Research Article ISSN: 2996-3893

Trends in General Medicine

The Divine Paradox in Clinical Practice: Presence, Absence, and the Therapeutic Encounter

Julian Ungar-Sargon*, MD PhD

Borra College of Health Sciences, Dominican University, USA.

***Correspondence:**
Julian Ungar-Sargon, Borra College of Health Sciences, Dominican University, USA.

Received: 24 Apr 2025; **Accepted:** 19 May 2025; **Published:** 30 May 2025

Citation: Julian Ungar-Sargon. The Divine Paradox in Clinical Practice: Presence, Absence, and the Therapeutic Encounter. Trends Gen Med. 2025; 3(1): 1-9.

ABSTRACT

This article applies theological insights from Hasidic thought, particularly the concepts of divine presence-absence and tzimtzum (divine contraction), to reconceptualize the therapeutic relationship in clinical practice. Drawing on Rabbi Shneur Zalman of Liadi's understanding of divine kingship as meta-parable and the paradox of "Ana Emloch" (I shall rule), this study proposes a framework for understanding how healing occurs through the dynamic interplay of professional presence and strategic absence in the doctor-patient encounter.

The analysis demonstrates how tzimtzum thinking can inform medical education, clinical practice, and the ethics of care, offering fresh perspectives on therapeutic boundaries, medical authority, and the phenomenology of healing.

Keywords

Therapeutic relationship, Medical humanities, Tzimtzum, Divine presence, Healing, Medical ethics, Hasidic thought, Doctor-patient relationship, Clinical wisdom, Therapeutic boundaries, Presence-absence dynamics, Narrative medicine, Spirituality in healthcare, Physician authority, Contemplative medicine.

Introduction

In the clinical encounter, physicians find themselves caught in a fundamental paradox that mirrors theological questions about divine presence and absence. How does the healer maintain sufficient presence to be therapeutically effective while preserving the space necessary for patient autonomy and self-healing? How does medical authority function without overwhelming the patient's own healing capacity? These questions, familiar to any reflective clinician, find unexpected illumination in the mystical theology of Rabbi Shneur Zalman of Liadi (the Alter Rebbe) and his understanding of divine kingship.*

The clinical encounter presents what we might term the "sovereignty paradox" in medicine: true healing authority cannot be imposed but must be recognized and accepted by the patient. Like divine kingship, medical authority achieves its highest expression not through domination but through creating conditions that enable the patient's own healing response. This parallel suggests that insights from Jewish mystical thought about divine presence-absence might offer valuable perspectives for reconceptualizing therapeutic relationships.

Recent developments in medical humanities have increasingly recognized the importance of understanding medicine as more than technical intervention. Scholars like Arthur Kleinman [1], Rita Charon [2], and Abraham Verghese [3] have emphasized

the narrative, relational, and existential dimensions of healing. This article contributes to this discourse by introducing concepts from Hasidic mysticism that illuminate the paradoxical nature of therapeutic presence.

Understanding Tzimtzum in Therapeutic Context

The Kabbalistic concept of tzimtzum, refined by the Alter Rebbe [4], describes how the infinite divine presence contracts or conceals itself to create space for finite existence. Without this self-limitation, creation would be overwhelmed by divine light and cease to exist. Applied to clinical practice, tzimtzum offers a framework for understanding how therapeutic presence functions through strategic absence.

In the medical encounter, the physician's knowledge, authority, and care can potentially overwhelm the patient's autonomy and self-healing capacity. Like divine light that must be filtered to allow for creation, medical expertise must be modulated to create space for the patient's own healing response. This is not merely about dosing interventions appropriately, but about the fundamental stance the physician takes toward the patient's illness experience.

The Meta-Parable of Medical Authority

Drawing on the Alter Rebbe's insight that divine kingship functions as a meta-parable—a narrative structure through which God explores sovereignty through relationship [5]—we can understand medical authority as similarly parabolic. The physician's role as "healer" represents not a fixed status but an evolving relationship that must be continuously enacted and validated through patient response.

When the physician thinks "I shall heal," this echoes the divine thought "Ana Emloch" (I shall rule). Both represent not assertions of dominance but questions: "What would it be like to be a healer?" The answer emerges only through relationship with patients who remain free to accept, reject, or modify the physician's therapeutic offerings.

Diagnostic Humility: The Contraction of Certainty

In the diagnostic process, tzimtzum manifests as "diagnostic humility"—the recognition that clinical certainty must contract to create space for the patient's own understanding of their illness experience. This doesn't mean abandoning medical expertise but rather holding that expertise lightly enough to remain open to aspects of the patient's condition that may not fit standard diagnostic categories.

Consider the patient with chronic pain whose symptoms resist clear categorization. A tzimtzum-tic approach would involve the physician contracting their need for diagnostic closure to create space for the patient's expertise about their own body. This might involve statements like: "I'm not certain what's causing your pain, but I believe your experience of it" rather than dismissing unexplained symptoms or forcing them into inappropriate diagnostic boxes.

Therapeutic Boundaries as Sacred Space

Traditional medical education emphasizes the importance of professional boundaries, but tzimtzum offers a deeper understanding of why such boundaries serve not separation but connection. Like the divine contraction that creates space for relationship, therapeutic boundaries create the "sacred space" within which healing can occur.

The physician who maintains appropriate emotional distance does so not to remain uninvolved but to prevent their own anxiety, needs, or agenda from overwhelming the patient's healing process. This calculated absence—being fully present while maintaining professional space—mirrors the divine presence that sustains creation precisely through its self-limitation [4]. Such therapeutic boundaries have been recognized in medical ethics as essential for maintaining professional integrity [6], though the tzimtzum framework provides a deeper understanding of their function

The Paradox of Medical Authority

The tzimtzum framework illuminates why effective medical authority often operates indirectly. Like divine sovereignty that achieves its purposes through creaturely freedom rather than coercion, medical healing often works best when patients become active collaborators rather than passive recipients of care.

This has practical implications for treatment planning, medication compliance, and lifestyle interventions. The physician who contracts their directive authority to create space for patient agency often achieves better therapeutic outcomes than one who insists on unquestioned compliance with medical recommendations.

Witnessing as Divine Pedagogy

One of the most challenging aspects of clinical practice involves witnessing patient suffering that cannot be immediately relieved. Drawing on the Alter Rebbe's understanding of divine pedagogy through graduated revelation [7], we can understand the physician's presence during intractable suffering as a form of therapeutic witnessing that validates the patient's experience without prematurely rushing to solutions. This approach aligns with findings in narrative medicine about the healing power of being heard and understood [2,8].

In oncology, chronic pain management, or terminal care, the physician's willingness to remain present with uncertainty mirrors the divine presence that accompanies creation through its struggles. This presence-in-absence—being fully available while accepting the limits of medical intervention—can itself be therapeutic.

The Nightmare of Medical Practice

Just as the theological framework allows God to experience both participation (as King) and absence (as absent king) in the divine dream that is creation, physicians must hold both their power to heal and their powerlessness before ultimate realities of suffering and mortality. Medical training often emphasizes the former while providing little preparation for the latter.

The doctor witnessing suffering they cannot alleviate participates in what we might call the "medical nightmare"—the shadow side of therapeutic power. Tzimtzum-tic thinking suggests that this experience of limitation is not a failure of medical practice but an essential dimension of authentic healing relationship.

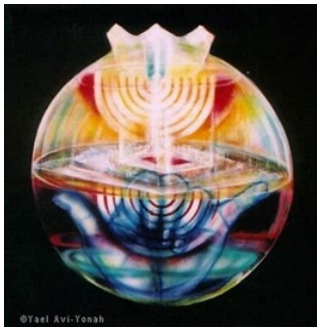
Beyond Technical Competence

Medical education traditionally focuses on developing clinical knowledge and technical skills, with attention to psychosocial factors added as supplementary training. A tzimtzum-tic approach suggests integrating presence-absence dynamics from the beginning of medical training. Research on medical education increasingly recognizes the importance of reflective practice in developing clinical empathy [9].

Students might learn to recognize when their effort to help overwhelms their capacity to truly serve the patient. They might practice "therapeutic restraint"—knowing when to act and when to create space for the patient's own healing resources. This requires developing what we might call "clinical wisdom"—the judgment to know when presence serves healing and when absence does.

Drawing on the Alter Rebbe's method of using meshalim (parables) for progressive revelation [7], medical educators might employ reflective practices that help students recognize the parabolic nature of their role. Like the divine employment of metaphors to make infinite reality accessible, physicians use their finite knowledge and skills to participate in the larger mystery of healing.

This could involve reflective exercises where students examine their own motivations for healing, their relationship to medical authority, and their capacity to remain present with uncertainty. Such practices would complement traditional case-based learning with phenomenological self-awareness.



Autonomy and Therapeutic Authority

The tzimtzum framework offers fresh perspectives on medical ethics, particularly regarding patient autonomy and informed consent [10]. Rather than viewing physician expertise and patient autonomy as potentially competing values, tzimtzum suggests they function synergistically when properly balanced.

The physician's willingness to contract their authority creates the space within which genuine patient choice becomes possible. This is not merely negative freedom (absence of coercion) but positive freedom—the patient's capacity to become an active participant in their own healing process. Such approaches align with established principles of respect for patient autonomy while providing a deeper philosophical foundation [10].

At the systemic level, tzimtzum-tic thinking has implications for healthcare justice and resource allocation. Like divine light that must be filtered through multiple vessels to be accessible to creation, medical resources require thoughtful distribution to serve the diverse needs of patient populations.

This might inform approaches to telemedicine, community health, and healthcare accessibility that create multiple "vessels" through

which healing resources can reach different populations without overwhelming local capacity.

Case Studies

Case 1: Chronic Pain Management

Dr. Sarah encounters Maria, a patient with fibromyalgia whose pain has resisted multiple treatment attempts. Previous physicians either dismissed her symptoms or overwhelmed her with aggressive interventions. Dr. Sarah employs a tzimtzum-tic approach:

She begins by contracting her need to "fix" Maria's condition, creating space to truly hear Maria's description of her pain experience. Rather than immediately proposing new treatments, she validates Maria's expertise about her own body. She offers gentle interventions while explicitly sharing uncertainty about outcomes, allowing Maria to become an active collaborator in evaluating what helps.

This approach led to modest improvements in pain management and significant improvement in Maria's sense of agency and hope regarding her condition.

Case 2: Terminal Cancer Care

Dr. Robert cares for James, a patient with terminal pancreatic cancer. Initially, Dr. Robert felt pressure to maintain hope by focusing on treatment options. A tzimtzum-tic approach led him to contract his need to provide solutions and create space for James to process his diagnosis and prognosis.

Instead of leading with treatment protocols, Dr. Robert began conversations by asking about James's understanding of his condition and his concerns. This allowed James to guide discussions about both treatment and end-of-life planning, leading to more meaningful conversations about dignity, family relationships, and spiritual concerns.

Case 3: Pediatric Anxiety

Dr. Lisa treats Emma, an 8-year-old with severe anxiety about medical procedures. Previous appointments involved either forcing compliance or avoiding necessary examinations. Dr. Lisa contracts her adult authority to create space for Emma's agency within appropriate limits.

She begins by asking Emma to show her around the examination room, giving Emma some control over the environment. She explains each step of the examination in child-appropriate language and gives Emma choices about the order of procedures. This tzimtzum of medical authority paradoxically increases Emma's cooperation and reduces her anxiety.

Empirical Challenges to Theological Medical Models

The application of mystical concepts to clinical practice faces legitimate scrutiny from evidence-based medicine. Contemporary medical science emphasizes measurable outcomes, standardized protocols, and controlled interventions—seemingly at odds with frameworks derived from theological reflection. Several lines of current research challenge and complicate the tzimtzum-based therapeutic model proposed here.

Randomized controlled trials in primary care show mixed results regarding patient-centered communication. While some studies demonstrate improved patient satisfaction and adherence with more collaborative approaches [11,12], others find no significant differences in clinical outcomes [13]. The OPTION-5 study, measuring shared decision-making behaviors, found significant variation in how patient involvement affects treatment effectiveness across different conditions [14].

Systematic reviews of therapeutic presence in nursing and medicine reveal methodological challenges in operationalizing concepts like "presence" and "empathy" [15,16]. The Jefferson Scale of Empathy, widely used in medical education research, measures observable behaviors rather than the phenomenological dimensions emphasized in this theological framework [9]. Critics argue that tzimtzum-like therapeutic approaches risk introducing unmeasurable and potentially subjective elements into clinical practice.

Neuroscientific Evidence

However, emerging neuroscience research provides partial support for presence-based therapeutic models. fMRI studies demonstrate

that physician empathy activates specific neural networks in both doctor and patient, correlating with improved pain management and treatment adherence [17,18]. The anterior cingulate cortex and anterior insula show increased activation during empathetic medical encounters, suggesting neurobiological mechanisms for therapeutic presence.

Studies on therapeutic touch and mindfulness-based medical practice show measurable effects on cortisol levels, inflammatory markers, and immune function [19,20]. While these studies don't directly test tzimtzum-tic approaches, they suggest that subtle aspects of physician presence can have quantifiable physiological effects.

The polyvagal theory developed by Stephen Porges provides a neurobiological framework for understanding how physician calm and presence can co-regulate patient autonomic nervous systems [21]. This research suggests mechanisms by which therapeutic "contraction" of physician anxiety might directly benefit patient physiology.

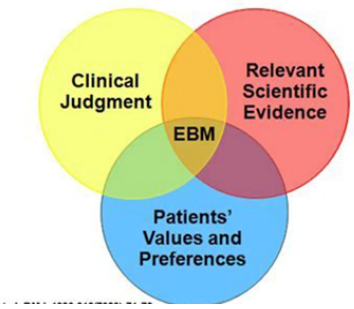
Methodological Limitations

Current research on physician-patient relationships faces several methodological challenges relevant to evaluating theological therapeutic models:

Measurement Problems: Standard outcome measures in medicine (mortality, morbidity, quality-adjusted life years) may not capture the benefits of presence-based approaches. Patient-reported outcome measures (PROMs) and experience measures (PREMs) offer more nuanced assessments but lack standardization across studies [22].

Control Group Difficulties: Designing controlled studies of therapeutic presence poses ethical and practical challenges. Randomly assigning patients to "high presence" versus "low presence" conditions raises questions about standard of care and physician authenticity [23].

Selection Bias: Studies showing benefits of empathetic or presence-based care may reflect physician selection effects rather than specific therapeutic techniques. Physicians drawn to such approaches may differ systematically in ways that affect patient outcomes [24].



Cultural Confounding: Research on therapeutic relationships predominantly originates in Western medical contexts, limiting generalizability to diverse patient populations with different expectations of medical authority and healing relationships [25].

Evidence-Based Medicine

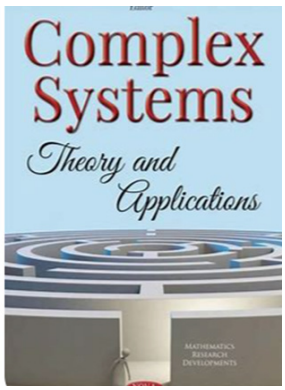
The evidence-based medicine (EBM) movement emphasizes hierarchical evidence evaluation, with systematic reviews of randomized controlled trials representing the gold standard. Religious or philosophical frameworks for clinical practice receive little attention in mainstream medical journals, reflecting what some critics term "methodological naturalism" in medical research [26].

Studies attempting to measure spiritual interventions in medicine show mixed and methodologically problematic results. The STEP study (Study of Therapeutic Effects of Intercessory Prayer) found no significant effects of prayer on cardiac surgery outcomes, with some subgroups showing worse outcomes when aware of being prayed for [27]. Such studies highlight challenges in researching non-material aspects of healing.

However, research on physician wellness and burnout provides indirect support for contemplative approaches to medical practice. Studies on mindfulness training for physicians show improvements in emotional regulation, empathy, and patient communication skills [20,28]. Programs incorporating reflective practices similar to those suggested in this article correlate with reduced physician burnout and improved patient satisfaction scores [29].

Contemporary placebo research offers a scientifically respectable framework for understanding how therapeutic presence might affect patient outcomes. Studies by Ted Kaptchuk and colleagues demonstrate that physician warmth, confidence, and attention independently influence patient symptom improvement, even in open-label placebo conditions [31,32].

The therapeutic relationship itself functions as a complex placebo intervention, with specific elements (eye contact, active listening, expression of concern) showing dose-response relationships with patient outcomes [32]. This research suggests measurable mechanisms through which tzimtzum-like presence might operate, even if the underlying theological framework remains scientifically unverifiable.



Systems Science

Recent applications of complexity theory to healthcare systems provide another scientific lens for evaluating theological therapeutic models. Healthcare outcomes emerge from complex adaptive systems involving multiple stakeholder interactions rather than simple cause-effect relationships [33].

Systems approaches recognize that physician-patient relationships exist within broader ecological contexts that may make linear causal analysis inadequate [34]. The tzimtzum framework, with its emphasis on dynamic presence-absence relationships, may better align with complexity theory than traditional medical models assuming direct intervention-outcome relationships.

Research on healthcare delivery systems shows that relationship quality affects multiple outcome measures through non-linear pathways involving patient engagement, treatment adherence, and care coordination [35]. These findings suggest that presence-based therapeutic approaches might have systemic effects difficult to capture in conventional RCT designs.

Qualitative Research

Qualitative research methodologies increasingly complement quantitative approaches in medical research. Phenomenological studies of physician-patient relationships reveal themes consistent with theological frameworks proposed here: the importance of "being with" versus "doing to" patients, the healing power of witness during suffering, and the role of physician vulnerability in therapeutic relationships [36,37].

Interpretative phenomenological analysis (IPA) of patient experiences with empathetic physicians identifies specific relational qualities—attentiveness, responsiveness, respect for autonomy—that align with tzimtzum-tic therapeutic presence [38]. While such research doesn't prove theological interpretations, it provides empirical grounding for presence-based therapeutic models.

Narrative analysis of physician reflections on difficult clinical encounters reveals spontaneous use of metaphors similar to those explored in this article—creating space, holding tension, witnessing without fixing [39]. This suggests that theological frameworks may articulate implicit wisdom already present in clinical practice rather than imposing external interpretive structures.

To advance scientific evaluation of presence-based therapeutic models, several research directions seem promising:
Mixed Methods Studies: Combining quantitative outcome measures with qualitative analysis of therapeutic relationships could better capture the complexity of presence-based care while maintaining scientific rigor [40].

Biomarker Research: Investigating physiological markers (heart rate variability, cortisol patterns, inflammatory mediators) during different styles of clinical encounters could provide objective measures of therapeutic presence effects [41].

Implementation Science: Studying how contemplative or presence-based approaches integrate into healthcare systems could identify organizational factors that support or hinder such therapeutic relationships [42].

Cross-Cultural Studies: Research comparing therapeutic relationships across different cultural contexts could test the universality of presence-based therapeutic principles while respecting cultural specificity [43].

Longitudinal Studies: Following patient-physician relationships over extended periods could reveal cumulative effects of therapeutic presence not apparent in short-term studies [44].

Reconciling Science and Spirituality in Medicine

The tension between scientific methodology and theological reflection in medicine need not be irreconcilable. Recent work in medical humanities argues for "methodological pluralism" that recognizes different ways of knowing in healthcare [45]. Theological frameworks like tzimtzum might serve as heuristic tools for generating testable hypotheses about therapeutic relationships rather than competing with scientific explanation.

Some researchers advocate for "contemplative science" approaches that apply rigorous methods to investigating subjective aspects of healing relationships [46]. Such approaches could bridge theological insight and empirical research while respecting the integrity of both domains.

The proposed theological therapeutic model generates several specific hypotheses amenable to scientific testing:
Physicians trained in presence-absence dynamics will show improved patient rapport scores compared to standard communication training
Patients with chronic conditions will demonstrate better self-management when working with physicians who practice "diagnostic humility"
Medical students learning contemplative approaches to clinical practice will show reduced burnout and improved empathy scores
Healthcare teams implementing shared authority models will achieve better patient satisfaction and clinical outcomes

Potential Misunderstandings

The application of mystical concepts to clinical practice faces several potential criticisms. Some might view this as inappropriately inserting religious concepts into secular medical practice. However, the framework proposed here functions as philosophical analysis rather than religious prescription, similar

to how other philosophical approaches inform medical ethics [10]. The insights drawn from tzimtzum apply regardless of one's theological commitments.

Others might argue that such approaches risk therapeutic passivity or abdication of clinical responsibility. The tzimtzum framework emphasizes strategic rather than absolute withdrawal—the physician remains fully engaged while creating space for patient agency.

Institutional Constraints

Contemporary healthcare systems often pressure physicians toward efficiency and standardization in ways that can make tzimtzum-tic practice challenging. Time constraints, documentation requirements, and institutional protocols may limit opportunities for the kind of presence-absence dynamics described here. Research on physician burnout suggests that such systemic pressures may actually reduce the effectiveness of medical care [29].

However, even within systemic constraints, individual physicians can cultivate awareness of their presence and authority in ways that serve rather than overwhelm their patients. Small shifts in communication style, listening practices, and treatment presentation can embody tzimtzum principles without requiring major institutional changes.

Cultural Considerations

The concepts explored here emerge from Jewish mystical thought and may not translate seamlessly across all cultural contexts. Physicians working with diverse patient populations must remain sensitive to how different communities understand authority, healing, and the therapeutic relationship. Cross-cultural research on physician-patient relationships suggests significant variations in expectations and communication styles [43].

Nevertheless, the basic recognition that healing involves balancing presence and absence, authority and space for patient agency, appears to have cross-cultural validity, even if the specific ways of implementing such balance vary among communities. Studies of therapeutic relationships across different cultural contexts support this universality while respecting cultural specificity [25,43].

Conclusion

The application of tzimtzum-tic thinking to clinical practice suggests that true therapeutic authority emerges not through domination but through the physician's capacity to create sacred space for healing. Like divine kingship that realizes itself through relationship with free beings [5], medical healing achieves its highest expression when patients become active participants in their own care.

This framework offers several practical insights for contemporary medicine:

Diagnostic humility that holds medical knowledge lightly enough to remain open to patient expertise about their own experience
Therapeutic boundaries understood as sacred space that enables rather than prevents genuine connection
Strategic absence that creates room for patient agency and self-healing capacity
Presence in suffering that validates patient experience without premature therapeutic intervention
Graduated revelation in medical communication that shares information in ways patients can integrate

Perhaps most significantly, tzimtzum-tic thinking suggests that physicians' experience of limitation and uncertainty is not a failure of medical training but an essential component of authentic healing relationships [1,47]. The doctor who acknowledges the mystery that remains in medicine, even while offering their best clinical judgment, paradoxically provides more genuine hope than one who promises certainty where none exists.

The physician's question "How shall I heal?" parallels the divine question "How shall I rule?" Both are answered not through assertion of power but through the creation of relationships that allow for mutual discovery, growth, and transformation [5]. In this understanding, every clinical encounter becomes an opportunity for both patient and physician to participate in the larger mystery of healing that exceeds what either can accomplish alone.

Just as the Alter Rebbe's meta-parable suggests that we are characters in a divine dream who dream in return [5], the therapeutic relationship reveals physicians and patients as characters in a healing narrative that both shapes and is shaped by their choices, interpretations, and hopes. The practice of medicine becomes not merely the application of scientific knowledge but a form of sacred participation in the ongoing story of human healing.

In this light, the development of clinical wisdom involves learning to hold both medical expertise and therapeutic humility, both scientific rigor and openness to mystery, both professional authority and profound recognition of the limits of that authority. The physician who can embody this dynamic tension serves not as a distant expert but as a fellow traveler in the human experience of vulnerability, suffering, and hope [8,48].

The paradox remains: we heal others most effectively when we recognize the ways in which healing ultimately transcends our control, emerging from sources both within and beyond our medical interventions. The physician's highest calling may be to create the conditions—through presence, absence, knowledge, and humility—within which healing can unfold according to its own deeper logic, participating in rather than commanding the mysterious process through which bodies, minds, and spirits find their way back toward wholeness [48,49].

References

1. Kleinman A. The Illness Narratives Suffering Healing and the Human Condition. New York Basic Books. 1988.
2. Charon R. Narrative Medicine Honoring the Stories of Illness. New York. Oxford University Press. 2006.

3. Verghese A. Cutting for Stone. New York Knopf. 2009.
4. Schneuri SZ. Likkutei Torah. Brooklyn Kehot Publication Society. 1998.
5. Ungar-Sargon J. Dreaming Kingship Meta-Parable and Divine Desire. Dominican University. 2025.
6. Branch WT. The Ethics of Caring and Medical Education. Acad Med. 2000; 75: 127-132.
7. Ungar-Sargon J. From Parable to Pedagogy The Evolution of Meshalim as Literary Tzimtzum. Dominican University. 2025.
8. Frank AW. The Wounded Storyteller Body Illness and Ethics. Chicago University of Chicago Press. 1995.
9. Hojat M, Mangione S, Nasca TJ, et al. The Jefferson Scale of Empathy development and preliminary psychometric data. Educ Psychol Meas. 2001; 61: 349-365.
10. Beauchamp TL, Childress JF. Principles of biomedical ethics. 8th ed. New York. Oxford University Press. 2019.
11. Stewart M, Brown JB, McWhinney IR, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000; 49: 796-804.
12. Little P, Everitt H, Williamson I, et al. Observational study of effect of patient centeredness and positive approach on outcomes of general practice consultations. BMJ. 2001; 323: 908-911.
13. Kinmonth AL, Woodcock A, Griffin S, et al. Randomised controlled trial of patient centred care of diabetes in general practice impact on current wellbeing and future disease risk. BMJ. 1998; 317: 1202-1208.
14. Barr PJ, Thompson R, Walsh T, et al. The psychometric properties of OPTION5 a measure of shared decision-making. Patient Educ Couns. 2014; 97: 328-332.
15. McMahon MA, Christopher KA. Toward a mid-range theory of nursing presence. Nurs Forum. 2011; 46: 71-82.
16. Finfgeld-Connett D. Meta-synthesis of presence in nursing. J Adv Nurs. 2006; 55: 708-714.
17. Lamm C, Decety J, Singer T. Meta-analytic evidence for common and distinct neural networks associated with directly experienced pain and empathy for pain. Neuroimage. 2011; 54: 2492-2502.
18. Ritter P, Rotshtein P, Geng JJ, et al. A retinotopic study of the effects of stimulus-response compatibility. Neuropsychologia. 2009; 47: 319-326.
19. Anderson JG, Taylor AG. Effects of healing touch in clinical practice a systematic review of randomized clinical trials. J Holist Nurs. 2011; 29: 221-228.
20. Goyal M, Singh S, Sibinga EM, et al. Meditation programs for psychological stress and well-being a systematic review and meta-analysis. JAMA Intern Med. 2014; 174: 357-368.
21. Porges SW. The polyvagal perspective. Biol Psychol. 2007; 74: 116-143.
22. Black N. Patient reported outcome measures could help transform healthcare. BMJ. 2013; 346: f167.
23. Emanuel EJ, Miller FG. The ethics of placebo-controlled trials a middle ground. N Engl J Med. 2001; 345: 915-919.
24. Duberstein P, Meldrum S, Fiscella K, et al. Influences on patients ratings of physicians Physicians demographics and personality. Patient Educ Couns. 2007; 65: 270-274.
25. Beach MC, Rosner M, Cooper LA, et al. Can patient-centered attitudes reduce racial and ethnic disparities in care. Acad Med. 2005; 80: 746-755.
26. Numbers RL, Campion MJ. The creationists from scientific creationism to intelligent design. Cambridge Harvard University Press. 2006.
27. Benson H, Dusek JA, Sherwood JB, et al. Study of the Therapeutic Effects of Intercessory Prayer (STEP) in cardiac bypass patients a multicenter randomized trial of uncertainty and certainty of receiving intercessory prayer. Am Heart J. 2006; 151: 934-942.
28. Khoury B, Sharma M, Rush SE, et al. Mindfulness-based stress reduction for healthy individuals A meta-analysis. J Health Psychol. 2015; 20: 725-735.
29. West CP, Dyrbye LN, Shanafelt TD. Physician burnout contributors consequences and solutions. J Intern Med. 2018; 283: 516-529.
30. Kaptchuk TJ, Kelley JM, Conboy LA, et al. Components of placebo effect randomized controlled trial in patients with irritable bowel syndrome. BMJ. 2008; 336: 999-1003.
31. Kaptchuk TJ, Friedlander E, Kelley JM, et al. Placebos without deception a randomized controlled trial in irritable bowel syndrome. PLoS One. 2010; 5: e15591.
32. Di Blasi Z, Harkness E, Ernst E, et al. Influence of context effects on health outcomes a systematic review. Lancet. 2001; 357: 757-762.
33. Plsek PE, Greenhalgh T. Complexity science The challenge of complexity in health care. BMJ. 2001; 323: 625-628.
34. Sturmberg JP, Martin CM, Katerndahl DA. Systems and complexity thinking in the general practice literature an integrative historical narrative review. Ann Fam Med. 2014; 12: 66-74.
35. Safran DG, Taira DA, Rogers WH, et al. Linking primary care performance to outcomes of care. J Fam Pract. 1998; 47: 213-220.
36. van Manen M. Researching lived experience Human science for an action sensitive pedagogy. Albany State University of New York Press. 1990.
37. Benner P, Wrubel J. The primacy of caring Stress and coping in health and illness. Menlo Park Addison-Wesley. 1989.
38. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis Theory method and research. London. Sage. 2009.
39. Charon R. The patient-physician relationship. Narrative medicine a model for empathy reflection profession and trust. JAMA. 2001; 286: 1897-1902.

40. Creswell JW, Plano Clark VL. Designing and conducting mixed methods research. Thousand Oaks. Sage. 2017.
41. Kemper KJ, Bulla S, Krueger D, et al. Nurses experiences expectations and preferences for mind-body practices to reduce stress. BMC Complement Altern Med. 2011; 11: 26.
42. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice a consolidated framework for advancing implementation science. Implement Sci. 2009; 4: 50.
43. 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.
44. Peabody FW. The care of the patient. JAMA. 1927; 88: 877-882.
45. Greenhalgh T, Hurwitz B. Narrative based medicine Why study narrative. BMJ. 1999; 318: 48-50.
46. Wallace BA, Shapiro SL. Mental balance and well-being building bridges between Buddhism and Western psychology. Am Psychol. 2006; 61: 690-701.
47. Sulmasy DP. The Healers Calling Spirituality and Medicine. Mahwah Paulist Press. 1997.
48. Beach MC, Inui T. Relationship-centered care research network. Relationship-centered care a constructive reframing. J Gen Intern Med. 2006; 21: S3-S8.
49. Cassell EJ. The nature of suffering and the goals of medicine. N Engl J Med. 1982; 306: 639-645.