

The Epistemology of Clinical Judgment: Language, Power, and the Social Construction of Medical Knowledge

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ABSTRACT

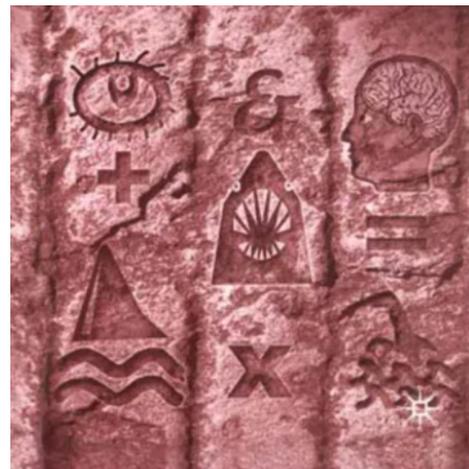
Medical diagnosis represents a complex epistemological practice that simultaneously produces scientific knowledge and exercises social power. This essay examines how clinical language constructs reality, shapes professional authority, and mediates the relationship between physician expertise and patient experience. Drawing extensively on Jerome Groopman's empirical studies of diagnostic reasoning, Michel Foucault's archaeology of medical discourse, Thomas Szasz's critique of psychiatric classification, and the medical sociology of Arthur Kleinman, Byron Good, Margaret Lock, and Eliot Freidson, alongside Julian Ungar-Sargon's hermeneutic and theological frameworks for therapeutic practice, this analysis reveals that medical epistemology is inseparable from questions of linguistic power, professional monopoly, and the moral dimensions of illness. The essay argues that understanding medicine's way of knowing requires examining not only its scientific methods but also its discursive practices, institutional structures, and the social processes through which certain forms of knowledge gain authority while others are marginalized.

Keywords

Medical epistemology, Clinical judgment, Diagnostic reasoning, Hermeneutic medicine, Medical language, Professional power, Illness narratives, Epistemic injustice, Kabbalistic hermeneutics, Therapeutic encounter, Sacred listening, Patient-centered care, Medical anthropology, Psychiatric classification, Tzimtzum model.

Introduction

Every clinical encounter involves an epistemological transaction. A patient presents symptoms; a physician interprets signs. Between the subjective experience of suffering and the objective language of pathology lies a complex process of translation, one that shapes not merely diagnosis but the very nature of illness itself. As Foucault observed, "The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time" [1]. This superimposition—the alignment of symptom, sign, and lesion—represents a particular historical formation of medical knowledge, one whose contingency we have largely forgotten.



The language physicians use to describe disease is neither transparent nor neutral. Medical terminology does not simply name pre-existing natural kinds; it actively constructs the objects

of medical knowledge. When a physician diagnoses "major depressive disorder" rather than "melancholia" or "acedia," when pain is classified as "organic" or "functional," when symptoms are deemed "medically unexplained"—these linguistic acts carry profound epistemological and ethical consequences. They determine what counts as legitimate illness, who possesses authority to speak about suffering, and which experiences merit medical attention and resources.

Jerome Groopman's clinical investigations reveal that diagnostic errors stem not primarily from insufficient knowledge but from flawed reasoning processes embedded in linguistic habits and cognitive heuristics [2]. His work demonstrates that the epistemology of medicine operates not in abstraction but through concrete practices of perception, interpretation, and judgment—all mediated by language. When combined with the sociological insights of Eliot Freidson, who examined medicine as a profession claiming monopolistic authority over a domain of knowledge [3] and the anthropological perspectives of Arthur Kleinman and Byron Good, who reveal the cultural construction of illness categories [4,5], a richer picture emerges: medical epistemology is simultaneously scientific, social, and political.

Ungar-Sargon's hermeneutic approach to medicine offers a complementary framework that challenges the presumed objectivity of biomedical epistemology [6,7]. By conceptualizing the patient as a "sacred text" requiring interpretation rather than merely a biological system to be decoded, his work bridges theological hermeneutics and clinical practice, arguing that authentic healing emerges from recognizing the interpretive dimensions inherent in all therapeutic encounters [6]. This hermeneutic turn reveals that medical knowledge is not simply discovered but co-created through the dialogical relationship between physician and patient.

This essay examines the epistemology of clinical medicine through five interconnected dimensions: (1) the historical emergence of the medical gaze and clinical language; (2) the cognitive architecture of diagnostic reasoning and its systematic errors; (3) the professional and institutional structures that shape medical knowledge; (4) the cultural construction of illness categories and the politics of classification; and (5) the patient's epistemological position and the struggle for narrative authority. Throughout, the central argument is that medical knowing cannot be separated from medical power, and that the reform of medicine requires not only better science but also more reflexive attention to the language and social practices through which medical knowledge is produced and legitimated.

The Birth of Clinical Language

Michel Foucault's archaeology of medical perception fundamentally reoriented our understanding of medical epistemology. In *The Birth of the Clinic*, Foucault traced the emergence of modern clinical medicine not as a progressive revelation of natural truths but as a specific historical configuration of knowledge and power [1]. The shift from bedside medicine to hospital-based clinical observation in the late eighteenth and early nineteenth centuries inaugurated what Foucault called "the medical gaze"—a new form of seeing

that transformed the patient from a speaking subject into a visible object.

Prior to the clinical revolution, medical knowledge centered on the patient's narrative. Physicians attended primarily to symptoms—the patient's subjective experiences and complaints. Disease existed primarily in the realm of discourse, constructed through the patient's account of suffering. The late eighteenth century witnessed a radical transformation: the emergence of pathological anatomy and the clinical-anatomical method established the corpse as the ultimate arbiter of diagnostic truth. As Foucault writes, "The living night is dissipated in the brightness of death"[1].

This transformation had profound epistemological consequences. Symptoms became secondary to signs—objective, observable phenomena accessible to medical perception. The disease entity became localized in tissue lesions rather than dispersed across the patient's narrative. Medical knowledge shifted from interpreting what patients said to observing what their bodies displayed. This new clinical epistemology privileged vision over listening, the objective over the subjective, the measurable over the meaningful.

The language of medicine changed accordingly. Latin medical terminology, abstract disease classifications, and increasingly technical vocabularies created what Foucault termed a "well-made language"—a specialized discourse that appeared to capture reality with scientific precision [1]. Yet this language also functioned as a boundary, separating those who could speak authoritatively about illness (physicians) from those who merely experienced it (patients). Medical terminology became simultaneously an instrument of knowledge and an instrument of power.

Ungar-Sargon's critique extends Foucault's analysis by arguing that the Cartesian dualism embedded in modern medical epistemology perpetuates a false dichotomy between mind and body, subjective and objective, that fundamentally distorts clinical understanding [8]. This "Cartesian split" not only fragments the patient's experience but also creates epistemic blindness to dimensions of suffering that resist quantification or objective verification [8]. His work demonstrates how overcoming this dualism requires reconceptualizing the therapeutic encounter as a hermeneutic event where meaning is co-created rather than merely discovered [6,7].

The Clinic as Disciplinary Space

Foucault's later work extended this analysis to show how medical institutions function as sites of discipline and normalization [9]. The hospital, the psychiatric asylum, and the public health clinic operate as spaces where bodies are observed, recorded, classified, and regulated. Medical records transform individual experiences into administrative data; diagnostic categories enable bureaucratic management of populations. The physician becomes not merely healer but also agent of surveillance, extending state power into the intimate realm of bodily experience.

This disciplinary function persists in contemporary medicine. Electronic health records fragment the patient's story into discrete

data fields; insurance coding systems (ICD-11, DSM-5-TR) reduce complex suffering to billable diagnoses; quality metrics and clinical pathways standardize medical judgment. Each of these practices embeds particular epistemological assumptions about what counts as medically relevant information. They privilege quantifiable data over narrative meaning, standardized categories over individual variation, administrative efficiency over clinical nuance.

Ungar-Sargon's work on evidence distortion reveals how these bureaucratic structures actively shape clinical decision-making in ways that often undermine patient welfare [10]. Drawing on research into placebo and nocebo effects, he demonstrates that the presumed objectivity of evidence-based medicine obscures how pharmaceutical industry influence, insurance protocols, and defensive medicine systematically bias prescribing practices [10]. The epistemology of modern medicine thus serves not merely scientific truth but also economic and institutional interests that frequently conflict with patient-centered care.

The Violence of Medical Naming

Foucault's work illuminates what might be called the "violence of medical naming"—the ways in which diagnostic language can silence, pathologize, and objectify. To be diagnosed is to be renamed in institutional terms. The schizophrenic, the diabetic, the cancer patient—these labels subsume personal identity under medical categories. While diagnosis can provide clarity and enable treatment, it also fixes identity and constrains possibility. The diagnostic label becomes what Pierre Bourdieu called a "symbolic violence"—an imposition of meaning that appears natural but actually reflects institutional power [11].

Contemporary medicine has largely absorbed Foucault's critique without fundamentally altering its practices. Physicians acknowledge the dehumanizing potential of medical language while continuing to use it. The tension between seeing patients as persons and seeing them as cases remains largely unresolved. As we shall see, this tension reflects deeper epistemological contradictions within medical practice itself.

The Cognitive Architecture of Clinical Judgment

Jerome Groopman's *How Doctors Think* offers a complementary perspective to Foucault's structural analysis: an empirical investigation of diagnostic reasoning as it actually occurs in clinical practice [2]. Groopman, a practicing physician and medical journalist, conducted extensive interviews with clinicians and analyzed case studies of both successful diagnoses and catastrophic errors. His work reveals that medical epistemology operates not through pure logical inference but through cognitive heuristics, emotional responses, and linguistic framing—all of which introduce systematic biases into clinical judgment.

Groopman identifies several cognitive patterns that systematically distort diagnostic reasoning:

Availability bias: Physicians tend to consider diagnoses that readily come to mind, often because of recent cases or dramatic presentations. A doctor who recently treated a pulmonary embolism

becomes more likely to suspect that diagnosis in subsequent patients with chest pain, even when other explanations are more probable [2].

Anchoring: Early in a diagnostic process, physicians form an initial hypothesis that then anchors subsequent reasoning. Contrary evidence is often assimilated to the initial diagnosis rather than prompting reconsideration. Groopman describes cases where physicians clung to initial diagnoses despite accumulating disconfirming evidence, sometimes with fatal consequences [2].

Confirmation bias: Once a diagnostic hypothesis forms, physicians selectively attend to evidence that confirms it while discounting contradictory information. This is not willful blindness but a natural consequence of how pattern recognition operates. However, it can lead to premature closure—declaring diagnostic certainty before alternative explanations have been adequately considered [2].

Attribution errors: Physicians often attribute symptoms to psychological causes or to the patient's personality rather than investigating biological explanations. This is particularly common with patients who are anxious, "difficult," or who have psychiatric histories. Groopman documents cases where physicians dismissed organic disease as anxiety or somatization, sometimes with tragic results [2].

Commission and omission bias: Physicians may be more inclined toward action (commission) or inaction (omission) depending on their training, personality, and institutional culture. Some doctors order excessive tests to avoid missing diagnoses; others maintain "watchful waiting" even when intervention is needed. Both patterns can lead to errors, yet medical culture often privileges action over restraint [2].

Ungar-Sargon's analysis of intuition and imagination in clinical decision-making extends Groopman's cognitive framework by arguing that effective diagnosis requires not merely logical deduction but also what he terms "clinical imagination"—the capacity to envision alternative possibilities and hold multiple interpretations simultaneously [12]. This imaginative capacity, he argues, is systematically undermined by the reductionist training physicians receive, which privileges algorithmic thinking over hermeneutic flexibility [12].

Groopman's most significant contribution to epistemology lies in his analysis of how language shapes diagnostic reasoning. Medical terminology is not merely descriptive; it actively structures perception and constrains inquiry.

Consider the term "functional disorder." When physicians diagnose functional abdominal pain or functional headache, the term "functional" implies absence of organic pathology—despite the fact that all mental processes are neurobiological and thus "organic." The functional/organic distinction encodes a Cartesian dualism that contemporary neuroscience has largely abandoned, yet it persists in clinical language. As Groopman observes, labeling

pain as "functional" often signals epistemic closure: the physician has ceased investigation [2].

Similarly, terms like "medically unexplained symptoms" or "psychosomatic" carry implicit judgments. They suggest that the patient's suffering lacks objective reality or stems from psychological rather than physiological causes. Yet as Groopman demonstrates, symptoms frequently defy explanation not because they are imaginary but because medical knowledge remains incomplete. The language of "unexplained" symptoms deflects attention from the limits of medical understanding onto the patient's psyche [2].

Ungar-Sargon's work on "the crisis of language in therapeutic spaces" provides a philosophical foundation for understanding these linguistic failures [13]. He argues that medical language has become degraded—reduced to technical jargon that obscures rather than illuminates the human reality of illness [13]. Drawing on theological conceptions of language as inherently meaningful and revelatory, he proposes that clinical discourse must recover its capacity to honor the sacred dimensions of suffering rather than merely categorizing symptoms [13]. This requires what he terms "sacred listening"—a mode of attention that recognizes the patient's narrative as containing wisdom that exceeds biomedical categories [14].

Groopman also explores how metaphors shape clinical reasoning. Describing cancer as an "enemy" to be "fought" with "aggressive" treatment frames therapeutic decisions in militaristic terms, potentially biasing physicians toward intervention over palliation. Describing diabetes as a "management" problem emphasizes control and compliance, potentially obscuring the social determinants and systemic inequalities that shape disease outcomes [2]. These metaphors are not incidental; they structure thought and guide action.

Epistemic Humility and Diagnostic Excellence

Groopman's prescription for improving clinical judgment centers on epistemic humility—recognizing the limits of medical knowledge and the fallibility of clinical reasoning. He advocates for metacognition: physicians should actively reflect on their own thought processes, questioning initial hypotheses and seeking disconfirming evidence [2].

Effective clinicians, in Groopman's account, cultivate several epistemic virtues:

- *Curiosity: Maintaining openness to alternative explanations rather than prematurely closing inquiry.*
- *Tolerance for ambiguity: Resisting the pressure to provide definitive answers when uncertainty persists.*
- *Attention to narrative: Listening carefully to patients' stories, including details that fall outside standard diagnostic categories.*
- *Reflexivity: Monitoring one's own emotional responses, biases, and cognitive shortcuts [2].*

These virtues stand in tension with the institutional demands of contemporary medicine: productivity pressures, documentation requirements, and the expectation of diagnostic certainty. Groopman's work thus reveals a structural contradiction: medicine demands both epistemic humility and authoritative judgment, both cautious deliberation and efficient decision-making. This contradiction cannot be resolved through individual effort alone; it requires institutional reform.

Ungar-Sargon's theological framework offers resources for navigating this tension by reconceptualizing the physician-patient relationship in covenantal rather than contractual terms [7]. A contractual model treats the clinical encounter as an economic exchange governed by reciprocal obligations; a covenantal model recognizes it as a sacred bond that transcends transactional logic [7]. This shift, he argues, creates space for genuine epistemic humility because the physician's authority derives not from omniscience but from the willingness to accompany the patient through uncertainty [7,14].

The Myth of Mental Illness

Thomas Szasz's critique of psychiatry represents the most radical challenge to medical epistemology [15]. Szasz argued that "mental illness" is not a literal disease but a metaphor—a way of medicalizing moral, social, and existential problems. Psychiatric diagnoses, in his view, are not discoveries of natural kinds but social constructions that extend medical authority into realms properly belonging to ethics, law, and politics.

Szasz distinguished between diseases of the brain (neurological disorders with identifiable pathophysiology) and diseases "of the mind" (psychiatric diagnoses defined by behavioral and experiential criteria) [15]. The former involve demonstrable biological lesions; the latter involve judgments about appropriate conduct, normal emotion, and acceptable thought. By classifying certain behaviors as illnesses, psychiatry transforms moral and political questions into medical problems—a process Szasz termed "the medicalization of deviance" [15].

This medicalization serves multiple functions. It provides a humanitarian alternative to punitive responses to disturbing behavior; it offers relief from moral responsibility for those diagnosed; and it legitimates state intervention in the name of treatment rather than punishment. Yet it also extends medical authority over increasingly broad domains of human experience. Sadness becomes major depressive disorder; shyness becomes social anxiety disorder; childhood misbehavior becomes oppositional defiant disorder. Each reclassification expands the jurisdiction of psychiatry and the pharmaceutical industry [15].

Szasz's critique is not merely philosophical but political. He observed that psychiatric diagnosis has historically been used to suppress dissent and enforce conformity. Soviet psychiatry diagnosed political dissidents with "sluggish schizophrenia"; American psychiatry pathologized homosexuality until 1973; contemporary psychiatry diagnoses "oppositional defiant disorder"

in children who resist authority [15,16]. In each case, the language of mental illness transforms political, moral, or social conflicts into individual pathologies requiring medical intervention.

Ungar-Sargon's work on "spiritual crisis and the crisis of psychiatry" extends Szasz's critique by arguing that contemporary psychiatry systematically pathologizes experiences of existential and spiritual significance [17]. Drawing on phenomenological and theological frameworks, he demonstrates how states that traditional cultures recognize as mystical experiences, dark nights of the soul, or spiritual emergencies are routinely diagnosed as psychotic episodes or mood disorders [17]. This diagnostic imperialism, he argues, reflects not merely professional overreach but a fundamental epistemological failure: the inability of materialist biomedicine to recognize dimensions of human experience that exceed its conceptual apparatus [17].

The Epistemological Status of Psychiatric Categories

Szasz's epistemological critique centers on the nature of psychiatric classification. Unlike diseases defined by pathophysiology, psychiatric disorders are defined by committees that vote on diagnostic criteria. The DSM is not a scientific textbook but a political document produced through negotiation among professional guilds, government agencies, and pharmaceutical companies [16]. Diagnostic boundaries shift with each edition, not because of new scientific discoveries but because of changing social norms and economic incentives.

Consider the case of ADHD (Attention-Deficit/Hyperactivity Disorder). Prior to the 1980s, hyperactive children were described in moral terms (as undisciplined) or educational terms (as requiring different pedagogical approaches). The creation of ADHD as a psychiatric diagnosis transformed this behavioral pattern into a brain disorder requiring pharmaceutical treatment [16]. Yet the neurobiological basis of ADHD remains contested, diagnosis relies entirely on behavioral observation, and treatment outcomes vary widely. Is ADHD a genuine disease entity or a medicalization of normal variation in temperament and attention?

Szasz would argue that such questions cannot be answered scientifically because they involve normative judgments disguised as empirical claims. To diagnose ADHD is not to discover a pre-existing natural kind but to impose a particular interpretive framework—one that privileges pharmaceutical intervention over educational reform, individual pathology over environmental design, and medical authority over parental judgment [15].

Constructive Critiques of Psychiatric Epistemology

While Szasz's libertarian conclusions (abolishing involuntary commitment, ending insurance coverage for psychotherapy) remain controversial, his epistemological critique has been influential. Subsequent scholars have developed more nuanced accounts of psychiatric classification that acknowledge both its social construction and its clinical utility.

Allan Horwitz and Jerome Wakefield distinguish between "normal

sadness" (appropriate responses to loss and adversity) and genuine depressive disorder [18]. They argue that the DSM has eliminated context from diagnosis, pathologizing normal human suffering. However, unlike Szasz, they maintain that some psychiatric conditions represent genuine dysfunctions requiring treatment.

Ian Hacking's concept of "making up people" illuminates how psychiatric categories create new ways of being [19]. Once a diagnosis becomes culturally available, people begin to experience themselves in those terms, producing feedback loops between classification and experience. Borderline personality disorder, dissociative identity disorder, and chronic fatigue syndrome are not purely discovered or purely invented; they emerge through complex interactions between medical discourse, patient experience, and social context [19].

The epistemological lesson is that psychiatric diagnosis operates differently from diagnosis in other medical specialties. It involves irreducible interpretive and normative dimensions that cannot be eliminated through more rigorous science. Recognizing this does not invalidate psychiatry but requires acknowledging the limits of its epistemological claims and the ethical responsibilities attendant on diagnostic power.

Professional Power and Medical Monopoly

Eliot Freidson's sociology of medicine provides essential context for understanding medical epistemology [3]. Freidson argued that medicine's cognitive authority—its ability to define health, illness, and appropriate treatment—derives not primarily from scientific validity but from professional power. Medicine is a monopoly, legally empowered to control access to its own domain through licensing, credentialing, and the exclusive right to prescribe treatments and authorize medical leave.

Freidson distinguished between technical knowledge (scientific understanding of disease) and social authority (the right to make binding judgments about illness) [3]. While medicine's technical knowledge is extensive, its social authority exceeds its scientific certainty. Physicians claim expertise not only over clearly defined biomedical conditions but also over ambiguous symptoms, lifestyle behaviors, and existential concerns. This expansive jurisdiction is maintained through professional control over medical education, research funding, and the legal definition of medical practice [3].

The language of medicine serves this monopolistic function. Specialized terminology creates barriers to entry, ensuring that only those with extensive training can speak authoritatively about illness. Latin-derived nomenclature, statistical concepts, and knowledge of pharmaceutical mechanisms constitute a form of "guild knowledge"—expertise that validates professional status and excludes lay participation [3]. As Andrew Abbott observed, professions maintain their monopolies not primarily through superior effectiveness but through control over abstract knowledge systems [20].

This professional dominance shapes medical epistemology in

several ways. First, it determines what counts as legitimate medical knowledge. Research conducted by physicians is granted epistemic authority; patient experience and alternative healing traditions are marginalized as "anecdotal" or "unscientific." Second, it structures the physician-patient relationship as fundamentally asymmetrical: the physician knows; the patient experiences. Third, it resists external accountability, claiming that only physicians can evaluate physician performance—a claim that protects the profession from scrutiny but also from learning [3].

Ungar-Sargon's critique of "medical orthodoxy" demonstrates how professional monopoly actively suppresses therapeutic innovations that challenge biomedical hegemony [21]. Drawing on historical examples ranging from osteopathy to acupuncture, he shows that medicine's gatekeeping function serves not patient welfare but professional self-interest, systematically excluding approaches that might prove effective but that lack institutional legitimacy [21]. His alternative framework, grounded in what he terms "dialogical practice," argues for democratizing medical knowledge production by validating multiple epistemologies rather than enforcing a single paradigm [21].

Freidson built on Talcott Parsons's concept of the "sick role" to analyze medicine's function as a system of social control [22]. Parsons argued that illness is not merely a biological state but a social role with specific rights and obligations. The sick person is exempted from normal responsibilities but obligated to seek medical treatment and cooperate with recovery efforts. The physician serves as gatekeeper, determining who legitimately occupies the sick role and who is malingering [22].

This gatekeeping function extends medical authority into economic and political domains. Physicians authorize medical leave, disability benefits, insurance claims, and legal accommodations. They determine who qualifies for psychotropic medications, surgical interventions, and experimental treatments. Each of these determinations involves not merely scientific judgment but also moral evaluation: Is this person truly sick? Is their suffering legitimate? Do they deserve medical resources? [3].

The language of diagnosis mediates these judgments. Certain diagnoses (cancer, heart disease, traumatic brain injury) confer unambiguous legitimacy; others (fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity) occupy contested epistemic territory. Patients with contested diagnoses must not only cope with their symptoms but also fight for recognition—a "double burden" that reflects medicine's gatekeeping function [3,23].

Challenges to Medical Dominance

Freidson's later work acknowledged growing challenges to medical dominance: the rise of managed care and corporate medicine, increasing patient activism and consumerism, and the proliferation of alternative and complementary medicine [24]. These developments have partially democratized medical knowledge, making information previously confined to professional circles

widely accessible through the internet and patient communities.

Yet professional dominance persists in modified form. While patients can access medical information, they cannot prescribe medications, order imaging studies, or authorize surgery. The legal monopoly remains intact, even as its legitimacy faces new challenges. Moreover, the expansion of medical jurisdiction continues: medicalization extends into new domains (sexual function, aging, cosmetic appearance, cognitive enhancement), often driven by pharmaceutical marketing rather than patient demand [25].

Understanding medical epistemology therefore requires attention to institutional structures and professional interests. Medical knowledge is not produced in isolation from social power; it emerges within specific institutional contexts that shape what questions are asked, what methods are validated, and what counts as evidence. The reform of medical epistemology cannot proceed without also reforming the professional structures that shape medical knowledge production.

Illness Narratives and Medical Anthropology

Medical anthropology challenges medicine's epistemological assumptions from a different direction: by insisting that illness is irreducibly cultural and meaningful. Arthur Kleinman, Byron Good, Margaret Lock, and others have demonstrated that illness categories are not universal natural kinds but culturally specific interpretations of bodily experience [4,5,26].

Disease versus Illness

Kleinman distinguishes between "disease" (the biomedical understanding of pathophysiology) and "illness" (the lived experience of suffering embedded in cultural meaning) [4]. Disease is what physicians diagnose; illness is what patients experience. The two do not map neatly onto each other. One can have disease without illness (asymptomatic hypertension) or illness without disease (medically unexplained symptoms). The relationship between disease and illness is mediated by culture, which provides the interpretive frameworks through which bodily experiences become meaningful [4].

This distinction reveals a fundamental epistemological gap. Biomedicine claims to study disease objectively, abstracting from cultural context and subjective meaning. Yet patients present with illnesses—suffering embedded in social relationships, cultural expectations, and personal history. When physicians translate illness into disease categories, something essential is lost. The patient's narrative—the story that makes suffering intelligible—is reduced to a constellation of symptoms. Meaning is sacrificed for measurement [4].

Kleinman advocates for a "meaning-centered" approach to medicine that attends to the explanatory models patients use to understand their suffering [4]. What do patients believe caused their illness? What do they think will help? What are they most worried about? These questions elicit not merely psychological

reactions to disease but the cultural frameworks that constitute illness as a meaningful experience. A physician who understands these frameworks can provide care that addresses not only biological dysfunction but also existential and social distress [4].

Ungar-Sargon's hermeneutic framework extends Kleinman's disease/illness distinction by proposing that the patient's narrative should be approached as a "sacred text" requiring interpretation [6]. Just as religious texts contain multiple layers of meaning accessible through different hermeneutic methods, so too does the patient's story of suffering contain dimensions that exceed literal biological interpretation [6]. This hermeneutic approach transforms the clinical encounter from interrogation into dialogue, from extraction of data into collaborative meaning-making [6,14].

The Narrative Construction of Clinical Reality

Byron Good's work extends this analysis to clinical practice itself, showing how medical discourse actively constructs clinical reality [5]. Good conducted ethnographic research in medical education, observing how students learn to "see" patients through biomedical categories. This learning involves not merely acquiring factual knowledge but also internalization of a particular "mode of engagement" with illness—one that brackets meaning in favor of mechanism [5].

Good describes diagnosis as a form of storytelling—not a transparent representation of nature but a narrative construction that imposes coherence on ambiguous symptoms [5]. Medical stories follow conventional plot structures: onset, progression, complication, resolution. They privilege certain actors (pathogens, immune systems, genetic mutations) while marginalizing others (poverty, workplace conditions, family dynamics). They employ characteristic literary devices: metaphor (the body as machine), synecdoche (the patient as "the MI in room 5"), and metonymy (elevated troponin standing in for myocardial infarction) [5].

These narrative conventions are not arbitrary but reflect medicine's epistemological commitments. By constructing illness as a natural history unfolding within individual bodies, biomedicine obscures the social and political dimensions of health. By fragmenting the patient's story into discrete symptoms and signs, it renders invisible the connections between bodily suffering and life circumstances. Good argues that recognizing medicine's narrative construction does not invalidate medical knowledge but highlights its partial and perspectival character [5].

Cultural Politics of Menopause

Margaret Lock's comparative ethnography of menopause in Japan and North America illustrates how supposedly universal biological processes are culturally constructed [26]. Lock found that Japanese women experience menopause differently from North American women—not merely interpreting the same symptoms differently but actually having different symptom profiles. Hot flashes, considered the paradigmatic menopausal symptom in North America, are relatively rare in Japan. Conversely, Japanese women report shoulder stiffness, a symptom Western medicine does not

associate with menopause [26].

This divergence cannot be explained by genetic differences alone; it reflects the cultural meaning of aging, femininity, and the life course. In North America, menopause is medicalized as estrogen deficiency requiring hormone replacement. In Japan, it is experienced as a natural life transition that may require adjustment but not medical intervention. The language used to describe menopause shapes experience: "estrogen deficiency" frames aging as pathology; "life transition" frames it as normal development [26].

Lock's work reveals that even ostensibly biological categories like "menopause" are culturally constructed. What counts as a symptom, what warrants treatment, and what constitutes normal aging are not universal givens but culturally variable judgments. Medical anthropology thus challenges the epistemological assumption that biomedicine discovers pre-existing natural kinds. Instead, it reveals how medical categories actively shape bodily experience—a process Anne Fausto-Sterling terms the "biological production of cultural categories" [27].

The Authority of Experience versus Professional Knowledge

Medical anthropology insists on the epistemological validity of patient experience. While biomedicine privileges professional knowledge—gained through training, research, and clinical experience—anthropology argues that patients possess complementary knowledge: intimate familiarity with their own bodies, understanding of how illness affects their lives, and expertise in navigating healthcare systems [4,5].

This creates an epistemological tension. Medicine claims that professional knowledge is superior because it is objective, systematic, and scientifically validated. Patients claim that experiential knowledge is superior because it is concrete, contextual, and personally meaningful. Neither claim is entirely correct. Professional knowledge without patient experience produces technically correct but humanly inadequate care; patient experience without professional knowledge can miss treatable conditions or embrace ineffective treatments.

The resolution lies not in privileging one form of knowledge over the other but in recognizing their complementarity. As Kleinman argues, effective clinical care requires "empathic witnessing"—physicians must enter imaginatively into patients' illness experience while also bringing biomedical knowledge to bear [4]. This requires epistemic humility: acknowledging that medical knowledge is partial, that patients know things physicians cannot, and that healing involves addressing meaning as well as mechanism.

Ungar-Sargon's concept of "epistemology versus ontology in therapeutic practice" offers a theological framework for understanding this complementarity [28]. Drawing on Kabbalistic notions of *tzimtzum* (divine contraction), he argues that the physician must practice a form of epistemic self-limitation—

contracting their authoritative knowledge to create space for the patient's experiential knowledge to emerge [28]. This parallels the divine act of self-limitation that, in Kabbalistic thought, creates space for creation itself. The therapeutic relationship thus becomes a sacred partnership in which healing emerges from the dialogue between different ways of knowing [28].

The Politics of Classification: DSM, ICD, and the Bureaucratization of Diagnosis

The languages of medical classification—particularly the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD)—represent the apex of medical epistemology's bureaucratic rationalization. These taxonomies claim to organize medical knowledge systematically, yet they also reflect institutional politics, economic incentives, and cultural ideologies [16,29].

The DSM has undergone five major revisions since its first edition in 1952, each dramatically reorganizing psychiatric nosology [16]. These revisions are presented as scientific progress—accumulating knowledge correcting previous errors. Yet scholarship on the DSM's development reveals a more complex picture: diagnostic categories emerge through committee negotiations influenced by professional turf battles, pharmaceutical industry lobbying, insurance reimbursement policies, and cultural anxieties [16,29].

Allan Frances, chair of the DSM-IV task force, later expressed regret about diagnoses he helped create or expand, acknowledging that the manual pathologized normal human variation and fueled epidemic overdiagnosis [30]. The successive lowering of diagnostic thresholds for ADHD, bipolar disorder, and autism spectrum disorder reflected not new scientific discoveries but changed consensus about acceptable behavior. These changes had profound social consequences: exponential increases in psychiatric medication, expanding markets for pharmaceutical companies, and altered self-understandings for millions of people [20].

The DSM's claim to atheoretical objectivity is particularly problematic. The manual purports to describe mental disorders without theoretical commitments about their causes. Yet the very decision to classify distress categorically rather than dimensionally, to define disorders by symptoms rather than etiology, and to treat psychiatric conditions as individual pathologies rather than social problems—all involve theoretical commitments that privilege certain research programs and clinical approaches over others [16].

The ICD, maintained by the World Health Organization, classifies all diseases, not merely psychiatric ones [29]. Its primary function is administrative: enabling international comparison of mortality and morbidity statistics, standardizing insurance billing, and facilitating public health surveillance. Yet this administrative function shapes clinical epistemology in consequential ways.

ICD coding pressures physicians to fit patient presentations into predefined categories. Ambiguous or atypical cases must be forced into available codes to generate billable diagnoses. Complex

multimorbidity is reduced to ranked lists of discrete conditions. The richness of clinical presentation—the patient's narrative, the social context, the existential dimensions of suffering—is compressed into alphanumeric codes [29].

This is what Max Weber termed "rationalization": the systematic organization of social life according to calculable rules [31]. Medical rationalization enables bureaucratic management of healthcare but at the cost of reducing patients to data points and physicians to technicians implementing standardized protocols. As Freidson observed, this rationalization threatens medicine's claim to be a profession (requiring independent judgment) by transforming it into a bureaucracy (requiring rule-following) [3].

Cultural Imperialism and Local Biologies

Medical anthropologists have criticized the ICD and DSM for imposing Western categories on non-Western contexts [32]. Depression, for instance, is a culture-bound syndrome reflecting Western individualism and the valorization of emotional expression. In many Asian cultures, psychological distress is expressed somatically—through headaches, fatigue, or digestive complaints—rather than through affective symptoms. Forcing these presentations into Western diagnostic categories can distort clinical understanding and lead to inappropriate treatment [32].

Lock's concept of "local biologies" captures this point: biological processes are shaped by cultural practices and environmental conditions, producing population-level variation in disease presentation [26]. Standardized international classifications erase this variation, treating human biology as universally identical. While standardization facilitates research and public health surveillance, it also represents a form of epistemological imperialism—the imposition of particular knowledge systems on diverse populations.

The politics of classification thus extends beyond national borders, reflecting and reinforcing global power hierarchies. Western biomedicine claims universality while often reflecting culturally specific assumptions. Recognizing the culturally situated nature of medical categories does not require abandoning classification but demands greater reflexivity about the epistemic assumptions embedded in diagnostic systems.

Diagnostic Uncertainty and Epistemic Humility

One of the most consequential yet under-acknowledged features of medical epistemology is uncertainty. Despite medicine's scientific sophistication, vast domains of clinical practice remain characterized by incomplete knowledge, ambiguous evidence, and contested interpretations [33]. Yet medical culture often struggles to acknowledge uncertainty, creating pressure for premature diagnostic closure and authoritative pronouncements that exceed evidential support.

Groopman estimates that diagnostic errors occur in 10-15% of clinical encounters, though the true rate is unknown because many errors remain undetected [2]. Autopsies routinely reveal major

diagnoses that were missed during life. Even when diagnoses are technically correct, they often fail to capture the full complexity of patient's conditions—comorbidities, medication side effects, social determinants of health, and the interaction between physical and psychological suffering [2].

Several factors contribute to diagnostic uncertainty:

- *Symptom nonspecificity: Most symptoms (pain, fatigue, nausea, dizziness) have numerous potential causes, making differential diagnosis challenging.*
- *Atypical presentations: Diseases frequently present differently from textbook descriptions, especially in elderly, pediatric, or immunocompromised patients.*
- *Evolving presentations: Early in disease courses, diagnostic features may not yet be apparent, requiring watchful waiting rather than immediate diagnosis.*
- *Limited time: Productivity pressures allow insufficient time for thorough history-taking and examination.*
- *Cognitive biases: As Gropman documents, heuristics that usually serve physicians well can lead systematically astray [2].*

Despite this pervasive uncertainty, medical culture pressures physicians toward diagnostic confidence. Patients want answers; institutions demand efficiency; legal liability creates defensive medicine; professional identity is bound up with authoritative expertise. These pressures discourage acknowledgment of uncertainty and create conditions for epistemic overreach.

The Functions of "Trash Bucket" Diagnoses

When physicians cannot identify a definitive biomedical explanation, they often resort to what disability scholar Susan Wendell calls "trash bucket diagnoses"—vague labels like "functional disorder," "chronic pain syndrome," or "medically unexplained symptoms" [23]. These labels acknowledge symptom reality while maintaining uncertainty about etiology. However, they often function to close inquiry rather than maintain productive uncertainty.

As Gropman observes, functional diagnoses frequently end investigation: having labeled pain as functional, physicians may not pursue additional workup even when new symptoms emerge [2]. The label becomes a cognitive stop sign, signaling that further investigation is unwarranted. Moreover, functional diagnoses carry stigma. They implicitly suggest that symptoms stem from psychological causes, malingering, or symptom exaggeration—attributions that damage therapeutic relationships and leave patients feeling disbelieved [2,23].

Alternative approaches to diagnostic uncertainty exist. Physicians can acknowledge uncertainty explicitly, explaining what is known and unknown while committing to ongoing investigation. They can employ "working diagnoses"—provisional explanations subject to revision as new information emerges. They can involve patients as collaborators in diagnostic reasoning, pooling professional and experiential knowledge. Yet these practices require time,

institutional support, and cultural validation that current medical systems often fail to provide [23].

Epistemic Humility as Professional Virtue

Kathryn Montgomery's account of medicine as an "imperfect science" argues that clinical reasoning cannot be fully algorithmic or evidence-based because it involves applying general knowledge to particular cases—an interpretive act requiring judgment [34]. While evidence-based medicine has improved clinical practice by demanding rigorous evaluation of interventions, it cannot eliminate uncertainty. Randomized trials produce probabilistic generalizations; individual patients present with unique combinations of pathology, comorbidity, and life circumstances. The application of population-level evidence to individual cases requires what Aristotle called "practical wisdom" (phronesis)—judgment honed through experience [34].

This recognition supports epistemic humility as a professional virtue. Physicians should acknowledge the limits of their knowledge, remain open to alternative interpretations, and avoid premature closure. Yet epistemic humility exists in tension with other professional values: decisiveness, confidence, and the obligation to provide answers. Balancing these competing values requires institutional support—cultures that validate uncertainty, time for deliberation, mechanisms for second opinions, and protection from liability when cautious approaches delay diagnosis [33,34].

Gropman's prescription for reducing diagnostic error emphasizes metacognitive strategies: physicians should actively question their initial hypotheses, seek disconfirming evidence, consider alternative diagnoses, and consult colleagues when uncertain [2]. These practices require not merely individual commitment but institutional cultures that reward thoughtfulness over efficiency, deliberation over speed, and humility over authority.

Narrative Medicine and Epistemic Justice

A recurring theme across Foucault, Szasz, Kleinman, and Gropman is the marginalization of patient voices within medical epistemology. While patients initiate clinical encounters by reporting symptoms, their narratives are quickly translated into professional language, fragmented into discrete symptoms, and subordinated to physician interpretation. Medical epistemology privileges professional knowledge over patient experience, objective data over subjective meaning, measurement over narrative.

The Wounded Storyteller

Arthur Frank's *The Wounded Storyteller* argues that illness disrupts personal narrative: the predictable life story is interrupted by bodily breakdown, medical uncertainty, and the prospect of disability or death [35]. To regain agency, patients must author new narratives—stories that incorporate illness while maintaining personal identity. Yet medical institutions discourage patient storytelling. Clinical encounters are structured to elicit information efficiently; medical records fragment narratives into problem lists and billing codes;

physicians interrupt patients within seconds of their beginning to speak [35].

Frank identifies three narrative types of patients employ to make sense of illness: restitution narratives (emphasizing cure and return to normalcy), chaos narratives (expressing suffering that overwhelms meaning-making), and quest narratives (finding meaning or purpose through illness) [35]. Each reflects different relationships to medical authority. Restitution narratives align with biomedicine's curative goals; chaos narratives resist medical sense-making; quest narratives appropriate illness for personal growth. Physicians comfortable only with restitution narratives may pathologize or dismiss chaos and quest narratives as maladaptive coping [35].

Narrative Medicine

Rita Charon's program of "narrative medicine" seeks to restore narrative to clinical practice [36]. Narrative medicine trains physicians in close reading, reflective writing, and empathic listening—skills borrowed from literary studies and applied to clinical care. The goal is not merely improved communication but epistemic transformation: recognizing that patient narratives contain knowledge essential to diagnosis and treatment [36].

Charon argues that attention to narrative reveals dimensions of illness invisible to biomedical examination: the social context of suffering, the patient's explanatory models, the impact of illness on identity and relationships, and the moral significance of medical decisions [36]. A narrative approach transforms the clinical encounter from interrogation to collaborative sense-making. Rather than extracting information to fit predetermined categories, physicians enter into dialogue, seeking to understand illness from the patient's perspective [36].

Critics argue that narrative medicine, while valuable, does not fundamentally challenge medical power structures. Physicians still control diagnostic authority and treatment decisions; narrative simply becomes additional data to be extracted and interpreted professionally. Unless narrative medicine is accompanied by institutional reforms that democratize medical decision-making, it risks becoming what Nancy Tomes calls "therapeutic ventriloquism"—physicians speaking for patients in narrative form while maintaining professional dominance [37].

Ungar-Sargon's hermeneutic framework addresses this limitation by proposing that the patient's narrative possesses inherent authority that cannot be subsumed under professional interpretation [6,14]. Just as sacred texts in theological hermeneutics possess authority that exceeds any single interpretation, so too does the patient's lived experience contain truths that physicians must receive rather than master [6]. This requires what he terms "sacred listening"—a mode of attention that recognizes the patient as teacher, not merely object of study [14]. Such listening transforms the power dynamics of the clinical encounter by acknowledging multiple sources of valid knowledge [14].

Epistemic Injustice in Medicine

Miranda Fricker's concept of "epistemic injustice" illuminates systematic ways certain social groups are wronged in their capacity as knowers [38]. Testimonial injustice occurs when someone's testimony is given less credibility due to prejudice; hermeneutical injustice occurs when someone lacks conceptual resources to understand their own experience. Both forms are prevalent in medicine.

Women, racial minorities, disabled people, and psychiatric patients systematically face testimonial injustice: their reports of pain, symptoms, and treatment preferences are discounted or dismissed [38,39]. Physicians interrupt women more frequently than men, take women's pain reports less seriously, and attribute women's symptoms to anxiety or "hysteria" [39]. Black patients receive less aggressive pain management than white patients with identical symptoms, reflecting racist stereotypes about pain tolerance [40]. Disabled patients report that physicians assume poor quality of life and recommend aggressive treatments or withholding of treatments based on disability bias rather than patient preferences [41].

Hermeneutical injustice occurs when medical language lacks categories for certain experiences. Before the concept of "sexual harassment" existed, women lacked language to articulate their experiences; they knew something was wrong but had no way to name it. Similarly, patients with contested illnesses—fibromyalgia, chronic fatigue syndrome, long COVID—often struggle for years without diagnosis, lacking conceptual resources to make sense of their suffering [23,38]. When medicine eventually recognizes these conditions, it validates patient experience while also subjecting it to professional interpretation and control.

Addressing epistemic injustice requires not merely improved communication but structural change: diversifying the medical profession, including patients in research design and guideline development, validating patient-generated knowledge, and developing mechanisms for patients to challenge professional judgment without retaliation. These reforms would democratize medical epistemology, recognizing that patients possess forms of knowledge essential to good care.

Ungar-Sargon's critique of healthcare bias demonstrates how epistemic injustice is embedded in the very structure of clinical reasoning [42]. Drawing on research into interoception and unconscious bias, he shows that physicians' bodily responses—their gut feelings about patients—are shaped by implicit biases that systematically disadvantage marginalized groups. These somatic biases operate below conscious awareness, making them resistant to explicit commitments to equity. Addressing epistemic injustice thus requires not merely cognitive reform but embodied transformation—what he calls "embodied clinical practice" that cultivates bodily awareness and interoceptive literacy [42].

Toward a Hermeneutic Medical Epistemology: Synthesis and Vision

Having examined medical epistemology through multiple lenses—

Foucault's archaeology of discourse, Groopman's cognitive science, Szasz's political critique, Freidson's sociology, Kleinman and Good's anthropology, and Ungar-Sargon's theological hermeneutics—we can now articulate a synthetic vision for reforming medical knowledge production and clinical practice.

Five fundamental insights emerge from this analysis:

First, medical language is not neutral but constitutive: it constructs the objects of medical knowledge while also establishing professional authority and marginalizing alternative ways of knowing. From Foucault's medical gaze to Szasz's critique of psychiatric labeling to Ungar-Sargon's analysis of language degradation in therapeutic spaces, we see that diagnostic categories are social constructions with profound consequences for patient experience and social order.

Second, diagnostic reasoning is fallible, shaped by cognitive biases, linguistic habits, and institutional pressures. Groopman's empirical studies demonstrate that medical knowledge is produced through interpretive practices vulnerable to systematic error. Improving clinical judgment requires not only better scientific knowledge but also metacognitive awareness, epistemic humility, and institutional cultures that validate uncertainty.

Third, professional power shapes medical knowledge in consequential ways. Freidson's sociology reveals that medicine's cognitive authority depends on monopolistic control over specialized knowledge, licensing, and the authority to define legitimate illness. This professional dominance serves some functions (ensuring competence, protecting patients) while also resisting accountability and marginalizing alternative knowledge sources. Ungar-Sargon's critique of medical orthodoxy demonstrates how this monopoly actively suppresses therapeutic innovations that challenge biomedical hegemony.

Fourth, illness is culturally constructed and individually meaningful. Medical anthropology demonstrates that disease categories are not universal natural kinds but culturally specific interpretations of bodily experience. Effective care requires attending to the meanings patients ascribe to suffering, not merely the biological mechanisms underlying symptoms. Ungar-Sargon's hermeneutic framework provides theological resources for conceptualizing the patient's narrative as possessing sacred authority that demands respectful interpretation rather than reductive translation.

Fifth, medical epistemology systematically marginalizes patient knowledge and experience. Despite rhetoric about patient-centered care, institutional structures privilege professional interpretation over patient testimony, objective data over subjective experience, and standardized categories over individual narratives. Addressing epistemic injustice requires democratizing medical knowledge production and decision-making while cultivating embodied practices that honor multiple sources of valid knowledge.

Ungar-Sargon's concept of "the parabolic world" offers a distinctive

contribution to medical epistemology by integrating Kabbalistic wisdom with clinical hermeneutics [43]. Drawing on the Jewish mystical tradition that views creation as continuous divine revelation—a "Book of Nature" requiring ongoing interpretation—he proposes that the therapeutic encounter should be understood as a site of sacred meaning-making [43].

The parabolic model holds that just as parables in religious traditions convey multiple layers of meaning (literal, allegorical, moral, mystical), so too do patients' illness narratives contain dimensions that exceed biomedical interpretation [43]. The physician's task is not merely to decode symptoms into diagnoses but to engage in collaborative hermeneutics—interpreting the patient's story alongside the patient, acknowledging that ultimate meaning may remain elusive yet seeking understanding nevertheless [43].

This model challenges the presumption that medical epistemology should aspire to univocal certainty. Instead, it embraces what Ungar-Sargon terms "sacred ambiguity"—the recognition that human suffering contains depths that resist complete comprehension. This does not mean abandoning scientific rigor or diagnostic precision; rather, it means situating biomedical knowledge within a larger framework that honors mystery, meaning, and the irreducible particularity of individual experience [43].

Reforming Clinical Practice

Translating these theoretical insights into practical reforms requires changes at multiple levels:

Educational reform: Medical training should incorporate explicit instruction in medical epistemology, helping future physicians understand how knowledge is constructed, how biases operate, and how professional power shapes clinical reasoning. This includes training in hermeneutic methods, narrative medicine, and critical reflection on the social dimensions of diagnosis.

Institutional transformation: Healthcare organizations should create structures that support epistemic humility—time for deliberation, mechanisms for second opinions, protection from liability when uncertainty is acknowledged, and quality metrics that reward thoughtful care rather than mere efficiency. Ungar-Sargon's vision of "revising healthcare" calls for economic restructuring that prioritizes healing relationships over profit maximization [44].

Clinical practices: Physicians should cultivate specific epistemic practices:

- *Sacred listening: Approaching patient narratives as containing wisdom that exceeds biomedical categories, requiring respectful interpretation rather than reductive translation [14].*
- *Acknowledging uncertainty: Explicitly discussing what is known and unknown, avoiding false confidence, and engaging patients as collaborators in ongoing diagnostic reasoning [2,33].*
- *Hermeneutic flexibility: Holding multiple interpretive frameworks simultaneously, recognizing that different*

perspectives illuminate different dimensions of illness [6,43].

- *Embodied awareness: Cultivating interoceptive literacy to recognize how implicit biases shape clinical judgment at the somatic level [42].*

Patient empowerment: Healthcare systems should include patients in knowledge production through participatory research, patient advisory councils, and mechanisms for challenging professional judgment. The goal is not to eliminate professional expertise but to create dialogical relationships in which different forms of knowledge complement rather than subordinate each other [21].

Covenantal rather than contractual relationships: Following Ungar-Sargon's theological framework, the physician-patient relationship should be reconceptualized in covenantal terms—as a sacred bond that transcends transactional logic and creates mutual obligations grounded in compassion rather than mere contract [7]. This shift reframes the epistemological encounter: knowledge emerges from relationship, not merely from technical expertise applied to passive objects.

Epistemology and Ontology

Perhaps Ungar-Sargon's most profound contribution to medical epistemology is his application of the Kabbalistic concept of *tzimtzum* (divine contraction) to the therapeutic relationship [41]. In Kabbalistic cosmology, God contracts the divine presence to create space for finite creation; similarly, the physician must practice epistemic self-limitation—contracting authoritative knowledge to create space for the patient's experiential knowledge to emerge [41].

This *tzimtzum* model resolves the apparent tension between professional expertise and patient authority by reframing epistemology itself. Knowledge is not something the physician possesses and imposes but something that emerges in the space between physician and patient when the physician relinquishes claims to omniscience. The act of epistemic contraction paradoxically enables fuller knowledge—not despite but because of its humility [41].

This theological insight has practical implications: it suggests that the most epistemologically rigorous clinical practice involves not maximizing professional control but creating conditions for genuine dialogue. The physician who can diagnose without silencing, who can name without negating, who can wield authority while acknowledging limits—such a physician embodies the epistemic virtues necessary for humanistic medicine.

Conclusion: Healing the Language of Medicine

This extended analysis reveals medical epistemology as simultaneously scientific and social, cognitive and political, individual and institutional. The way medicine knows is inseparable from the power it exercises, the language it employs, and the institutional structures that shape knowledge production.

Medical epistemology stands at a crossroads. The reductionist paradigm that has dominated biomedicine for two centuries—rooted in Cartesian dualism, mechanistic materialism, and the presumption of objective neutrality—faces mounting challenges. From Foucault's historical analysis to Groopman's cognitive science to Szasz's political critique to Kleinman's anthropology to Ungar-Sargon's theological hermeneutics, diverse voices converge on a common insight: medicine's greatest strength—its language of precision—becomes its greatest danger when it silences the patient or shields the profession from critique.

The reform of medicine, therefore, is not only institutional but linguistic. Healing must begin in the dialogue between words and wounds, knowledge and humility. The path forward requires:

- *Acknowledging the constructed nature of medical categories without abandoning systematic classification*
- *Recognizing professional power's role in shaping knowledge while maintaining appropriate expertise*
- *Attending to cultural variation and meaning alongside biological mechanisms*
- *Validating patient experience as epistemologically authoritative alongside professional knowledge*
- *Embracing uncertainty and ambiguity as intrinsic to the human condition rather than failures to be eliminated*
- *Cultivating sacred listening and hermeneutic sensitivity that honors the depths of human suffering*

Ungar-Sargon's parabolic model offers a particularly generative vision: viewing the therapeutic encounter as a site of ongoing revelation where meaning emerges through dialogue, where multiple interpretations coexist, and where the physician's epistemic humility creates space for genuine healing relationships [43]. This model does not reject biomedical science but situates it within a larger framework that honors mystery, respects patient authority, and recognizes the sacred dimensions of human suffering.

The epistemology of medicine must evolve from monologic certainty to dialogic wisdom—from the presumption that knowledge flows unidirectionally from expert to patient toward recognition that healing emerges from the space between different ways of knowing. The physician who can diagnose without silencing, who can name without negating, who can wield authority while practicing *tzimtzum* (epistemic self-limitation)—such a physician restores both science and humanity to their rightful balance.

Ultimately, medical epistemology must become hermeneutic: recognizing that the patient is not merely a biological system to be decoded but a sacred text to be interpreted with reverence, a parable containing layers of meaning, a fellow human being whose suffering calls forth not merely technical expertise but compassionate witness. In this transformation lies the possibility of a medicine that knows without dominating, that heals without violating, that serves life in all its irreducible complexity.

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