroad. 1989.
29. Ricoeur P. The model of the text: meaningful action considered as a text. Soc Res. 1971; 38: 529-562.
30. DelVecchio Good MJ, Brodwin PE, Good BJ, Kleinman A. Pain as human experience: an anthropological perspective. Berkeley: University of California Press. 1992.
31. Ungar-Sargon J. The patient history: reimagining the body in illness. Am J Med Clin Sci. 2024; 9: 1-9.
32. Ungar-Sargon J. Contextual errors in medical decision making: reclaiming the human situation in clinical care. J Med Clin Res Rev. 2025; 9: 1-15.
33. Ungar-Sargon J. The epistemology of clinical judgment: language, power, and the social construction of medical knowledge. Jpn J Med Res. 2025; 3: 1-14.
34. Leder D. Clinical interpretation: the hermeneutics of medicine. Theor Med. 1990; 11: 9-24.
35. Svenaeus F. The hermeneutics of medicine and the phenomenology of health: steps towards a philosophy of medical practice. Dordrecht: Kluwer. 2000.
36. Mattingly C. Healing dramas and clinical plots: the narrative structure of experience. Cambridge: Cambridge University Press. 1998.
37. Mattingly C, Fleming MH. Clinical reasoning: forms of inquiry in a therapeutic practice. Philadelphia: FA Davis. 1994.
38. Mattingly C. The paradox of hope: journeys through a clinical borderland. Berkeley: University of California Press. 2010.
39. Mattingly C. Moral laboratories: family peril and the struggle for a good life. Oakland: University of California Press. 2014.
40. Mattingly C. Two virtue ethics and the anthropology of morality. Anthropol Theory. 2012; 12: 161-184.
41. Ungar-Sargon J. The patient as parable: highlighting the interpretive framework: applying mystic hermeneutics to patient narratives. Int Med J. 2025; 25: 41-50.
42. Ungar-Sargon J. The parabolic encounter III: from ancient mashal to patient as sacred text. J Behav Health. 2025; 14: 1-7.
43. Ungar-Sargon J. And so, it goes with God': the patient's two accounts, the mashal as clinical instrument, and what Life of Pi teaches hermeneutic medicine. J Behav Health Psychol. 2026; 15: 1-12.
44. Ungar-Sargon JY. Fraternal rupture and somatic pathology: the Joseph narrative as clinical paradigm for family and communal conflict. Adv Med Clin Res. 2025; 6: 238-242.
45. Das V. Life and words: violence and the descent into the ordinary. Berkeley: University of California Press. 2007.
46. Das V. Affliction: health, disease, poverty. New York: Fordham University Press. 2015.
47. Lambek M. Ordinary ethics: anthropology, language, and action. New York: Fordham University Press. 2010.
48. Laidlaw J. For an anthropology of ethics and freedom. J R Anthropol Inst. 2002; 8: 311-332.
49. Zigon J. Moral breakdown and the ethical demand: a theoretical framework for an anthropology of moralities. Anthropol Theory. 2007; 7: 131-150.
50. Zigon J. Morality: an anthropological perspective. Oxford: Berg. 2008.
51. Ungar-Sargon J. The crisis of language in therapeutic practice: integrating Wittgenstein, Heidegger, Lacan, and mystical approaches. J Behav Health. 2025; 14: 1-6.
52. Ungar-Sargon J. The third grammar: an anti-theodicy for the clinical encounter. Am J Med Clin Res Rev. 2026; 5: 1-30.
53. Ungar-Sargon J. The patient who cannot be discharged: licensed access, retrospective consent, and the ethics of release in the clinical encounter. Am J Med Clin Res Rev. 2026; 5: 1-21.
54. Mol A. The body multiple: ontology in medical practice. Durham (NC): Duke University Press. 2002.
55. Mol A. The logic of care: health and the problem of patient choice. London: Routledge. 2008.
56. Mol A, Moser I, Pols J. Care in practice: on tinkering in clinics, homes and farms. Bielefeld: transcript. 2010.
57. Ungar-Sargon J. Worn out philosophical ideas still pervade the practice of medicine: the Cartesian split lives on. Int J Phys Med Rehabil. 2024; 1: 1-10.
58. Ungar-Sargon J. Beyond the Cartesian split: the dreambody approach to chronic pain and healing. Addict Res. 2025; 9: 1-6.
59. Ungar-Sargon J. Epistemology versus ontology in therapeutic practice: the tzimtzum model and doctor-patient relationships. Adv Med Clin Res. 2025; 6: 94-101.
60. Ungar-Sargon J. Reimagining healthcare through actor-network theory: a Latourian critique of modern medical hierarchies. Am J Med Clin Sci. 2025; 10: 1-7.
61. Scheper-Hughes N, Lock MM. The mindful body: a prolegomenon to future work in medical anthropology. Med Anthropol Q. 1987; 1: 6-41.
62. Kirmayer LJ. Mind and body as metaphors: hidden values in biomedicine. Biomedicine examined. Dordrecht: Kluwer. 1988; 57-94.

63. Rosenberg CE. The tyranny of diagnosis: specific entities and individual experience. Milbank Q. 2002; 80: 237-260.

64. Kirmayer LJ. Rethinking cultural competence. Transcult Psychiatry. 2012; 49: 149-164.

65. Kirmayer LJ. Broken narratives. In: Healing and the invention of metaphor: toward a poetics of illness experience. Cambridge: Cambridge University Press. 2025; 61-85.

66. Kirmayer LJ. Cultural poetics of illness and healing. Transcult Psychiatry. 2023; 60: 753-769.

67. Gómez-Carrillo A, Kirmayer LJ, Aggarwal NK, Bhui KS, Fung KP, et al. Integrating neuroscience in psychiatry: a cultural-ecosocial systemic approach. Lancet Psychiatry. 2023; 10: 296-304.

68. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): American Psychiatric Publishing. 2013.

69. Lewis-Fernández R, Aggarwal NK, Hinton L, Hinton DE, Kirmayer LJ. DSM-5 handbook on the cultural formulation interview. Washington (DC): American Psychiatric Publishing. 2016.

70. Lewis-Fernández R, Aggarwal NK, Bäärnhielm S, Rohlof H, Kirmayer LJ, et al. Culture and psychiatric evaluation: operationalizing cultural formulation for DSM-5. Psychiatry. 2014; 77: 130-154.

71. Aggarwal NK, Jarvis GE, Gómez-Carrillo A, Kirmayer LJ, Lewis-Fernández R. The Cultural Formulation Interview since DSM-5: prospects for training, research, and clinical practice. Transcult Psychiatry. 2020; 57: 496-514.

72. Ungar-Sargon J. Presence within and beyond words: sacred listening as experiential encounter. Am J Med Clin Sci. 2025; 10: 1-7.

73. Ungar-Sargon J. Religious trauma and the hermeneutic clinical encounter: from modern scholarship to an integrated recovery-informed framework. Biomed J Sci Tech Res. 2026; 65: 57897-57909.

74. Ungar-Sargon J. Spiritual crisis and the crisis of psychiatry: rethinking diagnosis at the intersection of madness and meaning. British Society for the Contemplation of Religion. 2025; 7: 27-42.

75. Ungar-Sargon J. Beyond race: toward an ethically integrated model of healthcare justice. Int J Psychiatry. 2025; 10: 1-6.

76. Frank AW. The wounded storyteller: body, illness, and ethics. Chicago: University of Chicago Press. 1995.

77. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, et al. The CARE guidelines: consensus-based clinical case reporting guideline development. J Med Case Rep. 2013; 7: 223.

78. Ungar-Sargon J. From anonymity to identity: reimagining medical education through the lens of names and narratives. Am J Med Clin Res Rev. 2025; 4: 1-25.

79. Ungar-Sargon J. Self-kenosis and the hermeneutic clinician. Am J Med Clin Res Rev. 2026; 5: 1-19.

80. Ungar-Sargon J. The last council of myth: Sussex, 1993, and the long formation of a hermeneutic medicine. Am J Med Clin Res Rev. 2026; 5: 1-20.

81. Weiner SJ, Schwartz A. Contextual errors in medical decision making: overlooked and understudied. Acad Med. 2016; 91: 657-662.

82. Ungar-Sargon J. Capitalism and health care: a critique. Jpn J Med Sci. 2024; 5: 174-184.

83. Ungar-Sargon J. A healing space for caregiver and patient: a novel therapeutic clinic model integrating holistic healing principles. Med Clin Case Rep. 2025; 5: 1-11.

84. Ungar-Sargon J. Eastern religious symbols in therapeutic practice: transcending epistemological categories for ontological transformation. J Pharmaqube. 2025; 1: 1-20.

85. Ungar-Sargon J. Spiritual pathways to healing: an integration of Alcoholics Anonymous's Twelve Steps and Ramchal's Mesilat Yesharim in contemporary therapeutic practice. J Relig Theol. 2025; 7: 24-34.

86. Ungar-Sargon J. When the body breaks: a four-dimensional case study in embodied theology and the wounded healer. Am J Neurol Res. 2025; 4: 1-6.

87. Ungar-Sargon J. The blessing of dementia: a neurologist's theological and clinical meditation on forgetting as sacred return. Neurol Neurosci. 2025; 6: 044.

88. Ungar-Sargon J. The blessing of memory loss: toward a sacred phenomenology of forgetting. Int J Res Phys Med Rehabil. 2026; 4: 1-9.

89. Ungar-Sargon J. Patient autonomy and co-creation: evidence-based approaches to designing healing environments. J Psychol Neurosci. 2025; 7: 1-9.

90. Ungar-Sargon J. When the healer mourns: physician grief after a patient's death. Trends Gen Med. 2025; 3: 1-10.

91. Ungar-Sargon J. The sacred temporality of healing: solitude, embodied presence, and the physician as witness. Am J Med Clin Res Rev. 2025; 4: 1-16.

92. Ungar-Sargon JY. The sacred epistemology of not-knowing: uncertainty and doubt as foundations for humility in medicine and religion. Clin Rev Cases. 2026; 8: 1-8.

93. Ungar-Sargon J. The science of interoception and unconscious bias in healthcare: a call for embodied clinical practice. Neurol Neurosci. 2025; 6: 026.